AGENDA
REGULAR MEETING OF THE EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

Tuesday, October 18, 2022 – 5:30 pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

1-669-900-9128, MEETING CODE: 934-2874-7401#. No participant code. Just press #.

To watch the meeting livestream, please visit: http://www.elcaminohealthcaredistrict.org/meetingstream
Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

PURPOSE: The purpose of the District shall be (i) to establish, maintain and operate, or provide assistance in the operation of, one or more health facilities (as that term is defined in California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District; (ii) to acquire, maintain and operate ambulances or ambulance services within or without the District; (iii) to establish, maintain and operate, or provide assistance in the operation of free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and such other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the District; and (iv) to do any and all other acts and things necessary to carry out the provisions of the District's Bylaws and the Local Health District Law.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julia Miller, Board Chair		**5:30 – 5:31pm**
2.	**SALUTE TO THE FLAG**	Dan Woods, CEO		**information 5:31 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julia Miller, Board Chair		**information 5:33 – 5:34**
4.	**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	Julia Miller, Board Chair		**information 5:34 – 5:37**
5.	**COMMUNITY BENEFITS SPOTLIGHT** **RESOLUTION 2022-11: DAY WORKER CENTER OF MOUNTAIN VIEW**	Julia Miller, Board Chair Jon Cowan, Senior Director, Government Relations and Community Partnerships Maria Marroquin, Executive Director, Day Worker Center of Mountain View	*public comment*	**motion required 5:37 – 5:47**
6.	**CONSENT CALENDAR** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Continuation of Resolution 2021-10; AB361 b. Minutes of the Open Session of the District Board Meeting (05/17/22) c. Resolution 2022-08: Appointment of FY23 El Camino Hospital Board Member Ad Hoc Committee Advisory Members d. FY22 Year-End Community Benefit Report	Julia Miller, Board Chair	*public comment*	**motion required 5:47 – 5:50**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Information e. Community Benefit Sponsorship Report f. Report on Covid-19 Community Program g. FY23 Pacing Plan h. Board Educational Activity Report – Director Zoglin i. Board Educational Activity Report – Director Somersille			
7.	**EL CAMINO HEALTHCARE DISTRICT** Possible Compensation Modification	John Zoglin, Board Member		**discussion** **5:50 – 6:00**
8.	**EL CAMINO HEALTHCARE DISTRICT BOARD MEMBER TRANSITION TO W-2 EMPLOYEES** District Board Members Healthcare Benefits	Deanna Dudley, CHRO	*public comment*	**possible motion** **6:00 - 6:15**
9.	**ECHD FY22 FINANCIALS** a. FY23 Period 2 b. Year End Stand-Alone Financial Statements	Carlos Bohorquez, CFO	*public comment*	**motion required** **6:15 – 6:25**
10.	**FY22 AUDITED FINANCIAL REPORT**	Carlos Bohorquez, CFO Joelle Pulver, Moss Adams		**discussion** **6:25 – 6:35**
11.	**COMMUNITY BENEFITS** a. Annual Adoption of Community Benefit Grants Policy b. FY24 Community Benefit Board Policy Guidance and FY23 Update	Jon Cowan, Senior Director, Government Relations and Community Partnerships	*public comment*	**motion required** **6:35 – 6:50**
12.	**ADJOURN TO CLOSED SESSION**	Julia Miller, Board Chair	*public comment*	**motion required** **6:50 – 6:51**
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julia Miller, Board Chair		**information** **6:52 – 6:53**
14.	**CONSENT CALENDAR** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* - Minutes of the Closed Session of the District Board Meeting (05/17/22)	Julia Miller, Board Chair		**motion required** **6:53 – 6:54**
15.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - FY22 Audited Financial Report	Carlos Bohorquez, CFO Joelle Pulver, Moss Adams		**discussion** **6:54 – 7:04**
16.	Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – CEO: - FY22 El Camino Healthcare Distict CEO Review	Julia Miller, Board Chair		**discussion** **7:04 – 7:19**
17.	Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – Senior Management: - Executive Session	Julia Miller, Board Chair		**discussion** **7:19 – 7:24**
18.	**ADJOURN TO OPEN SESSION**	Julia Miller, Board Chair		**motion required** **7:14– 7:25**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julia Miller, Board Chair		**information 7:25 – 7:26**
20.	**FY22 AUDITED FINANCIAL REPORT**	Julia Miller, Board Chair	*public comment*	**motion required 7:26– 7:27**
21.	**BOARD COMMENTS**	Julia Miller, Board Chair		**discussion 7:27 – 7:29**
22.	**ADJOURNMENT**	Julia Miller, Board Chair	*public comment*	**motion required 7:29 – 7:30pm**

Upcoming Meetings: December 14, 2022; February 8, 2023; March 28, 2023; June 20, 2023

Education Session: May 16, 2023

Presenters and speakers: Please remove your masks and annunciate when speaking; thank you.

RESOLUTION 2022-11

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

WHEREAS, the Board of Directors of the El Camino Healthcare District values and wishes to recognize the contribution of individuals who serve the District's community as well as individuals who exemplify the El Camino Healthcare District's mission and values.

WHEREAS, the Board wishes to honor and recognize the Day Worker Center of Mountain View for providing healthy meals and health education classes for day workers and their family members.

The El Camino Healthcare District and the Day Worker Center of Mountain View began a partnership in fiscal year 2016 to alleviate food insecurity, reduce stress, and provide mental and emotional support to low-income community members.

WHEREAS, the Board would like to acknowledge the Day Worker Center of Mountain View for its commitment to providing healthy, nutritious and culturally relevant meals as well as emotional support, healthy lifestyles skills training, nutrition education classes and workshops on important health related topics. Through this grant program, the Day Worker Center has served more than 2,550 individuals in the community with more than 30,000 services.

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

DAY WORKER CENTER OF MOUNTAIN VIEW

IN WITNESS THEREOF, I have here unto set my hand this **18 DAY OF OCTOBER, 2022.**

EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS:

Peter C. Fung, MD • Julia E. Miller • Carol A. Somersille, MD

George O. Ting, MD • John Zoglin

CAROL A. SOMERSILLE, MD
SECRETARY/TREASURER
EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District (ECHD) Board of Directors
From: Mary Rotunno, General Counsel
Date: October 18, 2022
Subject: Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings

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

Summary:

1. Situation: At the October 19, 2021 Board Meeting, the Board of Directors adopted Resolution 2021-10, which made findings to continue holding virtual public meetings under the Ralph M. Brown Act based on the continued state of emergency due to the COVID-19 pandemic and that either (a) the state of emergency continues to directly impact the ability to meet safely in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing.

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

2. Authority: On March 17, 2020, in response to the COVID-19 pandemic, Governor Newsom issued Executive Order N-29-20 suspending certain provisions of the Brown Act in order to allow local legislative bodies to conduct meetings telephonically or by other means.

   On June 11, 2021, Governor Newsom issued Executive Order N-08-21, which placed an end date of September 30, 2021, for agencies to meet remotely.

   On September 16, 2021, Governor Newsom signed Assembly Bill 361 (2021) ("AB 361") which allows for local legislative and advisory bodies to continue to conduct meetings via teleconferencing if the Board of Directors, by majority vote, make the findings set forth in paragraph 1 above, not later than thirty (30) days after teleconferencing for the first time under the AB 361 rules, and every 30 days thereafter.

3. Background: ECH outside counsel at Best Best & Krieger, LLP ("BB&K"), reviewed the legislation and prepared Resolution 2021-10.

List of Attachments:

AB 361 - Continuation of Resolution 2021-10
January 25, 2022

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

Suggested Board Discussion Questions:

1. None

RESOLUTION 2021-10

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

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

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

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

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

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

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

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

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

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

meet safety in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing;

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

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

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

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

WHEREAS, the Board of Directors desires to balance the rights of members of the public to participate in all Board meetings with the rights of the Board of Directors and District staff to conduct the meetings in a safe environment.

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

1. The Board of Directors finds and determines that, as a result of the COVID-19 pandemic emergency, meetings in which the public attends in-person on the campus of the Hospital would present imminent risks to the health and safety of the Board of Directors, District staff, members of the public, Hospital staff and patients of the Hospital.

2. The Board of Directors finds and determines that conducting meetings in a hybrid in-person/teleconference model provides the safest environment for the Board of Directors and District staff to conduct business, while allowing for maximum public participation.

3. The Board of Directors finds and determines that the Health Officer of the County of Santa Clara has recommended measures to promote social distancing as one means to reduce the risk of COVID-19 transmission.

4. The Board of Directors shall conduct teleconference meetings under AB 361 in accordance with the requirements of AB 361, found in subdivision (e) of Government Code section 54953.

5. Through the duration of the state of emergency, if the Board of Directors desires to continue utilizing teleconferencing meetings under the special provisions of AB 361, the Board of Directors will make findings by majority vote not later than thirty (30) days after this meeting (or, if there is no meeting within thirty (30) days of this meeting, at the start of the next meeting), and not later than every thirty (30) days thereafter (or, if there is no meeting within thirty (30) days thereafter, at the start of the next meeting), that the Board of Directors has reconsidered the circumstances of the state of emergency and that either (a) the state of emergency continues to directly impact the ability of the public to meet safely in person, or (b) that state or local officials continue to impose or recommend measures to promote social distancing.

PASSED AND ADOPTED at the regular meeting of the Board of Directors of El Camino Healthcare District held on October 19, 2021 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

DocuSigned by:
Julia Miller
30CE6DD9439C4ED...
El Camino Healthcare District,
Chair

DocuSigned by:
Carol A. Somersett
A58D6F7047A140C...
El Camino Healthcare District,
Secretary

Minutes of the Open Session of the
El Camino Healthcare District Board of Directors
Tuesday, June 14, 2022

Pursuant to Government code section 54953(e)(1), El Camino Health will not be providing a physical location to the public for this meeting. Instead, the public is invited to join the open session meeting via teleconference at:

Board Members Present	Board Members Absent	Members Excused
Peter C. Fung, MD Vice-Chair **Julia E. Miller**, Chair **Carol A. Somersille, MD** Secretary/Treasurer **George O. Ting, MD** **John Zoglin**		None

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	Chair Miller called to order the open session of the Regular Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 5:30 pm and reviewed the logistics for the meeting. A verbal roll call was taken; all Board members were present at the roll call, and a quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.	***Call to Order at 5:30 pm.***
2. SALUTE TO THE FLAG	Chair Miller asked Dan Woods, CEO, to lead all present in the Pledge of Allegiance.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Miller asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
4. PUBLIC COMMUNICATION	There was no public communication.	
5. CONSENT CALENDAR	Chair Miller asked if any member of the Board or the public wished to remove an item from the consent calendar. Director Ting requested to remove item 5a – Minutes of the Open Session of the 5/17/2022 District Board Meeting for changing the typo of Billion to Million. Director Zoglin requested to remove items5b – FY23 Regular Meeting Dates: Resolution 2022-07, and 5c – FY23 Operating Budget – ECHD and ECH & Affiliates for discussion. Director Zoglin asked for further clarification on the following items: • Page 110 regarding M&O Taxes and trajectory. • How the investment income is calculated, and what is it based on? Mr. Bohorquez clarified that the M&O Tax number is an estimate and conservative regarding potential economic slowdown. The investment income is based on district funds in the balance sheet and is a combination of 28.3M in Board designated funds, 2.4M in short term, and 17.6M in cash equity.	***The consent calendar was approved.***

	Motion: To approve the consent calendar with the correction to 5a: a. Minutes of the Open Session of the El Camino Healthcare District Board Meeting (05/17/2022) b. FY23 Regular Meeting Dates: Resolution 2022-07 c. FY23 Operating Budget – ECHD and ECH & Affiliates d. FY23 Pacing Plan e. Community Benefits Sponsorship Report **Movant:** Ting **Second**: Somersille **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	
6. APPOINTMENT OF LIAISON TO THE COMMUNITY BENEFIT ADVISORY COUNCIL	Chair Miller called for a motion to appoint Director Carol Somersille as Liaison to the Community Benefit Advisory Council. **Motion:** To approve the Appointment of Liaison to the Community Benefit Advisory Council **Movant:** Fung **Second**: Ting **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Appointment of Liaison to the Community Benefit Advisory Council was approved.***
7. APPOINTMENT OF FY23 HOSPITAL BOARD MEMBER REAPPOINTMENT AD HOC COMMITTEE ***Resolution 2022-08***	Chair Miller called for a motion to appoint Director Peter Fung to the FY23 Hospital Board Ad Hoc Committee. **Motion:** To approve Resolution 2022-008, Appointment of FY23 Hospital Board Member Reappointment Ad Hoc Committee **Movant:** Somersille **Second**: Ting **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Appointment of FY23 Hospital Board Members Reappointment Ad Hoc Committee was approved.***
8. EL CAMINO HEALTH DISTRICT MISSION STATEMENT REVIEW AD HOC COMMITTEE RECOMMENDATION	Director Somersille requested the Ad Hoc Committee's continuation to receive additional staff feedback to create a purpose statement. Chair Miller stated the Ad Hoc Committee's duties to have been completed with the changes to the Mission Statement. Chair Miller called for a motion to approve the recommended changes in the El Camino Health District Mission Statement. **Motion:** To approve El Camino Health District Mission Statement Review Ad Hoc Committee Recommendation **Movant:** Fung **Second**: Ting **Ayes:** Fung, Miller, Somersille, Ting, Zoglin	***El Camino Health District Mission Statement Review Ad Hoc Committee Recommendation was approved.***

	Noes: None **Abstentions**: None **Absent**: None **Recused**: None	
9. REQUESTING FOR AND CONSENTING TO CONSOLIDATION FOR ELECTION ***Resolution 2022-09***	Chair Miller informed the Members that elections are completed every 2 years, with Directors Ting and Fung up for re-election on November 8th, 2022. This resolution is to call upon candidates and the nomination period is open on July 18th and closes on August 12th. Each candidate will provide a statement, 400 words or less, and pay for their filing fee. **Motion:** To approve Resolution 2022-09, the Requesting for and Consenting to Consolidation for Election **Movant:** Somersille **Second**: Zoglin **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Resolution 2022-09 was approved.***
10. FY22 YTD ECHD FINANCIAL REPORT	Carlos Bohorquez, Chief Financial Officer, presented the FY22 YTD Financials and highlighted the following: • Increase of 20% in Patient Accounts Receivable in Current Assets • Board Designated Assets increased from 587M to 694M • Decreased in Long Term Investment from 603M to 515M • Decreased in Deferred Revenue from 67M to 28M associated with the repayment of Medicare vast payment as part of the Cares Act • Fund Balance, retained earnings, increased by 54M in the first 10 months of the fiscal year Mr. Bohorquez concluded that we are favorable in Patient Volume in the last 10 months of the fiscal year. Revenue is up by 19% when compared to the same timeframe as last year. Attribute to a strong recovery across the Service Lines. Chair Miller requested a line item at the Year End Budget for FY22: Outside Counsel Expenses. **Motion:** To approve FY22 YTD ECHD Financial Report **Movant:** Ting **Second**: Fung **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***FY22 YTD ECHD Financial Report was approved.***
11. ESTABLISHING TAX APPROPRIATION LIMIT FOR FY23 (GANN LIMIT)	Michael Walsh, Controller, reported that annually, the District Board must set the Tax Appropriation Limit (Gann Limit) for the following fiscal year and asked for approval of Resolution 2022-10 to the following measurements:	***Resolution 2022-10 was approved.***

Resolution 2022-10	1. For FY23, use the following measurement to calculate the District's change in the cost of living: a. The percentage change in the California per capita personal income from the preceding year (7.55%). 2. For FY23, use the following measurement to calculate the change in population in 2 primary areas: a. The county declined by 13K community members. Therefore the change in population within the County is a -0.0069%. b. The change within the District with an increase of 1500 community members. Therefore an increase to 0.0054% **Motion:** To approve Resolution 2022-10, Establishing appropriation Limit for FY23 (Gann Limit). **Movant:** Somersille **Second**: Ting **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	
12. DISTRICT CAPITAL OUTLAY FUNDS	Ken King, CASO, reported that The El Camino Hospital District has $9,750,831 of Capital Outlay Funds from the fiscal year 2020 that must be allocated for a land or building project greater than 100K and useful life of 10 years or more. He provided a brief history of allocated projects from 2014 and 2018. Mr. King is requesting to allocate the 2020 funds to the campus completion project bringing the total to $18,694,798. **Motion:** To approve District Capital Outlay Funds **Movant:** Zoglin **Second**: Fung **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***District Capital Outlay Funds were approved.***
13. FY23 COMMUNITY BENEFIT PLAN	Jonathan Cowan, Senior Director, Relations and Community Partnerships reviewed the FY23 Community Benefits Plan with the Board of Directors, focusing on incorporating feedback from the May Study Session and proposed actions for the FY23 and future community grant funding. **Motion:** To approve FY23 Community Benefit Plan **Movant:** Ting **Second**: Somersille **Ayes:** Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung **Recused**: None	***FY23 Community Benefit Plan was approved.***
14. ADJOURN TO CLOSED SESSION	To adjourn to closed session at 6:43 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed	***Adjourned to closed***

	Session of the District Board Meeting (05/17/2022), pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO. **Motion:** To approve to adjourn to closed session at 6:34 pm. **Movant:** Zoglin **Second**: Miller **Ayes**: Miller, Somersille, Ting**,** Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung **Recused**: None	***session at 6:34 pm.***
15. AGENDA ITEM 19: RECONVENE TO OPEN SESSION/ REPORT OUT	The open session of the El Camino Healthcare District Board of Directors was reconvened at 7:37 pm. Agenda items 15-18 were addressed in the closed session. During the closed session, the Board approved the closed session minutes of the May 17, 2022, El Camino Healthcare District Board of Directors by all Board Members present. (Directors Fung, Miller, Somersille, Ting, and Zoglin).	***Open Session reconvened at 7:37 pm.***
16. AGENDA ITEM 20: BOARD COMMENTS	None were noted.	
17. AGENDA ITEM 21: ADJOURNMENT	**Motion**: To adjourn at 7:38 pm. **Movant:** Ting **Second**: Somersille **Ayes:** Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung **Recused**: None	***Meeting adjourned at 7:38 pm.***

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

_____
Julia E. Miller
Chair, ECHD Board

_____
Carol Somersille, MD
Secretary/Treasurer, ECHD Board

Prepared by: Michele Collaco, Executive Assistant II
Reviewed by: Stephanie Iljin, Manager, Administration

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Julia E. Miller, Board Chair
Date: October 18, 2022
Subject: Revised Resolution 2022-08 Appointment of FY23 El Camino Hospital Board Member Reappointment Ad Hoc Committee Chair, Member, and Advisors.

Recommendation(s): To approve Revised Resolution 2022-08

Summary:

1. Situation: Two of the current El Camino Hospital ("ECH") Board Members (Julie Kliger and Bob Rebitzer) have terms expiring on June 30, 2023.

2. Authority: Pursuant to the Board-approved "Process for Appointment and Reappointment of Non-District Board Members to the El Camino Hospital Board of Directors" (the "Process"), the District Board appoints an Ad Hoc Committee to consider the reappointment of the ECH Board members whose terms are set to expire at the end of the upcoming fiscal year.

3. Background: The Process provides that the Committee will consist of two members of the ECHD Board. It also provides that the ECHD Board will appoint up to two advisors:

- The El Camino Hospital Board Chair should refer:
  - One Hospital Board Director who is not a member of the District Board and serving on the ECH Governance Committee; and
  - One Hospital Board Director who is not a member of the District Board

A. Article VII, Section 1 of the El Camino Healthcare District Bylaws, as further reviewed by General Counsel, provides for the Board Chair to appoint the Chairperson of the Committee and may self-appoint.

B. The Process allows the Board to appoint the other member of the Committee and up to two advisors. El Camino Healthcare District Membership includes Julia Miller, AdHoc Committee Chairperson, and Peter Fung, MD.

- Recommended appointment of the following advisory members as nominated by the Hospital Board Chair, Bob Rebitzer.
  - Jack Po, Ph.D., MD, El Camino Hospital Vice Chair.
  - Lanhee Chen, Ph.D., Chair of the Governance Committee,

4. Other Reviews: None

5. Outcomes: Appointment of Jack Po and Lanhee Chen as advisory members to the Ad Hoc Committee to consider the reappointment of ECH Board Members Julie Kliger and Bob Rebitzer to the ECH Board of Directors.

List of Attachments: None.

Suggested Board Discussion Questions: None.

EL CAMINO HEALTHCARE DISTRICT
REVISED RESOLUTION 2022-08
APPOINTMENT OF SPECIAL ADVISORY COMMITTEE FOR LIMITED PURPOSE AND LIMITED DURATION

WHEREAS, the Board of Directors has determined it is necessary to carefully consider and prepare for the reappointment or appointment of Directors to the El Camino Hospital Board,

WHEREAS, such work can be undertaken by a special advisory committee for presentation to and consideration by the Board of Directors at a future meeting; now, therefore, be it.

RESOLVED, that a temporary advisory special committee ("The El Camino Hospital Board Member Reappointment Ad Hoc Committee"), consisting of two members is hereby established pursuant to Article VII, Section 1 of the Bylaws of the El Camino Healthcare District, to carefully consider and prepare for the FY 2023 appointment or reappointment of one or more Directors to the El Camino Hospital Board.

RESOLVED, that the members of the temporary advisory special committee shall determine the time, place, date, and frequency of such committee meetings; be it further.

RESOLVED, that Julia E. Miller is appointed as Chair of the temporary advisory special committee; be it further

RESOLVED, that Peter Fung, MD, shall also serve as a member of the committee having been appointed by the El Camino Healthcare District Board of Directors; be it further

RESOLVED, that Lanhee Chen, shall serve as an advisor of the Committee, having been nominated by the Chair of the El Camino Hospital Board; be it further

RESOLVED, that Jack Po, MD, shall serve as an advisor of the Committee, having been nominated by the Chair of the El Camino Hospital Board.

DULY PASSED AND ADOPTED at a regular meeting held on October 18, 2022, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Carol A. Somersille, MD, Secretary
ECHD Board of Directors

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Senior Director, Government Relations and Community Partnerships
Date: October 18, 2022
Subject: FY22 Yearend Community Benefit (CB) Report

Purpose: To provide the FY22 Community Benefit Annual Report and the Yearend Grants Performance

Summary:

1. Situation: At the conclusion of each fiscal year, Community Partnerships staff review yearend grant reports to assess metric and budget performance against targets as well as review qualitative information on program successes, challenges and trends. Staff prepares an annual report and yearend dashboard (Attachments 1 and 2).

The report is also available online:
www.elcaminohealthcaredistrict.org/communitybenefit2022

2. Authority: The report is prepared by the Community Partnerships staff and approved by the Senior Director of Government Relations and Community Partnerships prior to presentation to the Board.

3. Background: In FY22, El Camino Healthcare District invested $7,744,739 in Community Benefit grants and sponsorships to address unmet local health needs. The framework for the grant funding priorities is the most recent El Camino Hospital Community Health Needs Assessment (CHNA), which is conducted every three years, as required by state and federal regulations.

A. **Grants** = $7,405,442 for 57 grants:
- 18 Healthcare Access & Delivery grants at $4,175,822
- 17 Behavioral Health grants at $1,474,900
- 13 Diabetes &Obesity grants at $1,120,822
- 4 Chronic Conditions treatment and prevention (other than diabetes and obesity) grants at $191,940
- 5 Economic Stability grants at $441,958

B. **Sponsorships** = $50,200 for 12 sponsorships

C. **COVID-19 testing and vaccinations** = $289,097 (included in $7,744,739 total)

D. **Grants Performance** is reflected in the yearend dashboard (Attachment 2):
- Community Health Themes
  - Demand rebounded for basic and preventive healthcare services, including dental services. Since so many people delayed care during the pandemic, this often meant that patients had a backlog of needs and/or were higher acuity.

- Grant partners transitioned back to in-person services and/or developed hybrid models for delivering their programs.
- Many grant partners noted challenges including rising costs for basic supplies and staffing shortages.
- Several agencies reported a shortage in availability of doctor appointments, especially for specialist care.
- While schools returned to in-person learning, many struggled with staffing shortages and high acuity student needs (especially for mental health services). Agencies that collaborate with schools were mostly able to return to providing services, despite challenges with re-establishing the partnerships with school administrators and educators.

- All Programs:
  - 79% of grants met or exceeded 90% across all of their metrics (FY21 = 68%)
  - Over 48,000 community members served – 11% over target (FY21: 57,000 served)
- Largest grant programs ($100k+):
  - 22 grants = $5,720,787 (77% of total grant spend)
  - 81% of grants met or exceeded 90% across all of their metrics (FY21=63%)
  - Over 31,000 community members served (FY21: 29,600 served)

- Performance of the Top 5 Largest Grants:

Agency	Awarded Amount	Metric Performance	Performance Narrative
Ravenswood Family Health Network	$1,300,000	92%	The clinic added dental and optometry services this year and continued to provide critical primary care services with multilingual staff. They also continued to provide COVID-19 vaccination clinics and focused on COVID outreach and education. They saw an increase in patients below 200% FL: ~90% of ECHD patients below 200% compared to 78% at midyear, and a decrease in uninsured: ~16% compared to 31% at midyear. Like other health care agencies during the pandemic, they had staffing challenges and worked to strengthen their HR department, which helped fill vacant positions.
Valley Medical Center - County of Santa Clara Health System	$530,000	95%	County of Santa Clara Health System – Valley Medical Center performed strongly in FY22. They were not able to meet their goal in reducing their no show rate, which can be attributed to continuing concerns with COVID, particularly with patients who have underlying health concerns.
South Asian Heart Center	$300,000	99%	In FY22, SAHC continued to optimize their virtual delivery options, which now include smartphone apps, and were able to reach over 100 additional community members compared to FY21. They also expanded their relationships in the community through monthly

			outreach events with community organization, schools, corporations, and physicians.
Momentum for Health	$290,000	88%	The La Selva Clinic is meeting a large unmet mental health need in the Latinx community with 81% of clients Spanish speaking. They struggled with volume metrics as many referrals do not meet ECHD geographic requirements. Agency has made progress in new referral partnerships, including with Sunnyvale Community Services, and is seeing improved consistency in referrals.
Agency	**Awarded Amount**	**Metric Performance**	**Performance Narrative**
Sunnyvale School District - School Nurse Program	$287,000	95%	During this first full year back to in-person school since the pandemic began, the School Nurse team led enforcement of COVID isolation and quarantine. Program was able to complete mandated health screenings despite COVID challenges. They met all metrics except 'Kindergarteners with a well-child,' which was achieved at 80% of target. Parents reported challenges with accessing medical appointments and some were still hesitant to take children to appointments due to the pandemic.

- Underperforming Grants (overall performance across all of an agency's metrics 74% or below):

Agency	**Awarded Amount**	**Metric Performance**	**Performance Narrative**
Mountain View Whisman – School Nurse Program	$280,000	65%	Mountain View Whisman was unable to meet the metric "students with failed screenings who saw a provider". Several factors contributed to the decreased number of students who received follow-up care following a vision or hearing referral. First, due to new COVID testing measures this school year, screenings for hearing and vision were delayed. Secondly, staffing challenges reduced the district's ability to follow up as effectively. Additionally, they did not meet the metric "students who report decreased anxiety levels" due to staffing changes, limited resources and time, and COVID restrictions which did not enable them to implement GoNoodle (mindfulness program). Due to the standardization of SNP metrics next year, this metric will not be included in FY23.
Los Altos School District – Mental Health Program	$100,000	74%	Los Altos School District performed strongly in 3 of its 4 metrics. However, the last metric, "Parents who report improvement in their child by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report for students age 10 and under" was marked as "0%", bringing their overall metric performance down. Regarding this metric, LASD was not successful in getting parents to take the pre and post SDQ measures. LASD

			will plan on adjusting this measurement for ease of delivery to parents.
Living Classroom Living Classroom (cont'd)	$60,000	66%	Living Classroom achieved 0% of the metric "student journaling work that demonstrates a change in eating habits or behavior that shows liking fresh fruits or vegetables more". This was because student journaling could not occur this year, since there were no tasting activities with the usual accompanying reflections. Due to COVID-19, eating/ tasting activities were eliminated. They achieved 30% of the goal "pounds of produce grown in school gardens for school lunches." It was difficult to anticipate how much would be produced and donated in 2021-2022. They made a "best estimate," not knowing when tasting and food preparation would resume. Living Classroom garden staff also experienced several unexpected issues: 1) gardens beds at several schools are within construction zones, therefore reducing the beds that could be utilized for growing; 2) water lines being turned off, resulting in a loss of crops, 3) aging beds that required a rebuild of outdated irrigation systems and beds being unused during the improvements. Apart from these two metrics that were impacted by COVID conditions, Living Classroom performed highly on their remaining metrics (students served, number of encounters, and teacher evaluations). The two metrics above will not be included in FY23. Our staff has worked with Living Classroom's Executive Director to create more meaningful metrics that reflect the efficacy of the program (services provided [number of nutrition and physical activity lessons], number of participants reporting increased consumption of fruits and vegetables, increased knowledge of healthy habits).
Palo Alto Medical Foundation – 5-2-1-0	$25,000	72%	Funding was paused in FY23 due to two consecutive years of poor performance and returned funds. Exploring options for filling the need through other partners.
Silicon Valley Bicycle Coalition	$25,000	52%	Had issues with staffing turnover and therefore were unable to hold their anticipated number of events. The events they were able to hold were well attended and successful.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

FY22 Yearend Community Benefit (CB) Report
October 18, 2022

1. FY22 Community Benefit Annual Report Executive Summary for the Board with full online report at: www.elcaminohealthcaredistrict.org/communitybenefit2022
2. FY22 El Camino Healthcare District Community Benefit Grants Yearend Dashboard

Suggested Board Discussion Questions: N/A- This is an informational item.

El Camino Healthcare District | El Camino Health

Community Benefit Annual Report FY 2022 — Executive Summary

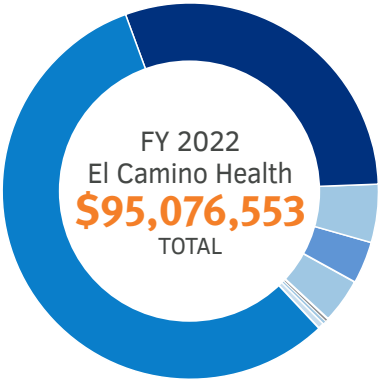
Our Commitment to Community Health

The steadfast support to our community during fiscal year 2022 has never been greater. The programs funded through our community benefit grants are a vital lifeline to basic needs and health resources for our neighbors. The **Community Benefit FY 2022 online report** highlights our investments including:

- **The Hospital's Total Community Benefit commitment of $95 Million – $7.8 Million more than last year – serving 253,160 people.** This includes charity care, community grants and more to serve vulnerable and underserved community members. See the financial report.
- **$11 Million combined total for 140 grants and sponsorships.** The District and the Hospital work with community partners to prevent disease, improve mental health, and make healthcare and healthy choices more accessible. See our community partners.
- **Providing four COVID-19 pop-up vaccination clinics** at local schools, administering nearly **19,500 COVID-19 tests** and donating **5,040 N95 masks and 4,440 at-home test kits** to schools and community service agencies. Learn how we and our partners supported the community's recovery.

Financial Report

$95M El Camino Health
TOTAL COMMUNITY BENEFIT



$53,629,517	Government-Sponsored Healthcare (Unreimbursed Medi-Cal)
$28,706,416	Subsidized Health Services
$4,730,832	Financial Assistance (Charity Care)
$3,300,189	Grants and Sponsorships
$3,863,728	Health Professions Education
$272,611	Clinical Research
$247,606	Community Benefit Operations
$325,654	Community Health Improvement Services

+$112M in Uncompensated Medicare
(Not Included in Community Benefit Total)

Please take a moment to visit **elcaminohealth.org/CommunityBenefit2022** and learn more about how we are addressing unmet health needs in our community.

EL CAMINO HEALTHCARE DISTRICT

El Camino Health

EL CAMINO HEALTHCARE DISTRICT

Community Benefit FY22 Yearend Grant Metrics Dashboard

- In June 2021, the ECHD Board of Directors approved $7,546,000 for 57 grants for FY22
- This Dashboard reflects FY22 yearend and two prior years' grant performance
    - Please note that there has been a change to how the overall metric performance is calculated and reported on the dashboard. Overall performance is now calculated by averaging the percentage met across each agencies' metrics. These columns are also now followed by the same color coding system as the individual metrics (green, yellow and red dots) to help highlight the agencies overall metric performance. Previously, the metric performance was a count of the metrics met at 90%+, which did not provide a comprehensive, accurate summary of overall performance.
- Grants are organized by three priority areas: Healthy Body, Healthy Mind & Healthy Community; Support Grants (≤$30k) are in the second section
- FY22 Metric Data: Columns X – AG
- Historical performance: Columns D – W
- See legend in footer for metric performance indicators
    - A dash " – " represents either 1) Program is new so no metrics from prior year(s), or 2) New metric, no historical data

EL CAMINO HEALTHCARE DISTRICT

Performance against target: ● = 90%+ ● = 75% - 89% ● = 0% - 74%

Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
HEALTHY BODY	**CSA-MV** ***Senior Intensive Case Management*** **FY23 Approved: $228,000** FY22 Approved: $228,000 FY22 Spent: $228,000 FY21 Approved: $210,000 FY21 Spent: $210,000 FY20 Approved: $235,000 FY20 Spent: $218,623 New Metrics: 0 of 5	Older adults served	52	74	●	100%	●	85	86	●	100%	●	50	69	●	100%	●	77	81	●	100%	●	54	85	●	100%	●	88	93	●	100%	●
		Services provided	2,250	2,804	●			4,750	5,322	●			2,250	4,194	●			4,500	9,853	●			2,400	5,191	●			4,800	9,280	●		
		Clients who were not re-hospitalized within 1 - 30 days for reasons related to a chronic health condition	90%	99%	●			90%	98%	●			90%	100%	●			90%	99%	●			92%	96%	●			92%	98%	●		
		Clients who were not re-hospitalized within 31 - 90 days for reasons related to a chronic health condition	85%	99%	●			85%	98%	●			85%	100%	●			85%	100%	●			90%	96%	●			90%	98%	●		
		Patients with hypertension who attained or maintained blood pressure <140/90 mmHg or blood pressure goal recommended by physician	65%	72%	●			65%	75%	●			70%	74%	●			70%	76%	●			70%	80%	●			70%	74%	●		
	Cupertino Union School District *School Nurse Program* **FY23 Approved: $100,000** FY22 Approved: $100,000 FY22 Spent: $100,000 FY21 Approved: $100,000 FY21 Spent: $100,000 FY20 Approved: $81,921 FY20 Spent: $81,921 New Metrics: 2 of 6	Students served	885	889	●	100%	●	1,770	1,640	●	98%	●	800	746	●	94%	●	1,550	1,454	●	99%	●	350	386	●	100%	●	700	1,124	●	98%	●
		Students who failed a health screening who saw a healthcare provider	-	-				-	-				-	-				-	-				25%	27%	●			35%	33%	●		
		Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	-	-				-	-				-	-				-	-				15%	16%	●			30%	28%	●		
		First grade students out of compliance with required physicals who become compliant	-	-				-	-				N/A	N/A				15%	62%	●			N/A	N/A				20%	38%	●		
		Students in TK, Kindergarten & 7th grade non-compliant with required vaccines who become compliant	-	-				-	-				25%	57%	●			50%	87%	●			35%	79%	●			50%	82%	●		
		Students who are out compliance with TB testing who become compliant	-	-				-	-				15%	40%	●			30%	88%	●			20%	80%	●			35%	85%	●		
	Fresh Approach **FY23 Approved: $73,500** FY22 Approved: $93,000 FY22 Spent: $93,000 FY21 Approved: $93,000 FY21 Spent: $93,000 FY20 Approved: $93,000 FY20 Spent: $93,000 New Metrics: 1 of 5	Individuals served	1,070	1,749	●	100%	●	2,240	2,359	●	84%	●	451	558	●	100%	●	1,602	1,917	●	88%	●	1,100	301	●	27%	●	2,401	1,013	●	88%	●
		Mobile Farmers' Market clients who report increasing their fruits and vegetable consumption by 1 serving per day since starting to shop with this program	N/A	N/A				70%	N/A				N/A	N/A				70%	50%	●			N/A	N/A				70%	100%	●		
		Mobile Farmers' Market clients who complete surveys will report that they purchase at least 50% of their weekly fruits and vegetables from this mobile market	-	-				-	-				N/A	N/A				75%	60%	●			N/A	N/A				75%	81%	●		
		VeggieRx participants who attend 6 or more classes will lose 2% or more of their original body weight	-	-				-	-				-	-				-	-				N/A	N/A				20%	45%	●		
		VeggieRx participants who attend 6 or more classes will report an increase of 1 additional serving of fruits and vegetables per day at the end of the program	-	-				-	-				N/A	N/A				85%	93%	●			N/A	N/A				75%	73%	●		
	Healthier Kids Foundation *HearingFirst & DentalFirst* FY22 Approved: $40,000 FY22 Spent: $40,000 FY21 Approved: $40,000 FY21 Spent: $37,380 FY20 Approved: $40,000 FY20 Spent: $40,000	Children dental screened	225	322	●	75%	●	450	385	●	90%	●	225	0	●	0%	●	450	170	●	53%	●	100	203	●	82%	●	450	362	●	91%	●
		Children hearing screened	225	399	●			450	417	●			N/A	N/A				226	164	●			100	199	●			450	378	●		
		Of children dental screened who received a referral, the percent that received and completed appropriate dental services	75%	77%	●			75%	60%	●			60%	0%	●			62%	75%	●			60%	17%	●			60%	72%	●		
		Of children hearing screened who received a referral, the percent that received and completed appropriate hearing services	20%	0%	●			35%	41%	●			N/A	N/A				30%	0%	●			21%	45%	●			21%	65%	●		
	Living Classroom **FY23 Approved: $60,000** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $ 60,000 FY21 Spent: $60,000 FY20 Approved: $78,000 FY20 Spent: $78,000 New Metrics: 4 of 5	Students served	3,300	3,600	●	93%	●	4,200	4,092	●	77%	●	2,500	2,814	●	100%	●	3,600	3,176	●	47%	●	2,460	2,204	●	98%	●	3,000	2,937	●	66%	●
		Encounters (Number of student attendance encounters with school-day lessons)	-	-				-	-				-	-				-	-				2,460	3,724	●			8,750	11,970	●		
		Pounds of produce grown in school gardens for school lunches	-	-				-	-				-	-				-	-				250	259	●			1,200	354	●		
		Teacher evaluations that average 4 or higher	-	-				-	-				-	-				-	-				80%	98%	●			95%	95%	●		
		Student journaling work that demonstrates a change in eating habits or behavior that shows liking fresh fruits or vegetables more	-	-				-	-				-	-				-	-				N/A	N/A				50%	0%	●		
	Medical Respite FY22 Approved: $50,000 FY22 Spent: $50,000 FY21 Approved: $80,000 FY21 Spent: $80,000 FY20 Approved: $80,000 FY20 Spent: $80,000 New Metrics: 0 of 3	Patients served in full program	105	94	●	95%	●	190	183	●	97%	●	105	88	●	91%	●	190	188	●	99%	●	90	67	●	82%	●	180	140	●	85%	●
		Hospital days avoided for total program (based on full Medical Respite program)	400	376	●			760	732	●			400	352	●			760	752	●			360	268	●			720	560	●		
		Patients linked to Primary Care home	92%	93%	●			92%	93%	●			92%	93%	●			92%	93%	●			92%	91%	●			92%	91%	●		
	Mountain View Whisman School District *School Nurse Program* **FY23 Approved: $290,000** FY22 Approved: $280,000 FY22 Spent: $280,000 FY21 Approved: $275,000 FY21 Spent: $275,000 FY20 Approved: $240,000 FY20 Spent: $227,614 New Metrics: 0 of 5	Students served	1,950	2,010	●	100%	●	3,900	4,019	●	75%	●	1,985	1,811	●	97%	●	3,970	3,622	●	65%	●	1,800	1,762	●	98%	●	3,600	3,617	●	65%	●
		Students with failed screenings who saw a provider	N/A	N/A				70%	37%	●			N/A	N/A				45%	0%	●			N/A	N/A				45%	22%	●		
		Students needing a Child Health and Disability Program exam who saw a provider	40%	43%	●			60%	53%	●			10%	39%	●			35%	49%	●			30%	36%	●			55%	45%	●		
		Students needing an oral health exam who saw a provider	30%	31%	●			70%	42%	●			10%	16%	●			40%	53%	●			30%	29%	●			60%	57%	●		
		Students who report decreased anxiety levels	N/A	N/A				70%	N/A				N/A	N/A				60%	0%	●			N/A	N/A				75%	0%	●		

Community Benefit Dashboard Notes

- ● A metric receives a "green" indicator if performance against target is 90% - 100+%
- ● A metric receives a "yellow" indicator if performance against target is 75% - 89%
- ● A metric receives a "red" indicator if performance against target is 0% - 74%

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 HEALTHCARE DISTRICT

Performance against target: ● = 90%+ ● = 75% - 89% ● = 0% - 74%

Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
	New Directions *Coordination of care and connection to safety-net services for homeless and at-risk individuals* **FY23 Approved: $220,000** FY22 Approved: $220,000 FY22 Spent: $220,000 FY21 Approved: $220,000 FY21 Spent: $220,000 FY20 Approved: $180,000 FY20 Spent: $180,000 New Metrics: 0 of 5	Individuals served	26	27	●	100%	●	36	40	●	100%	●	30	24	●	88%	●	44	47	●	93%	●	50	95	●	94%	●	79	146	●	97%	●
		Services provided	520	717	●			900	1,375	●			1,000	772	●			1,400	1,256	●			1,060	798	●			1,700	1,883	●		
		Enrolled patients in need of mental health or substance abuse treatment or services will be referred to and seen by a treatment provider	55%	88%	●			75%	81%	●			60%	67%	●			75%	62%	●			70%	71%	●			75%	64%	●		
		Enrolled clients will be connected to and establish services with a minimum of one basic needs benefits program	75%	93%	●			80%	90%	●			75%	71%	●			90%	85%	●			75%	93%	●			95%	96%	●		
		Enrolled patients will complete treatment within twelve months or less	N/A	N/A				95%	93%	●			N/A	N/A				95%	93%	●			N/A	N/A				95%	94%	●		
	On-Site Dental *Mobile Dental Services* **FY23 Approved: $200,000** FY22 Approved: $200,000 FY22 Spent: $200,000 FY21 Approved: $90,000 FY21 Spent: $90,000 New Metrics: 0 of 4	Individuals served	-	-		New Program in FY21		-	-		New Program in FY21		60	110	●	100%	●	120	190	●	100%	●	137	193	●	95%	●	275	298	●	97%	●
		Services provided, including periodontal and oral cancer screening, dentures, etc.	-	-				-	-				300	320	●			625	729	●			687	552	●			1,375	1,182	●		
		Patients missing multiple teeth who agree or strongly agree they experienced improved functionality when treatment was completed	-	-				-	-				90%	91%	●			90%	95%	●			91%	100%	●			91%	97%	●		
		Patients who agree or strongly agree accessing oral health services improved their oral health	-	-				-	-				90%	93%	●			90%	90%	●			92%	99%	●			92%	94%	●		
	Pathways **FY23 Approved: $60,000** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $60,000 FY21 Spent: $60,000 FY20 Approved: $60,000 FY20 Spent: $60,000 New Metrics: 1 of 4	Patients served	23	38	●	98%	●	45	71	●	100%	●	30	35	●	98%	●	45	87	●	97%	●	30	43	●	100%	●	45	43	●	99%	●
		Services provided	173	331	●			338	871	●			225	586	●			340	1,312	●			300	563	●			450	563	●		
		Home Health 60-day re-hospilaization rate* **Lower percentage desired*	-	-				-	-				-	-				-	-				14%	14% Lower percentage desired	●			14%	11% Lower percentage desired	●		
		Hospice patients who report getting as much help with pain as they needed	83%	84%	●			83%	81%	●			75%	82%	●			75%	83%	●			72%	85%	●			75%	84%	●		
HEALTHY BODY	**Planned Parenthood Mar Monte - Mountain View Health Center** **FY23 Approved: $225,000** FY22 Approved: $225,000 FY22 Spent: $225,000 FY21 Approved: $225,000 FY21 Spent: $225,000 FY20 Approved: $225,000 FY20 Spent: $131,446 New Metrics: 0 of 5	Patients served	137	127	●	88%	●	274	179	●	72%	●	150	198	●	96%	●	350	370	●	100%	●	175	158	●	79%	●	350	273	●	75%	●
		Visits provided	332	166	●			964	272	●			250	270	●			525	711	●			325	245	●			650	427	●		
		Primary care patients referred to specialists who receive care within 90 days	50%	48%	●			50%	69%	●			45%	38%	●			45%	70%	●			70%	48%	●			70%	23%	●		
		Hemoglobin A1c of less than 9 for diabetes patients	60%	79%	●			60%	68%	●			55%	66%	●			55%	99%	●			90%	55%	●			90%	86%	●		
		Annual colon cancer screening completed as appropriate for target age group	50%	57%	●			50%	34%	●			50%	47%	●			50%	52%	●			50%	57%	●			50%	88%	●		
	Playworks **FY23 Approved: $200,000** FY22 Approved: $200,000 FY22 Spent: $200,000 FY21 Approved: $218,000 FY21 Spent: $191,841 FY20 Approved: $216,034 FY20 Spent: $216,034 New Metrics: 0 of 5	Students served	5,600	5,273	●	94%	●	5,600	5,172	●	98%	●	5,150	4,467	●	87%	●	5,150	4,204	●	95%	●	4,450	4,467	●	100%	●	4,450	4,890	●	100%	●
		Teachers/administrators reporting that Playworks positively impacts school climate	N/A	N/A				95%	100%	●			N/A	N/A				95%	100%	●			N/A	N/A				95%	97%	●		
		Teachers reporting that overall student engagement increased use of positive language, attentiveness and participation in class	N/A	N/A				90%	100%	●			N/A	N/A				97%	89%	●			N/A	N/A				97%	96%	●		
		Teachers/administrators surveyed who agree or strongly agree that Playworks helps increase physical activity	N/A	N/A				95%	100%	●			N/A	N/A				96%	100%	●			N/A	N/A				96%	96%	●		
		Teacher/administrators who agree or strongly agree that Playworks helps reduce bullying at recess	-	-				-	-				N/A	N/A				85%	85%	●			N/A	N/A				88%	87%	●		
	Ravenswood Family Health Center/MayView Community Health Center **FY23 Approved: $1,250,000** FY22 Approved: $1,300,000 FY22 Spent: $1,300,000 FY21 Approved: $1,200,000 FY21 Spent: $1,200,000 FY20 Approved: $1,700,000 FY20 Spent: $1,700,000 New Metrics: 0 of 7	Uninsured patients served	1,260	1,631	●	98%	●	2,520	2,487	●	95%	●	1,200	1,708	●	84%	●	1,575	1,652	●	93%	●	1,300	1,300	●	84%	●	1,900	1,900	●	92%	●
		Patient visits provided (medical and behavioral health)	2,681	3,041	●			5,362	5,239	●			1,560	1,953	●			3,420	3,800	●			2,020	2,160	●			5,650	5,850	●		
		Insurance enrollment encounters	-	-				-	-				450	186	●			900	1,200	●			300	142	●			600	600	●		
		Patients age 50-75 with appropriate Breast Cancer Screening	48%	47%	●			50%	45%	●			45%	39%	●			45%	39%	●			45%	42%	●			45%	56%	●		
		Diabetic patients with HbA1c Levels less than 8 points	61%	63%	●			61%	59%	●			59%	54%	●			59%	63%	●			65%	81%	●			65%	50%	●		
		Patients aged 51-75 years with completed annual colorectal screening	40%	54%	●			45%	48%	●			48%	42%	●			48%	51%	●			55%	47%	●			55%	51%	●		
		Hypertension patients whose blood pressure is less than 140/90 mmHg	80%	71%	●			80%	72%	●			72%	57%	●			72%	48%	●			60%	36%	●			60%	44%	●		

Community Benefit Dashboard Notes

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● A metric receives a "yellow" indicator if performance against target is 75% - 89%

● A metric receives a "red" indicator if performance against target is 0% - 74%

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 HEALTHCARE DISTRICT

Performance against target: ● = 90%+ ● = 75% - 89% ● = 0% - 74%

Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*	●	FY20 6-month Metrics Met *Column G*	●	FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*	●	FY20 Annual Metrics Met *Column L*	●	FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*	●	FY21 6-month Metrics Met *Column Q*	●	FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*	●	FY21 Annual Metrics Met *Column V*	●	FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*	●	FY22 6-month Metrics Met *Column AA*	●	FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*	●	FY22 Annual Metrics Met *Column AF*	●
HEALTHY BODY	**Santa Clara Valley Medical Center - Mountain View & Sunnyvale** **FY23 Approved: $440,000** FY22 Approved: $530,000 FY22 Spent: $530,000 FY21 Approved: $750,000 FY21 Spent: $750,000 FY20 Approved: $700,000 FY20 Spent: $700,000 New Metrics: 1 of 5	Individuals served	470	617		94%		870	859		83%		740	818		88%		1,170	1,081		85%		468	530		96%		866	994		95%	
		Encounters provided	1,375	1,343				2,630	2,073				2,660	2,481				4,800	5,259				1,287	1,147				2,457	2,334			
		Dental patients who will receive prophylactic cleaning	35%	31%				40%	31%				35%	21%				40%	21%				20%	30%				25%	31%			
		Overall decrease in percentage of emergency dental visits* **Lower percentage desired*	15%	13% Lower percentage desired				12%	17% Lower percentage desired				15%	21% Lower percentage desired				12%	23% Lower percentage desired				21%	16% Lower percentage desired				20%	17% Lower percentage desired			
		Reduce no show rate* **Lower percentage desired*	-	-				-	-				-	-				-	-				8%	9% Lower percentage desired				8%	10% Lower percentage desired			
	Sunnyvale School District **FY23 Approved: $287,000** FY22 Approved: $287,000 FY22 Spent: $287,000 FY21 Approved: $285,000 FY21 Spent: $285,000 FY20 Approved: $282,000 FY20 Spent: $282,000 New Metrics: 0 of 5	Students served	2,243	2,252		91%		4,450	4,386		87%		2,006	2,079		100%		4,002	3,979		99%		2,069	1,925		82%		4,139	4,067		95%	
		Students with failed vision or hearing screenings who saw their health care provider	52%	28%				72%	53%				N/A	N/A				30%	75%				20%	20%				50%	48%			
		Students out of compliance with required immunizations become compliant	-	-				-	-				30%	82%				70%	96%				80%	95%				90%	98%			
		Kindergarten students who received a well-child exam as measured by the receipt of a completed Child Health and Disability Prevention Program (CHDP) Health Exam for School Entry" Form	33%	45%				66%	55%				20%	28%				40%	59%				30%	26%				60%	48%			
		Students who were assessed for potential not yet identified health needs based upon parent reporting health problem at point of registration	30%	32%				60%	54%				75%	79%				90%	87%				80%	25%				95%	100%			
	Teen Health Van **FY23 Approved: $98,000** FY22 Approved: $98,000 FY22 Spent: $98,000 FY21 Approved: $97,000 FY21 Spent: $97,000 FY20 Approved: $95,000 FY20 Spent: $95,000 New Metrics: 2 of 6	Students served	52	58		96%		104	92		97%		52	110		99%		104	106		97%		50	141		97%		100	153		100%	
		Services provided	209	183				418	419				225	217				450	537				200	181				400	395			
		Patients receiving catch up vaccinations to be able to enroll in school	-	-				-	-				-	-				-	-				35%	33%				75%	77%			
		Students who receive recommended vaccines (including influenza and HPV)	-	-				-	-				30%	32%				75%	75%				30%	30%				60%	61%			
		Patients who receive social worker consultation, treatment by the medical team, including a psychiatrist, and/or medications, after screening positive for depression	-	-				-	-				-	-				-	-				90%	90%				90%	90%			
		Students who receive nutrition consultations and demonstrate improvement in at least one lifestyle behavior related to weight management	N/A	N/A				60%	62%				N/A	N/A				30%	30%				N/A	N/A				20%	20%			
HEALTHY MIND	**Acknowledge Alliance** **FY23 Approved: $50,000** FY22 Approved: $50,000 FY22 Spent: $50,000 FY21 Approved: $50,000 FY21 Spent: $50,000 FY20 Approved: $50,000 FY20 Spent: $50,000 New Metrics: 0 of 4	Individuals served (students and educators)	335	271		91%		1,200	598		85%		300	448		79%		600	1,302		97%		300	386		100%		600	433		90%	
		Educators who receive resilience support services through one-on-one training, classroom observations, professional development, and/or teacher support groups	33	94				100	180				75	43				125	396				81	116				162	433			
		Teachers and administrators will increase their use of strategies to promote personal and professional resilience	N/A	N/A				70%	64%				N/A	N/A				75%	94%				N/A	N/A				80%	100%			
		Teachers and administrators will report that the Acknowledge Alliance Resilience Staff worked to promote a positive school climate	N/A	N/A				75%	75%				N/A	N/A				75%	65%				N/A	N/A				75%	66%			
	Avenidas **FY23 Approved: $60,000** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $55,000 FY21 Spent: $55,000 FY20 Approved: $52,000 FY20 Spent: $52,000 New Metrics: 0 of 5	Older adults and family members served	83	92		100%		103	114		100%		75	82		100%		92	94		99%		81	79		94%		100	102		97%	
		Services provided	1,035	1,201				1,997	2,181				922	904				1,801	1,820				999	1,004				1,950	1,963			
		Older adults with a history of multiple ER visits do not experience any emergency room visits	-	-				-	-				82%	97%				82%	91%				85%	78%				85%	84%			
		Older adults who maintain at least 3 essential Activities of Daily Living	93%	92%				93%	93%				90%	92%				90%	85%				90%	81%				90%	82%			
		Older adults who do not experience a hospital admission	-	-				-	-				80%	92%				80%	88%				80%	72%				80%	75%			
	CHAC **FY23 Approved: $280,000** FY22 Approved: $280,000 FY22 Spent: $280,000 FY21 Approved: $280,000 FY21 Spent: $280,000 FY20 Approved: $280,000 FY20 Spent: $280,000 New Metrics: 1 of 5	Students served through counseling	350	494		96%		975	761		88%		165	169		91%		438	300		85%		276	479		100%		744	861		100%	
		Services hours provided	4,050	3,724				9,000	7,400				2,000	1,630				6,000	4,379				2,480	4,980				7,500	10,330			
		Students who improve by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on self-report for students age 11-17	N/A	N/A				40%	36%				N/A	N/A				40%	40%				N/A	N/A				40%	39%			
		Students who improve by at least 3 points from pre-test to post test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher report for ages 10 and under	N/A	N/A				50%	38%				N/A	N/A				40%	50%				N/A	N/A				40%	41%			
		Students served who showed a 15% or better improvement in their level of Social Emotional Learning (SEL) knowledge on survey	-	-				-	-				-	-				-	-				N/A	N/A				70%	75%			

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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

EL CAMINO HEALTHCARE DISTRICT

Performance against target: ● = 90%+ ● = 75% - 89% ● = 0% - 74%

Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
HEALTHY MIND	**Cupertino Union School District - Mental Health Program** **FY23 Approved: $93,000** FY22 Approved: $90,000 FY22 Spent: $90,000 FY21 Approved: $90,000 FY21 Spent: $90,000 New Metrics: 1 of 5	Students served	-	-		New Program in FY21		-	-		New Program in FY21		50	61	●	100%	●	122	125	●	100%	●	45	37	●	87%	●	98	88	●	98%	●
		Service hours provided	-	-				-	-				530	647	●			1,305	1,522	●			480	594	●			1,070	1,561	●		
		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%	65%	●			80%	80%	●			60%	47%	●			80%	86%	●		
		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%	50%	●			N/A	N/A				50%	50%	●		
		Students who improved by at least 3 points from pre-test to post-test on the 40 point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher report for students age 10 and under	-	-				-	-				-	-				-	-				N/A	N/A				50%	72%	●		
	Law Foundation - Mental Health Advocacy Project **FY23 Approved: $60,000** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $60,000 FY21 Spent: $60,000 FY20 Approved: $60,000 FY20 Spent: $60,000 New Metrics: 0 of 5	Individuals served	81	102	●	100%	●	161	172	●	99%	●	90	65	●	85%	●	140	123	●	89%	●	82	59	●	79%	●	165	284	●	100%	●
		Individuals served through representation	27	27				54	50	●			30	33	●			60	57	●			27	34	●			55	72	●		
		Healthcare providers served through educational presentation	54	75				107	122	●			60	32	●			80	66	●			55	25	●			110	212	●		
		Providers receiving training who increase their understanding of their patients' rights to medical benefits and other forms of public assistance	90%	86%	●			90%	90%	●			90%	100%	●			90%	100%	●			N/A	N/A				90%	90%	●		
		Clients receiving services for benefits issues who successfully access or maintain health benefits or other safety-net benefits	80%	97%	●			80%	89%	●			85%	97%	●			85%	69%	●			90%	100%	●			90%	90%	●		
	Los Altos School District **FY23 Approved: $130,000** FY22 Approved: $100,000 FY22 Spent: $100,000 FY21 Approved: $100,000 FY21 Spent: $100,000 FY20 Approved: $100,000 FY20 Spent: $100,000 New Metrics: 0 of 4	Students served	50	78	●	100%	●	100	101	●	61%	●	50	32	●	71%	●	100	56	●	60%	●	25	17	●	84%	●	65	63	●	74%	●
		Services hours provided	250	409	●			500	629	●			250	193	●			500	505	●			250	257	●			500	594	●		
		Students who improve by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report for students age 11-17	N/A	N/A				50%	21%	●			N/A	N/A				50%	12%	●			N/A	N/A				50%	68%	●		
		Parents who report improvement in their child by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report for students age 10 and under	-	-				-	-				N/A	N/A				50%	N/A				N/A	N/A				50%	0%	●		
	Momentum for Mental Health **FY23 Approved: $290,000** FY22 Approved: $290,000 FY22 Spent: $290,000 FY21 Approved: $270,000 FY21 Spent: $270,000 FY20 Approved: $268,140 FY20 Spent: $268,140 New Metrics: 0 of 5	Patients served	65	88	●	100%	●	118	107	●	95%	●	70	71	●	99%	●	118	86	●	89%	●	71	67	●	91%	●	120	90	●	88%	●
		Services provided	858	842	●			1,715	1,754	●			858	817	●			1,735	1,524	●			870	550	●			1,764	1,276	●		
		Patients who report a reduction of two points or more in PHQ-9 measure severity of depression	-	-				-	-				75%	80%	●			85%	70%	●			75%	100%	●			85%	77%	●		
		Patients who report a reduction of two points or more in Generalized Anxiety Disorder-7 (GAD-7) to measure severity of anxiety	70%	78%	●			80%	72%	●			70%	75%	●			80%	80%	●			70%	100%	●			80%	83%	●		
		Patients who avoid psychiatric hospitalization for 12 months after admission	97%	100%	●			97%	100%	●			97%	100%	●			97%	100%	●			97%	100%	●			97%	100%	●		
	Mountain View Los Altos High School District **FY23 Approved: $210,000** FY22 Approved: $160,000 FY22 Spent: $160,000 FY21 Approved: $160,000 FY21 Spent: $160,000 FY20 Approved: $160,000 FY20 Spent: $160,000 New Metrics: 0 of 6	Students served	75	144	●	98%	●	150	200	●	77%	●	75	94	●	100%	●	150	169	●	100%	●	50	38	●	82%	●	100	72	●	93%	●
		Hours of services provided	1,260	1,192	●			2,520	2,196	●			1,200	1,323	●			2,400	2,522	●			600	519	●			1,200	1,129	●		
		Decrease the interference of psychosis/impulsivity/ depression / anxiety / opposition / conduct / anger / substance abuse / or trauma on functioning by more than or equal to 25%	-	-				-	-				N/A	N/A				60%	66%	●			N/A	N/A				50%	68%	●		
		Reduced frequency/quantity of high risk behavior by at least 25% on the CANS 50 assessment, among students with high risk behaviors	N/A	N/A				75%	19%	●			N/A	N/A				25%	33%	●			N/A	N/A				50%	47%	●		
		Decreased suicidal thoughts and feelings by at least 25% on the CANS 50 assessment, among students served with suicidal thoughts and feelings	N/A	N/A				75%	80%	●			-	-				-	-				N/A	N/A				50%	55%	●		
		Increased use of coping skills for trauma/ depression/anxiety/anger by at least 25% on the CANS 50 assessment, among students served with trauma, depression, anxiety, and/or anger	N/A	N/A				75%	54%	●			N/A	N/A				50%	50%	●			N/A	N/A				50%	74%	●		
	NAMI SCC (National Alliance on Mental Illness) **FY23 Approved: $100,000** FY22 Approved: $100,000 FY22 Spent: $100,000 FY21 Approved: $75,000 FY21 Spent: $73,165 FY20 Approved: $75,000 FY20 Spent: $65,376 New Metrics: 0 of 5	Participants	31	27	●	92%	●	62	51	●	91%	●	27	18	●	80%	●	55	60	●	100%	●	35	34	●	92%	●	70	71	●	96%	●
		Peer PALS and Peer Mentors visits	527	450	●			1,054	907	●			467	301	●			935	1,005	●			1,190	988	●			1,190	1,050	●		
		Peer PALS and Peer Mentors phone calls	1,054	912	●			2,108	1,814	●			935	625	●			1,870	2,065	●			595	476	●			2,380	2,135	●		
		Participants reporting that the program helped them feel more hopeful about their futures and their recovery	75%	75%	●			75%	83%	●			75%	90%	●			75%	84%	●			75%	89%	●			75%	80%	●		
		Participants reporting that the program helped them be more compliant with their treatment plan	80%	85%	●			80%	93%	●			80%	98%	●			80%	95%	●			80%	95%	●			80%	81%	●		

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EL CAMINO HEALTHCARE DISTRICT

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Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
HEALTHY MIND	**Parents Helping Parents** **FY23 Approved: $35,000** FY22 Approved: $35,000 FY22 Spent: $35,000 New Metric: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		20	68	●	100%	●	50	152	●	100%	●
		Encounters provided	-	-				-	-				-	-				-	-				150	187	●			288	424	●		
		Participants report therapist was knowledgeable and communicated effectively	-	-				-	-				-	-				-	-				80%	94%	●			80%	96%	●		
		Participants who would recommend the workshop to a friend	-	-				-	-				-	-				-	-				80%	96%	●			80%	97%	●		
		Participants who learn anything useful that help them as a parent of a child with special needs	-	-				-	-				-	-				-	-				80%	95%	●			80%	93%	●		
	YWCA *Trauma-informed Counseling for Victims of Domestic Violence and At-risk Youth* **FY23 Approved: $85,000** FY22 Approved: $75,000 FY22 Spent: $75,000 FY21 Approved: $75,000 FY21 Spent: $75,000 FY20 Approved: $65,000 FY20 Spent: $65,000 New Metrics: 0 of 5	Individuals served	14	13	●	99%	●	37	33	●	98%	●	10	21	●	40%	●	33	28	●	50%	●	15	15	●	100%	●	15	13	●	97%	●
		Counseling sessions provided	56	93	●			148	212	●			40	157	●			132	266	●			75	103	●			75	183	●		
		Individuals who increase their knowledge of trauma and the effects of trauma on their lives	80%	84%	●			80%	99%	●			80%	0%	●			80%	14%	●			80%	93%	●			80%	91%	●		
		Individuals who experience a reduction of trauma symptoms	60%	62%	●			60%	79%	●			60%	0%	●			60%	12%	●			70%	87%	●			70%	91%	●		
		Individuals who report they would be willing to seek counseling in the future	60%	77%	●			60%	79%	●			60%	0%	●			60%	15%	●			70%	100%	●			70%	100%	●		
HEALTHY COMMUNITY	**Abode Services** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $50,000 FY21 Spent: $50,000 New Metrics: 1 of 4	Individuals served	-	-		New Program in FY21		-	-		New Program in FY21		326	229	●	72%	●	651	651	●	100%	●	300	289	●	98%	●	599	556	●	98%	●
		Services provided	-	-				-	-				978	721	●			1,953	1,953	●			599	601	●			1,797	1,797	●		
		Participants who retain stable housing for at least 6-months	-	-				-	-				-	-				-	-				N/A	N/A				90%	91%	●		
		Clients who report being satisfied or very satisfied with housing navigation	-	-				-	-				N/A	N/A				75%	82%	●			N/A	N/A				75%	97%	●		
	American Heart Association *Health Screenings and Check. Change. Control Program* **FY23 Approved: $100,000** FY22 Approved: $110,000 FY22 Spent: $94,907 FY21 Approved: $110,000 FY21 Spent: $101,113 FY20 Approved: $110,000 FY20 Spent: $94,825 New Metrics: 0 of 6	Participants reached through education and community screenings	400	504	●	93%	●	1,100	809	●	87%	●	200	3,465	●	88%	●	900	4,498	●	77%	●	130	124	●	96%	●	730	412	●	91%	●
		Individuals served through Check.Change.Control blood pressure program	100	85	●			200	180	●			200	138	●			400	299	●			120	124	●			210	239	●		
		Heart Health Hub events coordinated	4	5	●			8	7	●			N/A	N/A				4	0	●			N/A	N/A				4	4	●		
		Participants who improve blood pressure by 10mmHg	30%	33%	●			30%	33%	●			30%	25%	●			30%	26%	●			40%	34%	●			40%	36%	●		
		Participants who are compliant with measuring their blood pressure eight times within the four months of the Check.Change.Control program	50%	40%	●			50%	40%	●			50%	43%	●			50%	66%	●			60%	70%	●			60%	60%	●		
		Participants who report adopting healthy behaviors to improve blood pressure by self-reporting increased fruits and vegetables consumption	30%	27%	●			30%	27%	●			30%	68%	●			30%	84%	●			40%	68%	●			40%	70%	●		
	Caminar (Family & Children Services) **FY23 Approved: $80,000** FY22 Approved: $60,000 FY22 Spent: $60,000 FY21 Approved: $50,000 FY21 Spent: $50,000 FY20 Approved: $50,000 FY20 Spent: $50,000 New Metrics: 0 of 5	Individuals served	40	33	●	95%	●	90	50	●	91%	●	25	47	●	100%	●	50	57	●	97%	●	30	46	●	100%	●	60	46	●	93%	●
		Service units provided (counseling, support groups, advocacy, and education)	375	351	●			700	708	●			200	377	●			453	586	●			350	516	●			700	616	●		
		Participants will maintain or improve their economic security	55%	60%	●			60%	94%	●			N/A	N/A				60%	54%	●			60%	75%	●			60%	72%	●		
		Participants who report that services are helpful to their healing process	80%	95%	●			80%	94%	●			N/A	N/A				85%	82%	●			85%	95%	●			85%	95%	●		
		Counseling/advocacy beneficiaries who will report increased knowledge of domestic violence and safety strategies	90%	98%	●			90%	100%	●			N/A	N/A				90%	90%	●			90%	97%	●			90%	95%	●		
	Chinese Health Initiative **FY23 Approved: $267,000** FY22 Approved: $267,000 FY22 Spent: $267,000 FY21 Approved: $269,030 FY21 Spent: $248,831 FY20 Approved: $235,000 FY20 Spent: $178,402 New Metrics: 1 of 5	Individuals served	375	339	●	88%	●	922	939	●	100%	●	410	522	●	100%	●	1,025	1,192	●	100%	●	553	808	●	100%	●	1,335	1,400	●	100%	●
		Services provided	700	584	●			1,666	1,674	●			760	1,779	●			1,900	3,248	●			1,275	1,946	●			2,857	3,750	●		
		Healthy Habits, Healthy Lifestyle participants who are very motivated or motivated to make lifestyle change on exercise, diet, sleep or stress-reduction	-	-				-	-				-	-				-	-				80%	95%	●			80%	93%	●		
		Participants who strongly agree or agree that dietitian consultations help them improve their eating habits	-	-				-	-				85%	98%	●			85%	96%	●			95%	96%	●			95%	97%	●		
		Participants who strongly agree or agree that the program's health education or screening helps them better manage their health	N/A	N/A				92%	91%	●			N/A	N/A				92%	94%	●			94%	94%	●			94%	96%	●		

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EL CAMINO HEALTHCARE DISTRICT

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Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
HEALTHY COMMUNITY	**Columbia Neighborhood Center** *Healthy Habits & Practices: A Fitness & Cooking Program for Low-Income Families and Youth* **FY23 Approved: $45,000** FY22 Approved: $35,000 FY22 Spent: $35,000 FY21 Approved: $25,000 FY21 Spent: $25,000 FY20 Approved: $24,500 FY20 Spent: $16,206 New Metrics: 3 of 4	Individuals served	57	41	●	72%	●	124	66	●	53%	●	20	25	●	100%	●	65	104	●	100%	●	20	27	●	100%	●	57	62	●	100%	●
		Services provided (fitness and cooking classes)	-	-				-	-				-	-				-	-				200	246	●			684	853	●		
		Participants who report at least a 45 minute weekly increase in moderate to strenuous physical activity as assessed by pre/post survey.	-	-				-	-				-	-				-	-				75%	75%	●			80%	88%	●		
		Participants who report increasing their home cooked meals/snacks by at least two per week for a month.	-	-				-	-				-	-				-	-				60%	89%	●			70%	95%	●		
	Falls Prevention Program *Farewell to Falls and Matter of Balance programs combined into this single grant in FY22* **FY23 Approved: $20,000** FY22 Approved: $46,100 FY22 Spent: $42,033 **Farewell to Falls** FY21 Approved: $35,000 FY21 Spent: $23,076 FY20 Approved: $31,800 FY20 Spent: $24,294 **Matter of Balance** FY21 Approved: $15,500 FY21 Spent: $15,500 FY20 Approved: $15,500 FY20 Spent: $13,399 New Metrics: 4 of 6	Older adults served	28	33	●	100%	●	73	57	●	86%	●	30	18	●	90%	●	65	43	●	92%	●	59	57	●	94%	●	128	128	●	97%	●
		Services provided	-	-				-	-				-	-				-	-				424	411	●			1,298	1,114	●		
		Older adults who make home modifications as recommended by Occupational Therapist during appointment	-	-				-	-				-	-				-	-				57%	55%	●			57%	61%	●		
		Older adults participants who feel more comfortable talking to family or friends about falling after having completed the Bingocize class	-	-				-	-				-	-				-	-				65%	77%	●			65%	92%	●		
		Older adult participants who feel more comfortable talking to family or friends about falling after completing the a Matter of Balance program	-	-				-	-				-	-				-	-				75%	100%	●			75%	89%	●		
		Older adults who did not have an injurious fall requiring medical attention	75%	92%	●			75%	86%	●			75%	85%	●			75%	90%	●			75%	55%	●			75%	72%	●		
	HLRC - MV **FY23 Approved: $175,000** FY22 Approved: $200,000 FY22 Spent: $200,000 FY21 Approved: $210,000 FY21 Spent: $211,853 FY20 Approved: $210,000 FY20 Spent: $159,286 New Metrics: 0 of 4	Individuals served	8,428	9,161	●	98%	●	15,899	14,911	●	99%	●	4,000	5,876	●	85%	●	8,000	10,321	●	87%	●	3,000	5,237	●	100%	●	6,000	9,710	●	100%	●
		Health consultations provided	112	125	●			212	258	●			43	17	●			86	41	●			25	37	●			50	75	●		
		Community members who strongly agree or agree that library services have been valuable in helping me manage my health or that of a friend or family member	57%	64%	●			57%	78%	●			65%	95%	●			65%	77%	●			65%	96%	●			65%	78%	●		
		Community members who strongly agree or agree that library information is appropriate for my needs	80%	73%	●			80%	94%	●			80%	98%	●			80%	97%	●			80%	96%	●			80%	97%	●		
	LifeMoves **FY23 Approved: $160,000** FY22 Approved: $160,000 FY22 Spent: $160,000 New Metrics: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		75	82	●	98%	●	160	185	●	95%	●
		Services provided	-	-				-	-				-	-				-	-				365	346	●			820	862	●		
		Clients who attend at least three individual therapy sessions who report improved functioning and well-being	-	-				-	-				-	-				-	-				N/A	N/A				85%	79%	●		
		Clients who learned how trauma affects themselves and their family	-	-				-	-				-	-				-	-				N/A	N/A				75%	71%	●		
		LVN clients will report feeling improved health due to medication management and other support with health care services	-	-				-	-				-	-				-	-				N/A	N/A				75%	64%	●		
	Maitri **FY23 Approved: $50,000** FY22 Approved: $50,000 FY22 Spent: $50,000 FY21 Approved: $50,000 FY21 Spent: $50,000 FY20 Approved: $50,000 FY20 Spent: $50,000 New Metrics: 0 of 5	Adults served	12	13	●	99%	●	30	32	●	100%	●	22	24	●	96%	●	45	45	●	98%	●	22	35	●	98%	●	50	51	●	98%	●
		Services provided	47	48	●			90	95	●			48	53	●			95	100	●			45	45	●			95	98	●		
		Legal clients who report increased awareness of their legal rights	75%	75%	●			75%	80%	●			75%	80%	●			75%	80%	●			75%	92%	●			75%	92%	●		
		Crisis callers will benefit from a safety plan to increase their safety	75%	72%	●			75%	90%	●			75%	74%	●			75%	74%	●			75%	69%	●			75%	69%	●		
		Clients will achieve their economic security goals, which may include finding a job, taking educational courses, or becoming more financially literate	70%	75%	●			70%	76%	●			70%	57%	●			70%	65%	●			70%	75%	●			70%	75%	●		
	RoadRunners - MV **FY23 Approved: $165,000** FY22 Approved: $200,000 FY22 Spent: $200,000 FY21 Approved: $240,000 FY21 Spent: $199,629 FY20 Approved: $230,000 FY20 Spent: $204,760 New Metrics: 0 of 4	Individuals served	575	614	●	100%	●	1,150	904	●	93%	●	300	439	●	90%	●	600	543	●	94%	●	200	286	●	100%	●	450	512	●	100%	●
		Services provided	4,519	5,821	●			9,038	8,590	●			3,500	2,549	●			7,000	5,898	●			1,600	4,061	●			5,300	7,902	●		
		Older adults who strongly agree or agree that services helped in maintaining their independence	90%	95%	●			90%	94%	●			91%	90%	●			91%	91%	●			91%	94%	●			91%	100%	●		
		Older adults who strongly agree or agree that services made it possible to get to their medical appointments	95%	93%	●			95%	91%	●			95%	84%	●			95%	95%	●			95%	100%	●			95%	95%	●		

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EL CAMINO HEALTHCARE DISTRICT

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Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*		FY20 6-month Metrics Met *Column G*		FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*		FY20 Annual Metrics Met *Column L*		FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*		FY21 6-month Metrics Met *Column Q*		FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*		FY21 Annual Metrics Met *Column V*		FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*		FY22 6-month Metrics Met *Column AA*		FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*		FY22 Annual Metrics Met *Column AF*	
	Second Harvest Food Bank **FY23 Approved: $40,000** FY22 Approved: $90,000 FY22 Spent: $90,000 New Metrics: N/A	Individuals served (unduplicated)	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		720	3,496	●	100%	●	1,440	3,496	●	100%	●
		Food distribution to food insecure clients	-	-				-	-				-	-				-	-				256,500	597,287	●			513,000	597,287	●		
		Food insecure clients who report preparing at least one new recipe using the nutritious foods from the distribution	-	-				-	-				-	-				-	-				15%	65%	●			15%	65%	●		
		Food insecure clients who report trying at least one new produce item from the distribution	-	-				-	-				-	-				-	-				35%	59%	●			35%	59%	●		
	South Asian Heart Center **FY23 Approved: $300,000** FY22 Approved: $300,000 FY22 Spent: $300,000 FY21 Approved: $210,001 FY21 Spent: $210,001 FY20 Approved: $140,000 FY20 Spent: $116,669 New Metrics: 0 of 6	Individuals served	77	84	●	99%	●	154	192	●	99%	●	125	136	●	98%	●	280	322	●	94%	●	180	208	●	98%	●	450	456	●	99%	●
		Services provided	420	459	●			840	1,056	●			680	738	●			1,450	1,639	●			975	1,086	●			2,075	2,099	●		
		Improvement in average level of weekly physical activity from baseline	20%	19%	●			21%	21%	●			21%	20%	●			21%	20%	●			21%	20%	●			21%	21%	●		
		Improvement in average levels of daily servings of vegetables from baseline	19%	20%	●			20%	19%	●			20%	19%	●			20%	20%	●			20%	18%	●			20%	19%	●		
		Improvement in levels of HDL-C as measured by follow-up lab test	5%	5%	●			5%	5%	●			5%	5%	●			6%	5%	●			5%	5%	●			5%	5%	●		
		Improvement in cholesterol ratio as measured by follow-up lab test	6%	7%	●			6%	6%	●			6%	6%	●			7%	6%	●			6%	6%	●			6%	6%	●		
HEALTHY COMMUNITY	**Sunnyvale Community Services** *Social Work Case Mgmt. & Homebound Client Services* **FY23 Approved: $197,000** FY22 Approved: $187, 000 FY22 Spent: $187,000 FY21 Approved: $154,000 FY21 Spent: $154,000 FY20 Approved: $153,344* FY20 Spent: $153,344 New Metrics: 0 of 5 *FY20 funding included the addition of	Individuals served	120	76	●	72%	●	196	215	●	100%	●	120	108	●	91%	●	196	205	●	100%	●	75	130	●	99%	●	197	217	●	98%	●
		Services provided (case management and homebound client services)	410	277	●			824	833	●			410	303	●			824	843	●			348	577	●			846	923	●		
		Participants whose scores on the Step Up Silicon Valley Self-Sufficiency Measure improve to an average of 3.0 or higher six months after entering Case Management	-	-				-	-				80%	N/A				80%	80%	●			80%	77%	●			80%	73%	●		
		Sheltered clients who maintain housing for 60 days after financial assistance and referrals	90%	100%	●			90%	90%	●			90%	100%	●			90%	96%	●			90%	97%	●			90%	99%	●		
		Homebound client participants who are connected to appropriate benefits programs, support programs and resources	70%	75%	●			70%	90%	●			70%	74%	●			70%	85%	●			70%	77%	●			70%	94%	●		
	Sunnyvale Community Services *Emergency Assistance* **FY23 Approved: $75,000** FY22 Approved: $75,000 FY22 Spent: $75,000 FY21 Approved: $65,000 FY21 Spent: $65,000 FY20 Approved: $65,000 FY20 Spent: $65,000 New Metrics: 0 of 3	Individuals served	18	18	●	100%	●	30	27	●	93%	●	60	38	●	82%	●	100	90	●	97%	●	60	31	●	84%	●	100	109	●	100%	●
		Individuals receiving financial assistance for medically related bills who are still housed 60 days after assistance - if they are not homeless when assisted	80%	100%	●			80%	89%	●			80%	100%	●			80%	94%	●			80%	88%	●			80%	100%	●		
		Homebound recipients of ECHD financial aid who are able to continue living independently	-	-				-	-				N/A	N/A				85%	100%	●			85%	100%	●			85%	100%	●		
	YMCA **FY23 Approved: $75,000** FY22 Approved: $65,000 FY22 Spent: $65,000 FY21 Approved: $65,000 FY21 Spent: $65,000 FY20 Approved: $70,000 FY20 Spent: $70,000 New Metrics: 0 of 3	Youth served (K-8)	330	328	●	90%	●	600	605	●	88%	●	275	227	●	94%	●	400	447	●	98%	●	275	259	●	96%	●	405	402	●	97%	●
		Families who agree or strongly that their children were more physically active after attending camp	95%	82%	●			95%	83%	●			85%	83%	●			85%	83%	●			85%	83%	●			85%	83%	●		
		Families who agree or strongly agree that their child eats more fruits and vegetables after attending camp	85%	71%	●			85%	66%	●			85%	81%	●			85%	81%	●			85%	81%	●			85%	81%	●		

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Support Grants ≤ $30,000																																
HEALTHY BODY	**5-2-1-0** FY22 Approved: $25,000 FY22 Spent: $3,876 FY21 Approved: $30,000 FY21 Spent: $14,885 FY20 Approved: $25,000 FY20 Spent: $22,942	Students served	3,500	3,211	●	92%	●	6,000	3,429	●	57%	●	2,750	598	●	22%	●	4,750	517	●	11%	●	1,120	543	●	48%	●	2,240	1,617	●	72%	●
	BAWSI *BAWSI Girls* **FY23 Approved: $26,000** FY22 Approved: $17,000 FY22 Spent: $17,000 FY21 Approved: $19,500 FY21 Spent: $19,500 FY20 Approved: $19,500 FY20 Spent: $19,500	Youth served	60	51	●	85%	●	125	83	●	66%	●	45	8	●	18%	●	90	11	●	12%	●	40	52	●	100%	●	80	106	●	100%	●
	BAWSI *BAWSI Rollers* **FY23 Approved: $21,000** FY22 Approved: $18,000 FY22 Spent: $18,000 FY21 Approved: $15,000 FY21 Spent: $15,000 FY20 Approved: $15,000 FY20 Spent: $15,000	Youth served	18	14	●	78%	●	18	19	●	100%	●	20	12	●	60%	●	20	12	●	60%	●	15	13	●	87%	●	15	13	●	87%	●
	Breathe California ***Seniors Breathe Easy*** **FY23 Approved: $25,000** FY22 Approved: $25,000 FY22 Spent: $25,000 FY21 Approved: $25,000 FY21 Spent: $23,077 FY20 Approved: $20,000 FY20 Spent: $20,000	Older adults served	320	423	●	100%	●	800	559	●	70%	●	150	506	●	100%	●	500	1,457	●	100%	●	400	190	●	48%	●	1,000	1,271	●	100%	●
	Day Worker Center **FY23 Approved: $30,000** FY22 Approved: $30,000 FY22 Spent: $30,000 FY21 Approved: $30,000 FY21 Spent: $30,000 FY20 Approved: $25,000 FY20 Spent: $25,000	Individuals served with nutritious meals	350	283	●	81%	●	500	455	●	91%	●	147	183	●	100%	●	221	205	●	93%	●	200	206	●	100%	●	205	207	●	100%	●
	Hope's Corner **FY23 Approved: $30,000** FY22 Approved: $30,000 FY22 Spent: $29,958 FY21 Approved: $30,000 FY21 Spent: $30,000 FY20 Approved: $25,000 FY20 Spent: $25,000	Low-income and homeless individuals served	275	275	●	100%	●	290	450	●	100%	●	425	886	●	100%	●	425	934	●	100%	●	900	991	●	100%	●	950	1,218	●	100%	●
	Virtual PrEP FY22 Approved: $20,000 FY22 Spent: $20,000 New Metrics: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		4	2	●	50%	●	8	8	●	100%	●
	Vista Center FY22 Approved: $30,000 FY22 Spent: $30,000 FY21 Approved: $30,000 FY21 Spent: $30,000 FY20 Approved: $30,000 FY20 Spent: $30,000	Individuals served	16	19	●	100%	●	40	41	●	100%	●	18	22	●	100%	●	38	39	●	100%	●	20	20	●	100%	●	38	41	●	100%	●

Community Benefit Dashboard Notes

● A metric receives a "green" indicator if performance against target is 90% - 100+%

● A metric receives a "yellow" indicator if performance against target is 75% - 89%

● A metric receives a "red" indicator if performance against target is 0% - 74%

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 HEALTHCARE DISTRICT

Health Priority Area *Column A*	Partner *Column B*	FY22 Metrics *Column C*	Performance against target: ● = 90%+ ● = 75% - 89% ● = 0% - 74%																												
			FY20 6-month Target *Column D*	FY20 6-month Actual *Column E*	● ● ●	FY20 6-month Metrics Met *Column G*	● ● ●	FY20 Annual Target *Column I*	FY20 Annual Actual *Column J*	● ● ●	FY20 Annual Metrics Met *Column L*	● ● ●	FY21 6-month Target *Column N*	FY21 6-month Actual *Column O*	● ● ●	FY21 6-month Metrics Met *Column Q*	● ● ●	FY21 Annual Target *Column S*	FY21 Annual Actual *Column T*	● ● ●	FY21 Annual Metrics Met *Column V*	● ● ●	FY22 6-month Target *Column X*	FY22 6-month Actual *Column Y*	● ● ●	FY22 6-month Metrics Met *Column AA*	● ● ●	FY22 Annual Target *Column AC*	FY22 Annual Actual *Column AD*	● ● ●	FY22 Annual Metrics Met *Column AF*	● ● ●
Support Grants ≤ $30,000 (Continued)																															
HEALTHY MIND	**EDRC** **FY23 Approved: $22,500** FY22 Approved: $25,000 FY22 Spent: $25,000 FY21 Approved: $22,500 FY21 Spent: $22,500 FY20 Approved: $20,000 FY20 Spent: $20,000	Individuals served	148	135	●	91%	●	296	267	●	90%	●	143	138	●	97%	●	286	167	●	58%	●	85	77	●	91%	●	170	128	●	75%	●
	Kara **FY23 Approved: $20,000** FY22 Approved: $20,000 FY22 Spent: $20,000 New Metric: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		45	35	●	78%	●	95	72	●	76%	●
	Mission Be FY22 Approved: $29,900 FY22 Spent: $29,900 FY21 Approved: $29,989 FY21 Spent: $29,989 FY20 Approved: $25,000 FY20 Spent: $25,000	Individuals served	240	200	●	83%	●	475	619	●	100%	●	245	560	●	100%	●	540	782	●	100%	●	250	485	●	100%	●	631	648	●	100%	●
	Project Safety Net **FY22 Approved: $35,000** FY22 Approved: $20,000 FY22 Spent: $20,000 New Metric: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		N/A	N/A				25	45	●	100%	●
HEALTHY COMMUNITY	**MVPD - Dreams and Futures Camp** **FY23 Approved: $25,000** FY22 Approved: $25,000 FY22 Spent: $17,981 FY21 Approved: $25,000 FY21 Spent: $7,676 FY20 Approved: $25,000 FY20 Spent: $25,000	Youth served	40	40	●	100%	●	85	102	●	100%	●	40	83	●	100%	●	85	83	●	98%	●	85	88	●	100%	●	85	88	●	100%	●
	Silicon Valley Bicycle Coalition **FY23 Approved: $30,000** FY22 Approved: $25,000 FY22 Spent: $25,000 New Metric: N/A	Individuals served	-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		-	-		New Program in FY22		75	48	●	64%	●	250	131	●	52%	●
	WomenSV **FY23 Approved: $30,000** FY22 Approved: $30,000 FY22 Spent: $30,000 FY21 Approved: $30,000 FY21 Spent: $30,000	Individuals served	-	-		New Program in FY21		-	-		New Program in FY21		20	29	●	100%	●	40	53	●	100%	●	20	20	●	100%	●	40	44	●	100%	●

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

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Senior Director Government Relations & Community Partnerships
Date: October 18, 2022
Subject: Community Benefit Sponsorships

Purpose:

To provide the Board with FY23 ECHD Sponsorships July 2022 – September 2022.

Summary:

1. Situation: Community Benefit Staff was asked to keep the Board informed regarding Community Benefit Sponsorships YTD.

2. Authority: Board reviewed and approved $85,000 for Sponsorships in the FY23 Community Benefit Plan in June 2022.

3. Background:

- Sponsorship information and instructions are available on the District website.
- Requests include sponsorship packets that outline event date, purpose, levels of sponsorship and requirements for sponsor acknowledgement. These requests are reviewed throughout the year as they come in by Community Benefit Staff and the other designated departments that provide community sponsorships (*e.g.*, Marketing & Communications and Government Relations & Community Partnerships).
- Community Benefit-funded Sponsorships provide general support for health-related agencies improving the well-being of the community.
- Community Benefit Sponsorships from **July 1, 2022- September 30, 2022** totaled **$15,000** for the following agencies:
    - Sponsored at $5,000 or less than $10,000
        - Sunnyvale Community Services
        - Healthier Kids Foundation
    - Sponsored at less than $5,000
        - Community Services Agency of Mountain View & Los Altos
        - Pink Ribbon Girls

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: N/A

Suggested Board Discussion Questions: None. This is an informational consent item.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District Board ("Board") of Directors
From: Dan Woods, CEO; Deb Muro, CIO; Omar Chughtai, Vice President of Operations
Date: September 30, 2022
Subject: Status Report on the El Camino Healthcare District Community COVID-19 Testing and Vaccination Program (the "District Program")

Recommendation: There are no recommendations to the El Camino Healthcare District at this time.

Summary:

1. Situation: On May 19, 2020, the Board approved funding and operations of a no-cost Community COVID-19 testing program for asymptomatic individuals who live, work, or go to school in the District. Thereafter, on June 16, 2020, the Board modified the approval to authorize (1) prepaying of $1.2 million in FY20 to El Camino Health to implement and manage the District Program in FY20 and FY21 and (2) distribution of $1.2 million in FY21 to provide ongoing services to the District Program in FY21. On December 29, 2020, the Board authorized the reallocation of $1,000,000 of the funds to provide COVID-19 vaccinations. Subsequently, on June 29, 2021, ECH is requested to approve reallocation of, and make available the remainder of unused FY20 & FY21 COVID-19 funds totaling $2.4 million through FY22 for the use of either COVID-19 testing or vaccination programs. In May 17, 2022, ECH requested the District Board to approve extending the remaining FY22 approved COVID-19 funds through FY23 COVID-19 vaccine and testing programs.

2. Authority: The District Board has authority to authorize the District CEO to distribute funding and manage public health initiatives in furtherance of its purpose, which includes providing assistance in the operation of health care services for the benefit of the District and the people served by the District. Pursuant to this authorization, the District entered into a Services Agreement with El Camino Health to operate the District Program.

3. Background: Pursuant to the Agreement with El Camino Health, COVID-19 tests have been collected at a number of locations through the District including (1) the El Camino Health Mountain View hospital campus, (2) public school sites in the Mountain View-Whisman, Sunnyvale, Los Altos and Mountain View/Los Altos High School Districts, (3) downtown retail districts in Mountain View, Los Altos and Sunnyvale and St. Francis High School. The mobile testing sites within the District's business districts were initially focused on serving employees of small businesses who are less likely to have insurance and whose work schedules make traveling to the El Camino Hospital campus impractical. However, due to low demand, we opened those sites to other members of the public. To provide good stewardship of the District's tax revenues, El Camino Health is successfully billing third party insurance and reserving District funds to cover the costs of testing when insurance is not available. As of August 31, 2022, we have provided 38,587 tests and 61,297 vaccine doses through our programs.

The testing program is patient centered to facilitate quick-prescheduled appointments, online scheduling, extended hours for appointments, electronic results, e-mail notification when results, including negative results, are available in MyChart. Testing is currently being offered at the Hospital Monday through Friday. El Camino Health

continues to rely on PCR (polymerase chain reaction) testing as this is the most sensitive and accurate mode. We do have antibody testing available in house but this has limited applicability because it does not guarantee lack of infectivity and does not guarantee immunity. Finally, to increase testing availability, El Camino Health has invested in antigen self-testing kits to be distributed through the El Camino Healthcare District testing program located at the El Camino Health outpatient lab at the Sobrato Pavilion. Updated information around antigen tests kits were made available at the end of January 2022 at ECH testing locations as identified on the website at https://www.elcaminohealth.org/covid-19-resource-center/testing-locations.

On January 19, 2021, El Camino Health rolled out its community vaccination program at our First Street Clinic for Tier 1a individuals as well as those 75 years of age and over in accordance with state and county guidelines. Reallocated funds are being used to provide vaccinations for people who live, work or go to school in the District. On March 15, 2021 we opened our second site to vaccinate in Sunnyvale with a primary focus of vaccinating individuals who live, work or go to school in the District as they become eligible per state and county guidelines and as Santa Clara County allocates vaccine supply to El Camino Health. On June 8, 2021 we initiated a mobile vaccination program.

On June 29, 2021 the El Camino Healthcare District Board approved the reallocation of, and made available the remainder of unused FY20 & FY21 COVID-19 funds totaling $2.4 million through FY22 for the use of either COVID-19 testing or vaccination programs. We began administering 3rd dose booster for qualified individuals at El Camino Health, Outpatient Pharmacy after September 24, 2021. In March and April 2022 we conducted mobile vaccinations clinics. In addition, a distribution of over 10,319 at-home test kits and 15,680 N95 masks were provided to schools, Federally Qualified Healthcare Clinics, and community service agencies within the healthcare district.

Appointments through El Camino Health, Mountain View Hospital Outpatient Pharmacy are available to schedule by visiting: https://www.elcaminohealth.org/covid-19-resource-center/vaccine-information.

Through August 31, 2022, over $1.3 million dollars have been invested for COVID-19 testing and vaccine response by the El Camino Healthcare District resulting with $1,006,817 remaining in balance of unused allocated funds for COVID-19 response.

Program Expenses in FY23 Period 2

COVID-19 Tests & Vaccines: $5,792

Labor: $7,253

Marketing: $0.00

Total: $13,045

Since Inception through FY23 Period 2 (August 31, 2022)

Total: $1,393,183

Remaining funds: $1,006,817

4. Assessment: The District Program operations are in place for testing and the vaccination.

5. Other Reviews: N/A

6. Outcomes: Addressing the COVID-19 pandemic through providing community testing and vaccination to decrease spread of COVID-19 in the community.

Suggested Board Discussion Questions:

Will we anticipate increase testing and vaccine spend in FY23?

Will current allocated funds last through FY23?

EL CAMINO HEALTHCARE DISTRICT
PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	10/18	NOV	12/13	JAN	2/8	3/28	APR	5/16	6/20
STANDARD												
Public Communication				✓				✓	✓		✓	✓
Spotlight Recognition				✓				✓			✓	
FINANCE[4]												
Financials				✓				✓	✓			✓
Budget											✓	✓
Tax Appropriation												✓
COMPLIANCE												
Financial Audit – Consolidated ECH District Financials				✓								
Approve Hospital Audit				✓								
COMMUNITY BENEFIT												
CB Year-End Report				✓								
CBAC Policy – Annual Approval				✓								
CB Plan Study Session											✓	
CB Mid-Year Metrics											✓	
Approval of CB Plan												✓
GOVERNANCE												
Appointment of El Camino Hospital Board Member Election Ad Hoc Committee & Advisors				✓								
El Camino Hospital Board Member Election Ad Hoc Committee Update								✓	✓			
Possible Election of El Camino Hospital Board Member									✓			
Review Process for Board Officer Election											✓	
Appointment of Liaison to the Community Benefit Advisory Council												✓
Approval of Pacing Plan & Meeting Dates												✓
Acceptance of Election Results						✓						
Administration of Oath						✓						
EXECUTIVE PERFORMANCE												
CEO Performance Review				✓								

Revised: 9/30/2022

El Camino Health

EL CAMINO HEALTHCARE BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Healthcare Board of Directors
From: John Zoglin, District Board Member
Date: October 18, 2022
Subject: Report on Educational Activity

Purpose: For information.

Summary:

Conference Title: AHA Leadership Summit, July 17-19, 2022

Sponsoring Organization: American Hospital Association

1. Key Educational Points, Lessons Learned: See Executive Summary

2. Do you recommend this conference to other members of the Board? ☒ Yes ☐ No

Attachments: Conference Presentations

American Hospital Association: Leadership Summit

Exec Summary/Potential ECH Opportunities

The team may already be involved in some/all of these activities:

Benchmarks/Best Practices. Truveta is a consortium of 20+ health systems <covering 16% of all our clinical care> that are pooling de-identified data to help develop more detailed benchmark data and identify best practices. In the future might also provide a platform for clinical trials. Could be worth our while to explore participating.

Employer Engagement. The team from Vanderbilt shared their case study of developing a unique value and episode-based bundle of care – for maternity – that they provided to the local school district that increased market share for Vanderbilt while saving both individuals and the school district money. While great to talk directly with employers as employers are looking for solutions, Vanderbilt's key to future expansion: Go through Brokers vs direct to employers. They are also adding bundles of care around: weight loss, ortho, hearing, spine. See attachment: FindingValueinProviderLedDirectoEmployer

How to be a good Board Chair: Good read for all of us, not just Bob. Also Sue Ellen Wagner, VP of trustee services AHA, could be good contact. https://hbr.org/2018/03/how-to-be-a-good-board-chair. Among their emphasis is**:**

- Lead the board not the organization
- Not the boss - no more authority than the full board
- Enable the board to counsel and supervise the management team

Enterprise Risk Management. Looks like we are fairly far along the maturity curve compared to other organizations. Did share this portal as a source of some great documents - American Society for Healthcare Risk Management**.** Ashrm.org/erm-trustees docs

Provider Partner with Payer; Big Data Analytics. Hackensack Meridian Health – NJ – partners with Horizon BCBS. Their CIN includes 80%, independent physicians. Develop contracts with shared upside based on volume and quality. Physicians are paid based on individual performance and performance of their "pod" of maybe 10 comparable physicians – great vehicle to encourage/peer pressure below average performers to adopt best practices - <both primary care and specialists>.

Working with a payer gives Hackensack Medical access to more/all patient touches -not just directly with Hackensack. They put out RFP with the requirement of 50-50 ownership and decision making – including the requirement to be only branded Medicare offering in the marketplace. BCBS handles claims, underwriting, and complaints. Hackensack provides care. Also partner with Lumeris. Lumeris does deep data analytics on care coordination of employee health plans, incentive structure, physician

engagement and utilization management and is paid based on cost savings they generate. See attachment: MakingTheMoveFromProveriderToPayer.

What Employers Want from Healthcare. Reiterating the value of just sitting and talking between employer and provider to identify needs and capabilities. Interesting company Morgan Health invested in: https://emboldhealth.com/ They work with employers, payers, And providers – applying analytics to identify the performance of physicians. They believe there is more variation within practices than across practices – so identifying the best performing provider for employers/payers can be impactful on cost and outcomes.

Healthy aging: creating "age-friendly health systems" (AFHS). Trying to develop a network of providers engaged/certified to address the needs of older patients. 2600 certified sites in 2022. 2035 more US residents >65 than <18 for the first time ever. The attached presentations include examples of improved performance for aging adults from cedars and Providence St. Joseph. See attachment: HelathyAgingCratingAgeFriendly.

Partnering with payers on downside risk. Key for providers is to generate enough data and analytics to evaluate, price, and manage risk to be able to commit to episode-based, value care. They need data from all patient's touches – helpful to get a broader picture from payers. This capability matches what the payer wants – the provider taking risks on episode-based services. Payers going forward will provide more tools to provider partners in terms of analytics, data capture, benchmarks, and guidelines on risk adjustments. Suggestion to include clinical, operations, and financial people in negotiations between provider and payers to identify shared win-win improvement opportunities vs only win-lose negotiations on pricing alone from financial people. See attachments: PartneringwithPayersDownsideRisk and PursuingPartnerValue.

El Camino Health

EL CAMINO HEALTHCARE BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Healthcare Board of Directors
From: Carol Somersille, MD, District Board Member
Date: October 18, 2022
Subject: Report on Educational Activity

Purpose: For information.

Summary:

Conference Title: AHA Leadership Summit, July 17-19, 2019

Sponsoring Organization: American Hospital Association

1. Key Educational Points, Lessons Learned:

A. Leadership Principles.
I attended many of the Governance/Trustee Track sessions.
Our healthcare system is ahead of the curve in many areas, including but not limited to our commitment to a culture of safety, our ongoing educational sessions, our board and committee structure, and our yearly self-assessment.
Principle educational points:
- Help committee members focus on the mission and values from a strategic standpoint.
- Concentrate more on the process (inputs) and less on the metrics (outputs).
- Rather than looking for a solution to a problem, facilitate the best way to have more meaningful discussion of the problem.
- Cultivate a culture of mission, meaning, and joy.

B. Heath Equity.
I attended many of the Health Equity sessions.
Our healthcare system is ahead of the curve in many areas because we are investing substantial resources in clinical programs that lose money, but address community needs and address health inequity in the community. Additionally, we provide direct funding for many programs.
Principle educational points:
- Collect more meaningful inpatient and outpatient data regarding the social determinants of health.
- Invest in analysis and research of our inpatient and outpatient community in order to deliver the best care. The Community Health Needs Assessment is not enough.
- Define what is culturally appropriate care in our healthcare district.

C. Collaboration with the Community
I attended the NOVA award recipient session in which “Winners are recognized for their work to improve community health status in collaboration with other stakeholders.” I am undoubtedly biased as a Community Benefit Advisory Council

Board liaison, but I believe our healthcare district is already worthy of receiving this award. Principle Educational Points:

- Engage our essential workers in our community partnerships in order to create transformative relationships and cultivate a culture of mission, meaning, and joy in work.
- Facilitate discussions through task forces of community partners that address the same needs (for example dental health) so we don't duplicate but help them fill in the gaps.
- Through the school nurse program, concentrate on the family and create family, school and healthcare district collaboration.

2. Has the conference improved your ability to fulfill your obligations as a member of the ECH Board? If so, how?

Yes. All lessons learned will benefit our healthcare organization as we continue to grow and evolve.

3. Were there speakers that ECH should consider inviting? ☒ Yes ☐ No

We should consider inviting Joy Lewis, MSW, MPH, Senior Vice President of Health Equity Strategies and Executive Director of the Institute for Diversity and Health Equity, American Hospital Association

4. Do you recommend this conference to other members of the Board? ☒ Yes ☐ No

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors

From: John Zoglin, District Board Member

Date: October 18, 2022

Subject: Possible Board Member Compensation Modification

Purpose:

To consider and discuss modifying the current language around Board stipends.

Summary:

1. Situation: On March 15, 2022, the El Camino Healthcare District Board approved resolution 2022-02 increasing compensation for district board members' attendance at meetings from $100 to $105 per day in accordance with Health and Safety code § 32103.

2. Assessment: Current language of Resolution No 2022-02 allows Board members to "opt-out" of this compensation, but does not give the flexibility to compensate Board members at different rates.

The item for discussion is whether to amend the resolution to allow each district board members to accept *up to* $105 per day rather than the fixed amount of $105.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District Board (ECHD) of Directors
From: Deanna Dudley, Chief Human Resource Officer
Date: October 19, 2022
Subject: El Camino Health District Board Member Group Benefits

Purpose: To inform El Camino Health District Board on group benefits for Members of the Board through guidance from the California Special Districts Association and a the relevant policy of the Desert Healthcare District (Palm Springs, California)

Summary:

1. Situation: In May, staff provided El Camino Health District Board Members with research materials to aid their discussion about health benefits for Board members.

2. Authority: None.

3. Background: In January 2022, El Camino Health District Board Members transitioned to El Camino Health W-2 employees for tax reporting purposes. At that time, the District Board raised the question as to whether or not Board members are eligible for employer-paid Health Benefits.

4. Assessment: None.

5. Other Reviews: Staff have discussed the possibility of Board members' participation in certain benefits offered to El Camino Health employees with El Camino's insurance broker.

   Potential offerings being investigated are:

   - Medical Insurance through Aetna
   - Dental Insurance through MetLife
   - Vision Insurance through VSP
   - Basic Life Insurance

   Election into the aforementioned programs, except for Medical Insurance, is plausible due to the programs being self-insured by El Camino Health. More research is required with respect to Board member enrollment in Medical Insurance, which is fully insured and subject to underwriting review by the insurer.

   The ability of Board members to elect to participate in El Camino group benefit programs requires a Resolution of the Board. This resolution shall be on a future agenda during open session and subject to public comment.

List of Attachments:

1. Special District Board Member Compensation Guide (refer to Pages 3 and 4)
2. Desert Healthcare District Board of Directors Policy 21

Suggested Board Discussion Questions:

1. Does the Board of Directors wish to proceed with a resolution for members to participate in the self-insured benefit programs sponsored by El Camino Health (dental and vision) and basic life insurance?
2. Does the Board of Directors wish Staff to continue the investigation of medical benefits participation for Board members?

meyers | nave

SPECIAL DISTRICT BOARD MEMBER COMPENSATION GUIDE

California Special Districts Association
Districts Stronger Together

UNDERSTANDING SPECIAL DISTRICT BOARD MEMBER COMPENSATION

By: Richard D. Pio Roda and Anthony Felix, Meyers Nave

This paper is intended to help you understand compensation for special district board members in California. Specifically, it describes (1) the statutory authority behind board member compensation, (2) the maximum compensation board members can receive, (3) how board members can increase compensation, (4) board member reimbursements for job-related expenses, (5) the extent to which board members may receive benefits, and (6) how small community services districts typically compensate board members.

Under what authority can special districts compensate board members?

Typically, special district board member compensation is set by the Legislature. Special districts have the general authority to compensate board members for attendance at meetings under the California Government Code. [1] However, this general authority is limited by statutes specific to particular types of districts, which prescribe rates and conditions for board member compensation. Special districts are granted authority either under principal acts or special acts. Principal acts are codified in state laws and are generic statutes that apply to all special districts of a particular type. Special acts are often uncodified and are narrowly focused on governing one or a few special districts to fit the unique needs of those districts. A board member interested in learning more about their district's authority to compensate its board members should first reference their district's formation or enabling documents to determine whether the district is governed by a principal act or a special act. Identifying which statutes govern a district is important because such statutes often vary in provisions for the maximum amount of compensation a board member may receive, how and if board members can increase compensation, and provisions regarding reimbursements and board member benefits.

What is the maximum amount of compensation a special district board member may receive?

Principal act districts that have been codified in state law vary on the maximum amount a board member may be compensated. Most code sections set the maximum compensation rate at $100 for each meeting attended by a board member or each day in which a board member is engaging in official duties. This includes special districts such as county water districts,[2] recreation and park districts,[3] community services districts, [4] public cemetery districts,[5] and more. Other code sections explicitly provide that special district board members are to receive no compensation in their roles as board members. These

[1] Gov. Code § 53232.1(a).
[2] Water Code § 30507.
[3] Pub. Res. Code § 5784.15(a).
[4] Gov. Code § 61047(a).
[5] Health and Safety Code § 9031(a).

districts include pest abatement districts,[6] police protection districts,[7] citrus pest control districts,[8] port districts,[9] river port districts,[10] and memorial districts.[11] Many districts set maximum compensation rates at amounts smaller than $100, such as $10,[12] $25,[13] or $50[14] per meeting attended by the board member. Some code sections authorize a flexible compensation rate to be determined by the board members themselves. The California Water Code sections governing levee districts[15] and reclamation districts[16] provide that each board member shall receive compensation for their services "… as the board determines to be just and reasonable…" Generally, these districts still compensate board members at a rate under $100 per meeting.

Can special district board members increase their compensation? If so, how can board members do so?

In addition to attending regularly scheduled board meetings, board members often must attend the meetings of other agencies or travel to conferences in order to better understand and fulfill their roles. In order to meet these often demanding and time-consuming duties, some special districts consider increasing the compensation of its board members. If a special district board is considering increasing the compensation of its board members it is important it starts by referencing its governing statutes or acts. A district's governing statutes or acts will determine whether board members can increase compensation, to what extent compensation can be increased, and how to increase compensation.

Many special districts can increase board member compensation pursuant to California Water Code section 20201, which both sets the maximum amount of compensation per meeting at $100 but also authorizes board members to increase compensation above $100.[17] Although this may be welcome news to districts interested in increasing compensation, there are three notable restrictions on a district's ability to do so. If a special district board can increase compensation via section 20201: (1) it must do so via ordinance,[18] (2) the increase may not exceed 5% for each calendar year,[19] and (3) voters may petition for a referendum on the ordinance increasing compensation.[20] As part of the ordinance requirement, special district boards must hold a public hearing for discussion of the compensation increase and publish a notice of the hearing.[21] Special districts should also note voter referendums may result in the ordinance appearing on a regular election or special election ballot for voter approval.[22] If the ordinance is struck down by voters, the special district board will be prohibited from adopting a new compensation increase ordinance for at least one year.[23]

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[6] Health and Safety Code § 2851
[7] Health and Safety Code § 20069
[8] Food and Ag. Code § 8508
[9] Har. and Nav Code § 6251.
[10] *Id*. at § 6836.
[11] Mil. and Vet Code § 1197.
[12] Wat. Code § 56031.
[13] Pub. Res. Code § 13041(b).
[14] Har. and Nav. Code § 7047.
[15] Wat. Code § 70078.
[16] *Id.* at § 50605(a).
[17] *Id.* at § 20201.
[18] *Id.*
[19] *Id.* at § 20202.
[20] *Id.* at § 20204.
[21] *Id.* at § 20203
[22] Wat. Code § 20206.
[23] *Id*.

On the other hand, many statutes and acts governing special districts are silent on a district's authority to adjust board member compensation. As a result of lacking a statutory authority to adjust board member compensation, special districts falling into this category may be unable to do so. Therefore, it is important that special districts interested in increasing board member compensation reference its district's formation documents to identify if its governing statutes or acts allow such actions.

Can board members be reimbursed for job-related expenses?

Special district board members are often expected to attend a variety of events in the performance of their duties, including trainings, community outreach events, conferences, and local agency meetings. The expenses associated with these activities, including travel, lodging, and food costs, can be significant. Fortunately, the Legislature has recognized the costs associated with serving as a board member and granted special districts with the authority to provide reimbursements. In fact, the vast majority of special districts have the authority to reimburse board members for expenses related to fulfilling their duties as board members.

Again, the most important starting point to determine whether a special district may reimburse its board members is identifying the governing acts or statutes. Most districts have the statutory authority to reimburse board members but are required to abide by the reimbursement procedures set out in Government Code sections 53232.2- 53232.4. In order to comply with Government Code section 53232.2, special districts generally must only reimburse board members for actual and necessary expenses incurred in the performance of official duties and adopt a written policy that specifies the types of expenses that may be reimbursed. Other requirements on board members include the filing of expense reports with special district boards and providing brief reports on the meetings requiring reimbursement.[24] Special districts should note the misuse of reimbursement funds can result in the loss of reimbursement privileges, civil penalties, and even criminal penalties.[25] Therefore, special districts governed by Government Code sections 53232.2- 53232.4 should ensure its reimbursement policies are consistent with these sections and that board members are only being reimbursed for actual and necessary expenses.

Some districts are not directly governed by the statutory requirements of Government Code sections 53232.2- 53232.4 but instead follow a less stringent reimbursement procedure. For example, in reclamation districts a board member's claims for expenses incurred are to be presented to the board and then paid in the same manner as other indebtedness of the district.[26] Although citrus pest control district board members are not entitled to any compensation, they may be reimbursed for actual and necessary expenses when claims for those expenses have been approved by the board.[27] Still, other districts lack the statutory authority to provide any reimbursements for board members, including police protection districts.[28]

To what extent can special district board members receive benefits?

Although only some special district board members may be entitled to compensation, all special district board members may receive group insurance benefits if the board elects to do so. Under Government Code section 53201 and 53205.1, a special district board may provide benefits to its board members,

[24] Gov. Code § 53232.3(a); Gov. Code § 53232.3(d).
[25] *Id*. at § 53232.4.
[26] Wat. Code § 50606.
[27] Food and Ag. Code § 8508.
[28] Health and Saf. Code § 20000 *et seq.*

retired board members, and the families of board members and retired board members. Benefits can include medical, dental, vision, and life insurance.[29]

California state law is relatively silent on the procedures a special district must take to adopt a benefits policy for its board members. The Office of the Attorney General provides some guidance on the issue by declaring that no official declaration of policy is required for a special district to provide health benefits to its elective officers.[30] The Attorney General's opinion noted that no procedure or mode for providing the benefits is set forth in Government Code section 53201.[31] The Attorney General concluded that a special district board may take action in any appropriate manner, whether by ordinance, resolution, motion, or otherwise.[32] Therefore, whether a district must approve a benefits plan by ordinance or resolution comes down to what the enabling or principal act governing it requires. Beyond that, the Brown Act requires changes in compensation, including fringe benefits, to be made during an open meeting.[33]

Special district boards should note that districts considering providing benefits to its board members have often received pushback from the community.[34] If a special district is considering providing a benefits program to its board members, it may be prudent for them to be transparent about the program's estimated costs and expected beneficiaries so the public is aware of the district's proposed expenditures.

With that being said, most of the principal acts governing special districts make no explicit mention of a board's authority to provide benefits to its board members. This is not to say these special districts may not provide benefits to its board members as Government Code section 53201, which grants districts the authority to provide benefits, still applies to them as well. The few special districts with principal acts that mention benefits separately (such as regional park and/or open space districts) note that board members are eligible for the same group medical or dental plans available to permanent employees of the district.[35]

How do small community service districts typically compensate board members?

In addition to applicable statutory restrictions, board member compensation for a small district may also be restricted if the district has a small budget. If a particular community services district is governed by the principal act requirements set out in Government Code section 61047, it may provide its board members with $100 each day for services provided. Community services districts may also increase board member compensation above $100 in accordance with the authority and requirements set out in Water Code section 20201.

Most community services district do not compensate board members. Some community services districts compensate its board members as much as $10,000 per year including the Phelan Pinon Hill Community

[29] Gov. Code § 53205.16.
[30] 86 Cal. Att'y Gen. Op. No. 92-1008 (May 5, 1993).
[31] *Id*.
[32] *Id*.
[33] Gov. Code § 5493(c)(3).
[34] Brad Branan, *Health benefits boost board compensation at Sacramento area special districts*, The Sacramento Bee (March 6, 2015, 6:20 PM), https://www.sacbee.com/news/investigations/the-public-eye/article12892430.html.; Paul Rogers, *Santa Clara Valley Water District considers idea for lifetime medical benefits for board members*, (August 27, 2012, 1:19PM), https://www.mercurynews.com/2012/08/27/santa-clara-valley-water-district-considers-idea-for-lifetime-medical-benefits-for-board-members/.
[35] Pub. Res. Code § 5536.

Services District[36] and the Rosamond Community Services District. [37] Many community services districts compensate board members at a rate consistent with Government Code section 61047, which amounts to $4,800 a year assuming board members provide services or attend meetings four days a month.

How a small district compensates its board members will come down to what the district's budget and needs are. Although all community services districts have the statutory authority to compensate board members at a rate more than $100 for each meeting attended, most small districts elect to compensate less than $100 per meeting or not at all.

Moving Forward

The California Government Code, through principal or special acts, generally provides special districts with the authority to compensate its board members. Although most districts set the maximum board member compensation rate at $100 for each meeting attended by a board member, some districts offer a flexible compensation rate, compensation under $100, or no compensation at all. Many special districts can increase board member compensation pursuant to California Water Code section 20201, which both sets the maximum amount of compensation per meeting at $100 but also authorizes board members to increase compensation above $100. The vast majority of districts have the authority to reimburse board members for the actual and necessary expenses incurred on the job, subject to those districts and board members meeting certain requirements. All special districts board members may receive group insurance benefits, including medical, dental, vision, and life insurance. Lastly, most small community services districts compensate board members at a rate less than $100 for each meeting attended or not at all, despite having the authority to compensate board members more than $100. Moving forward, a special district interested in compensating its board members should reference its enabling statutes because such statutes will often determine the maximum amount of compensation a board member may receive, how and if board members can increase compensation, and whether board members may be provided reimbursements and benefits.

[36] Government Compensation in California, https://publicpay.ca.gov/Reports/PositionDetail.aspx?employeeid=19490354, (last visited June 19, 2019).
[37] Government Compensation in California, https://publicpay.ca.gov/Reports/PositionDetail.aspx?employeeid=19955885, (last visited June 19, 2019).

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Updated: October 2019

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DESERT HEALTHCARE
DISTRICT & FOUNDATION

POLICY TITLE:	**MEETING & INSURANCE COMPENSATION POLICY**
POLICY NUMBER:	BOD-21
COMMITTEE APPROVAL:	02-09-2021
BOARD APPROVAL:	02-23-2021

POLICY #BOD-21: Meeting & Insurance Compensation Guidelines for the Desert Healthcare District ("District") Board of Directors ("Board").

A) Board Members may receive a stipend for attendance at up to 6 meetings per month, provided the meetings have a healthcare nexus or are related to the District's operations, mission, and vision, and include the following:

1. District Board and Board committee meetings.
2. Meetings for which a District Board member serves on the Desert Regional Medical Center's Board of Directors or its committees.
3. Attendance at ethics training.
4. Conferences and seminars held by organizations in which the District is a member, and for which the conference/seminar has a clear health care related nexus. Board members shall receive one stipend per conference or seminar.
5. Community meetings and events within the District, for which the meeting/event has a clear health care nexus, including the following:
    a) Board, policy committee, and formal business meetings of organizations in which the District is a member.
    b) Meetings with other government agencies or officials in which the subject involves health care or District business (e.g., State and local legislative officials, County Health & Human Services).
    c) Formal Meetings requested, necessitated, or approved by the CEO.

B) Non-compensable meetings shall include the following:

1. Informal meetings with other Board members or with District staff members, regardless of the topic(s) addressed.

2. Meetings of a political nature, whether partisan or non-partisan, regardless of the topic(s) addressed.
3. Meetings for which payment of a stipend or honorarium is provided by the host organization.
4. Meetings of other public bodies, unless invited as a participant by the host body or sent as a delegate by the District Board.
5. Meetings of organizations in which the member holds an individual membership or the primary purpose of which is to receive continuing professional educational credits.
6. Charity fundraising events.

Board members shall have an opportunity to report on meetings attended at the next regularly scheduled Board meeting following the meeting for which a stipend is received. Any questions regarding interpretations of these guidelines should be addressed to the District's General Counsel.

If more than one Board meeting is held in succession on the same calendar day, they collectively shall count as a single meeting for the payment of a stipend. Such classification applies only to regular, special, closed and executive sessions and shall not apply to successive Committee meetings in which a Director may be a member.

C) Board members shall receive compensation of insurance premiums up to $10,000 per fiscal year (July 1 to June 30). Insurance premiums (coverage may be applied to the Board member, their spouse or registered domestic partner, and children) include medical, dental, and vision and include any combination of the following.

1. Board member may receive insurance coverage through the District. Board member shall be responsible for reimbursing the District for premiums exceeding $10,000 per fiscal year.

2. Reimburse Medicare premiums.

3. Reimburse supplemental insurance premiums.

4. Reimburse the portion of insurance premiums withheld from Board member's payroll.

5. Reimbursement does not apply to COBRA insurance premiums when Board member leaves office.

AUTHORITIES

Desert Healthcare District Bylaws Article IV, section 4.6
Desert Healthcare District Resolution No. 19-08

DOCUMENT HISTORY

Revised	02-23-2021
Revised	04-23-2019
Approved	07-24-2018

Dedicated to improving the health and well being of the people in our community.

Board Finance Presentation
Fiscal Year 2023
7/1/2022-8/31/2022

Carlos Bohorquez, CFO
El Camino Healthcare District Board of Directors Meeting
October 18, 2022

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NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

El Camino Healthcare District

Consolidated Comparative Balance Sheet ($ Millions)

(Includes El Camino Hospital)

	Aug 31, 2022	Audited w/o eliminations June 30, 2022
ASSETS		
Current Assets		
Cash & Investments	$317	$327
Patient Accounts Receivable, net	224	210
Other Accounts and Notes Receivable	30	36
Inventories and Prepaids	39	50
Total Current Assets	**611**	**623**
Board Designated Assets		
Foundation Reserves	20	19
Community Partnership Fund	14	23
Operational Reserve Fund [1]	184	184
Workers Comp, Health & PTO Reserves	78	78
Facilities Replacement Fund [2]	400	356
Catastrophic & Malpractice Reserve [3]	29	27
Total Board Designated Assets	**725**	**686**
Non-Designated Assets		
Funds Held By Trustee [4]	30	35
Long Term Investments	493	496
Other Investments	30	31
Net Property Plant & Equipment	1,199	1,201
Deferred Outflows of Resources	15	15
Other Assets	248	256
Total Non-Designated Assets	**2,014**	**2,035**
TOTAL ASSETS	**$3,350**	**$3,343**

	Aug 31, 2022	Audited w/o eliminations June 30, 2022
LIABILITIES & FUND BALANCE		
Current Liabilities		
Accounts Payable & Accrued Exp [5]	$149	$177
Bonds Payable - Current	13	16
Bond Interest Payable	2	9
Other Liabilities	23	23
Total Current Liabilities	**187**	**225**
Deferred Revenue	**12**	**2**
Deferred Revenue Inflow of Resources	**104**	**105**
Long Term Liabilities		
Bond Payable	569	572
Benefit Obligations	44	44
Other Long-term Obligations	27	32
Total Long Term Liabilities	**640**	**648**
Fund Balance		
Unrestricted	2,212	2,181
Board Designated & Restricted	195	181
Capital & Retained Earnings	0	0
Total Fund Balance	**2,407**	**2,361**
TOTAL LIAB. & FUND BAL.	**$3,350**	**$3,343**

Note: Totals may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Consolidated Comparative Statement of Revenues & Expenses ($ Millions)

Year-to-Date through August 31, 2022

(Includes El Camino Hospital)

	Actual	Budget	Fav (Unfav) Variance	Prior YTD FY Actual
Net Patient Revenue [6]	227	219	8	206
Other Operating Revenues	7	8	(1)	7
Total Operating Revenues	**234**	**227**	**7**	**213**
Wages and Benefits	123	116	(7)	107
Supplies	32	32	1	30
Purchased Services	28	33	5	29
Other	8	10	2	7
Depreciation	13	13	(0)	12
Interest	3	3	(0)	3
Total Operating Expense [7]	**207**	**206**	**(0)**	**187**
Operating Income	**28**	**21**	**7**	**26**
Non-Operating Income [8]	11	9	2	11
Net Income	**38**	**29**	**9**	**37**

Note: Totals or variances may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Notes to Consolidated Financial Statements

Current FY2023 Actual to Budget

(Includes El Camino Hospital)

1) A 60 day reserve of expenses based on the last fiscal year's Hospital budget, to be adjusted to current year next month.
2) The current period Facilities Replacement Fund is comprised of ($ Millions):

ECH Capital Replacement Fund (i.e. Funded Depr.)	$338
ECHD Appropriation Fund (fka: Capital Outlay)	23
ECH Women's Hospital Expansion	30
ECH Campus Completion Project	9
	$400

3) The current period Catastrophic & Malpractice Fund is comprised of ($ Millions):

ECH Catastrophic Fund (aka: Earthquake Fund)	$27
ECH Malpractice Reserve	2
	$29

4) Funds Held by Trustee now only reflect the GO funds of the District. The decrease was due to the annual GO principal payment made on 8/1/22.
5) The decrease is primarily due to construction retentions accrued at fiscal year end for Women's Hospital Renovation and the MV Campus Completion projects.
6) Strong volumes continue to be the primary driver to such a favorable performance to budget.
7) Higher operating expenses are due to the increased volumes and associated expenses.
8) Positive to budget due to better investment returns than projected.

El Camino Healthcare District

Stand-Alone Comparative Balance Sheet ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	Aug 31, 2022	Audited June 30, 2022		Aug 31, 2022	Audited June 30, 2022
ASSETS			**LIABILITIES & FUND BALANCE**		
Cash & cash equiv [1]	$1,693	$11,955	Accounts payable	$53	$77
Short term investments [1]	1,412	8,905	Current portion of bonds	3,293	5,760
Due fm Retiree Health Plan [2]	36	36	Bond interest payable [10]	842	1,314
S.C. M&O Taxes Receivable [3]	3,803	0	Other Liabilities	275	349
Other current assets [3a]	82	2258			
Total current assets	$7,026	$23,154	**Total current liabilities**	$4,463	$7,500
Operational Reserve Fund [4]	1,500	1,500			
Capital Appropriation Fund [5]	22,657	11,129			
Capital Replacement Fund [6]	5,000	4,864	Deferred income	35	52
Community Partnership Fund [7]	4,160	4,259	Bonds payable - long term	102,354	105,647
Total Board designated funds	$33,317	$21,752	**Total liabilities**	**$106,852**	**$113,199**
Funds held by trustee [8]	**$29,921**	**$35,272**	**Fund balance**		
Capital assets, net [9]	**$10,654**	**$10,654**	Unrestricted fund balance	$50,683	$55,013
			Restricted fund balance [11]	(76,616)	(77,380)
			Total fund balance	**($25,933)**	**($22,367)**
TOTAL ASSETS	**$80,919**	**$90,832**	**TOTAL LIAB & FUND BALANCE**	**$80,919**	**$90,832**

Note: Totals may not agree due to rounding. See page 9 for footnotes.

El Camino Healthcare District

YTD Stand-Alone Stmt of Revenue and Expenses ($ Thousands)

Comparative Year-to-Date August 31, 2022

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

		Actual	Current Year Budget	Variance	Prior Full Year Actual
	REVENUES				
(A)	Ground Lease Revenue [12]	$ 18	18	$ -	$ 104
(B)	Redevelopment Taxes [13]	3	-	3	417
(B)	Unrestricted M&O Property Taxes [13]	2,356	2,356	-	9,804
(B)	Restricted M&O Property Taxes [13]	1,639	1,639	-	11,528
(B)	G.O. Taxes Levied for Debt Service [13]	1,867	1,867	-	12,304
(B)	IGT/PRIME Medi-Cal Program [14]	-	(500)	500	(2,613)
(B)	Investment Income (net)	(3,259)	141	(3,400)	(1,316)
(B)	Other income	-	-	-	-
	TOTAL NET REVENUE	2,624	5,520	(2,896)	30,228
	EXPENSES				
(A)	Wages & Benefits [15]	1	-	-	2
(A)	Professional Fees & Purchased Svcs [16]	65	135	70	472
(A)	Supplies & Other Expenses [17]	(11)	5	16	339
(B)	G.O. Bond Interest Expense (net) [18]	983	1,071	88	2,943
(B)	Community Partnership Expenditures [19]	4,116	1,277	(2,839)	7,472
(A)	Depreciation / Amortization	1	1	-	9
	TOTAL EXPENSES	5,155	2,489	(2,665)	11,237
	NET INCOME	$ (2,531)	$ 3,030	$ (5,561)	$ 18,992

(A) Operating Revenues & Expenses

(B) Non-operating Revenues & Expenses

	RECAP STATEMENT OF REVENUES & EXPENSE	
(A)	Net Operating Revenues & Expenses	$ (37)
(B)	Net Non-Operating Revenues & Expenses	(2,493)
	NET INCOME	$ (2,531)

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Comparative YTD Stand-Alone Stmt of Fund Balance Activity ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	August 31, 2022	June 30, 2022
Fiscal year beginning balance	**$ (22,367)**	**$ (25,293)**
Net income year-to-date	$ (2,531)	$ 18,992
Transfers (to)/from ECH:		
IGT/PRIME Funding [20]		$ 2,213
Capital Appropriation projects [21]	$ (1,035)	(18,279)
Fiscal year ending balance	**$ (25,933)**	**$ (22,367)**

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(1) Cash & Short Term Investments – The decrease is due to transfer to Community Partnership and Capital Appropriation Funds for 2023.

(2) Due from Retiree Health Plan – The monies due from Trustee for District's Retiree Healthcare Plan.

(3) S.C. M&O Taxes Receivable – Increase reflects property tax accruals for FY 2023.

(3a) Other Current Assets – This decrease is due to Healthcare District paying for IGT refund to the State that was to be paid by the Hospital.

(4) Operational Reserve Fund – Starting in FY 2014, the Board established an operational reserve for unanticipated operating expenses of the District.

(5) Capital Appropriation Fund – Commitment to the Women's Hospital renovation and Campus Completion projects.

(6) Capital Replacement Fund – Formerly known as the Plant Facilities Fund (AKA - Funded Depreciation) which reserves monies for the major renovation or replacement of the portion of the YMCA (Park Pavilion) owned by the District.

(7) Community Partnership Fund – This fund retains unrestricted (Gann Limit) funds to support the District's operations and primarily to support its Community Partnership Programs.

(8) Funds Held by Trustee – Funds from General Obligation tax monies, being held to make the debt payments when due. The 8/1/22 payment was paid.

(9) Capital Net Assets - The land on which the Mountain View Hospital resides, a portion of the YMCA building, property at the end of South Drive (currently for the Road Runners operations), and a vacant lot located at El Camino Real and Phyllis.

(10) Bond Interest Payable – The decrease is due to the semi-annual interest payment paid on 8/1/2022.

(11) Fund Balance – The negative fund balance is a result of the General Obligation bonds which assisted in funding the replacement hospital facility in Mountain View. Accounting rules required the District to recognize the obligation in full at the time the bonds were issued ; receipts from taxpayers will be recognized in the year they are levied, slowly reducing the negative fund balance over the next 15 years.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(12) Other Operating Revenue – Lease income from El Camino Hospital for its ground lease with the District.

(13) Taxes: Redevelopment, M&O, G.O. – Tax receipts (either received or to be received) during the period. Note amount for the G.O. Taxed Levied for Debt will come in less than prior year mostly due to the March 2017 G.O. Refunding that the District did that reduced the previously $12.90 of assessed property valuation per $100,000 to a current $10.00 per $100,000.

(14) IGT/PRIME Expense – Payments in support of the PRIME or IGT programs.

(15) Wages & Benefits – Due to a new IRS reg that board stipends previously paid as reportable 1099 transactions are now considered to be W-2 reportable transactions, and reported in this section, where previously reported in the "Supplies & Other Expenses." There will continue to be no other "employees" of the District.

(16) Professional Fees & Services – Actual detailed below:

• Community Partnership Support from ECH (54% of SW&B)	$ 60
• Legal Fees	5
	$ 65

(17) Supplies & Other Expenses – Actual detailed below:

• Marketing / Advertising (refund)	$ (27)
• Dues & Subscriptions	16
	$ (11)

(18) G.O. Bond Interest Expense – Starting in FY2023 the 2006 Capital Appreciation Bonds begin to be repaid, thus additional interest expense of $3.4M is now occurring.

(19) Community Partnership Expenditures – Starting in FY2014, the District is directly operating its Community Partnership Program at the District level. This represents amounts expended to grantees and sponsorships thus far in this fiscal year. Note the major payments to recipients are made in August & January of the fiscal year.

(20) IGT/PRIME Funding – Transfers from ECH for participation in the PRIME or IGT program thus far in FY 2022.

(21) Capital Appropriation Projects Transfer – This years net transfer is in support of MV Hospital's Campus Completion Project.

El Camino Healthcare District

Sources & Uses of Tax Receipts ($Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

Sources of District Taxes	**08/31/22**
(1) Maintenance and Operation and Government Obligation Taxes	$5,862
(2) Redevelopment Agency Taxes	3
Total District Tax Receipts	**$5,865**
Uses Required Obligations / Operations	
(3) Government Obligation Bond	1,867
Total Cash Available for Operations, CB Programs, & Capital Appropriations	**3,998**
(4) Capital Appropriation Fund – Excess Gann Initiative Restricted*	1,639
Subtotal	**2,359**
(5) Operating Expenses (Net)	37
Subtotal	**2,322**
(6) Capital Replacement Fund (Park Pavilion)	1
Funds Available for Community Partnership Programs	**$2,321**
*Gann Limit Calculation for FY2023	$10,601

(1) M&O and G.O. Taxes	• Cash receipts from the 1% ad valorem property taxes and Measure D taxes
(2) Redevelopment Agency Taxes	• Cash receipts from dissolution of redevelopment agencies
(3) Government Obligation Bond	• Levied for debt service
(4) Capital Appropriation Fund	• Excess amounts over the Gann Limit are restricted for use as capital
(5) Operating Expenses	• Expenses incurred in carrying out the District's day-to-day activities
(6) Capital Replacement Fund	• Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion)

Appendix: Major Budget Assumptions for FY2023

1. Pages 13 and 14: Are the pages 6 and 7 of the FY23 ECHD Stand-Alone Budget presented to the ECHD Board and approved on June 14, 2022.

2. Page 15: Additional detail about Community Partnership SW&B allocation process

Appendix: General Obligation Bond of the District

1. Pages 16 and 17: Description of the Bonds and annual debt service requirements grid.

Major Budget Assumptions – El Camino Healthcare District

Excludes El Camino Hospital & its affiliates

- Other Operating Revenue is based on the existing ground lease agreement.
- The Unrestricted M&O Property Taxes are budgeted at the FY2023 Gann Limit calculation as directed by the Finance Department of the State of California.
- This year the Redevelopment Agency revenues were once again budgeted as they continue to be distributed by the County without any lapse in payments in the past years. The budget for Fees and Purchased Services does have a $325,000 budget for November 2022 District Board election.
- Operating Expenses are based on historical payment information with adjustments made for non-recurring expenses.
- Community Partnership Support fee based on the cost of services as follows:

Community Partnership Staff FY2023		Total Paid FTEs	
Community Partnership Program Manager			1.00
Director Community Partnership			1.00
Administrative Assistant			1.00
Sr Community Partnership Spec			1.00
Business Coordinator			-
Total			4.00
Total Salaries, Wages & Benefits		$	687,657
Estimated allocation of time at 52% =		$	357,582

- Supplies and Other Expenses includes modest increases for Direct Mail material, website development, advertising and postage. The District's budgeted dues are expected to remain a constant of LAFCO at an amount of $18,000 and $7,000 for California Special Districts Association.
- G.O. Interest Expense (net), starting in FY2023 now includes the interest expense for the Series 2006 Capital Appropriation Bonds that are to be retired by 2031.
- Investment income is based on the expected return rate.
- Community Partnership expenditures are based on the Community Partnership plan.
- IGT – Medi-Cal (PRIME) program - It is expected that the District/Hospital will participate in the program again this year.

El Camino Healthcare District FY2023 Budget

Information excludes El Camino Hospital & its affiliates

($000s)

	Revenues	FY2021 Actual	FY2022 Actual	FY 2023 Budget	Change Favorable / (Unfavorable)	% Change
(A)	Other Operating Revenue	101	104	106	2	1.9%
(B)	Unrestricted M&O Property Taxes	9,221	9,804	10,601	797	8.1%
(B)	Restricted M&O Taxes	11,129	11,528	9,833	(1,695)	-14.7%
(B)	Taxes Levied for Debt Service	11,803	12,304	11,200	(1,104)	-9.0%
(B)	Investment Income (net)	(23)	(1,316)	1,034	2,350	-21.4%
(B)	Other - Redevelopment Agency	310	417	300	(117)	-28.1%
	Total Net Revenue	32,541	32,841	33,074	233	0.7%
	Expenses					
(A)	Community Partnership Support	416	381	358	23	-6.0%
(A)	Fees & Purchased Services	432	92	362	(270)	-74.6%
(A)	Supplies & Other Expenses	82	339	122	217	177.9%
(A)	Depreciation/Amortization/Interest Expense	53	9	4	5	125.0%
(B)	G.O. Interest Expense (net)	3,082	2,943	6,580	(3,637)	-55.3%
(B)	Community Partnership Program	7,196	7,472	7,665	(193)	-2.5%
(B)	IGT Medi-Cal Program Expense	4,460	2,613	3,000	(387)	-12.9%
	Total Expenses	15,721	13,849	18,091	(4,242)	-23.4%
	NET INCOME	16,820	18,992	14,984	(4,008)	-21.1%

	FY23 BUDGET RECAP STATEMENT OF REVENUES & EXPENSE	
(A)	Net Operating Revenues & Expen	(739)
(B)	Net Non-Operating Revenues & E	15,724
	NET INCOME	14,984

FY2023 Budget - Community Partnership SW&B Allocation

- Community Partnership staff are El Camino Hospital (ECH) employees who provide services to the District and to the Hospital Corporation.
- Pursuant to a Statement of Work (SOW) between El Camino Hospital and the District, Community Partnership Staff SW&B are allocated between the Hospital and the District.
- Per the SOW, the allocation is to be negotiated between the District Board Chair and the ECH Controller each spring for the coming fiscal year.
- For FY22, the total SW&B for the Community Partnership staff is budgeted at $705,558 with 54% ($381,001) allocated to the District. The Board Chair reviewed this allocation with Controller, Michael Walsh, and approved the allocation.
- For FY23, the total SW&B for the Community Partnership staff came in lower than FY22 at $687,657 with a change in the allocation percentage of 52%. Thus the allocation for FY23 will be a reduced amount of $357,582.

El Camino Healthcare District
General Obligation Bonds of the District

- 2006 General Obligation Bonds - Upon voter approval, in November 2003, the District issued in 2006, $148,000,000 principle amount of 2006 General Obligation Bonds, which consists of $115,665,000 of Current Interest Bonds. Interest on the Current Interest Bonds is payable semiannually at rates ranging from 4% to 5% and principal maturities ranging from $2,065,000 in 2016 to $18,050,000 in 2036 are due annually on August 1. Interest at rates ranging from 4.38% to 4.48% and principal of the Capital Appreciation Bonds are payable only at maturity. In March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the 2017 General Obligation Refunding Bonds.

- The Bonds are general obligations of the District payable from ad valorem taxes. Payment of principal, interest and maturity value of the Bonds, when due, is insured by a municipal bond insurance policy.

- 2017 General Obligation Bonds - Upon Board approval, in March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the $99,035,000 2017 General Obligation Refunding Bonds, which consists of $115,665,000 of Current Interest Bonds, and $32,335,000 of Capital Appreciation Bonds. Interest on the 2017 General Obligation Refunding Bonds is payable semiannually at rates ranging from 2% to 5% and principal maturities ranging from $3,570,000 in 2017 to $17,480,000 in 2036 are due annually on August 1. This refinancing resulted in a reduction of future interest payments with a present value of approximately $7,000,000.

Annual Debt Service Requirements

As of August 1, 2022

Year Ending (August 1)	2017 G.O Refunding Bonds Principal	2017 G.O Refunding Bonds Interest	2017 G.O Refunding Bonds Total Debt Service	Series 2006 Capital Appreciation Bonds (1) Principal	Series 2006 Capital Appreciation Bonds (1) Accreted Interest	Series 2006 Capital Appreciation Bonds (1) Total Debt Service	Aggregate Annual Debt Service on all general obligation bonds
2017	$ 3,570,000	$ 1,428,675	$ 4,998,675				$ 4,998,675
2018	3,310,000	3,915,600	7,225,600				7,225,600
2019	3,800,000	3,816,300	7,616,300				7,616,300
2020	4,400,000	3,626,300	8,026,300				8,026,300
2021	5,050,000	3,406,300	8,456,300				8,456,300
2022	5,760,000	3,153,800	8,913,800				8,913,800
2023		2,865,800	2,865,800	3,293,063	3,476,937	6,770,000	9,635,800
2024		2,865,800	2,865,800	3,397,871	3,922,129	7,320,000	10,185,800
2025		2,865,800	2,865,800	3,411,361	4,278,639	7,690,000	10,555,800
2026		2,865,800	2,865,800	3,551,505	4,843,495	8,395,000	11,260,800
2027		2,865,800	2,865,800	3,598,421	5,306,579	8,905,000	11,770,800
2028		2,865,800	2,865,800	3,673,863	5,846,137	9,520,000	12,385,800
2029		2,865,800	2,865,800	3,741,914	6,413,086	10,155,000	13,020,800
2030		2,865,800	2,865,800	3,802,634	7,007,366	10,810,000	13,675,800
2031		2,865,800	2,865,800	3,864,367	7,645,633	11,510,000	14,375,800
2032	12,000,000	2,865,800	14,865,800				14,865,800
2033	13,190,000	2,445,800	15,635,800				15,635,800
2034	14,525,000	1,918,200	16,443,200				16,443,200
2035	15,950,000	1,337,200	17,287,200				17,287,200
2036	17,480,000	699,200	18,179,200				18,179,200
Total	$ 99,035,000	$ 54,405,375	$ 153,440,375	$ 32,335,000	$ 48,740,000	$ 81,075,000	$ 234,515,375

Blue highlighted items are paid down

2017 Outstanding Principle $73,145,000. 2006 Outstanding Principle $32,335,000.

(1) The Series 2006 Capital Appreciation Bonds are payable only at maturity on August 1 of each year, and interest on the series 2006 Capital Appreciation Bonds is compounded semiannually on each February 1 and August 1

Dedicated to improving the health and well being of the people in our community.

Board Finance Presentation – Consolidated Statement
Fiscal Year 2022
7/1/2021-6/30/2022

Carlos Bohorquez, CFO
El Camino Healthcare District Board of Directors Meeting
October 18, 2022

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NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

El Camino Healthcare District

Consolidated Comparative Balance Sheet ($ Millions)

(Includes El Camino Hospital)

	June 30, 2022 Un-audited	June 30, 2021 Audited w/o Eliminations
ASSETS		
Current Assets		
Cash & Investments	$359	$457
Patient Accounts Receivable, net	210	166
Other Accounts and Notes Receivable	26	28
Inventories and Prepaids	36	23
Total Current Assets	**631**	**674**
Board Designated Assets		
Foundation Reserves	19	21
Community Benefit Fund	23	21
Operational Reserve Fund [1]	184	125
Workers Comp, Health & PTO Reserves	78	80
Facilities Replacement Fund [2]	357	313
Catastrophic & Malpractice Reserve [3]	27	27
Total Board Designated Assets	**686**	**587**
Non-Designated Assets		
Funds Held By Trustee [4]	35	37
Long Term Investments	499	603
Other Investments	31	35
Net Property Plant & Equipment	1,201	1,160
Deferred Outflows of Resources	15	20
Other Assets	174	148
Total Non-Designated Assets	**1,957**	**2,003**
TOTAL ASSETS	**$3,274**	**$3,264**

	June 30, 2022 Un-audited	June 30, 2021 Audited w/o Eliminations
LIABILITIES & FUND BALANCE		
Current Liabilities		
Accounts Payable & Accrued Exp [5]	$163	$154
Bonds Payable - Current	16	14
Bond Interest Payable	9	10
Other Liabilities	18	19
Total Current Liabilities	**206**	**198**
Deferred Revenue	**13**	**67**
Deferred Revenue Inflow of Resources	**51**	**46**
Long Term Liabilities		
Bond Payable	572	595
Benefit Obligations	44	48
Other Long-term Obligations	5	6
Total Long Term Liabilities	**621**	**649**
Fund Balance		
Unrestricted	2,202	2,157
Board Designated & Restricted	181	147
Capital & Retained Earnings	0	0
Total Fund Balance	**2,383**	**2,304**
TOTAL LIAB. & FUND BAL.	**$3,274**	**$3,264**

Note: Totals may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Consolidated Comparative Statement of Revenues & Expenses ($ Millions)

Un-audited Year-to-Date through June 30, 2022

(Includes El Camino Hospital)

	Actual	Budget	Fav (Unfav) Variance	Prior YTD FY Actual
Net Patient Revenue [6]	1,309	1,148	162	1,108
Other Operating Revenues	44	44	0	49
Total Operating Revenues	**1,354**	**1,192**	**162**	**1,156**
Wages and Benefits	656	629	(27)	588
Supplies	184	176	(8)	172
Purchased Services	182	173	(9)	182
Other	47	51	4	45
Depreciation	74	67	(7)	67
Interest	17	17	(0)	17
Total Operating Expense [7]	**1,159**	**1,113**	**(47)**	**1,070**
Operating Income	**194**	**79**	**115**	**86**
Non-Operating Income [8]	(132)	108	(240)	259
Net Income	**63**	**187**	**(125)**	**345**

Note: Totals or variances may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Notes to Consolidated Financial Statements

Current FY2022 Actual to Budget

(Includes El Camino Hospital)

1) A 60 day reserve of expenses based on the current fiscal year's Hospital budget.
2) The current period Facilities Replacement Fund is comprised of ($ Millions):

ECH Capital Replacement Fund (i.e. Funded Depr.)	$316
ECHD Appropriation Fund (fka: Capital Outlay)	11
ECH Women's Hospital Expansion	30
	$357

3) The current period Catastrophic & Malpractice Fund is comprised of ($ Millions):

ECH Catastrophic Fund (aka: Earthquake Fund)	$25
ECH Malpractice Reserve	2
	$27

4) This amount now reflects the GO Funds only.
5) The increase is primarily due to construction retentions accrued at fiscal year end for the Women's Hospital Renovation and MV Campus Completion Project.
6) Strong volumes recovery from COVID-19 continues to be the primary driver to such a favorable performance to budget.
7) Higher operating expenses are due to the increased volumes and expenses associated with the COVID-19 pandemic.
8) The variance is due to decreased investment returns.

Dedicated to improving the health and well being of the people in our community.

Board Finance Presentation – ECHD – Stand Alone
Fiscal Year 2022
7/1/2021-6/30/2022

Carlos Bohorquez, CFO
El Camino Healthcare District Board of Directors Meeting
October 18, 2022

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NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

El Camino Healthcare District

Stand-Alone Comparative Balance Sheet ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	June 30, 2022 Un-audited	June 30, 2021 Audited		June 30, 2022 Un-audited	June 30, 2021 Audited
ASSETS			**LIABILITIES & FUND BALANCE**		
Cash & cash equiv [1]	$11,955	$8,662	Accounts payable	$77	$2
Short term investments [1]	8,905	12,042	Current portion of bonds	5,760	5,050
Due fm Retiree Health Plan [2]	36	21	Bond interest payable [10]	1,314	1,419
S.C. M&O Taxes Receivable [3]	0	0	Other Liabilities	349	1,871
Other current assets [3a]	2258	3061			
Total current assets	$23,154	$23,786	**Total current liabilities**	$7,500	$8,342
Operational Reserve Fund [4]	1,500	1,500			
Capital Appropriation Fund [5]	11,129	18,657			
Capital Replacement Fund [6]	4,864	5,646	Deferred income	52	51
Community Benefit Fund [7]	4,259	3,030	Bonds payable - long term	105,647	111,422
Total Board designated funds	$21,752	$28,834	**Total liabilities**	**$113,199**	**$119,815**
Funds held by trustee [8]	**$35,272**	**$31,245**	**Fund balance**		
Capital assets, net [9]	**$10,654**	**$10,657**	Unrestricted fund balance	$55,013	$61,513
			Restricted fund balance [11]	(77,380)	(86,806)
			Total fund balance	**($22,367)**	**($25,293)**
TOTAL ASSETS	**$90,832**	**$94,522**	**TOTAL LIAB & FUND BALANCE**	**$90,832**	**$94,522**

Note: Totals may not agree due to rounding. See page 9 for footnotes.

El Camino Healthcare District

YTD Stand-Alone Stmt of Revenue and Expenses ($ Thousands)

Comparative Year-to-Date June 30, 2022

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

		Actual	Current Year Budget	Variance	Prior Full Year Actual
	REVENUES				
(A)	Ground Lease Revenue [12]	$ 104	102	$ 2	$ 101
(B)	Redevelopment Taxes [13]	417	300	117	310
(B)	Unrestricted M&O Property Taxes [13]	9,804	9,804	-	9,221
(B)	Restricted M&O Property Taxes [13]	11,528	8,717	2,811	11,129
(B)	G.O. Taxes Levied for Debt Service [13]	12,304	10,200	2,104	11,803
(B)	IGT/PRIME Medi-Cal Program [14]	(2,613)	(4,012)	1,399	(4,460)
(B)	Investment Income (net)	(1,316)	848	(2,164)	(23)
(B)	Other income	-	325	(325)	0
	TOTAL NET REVENUE	30,228	26,284	3,944	28,081
	EXPENSES				
(A)	Wages & Benefits [15]	2	-	-	0
(A)	Professional Fees & Purchased Svcs [16]	472	544	72	849
(A)	Supplies & Other Expenses [17]	339	32	(307)	82
(B)	G.O. Bond Interest Expense (net) [18]	2,943	2,968	25	3,082
(B)	Community Benefit Expenditures [19]	7,472	7,664	192	7,196
(A)	Depreciation / Amortization	9	9	-	53
	TOTAL EXPENSES	11,237	11,217	(18)	11,262
	NET INCOME	$ 18,992	$ 15,066	$ 3,926	$ 16,820

(A) Operating Revenues & Expenses

(B) Non-operating Revenues & Expenses

	RECAP STATEMENT OF REVENUES & EXPENSE	
(A)	Net Operating Revenues & Expenses	$ (718)
(B)	Net Non-Operating Revenues & Expenses	19,709
	NET INCOME	$ 18,992

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Comparative YTD Stand-Alone Stmt of Fund Balance Activity ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	June 30, 2022	June 30, 2021
Fiscal year beginning balance	**$ (25,293)**	**$ (38,734)**
Net income year-to-date	$ 18,992	$ 16,820
Transfers (to)/from ECH:		
IGT/PRIME Funding [20]	$ 2,213	$ 4,460
Capital Appropriation projects [21]	$ (18,279)	(7,839)
Fiscal year ending balance	**$ (22,367)**	**$ (25,293)**

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(1) Cash & Short Term Investments – The increase is insignificant.

(2) Due from Retiree Health Plan – The monies due from Trustee for District's Retiree Healthcare Plan.

(3) S.C. M&O Taxes Receivable – No change.

(3a) Other Current Assets – This decrease is due to Healthcare District paying for IGT refund to the State that was to be paid by the Hospital.

(4) Operational Reserve Fund – Starting in FY 2014, the Board established an operational reserve for unanticipated operating expenses of the District.

(5) Capital Appropriation Fund – Commitment to the MV Campus Completion Project or others.

(6) Capital Replacement Fund – Formerly known as the Plant Facilities Fund (AKA - Funded Depreciation) which reserves monies for the major renovation or replacement of the portion of the YMCA (Park Pavilion) owned by the District.

(7) Community Benefit Fund – This fund retains unrestricted (Gann Limit) funds to support the District's operations and primarily to support its Community Benefit Programs

(8) Funds Held by Trustee – Funds from General Obligation tax monies, being held to make the debt payments when due.

(9) Capital Net Assets - The land on which the Mountain View Hospital resides, a portion of the YMCA building, property at the end of South Drive (currently for the Road Runners operations), and a vacant lot located at El Camino Real and Phyllis.

(10) Bond Interest Payable – The decrease is due to the semi-annual interest payment paid on 2/1/2022.

(11) Fund Balance – The negative fund balance is a result of the General Obligation bonds which assisted in funding the replacement hospital facility in Mountain View. Accounting rules required the District to recognize the obligation in full at the time the bonds were issued ; receipts from taxpayers will be recognized in the year they are levied, slowly reducing the negative fund balance over the next 15 years.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(12) Other Operating Revenue – Lease income from El Camino Hospital for its ground lease with the District.

(13) Taxes: Redevelopment, M&O, G.O. – Tax receipts (either received or to be received) during the period. Note amount for the G.O. Taxed Levied for Debt will come in less than prior year mostly due to the March 2017 G.O. Refunding that the District did that reduced the previously $12.90 of assessed property valuation per $100,000 to a current $10.00 per $100,000.

(14) IGT/PRIME Expense – Payments in support of the PRIME or IGT programs.

(15) Wages & Benefits – Due to a new IRS reg that board stipends previously paid as reportable 1099 transactions are now considered to be W-2 reportable transactions, and reported in this section, where previously reported in the "Supplies & Other Expenses." There will continue to be no other "employees" of the District. This change started in April 2022.

(16) Professional Fees & Services – Actual detailed below:

• Community Benefit Support from ECH (54% of SW&B)	$ 381
• Legal Fees	71
• Miscellaneous	20
	$ 472

(17) Supplies & Other Expenses – Actual detailed below:

• Marketing / Advertising	$ 335
• Board Stipends	3
• Miscellaneous	1
	$ 339

(18) G.O. Bond Interest Expense – It is to be noted that on March 22, 2017 the District refunded $99M of its remaining $132M 2006 G.O. bond issue. Refunding of the 2006 G.O. debt, given current interest rates, caused a net present value savings of $7M.

(19) Community Benefit Expenditures – Starting in FY2014, the District is directly operating its Community Benefit Program at the District level. This represents amounts expended to grantees and sponsorships thus far in this fiscal year. Note the major payments to recipients are made in August & January of the fiscal year.

(20) IGT/PRIME Funding – Transfers from ECH for participation in the PRIME or IGT program in FY 2022.

(21) Capital Appropriation Projects Transfer – This years transfer is in support of MV Hospital's Campus Completion Project.

El Camino Healthcare District

Sources & Uses of Tax Receipts ($Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

Sources of District Taxes	**06/30/22**
(1) Maintenance and Operation and Government Obligation Taxes	$33,636
(2) Redevelopment Agency Taxes	417
Total District Tax Receipts	**$34,053**
Uses Required Obligations / Operations	
(3) Government Obligation Bond	12,304
Total Cash Available for Operations, CB Programs, & Capital Appropriations	**21,749**
(4) Capital Appropriation Fund – Excess Gann Initiative Restricted*	11,528
Subtotal	**10,221**
(5) Operating Expenses (Net)	718
Subtotal	**9,503**
(6) Capital Replacement Fund (Park Pavilion)	12
Funds Available for Community Benefit Programs	**$9,491**
*Gann Limit Calculation for FY2022	$9,804

(1) M&O and G.O. Taxes	• Cash receipts from the 1% ad valorem property taxes and Measure D taxes
(2) Redevelopment Agency Taxes	• Cash receipts from dissolution of redevelopment agencies
(3) Government Obligation Bond	• Levied for debt service
(4) Capital Appropriation Fund	• Excess amounts over the Gann Limit are restricted for use as capital
(5) Operating Expenses	• Expenses incurred in carrying out the District's day-to-day activities
(6) Capital Replacement Fund	• Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion)

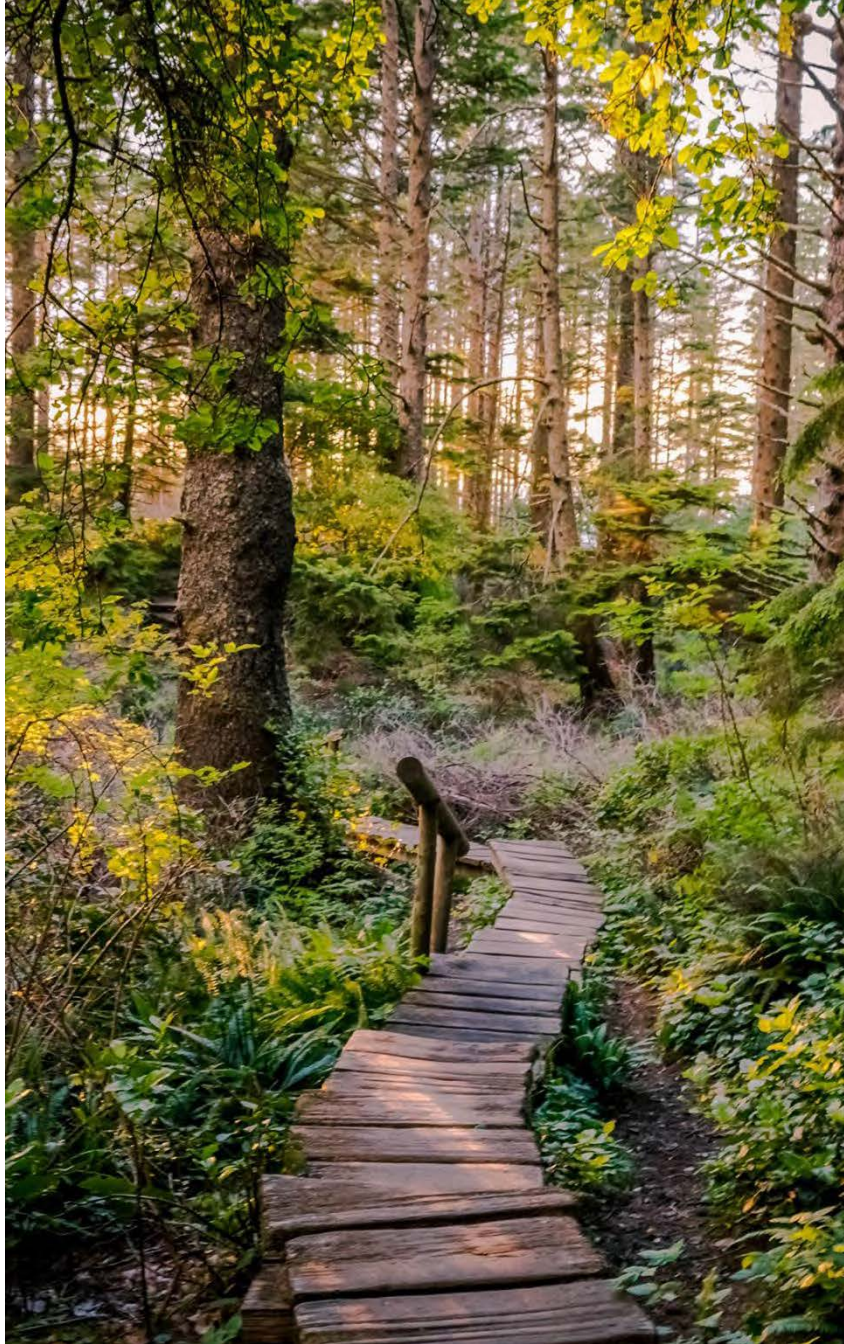
MOSSADAMS

El Camino Healthcare District

2022 AUDIT RESULTS

Agenda

1. Scope of Services
2. Auditor Opinion and Report
3. Significant Risks Identified
4. Matters to Be Communicated to the Governing Body
5. Statements of Net Position
6. Operations



Scope of Services

We have performed the following services for El Camino Healthcare District:

Annual Audits

- Annual consolidated financial statement audit as of and for the year ended June 30, 2022

Non-Attest Services

- Assist in drafting the consolidated financial statements and related footnotes as of and for the year ended June 30, 2022

Auditor Reports – Layout Changes

NEW REPORT LAYOUT

- ❑ Report on the Audit of the Financial Statements
- ❑ Opinion
- ❑ Basis for Opinion
- ❑ Emphasis of Matter, when appropriate
- ❑ Other Matter, when appropriate
- ❑ Responsibilities of Management for the Financial Statements
- ❑ Auditor's Responsibilities for the Audit of the Financial Statements

PRIOR REPORT LAYOUT

- ❑ Report on the Financial Statements
- ❑ Introductory paragraph
- ❑ Management's Responsibility for the Financial Statements
- ❑ Auditor's Responsibility
- ❑ Opinion
- ❑ Emphasis of Matter, when appropriate
- ❑ Other Matter, when appropriate

Significant Risks Identified

During the audit, we identified the following:

Significant Risks	Procedures
Valuation of patient accounts receivable	- Tie out of reserving schedules - Zero Balance Accounts (“ZBA”) analysis - Lookback analysis & subsequent collections analysis
Revenue recognition	- Hospital patient revenue analysis & cut-off analysis - Journal entry testing focusing on revenue reversals
Valuation of investments and related financial statement disclosures	- Third party confirmations - Independent price testing
Implementation of new accounting standard (GASB 87, Leases)	- Review management's lease implementation memo, including testing of discount rates used - Review Yardi schedules for completeness and accuracy - Tie-out management's implementation entry - Prepare financial statement disclosures - Perform comprehensive lease review, including embedded lease analysis testing

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with these auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

- Significant Unusual Transactions
- Significant Difficulties Encountered During the Audit
- Disagreements With Management
- Circumstances that affect the form and content of the auditor's report
- Other findings or issues arising from the audit that are, in the auditor’s professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process
- Corrected and uncorrected misstatements
- Management’s consultation with other accountants

MOSS ADAMS COMMENTS

No significant unusual transactions were identified during our audit of the entity’s financial statements.

CORRECTED MISTATEMENTS:

Decrease short term investments and net position by $13.09m

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

MOSS ADAMS COMMENTS

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by El Camino Healthcare District are described in the footnotes to the consolidated financial statements. During the year, the District adopted GASB 87, *Leases* and GASB 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period*. There were no other changes to significant accounting policies for the year ended June 30, 2022.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Management Judgments & Accounting Estimates:

The Compliance Committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

MOSS ADAMS COMMENTS

- Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacted the consolidated financial statements including the following: net patient service revenue; provision for uncollectible accounts; fair market values of assets and liabilities; uninsured losses for professional liability, pension and post retirement benefit liability, liability for workers' compensation; discount rates used to value gift annuities and beneficial interest in charitable remainder trust, useful lives of capital assets and right of use assets, discount rates and lease terms related to the District's operating lease right of use assets, lease liabilities, lease receivable and deferred inflows of resources – leases.

Matters to Be Communicated to the Governing Body

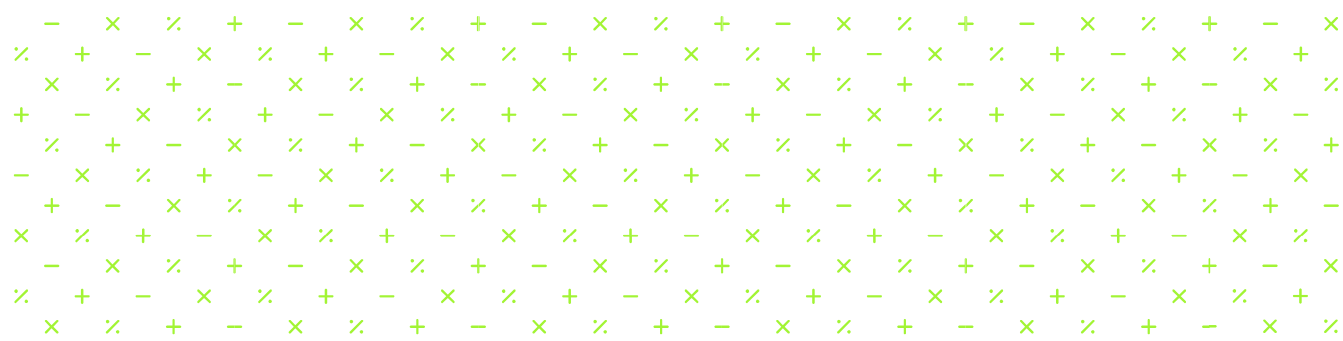
MATTERS TO BE COMMUNICATED

Management Judgments & Accounting Estimates:

The Compliance Committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

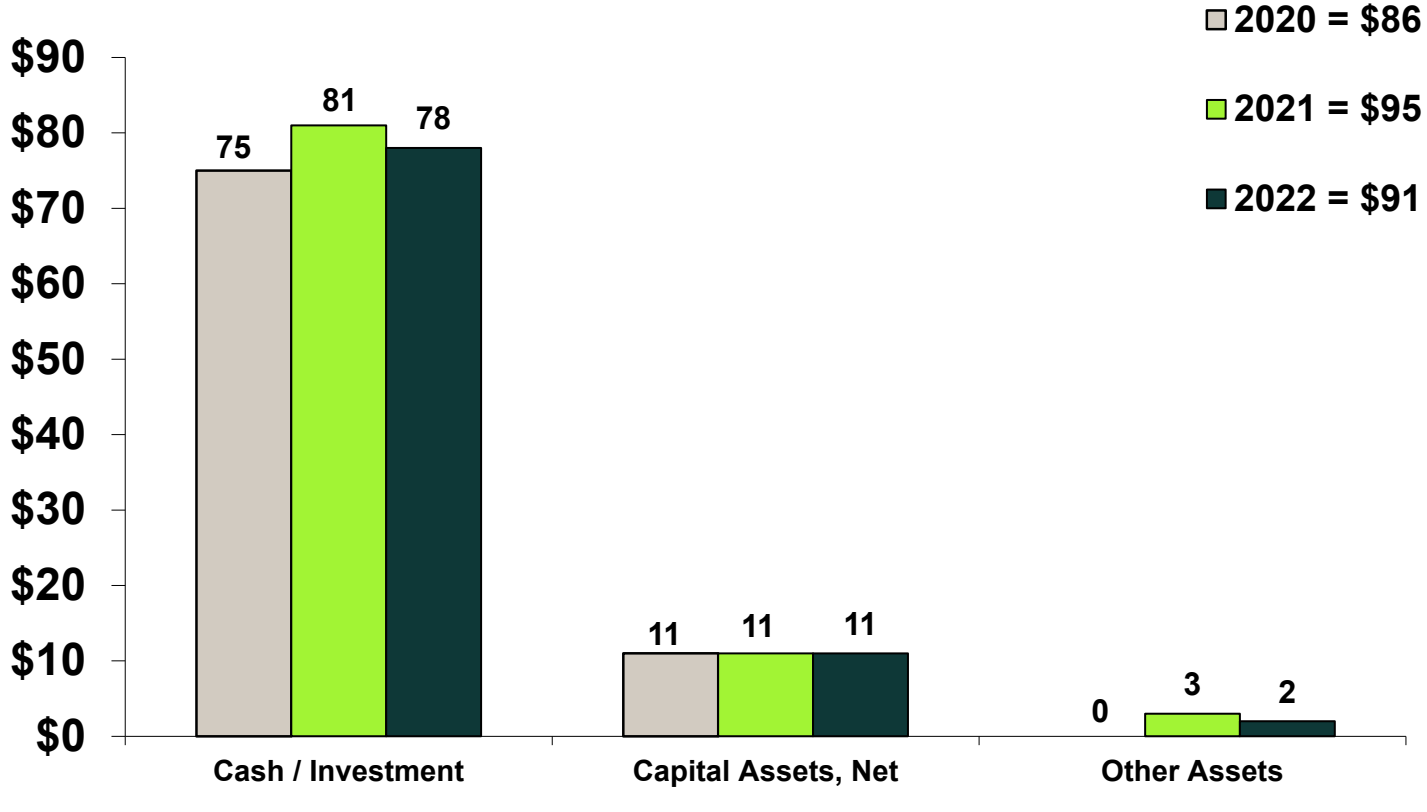
MOSS ADAMS COMMENTS

- The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. We call your attention to the following notes: significant concentration of net patient accounts receivable, investments and fair value of investments, capital assets, employee benefit plans, post-retirement medical benefits, insurance plans, bonds payable, and leases

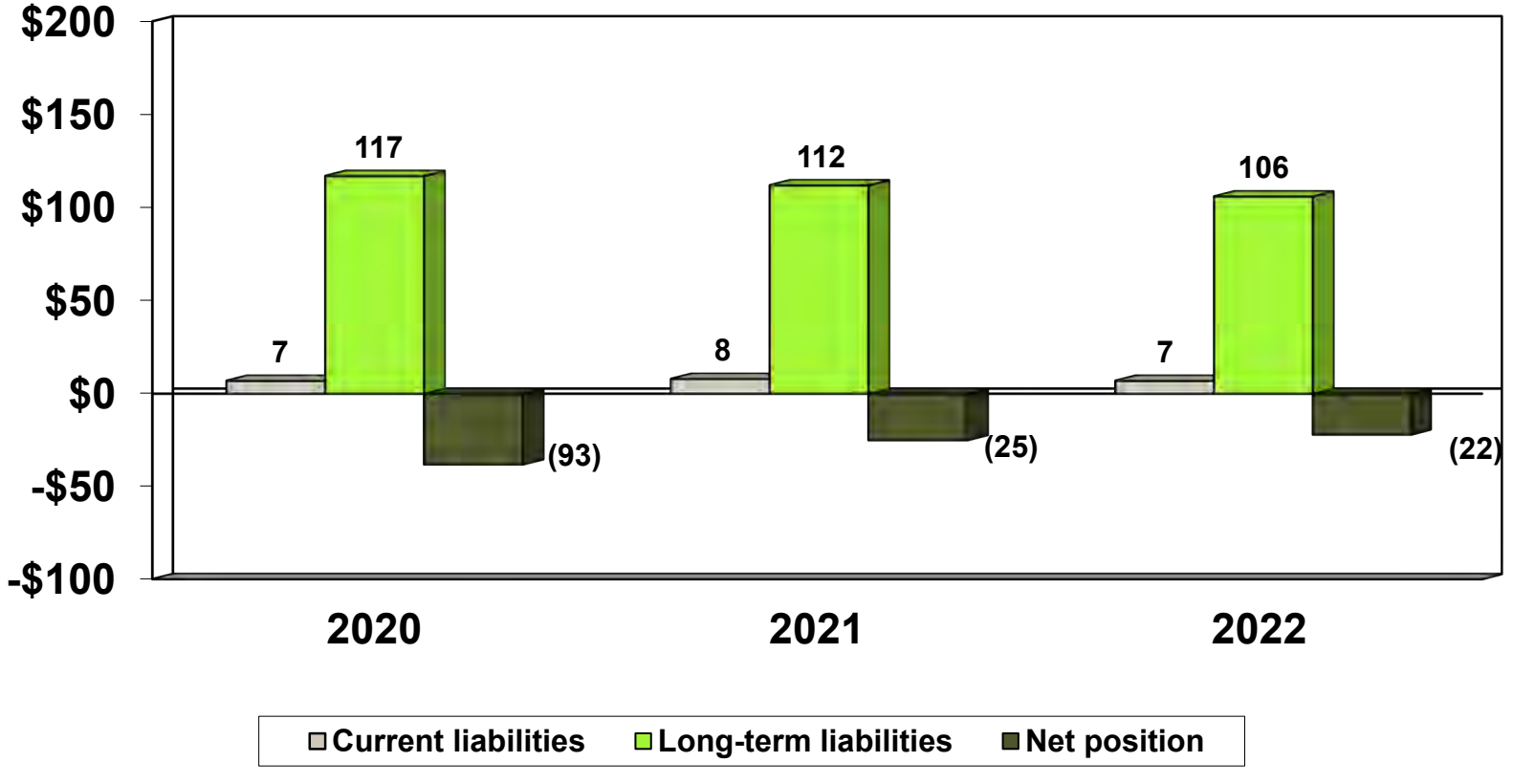


Statements of Net Position

Assets and Deferred Outflows (in millions)



Liabilities, Deferred Inflows, and Net Position (in millions)



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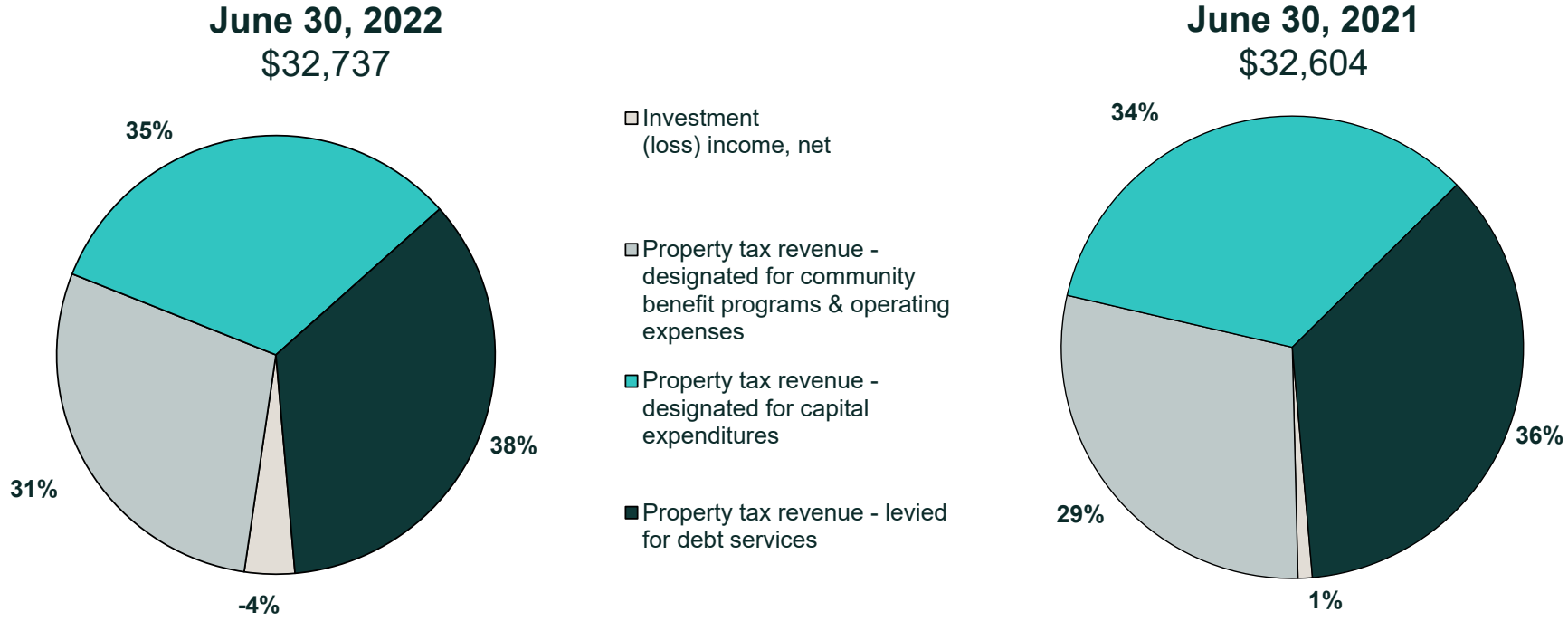
Operations

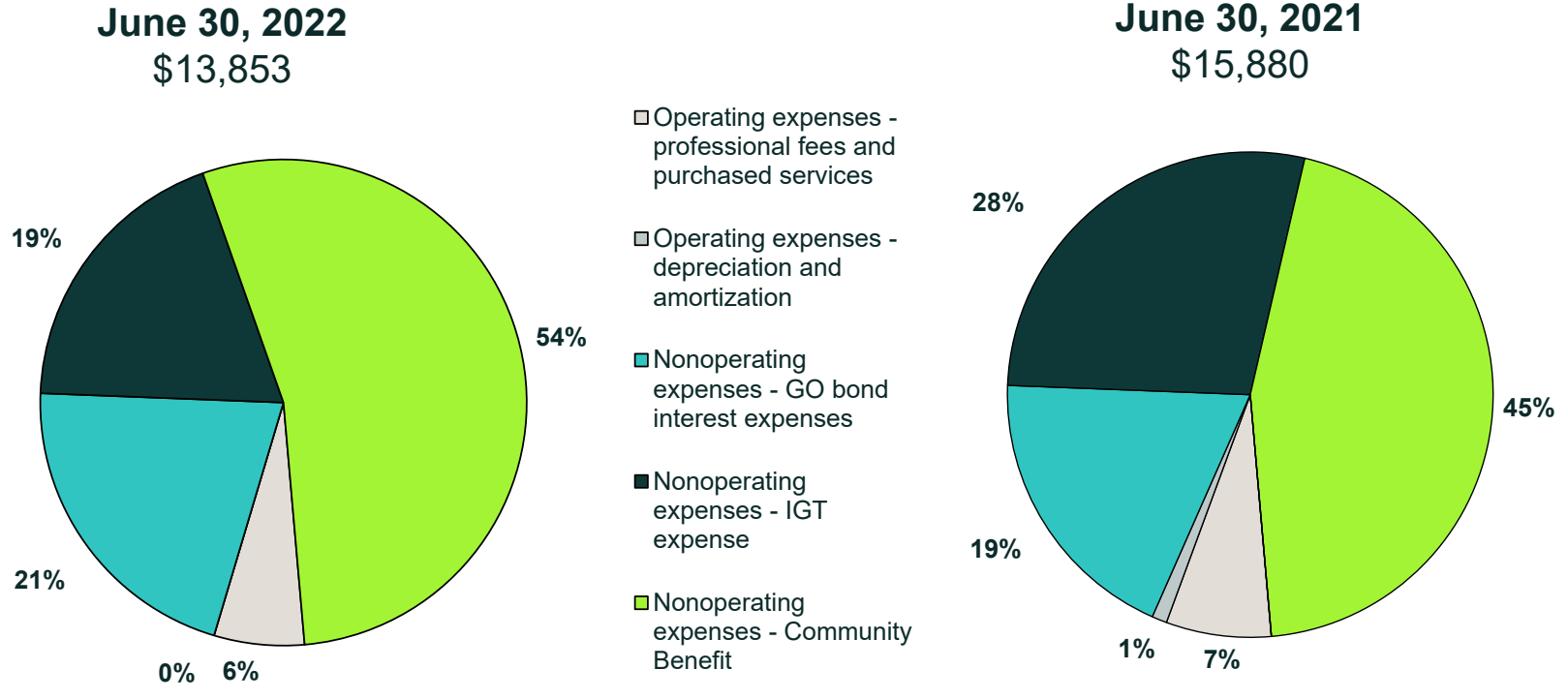
Income Statement Year to Year Comparison

Sources of Nonoperating Revenues (in thousands)



Income Statement Year to Year Comparison

Outflow of Expenses (in thousands)



GASB Accounting Updates

- GASB Statement No. 91, Conduit Debt Obligation. Effective for the District beginning July 1, 2022.
- GASB Statement No. 93, Replacement of Interbank Offered Rates. Effective for the District beginning July 1, 2020.
- GASB Statement No. 100, Accounting Changes and Error Corrections—an amendment of GASB Statement No. 62. Effective for the District beginning July 1, 2023.
- GASB Statement No. 101, Compensated Absences. Effective for the District beginning July 1, 2024.

Your Service Team

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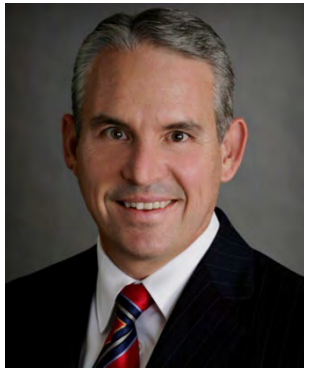

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THANK YOU

Report of Independent Auditors and Consolidated Financial Statements with Supplementary Information

El Camino Healthcare District

June 30, 2022 and 2021

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Management's Discussion and Analysis

El Camino Healthcare District (the "District") is comprised of five entities: the District, El Camino Hospital (the "Hospital"), El Camino Hospital Foundation (the "Foundation"), CONCERN: Employee Assistance Program ("CONCERN"), and Silicon Valley Medical Development, LLC ("SVMD").

SVMD was organized as a California Limited Liability Corporation ("LLC") that was formed in 2008. Starting in fiscal year 2019 and continuing into the current fiscal year, SVMD has expanded to 14 clinic and urgent care sites.

Overview of the Consolidated Financial Statements

This annual report consists of the consolidated financial statements and notes to those statements. These statements are organized to present the District as a whole, including all the entities it controls. Financial information for each separate entity is shown in the supplemental schedules on the last pages of the report. In accordance with the Governmental Accounting Standards Board ("GASB") Codification Section 2200, *Comprehensive Annual Financial Report,* the District presents comparative financial highlights for the fiscal years ended June 30, 2022, 2021, and 2020. This discussion and analysis should be read in conjunction with the consolidated financial statements in this report.

The consolidated statements of net position, the consolidated statements of revenues, expenses, and changes in net position, and the consolidated statements of cash flows provide an indication of the District's financial health. The consolidated statements of net position include all the District's assets and liabilities, using the accrual basis of accounting. The consolidated statements of revenues, expenses, and changes in net position report all of the revenues and expenses during the time periods indicated. The consolidated statements of cash flows report the cash provided by the operating activities, as well as other cash sources such as investment income and cash payments for capital additions and improvements.

Consolidated Financial Highlights

Year Ended June 30, 2022

For fiscal year ended June 30, 2022, the District increased its net position by $59 million. In 2022, operating revenues increased by $196 million over 2021; this was the result of increased volume.

Year Ended June 30, 2021

For fiscal year ended June 30, 2021, the District increased its net position by $355 million. In 2021, operating revenues increased by $119 million over 2020; this was the result of increased volume.

Year Ended June 30, 2020

For fiscal year ended June 30, 2020, the District increased its net position by $130 million. In 2020, operating revenues increased by $35 million over 2019; this was the result of an improved payer mix over FY 2019, Inter-Governmental Transfer ("IGT") / cost report settlements of $14.9 million, and Health and Human Services stimulus funds of $19.0 million. In April 2020 the organization received $75.8 million in advance Medicare payments, which will be withheld from future Medicare services starting 120 days after receipt.

Summary of Assets, Deferred Outflows, Liabilities, Deferred Inflows, and Net Position
As of June 30, 2022, 2021 and 2020

(In Thousands)

	2022	As restated 2021	2020
Assets:			
Current assets	$ 641,921	$ 687,412	$ 653,665
Board designated and restricted funds, net of current portion	1,181,535	1,198,200	872,034
Funds held by trustee, net of current portion	35,272	36,939	50,825
Capital assets, net	1,201,330	1,160,286	1,166,036
Right of use assets, net of amortization	29,241	30,493	-
Lease receivable, net of current portion	34,876	40,340	-
Other assets	174,247	151,294	114,359
Total assets	3,298,422	3,304,964	2,856,919
Deferred outflows:			
Loss on defeasance of bonds payable	11,160	11,761	12,361
Deferred outflows of resources	4,226	9,324	6,532
Deferred outflows - actuarial	792	1,005	1,861
Total deferred outflows	16,178	22,090	20,754
Total assets and deferred outflows	$ 3,314,600	$ 3,327,054	$ 2,877,673
Liabilities:			
Current liabilities	$ 208,831	$ 252,584	$ 221,415
Bonds payable, net of current portion	571,174	589,909	607,953
Lease liabilities, net of current portion	25,636	26,335	-
Other long-term liabilities	50,512	58,740	69,886
Total liabilities	856,153	927,568	899,254
Deferred inflows:			
Deferred inflows of resources	4,522	4,522	3,893
Deferred inflows of resources - leases	46,369	51,180	-
Deferred inflows - actuarial	46,610	41,339	26,806
Total deferred inflows	97,501	97,041	30,699
Net position:			
Unrestricted and invested in capital assets, net	2,324,347	2,271,363	1,919,091
Restricted by donors - charity and other	27,438	22,960	20,606
Restricted - endowments	9,161	8,122	8,023
Total net position	2,360,946	2,302,445	1,947,720
Total liabilities, deferred inflows, and net position	$ 3,314,600	$ 3,327,054	$ 2,877,673
Operating cash equivalents and short-term investments	$ 361,340	$ 456,605	$ 461,221
Board designated, funds held by trustee, and restricted funds	1,227,936	1,253,796	949,354
Total available cash & investments	$ 1,589,276	$ 1,710,401	$ 1,410,575

Investments

The District maintains sufficient cash balances to pay daily operational expenses and all short term liabilities. In late fiscal year 2012, the Hospital (exclusive of the District) selected an Investment Consultant to assist the Hospital and its subsidiaries in managing its investments, and both the investment policies for Surplus Cash and Cash Balance Plan were updated and approved by the Hospital Board of Directors (the "Board"). The policies allow for greater diversification in the investment portfolios to balance the need for liquidity with a long-term investment focus in order to improve investment returns and the organization's financial strength.

Capital Assets

Continuing in the current fiscal year was the Women's Hospital Expansion that was approved in February 2021 for $149 million. At fiscal year end, the project was approximately at 35% completion, expending $51 million. With the relocation of the physician medical offices previously on the 2nd and 3rd floors to the newly completed Integrated Medical Office Building (the Sobrato Pavilion), it is expected that work on the 2nd floor will be completed in the spring 2023, to accommodate the relocation of the twenty bed NICU currently on the first floor. The relocation will add 4 new beds, with 19 of the beds being in private rooms. The 3rd floor will accommodate improvements for 26 Post-Partum, Mom & Baby beds, all in private rooms. At this point the project will be approximately 65% completed with a total completion of the project projected to be February 2024.

During the late spring of the current fiscal year, the project to demolish the "Old Main Hospital" at the Mountain View campus and related site work began in earnest as a number of smaller building attached to the old six story hospital were taken down, along with the demolition of some of the interior floors of the main building. Currently the demolishment of the Old Main Hospital is projected to be completed by the end of December 2022. The project is budgeted at $24.9 million of which $10 million had been expended at year end.

Significant projects completed during the fiscal year were: 1) Replacement at the Mountain View site of its radiation oncology equipment - $10.3 million; 2) Renovation to the Mountain View Emergency Department - $6.5 million; 3) the relocation of the Cardiac Pulmonary Wellness Center into the newly completed Sobrato Pavilion - $5 million; 4) Major tenant improvements at two SVMD clinics - $3.1 million; 5) wireless upgrades to the most of the Mountain View campus - $3.3 million.

Still in progress from prior year is the replacement of Diagnostic Imaging and Interventional Radiology Imagining equipment with a budget cost of $49.6 million, of which $11.8 million had been expended at year end.

Adoption of GASB No. 87

The District adopted GASB No. 87 Leases (GASB 87) as of July 1, 2020. The District evaluated contracts that were formerly accounted for as operating leases to determine whether they meet the definition of a lease as defined in GASB 87. The contracts to lease office space met the definition of a lease and the District calculated and recognized a right-to-use assets, net, of $31 million and lease liabilities of $31 million as of June 30, 2021. As lessor, the District's adoption of GASB 87 resulted in recognition of lease receivable of $51 million and deferred inflow of $51 million as of June 30, 2021. The impact to beginning net position was not significant. See Note 14 in the notes to the consolidated financial statement.

Revenues and Expenses

The following table displays revenues and expenses for 2022, 2021, and 2020:

Revenues & Expenses
Years Ended June 30, 2022, 2021 and 2020
(In Thousands)

	2022	2021 (As restated)	2020
Operating revenues:			
Net patient service revenue net of bad debt of $7,429, $26,730, and $15,925, in 2022, 2021, and 2020, respectively	$ 1,309,152	$ 1,107,912	$ 982,697
Other revenue	37,031	42,221	48,440
Total operating revenues	1,346,183	1,150,133	1,031,137
Operating expenses:			
Salaries, wages and benefits	654,619	574,797	541,009
Professional fees and purchased services	178,190	177,981	170,994
Supplies	183,665	171,720	152,466
Depreciation and amortization	79,871	74,595	54,038
Rent and utilities	20,113	20,693	26,815
Other	20,915	15,140	22,167
Total operating expenses	1,137,373	1,034,926	967,489
Operating income	208,810	115,207	63,648
Nonoperating revenues (expenses) items:			
Bond interest expense, net	(19,831)	(20,031)	(12,879)
Intergovernmental transfer expense	(2,613)	(4,460)	(4,048)
Realized investment income	25,817	79,736	43,085
Unrealized investment (losses) gains	(197,886)	151,188	(2,231)
Property tax revenues	34,053	32,464	29,369
Restricted gifts, grants and other net of contributions to related parties	7,551	2,868	8,412
Unrealized gain (loss) on interest rate swap	3,049	1,883	(3,366)
Community benefit expense	(11,143)	(11,297)	(12,091)
Provider Relief Fund revenue	15,629	-	19,000
Other, net	(4,935)	7,167	902
Total nonoperating revenues and expenses	(150,309)	239,518	66,153
Increase in net position	58,501	354,725	129,801
Total net position, beginning of year	2,302,445	1,947,720	1,817,919
Total net position, end of year	$ 2,360,946	$ 2,302,445	$ 1,947,720

Fiscal Year 2022 Consolidated Financial Analysis

Net Patient Service Revenues

Net patient service revenue in fiscal year 2022 increased by $201 million, or 18% over fiscal year 2021. This increase was consistent with adjusted patient days increasing by 13%.

Specialty	2022 Days	2021 Days
Total days	111,538	98,386

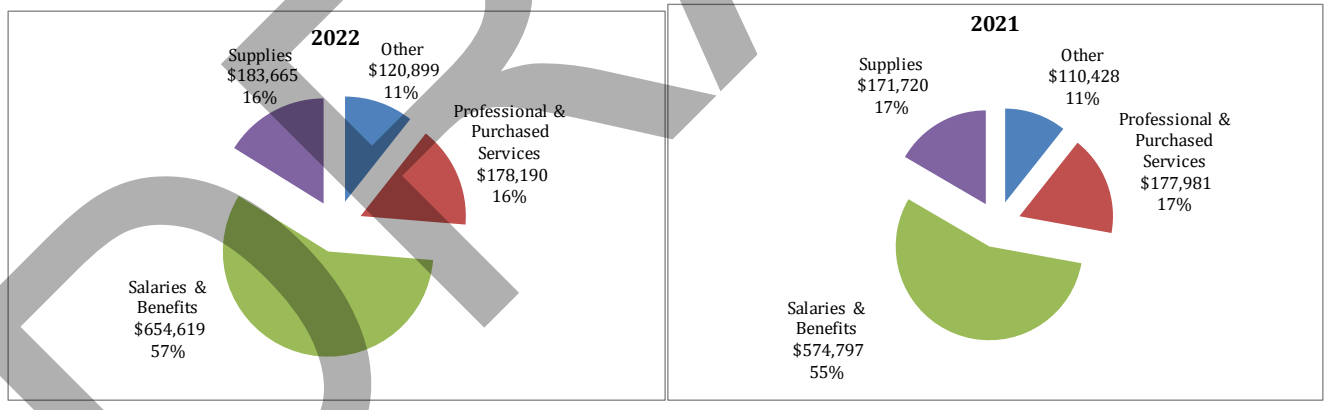
Specialty	2022 LOS	2021 LOS
Average Length of Stay ("LOS")	4.3	4.3

The overall case mix index, which is an indicator of patient acuity, was 1.58 in fiscal year 2022, and 1.62 in fiscal year 2021.

Other Revenue

Other revenue decreased by $5 million in fiscal year 2022 over the prior 2021 fiscal year. The primary decrease was due to a $2.2 million reduction in IGT receipts and $1.8 million decline in miscellaneous operating revenue.

Operating Expenses



Salaries and Wages

It is to be noted that the District as a stand-alone entity has no employees. All employees are at the Hospital and its related corporations.

Total salaries and wages (including employee benefits) increased by $80 million in fiscal year 2022 over 2021, which is 57% of total operating expenses and 3% more than fiscal year 2021. Due to the increased demand for services, there was an increase of 241 full-time equivalents ("FTEs") along with the increase in labor due the high demand for healthcare workers.

Employee Benefits

Aggregate employee benefits, including accrued Paid Time Off ("PTO") and Extended Sick Leave, increased by $14.1 million.

Significant changes were as follows:

- PTO accrued expense increased by $7.3 million over the 2021 fiscal year
- Healthcare (medical, dental, and vision) increased by $9.3 million in fiscal year 2021
- Employer match of 403B increased $1.1 million in 2021 over 2021.
- Pension expense decreased by $4.7 million, primarily by decreased investment returns on the Plan's investment in the past year.

Professional and Purchased Services

Total professional and purchased services remained the same year to year at $178 million.

Supplies

Total supplies increased by $12 million or 7% in fiscal year 2022 over 2021. This was mainly due to the increase in volume.

Depreciation and amortization

Depreciation and amortization expense this fiscal year increased by $5 million over fiscal year 2021. Increases were primarily due to completion of projects and the replacement of high dollar value equipment (Radiation Oncology, etc).

Rent and Utilities

Rent and utilities this fiscal year decreased by $0.5 million over fiscal year 2021.

Other Expense

Other expense increased in the current fiscal year by $5.8 million over the prior year, due to insurance rate increases, property tax and marketing and advertising

Nonoperating Revenue (Expense) Items:

Bond Interest Expense, net

Bond interest was consistent year to year at $20 million.

Change in Net Unrealized Gains and Losses on Investments

The Hospital experienced a change in net unrealized gains and losses on investments of $197.8 million during fiscal year 2022 and the change in net unrealized gains and losses for fiscal year 2022 was a year-over-year decrease of $349 million. This change was driven primarily by the change in net unrealized gains and loss of the Hospital's fixed income and mutual fund holdings. The fixed income change in net unrealized gains and losses was $54.2 million and the mutual fund holdings change in unrealized gains and losses was $132.8 million. The change in net unrealized gains and losses in 2022 was a result of a challenging environment in the capital markets due to rate tightening and rising inflation. These challenging conditions led to a rout in the fixed income market, as reflected in the Bloomberg U.S. Aggregate Index being down 10.3% and in equities, as reflected in the S&P Index being down 10.6.

Economic Factors and Next Year's Budget

The Board approved the fiscal year 2023 budget at the June 2022 meeting. For the fiscal year 2023, budgeted patient days are projected to increase 3.97% over FY2022 actuals.

Fiscal Year 2021 Consolidated Financial Analysis

Net Patient Service Revenues

Net patient service revenue in fiscal year 2021 increased by $125.2 million, or 12.7% over fiscal year 2020. This increase was consistent with adjusted patient days increasing by 9.5% and surgical volume increasing by 10.8%

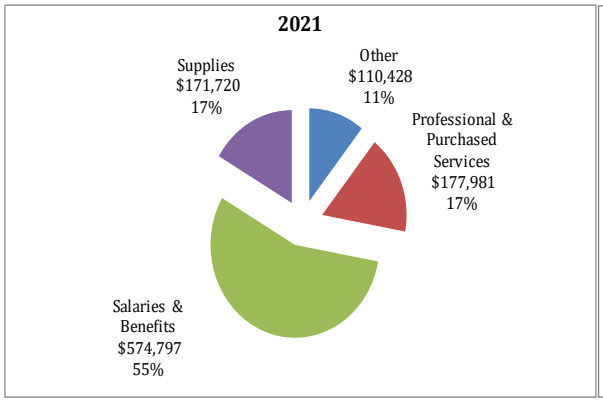
Specialty	2021 Days	2020 Days
Total days	98,386	92,714
Specialty	**2021 LOS**	**2020 LOS**
Average LOS	4.3	4.0

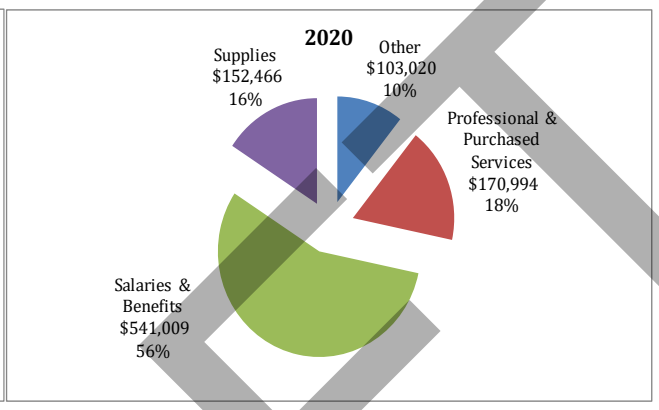
The overall case mix index, which is an indicator of patient acuity, was 1.62 in fiscal year 2021, and 1.54 in fiscal year 2020.

Other Revenue

Other revenues decreased by $6.2 million in fiscal year 2022 over the prior 2021 fiscal year. The primary decrease was due to the termination of a Hospitalist services agreement with the county hospitals.

Operating Expenses





Salaries and Wages

It is to be noted that the District as a stand-alone entity has no employees. All employees are at the Hospital and its related corporations.

Total salaries and wages (including employee benefits) increased by $33.8 million in fiscal year 2021 over 2020, which is 55% of total operating expenses and 1% less than fiscal year 2020. SVMD saw a 35.7 reduction in full-time equivalents ("FTEs") due to reorganization of the workforce during the fiscal year. Other areas within the Hospital also increased due to salary increases and volumes and activities. In total the FTE grew by 81 FTEs over fiscal year 2020.

Employee Benefits

Aggregate employee benefits, including accrued Paid Time Off ("PTO") and Extended Sick Leave, increased by $6.0 million.

Significant changes were as follows:

- PTO accrued expense increased by $5.1 million over the 2020 fiscal year
- Healthcare (medical, dental, and vision) increased by $4.2 million in fiscal year 2021 over 2020.
- Employer match of 403B increased $2.0 million in 2021 over 2020.
- Workers Compensation Expense increased by $1.5 million in 2021 over 2020.
- Employer FICA (Social Security and Medicare) taxes increased by $1.3 million in the current fiscal year.
- Pension expense decreased by $9.4 million, primarily by increased investment returns on the Plan's investment in the past year.

Professional and Purchased Services

Total professional and purchased services increased by $7 million over the prior fiscal year, mainly due to cost associated with COVID-19 testing and consulting fees for major projects (Workday and Construction).

Supplies

Total supplies increased by $19.3 million or 12.6% in fiscal year 2021 over 2020. This was mainly due to an $8.1 million increase in Other Medical Supplies due to COVID-19, including Personal Protective Equipment and testing supplies, $10.7 million in Implants, and $5.7 million in Surgical Supplies.

Depreciation and amortization

Depreciation expense in fiscal year 2021 increased by $21 million over fiscal year 2020. Increases were primarily due to the opening of the Integrated Medical Office Building, Sobrato Pavillion, in June 2020, and the first year implementation of GASB 87 as of July 1, 2020 which resulted in a right of use asset amortization expense of $6.9 million.

Rent and Utilities

Rent and utilities in fiscal year 2021 decreased by $6.1 million over fiscal year 2020, mainly due to the first year implementation of GASB 87 as of July 1, 2020 resulting in a reclass of rent expense as amortization expense.

Other Expense

Other expense decreased in the current fiscal year by $7.0 million over the prior year, due to an decrease in reserve settlement account.

Nonoperating Revenue (Expense) Items:

Bond Interest Expense, net

The increase of $7.2 million in fiscal year 2021 over the prior year was due to tentative completion of the Integrated Medical Office Building and the Behavioral Health Building in January 2020 that was being partially financed by the 2017 Bond issue.

Change in Net Unrealized Gains and Losses on Investments

The Hospital experienced a change in net unrealized gains and losses on investments of $151.2 million during fiscal year 2021 and the change in net unrealized gains and losses for fiscal year 2021 was a year-over-year ("YOY") increase of $153.4 million. The change in net unrealized gains and losses in 2021 was a result of strong investment results across all asset classes with the largest gains generated from equity and hedge fund investments. Equities and mutual funds-equity experienced a change in net unrealized gains and losses of $17.2 million and $95.0 million, respectively. Global equities as represented by the MSCI AC World Index gained 39.9% during fiscal year 2021. Hedge funds experienced a change in net unrealized gains and losses of $22.0 million during fiscal year 2021 as equity long/short, credit oriented, and macro hedge fund strategies performed well. The change in net unrealized gains and losses for fixed income was modest at $2.0 million as the Bloomberg U.S. Aggregate Index experienced a loss of 0.3% during the same time-period; however, the Hospital's active managers were able to add value in relation to the benchmark.

The year-over-year increase in net unrealized gains and losses was broad-based across asset classes, with the most significant increases resulting from equities, mutual funds-equity, hedge fund investments, and collective funds. Equities and mutual funds-equity combined to experience modest net unrealized gains in fiscal year 2020, while net unrealized gains in fiscal year 2021 were large. Hedge funds and collective funds experienced net unrealized losses in fiscal year 2020, while fiscal year 2021 saw solid net unrealized gains.

FIDUCIARY MD&A

Overview

The El Camino Hospital Cash Balance Plan (the "Cash Balance Plan") was established on July 1, 1963, by El Camino Hospital (the "Hospital") and has been amended from time to time since that date.

The Hospital also provides healthcare benefits and life insurance under the El Camino Hospital Postretirement Health and Life Insurance Benefit Plan (the "OPEB Plan"), a single-employer defined benefit Postretirement Benefits Plan, for retired employees who meet eligibility requirements as outlined in the plan document, as approved by the board of directors of the Hospital.

Financial Highlights – 2022

Cash Balance Plan – During the year ended June 30, 2022, the net position held in trust for pension benefits increased by approximately 7%. Employer contributions were $6.5 million in 2022 compared to $10.5 million in 2021. Benefit payments were $14.8 million in 2022 compared to $12.2 million in 2021. Net investment income was $33.2 million in 2022 compared to $43.8 million in 2021, which was the primary reason for the overall 7% increase in net position as of June 30, 2022.

OPEB Plan – Benefit payments were $0.9 million in 2022 and 2021.

Financial Highlights – 2021

Cash Balance Plan – During the year ended June 30, 2021, the net position held in trust for pension benefits increased by approximately 14%. Employer contributions were $10.5 million in 2021 compared to $13.0 million in 2020. Benefit payments were $12.2 million in 2021 compared to $14.7 million in 2020. Net investment income was $43.8 million in 2021 compared to $45.7 million in 2020, which was the primary reason for the overall 14% increase in net position as of June 30, 2021.

OPEB Plan – Benefit payments were $0.9 million in 2021 compared to $0.8 million in 2020.

Overview of the Fiduciary Financial Statements

The basic financial statements present information about the Cash Balance Plan and OPEB Plan's fiduciary net position and changes in fiduciary net position for the respective years. The basic financial statements also include notes to explain some of the information in the financial statements and to provide more details. The statement of fiduciary net position displays the assets and liabilities and resulting net position of the Plan as of the end of the year. All assets are valued at fair value.

The following is the abbreviated statement of fiduciary net position and statement of changes in fiduciary net position (in thousands):

	CASH BALANCE PLAN		
	2022	2021	2020
ASSETS			
Investments, at fair value	$ 363,419	$ 336,548	$ 294,470
Receivables	1,565	3,553	3,385
Noninterest-bearing cash	67	4	-
Net pending trades	(46)	-	-
NET POSITION RESTRICTED FOR PENSIONS	$ 365,005	$ 340,105	$ 297,855
ADDITIONS			
Investments income (loss)	$ 33,161	$ 43,836	$ 45,683
Contributions	6,513	10,636	13,042
Total additions	39,674	54,472	58,725
DEDUCTIONS			
Deductions	14,774	12,222	14,787
INCREASE IN NET POSITION RESTRICTED FOR PENSIONS	$ 24,900	$ 42,250	$ 43,938

	OPEB PLAN		
	2022	2021	2020
ASSETS			
Investments, at fair value	-	-	-
Receivables	-	-	-
NET POSITION RESTRICTED FOR OPEB	$ -	$ -	$ -
ADDITIONS			
Contributions	943	881	820
Total additions	943	881	820
DEDUCTIONS			
Deductions	943	881	820
INCREASE IN NET POSITION RESTRICTED FOR OPEB	$ -	$ -	$ -

Cash Balance Plan – During the year ended June 30, 2022, the Cash Balance Plan's fiduciary net position increased by 7%. The Cash Balance Plan's policies allow investments consisting of fixed income and equity marketable securities, alternatives, and cash. During the year ended June 30, 2021, the Cash Balance Plan's fiduciary net position increased by 14%. The Cash Balance Plan's policies allow investments consisting of fixed income and equity marketable securities, alternatives, and cash.

The statement of changes in fiduciary net position reflects the employer contributions and investment return, net of investment expenses, less benefits paid.

The decrease in investment income during the year ended June 30, 2022, compared to 2021, is due to a decrease in the net appreciation of fair value of investments due to smaller returns in global security markets and on the Cash Balance Plan's investments during the year. Benefit payments increased from the prior year due to an increase in the number of retirees and beneficiaries receiving benefits. The decrease in investment income during the year ended June 30, 2021, compared to 2020, is due to a decrease in the net appreciation of fair value of investments due to smaller returns in global security markets and on the Cash Balance Plan's investments during the year. Benefit payments decreased from the prior year due to a decrease in the number of retirees and beneficiaries receiving benefits

Report of Independent Auditors

The Board of Directors
El Camino Healthcare District

Report on the Audit of the Consolidated financial statements

Opinions

We have audited the consolidated financial statements of the business-type activities and the aggregate remaining fund information of El Camino Healthcare District (the "District") as of and for the years ended June 30, 2022 and 2021, and the related notes to the consolidated financial statements, which collectively comprise the District's basic consolidated financial statements as listed in the table of contents.

In our opinion, the accompanying consolidated financial statements referred to above present fairly, in all material respects, the respective consolidated net position of the business-type and the aggregate remaining fund information of El Camino Healthcare District as of June 30, 2022 and 2021, and the respective changes in consolidated net position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about District's ability to continue as a going concern for twelve months beyond the consolidated financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 1 to the consolidated financial statements, the District adopted Government Accounting Standards Board ("GASB") No. 87, Leases, as of July 1, 2020. Our opinion is not modified with respect to this matter.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis, supplemental pension and post-retirement benefit information, be presented to supplement the consolidated financial statements. Such information is the responsibility of management and, although not a part of the consolidated financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the consolidated financial statements in an appropriate operational, economic, or historical context.

We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position as of and for the year ended June 30, 2022 are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information of consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position as of and for the year ended June 30, 2022 is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

The accompanying supplemental schedule of community benefit for the year ended June 30, 2022, is presented for the purposes of additional analysis and is not a required part of the consolidated financial statements. Management of El Camino Healthcare District is responsible for the Schedule of Community Benefit for the year ended June 30, 2022. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements and accordingly, we do not express an opinion or provide any assurance on it.

[Signature]

San Francisco, California
October ___, 2022

Consolidated Financial Statements

El Camino Healthcare District
Consolidated Statements of Net Position
June 30, 2022 and 2021
(In Thousands)

	2022	2021 (As restated)
ASSETS AND DEFERRED OUTFLOWS		
Current assets		
Cash and cash equivalents	$ 207,923	$ 161,915
Short-term investments	153,417	294,690
Current portion of board-designated funds	11,129	18,657
Patient accounts receivable, net of allowances for doubtful accounts of $96,938 and $81,194 in 2022 and 2021, respectively	209,274	169,289
Current portion of lease receivable	10,403	10,651
Prepaid expenses and other current assets	49,775	32,210
Total current assets	641,921	687,412
Non-current cash and investments		
Board-designated funds	1,180,885	1,197,550
Restricted funds	650	650
Funds held by trustee	35,272	36,939
	1,216,807	1,235,139
Capital assets		
Nondepreciable	207,618	164,226
Depreciable, net	993,712	996,060
Total capital assets	1,201,330	1,160,286
Right of use assets, net of amortization	29,241	30,493
Lease receivable, net of current portion	34,876	40,340
Pledges receivable, net of current portion	2,200	3,053
Prepaid pension asset	137,149	111,162
Investments in healthcare affiliates	30,376	32,557
Beneficial interest in charitable remainder unitrusts	4,522	4,522
Total assets	3,298,422	3,304,964
Deferred outflows of resources		
Loss on defeasance of bonds payable	11,160	11,761
Deferred outflows of resources	4,226	9,324
Deferred outflows - actuarial	792	1,005
Total deferred outflows of resources	16,178	22,090
Total assets and deferred outflows of resources	$ 3,314,600	$ 3,327,054

See accompanying notes.

(In Thousands)

	2022	2021 (As restated)
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
Current liabilities		
Accounts payable and accrued expenses	$ 51,365	$ 39,788
Salaries, wages, and related liabilities	80,733	83,236
Medicare accelerated payments	-	65,635
Other current liabilities	41,624	31,392
Estimated third-party payor settlements	14,942	12,990
Current portion of lease liabilities	4,502	5,063
Current portion of bonds payable	15,665	14,480
Total current liabilities	208,831	252,584
Bonds payable, net of current portion	571,174	589,909
Lease liabilities, net of current portion	25,636	26,335
Other long-term obligations	6,700	11,081
Workers' compensation, net of current portion	14,029	17,002
Post-retirement medical benefits	29,783	30,657
Total liabilities	856,153	927,568
Deferred inflows of resources		
Deferred inflows of resources	4,522	4,522
Deferred inflows of resources - leases	46,369	51,180
Deferred inflows of resources - actuarial	46,610	41,339
Total deferred inflows of resources	97,501	97,041
Net position		
Invested in capital assets, net of related debt	649,763	592,836
Restricted - expendable	27,438	22,960
Restricted - nonexpendable	9,161	8,122
Unrestricted	1,674,584	1,678,527
Total net position	2,360,946	2,302,445
Total liabilities, deferred inflows of resources, and net position	$ 3,314,600	$ 3,327,054

El Camino Healthcare District
Consolidated Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2022 and 2021
(In Thousands)

	2022	2021 (As restated)
OPERATING REVENUES		
Net patient service revenue (net of provision for bad debts of $7,429 and $26,370 in 2022 and 2021, respectively)	$ 1,309,152	$ 1,107,912
Other revenue	37,031	42,221
Total operating revenues	1,346,183	1,150,133
OPERATING EXPENSES		
Salaries, wages, and benefits	654,619	574,797
Professional fees and purchased services	178,190	177,981
Supplies	183,665	171,720
Depreciation and amortization	79,871	74,595
Rent and utilities	20,113	20,693
Other	20,915	15,140
Total operating expenses	1,137,373	1,034,926
Income from operations	208,810	115,207
NONOPERATING REVENUES (EXPENSES)		
Investment (losses), net	(172,069)	230,924
Property tax revenue		
Designated to support community benefit programs and operating expenses	10,221	9,532
Designated to support capital expenditures	11,528	11,129
Levied for debt service	12,304	11,803
Bond interest expense, net	(19,831)	(20,031)
Intergovernmental transfer expense	(2,613)	(4,460)
Restricted gifts, grants and bequests, and other, net of contributions to related parties	7,551	2,868
Unrealized gain on interest rate swaps	3,049	1,883
Community benefit expense	(11,143)	(11,297)
Provider Relief Fund revenue	15,629	-
Other, net	(4,935)	7,167
Total nonoperating (expenses) revenues	(150,309)	239,518
Increase in net position	58,501	354,725
TOTAL NET POSITION, beginning of year	2,302,445	1,947,720
TOTAL NET POSITION, end of year	$ 2,360,946	$ 2,302,445

See accompanying notes.

El Camino Healthcare District
Consolidated Statements of Cash Flows
Years Ended June 30, 2022 and 2021
(In Thousands)

	2022	2021 (As restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from and on behalf of patients	$ 1,202,871	$ 1,056,241
Other cash receipts	37,031	28,725
Provider Relief Funds	26,930	-
Cash payments to employees	(654,369)	(555,737)
Cash payments to suppliers	(467,744)	(406,025)
Net cash provided by operating activities	144,719	123,204
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Property taxes	21,749	20,661
Restricted contributions and investment income	7,551	2,868
Net cash provided by noncapital financing activities	29,300	23,529
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of property, plant, and equipment	(112,569)	(67,965)
Payments on lease liability	(7,128)	(7,387)
Proceeds from lease receivable	12,884	13,496
Interest paid on General Obligation bonds payable	(2,943)	(3,071)
Repayments of bonds payable	(14,480)	(13,420)
Tax revenue related to General Obligation bonds payable	12,304	11,803
Net cash used in capital and related financing activities	(111,932)	(66,544)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(1,859,468)	(2,061,579)
Sales of investments	2,024,934	1,674,401
Investment (losses) income, net	(172,069)	230,924
Community benefit and other investing activities	(11,143)	(11,287)
Change in funds held by trustee, net	1,667	13,886
Net cash used in investing activities	(16,079)	(153,655)
Net increase (decrease) in cash and cash equivalents	46,008	(73,466)
CASH AND CASH EQUIVALENTS at beginning of year	161,915	235,381
CASH AND CASH EQUIVALENTS at end of year	$ 207,923	$ 161,915

El Camino Healthcare District
Consolidated Statements of Cash Flows (continued)
Years Ended June 30, 2022 and 2021
(In Thousands)

	2022	2021 (As restated)
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH FROM OPERATING ACTIVITIES		
Income from operations	$ 208,810	$ 115,207
Adjustments to reconcile income from operations to net cash net cash from operating activities		
Loss on disposal of property, plant and equipment	2,271	-
Amortization of bond premium and bond issuance costs	(3,070)	(3,564)
Depreciation and amortization	79,871	74,595
Provision for bad debts	7,429	26,370
Changes in assets and liabilities		
Patient accounts receivable, net	(47,414)	(66,174)
Prepaid expenses and other current assets	(34,819)	(34,244)
Medicare accelerated payments	(65,635)	(9,441)
Current liabilities	4,684	24,700
Other long-term obligations	(2,353)	(6,065)
Deferred inflows/outflows of resources - actuarial	5,484	15,389
Deferred inflows - leases	(9,665)	(13,496)
Post-retirement medical benefits	(874)	(73)
Net cash provided by operating activities	$ 144,719	$ 123,204
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING ACTIVITIES		
Noncash purchase of property, plant, and equipment	$ -	$ 5,848
Change in fair value of beneficial interest in charitable remainder unitrusts, and deferred inflow of resources, net	$ -	$ 629

See accompanying notes.

El Camino Healthcare District
Statements of Fiduciary Net Position
June 30, 2022 and 2021
(In Thousands)

	CASH BALANCE PLAN		OPEB PLAN		TOTAL	
	2022	2021	2022	2021	2022	2021
ASSETS						
Investments						
Mutual funds	$ 240,563	$ 230,806	$ -	$ -	$ 240,563	$ 230,806
Limited liability companies	59,573	49,390	-	-	59,573	49,390
Common stock	30,285	23,649	-	-	30,285	23,649
Partnerships	11,490	11,044	-	-	11,490	11,044
Pooled, common and collective trusts	11,686	9,158	-	-	11,686	9,158
Corporate bonds	3,265	5,304	-	-	3,265	5,304
U.S. government securities	815	3,310	-	-	815	3,310
Cash and cash equivalents	5,742	3,887	-	-	5,742	3,887
Total investments, at fair value	363,419	336,548	-	-	363,419	336,548
Receivables						
Employer contributions	1,500	3,500	-	-	1,500	3,500
Interest and dividends	65	53	-	-	65	53
Total receivables	1,565	3,553	-	-	1,565	3,553
Noninterest-bearing cash	67	4	-	-	67	4
Net pending trades	(46)	-	-	-	(46)	-
NET POSITION RESTRICTED FOR PENSIONS	$ 365,005	$ 340,105	$ -	$ -	$ 365,005	$ 340,105

El Camino Healthcare District
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2022 and 2021
(In Thousands)

	CASH BALANCE PLAN		OPEB PLAN		TOTAL	
	2022	2021	2022	2021	2022	2021
ADDITIONS						
Investments income						
Net appreciation in fair value of investments	$ 29,452	$ 39,954	$ -	$ -	$ 29,452	$ 39,954
Dividends	3,525	3,635	-	-	3,525	3,635
Interest	184	247	-	-	184	247
Total investment income	33,161	43,836	-	-	33,161	43,836
Contributions						
Employer contributions	6,500	10,500	943	881	7,443	11,381
Pending investment settlements	13	136	-	-	13	136
Total contributions	6,513	10,636	943	881	7,456	11,517
Total additions	39,674	54,472	943	881	40,617	55,353
DEDUCTIONS						
Benefits paid to participants	14,774	12,167	943	881	15,717	13,048
Administrative expenses	-	55	-	-	-	55
Total deductions	14,774	12,222	943	881	15,717	13,103
INCREASE IN NET POSITION	24,900	42,250	-	-	24,900	42,250
NET POSITION RESTRICTED FOR PENSIONS						
Beginning of year	340,105	297,855	-	-	340,105	297,855
End of year	$ 365,005	$ 340,105	$ -	$ -	$ 365,005	$ 340,105

See accompanying notes.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization – The El Camino Healthcare District (the "District") includes the following component units, which are included as blended component units of the District's consolidated financial statements: El Camino Hospital (the "Hospital"), El Camino Hospital Foundation (the "Foundation"), CONCERN: Employee Assistance Program ("CONCERN"), and Silicon Valley Medical Development, LLC ("SVMD").

The District is organized as a political subdivision of the State of California and was created for the purpose of operating an acute care hospital and providing management services to certain related corporations. The District is the sole member of the Hospital, and the Hospital is the sole corporate member of the Foundation and CONCERN. As sole member, the District (with respect to the Hospital) and the Hospital (with respect to the Foundation and CONCERN) have certain powers, such as the appointment and removal of the boards of directors and approval of changes to the articles of incorporation and bylaws.

SVMD was organized as a California Limited Liability Corporation ("LLC") that was formed in 2008. Starting in fiscal year 2019 and continuing into the current fiscal year, SVMD has expanded to 14 clinic and urgent care sites.

All significant inter-entity accounts and transactions have been eliminated in the consolidated financial statements.

The District utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and consolidated financial statements are prepared using the economic resources measurement focus.

The District has fiduciary responsibility for the El Camino Hospital Cash Balance Plan and El Camino Hospital Postretirement Health and Life Insurance Benefit Plan. See Notes 7 and 8.

El Camino Hospital Cash Balance Plan – The Plan was originally adopted as a defined benefit plan and was amended and restated in its entirety to a cash-balance formula effective January 1, 1995. Effective January 1, 2014, the Plan was restated and amended. The Plan is administered by the sponsor, El Camino Hospital (the "Hospital"), and Plan assets are held by the custodian of the Plan, Wells Fargo Bank, N.A. ("Wells Fargo"). The Plan is a noncontributory defined benefit plan intended to qualify under Section 401(a) of the Internal Revenue Code ("IRC"). At December 31, 2021, there were 4604 Plan participants consisting of 2927 active participants and 1677 inactive or separated participants, and at December 31, 2020, there were 4,389 Plan participants consisting of 2,824 active participants and 1,565 inactive or separated participants.

El Camino Hospital Postretirement Health and Life Insurance Benefit Plan – The Hospital also provides healthcare benefits and life insurance under the El Camino Hospital Postretirement Health and Life Insurance Benefit Plan (the "OPEB Plan"), a single-employer defined benefit Postretirement Benefits Plan, for retired employees who meet eligibility requirements as outlined in the plan document, as approved by the board of directors of the Hospital.

Accounting standards – Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Use of estimates – The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Estimates include contractual allowances related to net patient service revenue, provision for uncollectible accounts, fair market values of investments, uninsured losses for professional liability, minimum pension liability, workers' compensation liability, post-retirement medical benefits liability, valuation of gift annuities and beneficial interest in charitable remainder unitrusts, useful lives of capital assets, discount rate for leases, useful lives of right of use assets, and deferred inflows of resources. Actual results could differ from those estimates.

Cash and cash equivalents – Cash and cash equivalents include deposits with financial institutions, and investments in highly liquid debt instruments with an original maturity of three months or less. In addition, in fiscal years 2022 and 2021, cash and cash equivalents include repurchase agreements, which consist of highly liquid obligations of U.S. governmental agencies. Cash and cash equivalents exclude amounts whose use is limited by board designation or by legal restriction.

Investments – Investments consist primarily of highly liquid debt instruments and other short-term interest-bearing certificates of deposit, U.S. Treasury bills, U.S. government obligations, hedge funds, hedge fund of funds, and corporate debt, excluding amounts whose use is limited by board designation or other arrangements under trust agreements.

Board-designated and restricted funds include assets set aside by the Board of Directors (the "Board") for future capital improvements and other operational reserves, over which the Board retains control and may at its discretion use for other purposes; assets set aside for qualified capital outlay projects in compliance with state law; and assets restricted by donors or grantors.

Investment income, realized gains and losses, and unrealized gains and losses on investments are reflected as nonoperating revenue or expense.

Funds held by trustee – According to the terms of both indenture agreements (General Obligation and Revenue Bonds), these amounts are held by the bond trustee and paying agent and are maintained and managed by an investment manager or the trustee. These assets are available for the settlement of future current bond obligations and capital expenditures.

Lease receivable – The District's lease receivable is measured at the present value of lease payments expected to be received during the lease term. Under the lease agreement, the District may receive variable lease payments that are dependent upon the lessee's revenue. The variable payments are recorded as an inflow of resources in the period the payment is received. The deferred inflow of resources is recorded at the initiation of each lease in an amount equal to the initial recording of the lease receivable. The deferred inflows of resources are amortized on an effective interest method basis over the term of each lease.

Capital assets – Capital asset acquisitions are recorded at cost. Donated property is recorded at its fair market value on the date of donation. All purchases over $2,500 are capitalized. Equipment under capital lease is amortized on the straight-line basis over the shorter of the lease term or the estimated useful life of the equipment. Leasehold improvements are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the related assets. Depreciation is computed using the straight-line method over the estimated useful lives of the assets as follows:

Land improvements	16 years
Buildings and fixtures	25 to 47 years
Equipment	3 to 16 years

The District evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Right of use assets – The District has recorded right to use lease assets as a result of implementing Governmental Accounting Standards Board ("GASB") No. 87. The right to use assets are initially measured at an amount equal to the initial measurement of the related lease liability plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The right to use assets are amortized on a straight-line basis over the life of the related lease.

Prepaid expenses and other current assets – Prepaid expenses and other current assets consist primarily of premiums paid in advance, inventories, dues, and other receivables related to new capitation and hospitalist contracts associated with SVMD. Prepaid expenses and other current assets consisted of the following at June 30:

	2022	2021
Inventory	$ 19,546	$ 13,765
Prepaid expense and other deposits	16,931	9,920
Other receivables	13,298	8,525
	$ 49,775	$ 32,210

Investments in healthcare affiliates – The Hospital holds an interest in Pathways Home Health & Hospice ("Pathways"), and five Satellite Dialysis Centers, which are reported using the equity method of accounting.

Affiliate	Percent interest
Pathways	50%
Satellite Dialysis	30%

Deferred outflows and inflows – The District records deferred outflows or inflows of resources in its consolidated financial statements for consumption or acquisition of its consolidated net position that is applicable to a future reporting period. These financial statement elements are distinct from assets and liabilities.

	2022	2021
Deferred outflows of resources as of June 30:		
Loss on defeasance of bonds payable	$ 11,160	$ 11,761
Deferred outflows of resources - employee benefit plan contribution	3,000	7,000
Deferred outflows of resources - goodwill	1,226	2,324
Deferred outflows - actuarial, employee benefit plan	588	915
Deferred outflows - actuarial, post-retirement medical benefit	204	90
Total	$ 16,178	$ 22,090
Deferred inflows of resources as of June 30:		
Deferred inflows of resources - charitable remainder unitrusts	$ 4,522	$ 4,522
Deferred inflows of resources - leases	46,369	51,180
Deferred inflows - actuarial, employee benefit plan	46,075	41,141
Deferred inflows - actuarial, post-retirement medical benefit	535	198
Total	$ 97,501	$ 97,041

Risk management – The Hospital is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Self-insurance plans – The Hospital maintains professional liability insurance on a claims-made basis, with liability limits of $40,000,000 in aggregate, which is subject to a $500,000 deductible. Additionally, the Hospital is self-insured for workers' compensation benefits. The Hospital purchases a Workers' Compensation Excess Policy that insures claims greater than $1,000,000 with a limit of statutory and a $1,000,000 deductible. Actuarial estimates of uninsured losses for professional liability and workers' compensation have been accrued as other current liabilities and workers' compensation, net of current portion, respectively, in the accompanying consolidated financial statements.

The following is a summary of changes in workers' compensation liabilities for the years ended June 30 (in thousands):

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2022	$ 19,302	$ -	$ 2,973	$ 16,329	$ 2,300

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2021	$ 18,782	$ 2,827	$ 2,307	$ 19,302	$ 2,300

Compensated absences – Vested or accumulated vacation and sick leave are recorded as an expense and liability of the Hospital as the benefits accrue to employees. For most employees, the maximum accumulated vacation is 400 hours. Sick leave is accumulated indefinitely at a maximum of 40 hours for a full-time employee per year, and is not vested with the employee upon termination.The following is a summary of changes in compensated absences transactions for the years ended June 30, (in thousands):

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2022	$ 33,197	$ 58,222	$ 56,970	$ 34,449	$ 34,449

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2021	$ 28,124	$ 52,815	$ 47,742	$ 33,197	$ 33,197

Lease liabilities – The District recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative future payments on the contract exceeding $12,000 that meet the definition of an other than short-term lease. The District uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the District's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

The following is a summary of changes in lease liabilities, net for the years ended June 30 (in thousands):

	July 1	Increases	Decreases	June 30	Current Portion
2022	$ 31,398	$ 3,803	$ 5,063	$ 30,138	$ 4,502

	July 1	Increases	Decreases	June 30	Current Portion
2021	$ 34,151	$ 3,292	$ 6,045	$ 31,398	$ 5,063

Medicare accelerated payments and CARES Act grant – On March 11, 2020, the World Health Organization officially declared COVID-19, the disease caused by the novel coronavirus, a pandemic. Management is closely monitoring the evolution of this pandemic, including how it may affect operations and the general population. Management has not yet determined the full financial impact of these events. Centers for Medicare & Medicaid Services ("CMS") distributed $50 billion of the $100 billion in the form of grants to hospitals. For the years ended June 30, 2022 and 2021, the Hospital received approximately $26.9 million and $0 million of provider relief funds, respectively. The Hospital recognized $15.6 million included as "Provider Relief Fund revenue" (nonoperating revenue) in the consolidated statement of revenues, expenses, and changes in net position, for the year ended June 30, 2022, and deferred the remainder amount. The Hospital did not recognized any provider relief fund revenue for the year ended June 30, 2021. The Hospital will have to submit reports documenting lost revenue and expenses incurred to support the grant funds, among other terms and conditions.

Separately, CMS initiated an Accelerated Payment Program to hospitals. The Accelerated Payments represent advance payments for services to be provided and were based on a hospital's historical Medicare volume. In April 2020, the Hospital received approximately $75.1 million in Accelerated Payments. CMS began recoupment of these accelerated payments in April 2021 and will continue to recoup the accelerated payments from billings for services rendered until they are fully repaid. As of June 30, 2022 and 2021, the Hospital had $0 million and $65.6 million, respectively, in accelerated payments, included in Medicare accelerated payments in the consolidated statement of financial position. During the year ended June 30, 2022 and 2021, approximately $65.6 million and $9.4 million, respectively had been recouped.

Interest rate swap agreements – During the fiscal year ended June 30, 2007, the Hospital entered into derivative instruments in the form of three swap agreements to hedge variable interest rate exposure. During the fiscal year ended June 30, 2008, the underlying variable rate debt was refunded for fixed rate debt, leaving the Hospital with speculative derivative instruments that largely offset the variable rate debt issued in 2009. Two of these swaps were terminated in the fiscal year ended June 30, 2010. Refer to Note 10 for a full description of the interest rate swap agreements.

Net position – Net position of the District is classified as invested in capital assets, restricted-expendable, restricted-nonexpendable, and unrestricted net position.

Invested in capital assets, net of related debt – Invested in capital assets of $649,763,000 and $592,836,000 at June 30, 2022 and 2021, respectively, represent investments in all capital assets (building and building improvements, furniture and fixtures, and information and technology equipment), net of depreciation and amortization less any debt issued to finance those capital assets.

Restricted-expendable – The restricted-expendable net position is restricted through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation and includes assets in self-insurance trust funds, revenue bond reserve fund assets, and net position restricted to use by donors.

Restricted-nonexpendable – The restricted-nonexpendable net position is equal to the principal portion of permanent endowments.

Unrestricted net position – Unrestricted net position consists of net position that does not meet the definition of invested in capital assets, net of related debt, or restricted.

Statements of revenues, expenses, and changes in net position – For purposes of presentation, transactions deemed by management to be ongoing, major, or central to the provisions of healthcare services are reported as revenues and expenses. Peripheral or incidental transactions are reported as gains and losses. These peripheral activities include investment income, property tax revenue, gifts, grants and bequests, change in net unrealized gains and losses on short-term investments, unrealized losses or gains on interest rate swaps, and nonexchange contributions received from the Foundation's fundraising activities and are reported as nonoperating. Investments in Pathways Home Health & Hospice and Satellite Dialysis of Mountain View, LLC, are accounted for under the equity method. The Hospital's share of the operating income of these entities is included as other, net in the consolidated financial statements.

Net patient service revenue and patient accounts receivable – Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined. The distribution of net patient accounts receivable by payor is as follows:

	June 30,	
	2022	2021
Medicare	12%	13%
Medi-Cal	2%	3%
Commercial and other	85%	83%
Self pay	1%	1%
	100%	100%

Provision for uncollectible accounts – The Hospital provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible.

Charity care – The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of estimated costs for services and supplies furnished under the Hospital's charity care policy aggregated approximately $4,106,000 and $3,323,000 for the years ended June 30, 2022 and 2021, respectively.

Property tax revenue – The District received approximately 58% in 2022 and 9% in 2021 of its total increase in net position from property taxes. These funds were designated as follows (in thousands):

	2022	2021
Designated to support community benefit programs and operating expenses	$ 10,221	$ 9,532
Designated to support capital expenditures	$ 11,528	$ 11,129
Levied for debt service	$ 12,304	$ 11,803

Property taxes are levied by the County of Santa Clara on the District's behalf on January 1 and are intended to finance the District's activities of the same calendar year. Amounts levied are based on assessed property values as of the preceding July 1. Property taxes are considered delinquent on the day following each payment due date. Property taxes are recorded as nonoperating revenue by the District when they are earned.

Grants and contributions – From time to time, the District receives grants as well as contributions from individuals and private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues.

Income taxes – The District operates under the purview of the Internal Revenue Code (the "Code"), Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. CONCERN has also been granted tax-exempt status. However, income from the unrelated business activities of the Hospital and the Foundation is subject to income taxes. SVMD is a limited liability company and is treated as a pass-through entity for federal income tax purposes. Accordingly, no recognition has been given to federal income taxes in the accompanying consolidated financial statements.

New accounting pronouncements – The GASB also issued GASB Statement No. 87, *Leases* ("GASB No. 87"), which intends to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. GASB No. 87 increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. The statement establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. GASB No. 95 extended the effective date for GASB No. 87 to reporting periods beginning July 1, 2021. The District adopted GASB No. 87 Leases (GASB 87) as of July 1, 2020. The contracts to lease office space met the definition of a lease and the District calculated and recognized a right-to-use assets, net, of $31 million and lease liabilities of $31 million as of June 30, 2021. As lessor, the District's adoption of GASB 87 resulted in recognition of lease receivable of $51 million and deferred inflow of $51 million as of June 30, 2021. The impact to beginning net position was not significant. See Notes 13 and Note 14.

The GASB also issued GASB Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period* ("GASB No. 89"). GASB No. 89 establishes accounting requirements for interest cost incurred before the end of a construction period. This statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset reported in a business-type activity or enterprise fund. GASB No. 95 extended the effective date for GASB No. 89 to reporting periods beginning July 1, 2021. The adoption did not result in a material impact to the District's consolidated financial statements.

The GASB also issued GASB Statement No. 91, *Conduit Debt Obligation* ("GASB No. 91"). GASB No. 91 provides a single method of reporting conduit debt obligations by issuers and eliminate diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. This Statement achieves those objectives by clarifying the existing definition of a conduit debt obligation; establishing that a conduit debt obligation is not a liability of the issuer; establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations; and improving required note disclosures. GASB No. 95 extended the effective date for GASB No. 91 to reporting periods beginning July 1, 2022. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

The GASB also issued Statement No. 93, *Replacement of Interbank Offered Rates* ("GASB No. 93"). GASB No. 93 establishes accounting and reporting requirements related to the replacement of Interbank Offered Rates such as the London Interbank Offered Rate ("LIBOR") for hedging derivative instruments. As a result of global reference rate reform, LIBOR is expected to cease to exist in its current form after December 31, 2021. The requirements of this statement, except for paragraphs 11b, 13, and 14, are effective for reporting periods beginning after June 15, 2020. The requirement in paragraph 11b is effective for reporting periods ending after December 31, 2021. GASB No. 95 extended the effective date for paragraphs 13 and 14 to fiscal years beginning after June 15, 2021. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

NOTE 2 – OPERATING REVENUES

The Hospital and SVMD has agreements with third-party payors that provide for payments to the Hospital and SVMD at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, fee schedules, prepaid payments per member, and per diem payments or a combination of these methods. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated settlements under reimbursement agreements with third-party payors.

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. Inpatient services are paid at prospectively determined rates per discharge. Payments for outpatient services are based on a stipulated amount per procedure. The Hospital is reimbursed for cost reimbursable items at a tentative rate, with final settlements determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The effect of updating prior-year estimates for Medicare and other liabilities was to decrease 2022 income from operations by $5,305,000, and decrease 2021 income from operations by $5,519,000. The Hospital's cost reports have been audited by the Medicare fiscal intermediary through June 30, 2018.

Non-Designated Public Hospitals ("NDPHs"), including the Hospital, were authorized, in 2011's Assembly Bill ("AB") 113, to use intergovernmental transfers ("IGTs") to obtain federal supplemental funds for Medi-Cal inpatient fee-for-service. The IGTs are used to bring NDPHs, in the aggregate, up to their upper payment limit ("UPL"). The UPL is the federal maximum available under the Medicaid program, as calculated based on the actual costs of providing care. For the years ended June 30, 2022 and 2021, the Hospital recognized amounts under the IGT program of $8,283,000 and $12,974,000, respectively, which have been reported as net patient service revenue.

Medi-Cal and contracted rate payors are paid on a percentage of charges, per diem, per discharge, fee schedule, or a combination of these methods.

Laws and regulations governing the Medicare and Medi-Cal programs are complex and are subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term.

Other revenues for the year ended June 30, consisted of the following:

	2022	2021
Rental income	$ 13,794	$ 13,496
Prime IGT	1,441	3,616
SVMD other revenue	1,074	9,043
CONCERN & SVMD capitated revenue	11,464	11,843
Other operating revenue	9,258	4,223
	$ 37,031	$ 42,221

NOTE 3 – CASH DEPOSITS

At June 30, 2022 and 2021, District cash deposits had carrying amounts of $207,923,000 and $161,915,000, respectively, and bank balances of $224,679,000 and $167,845,000, respectively. All of these funds were held in cash deposits, which are collateralized with the California Government Code ("CGC"), except for $250,000 per account that is federally insured by the Federal Deposit Insurance Corporation ("FDIC").

The District participated in a cash management program provided by its primary depository institution that allows cash in District concentration accounts to be swept daily and invested overnight in reverse agreements that are not exposed to custodial credit risk because the underlying securities are held by the buyer-lender.

NOTE 4 – BOARD-DESIGNATED FUNDS, FUNDS HELD BY TRUSTEE, RESTRICTED FUNDS, AND INVESTMENTS

Board-designated funds, funds held by trustee, restricted funds, and short-term investments, collectively, as of June 30, 2022 and 2021, comprised the following (in thousands):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
2022				
Cash and cash equivalents	$ 86,014	$ 21	$ (85)	$ 85,950
Mutual funds	317,868	82,791	(25,039)	375,620
Real estate funds	36,512	16,371	(1,542)	51,341
Hedge funds	218,168	45,618	(9,043)	254,743
Equities	64,460	14,725	(3,573)	75,612
Fixed income securities	570,263	866	(33,042)	538,087
	$ 1,293,285	$ 160,392	$ (72,324)	$ 1,381,353

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
2021				
Cash and cash equivalents	$ 106,812	$ -	$ -	$ 106,812
Mutual funds	299,020	190,509	-	489,529
Real estate funds	60,736	17,824	(23)	78,537
Hedge funds	180,072	36,628	(4,102)	212,598
Equities	57,211	20,811	(327)	77,695
Fixed income securities	561,274	23,931	(1,890)	583,315
	$ 1,265,125	$ 289,703	$ (6,342)	$ 1,548,486

At June 30, 2022, investment balances and average maturities were as follows:

Investment Type	Fair Value (in thousands)	Investment Maturities (in years) Less than 1	1 to 5	6 to 10	More than 10
Short-term money market	$ 79,616	$ 79,616	$ -	$ -	$ -
Government and agencies	301,655	-	153,810	17,217	130,628
Corporate bonds	206,714	17,978	107,634	38,596	42,506
Domestic fixed income	36,052	-	20,289	9,884	5,879
	624,037	$ 97,594	$ 281,733	$ 65,697	$ 179,013
Equities	75,612				
Mutual funds	375,620				
Real estate funds	51,341				
Hedge funds	254,743				
Total	$ 1,381,353				

At June 30, 2021, investment balances and average maturities were as follows:

Investment Type	Fair Value (in thousands)	Investment Maturities (in years) Less than 1	1 to 5	6 to 10	More than 10
Short-term money market	$ 107,614	$ 107,614	$ -	$ -	$ -
Government and agencies	383,153	52,241	165,644	32,733	132,535
Corporate bonds	157,451	19,499	73,689	25,560	38,703
Domestic fixed income	41,909	528	21,470	11,380	8,531
	690,127	$ 179,882	$ 260,803	$ 69,673	$ 179,769
Equities	77,695				
Mutual funds	489,529				
Real estate funds	78,537				
Hedge funds	212,598				
Total	$ 1,548,486				

Interest rate risk – Through its investment policies, the District manages its exposure to fair value losses arising from increasing interest rates by limiting duration of fixed-income securities in its portfolio to no more than 30% of the designated benchmark.

Credit risk – District investment policies require fixed income investments to have a minimum of 85% of a money manager's assets in investment grade assets. The investment policy requires investment managers maintain an average of A- or higher ratings as issued by a nationally recognized rating organization. Additionally, the investment policy requires no more than 5% of a money manager's portfolio at the time of purchase shall be invested in the securities of any one issuer, with the exception of a United States government agency, agency MBS, or other Sovereign issues rated AAA or Aaa.

Foreign currency risk – The District's investment policy permits it to invest up to 30% of total investments in foreign currency denominated investments.

Alternative investments risk – The District's alternative investments include ownership interest in a wide variety of partnership and fund structures that may be domestic or offshore. Generally, there is little or no regulation of these investments by the Securities and Exchange Commission or U.S. state attorneys general. These investments employ a wide variety of strategies including absolute return, hedge, venture capital, private equity, and other strategies. Investments in this category may employ leverage to enhance the investment return. The District's holdings can include financial assets such as marketable securities, nonmarketable securities, derivatives, and synthetic and structured instruments; real assets; tangible and intangible assets; and other funds and partnerships. Generally, these investments do not have a ready market. Interest in these investments may not be traded without approval of the general partner or fund management.

Alternative investments are subject to all of the risks described previously relating to equities and fixed-income instruments. In addition, alternative strategies and their underlying assets and rights are subject to a broad array of economic and market vagaries that can limit or erode value. The underlying assets may not be held by a custodian either because they cannot be, or because the entity has chosen not to hold them in this form. Valuations determined by the investment manager, who has a conflict of interest in that he or she is compensated for performance, are considered and reviewed by the District's Investment Committee and the Board of Directors. Real assets may be subject to physical damage from a variety of means, loss from natural causes, theft of assets, lawsuits involving rights, and other loss and damage including mortgage foreclosure risk. These risks may not be insured or insurable. Tangible assets are subject to loss from theft and other criminal actions and from natural causes. Intangible assets are subject to legal challenge and other possible impairment.

The carrying amount of deposits and investments are included in the District's consolidated statements of net position as follows (in thousands):

	2022	2021
Included in the following consolidated statements of net position captions:		
Short-term investments	$ 153,417	$ 294,690
Current portion of board designated and funds held by trustee	11,129	18,657
Board designated, funds held by trustee, and restricted funds, less current portion	1,216,807	1,235,139
Total carrying amount of deposits and investments	$ 1,381,353	$ 1,548,486

NOTE 5 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the consolidated statements of net position at June 30, 2022 and 2021, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Mutual funds: Shares of mutual funds are valued at the net asset value ("NAV") of shares held by the District and are valued at the closing price reported on the active market on which the individual securities are traded.

Common stock: Common stock is valued at the closing price reported on the active market on which the individual securities are traded.

Asset-backed securities: Asset-backed securities are valued via model using various inputs such as but not limited to daily cash flow, U.S. Treasury market, floating rate indices such as LIBOR and Prime as a benchmark yield, spread over index, periodic and life caps, next coupon adjustment date, and convertibility of the bond.

Corporate bonds, foreign bonds, and municipal bonds: Valued using pricing models maximizing the use of observable inputs for similar securities which includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

U.S. government securities: Fixed income funds are valued at the NAV of shares held by the District and are valued at the closing price reported on the active market on which the individual securities are traded.

Pooled, common & collective trusts: Investments are valued using the NAV of the fund. The NAV of a pooled or collective investment fund is calculated based on a compilation of primarily observable market information. The number of units of the fund that are outstanding on the calculation date is derived from observable purchase and redemption activity in the fund.

Hedge funds: The fair value of the investments is recorded at the investment manager's net asset values, as determined by the fund administrator and subsequently audited by an external third party. The administrator has the appropriate expertise to determine the NAV. The District assesses the NAV and takes into consideration events such as suspended redemptions, restructuring, secondary sales, and investor defaults to determine if an adjustment is necessary. Additionally, asset holdings are reviewed within investment managers' audited financial statements.

Limited Liability Company and Limited Partnership Interests: The valuation of partnership interests may require significant management judgement. The District's ownership is based upon their percentage of limited partnership interests divided by the total commitment of the fund. Specifically, inputs used to determine fair value include financial statements provided by the investment partnerships, which typically include fair market value capital account balances.

Interest rate swaps: The fair value is estimated by a third party using inputs that are observable or that can be corroborated by observable market data and, therefore, are classified within Level 2 of the valuation hierarchy.

Beneficial interest in charitable remainder unitrusts: The beneficial interest in charitable remainder unitrusts is measured at fair value, which is estimated as the present value of the expected future cash flows from trusts.

The following table presents the fair value measurements of financial instruments for the consolidated District financials, recognized in the accompanying consolidated statements of net position measured at fair value on a recurring basis and the level within the GASB No. 72 fair value hierarchy in which the fair value measurements fall at June 30 (in thousands):

Description	Level 1	Level 2	Level 3	2022
Investments by fair value level				
Asset backed securities				
Corporate backed obligations	$ -	$ 29,079	$ -	$ 29,079
Mortgage backed obligations	-	31,891	-	31,891
U,S. Government Mortgage Pool	-	69,721	-	69,721
Common stock				
ADR & U.S. foreign stock	-	6,412	-	6,412
Consumer discretionary	12,381	-	-	12,381
Consumer staples	2,235	-	-	2,235
Energy	10,127	-	-	10,127
Financial services industry	13,855	-	-	13,855
Healthcare industry	7,974	-	-	7,974
Industrials	6,548	-	-	6,548
Information Technology	7,635	-	-	7,635
Materials	5,239	-	-	5,239
Other	3,205	-	-	3,205
Corporate, municipal and foreign bonds				
Corporate bonds	-	179,806	-	179,806
Foreign corporate bonds	-	5,959	-	5,959
Private placements	36,052	-	-	36,052
Municipal taxable	-	4,301	-	4,301
Municipal - tax-exempt	192			
Preferred stocks	1,324	-	-	1,324
Mutual funds				
Mutual funds - equity	375,619	-	-	375,619
Mutual funds - taxable	-	17,978	-	17,978
U.S. Government securities				
Government agencies	4,738	-	-	4,738
U.S. treasury notes and bonds	158,813	-	-	158,813
Limited partnership interests	-	-	46,067	46,067
Total investments by fair value level	$ 645,937	$ 345,147	$ 46,067	1,036,959
Cash equivalents				84,500
Investments measured at NAV				
Pooled, common & collective trusts				34,918
Equity hedge funds				67,583
Credit hedge funds				34,966
Macro hedge funds				27,487
Relative value hedge funds				92,580
Fixed income limited partnership				2,360
Total investments measured at NAV				259,894
Total investments				$ 1,381,353
Beneficial interest in charitable remainder unitrusts	$ -	$ -	$ 4,522	$ 4,522
Interest rate swap	$ -	$ (3,872)	$ -	$ (3,872)

Description	Level 1	Level 2	Level 3	2021
Investments by fair value level				
Asset backed securities				
Corporate backed obligations	$ -	$ 17,317	$ -	$ 17,317
Mortgage backed obligations	-	30,013	-	30,013
U,S. Government Mortgage Pool	-	75,847	-	75,847
Common stock				
ADR & U.S. foreign stock	-	6,217	-	6,217
Consumer discretionary	15,566	-	-	15,566
Consumer staples	3,791	-	-	3,791
Energy	7,255	-	-	7,255
Financial services industry	15,024	-	-	15,024
Healthcare industry	6,474	-	-	6,474
Industrials	10,992	-	-	10,992
Information Technology	8,554	-	-	8,554
Telecommunication services	-	-	-	-
Other	3,821	-	-	3,821
Corporate, municipal and foreign bonds				
Corporate bonds	-	157,451	-	157,451
Private placements	41,909	-	-	41,909
Municipal taxable	-	4,239	-	4,239
Preferred stocks	1,378	-	-	1,378
Mutual funds				
Mutual funds - equity	489,529	-	-	489,529
Mutual funds - taxable	-	24,248	-	24,248
U.S. Government securities				
Government agencies	-	-	-	-
U.S. treasury notes and bonds	246,022	-	-	246,022
Limited partnership interests	-	-	30,128	30,128
Total investments by fair value level	$ 850,315	$ 315,332	$ 30,128	1,195,775
Cash equivalents				106,576
Investments measured at NAV				
Pooled, common & collective trusts				37,609
Equity hedge funds				66,641
Credit hedge funds				26,116
Macro hedge funds				24,164
Relative value hedge funds				89,266
Fixed income limited partnership				2,339
Total investments measured at NAV				246,135
Total investments				$ 1,548,486
Beneficial interest in charitable remainder unitrusts	$ -	$ -	$ 4,522	$ 4,522
Interest rate swap	$ -	$ (7,923)	$ -	$ (7,923)

The following table provides the fair value and redemption terms and restrictions for investments redeemable NAV at June 30 (in thousands):

	2022 Fair Value	2021 Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice
Pooled, common & collective trusts	$ 34,918	$ 37,609	$ -	Monthly	30 days
Equity hedge funds	67,583	66,641	-	Quarterly	90 days
Credit hedge funds	34,966	26,116	-	Monthly, Quarterly	15 - 60 days
Macro hedge funds	27,487	24,164	-	Monthly, Quarterly	5 - 90 days
Relative value hedge funds	92,580	89,266	-	Quarterly, Annually	45 days
Fixed income limited partnership	2,360	2,339	-	Monthly	1 day
Total investments measured at NAV	$ 259,894	$ 246,135	$ -		
Limited partnership interests	$ 46,067	$ 30,128	$ 29,531	n/a	n/a

Pooled, common & collective trusts – includes investments that invest in domestic equity. Investments are valued using the NAV per share of the fund. The NAV per share is based on the value of the underlying assets owned by the fund, minus its liabilities, divided by the number of shares outstanding.

Equity hedge funds – includes investments that employ both long and short strategies primarily in common stocks. Equity hedge strategies typically have a directional bias (long or short) and trade in equities and equity related derivatives. The fair values of the investments in this type have been determined using the NAV per share of the investments. Investments representing approximately 20% of the value of the investments in this type include restrictions such as certain classes with side pocket investments which may only be redeemed upon realization of the underlying investments.

Credit hedge funds – includes investments that is comprised of distressed securities, credit long/short, emerging market debt and credit event driven. Credit hedge strategies typically have a directional bias and involve the purchase of various types of debt, equity, trade claims and fixed income securities. The fair values of the investments in this type have been determined using the NAV per share of the investments. All of the investments in this type include restrictions that do not allow for redemptions in the first year after acquisition and other imposed gates.

Macro hedge funds – includes investments that invests in global macro, managed futures, commodities and currencies. Macro hedge strategies typically have a directional bias and involve the purchase of a variety of securities and/or derivatives related to major markets. Managed future strategies trade similar instruments but are typically implemented by computerized system. The fair values of the investments in this type have been determined using the NAV per share of the investments. Investments representing approximately 36% of the value of the investments in this type include restrictions such as certain classes with side pocket investments which may only be redeemed upon realization of the underlying investments.

Relative value hedge funds – includes investments that typically does not display a distinct directional bias. Relative value encompasses a range of strategies covering different asset classes. The fair values of the investments in this type have been determined using the NAV per share (or its equivalent) of the investments. Less than 1% of the value of the investments may include lock up, imposed gates, and other restrictions that preclude them from redeeming their share or ownership interest for an uncertain or extended period of time from the measurement date.

Fixed-income limited partnership – includes investments in a limited partnership fund of funds that invest primarily in investment grade non-U.S. dollar denominated fixed income securities. The fund may enter into swap agreements, forward settlement agreements, futures, contracts, and options on future contracts as well as purchase and sell covered put and call options. Investments are valued using the NAV per share of the fund. There is a provision in the limited partnership agreement that allows the general partner to limit redemption under certain circumstances.

Limited partnership interests – investments in closed-end, commitment based private equity real estate partnerships. The valuation of partnership interests in these funds may require significant management judgement. The District's ownership is based upon their percentage of limited partnership interests divided by the total commitment of the fund. Inputs used to determine fair value include financial statements provided by the investment partnerships, which typically include fair market value capital account balances. These investments can never be redeemed with the funds. Instead, the nature of the investments in this category is that distributions are received through the liquidation of the underlying assets of the fund.

The following table presents the fair value measurements of financial instruments recognized in the accompanying fiduciary statements of net position measured at fair value on a recurring basis and the level within the GASB No. 72 fair value hierarchy in which the fair value measurements fall at June 30 (in thousands):

	2022			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 5,742	$ -	$ -	$ 5,742
Common stock	30,285	-	-	30,285
Corporate bonds	-	3,265	-	3,265
Mutual funds	240,563	-	-	240,563
U.S. government securities	815	-	-	815
Total assets in the fair value hierarchy	$ 277,405	$ 3,265	$ -	280,670
Investments measured at NAV practical expedient				82,749
Total assets, at fair value				$ 363,419

	2021			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 3,887	$ -	$ -	$ 3,887
Common stock	23,649	-	-	23,649
Corporate bonds	-	5,304	-	5,304
Mutual funds	230,806	-	-	230,806
U.S. government securities	3,310	-	-	3,310
Total assets in the fair value hierarchy	$ 261,652	$ 5,304	$ -	266,956
Investments measured at NAV practical expedient				69,592
Total assets, at fair value				$ 336,548

The following table provides the fair value and redemption terms and restrictions for investments redeemable NAV at June 30 (in thousands), for the fiduciary funds investments:

	Fair value June 30, 2022	Fair value June 30, 2021	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Limited Liability Company	$ 59,573	$ 49,390	$ -	Monthly/Semi-Annual	90 days
Common Collective Trust	11,686	9,158	-	Daily	Quarterly
Partnerships	11,490	11,044	-	No redemptions	N/A
	$ 82,749	$ 69,592			

NOTE 6 – CAPITAL ASSETS

Capital assets activity for the year ended June 30, 2022, was as follows (in thousands):

	Balance June 30, 2021	Increases	Decreases	Balance June 30, 2022
Capital assets not being depreciated				
Land	$ 94,725	$ 8,790	$ -	$ 103,515
Construction in progress	69,501	34,602	-	104,103
	164,226	43,392	-	207,618
Capital assets being depreciated				
Land improvement	19,201	2,434	-	21,635
Buildings	1,300,481	35,580	31,100	1,304,961
Capital equipment	426,511	35,985	10,819	451,677
	1,746,193	73,999	41,919	1,778,273
Less accumulated depreciation for				
Land improvement	12,561	773	-	13,334
Buildings	398,063	40,714	28,777	410,000
Capital equipment	339,509	32,589	10,871	361,227
	750,133	74,076	39,648	784,561
Total capital assets being depreciated, net	996,060	(77)	2,271	993,712
Total capital assets, net	$ 1,160,286	$ 43,315	$ 2,271	$ 1,201,330

Capital assets activity for the year ended June 30, 2021, was as follows (in thousands):

	Balance June 30, 2020	Increases	Decreases	Balance June 30, 2021
Capital assets not being depreciated				
Land	$ 92,904	$ 1,821	$ -	$ 94,725
Construction in progress	489,848	-	420,347	69,501
	582,752	1,821	420,347	164,226
Capital assets being depreciated				
Land improvement	15,768	3,433	-	19,201
Buildings	850,756	449,725	-	1,300,481
Capital equipment	399,247	27,306	42	426,511
	1,265,771	480,464	42	1,746,193
Less accumulated depreciation for				
Land improvement	11,891	670	-	12,561
Buildings	358,983	39,080	-	398,063
Capital equipment	311,613	27,938	42	339,509
	682,487	67,688	42	750,133
Total capital assets being depreciated, net	583,284	412,776	-	996,060
Total capital assets, net	$ 1,166,036	$ 414,597	$ 420,347	$ 1,160,286

Construction contracts of approximately $691,000,000 was approved for various projects, including the Women's Hospital Expansion, Demolition of the "Old Main" hospital and site work as well as replacement of the Diagnostic Imaging equipment at the Mountain Views campus. At June 30, 2022, the remaining commitment on these contracts is approximated $145,000,000.

There was no capitalized interest for the years ended June 30, 2022 and 2021, respectively.

NOTE 7 – EMPLOYEE BENEFIT PLANS

The Hospital sponsors a cash-balance pension plan (the "Cash Balance Plan"), which has been in effect since January 1, 1995. The Plan covers employees who are 21 years of age and have completed one year of credited service. Participants are entitled to a lump-sum distribution or monthly benefits at age 65 based on a predetermined formula that considers years of service and compensation. Effective July 1, 1999, employer benefits are calculated as 5% of a participant's annual plan compensation, and the annual interest is an indexed rate based on the return on 10-year U.S. Treasury securities. Participants are fully vested in their account balances after five pension years.

Participant accounts – The Cash Balance Plan maintains "participant account balances" equal to a participant's account balance established as of January 1, 1995, upon the conversion to the cash-balance formula, plus subsequent contribution credits and interest credits related to the participant's accumulated cash balance, participant match contribution credits, and participant match interest credits.

Contribution credits of 5% of eligible compensation for the year are credited to a participant's account as of the last day of the Cash Balance Plan year. Each year, interest credits related to a participant's cash balance are credited to the participant's account in an amount that is equal to a percentage of a participant's account balance at the beginning of the Cash Balance Plan year. The percentage rate used is the annual rate of return on 10-year treasury securities in effect for the third month (October) immediately preceding the first day of the applicable Cash Balance Plan year. The rates credited were 1.71% and 3.15% for the years beginning January 1, 2021 and 2020, respectively.

Employee contributions – Contributions by participants are not required or permitted by the Cash Balance Cash Balance Plan.

Employer contributions – The Hospital's funding policy is to contribute amounts to the Cash Balance Plan necessary to meet minimum funding requirements. The Hospital's contributions for 2019 and 2018 exceeded the minimum funding requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

Although it has not expressed any intention to do so, the Hospital has the right under the Cash Balance Plan to discontinue its contributions at any time and to terminate the Cash Balance Plan subject to the provisions set forth in ERISA.

Eligibility – Hospital employees are eligible to participate on the first day of the month succeeding the later of the date on which they complete one year of service, which is defined as working 12 months for a minimum of 1,000 hours, and they reach age 21.

Funding policy – The amount of employer contributions is determined based on actuarial valuations and recommendations as to the amounts required to fund benefits. Contributions are made by the Hospital based on the results of the actuarial recommendations. The Hospital intends to make contributions in amounts not less than the minimum required by the funding standards of ERISA and is required to keep the Cash Balance Plan qualified under Section 401(a) of the Internal Revenue Code ("IRC"). Participants are not permitted to contribute to the Cash Balance Plan.

Vesting – Participants are fully vested with their third year of service.

Pension benefits – Monthly benefit payments, based upon a formula described in the Cash Balance Plan document, commence within 30 days of the normal retirement date, early retirement date, or deferred retirement date. A participant may elect to defer retirement past the normal retirement age, which will result in benefits greater than 100%, based on a published scale. The eligibility requirement for early retirement is age 55. Early retirement benefits are calculated by multiplying the accrued benefit as of the early retirement date by a percentage defined in the Cash Balance Plan document.

Benefit terms provide for annual cost-of-living adjustments to each member's retirement allowance subsequent to the member's retirement date. The annual adjustments are 2.00% compounded annually.

On termination of service, a participant may elect to receive either a lump-sum amount equal to the value of the participant's account balance or annuity payments based upon formulas described in the Cash Balance Plan document.

Death benefits – The Cash Balance Plan provides death benefits in the form of a qualified pre-retirement survivor annuity for life equal to the annuity that would have been payable to the spouse if the participant had retired on the day preceding the participant's death. At the option of the beneficiary, the benefit may be paid in a lump-sum.

Basis of accounting – The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP") as applied to governmental units, using the accrual method of accounting. The GASB is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein; disclosure of contingent assets and liabilities; and the actuarial present value of accumulated Cash Balance Plan benefits, at the date of the financial statements. Actual results could differ from those estimates.

Investment valuation – The Cash Balance Plan's investments are stated at fair value, as certified by the Cash Balance Plan's custodian, based generally on quoted market prices.

Fair value is the price that would be received to sell an asset or paid to transfer a liability (the "exit price") in an orderly transaction between market participants at the measurement date. See Note 6 for discussion of fair value measurements.

Income recognition – Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. The net appreciation or depreciation in fair value of investments consists of both the realized gains or losses and unrealized appreciation (depreciation) of those investments.

Benefits paid to participants – Benefit payments to participants are recorded upon distribution.

Administrative expenses – Administrative fees, such as custodian, actuarial, and certain other administrative expenses, may be paid by the Cash Balance Plan or the Hospital.

The Hospital's net pension asset was measured as of June 30, 2022 and 2021, as determined by an actuarial valuation as of December 31, 2021 and 2020, rolled forward to June 30, 2022 and 2021, respectively.

Certain retired and terminated employees and certain participants covered by a collective bargaining agreement continue to participate under provisions of a defined-benefit retirement plan in effect prior to January 1, 1995. Participant data for the Plan, as of the measurement date January 1 for the indicated years is as follows:

	2022	2021
Active	2,946	3,001
Retirees and beneficiaries	619	600
Vested terminated	1,059	982
Total participants	4,624	4,583

Components of pension cost and deferred outflows and inflows of resources as calculated under the requirements of GASB No. 68 are as follows (in thousands):

	2022	2021
Deferred outflows of resources as of June 30:		
Difference between expected and actual experience	$ 588	$ 915
Total	$ 588	$ 915
Deferred inflows of resources as of June 30:		
Difference between expected and actual experience	$ (7,759)	$ (2,930)
Changes in assumptions	(4,295)	(3,732)
Difference between projected and actual investment earnings	(34,021)	(34,479)
Total	$ (46,075)	$ (41,141)
Contributions between the measurement date and fiscal year end recognized as a deferred outflows of resources	$ 3,000	$ 7,000

Amounts reported as deferred outflows and inflows of resources to pensions will be recognized in pension expense are as follows (in thousands):

2023	$ (12,592)
2024	(16,036)
2025	(9,693)
2026	(4,345)
2027	(1,474)
Thereafter	(1,348)
	$ (45,488)

The following table summarizes changes in pension liability for fiscal years ended June 30, 2022 and 2021, with a measurement date of December 31, 2021 and 2020, respectively, (in thousands):

	2022	2021
Service cost	$ 10,784	$ 10,166
Interest	13,737	13,206
Differences between expected and actual experience	(6,571)	(1,152)
Changes of assumptions	(2,263)	(550)
Benefit payments	(14,774)	(12,167)
Net change in total pension liability	913	9,503
Total pension liability beginning of fiscal year	225,443	215,940
Total pension liability end of fiscal year	$ 226,356	$ 225,443

	2022 with Measurement Date of December 31, 2022	2021 with Measurement Date of December 31, 2021
Total pension liability	$ 226,356	$ 225,443
Plan fiduciary net position	363,505	336,605
Net pension asset	$ (137,149)	$ (111,162)
Plan's fiduciary net position as a percentage of total pension liability	160.59%	149.31%
Covered payroll	$ 389,552	$ 359,322
Net pension asset as a percentage of covered payroll	-35.21%	-30.94%
Contributions between the measurement date and year ended June 30, as deferred outflow of resources	$ 3,000	$ 7,000

The following table summarizes the actuarial assumptions used to determine net pension asset and plan fiduciary net position as of June 30, 2022 and 2021:

Valuation Date	January 1, 2022 Actuarially determined contribution rates are calculated as of January 1.
Actuarial Cost Method	Entry Age Normal Method as a level percent of pay in accordance with GASB.
Asset Valuation Method	Market Value
Actuarial Assumptions	
Projected Salary Increases	4.00%
Mortality	Based on the Pri-2012 Total Employee and Retiree Mortality Tables (base year 2012) and projected with Mortality Improvement Scale MP-2021, except for current and future beneficiaries of deceased participants. For current and future beneficiaries of deceased participants, mortality is based on the Pri-2012 Contingent Survivor Mortality Tables and projected with Mortality Improvement Scale MP-2021.
Discount Rate	6.00%

Sensitivity of net pension asset (in thousands):

	1% Decrease 5%	Current Discount Rate 6%	1% Increase 7%
Net pension asset as of June 30, 2022	$ 115,891	$ 137,149	$ 155,615
Net pension asset as of June 30, 2021	$ 88,863	$ 111,162	$ 130,388

The following table summarizes target asset class for the plan fiduciary net position as of June 30, 2022 and 2021:

Asset Class	Neutral	Asset Rebalancing Range	Expected Long-Term Real Rate of Return
Domestic Equities	32%	27% - 37%	8.69%
International Equities	18%	15% - 21%	7.66%
Alternatives	20%	17% - 23%	5.38%
Broad Fixed Income	25%	20% - 30%	2.86%
Cash	5%	0% - 8%	1.04%
Total	100%		6.00%

Eligible employees of the Hospital may also elect to participate in a separate deferred compensation plan (the 403(b) plan) pursuant to Section 403(b) of the Code. The Hospital acts as the administrator and sponsor, and the 403(b) plan's assets are held by trustees designated by the Hospital's management. Employees are eligible to participate upon employment, and participants are immediately vested in their elective contributions plus actual earnings thereon. The Hospital will match employee contributions to the 403(b) plan, subject to a maximum of 4% of each participant's annual plan compensation. Participants are eligible for employer match in the second plan year in which they work at least 1,000 hours, and they must be on the payroll at the end of the plan year (December 31). Employer matching contributions under the 403(b) plan are made to the cash-balance pension plan and earn interest as defined by that plan. Employer matching contributions to the 403(b) plan of $14,698,000 and $13,373,000 in 2022 and 2021, respectively, are included in benefits expense. Participants are immediately vested in the employer contributions included in the cash-balance pension plan.

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Amounts determined regarding the funded status of the plan and the annual required contributions of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, presented as required supplementary information following the notes to the consolidated financial statements, presents multiyear trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

Projections of benefits for financial reporting purposes are based on the substantive plan (the plan as understood by the employer and the plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

NOTE 8 – POST-RETIREMENT MEDICAL BENEFITS

The Hospital provides healthcare benefits and life insurance for retired employees who meet eligibility requirements as outlined in the plan document, as approved by the board of directors of the Hospital. All employees who attain age 55 with a minimum of 20 years of enrollment in the Hospital's healthcare program and are enrolled in one of the plans upon retirement, and who were hired prior to July 1, 1994, are eligible. Under the plan, employees are credited with employment history accumulated under a prior Hospital plan.

Benefits are funded by the Hospital on a pay-as-you go basis. If a participant terminates from the Hospital after 20 years of enrollment but before reaching age 62, he or she can choose to contribute to the plan between ages 55 and 61 to retain the plan's benefits. At age 62, eligible retirees are given an annual credit based on years of service to pay for health benefits.

Employees covered – At June 30, the following employees were covered by the Hospital:

	2022	2021
Active	208	250
Inactive plan members or beneficiaries currently receiving benefits	341	327
Total participants	549	577

Components of post-retirement medical benefits expense and deferred inflows and outflows of resources as calculated under the requirements of GASB No. 75 are as follows (in thousands) as of June 30:

	2022	2021
Service cost	$ 226	$ 255
Interest	809	852
Differences between expected and actual experience	(1,029)	(284)
Changes of assumptions	393	107
Current period recognition of prior years' deferred inflows and outflows	(108)	253
Total post-retirement medical benefits expense	$ 291	$ 1,183

	2022	2021
Deferred outflows of resources as of June 30:		
Changes in benefit terms	$ -	$ -
Difference between expected and actual experience	-	-
Changes in assumptions	204	90
Total	$ 204	$ 90
Deferred inflows of resources as of June 30:		
Changes in benefit terms	$ -	$ -
Difference between expected and actual experience	(535)	(198)
Changes in assumptions	-	-
Total	$ (535)	$ (198)

Amounts reported as deferred outflows and inflows of resources to post-retirement medical benefits will be recognized in post-retirement medical benefits expense are as follows (in thousands):

2023	$ (331)
2024	-
2025	-
2026	-
2027	-
Thereafter	-
	$ (331)

The following table summarizes changes in post-retirement medical benefits liability for fiscal year ended June 30, 2022 and 2021, with a measurement date of July 1, 2021 and 2020, respectively (in thousands):

	2022	2021
Service cost	$ 226	$ 255
Interest	809	852
Differences between expected and actual experience	(1,565)	(479)
Changes in assumptions or other input	599	180
Benefit payments	(943)	(881)
Net changes	(874)	(73)
Net post-retirement medical benefits liability at beginning of year	30,657	30,730
Net post-retirement medical benefits liability at end of year	$ 29,783	$ 30,657

The following table summarizes the actuarial assumptions used to determine net post-retirement medical benefits as of June 30, 2022 and 2021:

Valuation Date	June 30, 2021; measurement date of June 30, 2021
Actuarial Cost Method	Entry Age Normal, level percent of pay
Asset Valuation Method	Not applicable
Actuarial Assumptions	
Projected Salary Increases	4.00%
Mortality	Mortality rates are according to the Pri-2012 Total Employee and Retiree Mortality Tables projected generationally using projection scale MP-2020. For current beneficiaries of deceased participants, mortality is based on the Pri-2012 Contingent Survivor Mortality Tables projected generationally using projection scale MP-2020. This assumption has been updated since the prior valuation based on information released by the Society of Actuaries in October 2020.
Discount Rate	2.18%
Healthcare cost trend rates:	7% for 2021-2022, graded to 4.5% for years 2027 and beyond for ages pre-65; and 5.5% for 2021-2022, graded to 4.50% for year 2027 and beyond for ages post-65.

Sensitivity of post-retirement medical benefits liability (in thousands) due to change in discount rates as of June 30:

	2022		
	1% Decrease 1.18%	Current Discount Rate 2.18%	1% Increase 3.18%
Net post-retirement medical benefits liability	$ 33,378	$ 29,783	$ 26,746

	2021		
	1% Decrease 1.66%	Current Discount Rate 2.66%	1% Increase 2.66%
Net post-retirement medical benefits liability	$ 34,399	$ 30,657	$ 27,508

Sensitivity of post-retirement medical benefits liability (in thousands) due to change in healthcare cost trend:

	1% Decrease	Current Trend rate	1% Increase
June 30, 2022	$ 29,378	$ 29,783	$ 30,259
June 30, 2021	$ 30,141	$ 30,657	$ 31,328

NOTE 9 – INSURANCE PLANS

The Hospital purchases professional, general, automobile, and directors and officers liability insurance from BETA Healthcare Group ("BHG"), and also purchases all-risk property insurance (including limited flood), fiduciary, crime, cyber, and excess workers' compensation coverage needs from Alliant Insurance Services ("Alliant"). The Hospital's coverage is under a claims-made policy with limits of $30 million per occurrence, $40 million in the annual aggregate, and with a self-insured retention level of $50,000 per claim.

There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted from services provided to patients. The Hospital has actuarial estimates performed annually on its self-insurance plans of professional liability and workers' compensation benefits. Estimated liabilities (which have not been discounted) have been actuarially determined at an expected 75% confidence level and include an estimate of incurred, but not reported, claims. The balances are included in salaries and wages payable, workers' compensation, and other long-term liabilities in the accompanying consolidated statements of net position.

NOTE 10 – BONDS PAYABLE

Bonds payable consists of the following obligations (in thousands):

	June 30, 2022	June 30, 2021
El Camino Hospital District		
2006 General Obligation Bonds		
Principal	$ 32,335	$ 32,335
Unamortized premium	14	178
2017 General Obligation Bonds		
Principal	78,905	83,955
Unamortized premium	168	183
El Camino Hospital Revenue Bonds		
Series 2009		
Principal	50,000	50,000
Series 2015A		
Principal	131,380	135,670
Unamortized premium	6,849	8,070
Series 2017A		
Principal	277,735	282,875
Unamortized premium	9,453	11,123
Total long-term debt	586,839	604,389
Less current maturities	15,665	14,480
Maturities due after one year	$ 571,174	$ 589,909

	2022			
	Balance at June 30, 2021	Increases	Decreases	Balance at June 30, 2022
General obligation bonds	$ 116,651	$ -	$ 5,228	$ 111,423
Revenue bonds	487,738	-	12,322	475,416
	$ 604,389	$ -	$ 17,550	$ 586,839

	2021			
	Balance at June 30, 2020	Increases	Decreases	Balance at June 30, 2021
General obligation bonds	$ 121,392	$ -	$ 4,741	$ 116,651
Revenue bonds	499,981	-	12,243	487,738
	$ 621,373	$ -	$ 16,984	$ 604,389

2006 General Obligation Bonds – Upon voter approval, in November 2003, the District issued in 2006, $148,000,000 principal amount of 2006 General Obligation Bonds, which consists of $115,665,000 of Current Interest Bonds. Interest on the Current Interest Bonds is payable semiannually at rates ranging from 4% to 5% and principal maturities ranging from $2,065,000 in 2016 to $18,050,000 in 2036 are due annually on August 1. Interest at rates ranging from 4.38% to 4.48% and principal of the Capital Appreciation Bonds are payable only at maturity. In March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the 2017 General Obligation Refunding Bonds.

The Current Interest Bonds maturing on or after August 1, 2017, may be redeemed prior to their respective stated maturity dates, at the option of the District, from any source of available funds, as a whole or in part on any date on or after February 1, 2017, at a redemption price equal to the principal amount of the Current Interest Bonds called for redemption, together with interest accrued thereon to the date of redemption, without premium.

2017 General Obligation Bonds – Upon voter approval, in March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the $99,035,000 2017 General Obligation Refunding Bonds, which consists of $115,665,000 of Current Interest Bonds, and $32,335,000 of Capital Appreciation Bonds. Interest on the 2017 General Obligation Refunding Bonds is payable semiannually at rates ranging from 2% to 5% and principal maturities ranging from $3,570,000 in 2017 to $17,480,000 in 2036 are due annually on August 1. This refinancing resulted in a reduction of future interest payments with a present value of approximately $7,000,000.

Both the 2006 and 2017 G.O. Bonds are general obligations of the District payable from ad valorem taxes. Payment of principal, interest and maturity value of the Bonds, when due, is insured by a municipal bond insurance policy.

Revenue Bonds, Series 2009 – In April 2009, the Hospital issued $50,000,000 of Santa Clara County Financing Authority Insured Revenue Bonds, Series 2009A, to fund completion of the Hospital replacement construction project. Interest on the bonds is payable on the business day immediately following the applicable remarketing period. Principal maturities on the bonds range from $100,000 in 2025 to $10,920,000 in 2044, and are due annually on February 1.

The 2009 Series Revenue bond agreement contains various restrictive covenants which include, among other things, minimum debt service coverage, maintenance of minimum liquidity, and requirement to maintain certain financial ratios.

The bonds are secured by a pledge of gross revenues to an Indenture of Trust ("Indenture") dated March 16, 2007. The Indenture contains certain covenants that, among other things, require the District to deposit all gross revenues of the Hospital as soon as practicable upon receipt. The Indenture also requires the Hospital to maintain a long-term debt service coverage ratio of 1.15 to 1.00. Failure to comply with the restrictive covenants of the Indenture could result in all of the unpaid principal and accrued interest of the bonds becoming due immediately, at the option of the trustee.

Revenue Bonds, Series 2015A – In May 2015, the Hospital advance refunded its Series 2007 Santa Clara County Financing Authority Insured Revenue Bonds ("Series 2007") through the issuance of the $160,455,000 of Santa Clara County Financing Authority Insured Revenue Bonds ("Series 2015A"). The issuance of the Series 2015A is to (i) finance and refinance certain capital expenditures owned by the Hospital (the Project – $40,300,000), (ii) advance refund ($120,100,000) the Santa Clara County Financing Authority Insured Revenue Bonds of the Hospital Series 2007A, 2007B, and 2007C, and (iii) pay costs incurred in the connection of the issuance of the Bonds.

Revenue Bonds, Series 2017A – In February 2017, the Hospital issued $292,435,000 of California Health Facilities Financing Authority Revenue Bonds ("Series 2017") to finance certain capital expenditures at facilities owned or operated by the Hospital, to finance a portion of the interest payable of the Series 2017 through January 31, 2019, and to pay costs incurred in connection with the issuance of the Series 2017. The Series 2017 consists of $130,660,000 Serial Bonds and $161,775,000 Term Bonds. Principal maturities for the Serial Bonds range from $4,665,000 in 2020 to $10,565,000 in 2037, and are due annually on February 1. Principal maturities for the Term Bonds range from $60,710,000 in 2042 to $101,065,000 in 2047, and are due annually on February 1.

Letter of credit – In March 2009, in connection with the issuance of the 2009 Series Revenue bonds, the Hospital obtained an irrevocable Letter of Credit issued by a bank for $50,000,000. This Letter of Credit expires October of 2022 and requires the Hospital to maintain a long-term debt service coverage ratio of 1.20 to 1.00.

Management believes all financial debt covenants were met for the years ended June 30, 2022 and 2021.

Debt service requirements for bonds payable are as follows (in thousands):

Year Ending June 30,	General Obligation Bonds		Revenue Bonds	
	Principal	Interest	Principal	Interest
2023	$ 5,760	$ 3,154	$ 9,905	$ 19,431
2024	3,293	6,343	10,400	18,935
2025	3,398	6,788	10,920	18,415
2026	3,411	7,144	11,460	17,874
2027	3,552	7,709	12,035	17,306
2028-2032	18,681	46,548	69,710	77,156
2033-2037	73,145	9,266	87,995	59,546
2038-2042	-	-	110,815	38,053
2043-2047	-	-	135,875	17,757
2048-2052	-	-	-	-
	$ 111,240	$ 86,952	$ 459,115	$ 284,473

Interest rate swap – On March 7, 2007, the Hospital entered into three interest rate swap agreements in connection with the issuance of the Series 2007 Revenue Bonds. The intention of the swap is to create debt with a synthetic, fixed interest rate on the variable-rate Revenue Bonds. The swaps were effective March 23, 2007, with a termination date of February 1, 2041, and notional amounts of $50 million each; these terms match the terms of the underlying Series 2007 Revenue Bonds. Under each swap transaction, the Hospital pays a fixed rate of interest of 3.204% and the counterparty pays a variable rate of interest equal to the sum of (i) 56% of USD-LIBOR-BBA plus (ii) 0.23%. In March 2008, the Hospital Board directed management to terminate the floating to fixed interest rate swap when economically prudent in connection with the refunding of their Series 2007 Revenue Bonds. In December 2009, two of the three swaps were terminated. The fair value of the remaining swap is a liability of $3,872,000 at June 30, 2022, and $7,923,000 at June 30, 2021, included in other long-term obligations in the consolidated statements of net position.

Risks associated with the swap agreements – From the Hospital's perspective, the following risks are generally associated with swap agreements:

Credit risk – The counterparty becomes insolvent or is otherwise not able to perform its financial obligations. In the event the counterparty becomes insolvent or their credit rating falls below BBB-/Baa2, the Hospital has the right to terminate the swap. Upon exercise of early termination, the amounts due from or to the counterparty will be determined by the market pricing of the swaps at the time of termination.

Termination risk – The Hospital or counterparty may terminate the swap if the other party fails to perform under the terms of the contract. If, at the time of the termination, the swap has a negative fair value, the Hospital would be liable to the counterparty for that payment.

NOTE 11 – RESTRICTED NET POSITION

Restricted net position consists of donor-restricted contributions and grants and cash restricted for regulatory requirements, which are to be used as follows (in thousands):

	2022	2021
Charity and other	$ 27,438	$ 22,960
Endowments	8,511	7,472
Restricted by donor for specific uses	35,949	30,432
Restricted by Department of Managed Health Care	650	650
Total restricted net position	$ 36,599	$ 31,082

Permanently restricted contributions (“endowments”) remain intact, with the earnings on such funds providing an ongoing source of revenue to be used primarily for education.

NOTE 12 – CHARITABLE REMAINDER UNITRUSTS

The Foundation is the beneficiary of several irrevocable charitable remainder unitrusts in which the gift assets are held by trustees and administered for the benefit of the Foundation and other beneficiaries. The assets are held under trust agreements with an outside trustee. The donors maintain the right to income earned on the assets during their lifetime and, in some cases, during the lifetime of their survivors.

Pursuant to GASB No. 81, the Foundation recognizes an asset and a deferred inflow of resources when it becomes aware of the agreements and has sufficient information to measure the beneficial interest, in accordance with the asset recognition criteria in GASB No. 81. The beneficial interest asset is measured at fair value, which is estimated as the present value of the expected future cash flows from trusts. The applicable federal discount rate for June 2022 and June 2021 of 2.5% and 0.25% per annum, respectively, and The Standard Ordinary Mortality Rate Table were used to arrive at the present value. Change in the fair value of the beneficial interest asset is recognized as an increase or decrease in the related deferred inflow of resources. As the remainder interest beneficiary, the Foundation recognizes revenue for the beneficial interest at the termination of the agreement, as stipulated in the agreements.

NOTE 13 – LEASES

The District is a lessee for noncancellable lease of office space and equipment with lease terms through 2039. There are no residual value guarantees included in the measurement of District’s lease liability nor recognized as an expense for the years ended June 30, 2022 and 2021. The District does not have any commitments that were incurred at the commencement of the leases. The District is subject to variable equipment usage payments that are expensed when incurred. There were no amounts recognized as variable lease payments as lease expense on the statement of changes of net position for the years ended June 30, 2022 and 2021. No termination penalties were incurred during the fiscal year.

The District has the following right to use activities as of June 30:

2022	July 1	Increases	Decreases	June 30
Right of use assets	$ 37,400	$ 4,543	$ -	$ 41,943
Less accumulated amortization	6,907	5,795	-	12,702
Right to use assets, net	$ 30,493	$ (1,252)	$ -	$ 29,241

2021	July 1	Increases	Decreases	June 30
Right of use assets	$ 34,151	$ 3,249	$ -	$ 37,400
Less accumulated amortization	-	6,907	-	6,907
Right to use assets, net	$ 34,151	$ (3,658)	$ -	$ 30,493

For the years ended June 30, 2022 and 2021, the District recognized $5,705,000 and $6,907,000, respectively, in amortization expense included in depreciation and amortization expense on the consolidated statements of activities and changes in net position.

The future principal and interest lease payments as of June 30, 2022, were as follows:

Year Ending June 30	Principal Payments	Interest Payments	Total
2023	$ 4,502	$ 1,205	$ 5,707
2024	4,709	866	5,575
2025	4,415	811	5,226
2026	3,364	647	4,011
2027	2,566	526	3,092
Thereafter	10,582	2,387	12,969
	$ 30,138	$ 6,442	$ 36,580

The District evaluated the right-to-use assets for impairment and determined there was no impairment for the years ended June 30, 2022 and 2021.

The District is also a lessor for noncancellable leases of office space with lease terms through 2032. For the years ended June 30, 2022 and 2021, the District recognized $9,665,000 (FY22) in lease revenue released from the deferred inflows of resources related to the office lease included in other revenue on the statement of changes in net position. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during fiscal years ended June 30, 2022 and 2021.

NOTE 14 – RESTATEMENTS

The adoption of GASB 87 resulted in adjustments to the prior period financial statements as follows at June 30, 2021:

	As previously presented	Adjustment	As restated
Statement of net position			
Assets and deferred outflows:			
Right of use assets, net of amortization	$ -	30,493	$ 30,493
Current portion of lease receivable	-	10,651	10,651
Lease receivable, net of current portion	-	40,340	40,340
Liabilities, deferred inflows and net position:			
Current portion of lease liabilities	-	5,063	5,063
Lease liabilities, net of current portion	-	26,335	26,335
Other long-term obligations	12,175	(1,094)	11,081
Deferred inflows of resources - leases	-	51,180	51,180
Net position, end of year	2,302,445	-	2,302,445
Statements of revenues, expenses and changes in net position:			
Depreciation and amortization expense	67,688	6,907	74,595
Rent and utilities	27,600	(6,907)	20,693
Income from operations	115,207	-	115,207
Total nonoperating revenues	239,518	-	239,518
Increase in net position	354,725	-	354,725
Statements of cash flows:			
Cash flows from operating activities			
Other cash receipts	42,221	(13,496)	28,725
Cash payments to suppliers	(413,412)	7,387	(406,025)
Net cash provided by operating activities	129,313	(6,109)	123,204
Cash flows from financing activities			
Payments on lease liability	-	(7,387)	(7,387)
Proceeds from lease receivable	-	13,496	13,496
Net cash used in capital and related financing activities	(72,653)	6,109	(66,544)

NOTE 15 – RELATED-PARTY TRANSACTIONS

The Hospital pays vendor-related expenses on behalf of the Foundation and is reimbursed for these costs incurred. The Hospital also pays employee-related expenses, which are reimbursed by the Foundation. The Foundation's employees also participate in the cash-balance pension plan, sponsored by the Hospital. Full footnote disclosures relating to the cash-balance pension plan is included in the consolidated financial statements. The Hospital performs certain administrative functions on behalf of the Foundation for which no amounts are charged to the Foundation. As of June 30, 2022 and 2021, the Foundation has a payable to the Hospital in the amount of $498,000 and $191,000, respectively. During the fiscal years 2022 and 2021, the Foundation paid the Hospital $2,830,000 and $3,062,000 for such expenses, respectively, which included amounts for operations, but also disbursements from Donor Restricted Funds in support of Hospital operations and capital acquisitions.

In June 2012, the Hospital Board approved the funding of the Foundation's salaries, wages, benefits, and rent for a maximum of $1,783,000 annually on an ongoing basis. All related-party transactions are eliminated upon consolidation.

As of June 30, 2022 and 2021, CONCERN has a payable to the Hospital in the amount of $2,604,000 and $2,543,000, respectively. During the fiscal years ended June 30, 2022 and 2021, CONCERN paid the Hospital $6.667,000 and $7,041,000 for these expenses, respectively. All related party transactions are eliminated upon consolidation.

As of June 30, 2022 and 2021, SVMD has a payable to the Hospital of $7,775,000 and $8,400,000, respectively. During fiscal years ended June 30, 2022 and 2021, SVMD paid the Hospital $27,500,000 and $22,688,000 for its expenses, respectively. All related-party transactions are eliminated upon consolidation.

NOTE 16 – COMMITMENTS AND CONTINGENCIES

Litigation – The District is a defendant in various legal proceedings arising out of the normal conduct of its business. In the opinion of management and its legal representatives, the District has valid and substantial defenses, and settlements or awards arising from legal proceedings, if any, will not exceed existing insurance coverage, nor will they have a material adverse effect on the financial position, results of operations, or liquidity of the District.

Regulatory environment – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. The District is subject to routine surveys and reviews by federal, state and local regulatory authorities. The District has also received inquiries from healthcare regulatory authorities regarding its compliance with laws and regulations. Although the District management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and ongoing surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and noncompliance with survey corrective action requests could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Hospital Seismic Safety Act – In the 2010 fiscal year, the Mountain View campus completed its three-year construction of the Hospital Replacement Project with the opening of its new five story, 450,000-square-foot, state-of-the-art hospital facility on November 15, 2009. This completion made the Mountain View hospital campus in compliance with the State of California's Senate Bill ("SB") 1953 in meeting all requirements of the Hospital Seismic Safety Act of 1994.

At the Los Gatos campus, where most of the buildings were constructed in the 1960s, the campus has been going through a seismic compliance review. During 2015, all required seismic upgrades were made to the Los Gatos site for seismic compliance up to 2030.

Collective bargaining agreement – Approximately 79.1% of the Hospital's employees are covered by collective bargaining agreements. These employees are members of three unions.

NOTE 17 – SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the consolidated statement of net position date but before the consolidated financial statements are available to be issued. The District recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the consolidated statement of net position date, including the estimates inherent in the process of preparing the consolidated financial statements. The District's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the consolidated statement of net position date but arose after the consolidated statement of net position date and before consolidated financial statements are issued.

Supplementary Information

El Camino Healthcare District
Consolidating Statement of Net Position
June 30, 2022
(In Thousands)

	El Camino Healthcare District	El Camino Hospital	El Camino Hospital Foundation	CONCERN	Silicon Valley Medical Development	Eliminations	El Camino Healthcare District and Affiliates
ASSETS AND DEFERRED OUTFLOWS							
Current assets							
Cash and cash equivalents	$ 11,955	$ 183,588	$ 4,786	$ 2,355	$ 5,239	$ -	$ 207,923
Short-term investments	8,905	128,165	3,488	12,859	-	-	153,417
Current portion of board-designated funds	11,129	-	-	-	-	-	11,129
Patient accounts receivable, net of allowances for doubtful accounts of $96,938	-	204,494	-	-	4,780	-	209,274
Current portion of lease receivable	-	11,117	-	-	-	(714)	10,403
Prepaid expenses and other current assets	2,294	55,857	478	475	4,495	(13,824)	49,775
Total current assets	34,283	583,221	8,752	15,689	14,514	(14,538)	641,921
Non-current cash and investments							
Board-designated funds	10,623	1,122,664	47,598	-	-	-	1,180,885
Restricted funds	-	-	-	650	-	-	650
Funds held by trustee	35,272	-	-	-	-	-	35,272
	45,895	1,122,664	47,598	650	-	-	1,216,807
Capital assets							
Nondepreciable	10,654	196,964	-	-	-	-	207,618
Depreciable, net	-	978,012	2	1,496	14,202	-	993,712
Total capital assets	10,654	1,174,976	2	1,496	14,202	-	1,201,330
Right of use assets, net of amortization	-	10,926	-	-	25,173	(6,858)	29,241
Lease receivable, net of current portion	-	42,111	-	-	-	(7,235)	34,876
Pledges receivable, net of current portion	-	-	2,200	-	-	-	2,200
Prepaid pension asset	-	137,149	-	-	-	-	137,149
Investments in healthcare affiliates	-	30,376	-	-	-	-	30,376
Beneficial interest in charitable remainder unitrusts	-	-	4,522	-	-	-	4,522
Total assets	90,832	3,101,423	63,074	17,835	53,889	(28,631)	3,298,422
Deferred outflows of resources							
Loss on defeasance of bonds payable	-	11,160	-	-	-	-	11,160
Deferred outflows of resources	-	4,226	-	-	-	-	4,226
Deferred outflows - actuarial	-	792	-	-	-	-	792
Total deferred outflows of resources	-	16,178	-	-	-	-	16,178
Total assets and deferred outflows of resources	$ 90,832	$ 3,117,601	$ 63,074	$ 17,835	$ 53,889	$ (28,631)	$ 3,314,600

El Camino Healthcare District
Consolidating Statement of Net Position (continued)
June 30, 2022
(In Thousands)

	El Camino Healthcare District	El Camino Hospital	El Camino Hospital Foundation	CONCERN	Silicon Valley Medical Development	Eliminations	El Camino Healthcare District and Affiliates
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION							
Current liabilities							
Accounts payable and accrued expenses	$ 411	$ 52,472	$ 496	$ 2,765	$ 9,045	(13,824)	$ 51,365
Salaries, wages, and related liabilities	-	79,205	-	457	1,071	-	80,733
Other current liabilities	1,366	36,352	745	267	2,894	-	41,624
Estimated third-party payor settlements	-	14,942	-	-	-	-	14,942
Current portion of lease liabilities	-	1,090	-	-	4,126	(714)	4,502
Current portion of bonds payable	5,760	9,905	-	-	-	-	15,665
Total current liabilities	7,537	193,966	1,241	3,489	17,136	(14,538)	208,831
Bonds payable, net of current portion	105,662	465,512	-	-	-	-	571,174
Lease liabilities, net of current portion	-	10,361	-	-	22,510	(7,235)	25,636
Other long-term obligations	-	6,694	-	-	6	-	6,700
Workers' compensation, net of current portion	-	14,029	-	-	-	-	14,029
Post-retirement medical benefits	-	29,783	-	-	-	-	29,783
Total liabilities	113,199	720,345	1,241	3,489	39,652	(21,773)	856,153
Deferred inflows of resources							
Deferred inflows of resources	-	-	4,522	-	-	-	4,522
Deferred inflows of resources - leases	-	53,227	-	-	-	(6,858)	46,369
Deferred inflows of resources - actuarial	-	46,610	-	-	-	-	46,610
Total deferred inflows of resources	-	99,837	4,522	-	-	(6,858)	97,501
Net position							
Invested in capital assets, net of related debt	(65,496)	699,559	2	1,496	14,202	-	649,763
Restricted - expendable	-	-	27,438	-	-	-	27,438
Restricted - nonexpendable	-	-	8,511	650	-	-	9,161
Unrestricted	43,129	1,597,860	21,360	12,200	35	-	1,674,584
Total net position	(22,367)	2,297,419	57,311	14,346	14,237	-	2,360,946
Total liabilities, deferred inflows of resources, and net position	$ 90,832	$ 3,117,601	$ 63,074	$ 17,835	$ 53,889	$ (28,631)	$ 3,314,600

El Camino Healthcare District
Consolidating Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended June 30, 2022
(In Thousands)

	El Camino Healthcare District	El Camino Hospital	El Camino Hospital Foundation	CONCERN	Silicon Valley Medical Development	Eliminations	El Camino Healthcare District and Affiliates
Operating revenues							
Net patient service revenue (net of provision for bad debts of $7,429)	$ -	$ 1,274,126	$ -	$ -	$ 35,026	$ -	$ 1,309,152
Other revenue	104	23,792	-	9,756	10,795	(7,416)	37,031
Total operating revenues	104	1,297,918	-	9,756	45,821	(7,416)	1,346,183
Operating expenses							
Salaries, wages and benefits	2	631,451	1,752	2,254	19,160	-	654,619
Professional fees and purchased services	814	131,804	693	4,066	44,676	(3,863)	178,190
Supplies	-	179,890	56	6	3,713	-	183,665
Depreciation and amortization	9	71,811	1	141	7,909	-	79,871
Rent and utilities	-	17,126	134	106	3,501	(754)	20,113
Other	-	18,493	103	420	1,899	-	20,915
Total operating expenses	825	1,050,575	2,739	6,993	80,858	(4,617)	1,137,373
(Loss) income from operations	(721)	247,343	(2,739)	2,763	(35,037)	(2,799)	208,810
Nonoperating revenues (expenses):							
Investment losses, net	(1,316)	(165,782)	(3,300)	(1,671)	-	-	(172,069)
Property tax revenue							
Designated to support community benefit programs and operating expenses	10,221	-	-	-	-	-	10,221
Designated to support capital expenditures	11,528	-	-	-	-	-	11,528
Levied for debt service	12,304	-	-	-	-	-	12,304
Bond interest expense, net	(2,943)	(16,888)	-	-	-	-	(19,831)
Intergovernmental transfer expense	(2,613)	-	-	-	-	-	(2,613)
Restricted gifts, grants and bequests, and other, net of contributions to related parties	-	-	7,551	-	-	-	7,551
Unrealized gain on interest rate swap	-	3,049	-	-	-	-	3,049
Community benefit expense	(7,472)	(2,997)	-	(1,690)	-	1,016	(11,143)
Provider Relief Fund revenue	-	15,629	-	-	-	-	15,629
Other, net	-	(7,660)	(141)	(3)	(527)	3,396	(4,935)
Total nonoperating revenues (expenses)	19,709	(174,649)	4,110	(3,364)	(527)	4,412	(150,309)
Excess (deficit) of revenues over expenses before capital transfers	18,988	72,694	1,371	(601)	(35,564)	1,613	58,501
Capital transfers	(16,066)	(14,159)	-	(139)	30,364	-	-
Increase (decrease) in net position	2,922	58,535	1,371	(740)	(5,200)	1,613	58,501
Total net (deficit) position, beginning of year	(25,289)	2,238,884	55,940	15,086	19,437	(1,613)	2,302,445
Total net (deficit) position, end of year	$ (22,367)	$ 2,297,419	$ 57,311	$ 14,346	$ 14,237	$ -	$ 2,360,946

Supplemental pension information – The following tables summarize changes in net pension asset (in thousands):

	2022	2021
Service cost	$ 10,784	$ 10,166
Interest	13,737	13,206
Differences between expected and actual experience	(6,571)	(1,152)
Changes of assumptions	(2,263)	(550)
Benefit payments	(14,774)	(12,167)
Net change in total pension liability	913	9,503
Total pension liability beginning of fiscal year	225,443	215,940
Total pension liability end of fiscal year	$ 226,356	$ 225,443

	2022	2021
Contributions	$ 8,500	$ 10,300
Net investment income	33,174	43,917
Benefit payments, including refunds of member contributions	(14,774)	(12,167)
Net change in Plan fiduciary net position	26,900	42,050
Plan fiduciary net position beginning of fiscal year	336,605	294,555
Plan fiduciary net position end of fiscal year	363,505	336,605
Plan's net pension asset end of the fiscal year	$ (137,149)	$ (111,162)
Covered payroll	$ 389,552	$ 359,322
Net pension asset as a percentage of covered payroll	-35.21%	-30.94%
Contributions	$ 3,000	$ 7,000

The following table summarizes the contribution status of the Hospital's cash-balance pension plan (in thousands) over the last 10 years:

	FY2022	FY2021	FY2020	FY2019	FY2018
Actuarially determined contribution	$ -	$ -	$ 7,801	$ 10,888	$ 10,154
Contributions related to actuarially determined contribution	$ 4,500	$ 8,500	$ 10,300	$ 12,900	$ 11,600
Contribution deficiency (excess)	(4,500)	(8,500)	(2,499)	(2,012)	(1,446)
Covered payroll	389,552	359,322	$ 359,322	$ 315,317	$ 297,737
Contribution as % of covered payroll	1.16%	2.37%	2.87%	4.09%	3.90%
Contributions made during the fiscal year	$ 4,500	$ 14,000	$ 9,800	$ 12,800	$ 10,400

	FY2017	FY2016	FY2015	FY2014	FY2013
Actuarially determined contribution	$ 8,445	$ 2,735	$ -	$ 8,463	$ 7,613
Contributions related to actuarially determined contribution	$ 10,900	$ 10,500	$ 10,800	$ 14,400	$ 12,000
Contribution deficiency (excess)	(2,455)	(7,765)	(10,800)	(5,937)	(4,387)
Covered payroll	$ 283,435	$ 283,776	$ 266,844	$ 242,343	$ 223,754
Contribution as % of covered payroll	3.85%	3.70%	4.05%	5.94%	5.36%
Contributions made during the fiscal year	$ 10,900	$ 9,900	$ 14,400	$ 12,600	$ 23,610

Actuarially determined contributions are calculated as of January 1 and are based on the IRS minimum funding requirement. The contributions related to the actuarially determined contributions are amounts made for the plan year January 1 to December 31. Contributions made during the fiscal year are contribution amounts made during July 1 and June 30.

Supplemental post-retirement benefit information – As of June 30, 2021 and 2022, post-retirement medical benefits plan's fiduciary net position as a percentage of the total OPEB liability is 0%.

The 2022 and 2021 covered payroll for the active population eligible to participate in the post-retirement medical benefits plan is $29,920,100. The net post-retirement medical benefits liability as of July 1, 2021 and 2020, is $29,783,200 and $30,658,400, respectively. The net post-retirement medical benefits liability as a percentage of covered-employee payroll, as of the same time period, was 99.54% and 102.32%, respectively.

El Camino Healthcare District
Supplemental Schedule of Community Benefit (unaudited)
For the Years Ended June 30, 2022 and 2021

The District and the Hospital maintain records to identify and monitor the level of direct community benefit it provides. These records include the charges foregone for providing the patient care furnished under its charity care policy. For the years ended June 30, 2022 and 2021, the estimated costs of providing community benefit in excess of reimbursement from governmental programs were as follows (in thousands):

	2022	2021
Unpaid costs of Medi-Cal & Indigent programs	$ 54,255	$ 51,224
Other community-based programs		
Psychiatric	12,459	12,880
Clinical trial	273	290
Ambulatory care	12,732	11,659
Psychiatric outpatient	3,516	2,785
Total other community-based programs	28,980	27,614
Total community benefits	$ 83,235	$ 78,838

In furtherance of its purpose to benefit the community, the Hospital provides numerous other services to the community for which charges are not generated and revenues have not been accounted for in the accompanying consolidated financial statements. These services include providing access to healthcare through interpreters, referral and transport services, healthcare screening, community support groups and health educational programs, and certain home care and hospice programs. The estimated costs of Medicare programs in excess of reimbursement from Medicare were $112,217,000 and $123,810,000 for the years ended June 30, 2022 and 2021, respectively.

The Hospital also provides services to the community through the operations of the El Camino Hospital Auxiliary, Inc. (the “Auxiliary”). Services provided by volunteers of the Auxiliary, free of charge to the community, include assistance and counseling to patients and visitors, provision of scholarship awards to qualifying paramedical students, and daily personal contact with members of the community who are living alone.

Communications with Those
Charged with Governance

El Camino Healthcare District

June 30, 2022

Communications with Those Charged with Governance

The Board of Directors
El Camino Healthcare District

We have audited the consolidated financial statements of El Camino Healthcare District (the "District") its aggregate discretely presented component units, the El Camino Hospital Cash Balance Plan, and the El Camino Hospital Postretirement Health and Life Insurance Benefit Plan, as of and for the year ended June 30, 2022 and have issued our report thereon dated October ___, 2022. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated March 30, 2022, we are responsible for forming and expressing an opinion about whether the consolidated financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with U.S. generally accepted accounting principles and the California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Districts. We will also report on whether the consolidating statement of net position, consolidating statement of revenues, expenses, and changes in net position, and supplemental pension and postretirement benefit information, presented as supplementary information, are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole. Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with *Government Auditing Standards*, auditing standards generally accepted in the United States of America (U.S. GAAS), and the California Code of Regulations, Title 2 Section 1131.2, State Controller's Minimum Audit Requirements for California Special Districts. As part of an audit conducted in accordance with the standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over financial reporting. Accordingly, we considered the District's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the consolidated financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated March 30, 2022, and in our presentation to the Audit & Compliance Committee.

Significant Audit Findings and issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 2 to the consolidated financial statements. In 2022, the District adopted GASB Statement No. 87, *Leases*. See Note 14 for impact of adoption. The District also adopted GASB Statement No. 89, Accounting for Interest Cost Incurred Before the End of a Construction Period. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2022. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the consolidated financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the consolidated financial statements were:

- Management's estimate of net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. El Camino Hospital provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. We evaluated the key factors and assumptions used to develop the provision for uncollectible accounts. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We evaluated the key factors and assumptions used to develop the fair market value of investments. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of uninsured losses for professional liability is recognized based on management's estimate of historical claims experience. We evaluated the key factors and assumptions used to develop the actuarial estimates of uninsured losses for professional liabilities and workers' compensation. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the minimum pension liability is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimated liability for workers' compensation claims is recognized based on management's estimate of historical claims experience and known activity subsequent to year-end. We evaluated the key factors and assumptions used to develop the actuarial estimates of uninsured losses for professional liabilities and workers' compensation. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimated liability for post-retirement medical benefits is actuarially determined using assumptions on the long-term rate of return on plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimates of useful lives of capital assets are based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the discount rate used to value the gift annuities and beneficial interest in charitable remainder unitrusts have been estimated based on certain variables related to specific donor information. We evaluated key factors and assumptions used to develop the discount rate used to value the gift annuities and beneficial interest in charitable remainder unitrusts in determining that they are reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimates of the discount rate, useful lives, lease terms related to the District's operating lease right of use assets, lease liabilities, lease receivable, and deferred inflows of resources - leases. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the District's consolidated financial statements taken as a whole

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the Unites States of America, any change in these estimates is reflected in the consolidated financial statements in the year of change.

Financial Statement Disclosures

The disclosures in the consolidated financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the consolidated financial statements were disclosures relating to significant concentration of net patient accounts receivable, investments and fair value of investments, capital assets, employee benefit plans, post-retirement medical benefits, insurance plans, bonds payable, and leases.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the District's consolidated financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the District's consolidated financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the consolidated financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with auditing standards generally accepted in the United States of America (GAAS) and *Government Auditing Standards*. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management.

Corrected Misstatements: Below table summarizes material misstatements detected as a result of our audit procedures and corrected by management.

	DR	CR
Short-term investments		$ 13,039,000
Net position	$ 13,039,000	

Uncorrected Misstatements: There were no uncorrected misstatements identified.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October ___, 2022.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Board of Directors and management of the District, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October ___, 2022

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Senior Director Government Relations and Community Partnerships
Date: October 18, 2022
Subject: Annual Adoption of Community Benefit Grants Policy

Recommendation(s):

To approve the annual adoption of the Community Benefit Grants Policy

Summary:

1. Situation: California Assembly Bill 2019 ("AB 2019") was approved by Governor Brown on September 5, 2018. The Bill, among other things, amended California Health and Safety Code Section 32139 ("Section 32139"). The amendments expanded what Healthcare Districts were required to include in their community benefit policy by January 1, 2019. Pursuant to those requirements, this Board adopted a revised policy on December 5, 2018. AB 2019 also amended Section 32139 providing for additional requirements [See, Section 32139(c)(6)] that are effective January 1, 2020. The Community Benefit Policy was subsequently revised on December 11, 2019 to address these additional requirements. The amendments to the California Health and Safety Code Section 32139(c) also require an annual adoption of the Community Benefit Grants Policy. This annual adoption was last completed on October 19, 2021.

2. Authority: To comply with the amended law, ECHD must annually adopt the Community Benefit Grants Policy.

3. Background: As amended, Section 32139(c)(6)(A-H) provides that a Healthcare District's policy for providing assistance or grant funding, if the district provides assistance or grants pursuant to California Health and Safety Code Section 32126.5 or any other law, shall include guidelines for all of the following:

(A) Awarding grants to underserved individuals and communities, and to organizations that meet the needs of underserved individuals and communities.

(B) Considering the circumstances under which grants may be awarded to multiple or single recipients, and exceptions to these circumstances.

(C) Evaluating the financial need of grant applicants.

(D) Considering the types of programs eligible for grant funding, including direct patient care, preventive care, and wellness programs.

(E) Considering the circumstances under which grants may be provided to prior grant recipients, and exceptions to these circumstances.

(F) Considering sponsorships of charitable events.

(G) Funding other government agencies.

(H) Awarding grants to, and limiting funds for, foundations that are sponsored or controlled by,
or associated with, a separate grant recipient.

4. Assessment:

- The earlier approved policies were reviewed by outside counsel to confirm that they met the requirements under Section 32139 (c)(6) for what must be contained in policy.
- The proposed changes at this time include:
    - Correction of the name “Community Benefit Plan” to the formal name “Implementation Strategy Report and Community Benefit Plan.”
    - The specification of the allowance of two year grants (previous policy allowed for “three year grants.”)
    - The addition of the CHNA and priority health needs under 9. Grant Application Process.
    - Describing how any awarded two year grants will be disbursed.

5. Outcomes:

- This policy will be brought back to the Board for review and approval on an annual basis as required by law.

List of Attachments:

1. Draft Community Benefit Grants Policy (redline)

Suggested Board Discussion Questions: None

ID #: 1.00
Adopted: 03/05/2014
Last Approved: 10/19/2021
Area: District Board
Category: Policy

EL CAMINO HEALTHCARE DISTRICT
COMMUNITY BENEFIT GRANTS POLICY

I. Coverage: Community Benefit Program

II. Procedure:

The El Camino Healthcare District ("ECHD or "District") recognizes that the health of the community is improved by the efforts of many different organizations, and the District has a history of supporting those organizations through grants that address specific health needs. The grant making process includes soliciting applications, evaluating the proposed use of the funds, and including the advice of a Community Benefit Advisory Council ("CBAC"). The District annually approves a plan, which includes a provisional list of organizations and the amount of the expected grants to each.

To ensure that the ECHD can be responsive to the changing health needs in the District during a fiscal year, the Community Benefit staff will follow the guidelines below:

1. The total annual Community Benefit expenditures, as authorized by the ECHD Board of Directors' approval of the District's annual Implementation Strategy Report and Community Benefit Plan, cannot exceed the total aggregate amount approved by the ECHD Board.

2. Approved individual grant amounts, as stated in the Implementation Strategy Report and Community Benefit Plan, may be increased after need is demonstrated. Grant metrics must be revised to reflect the additional resources. Any grant increases must be within the total aggregate amount of the annual Implementation Strategy Report and Community Benefit Plan approved by the ECHD Board. Increases to these previously awarded grants up to $50,000 must be approved by the Senior Director of Government Relations and Community Partnerships and increases in excess of $50,000 up to $150,000 require the approval by the CEO. Increases to these previously awarded grants in excess of $150,000 must be presented to the CBAC, receive their recommendation for support, and be approved by the ECHD Board.

3. New grants may be added during the fiscal year if need is demonstrated. Proposals with detailed budgets and metrics must be presented to the CBAC and receive their recommendation for support. Any new grants must be within the total aggregate amount of the annual Implementation Strategy Report and Community Benefit Plan approved by the ECHD Board. New grants up to $50,000 must be approved by the CEO, and new grants in excess of $50,000 require the approval of the ECHD Board.

4. There are times when an individual grant award is not needed to the extent it was in the original plan. In these cases, the funds not needed may be used to fund the grant increases detailed in paragraphs 2 and 3 above.

5. The CBAC and the ECHD Board will receive a report identifying all grant funding changes at the end of the fiscal year.

6. ~~Three~~ Two year grant funding may be awarded to selected grantees. The total amount of funding within an individual fiscal year for ~~multi-year~~ two year grants may not exceed 30% of the total aggregate amount of annual Implementation Strategy Report and Community Benefit Plan approved by the ECHD Board. Grantees will be required to submit mid-term and annual reports and must demonstrate success meeting outcome metrics and budgetary goals.

7. ECHD-funded community benefit grants shall be allocated in support of ECHD's mission and purpose which is "to establish, maintain and operate, or provide assistance in the operation of, one or more health facilities or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District and to do any and all other acts and things necessary to carry out the provisions of ECHD's Bylaws and the Local Health District Law." Applications that do not establish a nexus to ECHD's mission, purpose and healthcare will not be awarded funding.

8. To ensure that El Camino Healthcare District allocated grant funding is spent consistently with the grant application and ECHD's mission and purpose, all ECHD grantees must adhere to the following:

    a. Grantees must submit a signed grant agreement and, if the actual requested amount differs from the awarded amount, grantees must submit a revised budget.

    b. Community Benefit staff shall ensure that Grantees submit mid-year and annual reports which include actual and line item expenses against the budgeted expenses in the approved application.

    c. Grantees may not adjust approved itemized spending without the approval of
    ECHD's Senior Director of Government Relations and Community Partnerships.

    d. All unused funds must be returned to the District.

9. Grant Application Process

    a. In December of the preceding fiscal year, the District will announce the open application period, post the application, and post a timeline and a grant guidebook on its website and via direct communication to current grantees. The timeline will include a specified due date in February.

    b. Applications must include an itemized budget and will be evaluated by staff and then reviewed for recommendation to the ECHD Board by CBAC.

    c. To evaluate the financial need of applicants, agencies are required to provide the most recent audited financials and a line item budget for requested funding which includes other sources of support.

d. Grant proposals should focus on the underserved consistent with the definition from the Department of Health and Human Services, which characterizes the underserved, vulnerable, and special needs populations as communities that include members of minority populations or individuals who have experienced health disparities.

e. Grants must align with the Community Health Needs Assessment and the priority health needs: Healthcare Access & Delivery, Behavioral Health, Diabetes & Obesity, Chronic Conditions, and Economic Stability.

f. Grants must provide direct healthcare service, preventive care or wellness/health information oriented programs.

g. Grants will be awarded to multiple recipients. Individual grant recipients may apply for and be awarded more than one grant.

h. Prior or existing recipients may apply for funding. Significant attention will be given to prior program performance.

i. Other government agencies may be eligible for funding and are evaluated under the same process as all other applicants.

j. Awarding of grants to foundations that are sponsored by, or associated with, a separate grant recipient shall be considered on a case by case basis

k. CBAC's recommendations will be brought forward to the ECHD Board for review at a Study Session in May and then to the ECHD Board for approval in June. CB staff will notify applicants following ECHD Board approval.

l. Individual meetings regarding grant applications between a grant applicant and a district board member, officer, or staff are prohibited outside of this established process. Notwithstanding the above, individual meetings regarding grant applications between a staff member and a grant applicant are permissible, but only for the purpose of clarifying information submitted on the application documents.

10. The District will distribute grant funds as follows:

a. Grants greater than or equal to $100,000 will be disbursed in two installments. The first installment will be disbursed upon receipt of the signed grant agreement. The second installment will be disbursed upon receipt of mid-year reporting.

b. Grants less than $100,000 will be disbursed in one lump sum upon receipt of the signed grant agreement.

c. Two year grants will be disbursed in four installments. The first installment will be disbursed upon receipt of the signed grant agreement. The second installment will be disbursed upon receipt of mid-year

reporting. The third installment will be disbursed when the next fiscal year's first installments are disbursed. The fourth installment will be disbursed upon receipt of mid-year reporting in the next fiscal year.

11. District funds may also provide sponsorships of charitable events. Requests must meet the following criteria:

a. Recipients must be a non-profit organization or government agency improving the health and well-being of individuals who live, work or go to school in the District.
b. The District will place emphasis on organizations that address the needs of the underserved or reduce or prevent adverse health related conditions or address health disparities.
c. Exclusions include but are not limited to:
   i. Political campaigns
   ii. Contributions for individual entry fees to charitable races, conferences, etc.
   iii. Requests that benefit an individual family or group
   iv. Religious activities
   v. Travel expenses
   vi. Athletic programs such as sports teams or leagues
   vii. Research

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Senior Director of Government Relations and Community Partnerships
Date: October 18, 2022
Subject: FY24 Community Benefit Board Policy Guidance and FY23 Update

Purpose: To endorse or to modify via a motion the proposed FY24 "Guiding Principles," "Ranked & Prioritized Health Needs."

Summary:

1. Situation: In FY22, management and staff presented the Board with "Guiding Principles" and "Ranked & Prioritized Health Needs" to provide policy direction. This policy direction will continue to be requested annually at the October Board meeting. It is to be implemented in FY23 for the FY24 grant cycle.

2. Background:

- The proposed "Guiding Principles" are those that were adopted to guide the FY23 grant cycle
- The proposed "Ranked & Prioritized Health Needs" are those that were adopted to guide the FY23 grant cycle
- For FY24, management and staff are proposing two-year grants that can be awarded for a select group of grantees
- Management and staff propose additional detail to guide when a grantee may be eligible for dual funding
- Progress updates on other major items are included in the attached presentation

3. Assessment: The "Guiding Principles" and "Ranked & Prioritized Health Needs" are helpful policy guidance for management and staff as they evaluate grant applications.

4. Outcomes: Management and staff will execute the FY24 grant cycle incorporating the "Guiding Principles" and the "Ranked & Prioritized Health Needs" with approximate grant funding percentages approved by the Board.

List of Attachments:

1. FY24 Community Benefit Board Policy Guidance and FY23 Update Presentation

Suggested Board Discussion Questions:

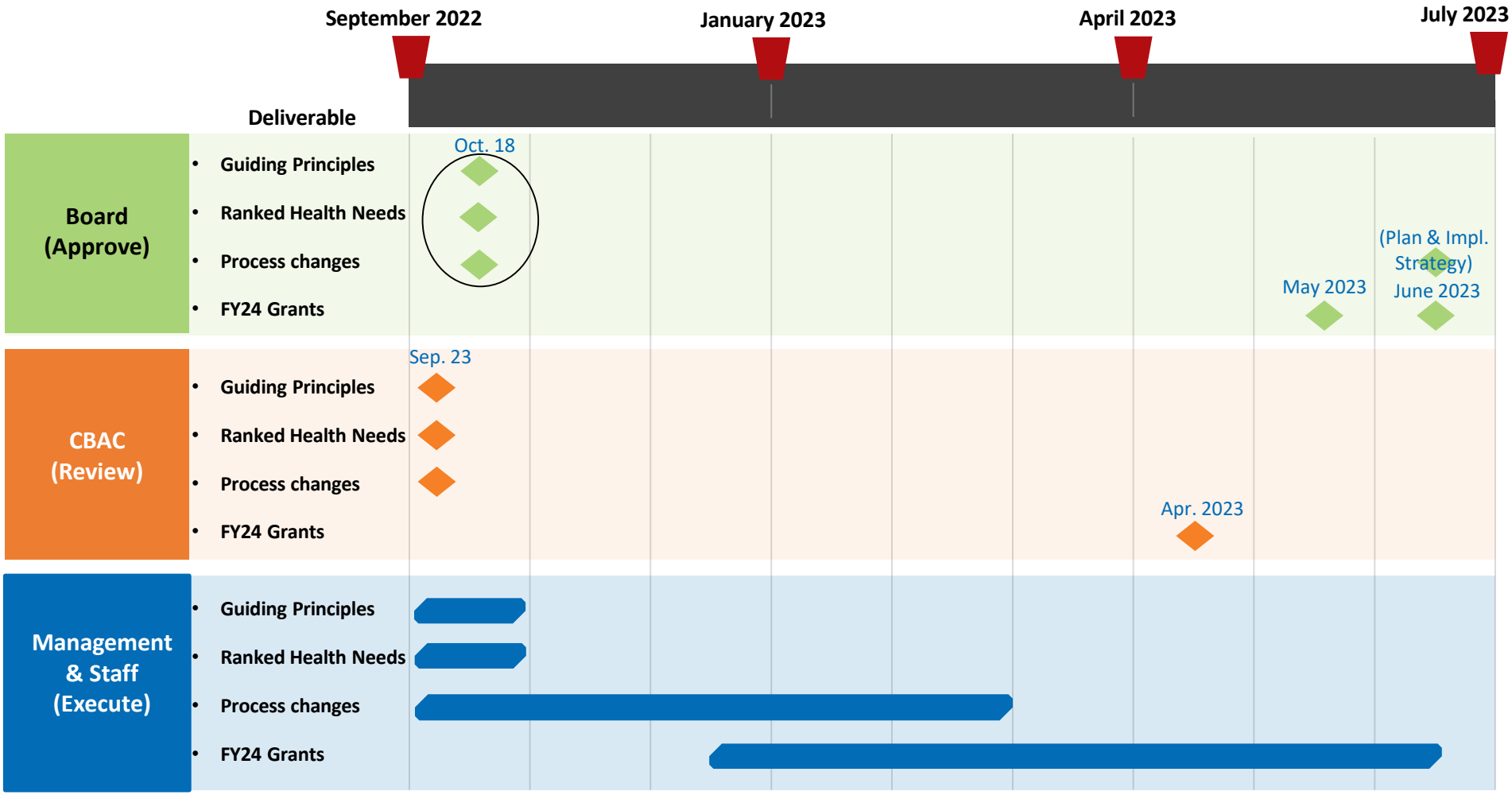
1. Does the Board have any modifications or changes to the "Guiding Principles?"
2. Does the Board have any modifications or changes to the El Camino Healthcare District "Ranked & Prioritized Health Needs," including the approximate grant funding percentages for each of the five health needs?
3. Is there any feedback that the Board wishes to provide about the planned FY24 changes?

Dedicated to improving the health and well being of the people in our community.

FY24 Community Benefit Board Policy Guidance and FY23 Update

Jon Cowan
Senior Director, Government Relations & Community Partnerships
October 18, 2022

Timeline for District Community Benefit



Agenda

- Guiding Principles
- Ranked & Prioritized Health Needs
- FY24 Planned Changes
- FY23 Update

Guiding Principles: Definition

"Guiding Principles" are a list of 6-10 policy statements that set the parameters and guardrails which guide Community Benefit's philosophy for health improvement. An example is "emphasize locally focused vs. national organizations."

Guiding Principles for Evaluating and Prioritizing Appropriateness of Grant Proposals

Required

1. Serve those who live, work or go to school in El Camino Healthcare District's targeted geography
2. Demonstrate a competence and capacity to address at least one of the identified health needs
3. Focus primarily, but not exclusively, on the results of increasing access to healthcare services, behavioral health services, as well as the management of rising risk chronic health conditions (diabetes, obesity, cardiovascular disease, cancer, and respiratory conditions)
4. Have an emphasis on populations that are underserved, experiencing health disparities, and/or facing health challenges

Preferred

5. Aim to reflect the diversity of El Camino Healthcare District's targeted geography
6. Focus on operational programmatic costs for service delivery, over capital campaigns. Do not fund drives or political initiatives
7. Emphasize locally focused vs. national organizations
8. Emphasize the most effective and impactful programs while welcoming new and innovative applicants

Discussion Draft: ECHD Ranked & Prioritized Health Needs

Health Need	FY22 Approved	FY23 Approved	FY24 Proposed
Healthcare Access & Delivery (including oral health)	56%	51%	~50%
Behavioral Health (including domestic violence and trauma)	23%	25%	~25%
Diabetes & Obesity	9%	14%	~15%
Chronic Conditions (other than Diabetes & Obesity)	5%	5%	~5%
Economic Stability (including food insecurity, housing & homelessness)	5%	5%	~5%

FY24 Two-Year Grants

Based on CBAC and District Board feedback, the Community Partnerships team has explored the feasibility of a two-year grant cycle for a select group of grantees.

- Proposing to start with school nurse programs, school mental health programs and Community Service Agencies (CSAs)
- 7 schools grants: $1.39 million
- 3 CSA grants: $500,000
- Total: 10 grants, $1.89 million, 25% of the portfolio

FY24 Dual Funding Criteria

Original

- Addresses a gap in specific health services within both the District and wider Hospital service area
- Capacity to serve community members in both geographies; District grants have specific geographic requirements for reaching individuals served
- At least one successful grant cycle in either ECH or ECHD

Proposed Edits

- Organizations with broad reach that address a community health gap not otherwise filled by other applicants
- Clear alignment with the CHNA priority health needs
- Capacity to successfully serve community members in both geographies; District grants have specific geographic requirements for reaching individuals served
- At least one successful grant cycle in either ECH or ECHD
- Strong brand alignment for both ECH and ECHD

FY24 Grant Application Changes

Feedback from grant partners:

- 46% found the application "lengthy" and 35% were "neutral" on the length of the application
- Mixed feedback on the metrics, with many commenting that they are a positive part of the process while others commenting that they are challenging (76% said the metrics were "valuable" or "very valuable")

FY24 application changes:

- Reduced required attachments (from 9 required to 4 required/2 optional)
- Added functionality to track alignment with the Implementation Strategy, health inequities identified in the CHNA targeted by grants, and languages of services
- Aiming to streamline metrics requirements to 4 metrics per grantee where possible
- Added word limits to more sections (to encourage succinct responses to prompts)
- Added lists and dropdowns where possible to replace free text
- Simplified instructions

Feedback from ECHD Board and CBAC

Item	Proposed Action in June 2022	Progress Update
FY23 grant decisions	Offer technical assistance to grant applicants who were not recommended for funding this year, so that they have the opportunity to write a stronger application in FY24	The Community Partnerships team offered technical assistance to the 11 organizations that were not funded in FY23. Four organizations requested assistance and met with the staff to discuss the application process and to explore ways their programs/services could better align with the CHNA and priority health needs
FY23 metrics reporting	In addition to the metric dashboard, include more narrative about the performance of the largest grants and trends within the grant portfolio in future memos to the District Board	Additional narrative about the performance of the largest grants and trends within the grant portfolio is now included in the ECHD FY22 Yearend Community Benefit Report memo and will continue to be included in future memos
FY24 multi-year grants	Evaluate the feasibility of a multi-year grant cycle, develop criteria, bring back a proposal for board approval	The Community Partnerships team has explored the feasibility of multi-year grants and have a proposed plan to start with the ECHD-funded schools and Community Service Agencies (CSAs), beginning with the FY24 application

Feedback from ECHD Board and CBAC *(continued)*

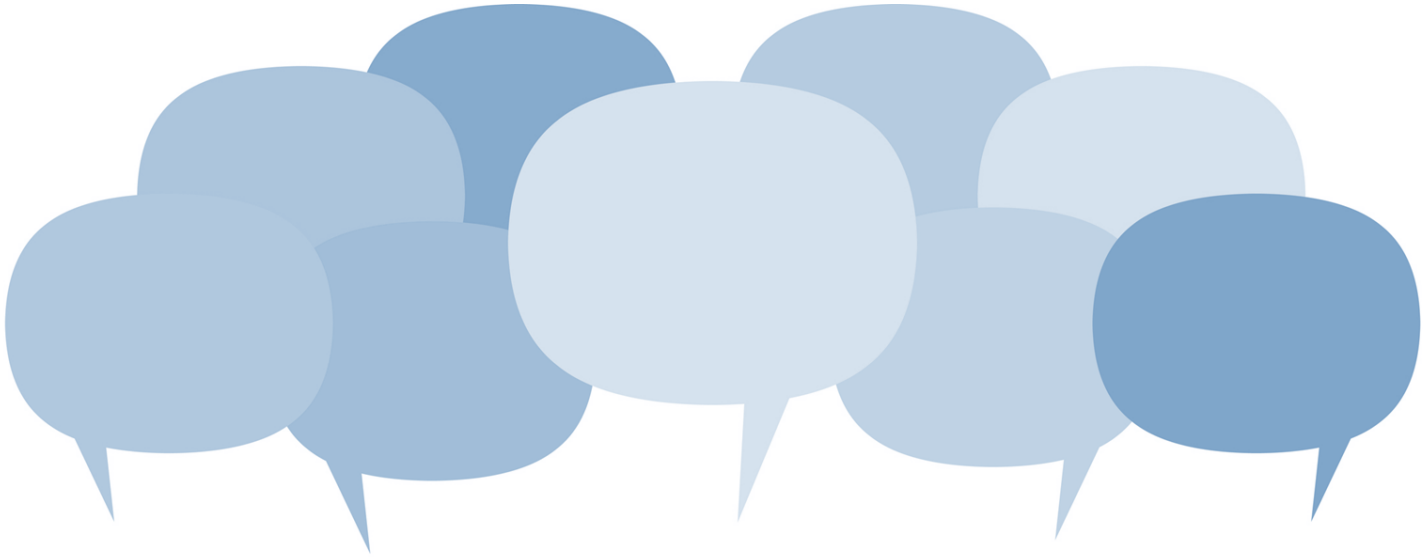
Item	Proposed Action in June 2022	Progress Update
FY24 dual funding	Look for opportunities to reduce dual funding	Updated criteria is included in this presentation
FY24 partnership evaluation	Determine whether the district should continue funding health programs offered by Stanford and other health systems	Propose eliminating the Stanford falls prevention program in FY24 (due to lack of alignment with CHNA), but continue with Teen Health Van as it's filling a need not otherwise met. PAMF 5210 program not funded in FY23 due to poor performance
Analyze economic need of individuals using Road Runners	Add a question on income range and insurance type to next survey of Road Runners participants	The RoadRunners staff will add a question about income range and insurance type to next survey of participants (administered twice per year)

FY23 Progress Update

Acknowledgement of Funds:

- Ravenswood Family Health Network MayView Community Health Center in Mountain View and Sunnyvale, On Site Dental, the CSAs in Mountain View and Sunnyvale are in the design process for building and mobile van signage with plans to implement by the end of the calendar year.
- Grant partners will be required to report on their acknowledgements in midyear reports.
- Grant managers are reinforcing the guidelines and ensuring that grant partners follow through in FY23.

Board Discussion



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Finding Value in Provider-Led Bundles

C.J. Stimson, M.D., J.D.
Chief Medical Officer at Vanderbilt University Medical Center

Sabrina Poon, M.D., M.P.H.
Medical Director of the Office of Episodes of Care

Agenda

- VUMC's value-based background
- Our method for creating a model
- Applying that model to Metro Nashville Public Schools
- Human and financial results
- What's next

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In the End

- It must involve everyone.
- Partners are finding each other. Be ready.
- The opportunity is real.

Agenda

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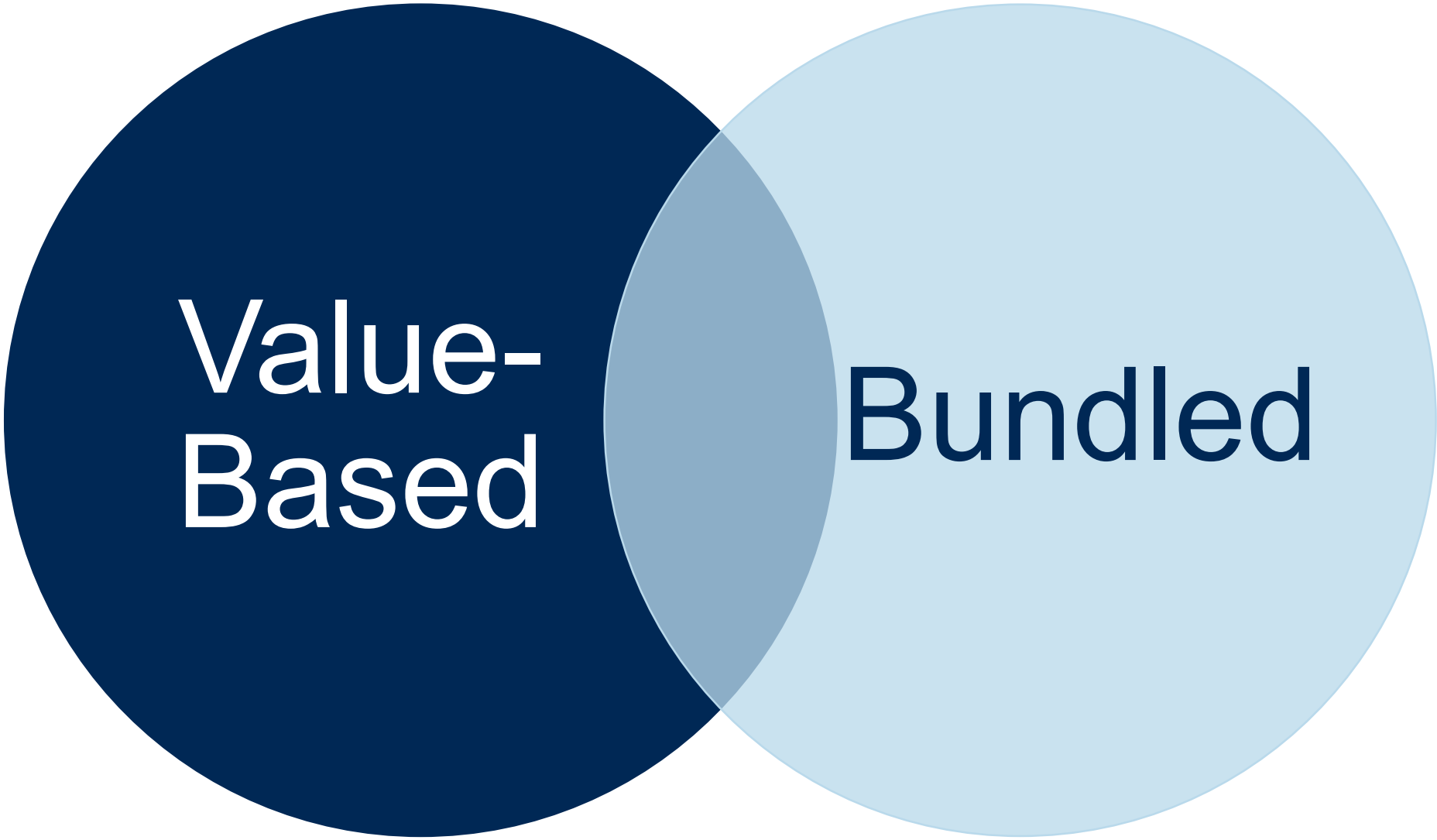
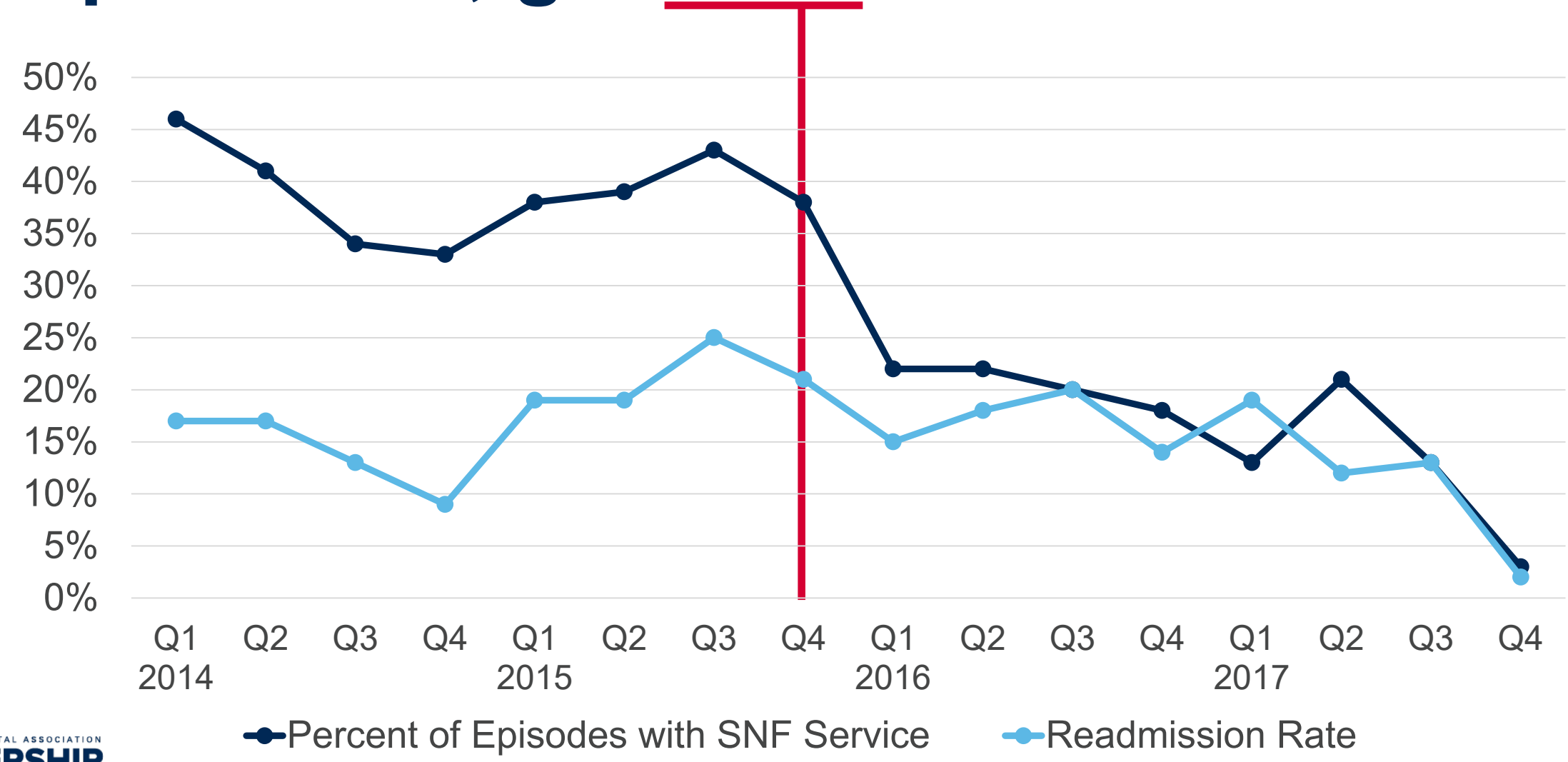
/’valyo͞o/ = Outcomes / Spend


Value-
Based
Bundled

Spend less, get more.



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VUMC's Transformation Priorities

Clinical Transformation

Improve the care model,
better outcomes for patients

Financial Transformation

Practice with risk, tie payment with performance,
market share growth

Service Transformation

Deliver a superior, market-leading care experience
that would eventually become the standard

Agenda

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Quality First

strategy  Improve care outcomes to improve spend.

Provider Bundles	VS	Payor Bundles
Less risk for employer. *Longer episodes. Many services included.*	Risk	**More risk** for employer. *Shorter episodes. Fewer services included.*
Start with care delivery.	Redesign	Start with payment.
Fewer restrictions on employee eligibility.	Eligibility	**More restrictions** on employee eligibility.
Real-time financial and clinical **feedback.**	Feedback	**Delayed feedback** based on claims data.

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VUMC's Design

- Reduced employer spend
- Patient incentives, such as:
  - Little to no out-of-pocket spend
  - Improved experience
- New volume and margin for VUMC
- Increased net revenue for providers via Incentive Fund Model

VUMC's Value-Based Offerings: MyHealth Bundles

MyMaternity Health

MyWeightLoss Health

Surgical Weight Loss
Medical Weight Loss

MySpine Health

MyOrtho Health

Hip & Knee Surgery
Osteoarthritis
Shoulder Pain

MyHearing Health

Agenda

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Metro Nashville Public Schools

Overview

42nd
Largest School District in the Nation

159
Schools

81,500
Students

6,500
Teachers

3,800
Support Staff

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Metro Nashville Public Schools

Health Plan

18K
Covered Lives
Including certificated employees, dependents and retirees

Self Funded

$100 Million
Annual Spend

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High Neonatal and Maternity Costs

High Risk

High risk for potentially catastrophic births

High Cost

Costs can reach $2.6 million per case

High Volatility

High volatility in neonatal spend

How it works
for the health plan

One, predictable, fixed price for all pregnancies and deliveries for the year

Same cost or less than fee-for-service

VUMC assumes the risk for each pregnancy and delivery

Addendum to current health plan.

Patient Navigators offer personalized service to employees

Partnered with VUMC on engaging MNPS employees in Bundles to drive enrollment

How it works for Employees

- Zero out of pocket costs
- Dedicated patient navigator
- High-touch service
- Telehealth services

Agenda

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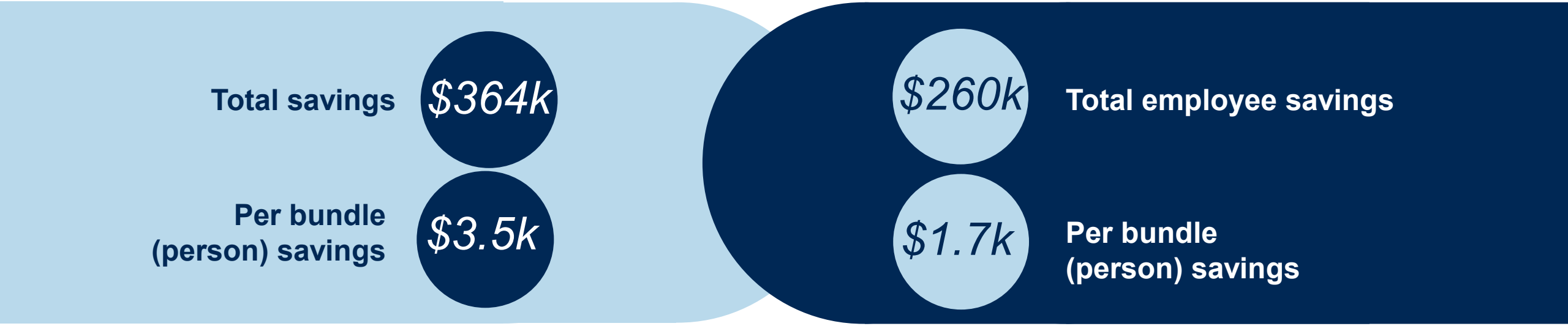
MyMaternity Health & Nashville Public Schools



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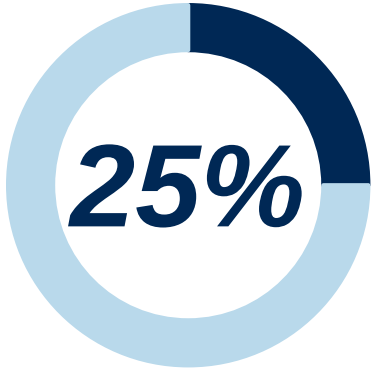
MyMaternity Health & Nashville Public Schools

88

Employee Satisfaction
Net Promoter Score



C-section rates decreased
compared to the market

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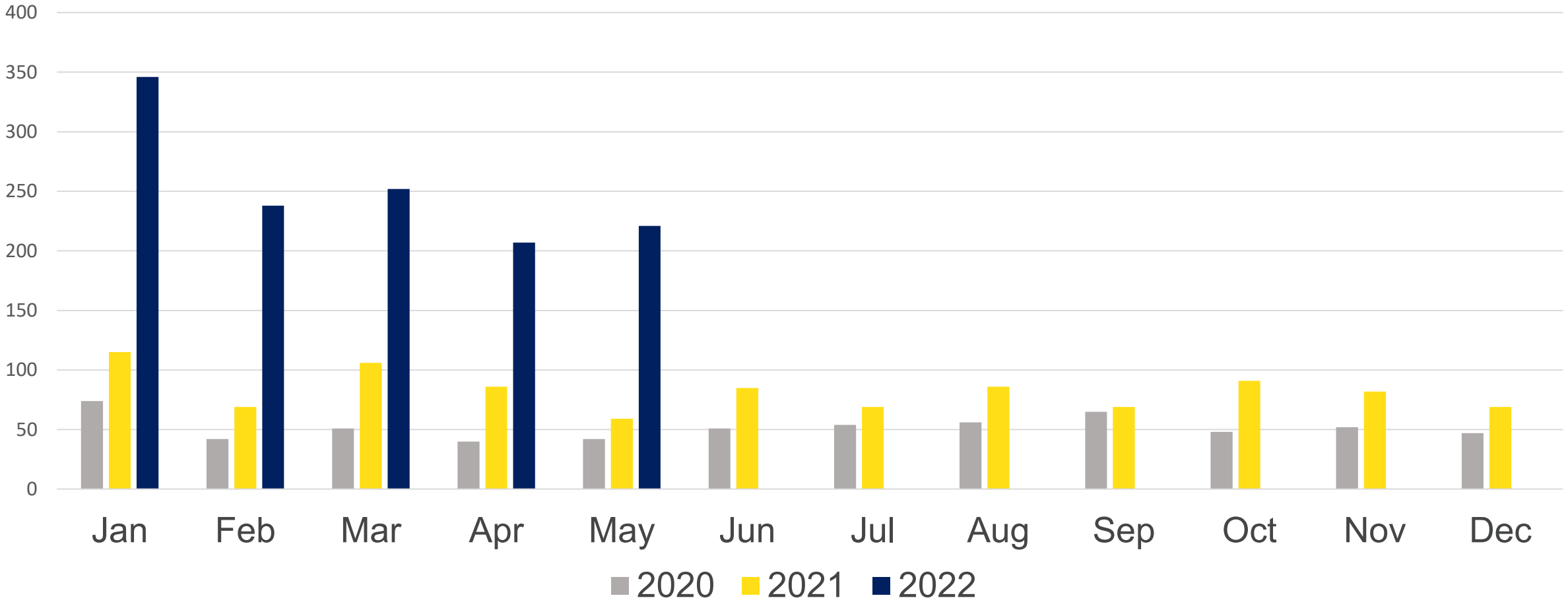
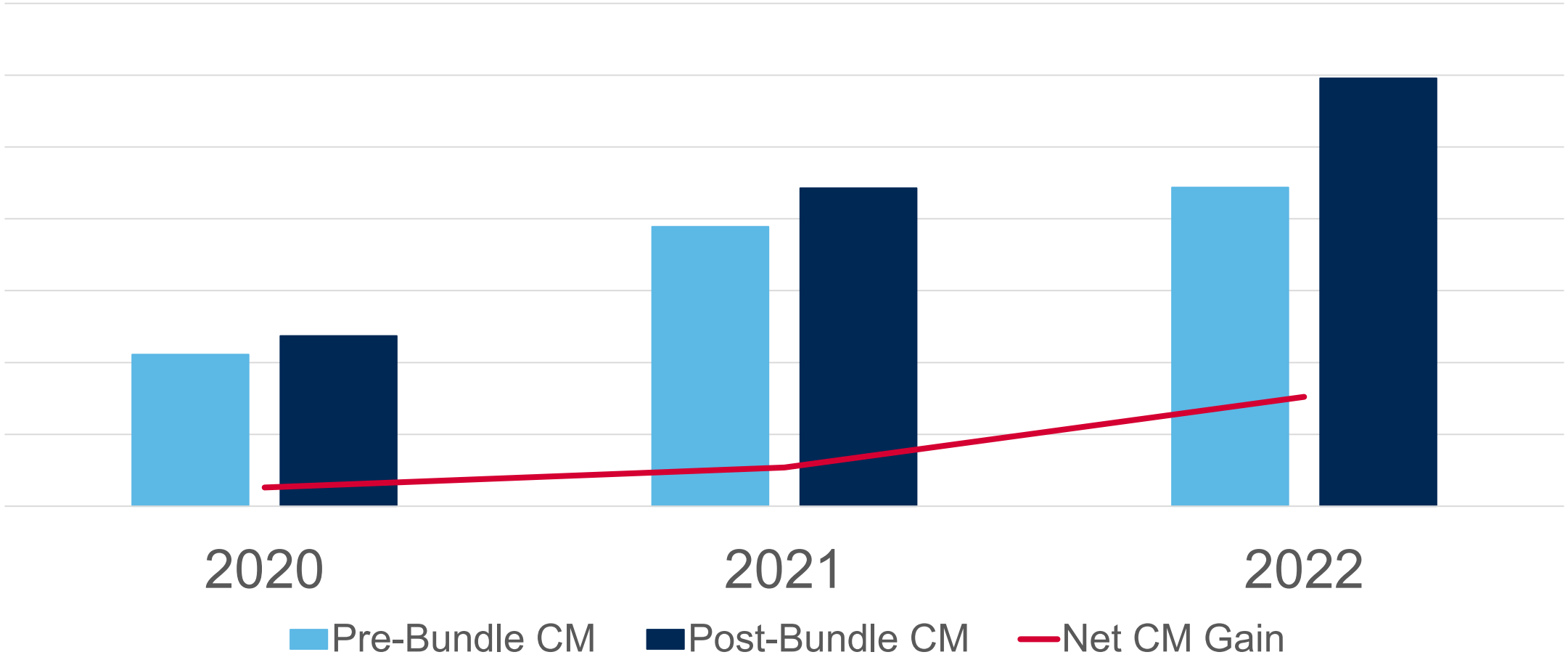
MyHealth Bundles Enrollment Volume



MyHealth Bundles Financials



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Agenda

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What's Next?

Innovate.
Prove.
Deliver.
Repeat.

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Up and Coming

- Expanding condition-based bundles
- Value-added models without a bundled payment
- Expanding location & services
- Distributed workforce solution
- Provider incentive alignment

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Making the Move from Provider to Payer

Patrick R. Young
President, Population Health
Hackensack Meridian Health

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

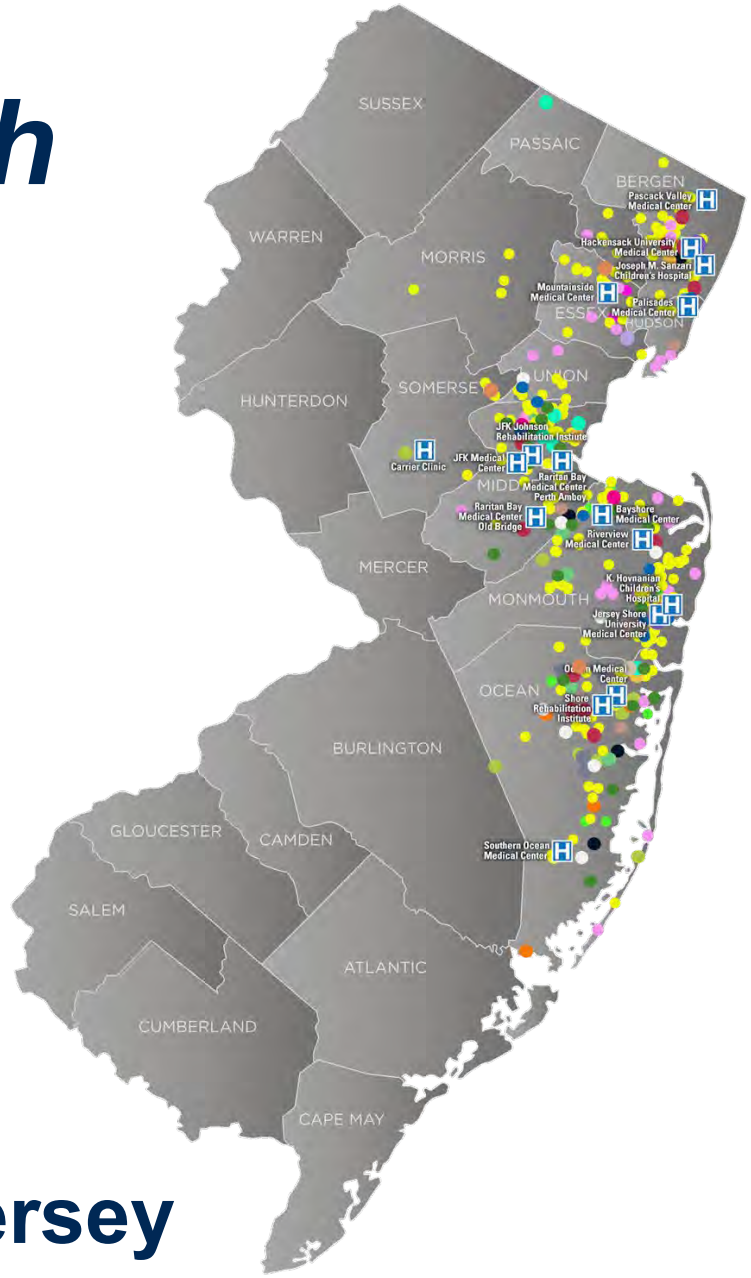
Hackensack Meridian *Health*

17 Hospitals
- 3 Academic Centers
- 9 Community Hospitals
- 2 Children's Hospitals
- 2 Rehabilitation Hospitals
- 1 Behavioral Health Hospital

500+ Patient Care Locations
- 3 Academic Centers
- 9 Community Hospitals
- 2 Children's Hospitals
- 2 Rehabilitation Hospitals
- 1 Behavioral Health Hospital

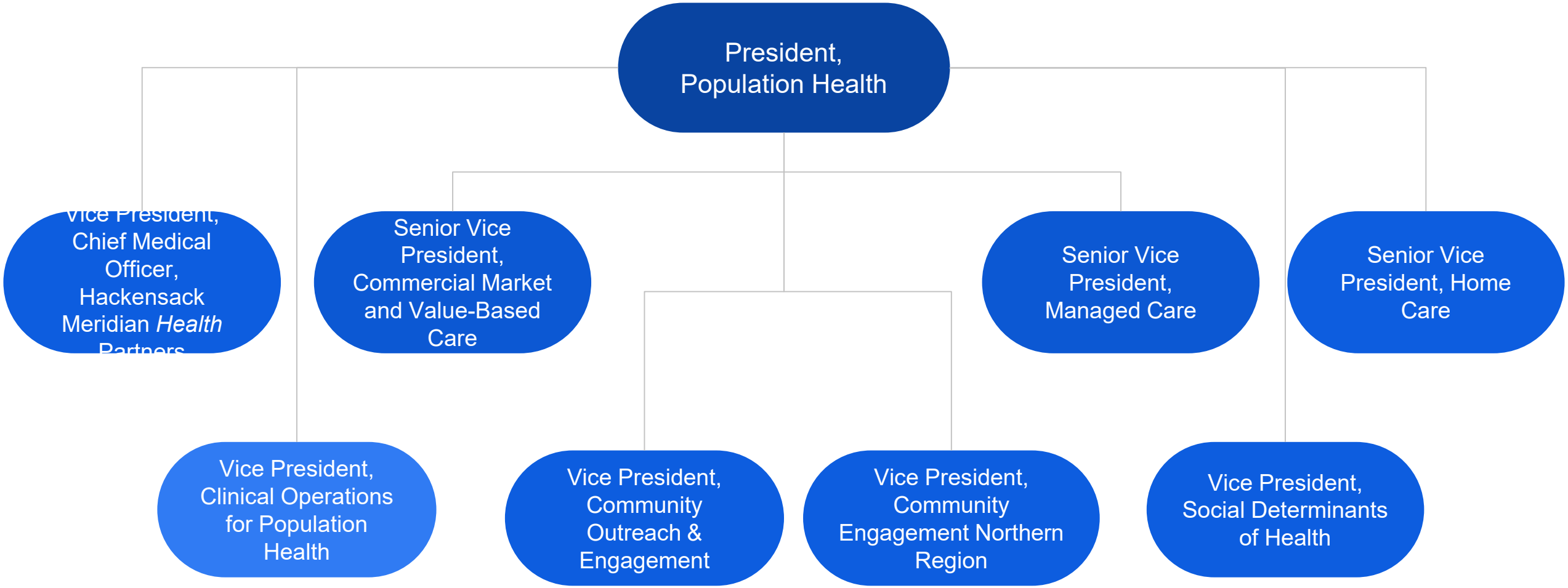
36,000+ Team Members

7,000+ Physicians



Largest health system in New Jersey

Population Health Leadership



Value-Based Payer Contracting Strategy

Commercial "Product Based" Network

- Take a local health care approach with a narrow network
- Offer Hackensack Meridian *Health* Partners on an exclusive Tier 1 basis to all business segments (ie: self funded, fully insured, small and large employers)

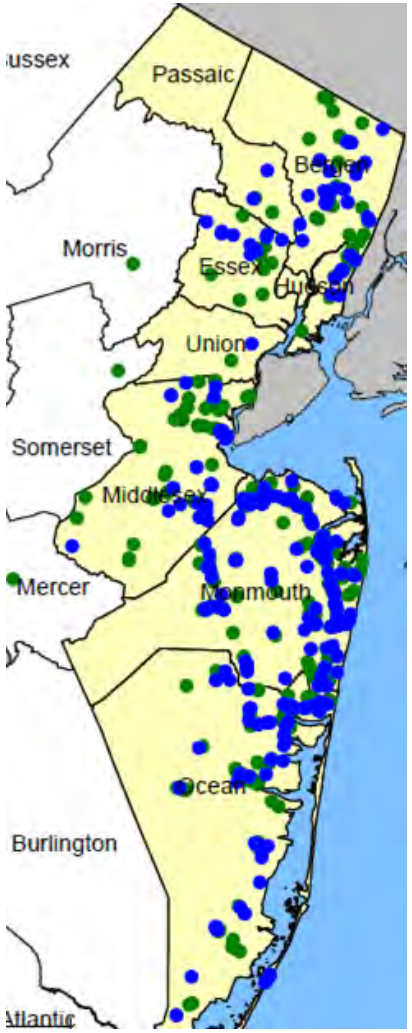
Shared Savings Network Model Migration to Risk

- Create collaborative, sustainable, quality-driven agreements that reduce cost.
  - ❑ Upside only shared savings and unrecoverable care coordination payments to increase physician engagement
  - ❑ Incentivize based on quality performance and total cost of care savings with efficiency metrics (ie: ER visits, readmissions, skilled nursing utilization, PMPM costs)
  - ❑ Understand total cost of care as a percent for premium; establishing savings targets based on percentage of medical loss ratio (MLR)
- Higher savings split to Hackensack Meridian *Health* Partners (70%/30% split for most contracts)
- 2022 limited downside risk contracts, but shared savings to 85% split

Medicare Shared Savings Program, Medicare Advantage Joint Venture and Risk Migration

- Upside-only shared savings, Track 1 until end of 2022. Shared savings distribution eligibility reduced to 40%
- Quality and efficiency metrics that enhance STAR ratings
- Braven risk arrangement based on MLR target with limited downside risk

Hackensack Meridian *Health* Partners



Contracting Vehicle for:

- value-based contracting
- bundle arrangements
- Medicare Advantage Joint Venture
- Upside/downside risk arrangement

Hackensack Meridian *Health* Partners can assume financial risk and pay providers:

✓ Obtained ODS license
✓ Approved for DOBI insurance license
✓ Filed with CMS for a Medicare Advantage product

4,500+ Participating Physicians

aetna® AmeriHealth NEW JERSEY Cigna Horizon

2022 Key Initiatives

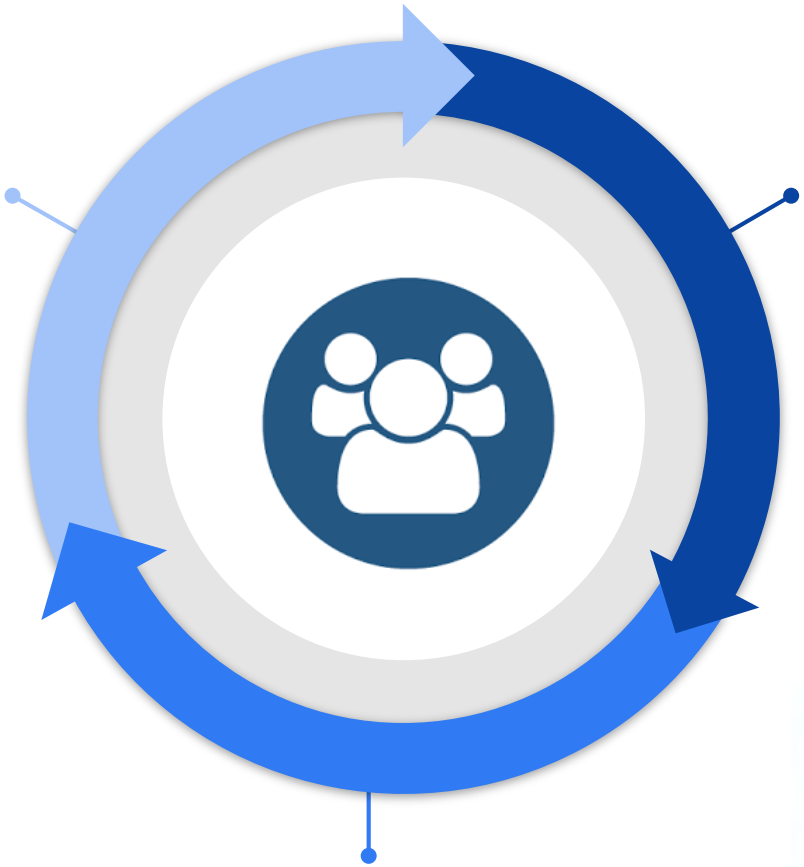
- Roll out Specialist quarterly performance metrics
- Integrate clinical data from independent practices
- Establish minimal threshold for quality and efficiency metrics

✓ Roll out Lumeris/Cerner new population health analytics and data hierarchy

An Integrated Approach to Patient Care

Social Determinants of Health

- Food Security
- Housing Stability
- Transportation and Mobility Access
- Caregiver Support
- Mental Health/Behavioral Health/SUD



Physician Practice

- Administer clinical care

Care Management

- Close gaps in care
- Stratify patients
- Connect patient to appropriate care setting

ACCREDITED NCQA CASE MANAGEMENT

New Jersey Medicare Advantage Market

- 1.5 Million Medicare Beneficiaries live in New Jersey.
- In 2018, only 300,000 Medicare Beneficiaries are enrolled in MA plans – approximately **10-15% lower** than the national average.
- New Jersey Medicare Advantage plans enrollment have increased over the last dozen years.
  - In mid-2020, approximately 32% of Medicare beneficiaries were enrolled in Medicare Advantage plans versus a nationwide average of 40%.
- **More than half** of the state's eligible MA members live in Hackensack Meridian *Health's* eight county market area.

Medicare Advantage Opportunity

Improve of Medicare line of business by:

- Participating in underwriting returns in addition to fee for service earnings.
- Generating net new volume to Hackensack Meridian *Health* through distribution of high-value products and limited network.

Joint venture enables Hackensack Meridian *Health* to:

- Share risk,
- Start with significant membership,
- Leverage partner's experience with administrative and actuarial activities, and
- Create a partnership with a large continuum of care across several counties.

Joint Venture Structure

Term	Detail
JV Purpose	Create a differentiated, high-value experience for members of the Joint Venture health plan and other attributed beneficiaries that improves patient experience and outcomes while managing medical costs.
Ownership	50% Horizon Blue Cross Blue Shield of New Jersey 40% Hackensack Meridian *Health* 10% RWJBarnabas Health*
Capitalization	• Pro rata, based on ownership • Membership Acquisition Cost: Hackensack Meridian *Health* will contribute to the Joint Venture or provide payor with funds representative of 50% of the value of payor's membership contributed to the Joint Venture.
Scope	• The Joint Venture will secure health plan license(s) to offer Individual (i.e. consumer) and Group Medicare Advantage products in the Joint Venture service area.
Exclusivity	The Joint Venture is each Party's exclusive vehicle to offer Individual and Group Medicare Advantage insurance products in the Joint Venture service area with some exceptions
Governance	Shared 50:50 with unanimous approval required for material decisions concerning the JV

*Opportunity for other partners to buy up to 6% into the Joint Venture

Joint Venture Medicare Advantage Plan

Horizon Blue Cross Blue Shield of New Jersey

+ Underwriting

+ Claims Processing

+ Provider Complaints & Appeals

Hackensack Meridian *Health*

+ Care Management

+ Care Utilization

Lumeris

Physician Engagement

Care Management

Analytics

Cerner

Data Management (HealtheIntent)

Lumeris Partnership

- Care Coordination of Employee Health Plan
- Physician Engagement
- Governance
- Incentive Structure
- Delegated Utilization Management
- Data Analytics
- Value-Based Care Transition

Being a Trusted Voice

Partnered with HealthShare360 to educate and inform patients about their Medicare options:

- Direct Mail Letter
  - ❑ Sent 3 and 2 months before 65th birthday
  - ❑ Average 5,260+ letters sent per birthday month
- Email using Hackensack Meridian *Health's* CRM
  - ❑ Sent 4, 3 and 2 months before 65th birthday
  - ❑ Average 1,000+ emails sent per birthday month
- Educational webinars listed on Hackensack Meridian *Health* website
- Flyers provided to Hackensack Meridian *Health* physician practices

June 2022

Matter of Balance: Managing Concerns about Falls

June 09, 2022 – July 28, 2022

Hackensack Meridian Fitness & Wellness

Do you have concerns about falling? Many older adults experience concerns about falling and restrict ...

Medicare Questions Answered

June 09, 2022 at 10:00 AM – 11:00 AM ET

Virtual Zoom Meeting

QUESTIONS ABOUT MEDICARE?

To help you better understand your Medicare options, Hackensack Meridian *Health* has partnered with HealthShare360. They are a local resource for local Medicare solutions. Through our partnership, they can help you choose the right Medicare plan for you.

REGISTER FOR A VIRTUAL MEETING BY CALLING:
855-513-5897 (TTY: 711)
A licensed agent will answer your call.
Monday - Friday: 9 a.m. - 5:30 p.m.

OR VISITING

MedicareAnswers360.com/HMH

Virtual meetings are held the second Thursday of every month at 10 a.m. and 5:30 p.m., and the second Saturday of every month at 10 a.m.

HealthShare360 Inc. is a licensed and certified health insurance agency that works with Medicare enrollees to explain Medicare Advantage, Medicare Supplement Insurance, and Prescription Drug Plan options with a Medicare contract. Enrollment in any Medicare plan depends upon contract renewal. For a complete listing of available Medicare plans, please contact 1-800-Medicare (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week or consult www.Medicare.gov. For accommodations of persons with special needs at meetings call 855-513-5897 (TTY: 711).

KEEP GETTING BETTER

Hackensack Meridian *Health*

Launched September 14, 2020


Braven
HEALTH
Together, we're creating an improved health care experience guided by those who know our members' health best: their doctors. With more collaboration between the physicians and the health plan, it's a whole new approach to Medicare for a new generation of Medicare members.

Executing a Coordinated Approach

- ✓ TV commercial featuring HMH physicians
- ✓ Letters signed by HMH PCPs
- ✓ Built off existing Age-In campaign
- ✓ Partnership with HealthShare 360
- ✓ Physician Advisory Council

Braven Health Breaks Records

AEP 2021

- **Highest enrollment** in its 8-county area for any Medicare Advantage plan in New Jersey history.
- Braven Health **enrolled more members** than all New Jersey Medicare Advantage plans did in its 8-county area for 2021.
- Braven Health enrolled **75%** of its 8-county area for 2021.

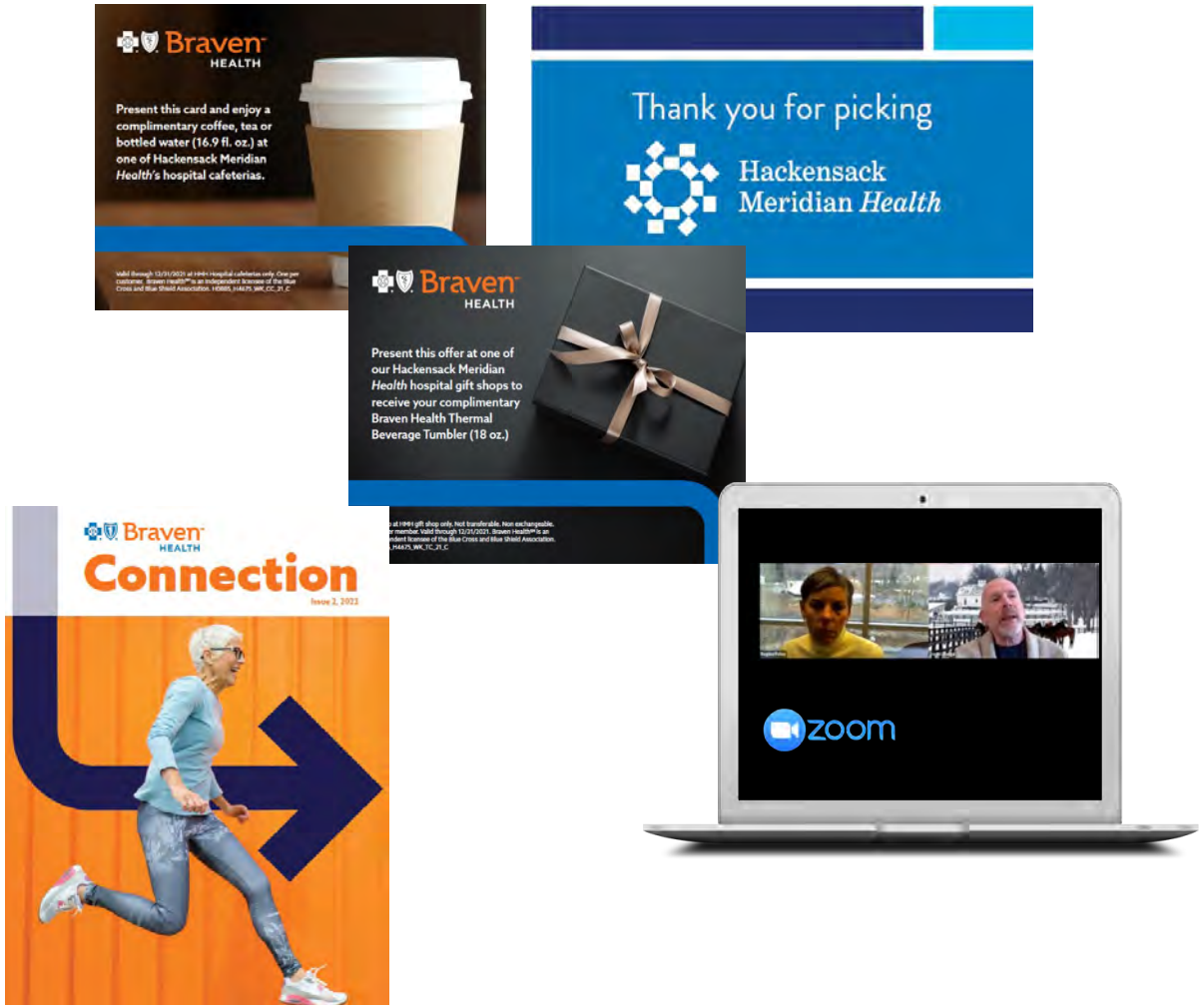
ROI
roi-nj.com

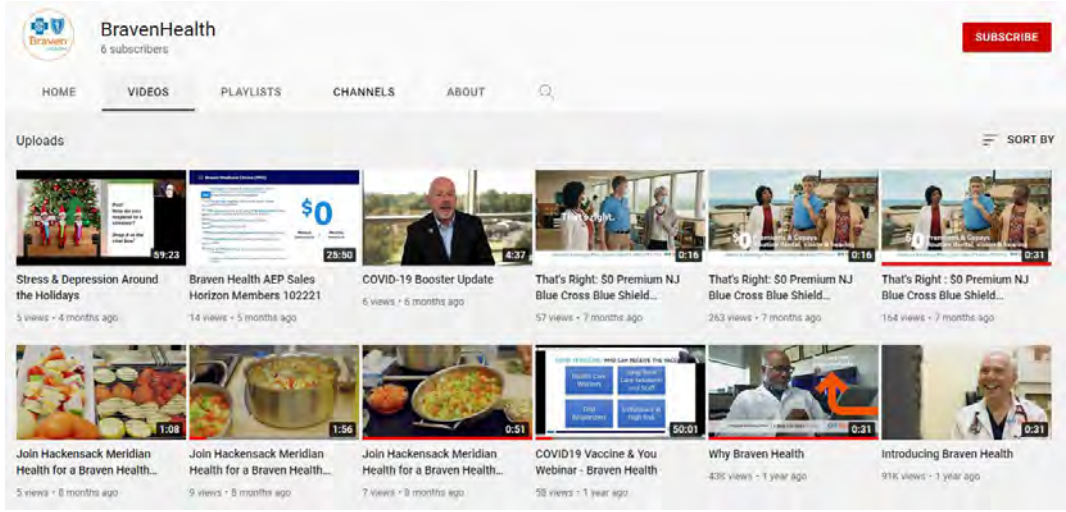
Braven Health's initial enrollment tops all other Medicare Advantage plans

BECKER'S
PAYER ISSUES

Braven, health insurer created by Hackensack, RWJBarnabas and Horizon, enrolls 13,000

Maintaining Member Satisfaction





- ✓ Perks at Hackensack Meridian *Health* hospitals
- ✓ Exclusive webinars for members
- ✓ Video content featuring Hackensack Meridian *Health* experts
- ✓ Newsletter content featuring Hackensack Meridian *Health* and RWJBarnabas Health experts

Medicare Advantage Competitive Environment – Braven Health Counties Only
NJ MA Enrollment – Individual vs. EGWP (SNP excluded)

Company	MA Individual	MA Individual Market Share	MA EGWP	MA EGWP Market Share	MA TOTALS	Total Market Share
UnitedHealthcare	89,028	42.8%	19,601	18.2%	108,629	34.4%
Clover	48,454	23.3%	0	0.0%	48,454	15.3%
Braven Health	24,169	11.6%	1,819	1.7%	25,988	8.2%
aetna	19,334	9.3%	83,378	77.6%	102,712	32.5%
WellCare	13,779	6.6%	0	0.0%	13,779	4.4%
Humana	6,737	3.2%	395	0.4%	7,132	2.3%
Amerigroup	6,068	2.9%	2,081	1.9%	8,149	2.6%
Cigna	408	0.2%	0	0.0%	408	0.1%
Horizon	0	0.0%	101	0.1%	101	0.0%
All Others	266	0.1%	52	0.0%	318	0.1%
TOTAL	208,243	100%	107,427	100%	315,670	100%

Source: Mark Farrah Associates, Totals reflect enrollment as of the June 1, 2022 payment. The payment reflects May enrollments accepted through May 6, 2022 (Membership not reflected in these membership numbers).

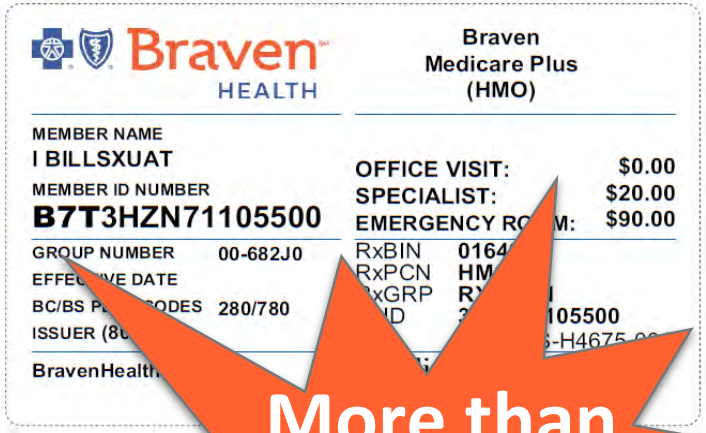
Still Breaking Records

AEP 2022

- **Highest two-year enrollment** in the last 16 years for any New Jersey Medicare Advantage plan.
- **Third largest** Consumer Medicare Advantage plan in the area.

OEP 2022

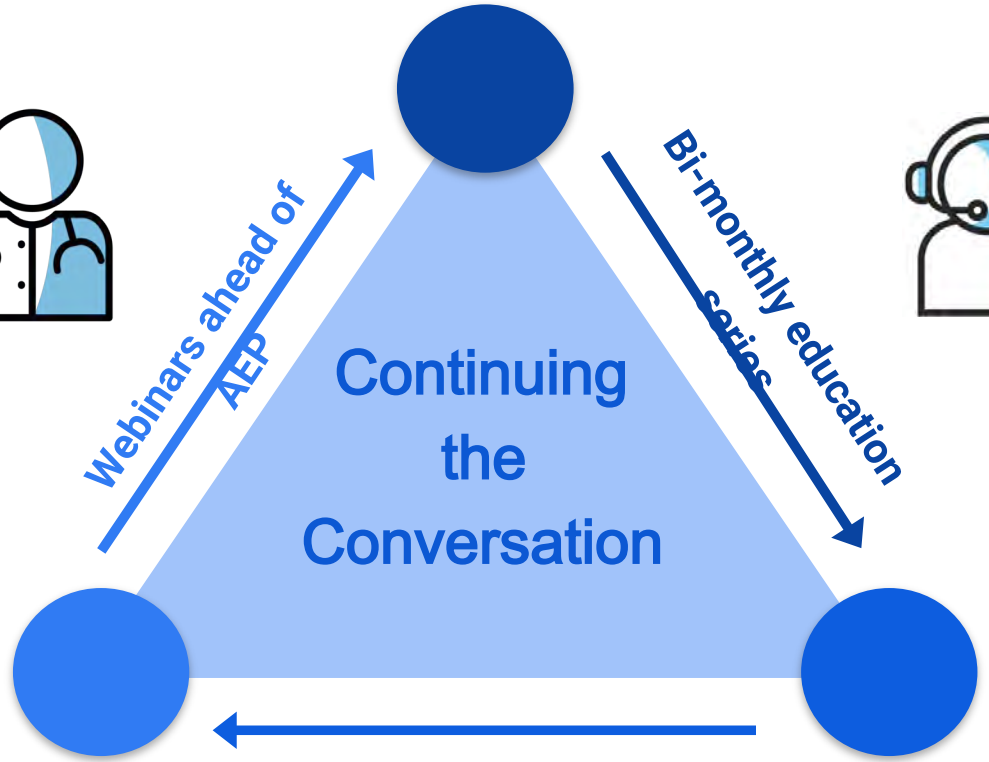
- Added **more than 1,000** members in the first quarter of 2022.
- Enrolled **72%** of all new members in the area.



More than 27,000 Members*

**As of June 20, 2022*

Educating for AEP 2023



Preparing for AEP 2023

Expanding service area to all **21 counties** in New Jersey*

- Execute previous on successful marketing strategies
  - ❑ AEP Marketing Campaign will consist of direct mail, email, social media and digital advertising
  - ❑ Updated design for direct mail & email based on marketing research
  - ❑ Provider affiliation letter will be first direct mail piece
  - ❑ In-person & virtual sales meetings at partner and non-partner locations
- Identify strategic partners in new territories

Braven HEALTH

Hackensack Meridian *Health*

Horizon

RWJBarnabas HEALTH

**Awaiting regulatory approvals*

Questions?

Thank you

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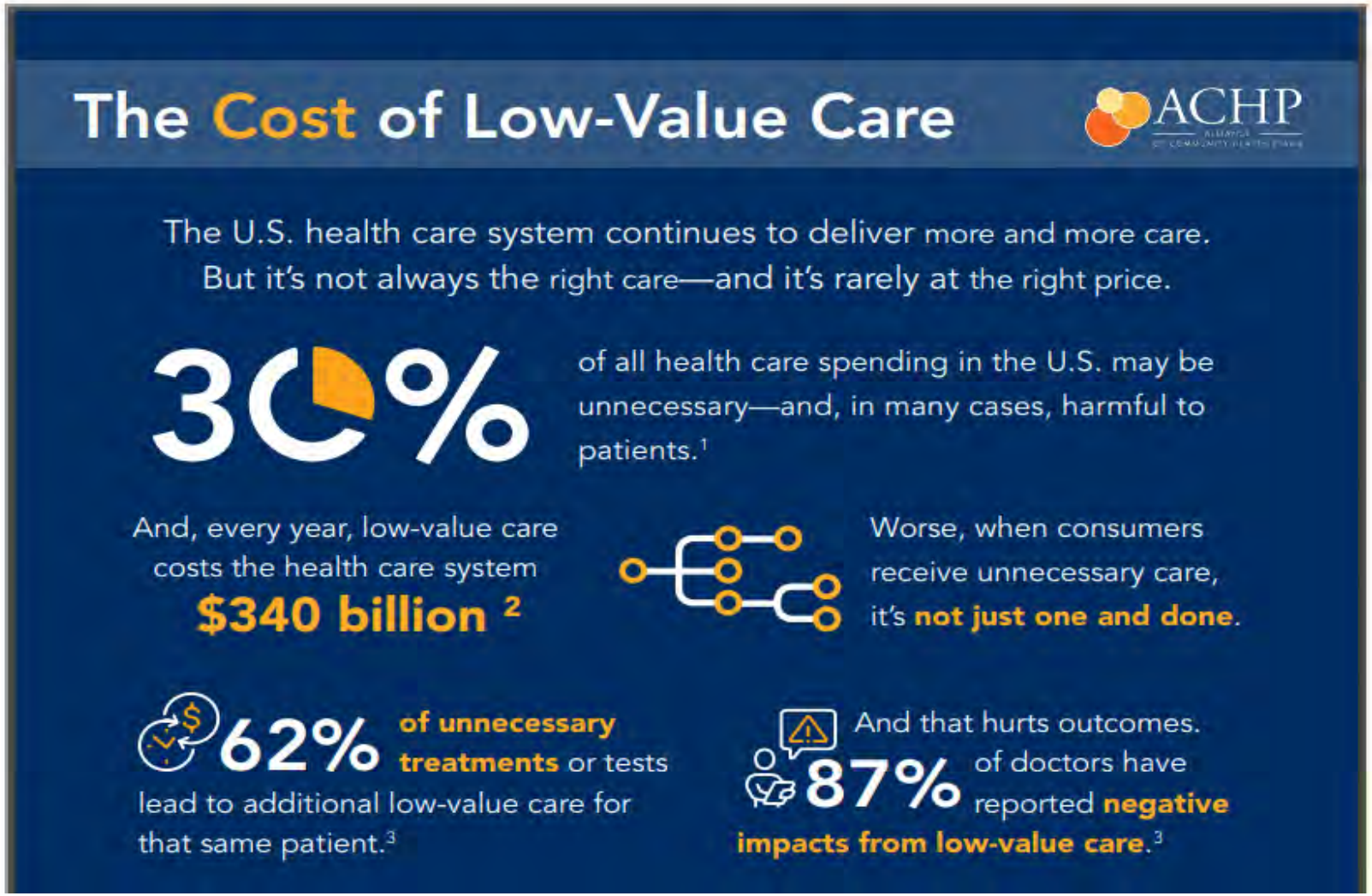
Partnering with Payers on Downside Risk

Ilan Shapiro, MD, Chief Medical Affairs Officer, AltaMed

Eric Evenson, FACHE, Leader of Clinical Strategy and VBC, 3M Health Information Systems

Sandeep Wadhwa, MD, Global Chief Medical Officer, 3M Health Information Systems

Low value care drives up costs and impairs patient safety



ACHP identifies 30% as the cost of low value care

The 3M Office of Clinical and Economic Research has found 5-7% costs can be addressed by improving a health systems; visibility to potentially preventable events.

Who is Alta Med?

Founded in **1969**, AltaMed Health Services Corporation is a network of federally qualified health centers

41 service sites (Los Angeles & Orange Counties)

~1 million encounters for primary care, behavioral health, dental services, senior care, and other social services for **350K** unique patients.

Approximately **86-97%** of our patient population self-identifying as Latino.

ishapirostrygler@altamed.org

Quality defects can be tracked

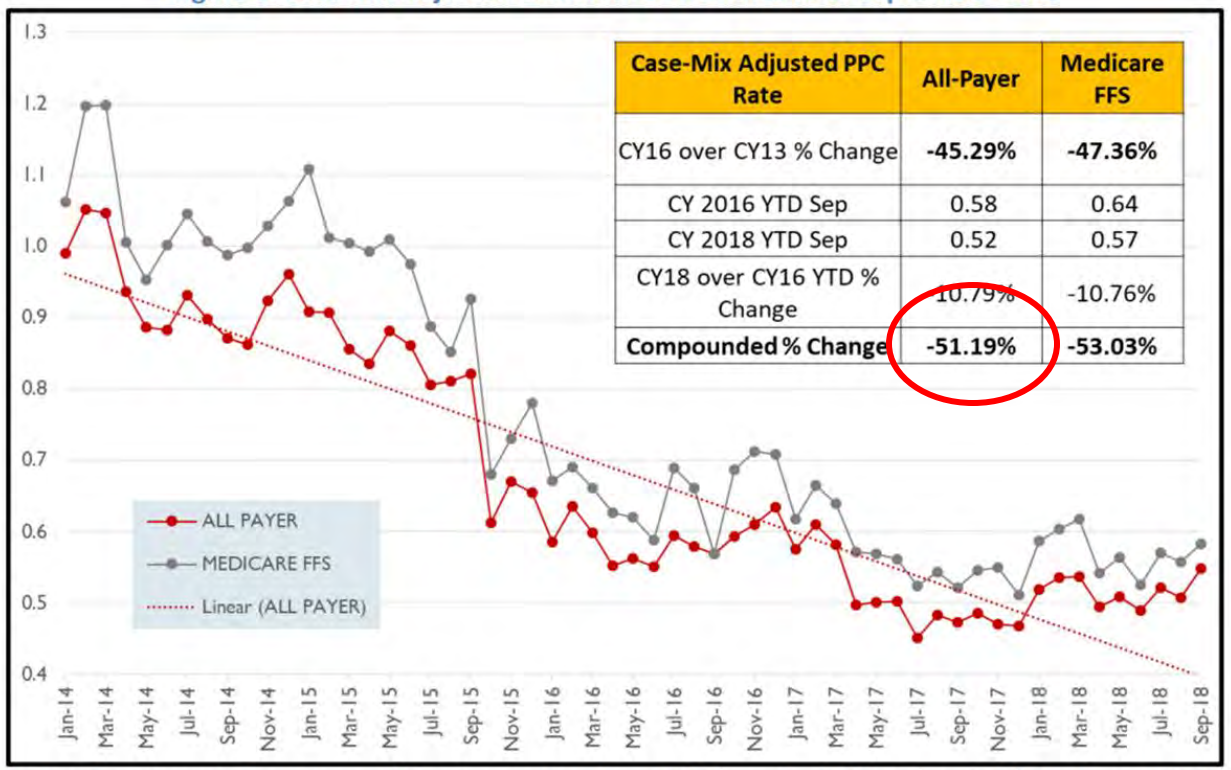
Fragmentation	Complications	Poor access	Poor Care Coordination	Unnecessary services
Result of poor continuity/ transitions of care	Result of insufficient processes of care	Result of inadequate access to care or resources	Result of inadequate access to care or resources	Avoidable services ambulatory settings
				
Potentially Preventable Readmissions (PPR)*	**Potentially Preventable Complications (PPC)**	**Potentially Preventable Emergency Department Visits (PPV)***	**Potentially Preventable Admissions (PPA)***	**Potentially Preventable Ancillary Services (PPS)**

Maryland: reduction in complications

Maryland's all-payer hospital system decreased PPCs by 51% from 2013 to September 2018.

Maryland PPCs include such common and serious complications such as septicemia and severe infections, post-op hemorrhage, respiratory failure, shock, and pulmonary embolism

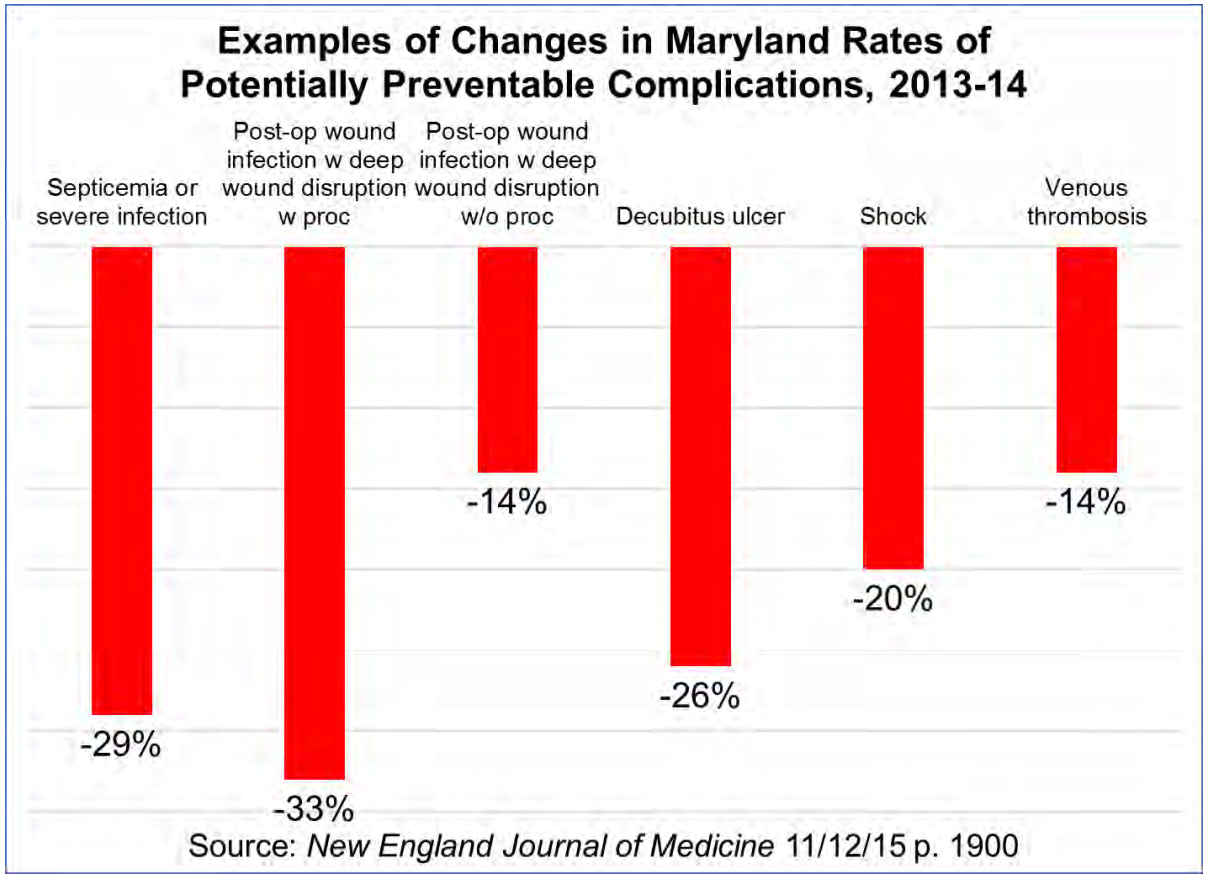
Figure 3. Case Mix Adjusted Cumulative PPC Rates as of September 2018



Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY16 over CY13 % Change	-45.29%	-47.36%
CY 2016 YTD Sep	0.58	0.64
CY 2018 YTD Sep	0.52	0.57
CY18 over CY16 YTD % Change	-10.79%	-10.76%
Compounded % Change	**-51.19%**	**-53.03%**

Note: Line graph based on v32 prior to October 2015; and v35 October 2015 to June 2018; all data are final, but are subject to validation.

Source: Maryland HSCRC, Final Recommendation for the MHAC Program for Rate Year 2022



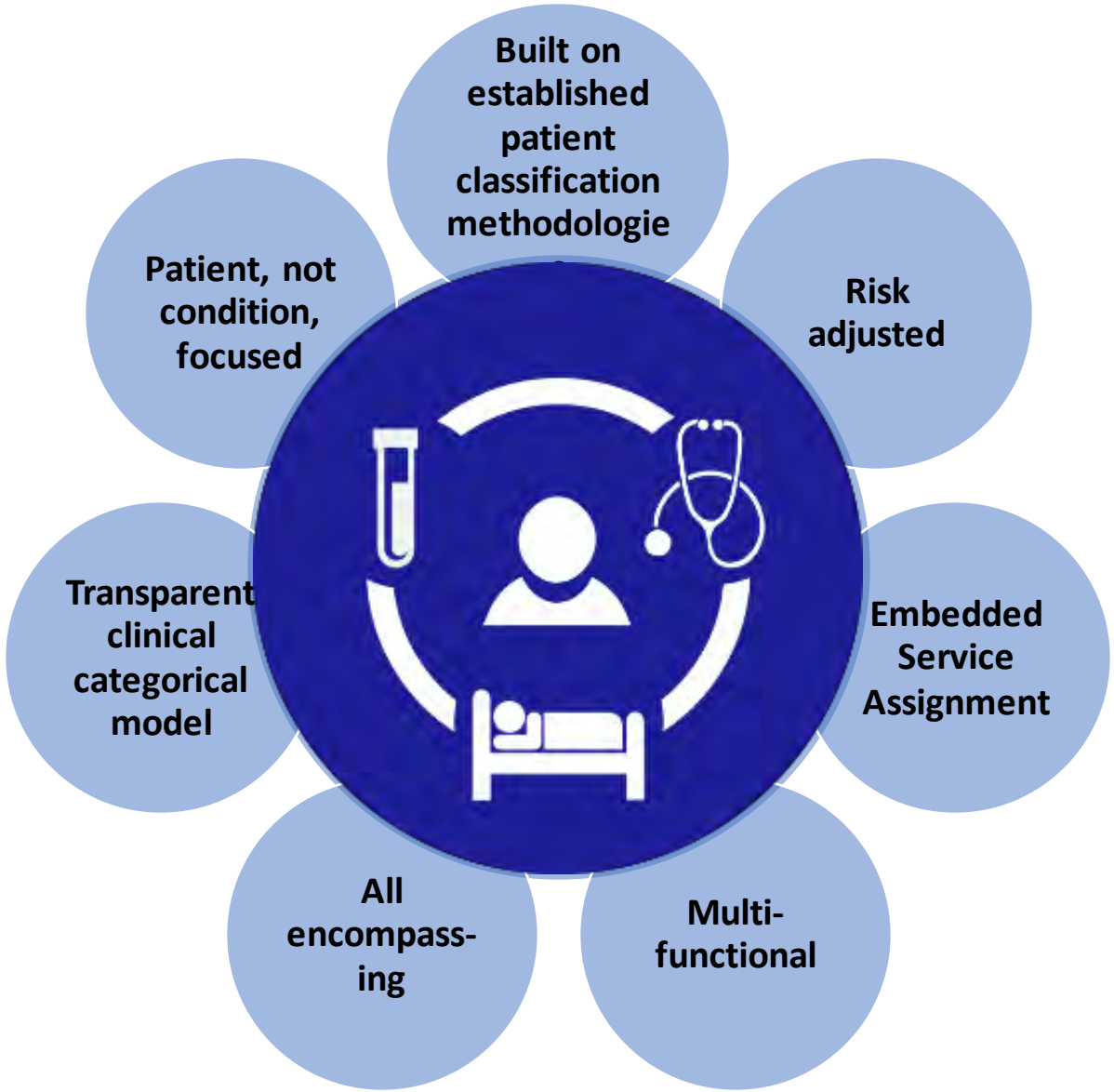
Discussion Questions

1. How is your organizations measuring quality and operational efficiency across all care settings? What barriers have you encountered?
2. How do you measure/understand clinician variation in a clinic or outpatient setting?
3. Do you have metrics that span the continuum and in the transitions of care?
4. How does your organization define an episode of care and risk adjust across the continuum?
5. What technologies are you leveraging to provide insights and drive improvement across all your sites and services?

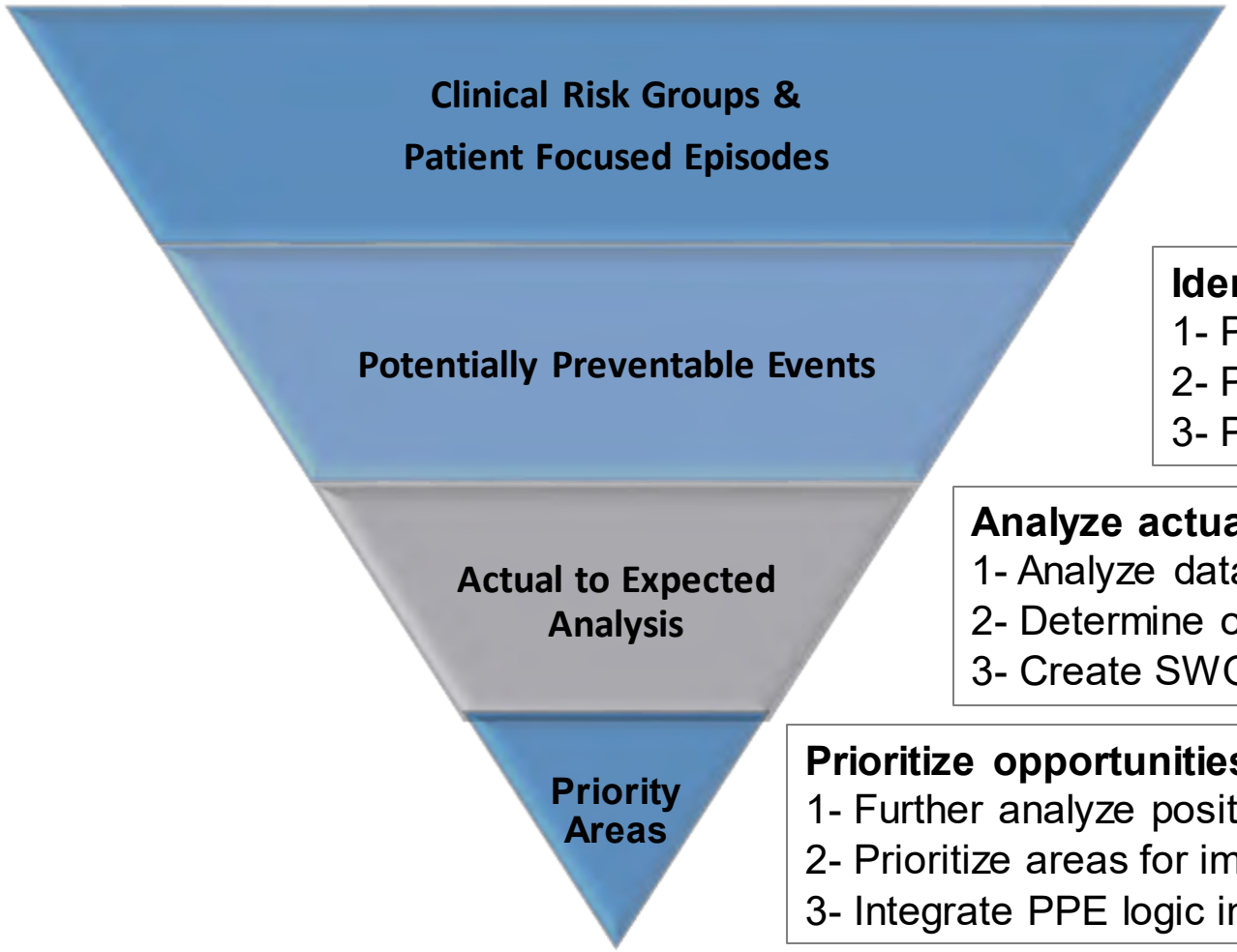
Q & A

Appendix

Patient-Focused Episodes of Care



Integrated Payments with Actionable Quality Defects Identification Improve Safety and Efficiency



Stratify and analyze population:
1- Population
2- Cohort (specific diseases)
3- Events

Identify Potentially Preventable Events to remove waste
1- Potentially Preventable Readmissions and Revisits to the ED
2- Potentially Preventable Complications
3- Potentially Preventable Admissions, Visits, Services

Analyze actual to expected results
1- Analyze data across the continuum of care
2- Determine outcomes by provider, payer, service line, practices, etc.
3- Create SWOT-type analysis based upon data

Prioritize opportunities for improvement and/or replication
1- Further analyze positive outcomes areas and determine potential replication.
2- Prioritize areas for improvement.
3- Integrate PPE logic into dynamic “real time” alerts.

Potentially Preventable Services

High volume, low value services in these 14 service lines is absolutely central to VBC performance.

These PPS defined procedures show high amounts of variation in practice patterns and utilization.

- General Surgery
- Orthopedic Surgery
- Rehabilitation
- Cardiology
- Interventional Cardiology
- Gastroenterology
- Neurology
- Ophthalmology Surgery
- Diagnostic Radiology
- Diagnostic Nuclear Medicine
- Laboratory
- Chemotherapy and Pharmacotherapy
- Orthopedics
- Interventional Radiology

2020 Medicare FFS Hospital Outpatient Facility Data:

- ~5 Million Procedures at risk for complication
- ~175,000 Potentially Preventable Complications Identified
  - ~30,000 occurring in ED
  - ~65,000 occurring in Hospital Inpatient Setting
  - ~ 80,000 occurring in Outpatient Setting
- At risk cases are with Expected: Observed complication ratios ranging from .5 – 1.5

High Complication Rates

Procedure Group	Complication %
Upper Genitourinary Catheter (Percutaneous) Procedures	18.29%
Laparoscopic Procedures with Insertion or Revision of Intraperitoneal Catheter	15.11%
Cardiothoracic - Thoracoscopy Procedures	14.6%

Low Complication Rates

Procedure Group	Complication %
Hand and Wrist Arthroscopy Procedures	0.73%
Shoulder and Elbow Arthroscopy Procedures	0.91%
Strabismus and Extraocular Muscle Procedures	0.92%

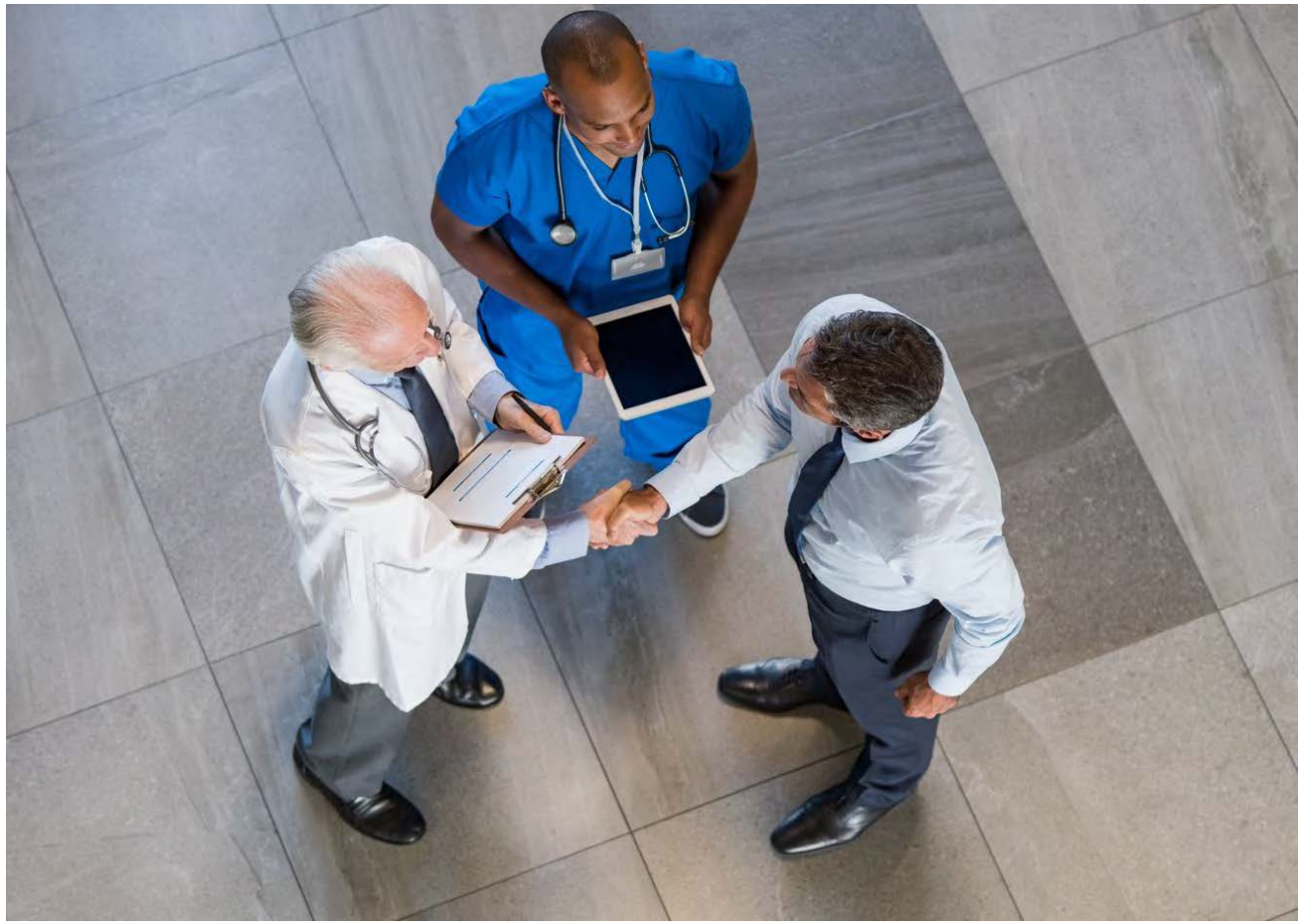
Outpatient Procedures and Quality

80% procedures performed in outpatient settings

Limited outcomes/quality measurement system

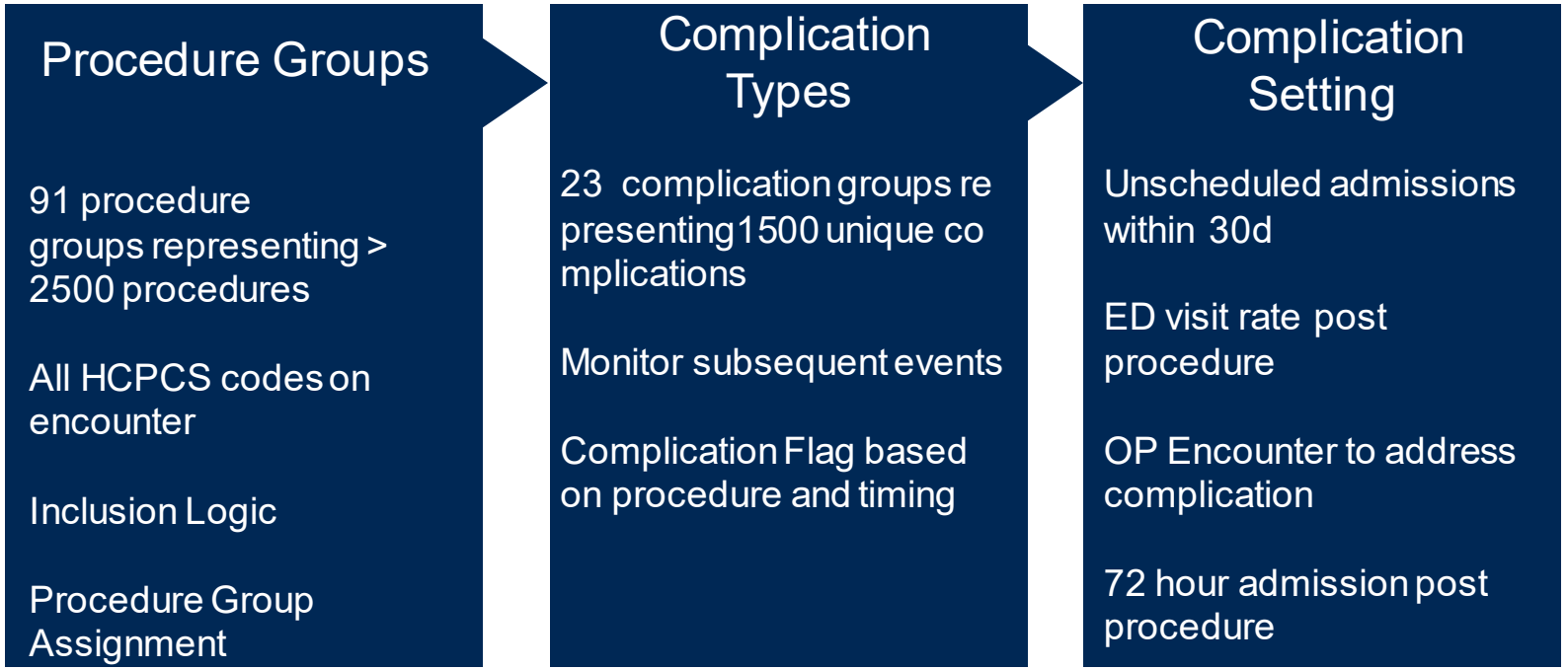
Comprehensive quality outcomes system for ASC/HOPD procedures – 2% defect rate

Benchmarks against regional/national performance; by sites, service lines, physicians for reducing variation and targeting poorer outcomes



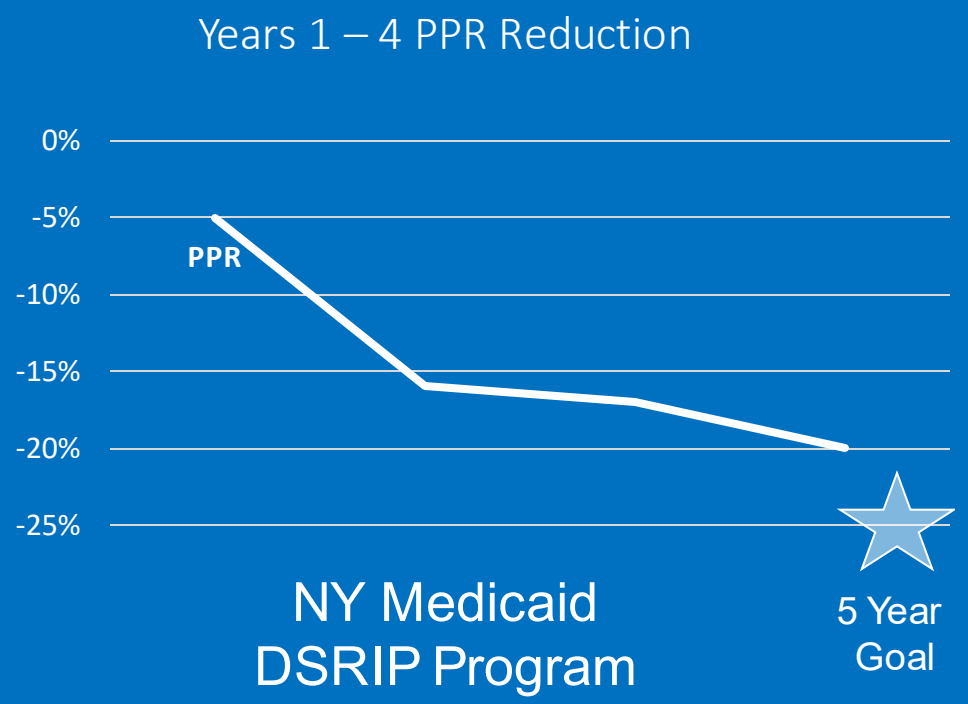
Outpatient Complications

- Aggregate procedure Groups developed specific ally for procedures of interest
- Supports procedure code, service line, site of service, and physician level detail to target improvements
- Only use claims data
- Extends expertise gained building inpatient complication measures



Reducing Avoidable Hospital Use in NY

The primary goal of the program is to reduce avoidable hospital use by 25% in five years.



$262 million

In savings from reducing avoidable hospital use, PPR, and PPVs

$89 million

In savings from reducing behavioral health related PPVs after hospitalization for Mental Illness within 30 days

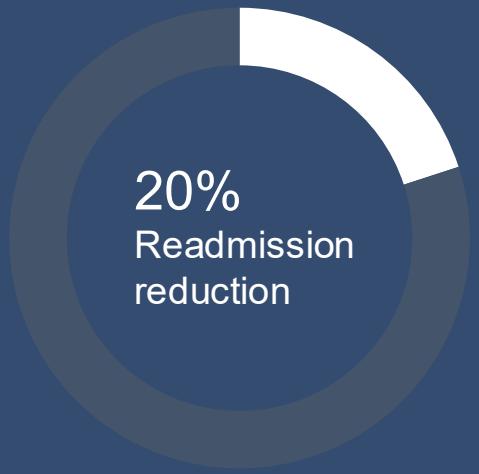
Source: New York Department of Health. Delivery System Reform Incentive Payment (DSRIP) Amendment Request. Albany, NY: NYDOH, Sept. 17, 2019

PPR = Potentially Preventable Readmissions
PPV = Potentially Preventable ED Visits

Better results.

Fewer readmissions.

20% reduction in readmissions—or 8,800 healthy nights at home—leading to **$70 million** in savings*

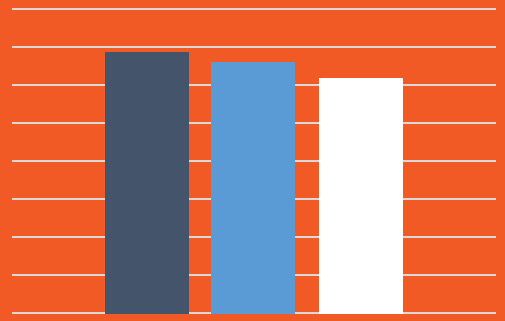


* Minnesota
Medicaid and DOH using PPRs

Sustainable cost savings.

With better quality.

$35 million in avoided costs with better primary care, reduced ER visits and readmissions, and higher continuity of care*



$35 million
In waste avoided

* Wellmark
Commercial ACOs in Iowa

Provider-Partnered Health Plan Network Board **Task Force**

Learnings & Recommendations

July 2022

American Hospital Association™

Advancing Health in America

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American Hospital Association™

Advancing Health in America

Executive Summary

Plan networks in the commercial insurance market can help provider organizations transition to new models of care in which they bear greater financial risk to have greater control over the care they give and the dollars they receive. This is not just a means to more sustainable spending on care. It is a path to impact the quality, affordability, accessibility, and equity of care for individuals and communities.

Key Findings

Participating in networks of provider-partnered health plans is an option to achieve ***greater financial sustainability*** for care delivery organizations

Selecting partners takes time and care: ***Partners also must align on many fronts*** for a successful collaboration

Provider organizations ***start in different places*** when participating in plans — just as their communities do in accepting such plans

Potential partners come in all shapes and sizes — consultants, service providers, third-party insurers — depending on the needs of a provider organization

Readiness to assume risk — as a provider, an insurer or a partner — is a prerequisite for participation and needs assessing in the context of both provider capabilities and market dynamics

Decisions to own, operate or partner depend on organizations' ***capacities, competencies, communities and commonalities*** vis-à-vis other organizations

Provider-partnered plans must ***be clear on the value they will deliver*** to consumers, purchasers, state agencies, their partners and themselves

Networks offer provider-partnered health plans the ***impact, scale and economics*** to be viable alternatives to third-party health plans

Building a plan takes time — plan and resource accordingly

Building plan networks is complex due to plan variation in maturity, markets, offerings, strategies, operations and results

Make-versus-buy decisions drive partnership selections: To offer plans in their communities, provider organizations must decide what they will do and what they need partners to do

Most provider-partnered health plans will find ***regional network models more feasible***, whether as an endpoint or as a step toward a national network

Introduction

Caregivers and care delivery organizations face unprecedented change, the breadth and pace of which have only increased since the pandemic. Familiar challenges (workforce shortages, regulatory burdens and reimbursement disputes) worsen while new challenges (supply chain, public perception) emerge. They threaten the survival of current health care delivery models built mainly on fee-for service reimbursement. The AHA has estimated that hospitals lost billions since the onset of the COVID-19 pandemic. Many hospitals at the brink prior to the pandemic now struggle to remain open. The financial model must change.

Yet while providers and insurers have long explored approaches to improving clinical outcomes through value-based care delivery and payment — that is, through providers taking on greater financial responsibility for the total cost of care and outcomes for a defined population — barely more than a third of U.S. health care payments flow through such alternative payment models today, and nearly all of these are tied to shared savings/losses models built atop fee-for-service systems rather than population-based payments or capitation.

Transactional care that does not align incentives and coordinate delivery is suboptimal. It can fracture the patient's treatment and fail to address underlying needs. It can prove too costly for the patient even as it does not cover the costs of the caregiver. It can increase administrative burden for all parties. Moreover, as the pandemic demonstrated, volatility in volume can make the traditional fee-for-service model unstable. To achieve a more sustainable model for health care, there must be greater commitment to and adoption of value-based care.

Following an October 2020 session of the Executive Committee of the AHA Board of Trustees, the Board formed two task forces — one to explore primary care capitation and one to explore provider networks — in a multipronged approach to improve care and make it more affordable, accessible, and equitable for all, and to ensure hospitals and health systems remain financially viable in the future. Though the task forces would explore different approaches, they shared a desire to free providers to deliver the best mix of services for their patients instead of relying on insurers to determine how their time would be spent.

The resources in the system need to be deployed much differently to deliver good care that all can access and afford. Provider organizations that run their own health plans have long known the value they bring in knitting the care delivery system with the payment system. Yet these plans struggle with scale. Many are successful in their local markets and need help offering a national product. Many compete with national carriers that have different measures of success and different incentives to achieve it. Additionally, many lack value-based contracts with their network providers that could yield greater alignment of incentives and coordination of care.

Janice Nevin, M.D., MPH, president and CEO of ChristianaCare, chaired the task force to explore how building networks of provider health plans could achieve greater scale and impact. Serving on the task force were 18 health care executives from AHA member and allied organizations. The task force held its first meeting in April 2021 with the charge to consider how AHA member organizations could collaborate to provide superior patient care and an enhanced patient experience, and to identify suitable options for members accounting for their range of missions, capabilities and experience with risk-based arrangements.

Charged to explore a national provider network concept, the task force — in its first session and with subsequent confirmation from the AHA Regional Policy Boards — widened its focus to all networks of provider-partnered health plans. Local and regional networks are sustainable models that often see provider organizations partner with non-provider organizations, including third-party insurers, to operate and grow. The task force considered provider organizations that have their own plans, intend to launch plans, or prefer to work with others' plans. While some provider organizations may not be ready to participate in networks of plans, the task force addressed their need for information to inform future decision-making and planning.

Provider-partnered health plans offer hospitals and health systems the opportunity for a more direct experience with patients and plan sponsors that benefits access, decision-making, coordination, delivery, social and environmental considerations, and costs. The core work of the task force is to identify what is needed to achieve these benefits via networks of provider-partnered health plans that contract with employers and government entities to meet the needs of their enrollees. Specifically, the task force set out to:

1. ***Define the challenges*** that networks of provider-partnered health plans can and should address
2. ***Identify the accomplishments***, findings and failures of prior similar efforts
3. ***Address the expectations*** of stakeholders, including clinicians, provider organizations, plan sponsors, consumers/patients, governmental agencies, insurers, investors, etc.
4. ***Assess the SWOT*** — strengths, weaknesses, opportunities, threats — and the partners needed to compensate for what is lacking or at risk
5. ***Illustrate representative models*** and pathways for provider organizations ready to explore or participate in them
6. ***Summarize learnings and recommendations*** for the AHA Board of Trustees in January 2022 for deliberation and action

To achieve these goals, the task force formed three subgroups that worked in parallel, meeting in between the sessions of the full task force. The subgroups focused on Vision/Value, Product, and Partnerships, respectively. Task Force members provided their own experiences and heard from other experts in the field. This document includes feedback from all task force, subgroup, and AHA Regional Policy Board meetings.

Fundamentals

Who are the stakeholders?

- ***Provider organizations*** are the hospitals and health systems delivering care to their communities
- ***Purchasers*** are the employers, state and federal governments, and other plan sponsors making health insurance options available to their enrollees
- ***Enrollees*** are the consumers in a community covered by insurance offered by their employers or plan sponsors, and patients of the provider organizations serving the community
- ***Third-party insurers*** are the national and regional insurance companies unaffiliated with provider organizations

What is a provider-partnered health plan?

Health plans sponsored by provider organizations are not new. For nearly as long as there have been provider organizations, there have been some owning, leading and operating plans. They take many forms — from the highly integrated models of Kaiser Permanente and UPMC, to the joint ventures of regional insurers and health systems, to the employee health plans offered by hundreds of hospitals across the U.S.

The term "provider-partnered health plan" denotes a health plan that a provider organization partners with others — whether insurers or provider organizations — to offer. This term captures the breadth of how provider organizations, now and in the future, can offer health plans to their communities that provide a distinctly different approach than third-party insurers on their own can do.

Why are provider-partnered health plan networks needed?

Providers and insurers should share goals for patient care and community health. However, the increasing concentration of commercial health insurance markets creates less incentive for insurers to cooperate with providers. According to the American Medical Association, nearly half the country's metropolitan areas have an insurer that controls at least half of the market, and nearly 90% have an insurer that controls at least a third of the market. As the consolidation of third-party insurers continues, providers increasingly need to develop a strategy that allows them to stay competitive.

The largest third-party health plans rely largely on fee-for-service models that create zero-sum games, and increasingly use aggressive tactics, such as prior authorization, that inhibit patients from getting the care they need. Consolidation not only makes it easier for plans to wield such tactics, it adds coverage costs, reduces access to care, and increases the burdens patients and providers must surmount.

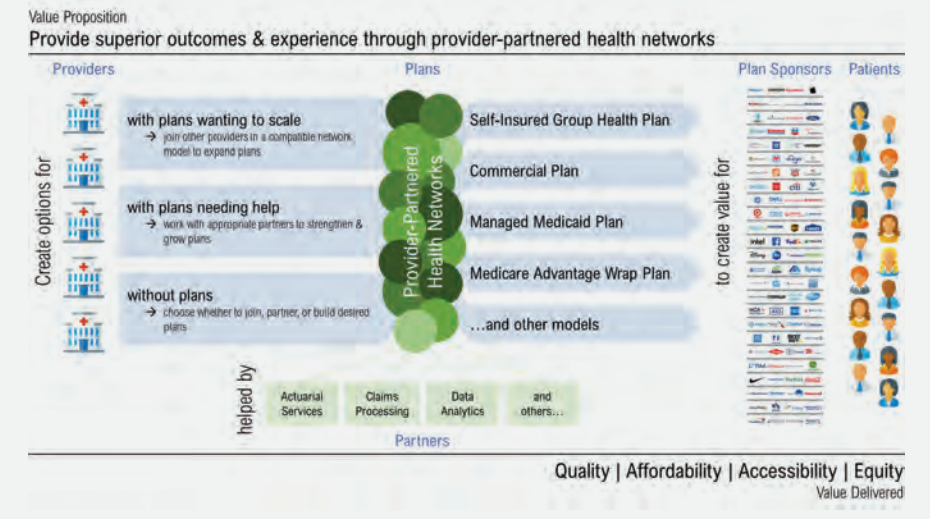
Alternatively, when providers partner with one another and with insurers to offer health plans aligned to value-based care and payments, they can both achieve greater cooperation and greater long-term financial sustainability. Patients benefit from care that is centered to their needs, that coordinates their caregivers, and incents for the outcomes they achieve versus the services they receive.

Table 1

Today, few of these plans exist. Fewer still have the scale to serve more than a local market. It takes considerable investment to overhaul
a long-standing fee-for-service system to prepare the people, processes, technology and culture to succeed with value-based payments. It is a classic "jumping the S-curve" situation in which the return on investment comes after the transition (see Table 1).

Hospitals and health systems that see value-based care as their future and launch or participate in provider-partnered health plans can attain scale to allow their plans to thrive in their markets, network with other plans for greater impact across broader geographies, accelerate the field's journey toward value-based care, and ultimately reduce the total cost of care in the U.S.

Table 2



What do networks look like?

The following illustrates the value proposition and expectation of provider-partnered health plan networks along different pathways providers may take according to their strategies. Early on, the task force developed this to account for the various stakeholders, aims and approaches that a network may represent (see Table 2).

At the top-left, the illustration begins with a value proposition compelling to the stakeholders for the network to grow and thrive in the market. As patients, individuals expect good care outcomes. As consumers, individuals expect good care experiences. Individuals also want care they can access and afford. Plan sponsors have related expectations for the quality and affordability of care.

To meet these expectations, most networks will need partners. The types of partners and they roles they play will vary. Some provider organizations may partner with an insurer to handle a wide array of activities. Some may partner with vendors for specific services only. Some may choose to work with new entrants such as Oscar and Bright to be more nimble or flexible in bringing specific plan models into their markets.

In choosing their partners, provider organizations must recognize that their preexisting local market networks — needed to offer complete coverage in their immediate communities of care — are themselves not enough to achieve the "network of networks" necessary to span geographies and create the scale that will attract large plan sponsors.

What can networks accomplish?

These considerations inform the decisions reflected in the previous illustration. A provider organization must have a good sense of which path, which model, which partners, and what value propositions it needs before acting. Otherwise, the organization risks taking a path that will not succeed.

Though the value of provider-partnered health plan networks will vary somewhat for each stakeholder and within each network, there are propositions that consistently hold firm.

For providers

- Faster adoption of value-based payment models
- Reduced care delivery fragmentation across the network
- Community resources to address social determinants of health
- Lower cost of care through appropriate utilization and eliminating redundancies
- Greater scale of back-office functions (e.g., billing, marketing, data, analytics)

For patients

- Access to high-quality, affordable care whether home or away
- Convenient access and ease of use

- Person-centered care that treats the whole person: medical, wellness, behavioral health
- Reduced care delivery fragmentation across the network
- Universal access to health records

For plan sponsors

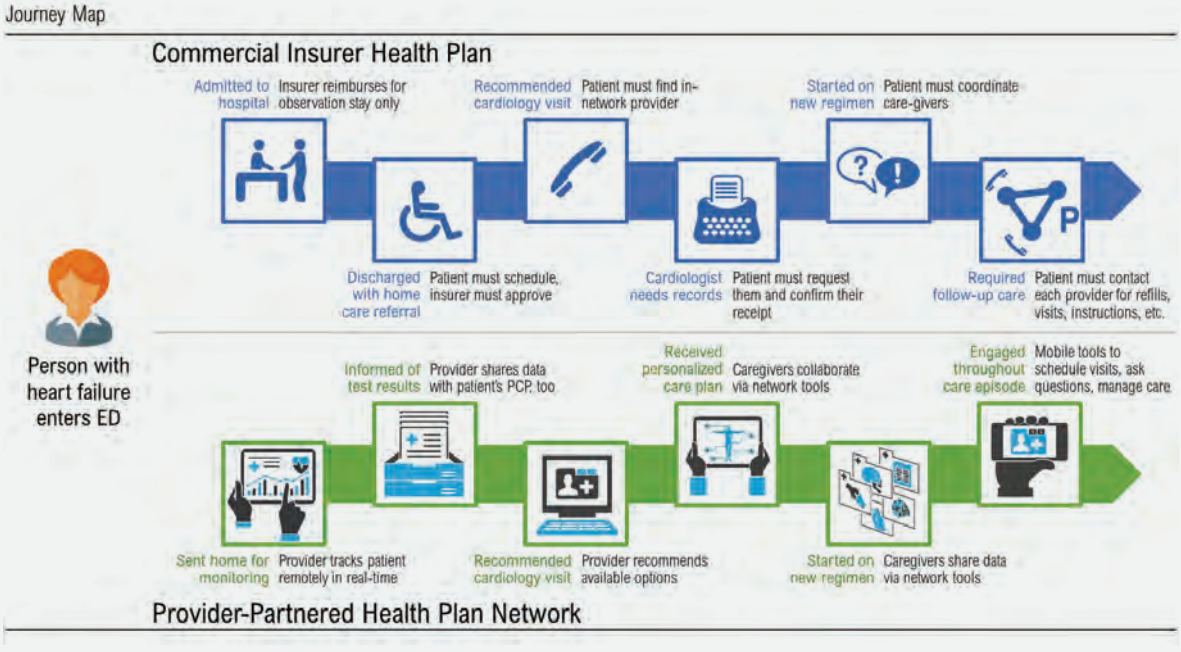
- Flattened cost curve through coordinated, integrated, high-value care
- Benefit plans that are affordable and incent healthy behaviors
- Community resources to address social determinants of health
- Aligned incentives with providers and patients to achieve optimal care experiences
- Improved workforce productivity through better population health

For partners

- Broader market reach without needing all the components to go it alone
- Testing multiple models before committing to any one
- More data to inform best outcomes, models and programs of care across a broader set of experience
- Addressing unmet needs in local communities
- Alternatives to ceding the market to third-party insurers
- Extend competencies and capacities to others as a business line

If the provider organization achieves improvements only for itself and not for its consumers and customers, it will compete with third-party insurers at a disadvantage. Third-party insurers wield bigger networks, deeper discounts and greater economies of scale. Yet if the provider organization can deliver a strong value proposition for patients and plan sponsors that improve the experience of care and lower the cost of care, the provider can compete effectively.

Table 3



Consider the difference in the following illustration where a provider organization offers a network plan that improves care outcomes and the care experience while lowering costs. The difference is stark. Even if the value proposition is a longer-term aspiration for a provider that is immediately looking at network options to drive market share or operating efficiencies or in-network utilization, the proposition must be clear at the outset to itself and its market (see Table 3).

What needs consideration?

No two provider organizations are the same. Each has different internal assets and external conditions to consider. No one network model or pathway, no matter how compelling, can meet the needs of every provider organization. Instead, there are multiple models and many paths an organization can take to participate in a network. When deciding which model and path are best suited to its strategy — or whether to do this — an organization must consider:

- Moving through the diagram, ***which strategies are consistent with the mission and vision*** of the organization?
- Is the organization ***committed to delivering value to plan sponsors and patients*** as well as to its own organization? The answer will influence every other question that follows.
- ***Which insurance products are suitable*** for the enrolled population the organization intends to serve? This is a fundamental consideration for any provider organization, whether it has a plan, wants a plan or wishes to participate in another's plan.
- If the organization has a health plan, ***does it have the size and maturity to expand*** organically into new markets or does it need to partner with plans in other markets to achieve the desired growth?
- ***How competitive is the environment?*** While some provider-partnered plans may be operating successfully against market alternatives, smaller or newer plans may be experiencing growing pains that need to be addressed prior to further expansion.
- If the organization does not have a plan, but wishes to build or buy one, it must ***assess its capacities and competencies honestly***. What does it have? What does it need? With whom can the organization partner to complement what is needed?
- ***What attributes should an organization look for in a partner?*** What does it need to have in common with its partners (e.g., strategies, operating goals, financial incentives) to succeed?
- Is the organization ***prepared to be paid differently***? Provider-partnered health plans must compete on price with other plan options. They will not survive if they are too costly for plan sponsors to offer or for enrollees to use. While they need not be the cheapest market option, provider-partnered health plans must demonstrate value. A value-based care model opens opportunities to price differently — for example, through a capitated model — that aligns incentives so fully as to support a competitive price.
- If the organization does not have a plan, and does not intend to buy or build one, ***does it make sense to participate in another provider's plan***? If so, will the organization bring that plan into its communities? Will the plan carry the brand of the local organization or the parent organization? Will the answer vary by market?

By addressing the value proposition early, a provider organization sparks internal conversations about purpose and success factors that would not arise until later. For example, health equity is emerging as a relevant extension of consideration as provider-partnered health plan networks develop. The impact of health equity on the total cost of care is growing clearer. Addressing unmet needs in under-represented communities — improving access and affordability that, in turn, improves health status — can elevate the U.S. health system's ability to deliver patient-centered care to all.

What role do partners play?

Just as there are many models that can achieve the goal of a provider-partnered health plan network, there are many partnership arrangements that can support them. Few provider organizations have the competencies and capacities to launch and operate a health plan entirely in-house. Even those that can often find value in bringing in partners, who may be more efficient or better known or simply able to take on workflow that the provider would prefer not to handle.

The purpose of any partnerships should be clearly articulated up front. Partnerships may include equity/ownership partners, shared savings partners and/or contracting partners.

Characteristics to consider:

- Unique knowledge of the population served
- Ability to share risk for outcomes and finances
- Commitment to quality, value, access and equity
- Experience in managing community health

Potential partners should be evaluated based on a variety of criteria, including their:

- Competencies and early/mid/late-stage capabilities
- Alignment with the network's culture, mission and values
- Knowledge of the market
- Operational expertise
- Technological capacity
- Experience using data analytics to improve outcomes

Potential partners should be committed to:

- Collecting and using clinical and Race, Ethnicity and Language (REAL) and social determinants of health data
- Long-term contractual relationships to allow time to demonstrate health status improvement
- Transparency of metrics and data sharing
- Motivation to simplify health care for the patient
- Willingness to listen to the population's needs and design solutions with them in mind
- Expertise in helping patients navigate the health care system

Provider organizations need to be committed to:

- Taking and increasing financial risk
- Ongoing physician education and fostering change management
- Conducting a readiness assessment to identify strengths and opportunities

Over time, provider organizations may take more of the operations in-house or put more with third parties depending on where they wish to be on the buy-versus-build continuum.

Input & Insights

Contributing voices and sources

To understand the perspectives of stakeholders beyond provider organizations, the task force invited representatives from the following areas to share their experience and expertise.

- Leaders of provider-partnered health plans
- AHA member-led groups addressing insurer and value-based care issues
- Health care practice leaders from global consultancies
- AHA practice leaders
- Health plan associations: Association for Community Health Plans, America's Health Insurance Plans
- Purchasing groups: National Business Group on Health, National Alliance of Health Care Purchasers, Purchaser Business Group on Health
- New market entrants partnering and/or competing with provider organizations to offer health plans

The findings and recommendations in this paper benefit greatly from the time, candor and thoughtfulness of these representatives.

Lessons learned

A global health consultant for a large third-party insurer was invited to share his perspective on how health plan sponsors, consumers and insurers can serve as a base of knowledge when considering a national network. The consultant noted that:

- Patients (i.e., the consumers) want to know who holds their health care information (they trust providers above others), what their out-of-pocket costs will be, and how the care experience will be tailored to them.
- Plan sponsors (i.e., the customers) want predictability in cost and a positive experience for enrollees. To satisfy these constituents, providers need to optimize the payment structure they use (fee schedule, bundle, capitation).
- Providers invite increased government scrutiny — and regulation — depending on who benefits financially and how.

A task force member shared the experience of his organization developing a provider network of six New Jersey health systems in 2017. None had a health plan. They collaborated to create a broad provider network for their employees, bidding out the third-party administrator services. Early in its operation, the provider plan network had to address challenges including network adequacy, care coordination and out-of-network care. As the model matures, it will be able to extend contracting with other employers — an important viability factor as employers demand networks wider than those focused on a single metropolitan area provide.

Two large provider-led health plans — one in New England, one in the West — operating for over a decade and competing effectively in their respective markets offered these insights:

- Insurance functions are vital in moving the needle on population health. Insurance models create the resources for care delivery organizations to fulfill the promise of value-based care.
- Beneficiaries must be part of the plan to improve health: increasing prevention, addressing social determinants, and transitioning to lower-intensity care settings will reduce the total cost of care.
- Strong partnerships with physicians — hospital-based and independent — are essential for population health improvements. It takes time to achieve the clinical integration that supports population health.

- Governance is critical. Board members who represent hospitals must be mindful of the plan's interests, versus their individual hospital's interests. It takes time to build that culture.
- The board needs high-level representatives from finance, clinical care and operations who hold the top positions in their organizations to make decisions nimbly.
- The primary care member experience is key to the sustainability of value-based arrangements. Focus on member satisfaction and quality, not financials.
- Maintain strong relationships with policy makers and government officials.
- Stress test whether the connection of the plan to providers resonates with consumers. Market research suggests patients fear they will be restricted to narrow networks if they perceive a plan is tied to a specific health system. Plans' connections to health systems are powerful, however, in leveraging relationships with government officials.
- Competitive rates are important for network stability. [This does not necessarily mean rates must be the same for each market served by a network.]
- Equity comes from focusing on quality measures. It is important to share actionable data to drive quality, especially if patients go out of the local market.
- Not all provider-partnered health plans need to be enormous. With strong partnerships, regional plans in select markets can be effective.
- It is easier to start with Medicare and Medicaid plans because the rates are set. Margins are harder to come by in the commercial lines dominated by large third-party insurers and dictated by self-insured purchasers offering only administrative rates.

Challenges to consider

Those who have previously explored provider network models and decided to launch them — or not — offered the following observations for consideration.

- Choose to cooperate. To offer a viable alternative to the third-party insurers, provider-partnered health plans need to cooperate to elevate the consumer experience of their plans for their markets. To build competitive alternatives, they must overcome "we tried this already" and "this is too hard" concerns. Naysaying can prevent organizations from seeing what is possible.
- Do not underestimate the importance of the platform. Raising it early in the formation process, realizing it is the hardest to understand for and solve for, will be valuable
- Understand that most systems with plans do not have adequate networks and will need to partner — with one another and with third parties — to build them
- Bring independent physicians and physician groups into the conversations early enough to incorporate their concerns and recommendations into the planning
- Decide early on whether and how to integrate behavioral health
- Acknowledge and anticipate the complexity of the regulatory environment upfront, especially when crossing state lines
- Demonstrate the value proposition to physicians (access to data, care coordination) so they can sell the network to their patients
- Expect difficulty winning contracts from large employers and other plan sponsors due to skepticism of the network concept. The value proposition must be clear and compelling for both the plan sponsor and its enrollees.

- Accept that these plans will not survive if they do not achieve critical mass. Larger members of task force are seeking options whereby if a few more health systems comparable to their own size partner together, then take collective plans and link affiliations, this may allow for achievement of enrollment that is sustainable. This outcome is compelling for plan sponsors and allows for delivery of core values identified in the network proposition: quality, affordability, accessibility, and equity, while creating the essence of that new partner-provided system's competitive differentiation.
- Anticipate the impact on existing relationships — including contracts — with third-party insurers of launching or participating in a provider-partnered health plan network.

The task force noted the importance of data not only in sustaining networks but in improving care delivery. Simply put, better data leads to better care. Caregivers with a more holistic view of individuals are better able to address their needs wholly. Likewise, caregivers are often in the best position to know where problems lie and how to resolve them. Access to all the data (e.g., eligibility, claims, medical records, etc.) is a strategic advantage. At scale, provider-partnered health plan networks can have a significant impact on the ability of provider organizations to share data in ways that create more targeted solutions.

Conclusion

By setting the stage for what provider-partner health plan networks are, why they are needed, and the many forms they can take, this paper is meant to encourage provider organizations to consider the future of how they will not only deliver care but also ensure healthy communities where all individuals achieve their highest potential for health. Plan networks are not easy nor are they for every organization. Yet they are a proven strategy for organizations ready to bear risk, ready to move fully from volume to value, and ready for greater control of their futures.

Hospitals and health systems have always evolved their care models in response to changes in their missions, communities, economic conditions and regulatory environments. The vertical integration model of adding health plans to the care delivery model is a compelling path for provider organizations as they address social factors to improve outcomes and manage the health of populations. This is true whether they need to partner with others to deploy the plan or not.

Networks of provider-partnered health plans are a path to increased financial stability for health systems that understand their opportunity and limits. They can accelerate value-based care delivery in ways that go beyond the current CMS accountable care models. At the same time, they can align incentives and operations among provider organizations working together to achieve greater scale and integration faster than they might otherwise. The most successful of these plans are those that started with a clear sense of where they wanted to go, why they wanted to go there and who could help them get there.

This paper covers only a portion of the possibilities of provider-partnered health plan networks. In producing it, the task force challenges hospitals and health systems to consider the potential of plan networks for their own organizations following a path supported by good partners, good principles and good products.

Questions for your organization to consider:

- Do vertically integrated models of care make sense for your organization?
- Is your organization ready to take on more clinical or financial risk?
- Are there suitable organizations with whom you can partner to deliver the care experience your communities and customers desire?
- Is your organization able to share data and committed resourcing that function?

The answers to these questions will lead your organization to a fuller consideration of provider-partnered health plan networks.

Recommendations

Whereas provider-partnered health plans, on their own and connected in networks, can achieve greater financial sustainability for provider organizations by accelerating adoption of value-based care, the task force offers the following recommendations.

Advocacy

1. Discuss at the board-level the tensions between fee-for-service and value-based care models and how the AHA can navigate them in its public positions and efforts.
2. Strengthen public policy and advocacy efforts to support and accelerate as appropriate the move to value-based care.
3. Advocate for federal investment to support and accelerate provider-partnered health plan networks as a path to value-based payments.

Thought Leadership

1. Develop a curriculum framework to foster better and more consistent understanding in the field.
2. Use *Seizing the Conversation* to emphasize the value of provider-partnered health plans.
3. Feature in AHA media the efforts of members to create scalable networks.

Knowledge Exchange

1. Offer opportunities at virtual and in-person events for members to trade experiences, showcase best practices and learn from one another.
2. Track member interest and achievement on adopting value-based care through plan network models.
3. Develop a knowledge center on www.aha.org to include a member-facing version of this paper and other resources useful to the field (e.g., case studies, planning & evaluation tools, adoption checklists).

Agent of Change

1. Explore AHA-owned alternatives to national rental network options and other components that providers often need partners to supply.
2. Because a national Medicare Advantage wrap network has such merit, it should be explored and developed by mature PPHPs ready to participate, and not necessarily with the AHA unless there is value in its convening abilities.
3. Share this white paper, without these recommendations, with select health plan and purchaser associations for their reactions. These groups will see the white paper once it is made available to AHA members, so it would be good to understand and prepare for their reactions in advance.

Appendix: Scenarios

There are many plan models suitable for provider networks. There is no one model that makes sense for all organizations. In this section, four model scenarios are presented. Each describes a different approach that a provider organization could take to offer plans in its communities and to network with other organizations. The four differ in terms of value proposition, partnership needs and other considerations. This is not meant to suggest there are only four models that can work. Instead, the four are composite case studies of some of the many models operating or under consideration in the field. They are meant to be journey maps outlining the essential components needed.

As noted in the Partnerships section under guiding principles, the provider-partnered health plans that thrive also adhere to certain principles:

- Offer competitive prices and/or value to the market
- Achieve sustainable financial outcomes that others do as a health plan *and* as a care delivery organization
- Deliver the quality outcomes that other options in the market do
- Take on risk *and* the structural changes necessary to manage it
- Commit fully to cooperation, collaboration and partnership

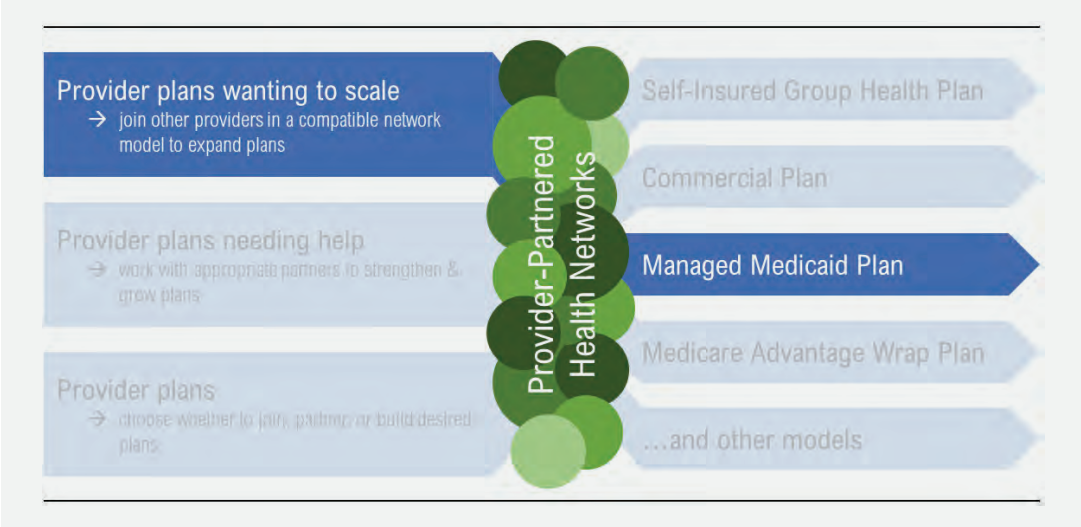
These principles are exemplified in the scenarios. Prospective network partners must address their needs and strategies and alignment in their early-stage planning as these will determine the downstream dynamics of their partnership, their plan offerings, and their impact on the populations they serve.

Target Populations

The commitment to cost, quality, access, coordination of care and equity is consistent for each population served in the scenarios:

- **Scenario 1:** Medicaid beneficiaries whose health status could be improved by a commitment to address social determinants of health
- **Scenario 2:** Medicare Advantage beneficiaries, many of whom travel or live part time outside their home base
- **Scenario 3:** Employees of hospitals and health systems in self-insured plans who prefer a broader geography of in-network coverage options
- **Scenario 4:** National/regional employers who seek broader in-network coverage for beneficiaries and their dependents, especially as working remotely has accelerated

Scenario 1: Managed Medicaid Plan



Situation: Providers in the state come together to improve care for underserved individuals → partner with one other to offer a managed Medicaid plan.

Overview: Hospitals and health systems in a rural Western state recognize the challenges that the current Medicaid program has in providing adequate coverage to enrollees and adequate payment to Medicaid providers. They agree to design a managed Medicaid plan to decrease the number of uninsured, address social determinants of health, reduce care fragmentation and advance health equity through a value-based care model that utilizes capitation.

Leadership: The new entity hires leaders with experience in Medicaid contracting and health plan operations.

Strategy

- The new not-for-profit entity signs a long-term contract with the state's Medicaid program
- The contract stipulates data collection, care coordination and outcomes reporting requirements to track the health of beneficiaries over time
- The value-based arrangement rewards overall improvement in population health
- The intent is to focus on the whole person and provide person-centered care (medical, wellness, behavioral health)

Partners

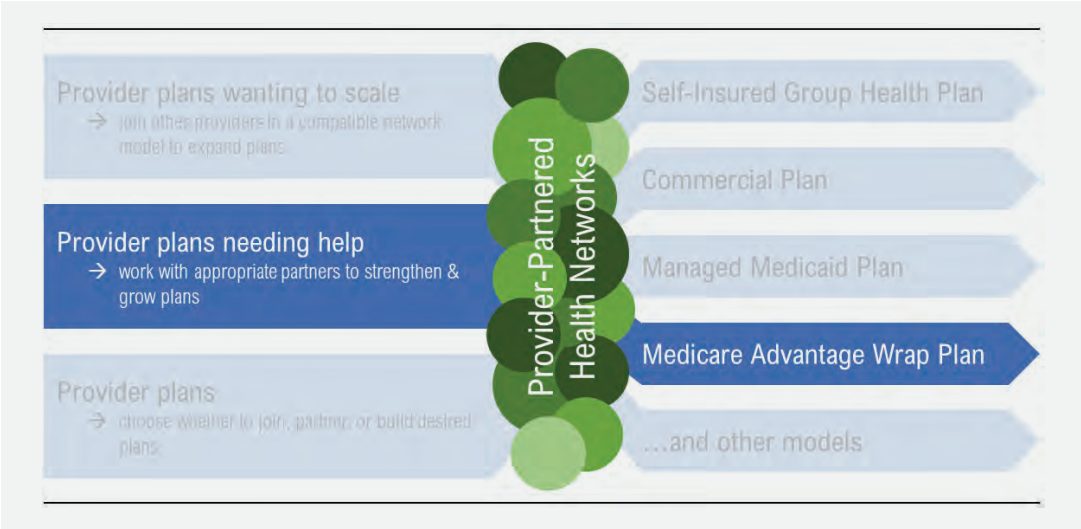
- Contract with an external IT vendor to develop a platform that integrates with the individual health systems' IT platforms
- Contract with third-party service providers for marketing and brokers
- Contract with insurance carriers for billing, network development, care, and utilization management
- Utilize outside consultants on benefit design, population health and data analytics.
- Carve out vision and dental services
- Work with the state Medicaid agency to understand its goals for the new model (e.g., limiting future cost increases, increasing access to care, integrating behavioral health care and medical care)
- Community health organizations and transportation providers are potential partners to deliver services that the health system cannot deliver at all or as effectively
- Health systems provide the inpatient, outpatient, and telemedicine care, as well as prescription drugs

Questions

- In continuing to meet the goal of helping patients get, and stay, healthy, increasing both quality of care and the patient experience, might your organization be moving toward taking on more risk?
- Does your strategic plan have action steps in place to improve health equity? Does interest exist in tapping available mechanisms for such infrastructure to address social determinants of health and move toward a more holistic view of the patient?
- Might potential exist for partnerships (academic medical centers, social service agencies, etc.) to combine efforts, better use data to address inequities and, in doing so, owning full coordination of care, focus on and better service the needs of the patient population? Might a more mission-focused plan allow for removal of barriers to care, and pave the way to stronger quality of care for younger populations?
- Are you seeking to increase the capacity to expand the number of commercial patients' elective procedures and surgeries?

Scenario 2: Medicare Advantage Wrap Plan

The task force identified this as the fastest path among the four scenarios to achieving regional or national scale. Medicare Advantage plans are easier to set up and manage, since prices are set by CMS and rental networks are a straightforward approach to addressing the needs of migratory enrollees.



Situation: Provider has a plan → partners with other providers to offer a Medicare Advantage wrap.

Overview: Three not-for-profit health systems, each with health plans, have a collective footprint in 17 states. They wish to partner to offer Medicare Advantage wrap coverage for their beneficiaries who travel to or live part-time in the service areas of the other systems. The focus is on driving value and affordability with an eye toward total cost of care vs. denial of care. The systems agreed to engage solely with the network product for Medicare Advantage and discontinue arrangements with other insurance products for that service line. Any revenue over expenses is divided among the three systems and invested in enhancing services.

Leadership: The wrap network uses a shared governance model, coordinated by leaders from each of the three systems.

Strategy: The systems form a for-profit corporation to implement the network.

Partners

- This new organization would work to contract with an IT vendor to develop its own platform that integrates data into the systems' existing platforms
- Contract with third-party service providers for marketing and brokers
- Utilize outside consultants on benefit design, population health, analytics
- Identify one system to take the lead for each of these functions (those noted as well as network development/ provider relations, care and utilization management, back-office functions, thereby reducing duplication of services
- Outsource vision and dental services
- Partners to be additionally considered include hospitals and health systems in target markets (or carrier rental network)
- Network reciprocity manager
- Claim adjudication

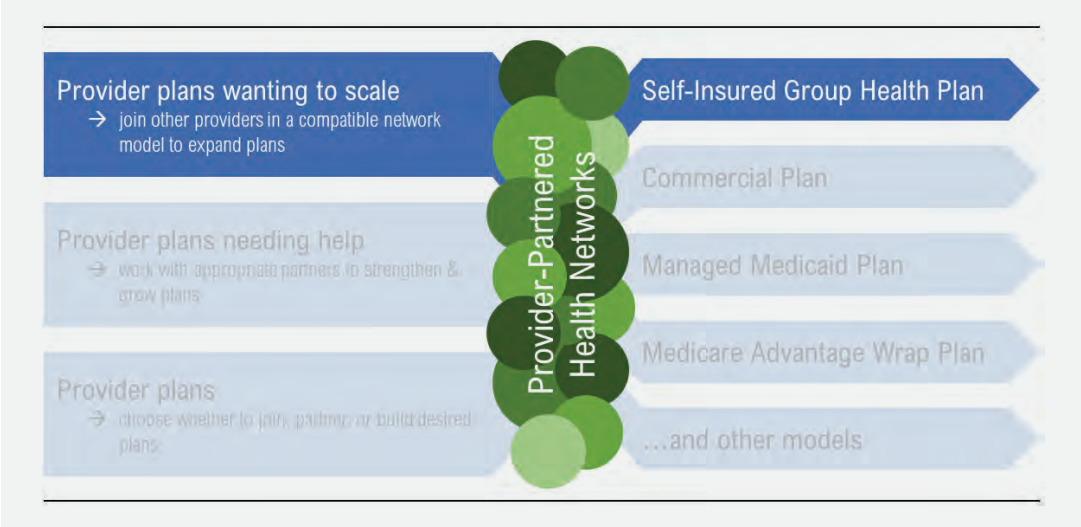
Questions

- Is there expressed interest in joining with other systems to form a for-profit corporation to implement a Medicare Advantaged Wrap Plan?
- Can you envision your organization deriving benefit from a wrap network that uses a shared governance model, coordinated by leaders from each of the multiple systems?
- Would a focus on driving value and affordability, with an eye toward total cost of care vs. denial of care, be an attractive option for a plan that would be offered to those beneficiaries who travel to or live part-time in the service areas of the other systems?

Scenario 3: Self-Insured Group Health Plan

Situation: Provider has a plan → partners with other providers to expand that plan for the commercial market.

Overview: A provider in the Northeast that has a health plan partnered with five other self-insured health systems in the state to provide coverage for their employees and dependents, thereby expanding in-network coverage.



Leadership

- The CEO is an executive from one of the member health systems
- The board of directors comprises the CEOs of each of the health systems
- A community advisory council also makes suggestions for service improvements

Strategy: The entity wishes to expand its commercial offerings to nearby national/regional employers who seek broader in-network coverage for beneficiaries and their dependents, especially as working remotely has accelerated due to the COVID-19 pandemic. Behavioral health and social determinants of health will be integrated into the benefits package.

Partners

- Coordinate IT platform in a way that allows the entity to use the platform created by one of the member health systems
- Ensure that leaders of back-office functions (marketing, brokers, billing, network development/provider relations, care and utilization management, benefit design, population health, data analytics) come from five of the six health systems
- Each system will handle credentialing for its providers, given the complexity and variation in jurisdictions
- Contract with a third-party vendor to outsource benefits related to prescription drugs, dental, vision, and health savings accounts
- Third-party administrator
- Actuarial services
- Reinsurer

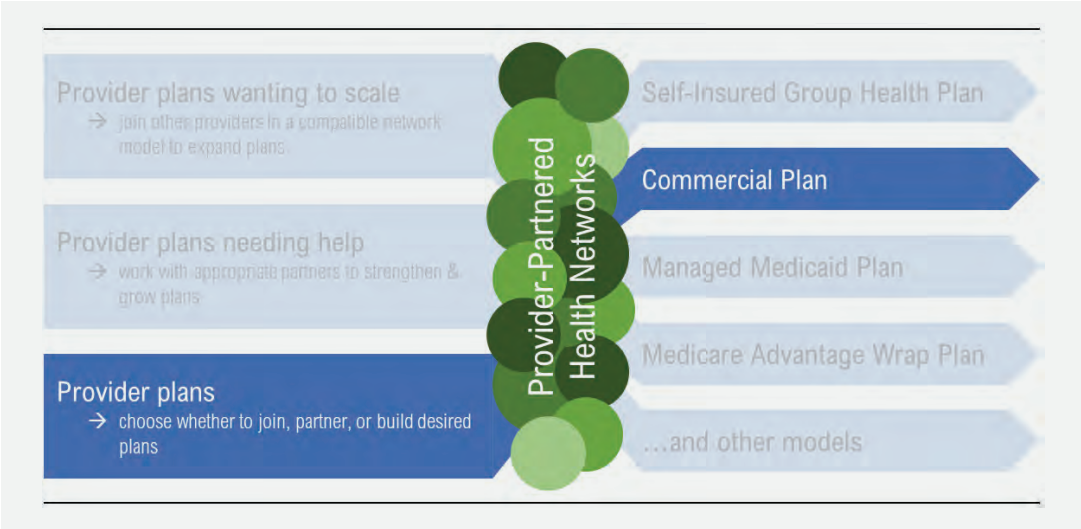
Questions

- Has the COVID-19 pandemic resulted in an increase in remote work by beneficiaries and their dependents?
- Is your organization considering expansion of its commercial offerings to nearby national/regional employers who seek broader in-network coverage for beneficiaries and their dependents?
- If yes to 1 and/or 2, might you also be seeking to have behavioral health and social determinants of health integrated into the benefits package?

Scenario 4: Commercial Plan

Situation: Provider does not have a plan → partners with a provider that has a commercial plan.

Overview: A small health system in the Midwest (System A) does not have a health plan but wishes to affiliate with a health system in the region that has a plan (System B).



Leadership

- System A will have a seat on System B's plan's board of directors
- System B will continue to lead the organization

Strategy

- System A's employees and dependents will be covered by System B's health plan
- System A will also offer Medicare Advantage coverage in its service area through System B's plan, expanding the collective service area for System A
- The intent is to reduce care delivery fragmentation by offering ease of access and integrated care throughout the network

Partners

- With regard to IT platform, System B's system would continue to be utilized
- Continue to use System B's services for back-office functions, including marketing, brokers, billing, network development/provider relations, care and utilization management, benefit design, population health, analytics
- Claims processing platform
- Underwriting
- Marketing (research, B2B, B2C)
- Outsource vision and dental

Questions

- Is there a focused intention to reduce care delivery fragmentation?
- Is the opportunity to offer ease of access and integrated care throughout the network appealing?
- If you are a provider without a health plan, might you wish to affiliate with a health system in the region that does?

Appendix: Functions Checklist

The following is an example of a checklist developed by an actual provider-partnered health plan. It denotes which functions the provider organization is handling versus its partners. It is a useful tool for partners in a plan to adapt and adopt for needs ranging from board awareness to RACI chart development.

Category	Provider?	Partner?	Notes
Administrative Services			
Premium billing & collections		✓	
Explanation of benefits (EOB)		✓	
Data provisioning & other reporting requirements		✓	
Claims review, adjudication & payment		✓	
Financial accounting		✓	
Marketing & communications		✓	
Sales		✓	
Enrollment		✓	
Broker relations/contracts	✓	✓	
Broker payments & reporting		✓	
Member Enrollment/Eligibility			
Ongoing eligibility, membership maintenance, updating & distribution of member lists		✓	
Reconciliation/eligibility file transfer to CIN		✓	
Product Development*			
Go-to-market strategy & positioning	✓	✓	
Pricing/actuarial design	✓	✓	
Benefit design	✓	✓	
Bidding process (for Medicare Advantage)	✓	✓	
Network Management*			
Network development & contracting	✓		
ACO/CIN, APM, credentialing	✓		
Attribution	✓	✓	
Provider/physician engagement	✓		
Providing covered medical services	✓		
Provider termination	✓		

Category	Provider?	Partner?	Notes
Physician access & availability	✓		
Network maintenance	✓		
Provider directory	✓	✓	
Utilization Management*			
Utilization management program		✓	
Medical policy & covered services		✓	
Prospective/prior authorization, concurrent review/ retrospective review of services • Hospital • Outpatient specialty (technical) • Outpatient specialty (professional) • Medical necessity		✓	
Care Management*			
Risk stratification	✓	✓	
Care pathways: identify, assess, establish, implement treatment plans	✓		
Patient engagement & outreach	✓	✓	
Care coordination	✓		
Case management	✓		
Complex case management (MCCs)	✓		
Confirm population-based needs	✓		
Concurrent review of treatment regimen	✓		
Urgent concurrent review of treatment regimen	✓		
Quality Management*			
Quality Improvement Initiatives	✓		
Performance Monitoring	✓		
Remediation & tools for physicians	✓		
NCQA & URAC compliance	✓		
Pharmacy			
Formulary definition*	✓	✓	
Prescription management	✓		
Benefit design	✓		

Category	Provider?	Partner?	Notes
Pharmacy claims		✓	
Pharmacy network development		✓	
Pharmacy discharge planning		✓	
Risk Adjustment*			
Hierarchical condition category (HCC) coding	✓		
Clinical condition documentation	✓		
Member Services/Customer Service			
Benefits communications		✓	
Other communications		✓	
Member appeals/grievances		✓	
Provider Relations			
Ongoing education	✓		
Member eligibility inquiries		✓	
Contact center		✓	
Medical director coordination	✓		
Network Partner Relations			
Continuation of coverage		✓	
Continuation of benefits		✓	
Coordination of benefits		✓	
Downstream agreements		✓	
Reciprocity		✓	
Data Management			
Member & enrollment analytics		✓	
Population health & chronic condition management analytics		✓	
Data governance	✓	✓	
Data access & collaboration across the network	✓	✓	
Corporate Structure			
Establish structure of network entity		✓	
Establish joint ventures and partnerships		✓	

Category	Provider?	Partner?	Notes
Licensure applications		✓	
Risk-based capital funding		✓	
Network adequacy		✓	
Compliance			
General compliance		✓	
Integrity & fraud		✓	
Notifications		✓	
Other		✓	

*** Functions recommended for the provider organization to operationalize and lead**

Appendix: RPB Feedback

Offered here is reaction from AHA Regional Policy Board (RPB) members at meetings in the summer and fall of 2021:

- With the understanding that networks are regional and local based on different models, input led to the consensus that provider-partnered health plan networks are the optimal, more inviting phrasing.
- The value proposition for the networks resonated. Those who provided input noted they could see that plan networks can improve outcome quality and care integration. The plurality also noted the potential to operate more independently of third-party insurers, a sentiment expressed by leaders of small and rural organizations, too.
- Overall input pointed to the sense that it is not too late to consider such a network was brought forth, as the field is still transitioning to value-based care, networks can help, and real progress in care integration is possible. One RPB member shared the experience of managing his son's chronic disease within PLHPs versus a traditional insurance plan, the latter being a nightmare because no one owns responsibility for coordinating care.
- Suggestion to retake the standards was well received. As providers have allowed third-party insurers to define the competitive ground, a need was expressed to take back how concepts are defined (observation stays, reasonable and customary, etc.).
- Building on the past was recommended, with many urging the task force to cull and apply lessons on what worked and what did not from previous efforts to create networks.
- Rural hospitals should be encouraged to not be dissuaded by disinterest, noting that participation being harder for rural hospitals will mean some will be able to take advantage, while most will not.
- A focus on getting the right leaders was noted as most important, as the skills to manage a network of plans are different from the skills to manage a system of providers.

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Marshfield, WI

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July 19th 7:15-8:15am PST

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

Agenda

- Opening Remarks- The John A. Hartford Foundation
  - Rani Snyder
- How to Restore Public Trust & Confidence
- Overview of Age-Friendly Health System Movement
- Importance of Community Partnerships
- Care Across the Continuum Speakers
  - Dr. Kevin Biese
  - Brynn Bowman
- Q&A
- Close Out

Today's Speakers

Marie Cleary-Fishman, MS, MBA

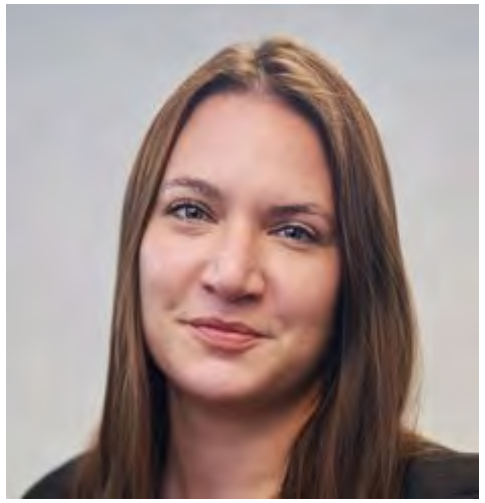
Vice President

Clinical Quality AHA

Kevin Biese, MD, MAT

Geriatric Emergency Department Collaborative Implementation PI,

Chair, Geriatric Emergency Department Accreditation



Brynn Bowman, MPA

Chief Executive Officer,
Center to Advance Palliative Care

The John A. Hartford Foundation

Healthy Aging: Creating Age-Friendly Health Systems

2022 American Hospital Association Leadership Summit

July 19, 2022

Rani Snyder, MPA

Vice President, Program

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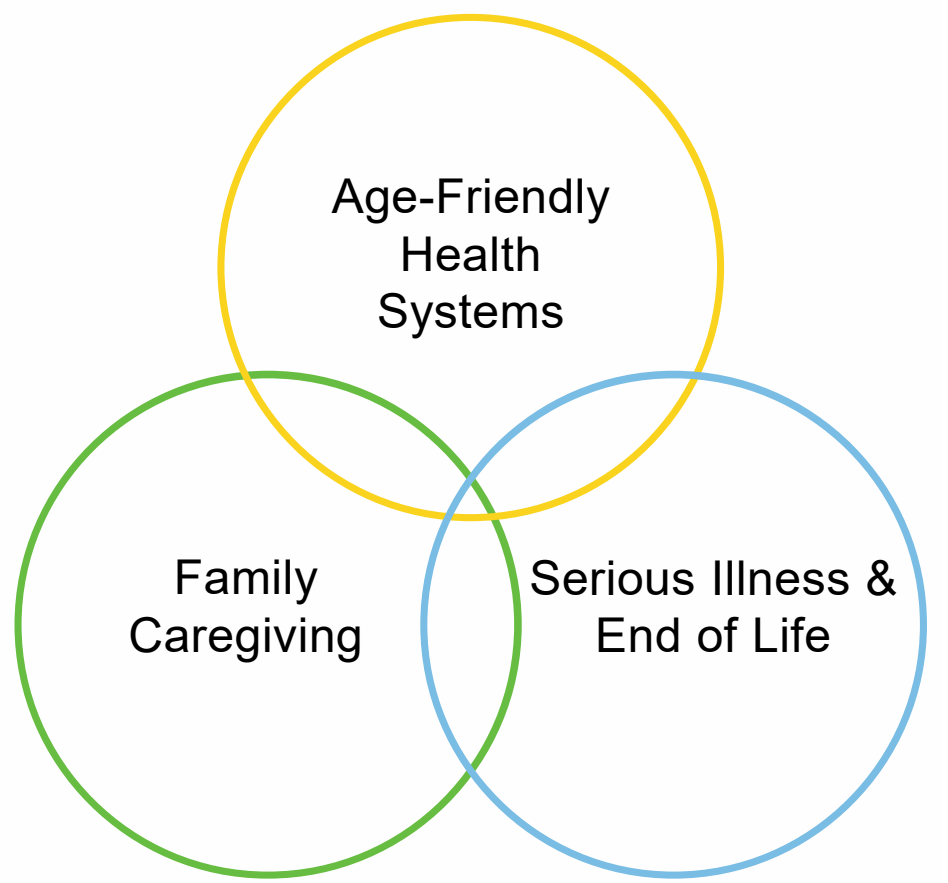

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Fulmer, et al. Moving Toward a Global Age-Friendly Ecosystem, *Journal of the American Geriatrics Society*, July 2020

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The John A. Hartford Foundation

- **Visit** johnahartford.org for information on all programs noted
- **Subscribe** and receive regular updates on resources and tools you can use
- **Share** your ideas with us about how to improve care for older adults through age-friendly care

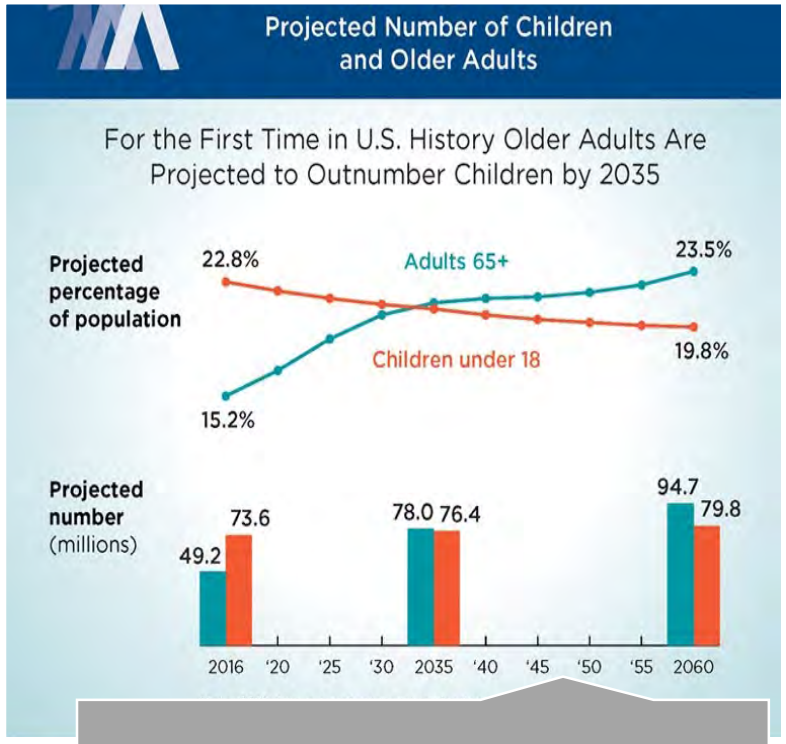
Thank You!

Rami.Snyder@johnahartford.org

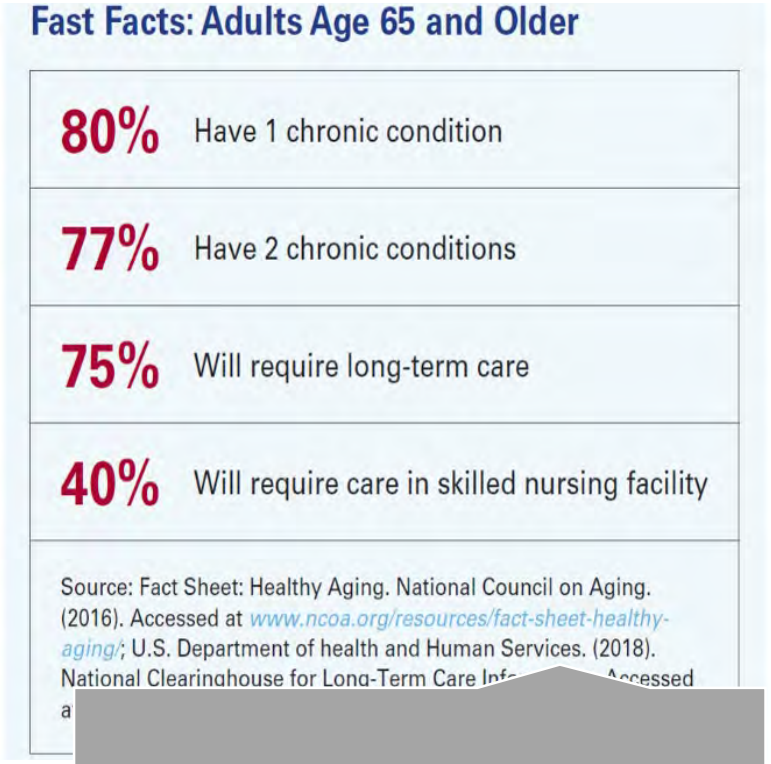
WWW.JOHNAHARTFORD.ORG

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

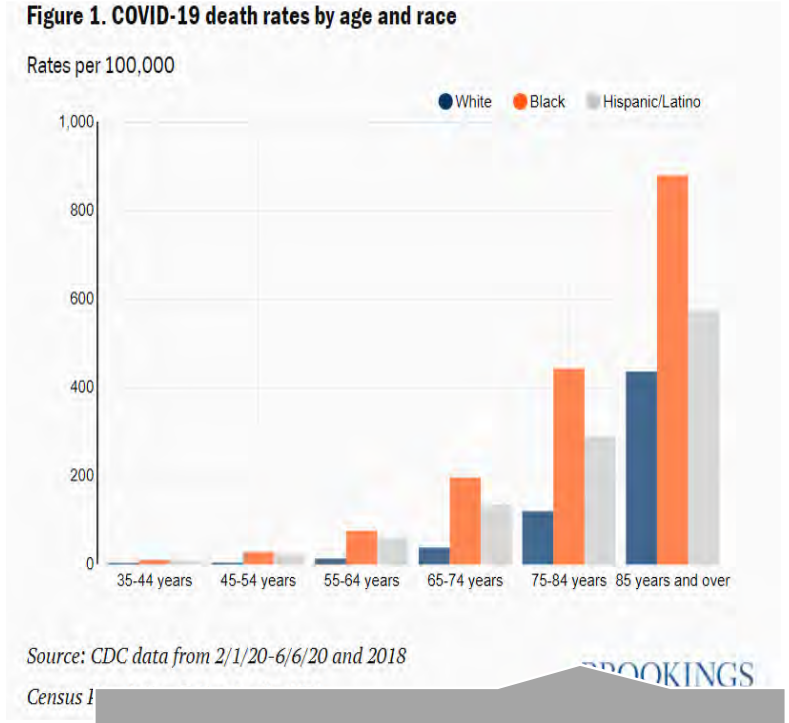
Why Age-Friendly Health Systems?



Demography

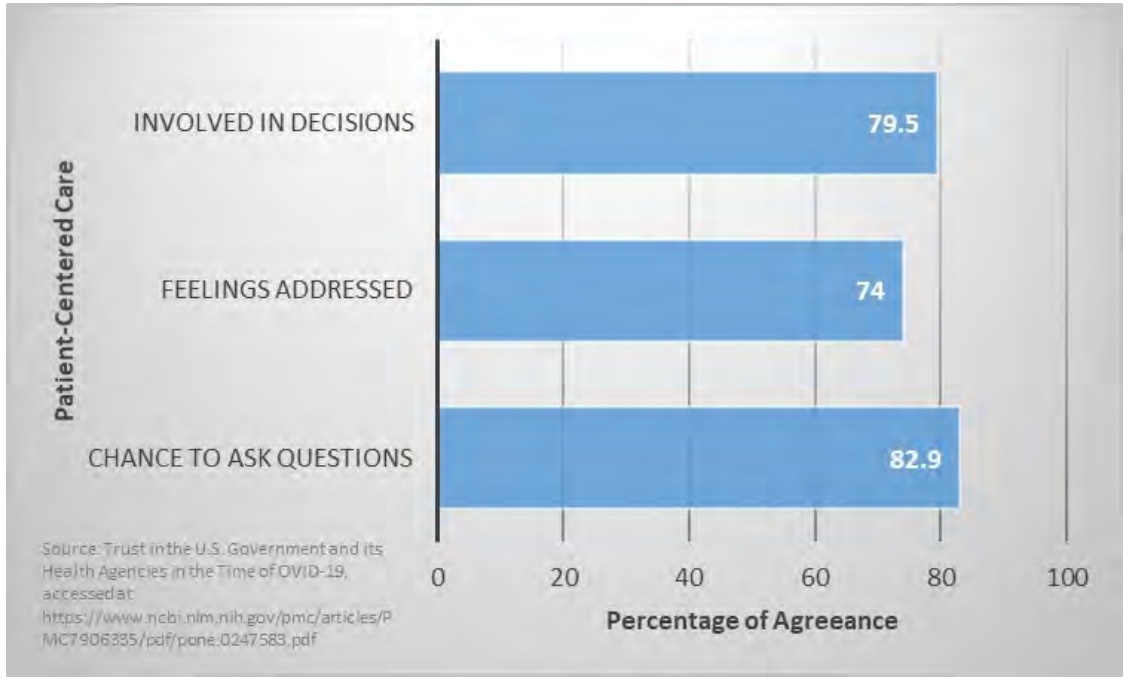


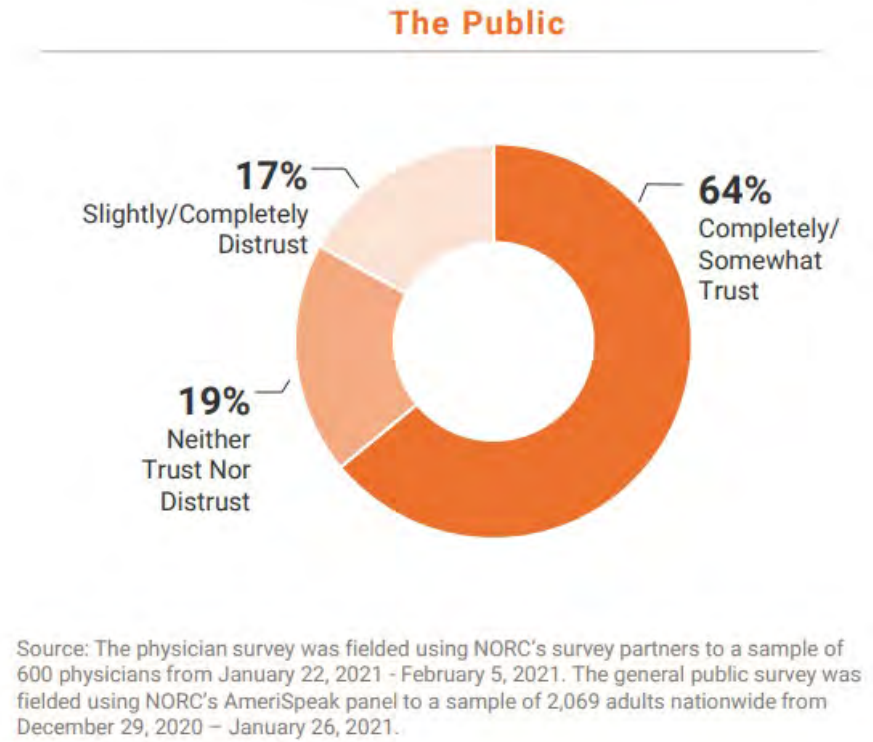
Complexity



Disproportionate Harm

Patient-Centered Care Directly Influences Levels of Public Trust in Healthcare Systems





Source: The physician survey was fielded using NORC's survey partners to a sample of 600 physicians from January 22, 2021 - February 5, 2021. The general public survey was fielded using NORC's AmeriSpeak panel to a sample of 2,069 adults nationwide from December 29, 2020 – January 26, 2021.

2022-2024 AHA/HRET Strategic Plan

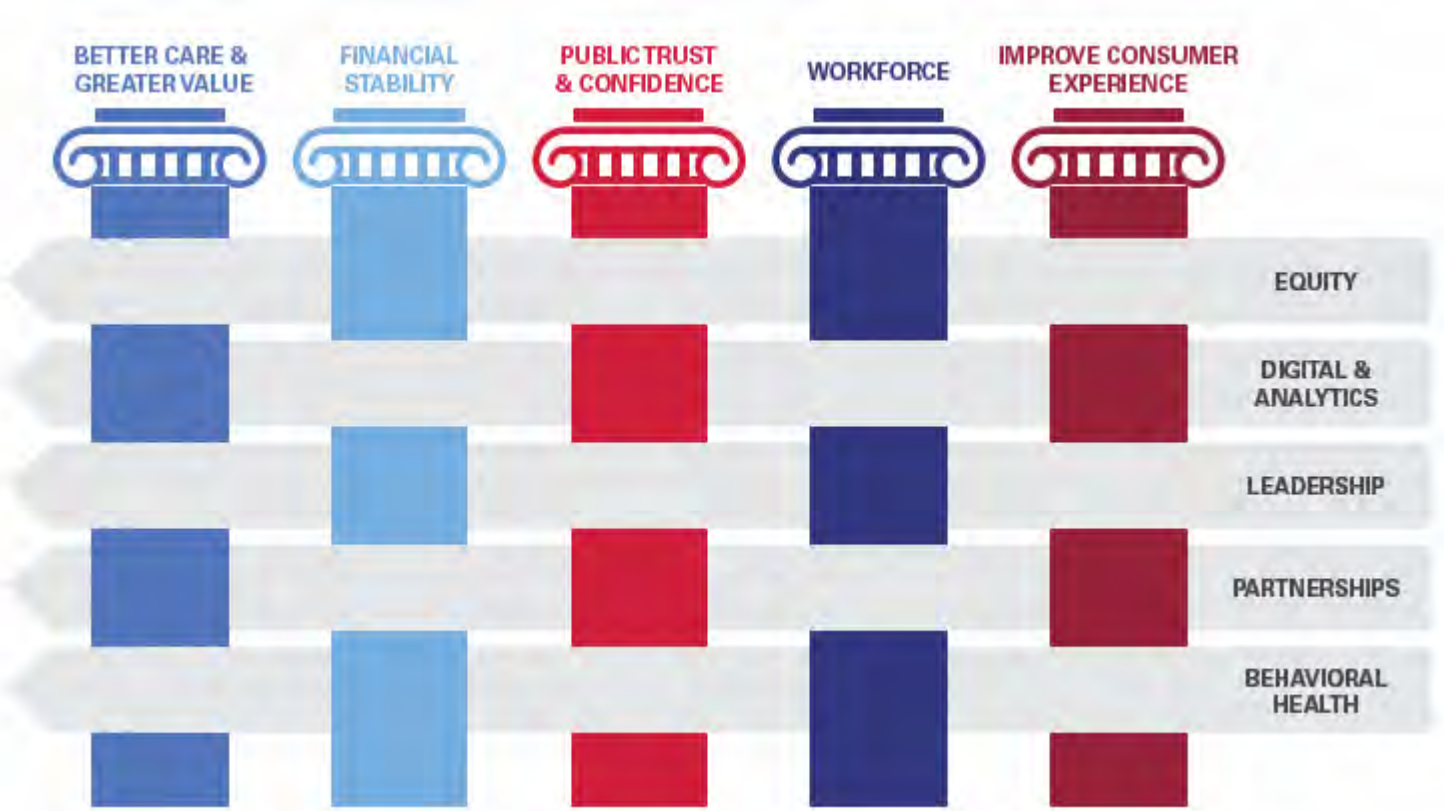
The strategies and priority issues of the AHA are focused on accomplishing the broader goals of:

- ► Provide Better Care and Greater Value
- ► Ensure the Financial Stability of Hospitals and Health Systems
- ► Enhance Public Trust and Confidence in Hospitals and Health Systems
- ► Address Workforce Challenges: Now, Near and Far
- ► Improve the Health Care Consumer Experience

The AHA is the trusted partner of hospitals and health systems and stands ready to work in collaboration to advance health in America. Visit www.aha.org for more.

AHA/HRET Strategic Plan

OUR PILLARS 7 GOALS (2022-2024)



OUR APPROACH

ADVOCACY/ REPRESENTATION	THOUGHT LEADERSHIP	KNOWLEDGE EXCHANGE	AGENT OF CHANGE
Advancing field priorities in Congress, with the Administration, in courts, in media, in public opinion and beyond.	Highlighting thoughts, data, insights and solutions that are new or do not yet have consensus.	Facilitating the exchange of information and best practices in a way participants can understand and apply it.	Supplying tools and information to empower people to enact change in organizations, systems and communities.

Our Partners

Terry Fulmer, PhD, RN
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Amy Berman, BSN, LHD
Senior Program Officer
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IHI

Julie Trocchio, MS,
Senior Director
Community Benefit and Continuing Care, CHA

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

What is Our Goal?

Build a social movement so ***all care*** with older adults is ***age-friendly care***:

- Guided by an essential set of evidence-based practices (4Ms);
- Causes no harms; and
- Is consistent with What Matters to the older adult and their family.

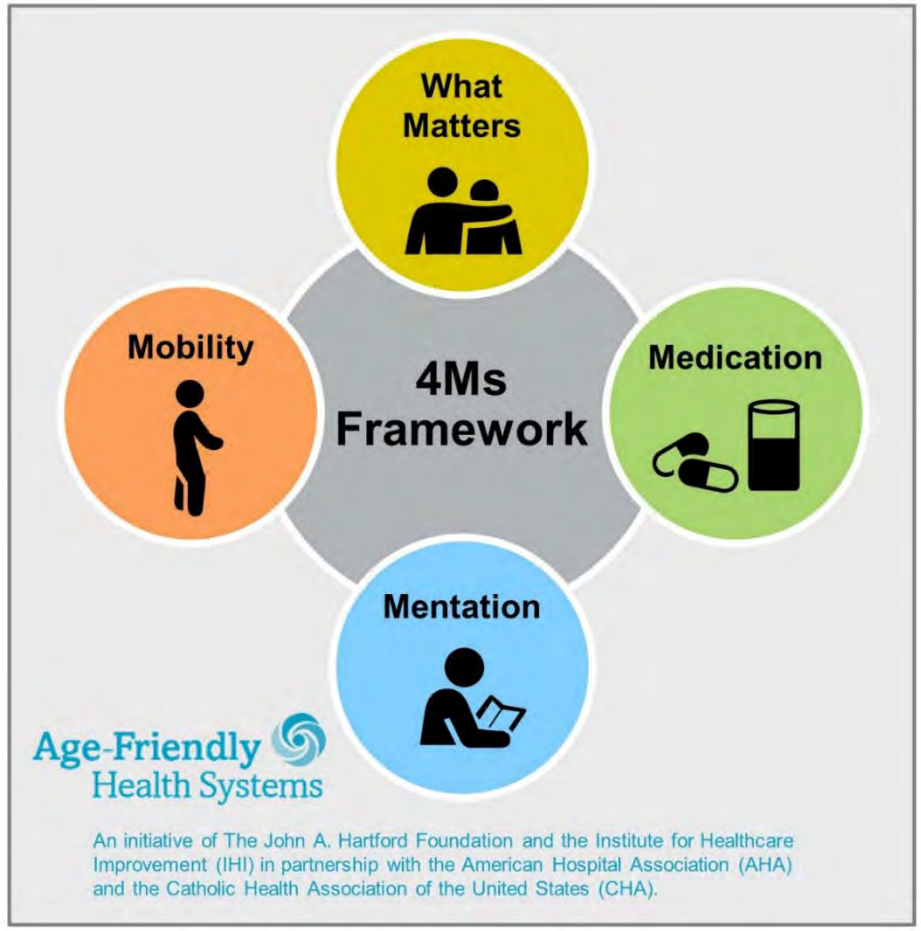
Specific Aims:

✓ By 12/31/20: Reach older adults in 1000 hospitals and practices recognized as Age-Friendly Health Systems

✓ By 6/30/23: Reach older adults in 2500 hospitals and practices, and 100 post acute communities recognized as Age-Friendly Health Systems

What is an Age-Friendly Health System?

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems while increasing effect
- Components are synergistic and reinforce one another



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Age-Friendly Health Systems

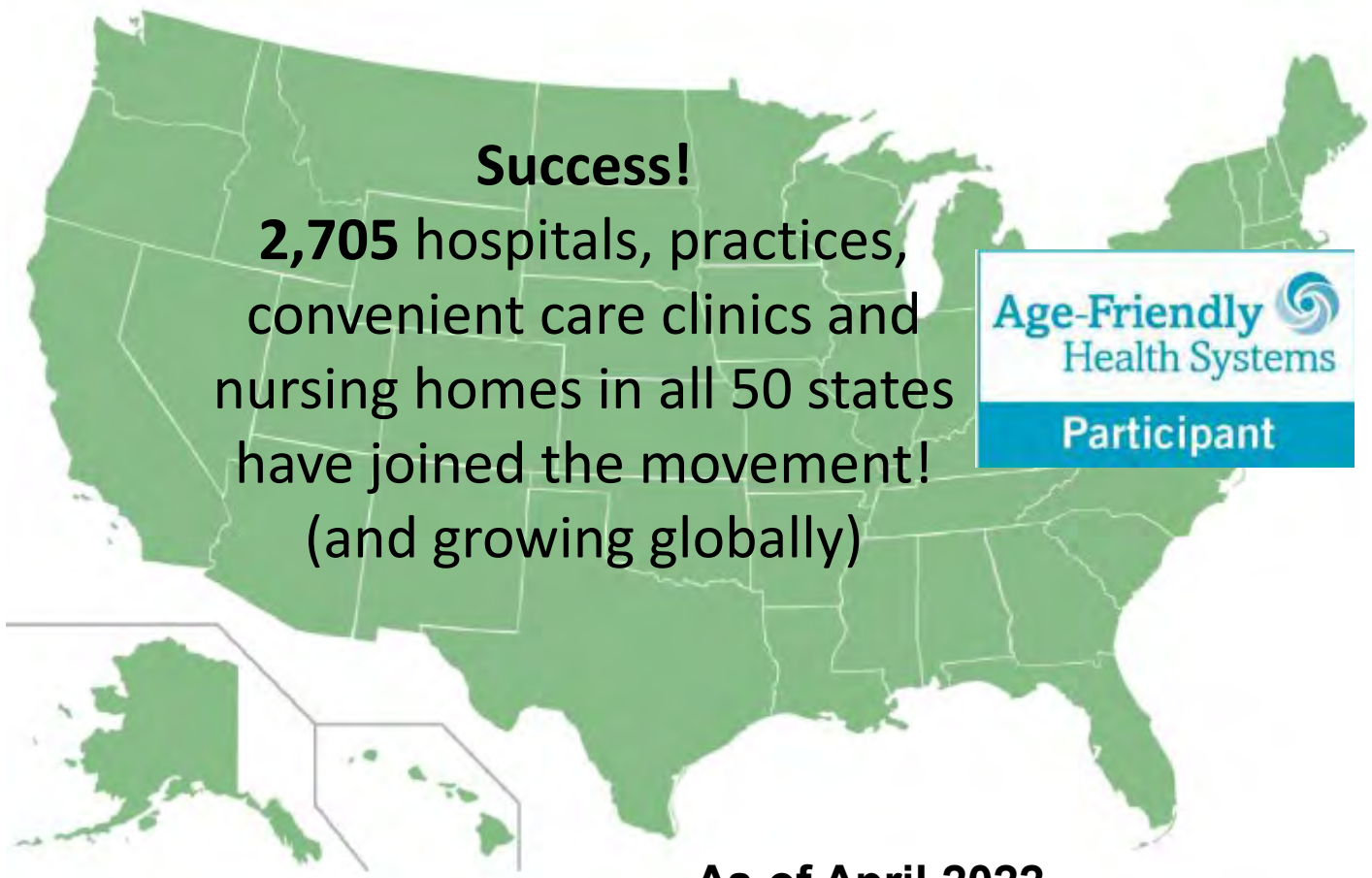
A Goal Met and a Growing Movement!

Goal #1 Achieved: **Spread to 1,000 sites by end of 2020**

Goal Achieved!

Goal #2 Achieved: **Spread to 2,600 sites by June 2023**

Goal Achieved!



As of April 2022

728

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

More than **1,400,000** older adults have been reached with 4Ms care

Age-Friendly Action Communities

In an Action Community, teams from across different organizations come together to accelerate their work of putting the 4Ms into practice. During the 7-month virtual learning community, your team will test the 4Ms Framework and share learnings.

- Multiple sites of care within an organization can join at the same time
- No cost to participate. The cost of participation includes the time teams must allocate to engage in 7 month Action Community activities
- The Action Community testing and learning is designed to occur as part of each person's existing activities and is, therefore, a re-purposing of time

Pioneers

Anne Arundel Medical Center

Ascension

Kaiser Permanente

Providence St. Joseph Health

Trinity Health

Age-Friendly Health Systems Pioneer

Age-Friendly Health Systems

Engage in the AHA Action Community

7 Months

Participate in monthly interactive webinars

- Monthly content calls focused on 4Ms
- Opportunity to share progress and learnings with other teams

In-person meeting

- One in-person or virtual meeting (TBD)

Test Age-Friendly interventions

- Test specific changes in your practice

Share data on a standard set of Age-Friendly measures

- Submit a 4Ms Care Description worksheet to IHI on a standard set of processes to identify opportunities for improvement

Join monthly topical coaching sessions

- Join other teams for measurement and testing support in monthly coaching sessions

Leadership track to support system-level scale up

- Leaders join quarterly C-suite/Board level calls to set-up local conditions for scale up (Hosted by IHI)

Age-Friendly Health System Action Community

Age-Friendly Health Systems

Age-Friendly Health System Recognition

An Age-Friendly Health System…

- **Defines** the 4Ms for its hospital and/or practice

- **Counts** the number of 65+ people whose care includes the 4Ms (reported by each site)

- **Scales** the work and **celebrates** recognition nationally

Age-Friendly Health Systems
Participant

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

Age-Friendly Health Systems

Improve Outcomes - Providence St. Joseph Health

- What Matters conversation guide, convened a patient advisory council, rolled out an outpatient mobility program
- Trained provider champions in 12 primary care clinics through a Geriatric Mini-Fellowship, formed in 2018.
  - 65 and older **twice as likely** to be screened for fall risk and cognitive impairment, were **4 times more likely** to receive fall-risk interventions, and **engaged** in more "what matters" conversations.
  - **3% reduction in high-risk medication** upon seeing a mini fellow, and **2%-7% decrease in hospitalizations** for patients seen at the mini fellow clinics.
- https://oregon.providence.org/forms-and-information/p/providence-selected-for-national-initiative-to-create-new-models-of-care-for-seniors/

Improve Outcomes – Cedars-Sinai Medical Center

- Time to surgery for hip and other serious fractures—meaning the time from arrival in the emergency room until entering the operating room—has declined by **41%.**
- Length of stay in the hospital was cut **11%**, down to four-and-a-half days.
- Program saved **$330,000 in direct costs** its first year, when it served 153 patients.
- Expanding to cover about 300 patients a year.
- Annual savings of about **$1 million** are projected.

Join AHA Action Community 2022-2023

- Join and get your Age-Friendly Recognition. It's FREE
- AHA AFHS Action Community is from September 2022 – April 2023
  - Starts Mid-September with 2 Kick off Calls
  - Starting October
    - Monthly all-team webinars
    - Quarterly Scale-up leaders webinars
    - Sharing testing and learnings on peer to peer calls
    - 1:1 coaching calls
  - Celebration of joining the movement!

- Download AHA's Invitation Guide
- Visit aha.org/agefriendly to learn more
- Email ahaactioncommunity@aha.org with any questions or to set up a 1:1 coaching call.

Enroll Today

Continuum of Care

Community Based Partnerships

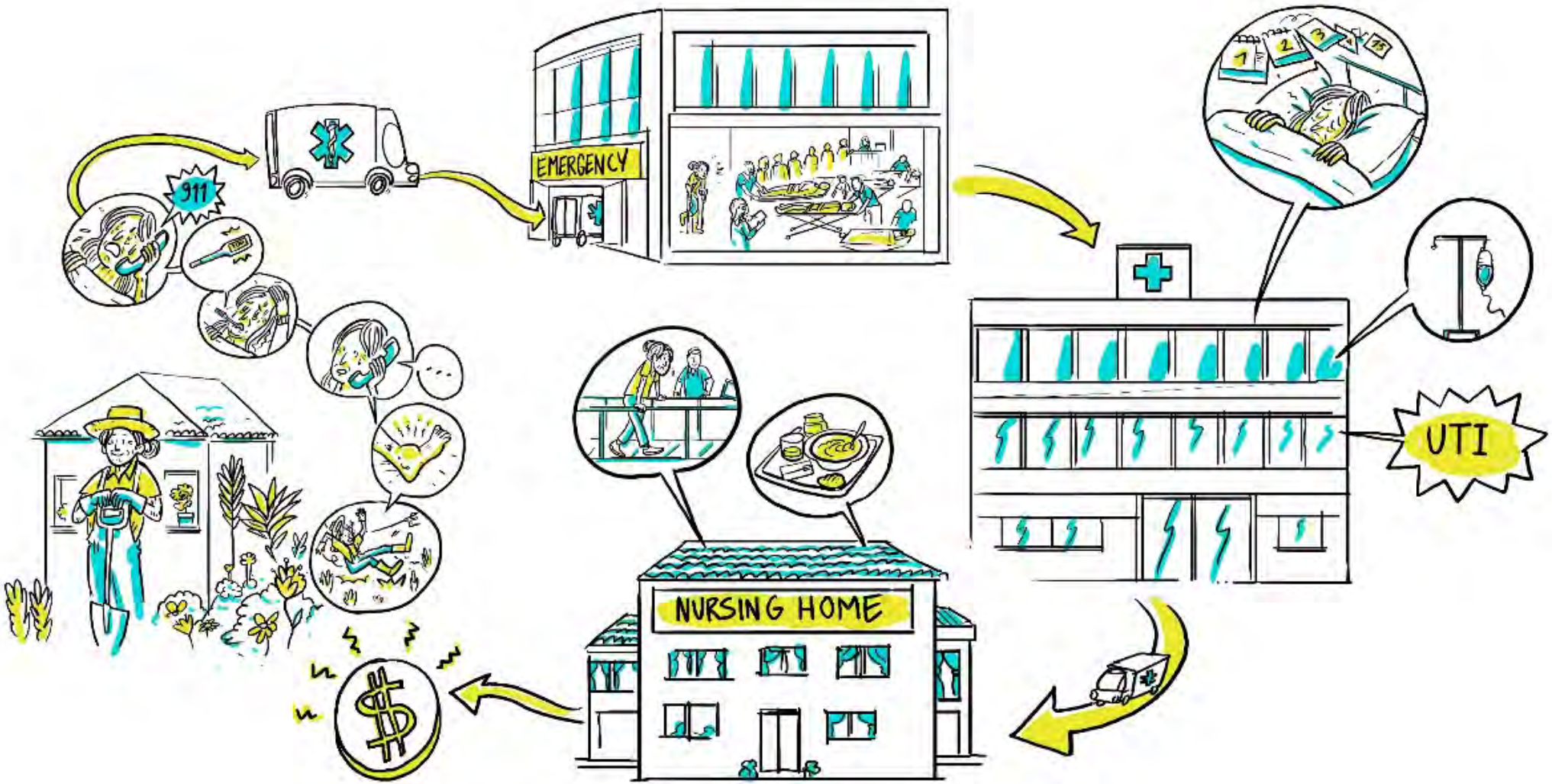
Geriatric EDs: Core capacity to treat an aging population

Kevin Biese
MD, MAT

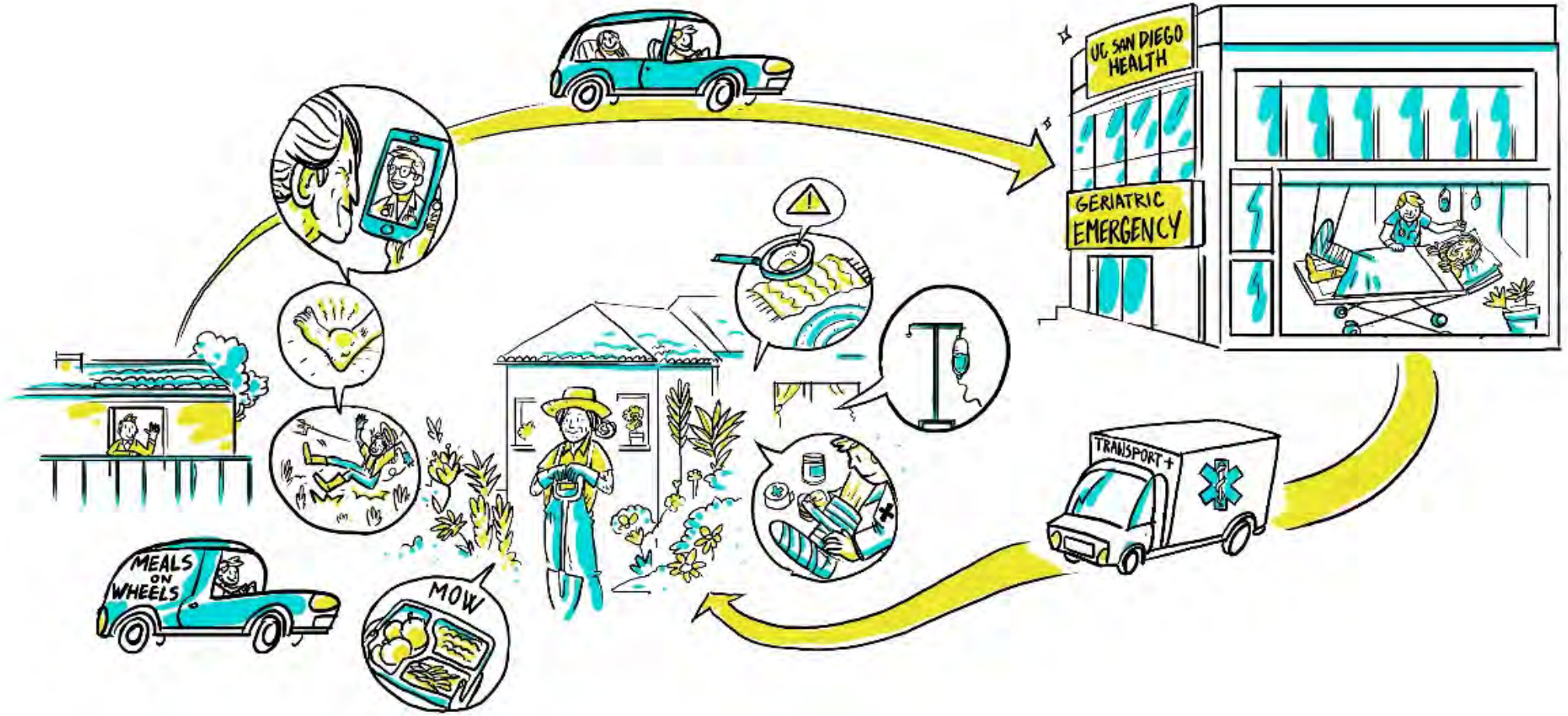
Geriatric Emergency Department Collaborative Implementation PI

Chair, Geriatric Emergency Department Accreditation

GEDC



GEDC



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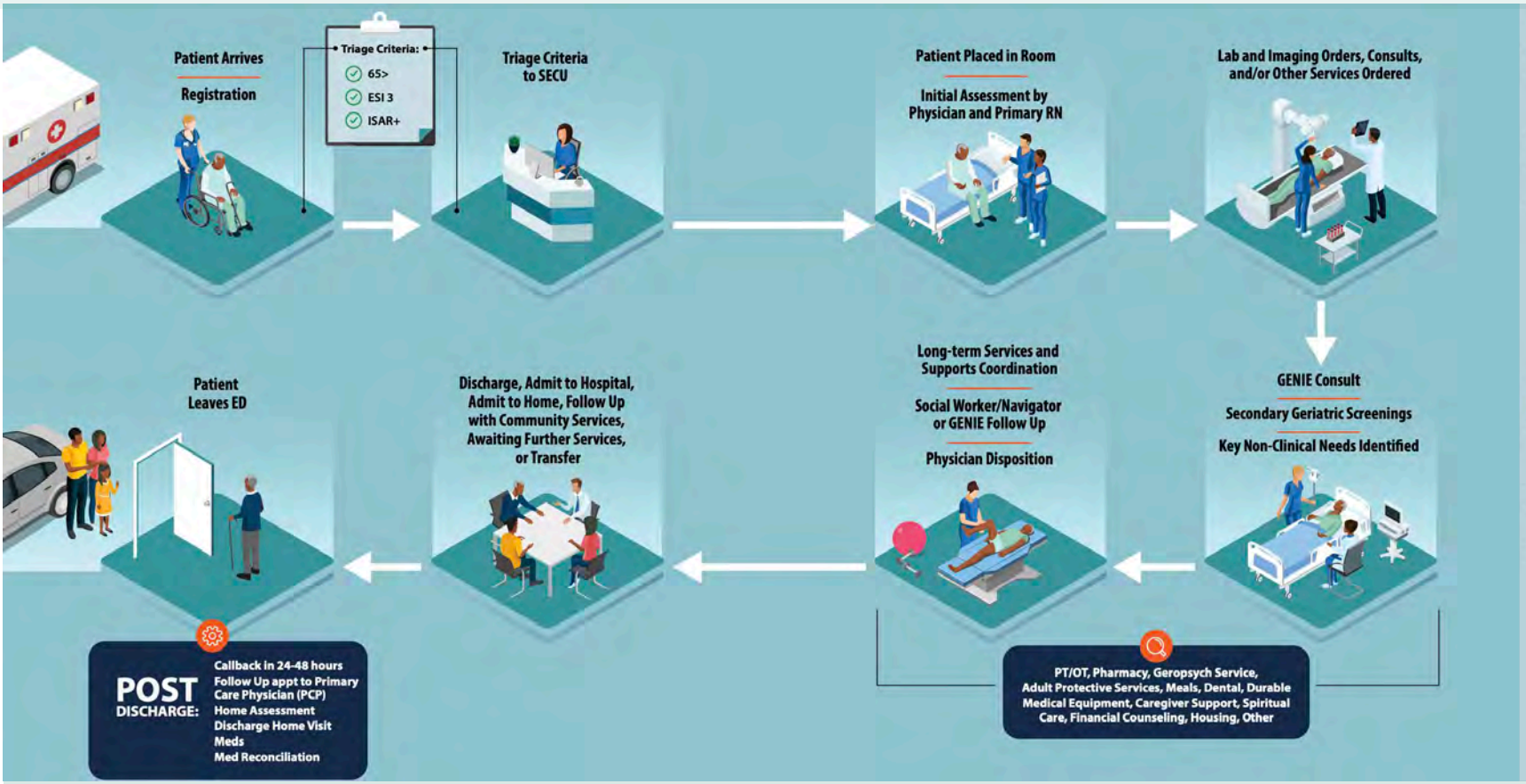
GEDs Provide Standardized and Integrated Care



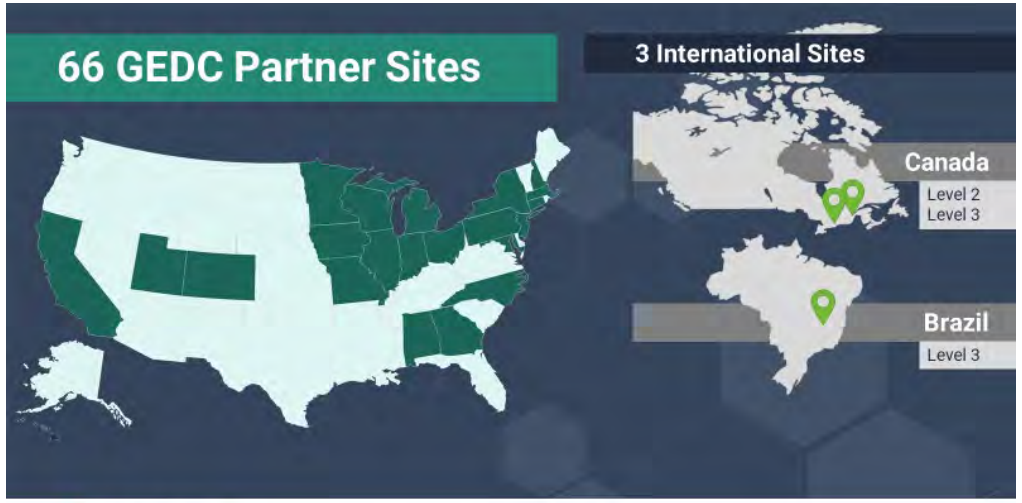
Staff
- Emergency & geriatrics-trained physician
- Geriatric nurse
- Care coordinator
- Geriatric nurse practitioner
- Geriatrician

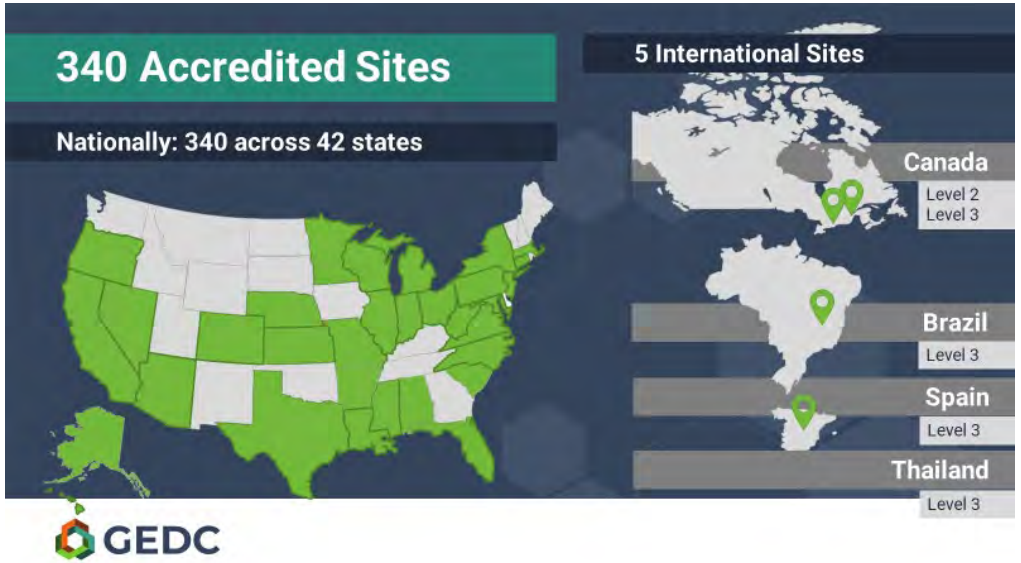
Processes
- Frailty
- Delirium & cognitive decline
- Functional Impairment
- Fall risk
- Social support
- Polypharmacy

Community
- Skilled nursing and assisted living facilities
- Home health
- Primacy Care Physician
- Meals on wheels
- Agencies on aging

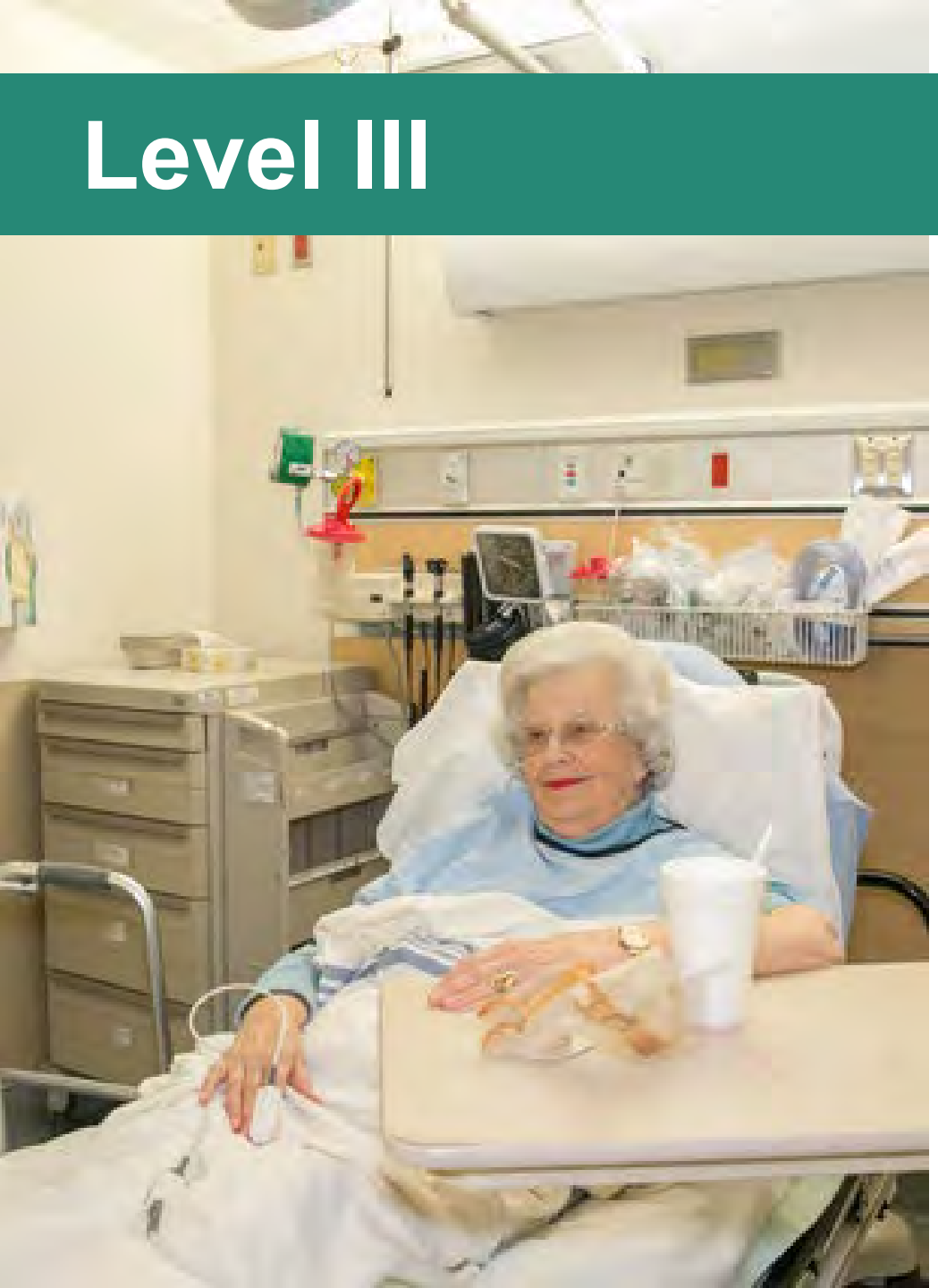
Physical Modifications
- Dedicated, separate space
- Few, dedicated beds at specific times
- No physical space changes

GEDC





Level III



Good geriatric ED care

- At least one MD and one RN with evidence of geriatric focus (champions)
- Evidence of geriatric focused care initiative
- Mobility aids
- Food & drink 24/7

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Level II

Advanced geriatric ED care

- Physician & nurse champions (medical/ nurse director) with focus on geriatric EM
- Geriatric-focused nurse case manager 56 hours/ week
- Geriatric assessment team: 2 of PT, OT, SW or Pharmacy available in ED
- Hospital executive-assigned supervision of and support for geriatric ED resources
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least 10 (of 26) policies and protocols
- QI process for selected policies
- Tracking at least 3 of 11 outcome measures
- Physical supplies and food/drink

Level I

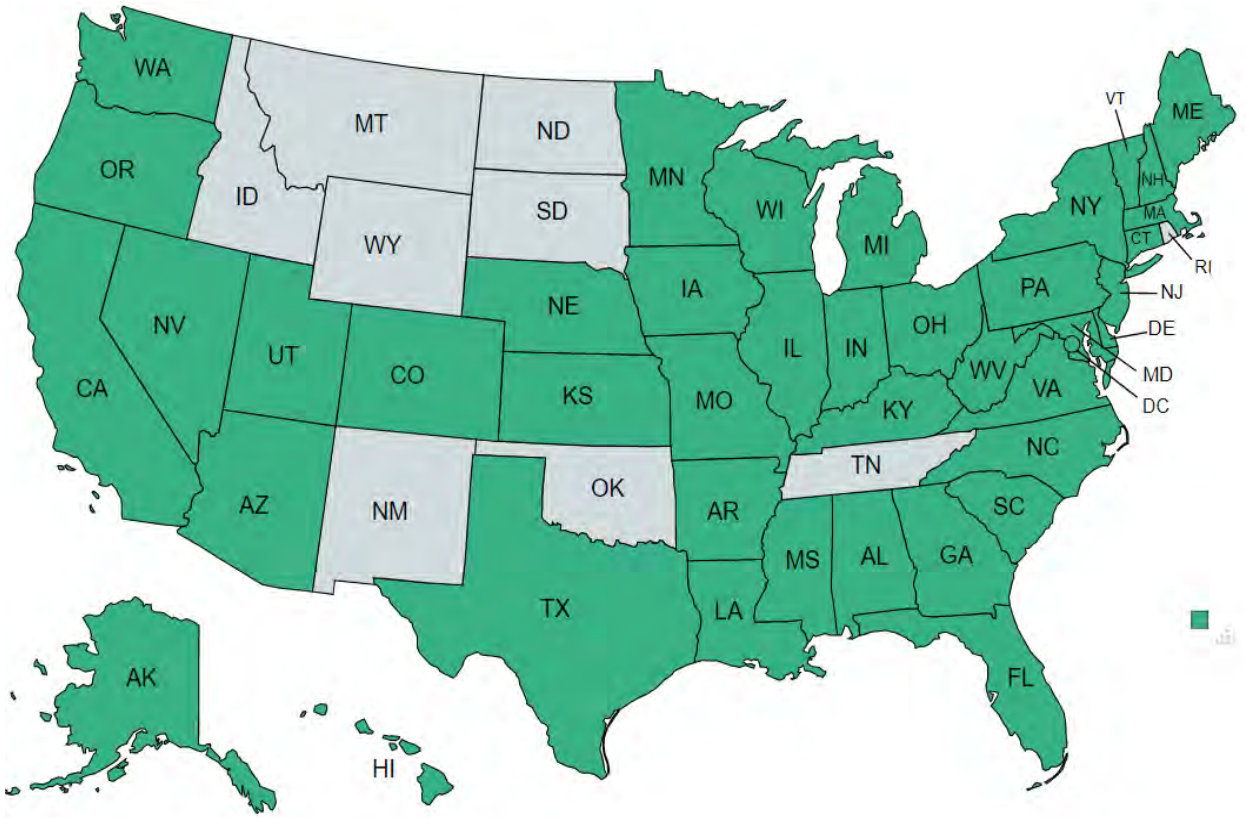
Center of excellence in geriatric ED care

- Physician & nurse champions (medical/nurse director) with focus on geriatric
  EM + patient advisor
- Geriatric-focused nurse case manager 56 hours/ week
- Geriatric assessment team: 4 of PT, OT, SW or Pharmacy available in ED
- Hospital executive-assigned supervision of and support for geriatric ED resources
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least 20 (of 27) policies and protocols
- QI process for selected policies
- Tracking at least 5 of 11 outcome measures
- More physical supplies, space modifications and food/drink

Geriatric EDs: Spread

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Level 1	22
Level 2	38
Level 3	280
	340



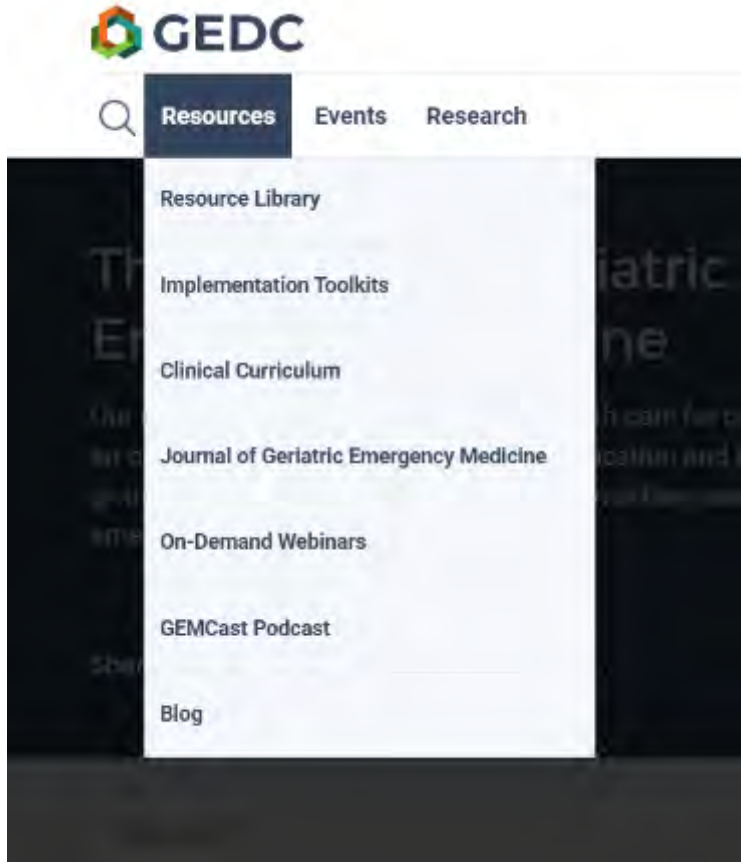
- 340 total GEDA sites
- 42 states represented
- >10% of all older adult ED visits occur at an accredited GED facility

GEDC

GEDCollaborative.com

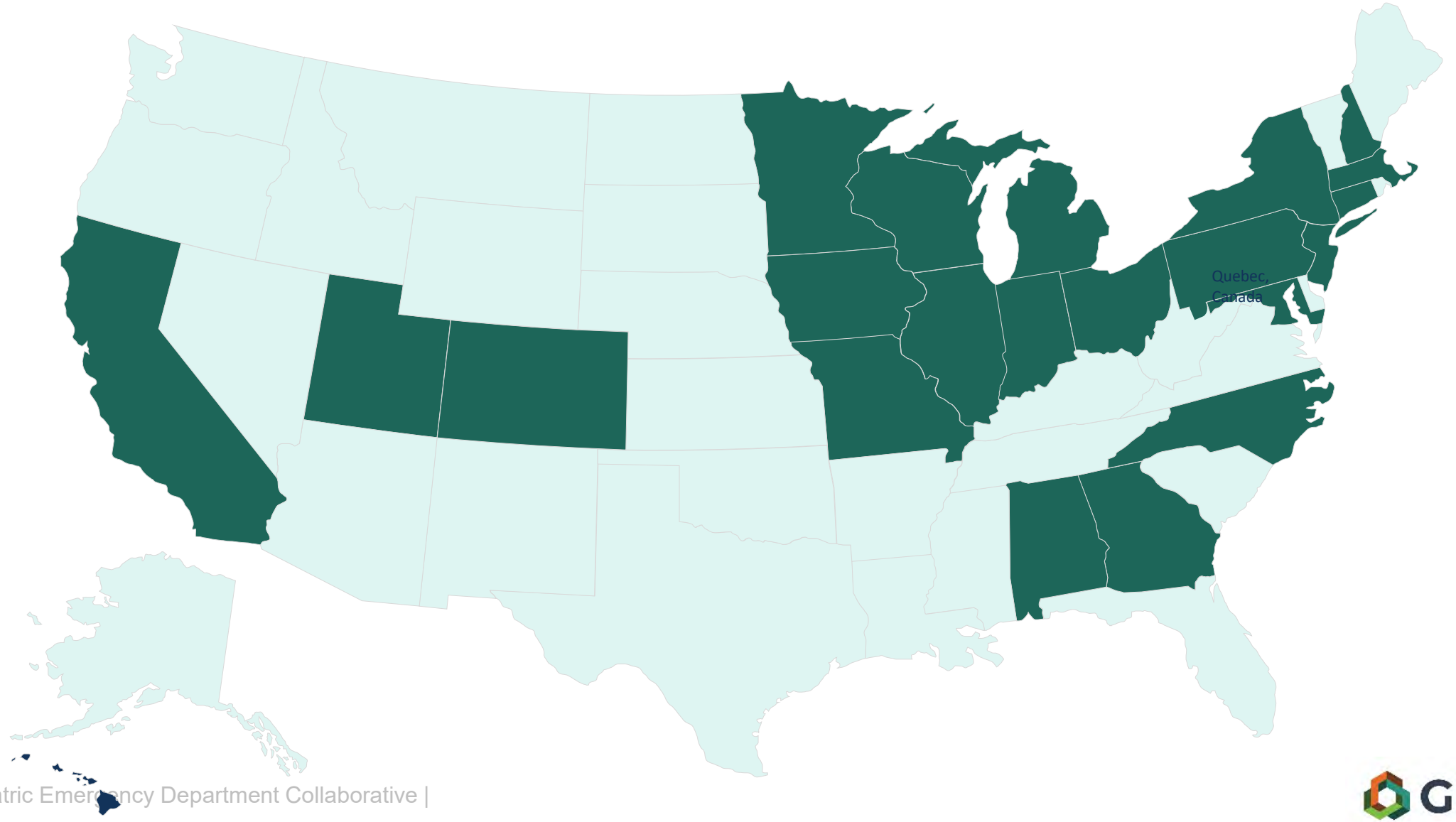
Resources

- Implementation Toolkits
- Clinical Curriculum
- Journal of Geriatric Emergency Medicine*
- On-Demand Webinars
- Blog
- Webinars
- Office Hours
- Tailored, unsearchable resource pages for partners
- Tailored Team Training
- Skills Fair
- Geri-EM
- GEMCAST Podcast



GEDC

66 GEDC Partner Sites



GEDC

Spread of GEDs…

… by system:

Advocate Aurora
- 14 EDs

Cleveland Clinic Health
- 10 EDs

Kettering Health
- 12 EDs

Northwell Health
- 18 EDs

Premier Health
- 7 EDs

Prime Health
- 16 EDs

VA
- 14 EDs (+ >30 sites under development)

Overall
- 32 Health systems have >1 GED

… by regional authority:

San Diego County, CA
- 20/20 EDs committed to becoming GEDs

Bay Area, CA
- 3 diverse EDs focused on dementia care

New York State
- 50% age-friendly health systems by 2023

University of California Health
- 5/5 EDs accredited/pursuing accreditation

GEDC

GEDC Health Care System Roundtable Members

Connection

Exchange among Health Care Systems leading the country in Geriatric Emergency Care

Collaboration

Identify ways each of your teams can support the others in their Quality Improvement Initiatives

Dissemination

Explore opportunities to share Roundtable insights with other health systems interested in GEDs

Direction

Identify major trends and topics to help lead change across health systems

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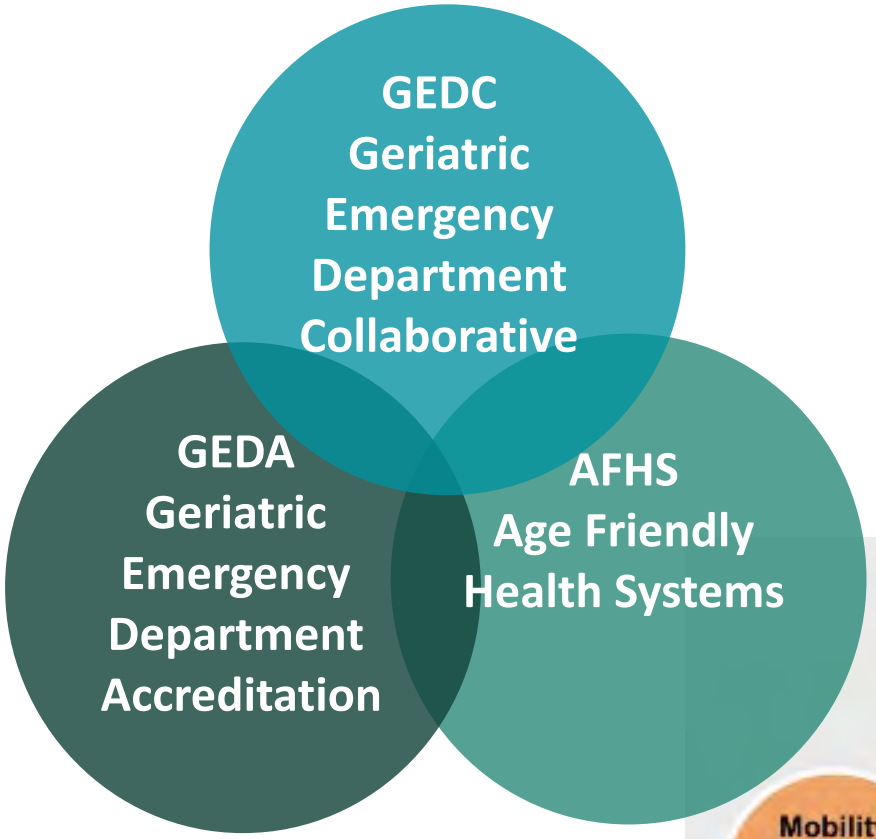
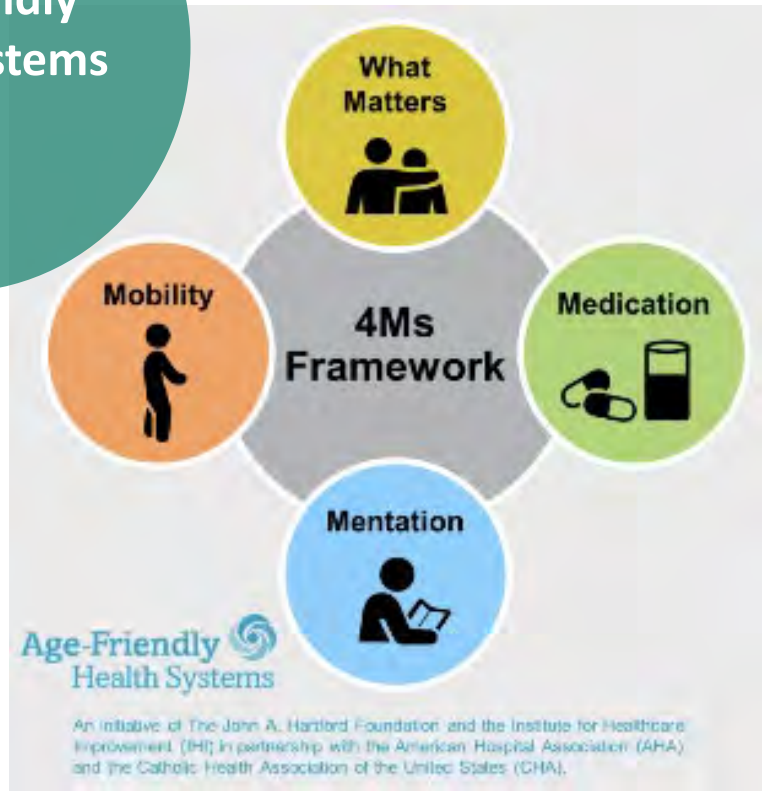
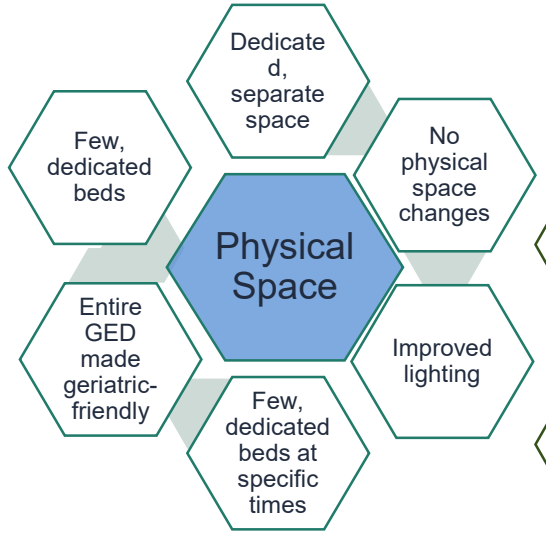
Geri ED Alignment

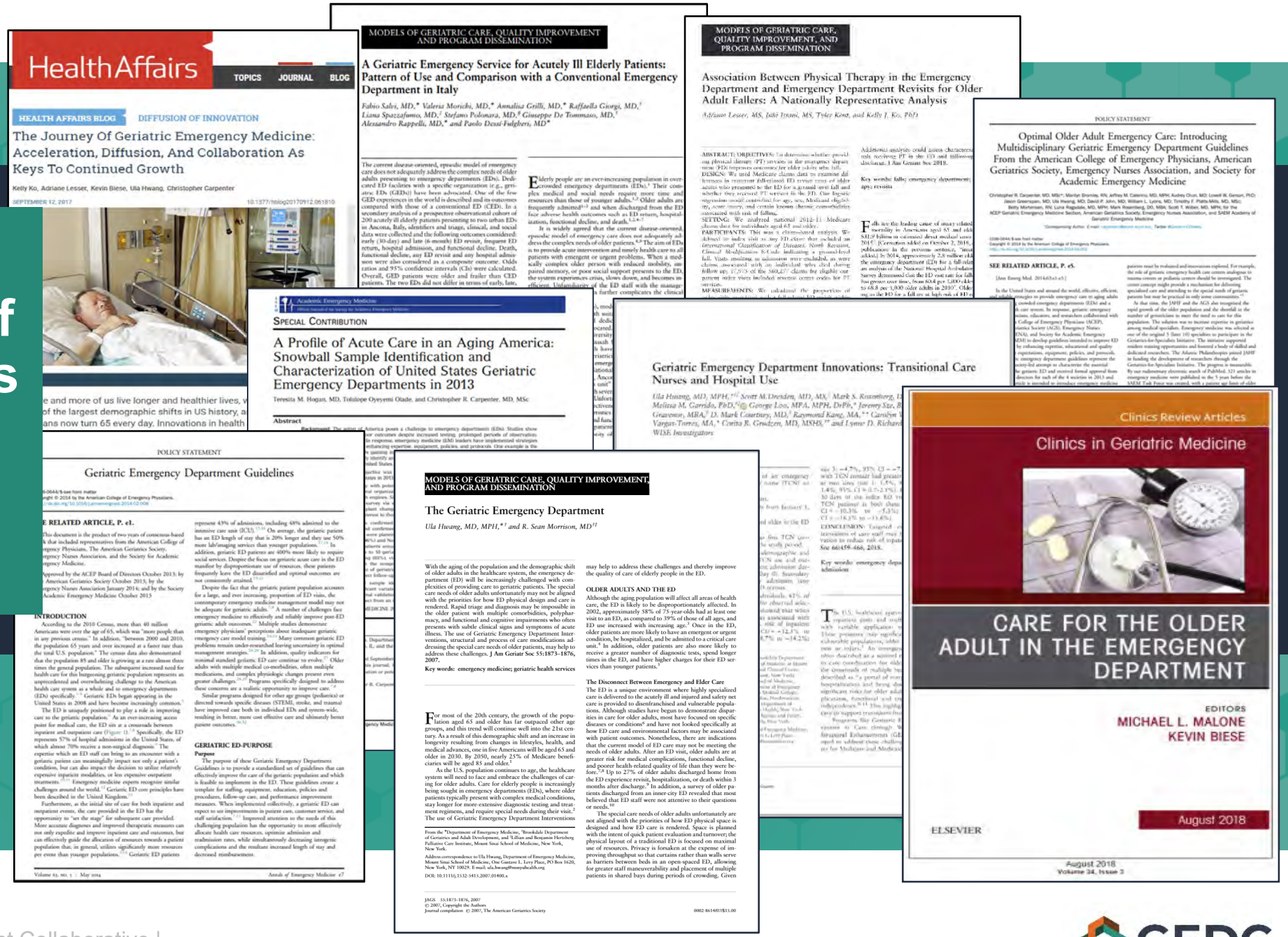






GEDC

A growing body of literature supports Geriatric EDs as a solution



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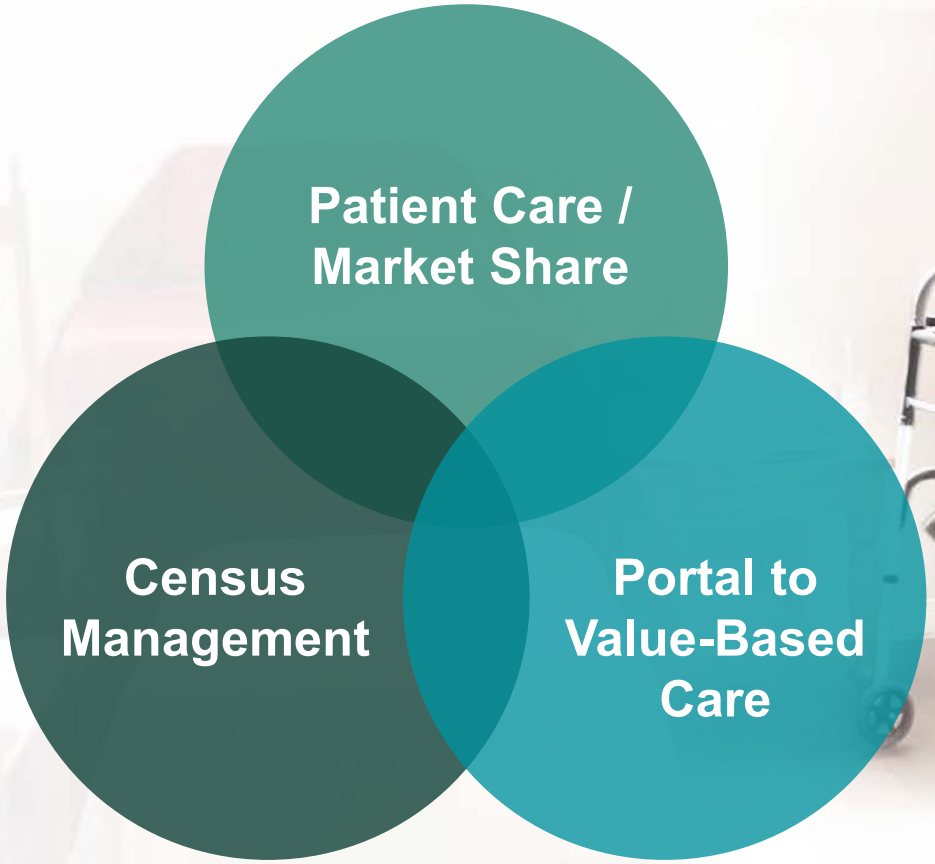
Healthcare System GED ROI



GEDC

What can a Geriatric Emergency Department do for my hospital?

Decrease readmissions

Recent update from SE US site:
13 Estimated Readmissions Prevented over first 3 months

Decrease ED revisits in high-risk pops

Midwest GED site: 9% decrease in ED revisits
JAGS article: PT in the ED associated with reduced 30 & 60 day revisits

Increase market share

Actual case: Urban safety net hospital seeking more Medicare patients

Better census management

CFO of academic system in NE: "I am tired of seeing the air-ambulance fly over us because we are on diversion. This can help us put our beds to better use."

Increase staff & patient satisfaction

Result seen at multiple health systems across all levels of accreditation

Reduce readmission penalties in senior patients

Geriatric Emergency Department		References
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; ***reduce iatrogenic complications, readmissions and penalties.***	• Koehler, et al., 2009 • Hwang, et al., 2018 • Caplan, et al., 2014
Target Population	Seniors experiencing a medical emergency	
Outcomes/ Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Potentially reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications / functional decline	

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Improve your bottom line

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes; ***reduce low or negative margin Medicare patients; and, backfill beds with high-margin admissions***	• Aldeen, et al., 2014 • Wallis, et al., 2018 • Conroy, et al., 2014 • Keyes, et al, 2014 • Wright, et al., 2014 • Hwang, et al, 2018
Target Population	Seniors experiencing a medical emergency	
Outcomes/ Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Reduce seniors' need for ED and hospital care; improve patient outcomes and reduce iatrogenic complications / functional decline; provide a more senior-friendly care experience	

GEDC

Increase market share

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes; ***backfill beds with high-margin admissions; and, attract new consumers to our system***	• Aldeen, et al., 2014 • Keyes, et al, 2014 • Hwang, et al, 2018 • Mion, et. al, 2003 • Cossette, et al., 2015 • Guttman, et al., 2004
Target Population	All seniors	
Outcomes/ Source of Hospital ROI	Increase patient satisfaction scores and clinical outcomes; build reputation in the community	
Source of Societal ROI	Improve patient outcomes and reduce iatrogenic complications / functional decline	

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Reduce crowding

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; and potentially ***reduce ED revisits among high-risk groups*** (e.g., falls, dementia)	• Jacob-sohn, et al., 2019 • Lesser, et al., 2018
Target Population	Seniors experiencing a medical emergency	
Outcomes / Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Potentially reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications / functional decline	

GEDC

March 1, 2021

Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries

Ula Hwang, MD, MPH[1,2]; Scott M. Dresden, MD, MS[3]; Carmen Vargas-Torres, MA[4]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(3):e2037334. doi:10.1001/jamanetworkopen.2020.37334

Editorial Comment

Key Points

Question Is there an association between geriatric emergency department (ED) programs and total costs of care for Medicare?

Findings In this cross-sectional study of 24 839 Medicare fee-for-service beneficiaries at 2 EDs, there was a significant association with reduced total costs of care after being seen by either a transitional care nurse and/or social worker trained to deliver geriatric emergency care. Per beneficiary, these savings were as much as $2905 after 30 days and $3202 after 60 days of the index ED visit.

Meaning These findings suggest that geriatric emergency department care programs may be associated with savings value to hospitals and payers.

Abstract

Importance There has been a significant increase in the implementation and dissemination of geriatric emergency department (GED) programs. Understanding the costs associated with patient care would yield insight into the direct financial value for patients, hospitals, health systems, and payers.

Objective To evaluate the association of GED programs with Medicare costs per beneficiary.

Invited Commentary | Health Policy

May 20, 2022

Emergency Department Care Transition Programs- Value-Based Care Interventions That Need System Level Support

Kevin Biese, MD, MAT[1,2]; Timothy A. Lash, MBA[2,3]; Maura Kennedy, MD, MPH[4]

» Author Affiliations | Article Information

JAMA Netw Open. 2022;5(5):e2213160. doi:10.1001/jamanetworkopen.2022.13160

Related Articles

Fruhan and Bills[1] report that their quality improvement callback program for patients presenting to the emergency department (ED) was associated with a decrease in 3-day and 7-day ED revisits compared with control patients who did not receive this intervention. Patients enrolled in the callback program received an automated telephone call 2 days after discharge that asked if they had questions about their discharge instructions and whether they wanted a follow-up telephone call from a clinician. Patients who requested a follow-up telephone call were called by a physician assistant or nurse practitioner. Over 10 weeks, 8110 patients were enrolled in the study, of whom 2958 (36.5%) were enrolled in the callback program. Importantly, the language spoken by the

Invited Commentary | Emergency Medicine

March 1, 2021

Geriatric Emergency Care Reduces Health Care Costs—What Are the Next Steps?

Maura Kennedy, MD, MPH[1,2]; Kei Ouchi, MD, MPH[2,3]; Kevin Biese, MD, MAT[4,5]

» Author Affiliations | Article Information

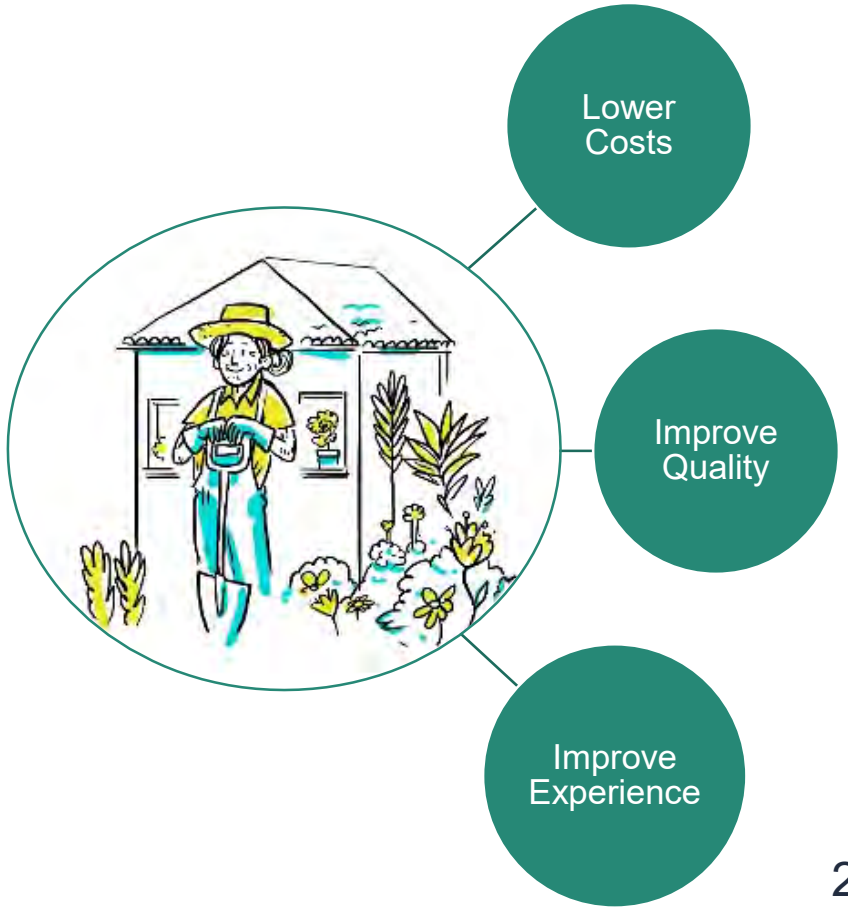
JAMA Netw Open. 2021;4(3):e210147. doi:10.1001/jamanetworkopen.2021.0147

Related Articles

Although older adults frequently receive care in emergency departments (EDs), conventional EDs may not adequately address the unique needs of geriatric patients, such as managing geriatric syndromes, addressing multimorbidity, and optimizing care transitions.[1] In direct response to the unique medical needs of older patients, the first self-identified geriatric ED (GED) in the United States was established more than a decade ago, after which there has been a rapid increase in the number of GEDs.[1] In 2018, the American College of Emergency Physicians launched a voluntary accreditation program, classifying GEDs as level 1 (gold), level 2 (silver), or level 3 (bronze) based on staffing, care processes, physical environment, and specialized equipment.[2] Despite rapid growth in the number of GEDs in the United States, there is limited research on the impact of GEDs and specialized geriatric emergency care models.

The most robust evidence supporting the GED model of care comes from the Geriatric Emergency Department Innovation in Care Through Workforce, Informatics, and Structural Enhancement (GEDI WISE) program. This multicenter care innovation program was supported by a Centers for Medicare & Medicaid Services (CMS) Health Care Innovations Award. It includes transitional care nurses (TCNs) and social workers (SWs) who staff the GEDI WISE level 1 GEDs and conduct geriatric assessments (including evaluations for delirium, fall risk, and functional decline), engage in

GEDs and VBC share similar goals



Up to 16.5% reduced risk of hospital admission[5] and 17.3% of readmission[6]

$3,202 savings per Medicare beneficiary after 60 days[7]

Decreased odds of 30 and 60 day fall-related ED revisit with PT services[8]

87.3% satisfaction with the clarity of discharge information and perceived wellbeing[9]

21 studies showcasing improved experience across a variety of interventions[10]

Collaborating Partnerships

GEDC

Geriatric EDs: THE FRONT PORCH

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

NY State Master Plan for Aging

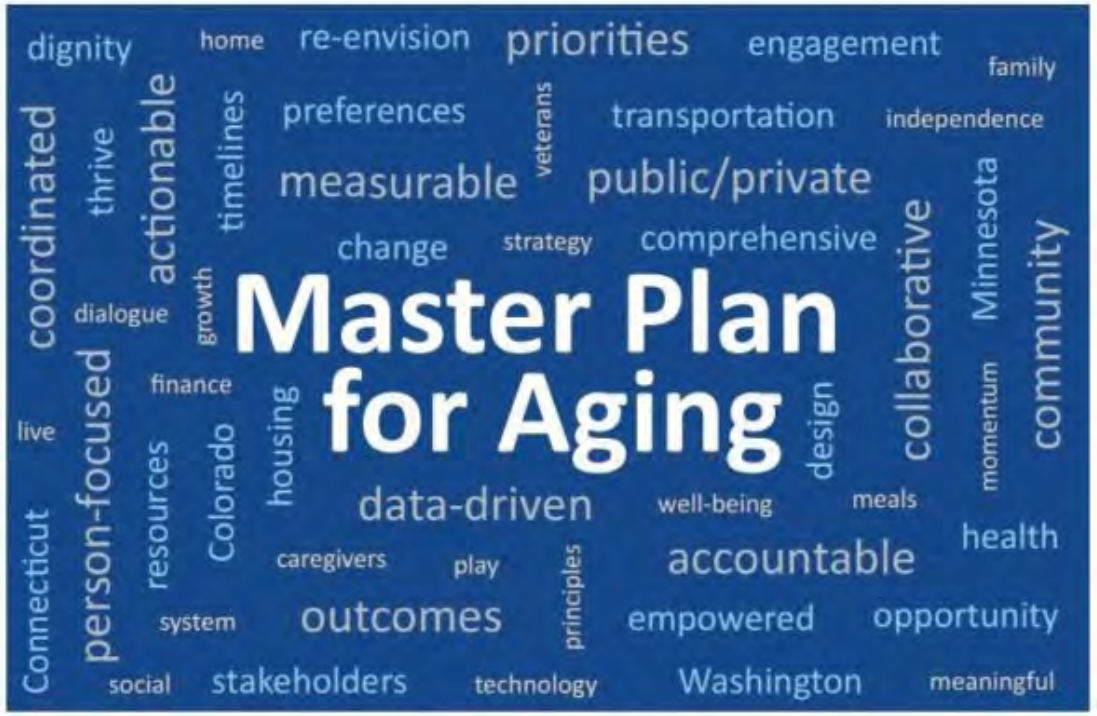
CA State Master Plan for Aging

Patients

NEW YORK STATE

Office for the Aging

- Meals on Wheels
- Area Agency on Aging
- At Home Healthcare



Together We ENGAGE
Master Plan for Aging

- Family Caregiver Alliance
- Transportation and Personal Care Services
- Case Management

Community Resources

EDs take care of those with no other place to go…

An opportunity to enhance Diversity, Equity and Inclusion

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Generously supported by

The John A. Hartford Foundation

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GEDC

Palliative Care:
Improving Quality by Addressing What Matters to Patients and Families

Brynn Bowman, MPA
Chief Executive Officer, Center to Advance Palliative Care

Center to Advance Palliative Care™

capc

Our Mission

The **Center to Advance Palliative Care (CAPC)** is a national organization dedicated to increasing the availability of quality health care for people living with a serious illness.

What is Palliative Care?

An interdisciplinary team-based specialty that:

→ Provides an added layer of support for relief of pain, symptoms, and stresses of serious illness

→ Focuses on patient and family quality of life at the same time as curative or life-prolonging treatment:

→Curable illness

→Chronic illness

→Progressive/terminal illness

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What does palliative care mean in the life of a patient and family?

Meet Mrs. Smith

Louise Smith is an 82-year-old female and is considering her second knee replacement. She had her previous total knee replacement (TKR) 12 years earlier with excellent results.

You are asked to evaluate her for medical optimization in preparation for her surgery.

Meet Mrs. Smith

Mrs. Smith is coping with:

- Chronic renal insufficiency and diabetes
- Mild cognitive impairment
- Urinary incontinence
- Caregiver for her spouse, who is frail, resulting in not being able to spend time with friends
- Unable to go for walks due to knee pain
- Depression
- 2 adult children who live out of town
- 7 prescribed medications

What is at stake for Mrs. Smith?

- **What Matters**: Mrs. Smith and her husband live independently, and want to stay that way

- **Medication and Mentation**: Mrs. Smith is at risk for delirium from surgery and hospitalization

- **Mobility**: Mrs. Smith is no longer able to take walks and care for her husband due to knee pain

How does palliative care help?

- Discuss the risks and benefits of surgery *in the context of what matters to Mrs. Smith*
- Given high risk of nursing home placement after surgery, decide *with Mrs. Smith* to try alternative ways to address pain prior to surgery
- Connect with physical therapy, arrange home safety evaluation, and order a lift chair
- Optimize pain regimen and reduce polypharmacy
- Connect Mrs. Smith with Meals on Wheels
- Identify a friendly visitor program in Mrs. Smith's community so that she can spend time with friends
- Communicate with Mrs. Smith's children about her and her husband's caregiving needs

The Palliative Care Approach

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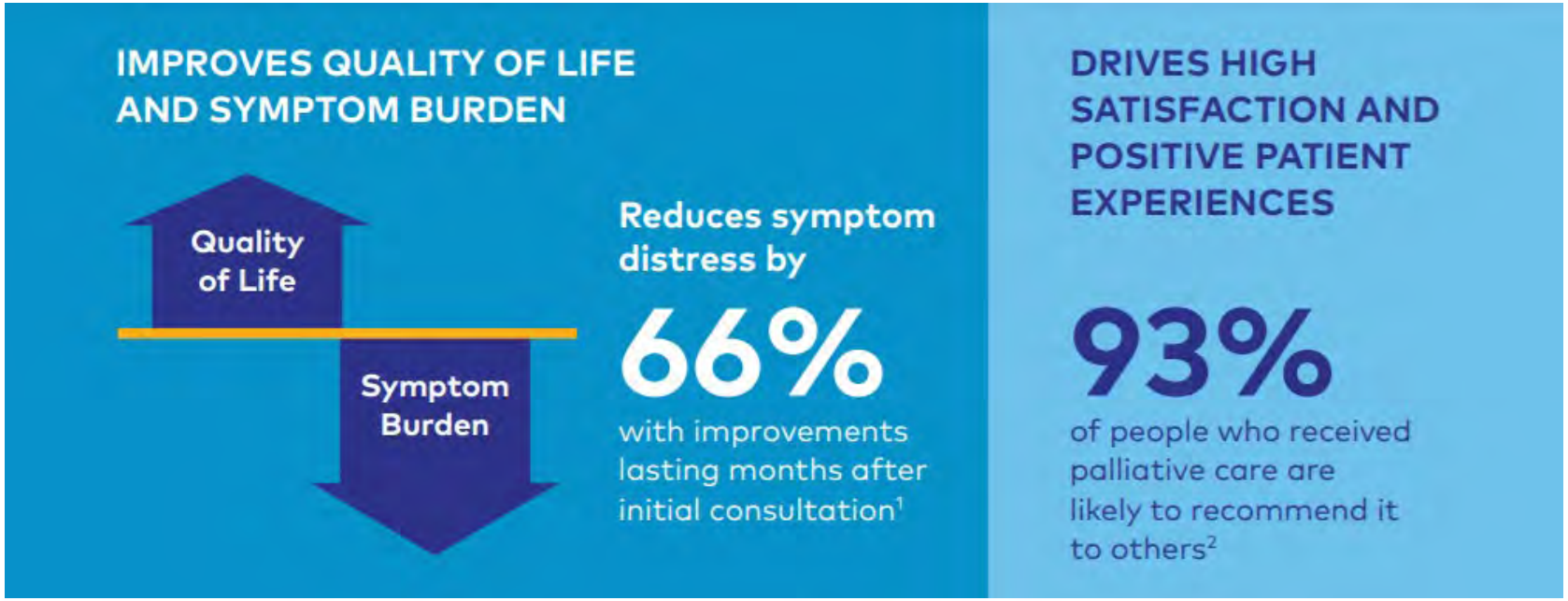
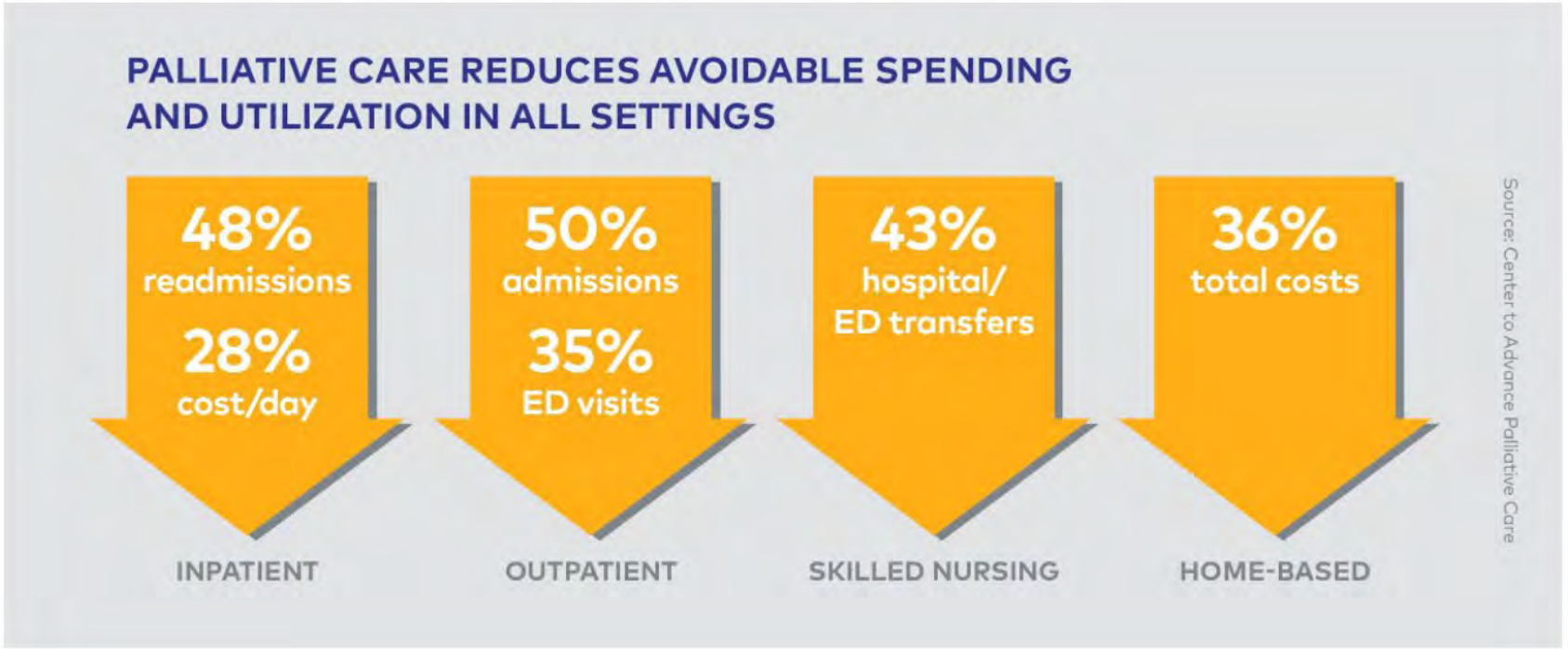
Palliative Care Impact





https://www.capc.org/documents/download/245/

Where is palliative care delivered?

POINT OF CRISIS:
HOSPITAL PALLIATIVE CARE

FILLING THE GAP

COMMUNITY BASED PALLIATIVE CARE
OFFICE CARE
HOME CARE
LONG TERM CARE SETTINGS

END OF LIFE:
HOSPICE

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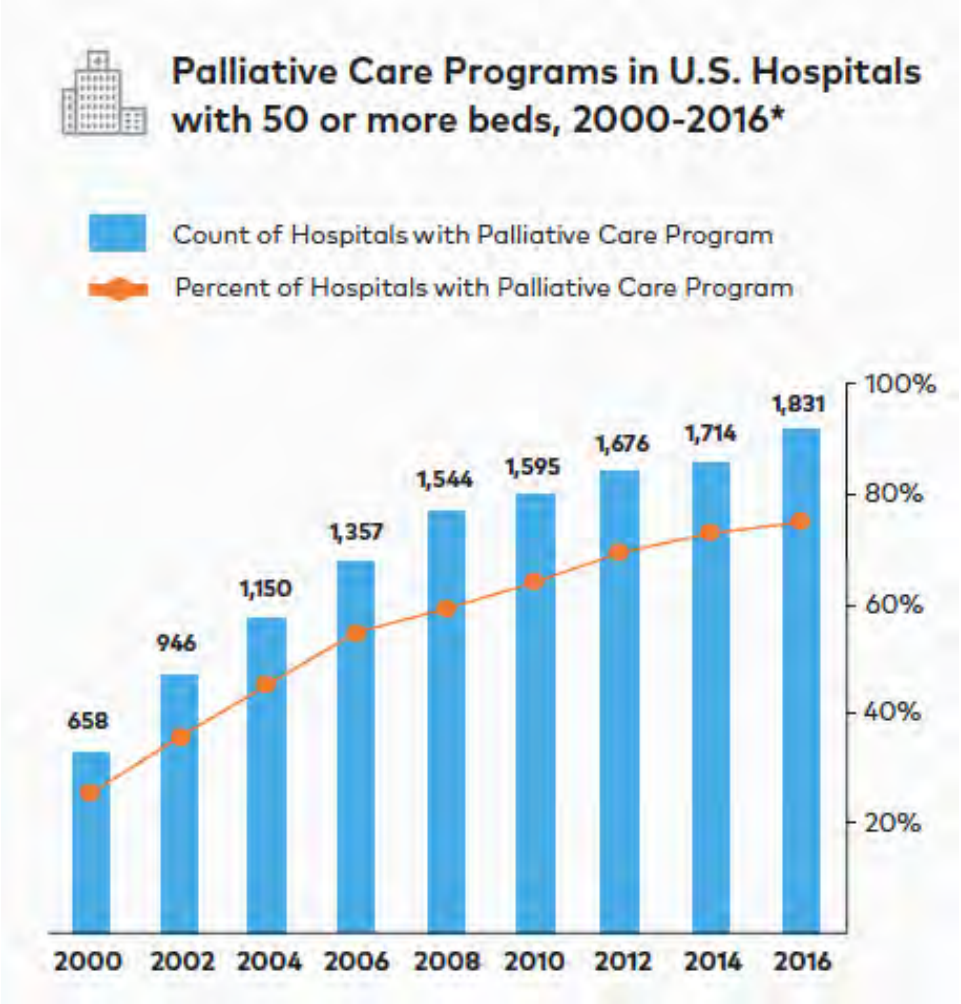
U.S. Hospital Palliative Care Growth

►In 2016, >1,800 hospital programs (78% of US hospitals) were serving over **10MM** patients each year.

►Palliative care prevalence and # of patients served has more than **tripled** since 2000.

►**100%** of the U.S. News 2015 – 2016 Honor Roll Hospitals and Children's Hospitals Have a Palliative Care Team.



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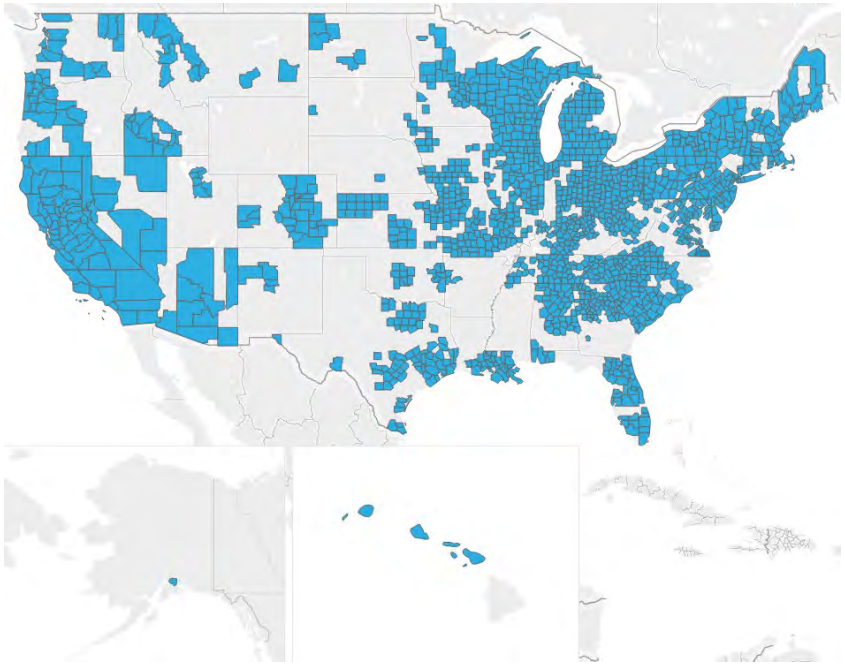
Palliative care in community settings

Nearly 3,000 office practices and long-term care facilities served by palliative care



At least 50% of US counties are served by a home-based palliative care program

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Racial disparities in the context of serious illness

→ Poorer quality pain management (Less assessment and less treatment)

→ Poorer quality clinician-patient communication (Verbal and non-verbal differences noted)

→ Lower likelihood of advance care planning discussion and documents

→ Measurable differences in caregiver experiences and caregiver availability

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Driving Toward Equity

CAPC is currently gathering best practices to address disparities in the care of Black patients with serious illness and their families.

The Vision:
Best Possible Quality of Life for All Older Adults with Serious Illness

- Inpatient palliative care during crisis
- Community-based palliative care to meet patient needs over time
- Integration of health care and community services to address gaps for patients and families

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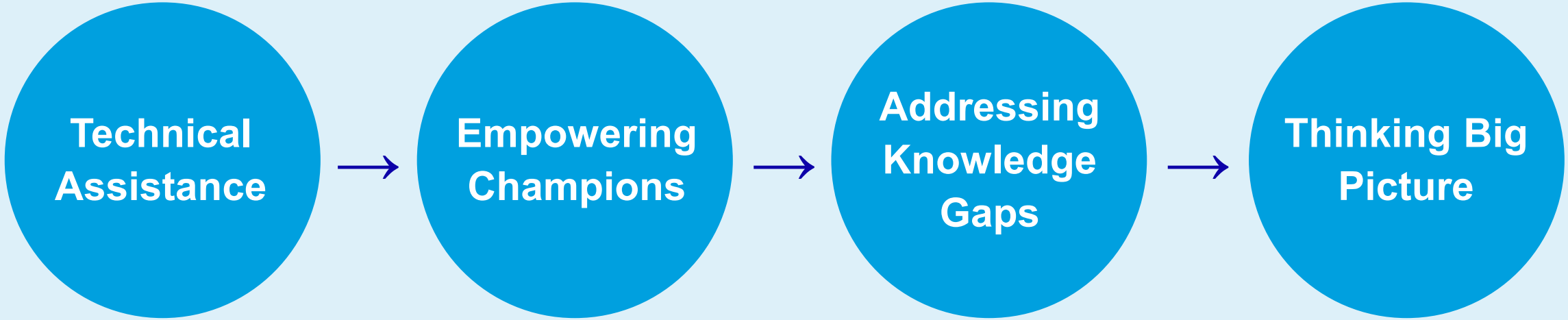
CAPC Can Help



Replicable best practices synthesized into tools and implementation support

Equipping palcare leadership with tools, coaching, and awareness to drive growth initiatives

Practical, clinical education on communication, symptom management, and person-centered care

Strategic support to align and integrate palliative care with other initiatives to improve care for older adults

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Q&A

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

2022
AMERICAN HOSPITAL ASSOCIATION
LEADERSHIP SUMMIT

Thank You!

- AHA Age Friendly team

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Appendix: Extra Slides

Measuring impact (samples)

Primary:

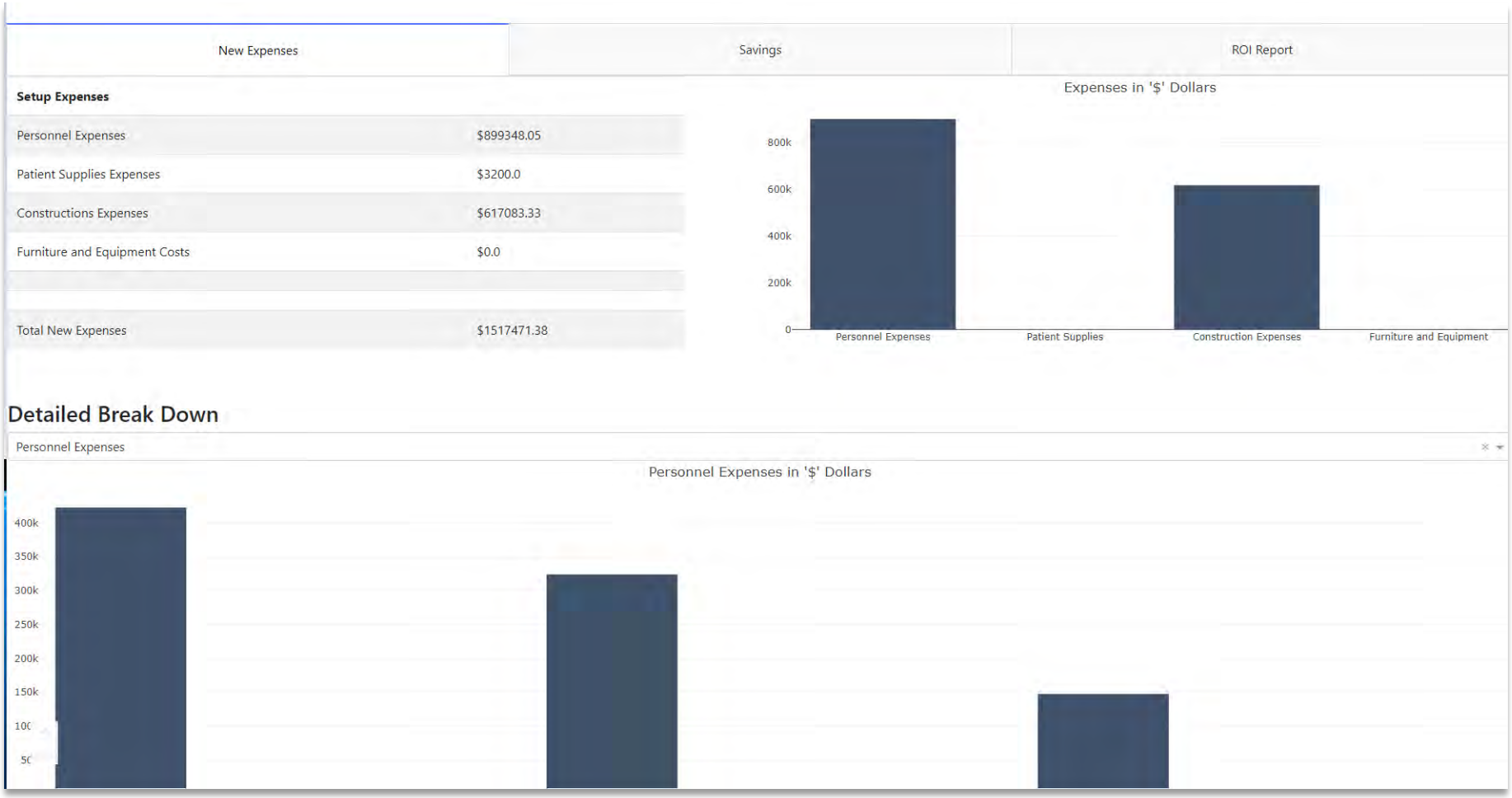
- Number of GED visits that result in an admission

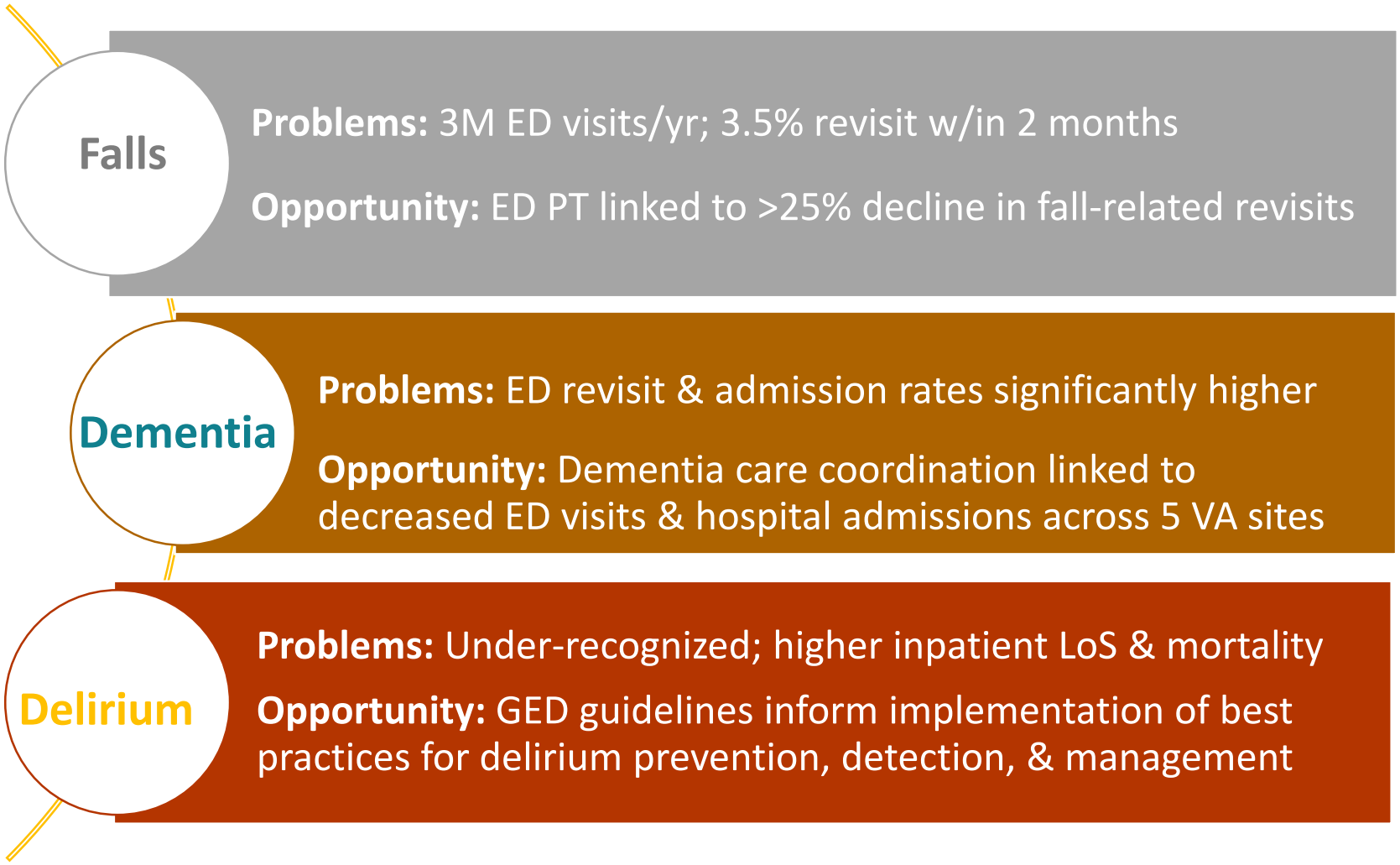
Secondary:

- GED revisit within 30 days of discharge from an index ED visit
- Total length of stay (in mins) in the GED

Other outcomes from the EHR: LOS in obs, LOS inpatient, revisit rates at 3, 10 and 30 days, case management consults, social work consults, specialist consults, discharge to home health or SNF, cost

Return On Investment Analysis




Falls
Problems: 3M ED visits/yr; 3.5% revisit w/in 2 months
Opportunity: ED PT linked to >25% decline in fall-related revisits
Dementia
Problems: ED revisit & admission rates significantly higher
Opportunity: Dementia care coordination linked to decreased ED visits & hospital admissions across 5 VA sites
Delirium
Problems: Under-recognized; higher inpatient LoS & mortality
Opportunity: GED guidelines inform implementation of best practices for delirium prevention, detection, & management

Patients

- Patients and families can make more informed decisions when choosing a facility by searching for GEDs.
- Transparency in services provides in the ED
- Screening/detection for geriatric syndrome which might've otherwise been missed

Hospitals

- Improved care for older adults, improves care for all
- Market differentiation for growing segment of the population
- Adaptable model of care to fit your institutions needs

Payers

- Defined set of measurable criteria, standardized to improve quality of emergency care for older adults
- Prioritize higher vs. lower performing EDs
- Cost to implement can vary depending on budget
- Improved care coordination, reducing more costly downstream utilization

GEDs can reduce high-cost care utilization

Decreased risk of admission at index visit

- Risk of admission decreased by up to 16.5% in a 3-site GED study

Decreased patients' total Medicare costs

- 2-site GED study shows savings of approx. $3,000/patient at 30 days post-discharge

Reduced or delayed SNF admission

- Transitional care at 2 EDs lowered SNF admissions for high-risk patients at 120 days (3% vs. 10%)