SONOMA VALLEY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
REGULAR MEETING AGENDA
Thursday, March 6, 2014
6:00 p.m. Regular Session

Location: Community Meeting Room
177 First Street West, Sonoma, CA

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Nevins*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.*	*Nevins*	
3. CONSENT CALENDAR Minutes A. Regular Board Minutes, 02.06.14 B. FC Minutes 01.28.14 C. GC Minutes 01.28.14 D. QC Minutes 01.29.14 Other E. QC Policy & Procedures F. MEC Credentialing Report, 02.26.14 G. GC April 2014 Work Plan	*Nevins*	Action
4. PARTNERSHIP HEALTHPLAN Elizabeth Gibboney, Deputy Executive Director/Chief Operating Officer, Partnership HealthPlan of California	*Gibboney*	Inform
5. HUMAN RESOURCES ANNUAL REPORT	*Davis*	Inform
6. FINANCIAL REPORT FOR JANURARY 2014	*Gritsutenko*	Inform
7. ADMINISTRATIVE REPORT FOR FEBRUARY 2014	*Mather*	Inform

8. CMO REPORT FOR FEBRUARY 2014	*Cohen*	Inform
9. OFFICER AND COMMITTEE REPORTS A. Chair's Report i. Vacancies on Quality Committee ii. FC Operating & Capital Budget Timeline FY15 B. Secretary's Report i. Northern California Health Care Authority (JPA) – Conduit Issuer of Debt Obligations ii. Association of California Healthcare Districts-Update C. Governance Committee i. Medi-Cal Funding Act 2014 ii. Media Policy iii.Biennial By Law Review iv. Investment Policy LD-118 D. Quality Committee i. Board Quality Committee Dashboard 2013	*All*	Inform/ Action
10. ADJOURN Next regular Board meeting, April 3, 2014	*Nevins*	

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS
REGULAR MEETING MINUTES
Thursday, February 6, 2013
Community Meeting Room

Board Present	Board Absent/Excused	Staff/Other Present	Staff/Other cont.
Bill Boerum Peter Hohorst Sharon Nevins Kevin Carruth Jane Hirsch		Fe Sendaydiego Dennis Ciocca Robert Cohen MD Kelly Mather Dick Fogg David Cox Kristina Gritsutenko Bob Kenney Sharon Cornelius	

AGENDA ITEM	DISCUSSION	ACTION	FOLL OW-UP
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	6:00 p.m.		
2. PUBLIC COMMENT SECTION	*Nevins*		
At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.	Sharon Cornelius the SVH Auxiliary President gave an overview of some of the services that the Auxiliary provides the Hospital and reported that last quarter the auxiliary team volunteered a total of 2,900 hours.		
3. CONSENT CALENDAR:	*Nevins*	Action	
COMMITTEE MINUTES A. Regular Board Minutes, 01.09.14 B. FC Minutes 12.3.13 (Nov); 1.7.14 (Dec) C. GC Minutes 12.23.13 D. QC Minutes 11.21.13; 12.19.13 COMMITTEE POLICIES & OTHER E. QC Approved Policies (5) F. MEC Credentialing Report, 1.29.14		**MOTION** by Boerum to approve A-F and 2nd by Hirsch. All in favor.	

AGENDA ITEM	DISCUSSION	ACTION	FOLL OW-UP
4. LEGISLATIVE UPDATES	*Sponseller*	Inform	
	Mr. Sponseller reported on the future of health care as well as legislative updates and took questions from the Board.		
5. OB UPDATE	*Mather/Cohen/Kenney*	Inform	
	Ms. Mather announced that previous recommendations to close OB have been delayed. A *Save the OB committee* and an OB Steering committee have been formed and both are confident together they can reduce monthly expenses by $20,000. Expenses and volumes will be tracked monthly and reported to the CEO who will in turn report results in her monthly Administrative Report.		
6. STRATEGIC PLAN UPDATE	*Mather*	Inform	
	Ms. Mather gave an update on the strategic plan.		
7. INFORMATION TECHNOLOGY ANNUAL REPORT	*Sendaydiego/Cohen*	Inform	
	Ms. Sendaydiego and Dr. Cohen gave the annual IT report.		
8. FINANCIAL REPORT FOR DEC 2013	*Fogg/Cox*	Inform	
	Mr. Cox gave the Financial Report for December 2013. In addition, the new SVH Controller, Kristina Gritsutenko was introduced and welcomed onboard. Mr. Ciocca spoke about the bond refinancing process which closed as of today and will bring taxpayers a substantial reduction in taxes. Praise and thanks to both Mr. Hicks and Mr. Boerum for their foresight (5 years ago) and contribution along the way in the bond process. A press release on bond refinancing went out today in the Sonoma Index Tribune.		
9. ADMIN REPORT FOR JAN 2014	*Mather*	Inform	
	Ms. Gritsutenko introduced herself to the Board. Ms. Mather gave the CEO Administrative Report for January 2014.		
8. OFFICER AND COMMITTEE REPORTS	*All*	Inform/Action	
A. **Chair's Report** i. Calendared Items & Ed. Topics 2014 B. **Governance Committee** i. Community Funding Policy ii. Gift, Ticket and Honoraria Policy iii. 2014 Work Plan (informational)	The Board agreed to add an educational topic on ***Partnership HealthPlan of California*** in March 2014.	**MOTION** by Hohorst to approve **8.B.i. and ii**. and 2nd by Boerum. All in favor	
9. ADJOURN	*Nevins*		
	Adjourn 7:40 p.m. Next Board meets 3/6/14		

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
MEETING MINUTES
Tuesday, January 28, 2014
Schantz Conference Room

Members Present	**Members Present** cont.	**Staff/ Public/Other**	**Other** cont.	**Excused/Absent**
Dick Fogg Phil Woodward Subhash Mishra, M.D. Richard Conley Peter Hohorst Shari Glago	Sharon Nevins Steve Barclay Mary Smith Keith Chamberlin, M.D. Kelly Mather	David Cox Cheryl Untermann Sam McCandless Dennis Ciocca Gigi Betta		Jeanette Tarver

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve and restore the health of everyone in our community.* *The vision of the SVHCD is that SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.*		
1. CALL TO ORDER	*Fogg* 5:00 p.m.		
2. PUBLIC COMMENT SECTION	*Fogg*		
	Mr. McCandless asked Ms. Mather if other departments have had a similar analysis to that of the OB department. Ms. Mather answered yes and further explained that all eleven service lines or departments have had such an analysis based on "contributions".		
3. CONSENT CALENDAR	*Fogg*	Action	
A. FC Minutes 1.7.14		**MOTION** by Smith to approve and **2nd** by Chamberlin. All in favor.	
4. 2009 SERIES-A GO BOND REFINANCING	*Fogg/Ciocca*	Inform	
	The GO Bond refinancing process is being overseen by Gary Hicks the	.	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	District's financial advisor. Total savings will be over $148, 000/year and these savings will go toward reducing the community tax rate. The total amount of the bonds being retired is over $12,000,000. Closing is scheduled for February 6th. Ms Nevins proposed a press release and suggested asking Mr. Hicks for assistance writing the script.		
5. DECEMBER 2013 FINANCIALS AND RAC UPDATE	*Cox*	Inform	
	Mr. Cox presented the Financial statements for December 2013 highlighting the payor mix chart on page one of the narrative in the Agenda Package. Mr. Hohorst pointed out that over the past 3 months, revenue has not increased in line with other indicators. Mr. Cox agreed to take a look at the Medicare contractuals and report back to the Committee on his findings.		
6. PROJECTED CASH FLOWS	*Cox*	Inform	
	Mr. Cox announced that the finance department is currently installing the Hospital's long-term financial planning program which will have the ability to project cash out on a multi-year basis. Mr. Woodward continues to express his concern and displeasure with the format of the Project Cash Flows and plans to present a proposal for change at a future Committee meeting.		
7. OB UPDATE	*Mather*	Inform	
	Ms. Mather gave some background on the recommended OB closure and the reasons for the recommendation. Since the Board meeting on 1.9.14, the Board and the CEO have agreed to delay its closure and look at ideas on how to save the OB. Toward that end, a *Save The OB* Committee has been formed with Mr. Hohorst as the Chair. If expenses are reduced and births increase, then it may be possible to continue the OB department. The savings goal is $22,000 per month and the break-even number of monthly births is 15.		
8. SVH FOUNDATION AUDIT UPDATE	*Untermann*	Inform	
	To date, there have been three proposals received from the solicited CPAs. These three proposals will be presented to the Foundation Board on 2.10.14 and then the Foundation's Executive Committee will make a decision. On an unrelated note, beginning in February, the Foundation will begin to re-pay SVH for expenses incurred on the capital campaign (totaling approximately $550,000). Hospital management decided to exclude		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	these (not yet received) repayments from the cash flow statements however, they are part of unbudgeted cash.		
9. PATIENT BILLING UPATE	*Cox*	Inform	
	Mr. Cox explained that these Patient Billing updates are produced by Bernadette Jensen who reports to Mr. Cox at Marin General. A new manager, Katherine Kyle has been hired to represent both PDH and SVH and she continues to implement her *process improvement plan* in patient billing . The goal is to have cash collections equal net revenue. As soon as Mr. Cox can get numeric projections from the consultants that have been hired, he will give the Committee an update. He estimates that this information will be available in about 3 month's time.		
11. ADJOURN	Fogg		
	Adjourn 6:13 p.m. Next FC meeting is February 25, 2014.		

SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE
REGULAR MEETING MINUTES
January 28, 2014
1st floor Solarium

Committee Members Present	Committee Members Absent	Administrative Staff Present
Bill Boerum Peter Hohorst		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP
MISSION AND VISION STATEMENTS			
1. CALL TO ORDER	8:35 AM		
2. PUBLIC COMMENT:			
	None		
3. CONSENT CALENDAR: **A.** GC Meeting Minutes, 12.23.13	*Boerum*	Action	
		MOTION by Hohorst to **APPROVE** Consent Calendar. All in favor.	Goes to 2/6 Board Consent Calendar.
4. 2014 WORK PLAN	*Hohorst*	Inform/Action	
	Approved as amended and GC recommends SVH Board approval.	**MOTION** by Hohorst to **APPROVE**. All in favor.	Goes to Board 2/6 under Committee Reports as inform item
5. COMMUNITY FUNDING POLICY	*Hohorst*	Inform/Action	
	Referred to legal counsel (Colin Coffey) for clarification of II.G. and III.A. with regard to speaking at religious institutions. Pending above legal advice, GC recommends SVH Board approval.	**MOTION** by Hohorst to **APPROVE** pending legal advice. All in favor.	Goes to Board 2/6 under Committee Reports as action item

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP
6. GIFT, TICKET, & HONORARIA POLICY	*Hohorst*	Inform/Action	
	Legal council has determined that payments for services to SVH Board members serving on other Boards are not in conflict with this policy. These payments are income and not considered honoraria. GC recommends SVH Board approval.	**MOTION** by Hohorst to **APPROVE**. All in favor.	Goes to Board 2/6 under Committee Reports as action item
7. CLOSING COMMENTS/ADJOURN	*Boerum* 9:21 AM Next meeting is Tuesday, February 25, 2014.		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
January 29, 2014
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Admin Staff /Other
Jane Hirsch John Perez Robert Cohen M.D. Susan Idell Paul Amara M.D.		Leslie Lovejoy Howard Eisenstark Joel Hoffman Kevin Carruth	Gigi Betta Mark Kobe

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
1. CALL TO ORDER	*Hirsch*		
	5:00 p.m.		
2. PUBLIC COMMENT	*Hirsch*		
3. CONSENT CALENDAR	*Hirsch*	Action	
A. QC Meeting Minutes, 12.19.13		**MOTION:** by Idell to approve and 2nd by Perez All in favor.	
4. POLICIES & PROCEDURES	*Kobe*	Action	
a) Home Care Manual b) Emergency Department (ER) c) Compounding, Sterile (Rx) d) Compounding, Outside (Rx) e) Blood Administration (Lab)	Mr. Kobe explained that the Committee will be seeing more of these policies as SVH prepares for the upcoming CIHQ visit. The QC recommends approval of all policies (a-e) by the Board at the next regular Board meeting on February 6, 2014.	**MOTION:** by Idell to approve (a-e) and 2nd by Perez. All in favor.	
5. QUALITY REPORTS FOR DEC. 2013 AND JAN. 2014	*Kobe*	Inform	
	Mr. Kobe reviewed both December and January reports in Ms. Lovejoy's absence.		
6. ROOT CAUSE ANALYSIS	*Cohen*	Inform	
	Dr. Cohen detailed a recent incident that took place in the hospital and the analysis that followed.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
7. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
	• For the remainder of 2014, all regular QC meetings will be held on the LAST Wednesday of the month EXCEPT when there is a conflict with a holiday (i.e. Thanksgiving and Christmas). In this case, the meeting will be moved up one week. • Ms. Hirsch asked QC Committee members to give feedback, express any concerns or bring up any opportunities concerning the hospital's environment.		
8. ADJOURN	*Hirsch*		
	5:30 pm		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
10. CLOSED SESSION	*Amara*	Action	
	By *Executive Action*, the Medical Staff Credentialing and Peer Review Report was approved by Mr. Carruth and Ms. Hirsch by telephone on 1.29.14 at 6:00 P.M.		
11. REPORT OF CLOSED SESSION/ADJOURN	*Hirsch*	Inform	
	Adjourn 5:36 pm Next QC meeting is on February 26, 2014.		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: MM8390-110 Pipercillin-Tazobactam Extended Infusion Dosing	
APPROVED BY: **Chief Quality Officer**	DATE: 10/23/13
Director's/Manager's Signature	Printed Name Chris Kutza, Director of Pharmacy

Douglas S Campbell, MD — 10/23/13
Chair ~~Medicine Committee~~ — Date

Michael Brown, MD — Date
Chair ~~Surgery Committee~~

Robert Cohen, MD — 10/23/13
Chief Medical Informatics Officer — Date

Kelly Mather — Date
Chief Executive Officer

D. Paul Amara, MD — 11/11/13
President of Medical Staff — Date
Chair, Pharmacy and Therapeutics Committee

~~Bill Boerum~~ Sharon Nevins — Date
Chair, Board of Directors

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Piperacillin-Tazobactam Extended Infusion Dosing	POLICY # MM8390-110
	PAGE 1 OF 2
DEPARTMENT: Pharmacy	EFFECTIVE: 5/2011
APPROVED BY: Chris Kutza, Director of Pharmacy	REVISED: 10/2013

Purpose:

Pipercillin-Tazobactam, as with other β-lactam antibiotics, exhibits **time-dependent** killing. Administering Pipercillin-Tazobactam as an extended infusion of 4 hours achieves longer duration of active antibiotic concentrations, reduces that patient's exposure to active drug, can decrease the risk of dose related side effects, and results in more cost-effective therapy.

Policy:

Orders for Pipercillin-Tazobactam are automatically converted to extended infusion administration (**4 hr infusion**) for all adult patients:

- Pipercillin-Tazobactam 3.375 gm IVPB administered as a 4 hour infusion every 8 hours will be administered to patients with a creatinine clearance greater than 20 ml/minute.
- Pipercillin-Tazobactam 3.375 gm IVPB administered as a 4 hour infusion every 12 hours will be administered to patients with a creatinine clearance less than or equal to 20 ml/minute.
- The **100ml** Pipercillin-Tazobactam **bag** is infused over 4 hours at **25 ml/hr** by Y-site into a line running with maintenance fluids.
- *This policy **DOES NOT INCLUDE** patients in the Emergency Department or patients with chemotherapy related neutropenic fever. These patients will receive Pipercillin-Tazobactam via standard infusion duration and dosing.*

Medication Ordered	Interchange With
Pip/Tazo 4.5gm IV q6hr	*Pip/Tazo* 3.375gm IV q8hr (4 hr infusion)
Pip/Tazo 3.375gm IV q6hr	*Pip/Tazo* 3.375gm IV q8hr (4 hr infusion)
Pip/Tazo 2.25gm IV q6hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)
Pip/Tazo 2.25gm IV q8hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)
Pip/Tazo 2.25gm IV q12hr	*Pip/Tazo* 3.375gm IV q12hr (4 hr infusion)

Procedure:

1. The pharmacist will review the patient's creatinine clearance, either as calculated by the computer OR using the Cockcroft-Gault equation (see below). Any patient over 75 years of age will have their creatinine clearance calculated using a minimum serum creatinine value of 1 for a more accurate estimation of renal function.

2. UNLESS the patient is being treated in the Emergency Department and/or has a diagnosis of neutropenic fever, the following automatic substitution for dosing regimens of Pipercillin-Tazobactam will occur:
    a. If it is determined that the patient's creatinine clearance is greater than 20 ml/min, the pharmacist will automatically change the dose of Pipercillin-Tazobactam to 3.375 grams over 4 hours IVPB q8hr and will enter that dose into the patient's profile.
    b. If the patient's creatinine clearance is less than or equal to 20 ml/min, the pharmacist will automatically change the dose of Pipercillin-Tazobactam to 3.375 grams over 4 hours IVPB q12h and will enter that dose into the patient's profile.

c. The pharmacist will discontinue the original order and communicate the fact the the original order was changed via an approved therapeutic interchange as per standard therapeutic interchange procedures.

COCKCROFT-GAULT EQUATION:

$$\frac{(140 - \text{AGE}) \times \text{IDEAL BODY WEIGHT}^*}{72 \times \text{SERUM CREATININE}} \quad \text{[MEN]}$$

$$\frac{(140 - \text{AGE}) \times \text{IDEAL BODY WEIGHT}^*}{72 \times \text{SERUM CREATININE}} \times 0.85 \quad \text{[WOMEN]}$$

IDEAL BODY WEIGHT FOR MEN = 50 + (2.3 X EVERY INCH OVER 5 FEET TALL)
IDEAL BODY WEIGHT FOR WOMEN 45.5 + (2.3 X EVERY INCH OVER 5 FEET TALL)

* *If the patient's ACTUAL body weight is LESS THAN the IDEAL body weight, use ACTUAL BODY WEIGHT in the equation.*

Reference:

1. Tam VH, Gamez EA, Weston JS, Gerard LN, et al. Outcomes of bacteremia due to *Pseudomonas aeruginosa* with reduced susceptibility to piperacillin-tazobactam: implications on the appropriateness of the resistance breakpoint. *Clin Infect Dis* 2008; 46: 862-867.
2. Eagye KJ, Sutherland CA, Christensen H, Kuti JL, Nicolau DP. Prevalence of *Pseudomonas aeruginosa* (PSA) with reduced susceptibility to piperacillin-tazobactam (TZP) at 40 hospitals. Poster# C2-201. Poster Presentation at the 48th Annual ICAAC/46th Annual IDSA Meeting, Washington D.C. 2008.
3. Lodise TP, Lomaestro BM, Drusano GL. Application of antimicrobial pharmacodynamic concepts into clinical practice: focus on β-lactam antibiotics: insights from the Society of Infectious Diseases Pharmacists. *Pharmacotherapy* 2006; 26: 1320-1332.
4. Kim A, Sutherland CA, Kuti JL, Nicolau DP. Optimal dosing of piperacillin-tazobactam for the treatment of Pseudomonas aeruginosa infections: prolonged or continuous infusion? *Pharmacotherapy* 2007; 27: 1490-1497.
5. Lodise TP, Lomaestro B, Drusano GL. Piperacillin-tazobactam for *Pseudomonas aeruginosa* infection: clinical implications of an extended-infusion dosing strategy. *Clin Infect Dis* 2007; 44: 357-363.
6. Patel N, Scheetz MH, Drusano GL, Lodise TP. Determination of antibiotic dosage adjustments in patients with renal impairment: description of a contemporary methodology. *Society of Infectious Diseases Pharmacists newsletter* 2008; 18:14-20.

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: MM8390-109 Pharmaceutical Care Consulting for Skilled Nursing Facility	
APPROVED BY: **Chief Quality Officer**	DATE: 10/23/13
Director's/Manager's Signature	Printed Name Chris Kutza, Director of Pharmacy

Douglas S Campbell, MD
Chair Medicine Committee — 10/23/13 — Date

Michael Brown, MD
Chair Surgery Committee — Date

Robert Cohen, MD
Chief Medical Informatics Officer — 10/23/13 — Date

Kelly Mather
Chief Executive Officer — Date

D. Paul Amara, MD
President of Medical Staff
Chair, Pharmacy and Therapeutics Committee — 11/11/13 — Date

~~Bill Boerum~~ Sharon Nevins
Chair, Board of Directors — Date

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SUBJECT: Pharmaceutical Care Consulting for Skilled Nursing Facility	POLICY #MM8390-109
	PAGE 1 OF 2
DEPARTMENT: Pharmacy	EFFECTIVE: 10/2013
APPROVED BY: Director of Pharmacy	REVISED:

Purpose:
To define the consulting services provided by the Consultant Pharmacist for the Skilled Nursing Facility and its patients.

Policy:
The Consultant Pharmacist or a pharmacist designee retained by the Facilities shall:

1. Devote a sufficient number of hours during a regularly scheduled visit for the purpose of coordinating, supervising, directing, and reviewing the pharmaceutical services within the facilities at least quarterly.
2. Serve on the Pharmaceutical Service Committee (Pharmacy and Therapeutics Committee) and the Patient Care Policy Committee (Performance Improvement Committee).
3. Review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes and laboratory test results.
4. Be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the Administrator and Director of Nursing Service.
5. Submit a monthly drug regimen review (DRR) report to the Director of Nursing Service and Administrator no later than the end of the month.
6. Submit a written report on the status of the pharmaceutical services to the Pharmacy and Therapeutics Committee at least quarterly.
7. Perform Skilled Nursing Unit Inspection monthly.

Procedure:

1. **The Consultant Pharmacist or a pharmacist designee will spend sufficient time to meet the needs of the residents per month on the following:**
    a. Reviewing selected resident's medication regimens
    b. Inspect medications in cassettes and automated dispensing cabinets.
    c. Review MAR's
    d. Inspect emergency trays
    e. Inspect pharmacy references
    f. Reconcile controlled substances count
    g. Inspect labeling and storage of medications
    h. Inspect all floor stock medications
    i. Attend interdisciplinary care plan meetings and record the services provided and hours spent in the unit.
2. **Pharmaceutical Service Committee (Pharmacy and Therapeutics Committee):**

a. Consists of the following members: Consultant Pharmacist or a pharmacist designee, Director of Nursing Service, Administrator and Medical Director.
b. Meets at least quarterly to address issues related to pharmacy services, revise pharmaceutical service policies and procedures, make recommendations for improvement, review the adequacy and appropriateness of the emergency drug content.
c. Develops a drug formulary to be used in the facility.
d. Receives input from the Consultant Pharmacist regarding the status of the pharmaceutical service in the facilities.

3. **Patient Care Policy Committee (Performance Improvement Committee)**
   a. Consists of Consultant Pharmacist or a pharmacist designee, Director of Nursing, Administrator and Medical Director.
   b. Meet every other month to discuss patient care plan policies.
4. **Interdisciplinary Team (IDT) Meeting Participation**
   a. Consultant Pharmacist or a pharmacist designee is a member of the IDT and shall provide input in pharmaceutical care plan as appropriate, based on resident needs and pharmacist availability.
   b. Pharmaceutical care plan may include but is not limited to evaluation of unnecessary drugs, psychotropic drug use, pain management, weight loss, and infectious control.
   c. If time and schedules permit, the Consultant Pharmacist or a pharmacist designee shall participate in IDT care plan meetings in addressing pharmaceutical needs for specific residents
   d. In the absence of a Consultant Pharmacist, other IDT members may submit a verbal or written request to the pharmacy requesting pharmacist involvement in pharmaceutical care plans.
   e. In response to the IDT requests, the Consultant Pharmacist shall provide input either verbally or in writing in a timely manner.
5. **Drug Regimen Review (DRR)**
   a. Refer to policy #MM8390-107 Drug Regimen Review for Skilled Nursing Facility

Reference:
Title 22:Sec 72375 , CFR Sec 483.60, Section 483.25

2014 GOVERNANCE COMMITTEE WORK PLAN

January ➢ **Annual work Plan** ➢ **Community Funding Policy** ➢ **Gift, Ticket & Honoraria Policy**	**February** • **Biennial By Law Review** • **Media Policy** • Board Ethics training status • Form 700 compliance status	**March** **No meeting**	**April** • Standing Committee Charter Review • Contracting procedures review, Best Value, Competitive Means definitions • Facility Contracting Policy • Contracting approval Matrix • Advise committees of charter review • Procurement Policy • Marin Affiliation Agreement Review
May • Record Retention and Access Policy	**June** • CEO annual objectives • AHA Summit • Compliance Reporting System	**July**	**August** • Compliance Report • CEO performance evaluation and compensation
September • Board self assessment • New Board member orientation update	**October** • Board annual retreat • Legislation Review	**November** •	**December** • Annual review of GC performance measures • Annual work plan

COMPLETED **IN PROCESS** **UNDONE**

Ongoing:

- Review and recommend legislation
- Monthly Board Development
- Review Board Policies
- From 2012 work plan, draft policies and decisions regarding governance performance and submit them to our Board for deliberation and action.
- Recommend quantitative measures to be employed by our Board to assess governance performance and contributions.
- Conduct the annual review of governance performance measures and submit an analysis to our Board for deliberation and action
- Conduct an assessment of Standing Committee members, vacancies and the desired traits for new members and alternates

6.

FINANCIAL REPORT FOR JANUARY 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: **SVH Finance Committee**
From: **Kristina Gritsutenko, Controller**
Date: **February 25, 2014**
Subject: **Financial Report for the Month Ending January 31, 2014**

Overall Results for January 2014

Overall for January, SVH has net income after the restricted contributions of $13,334 on budgeted income of $372,733, for an unfavorable variance of ($359,399). Total net patient service revenue was under budget by ($1,053,752), or 23%. Most of this variance is due to January volume significantly below budget primarily due to budget volume spread. Net revenue includes a RAC reserve of $141,671. Risk contracts are under budget by ($32,825) due to lower Napa State patients. SVH received the last installment of $1,052,328 for phase one EHR Meaningful Use implementation. Other Operating Revenue was adjusted for the receipt of EHR funds and is under budget by ($214,689) due to original EHR receivable and associated revenue higher than the funds received. Bringing Total Operating Revenue to $3,772,147 or ($1,301,266) under budget. Expenses were $4,552,921 on a budget of $5,091,887 or $538,966 under budget. The EBIDA prior to the restricted donations for the month was ($49,942) or -1.3%.

Patient Volumes - January

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	91	162	-71	159
Acute Patient Days	389	540	-151	613
SNF Patient Days	754	704	50	707
Home Care Visits	1,040	1,100	-60	1,076
OP Gross Revenue	$9,095	$9,099	-$4	$8,805
Surgical Cases	113	139	-26	116

Overall Payer Mix - January

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	56.7%	49.9%	6.9%	50.5%	49.3%	1.2%
Medi-Cal	12.6%	10.8%	1.9%	11.4%	10.7%	0.7%
Self Pay	4.3%	3.8%	0.4%	3.3%	3.8%	-0.5%
Commercial	17.7%	28.5%	-10.8%	25.2%	29.1%	-3.9%
Managed MC	3.3%	2.9%	0.4%	4.4%	2.9%	1.5%
Workers Comp	2.9%	1.4%	1.5%	3.1%	1.5%	1.7%
Capitated	2.4%	2.6%	-0.3%	2.1%	2.7 %	-0.7%
Total	100%	100%		100%	100%	

Total Operating Revenues

Total operating revenues for January were $3.8 million on a budget of $5.1 million or ($1,301,266) under budget. Below are January's favorable variances:

- Skilled Nursing Home volume was over budget by 50 days.
- Bad Debts and Charity Care were favorable to budget by $234,419.

Offset by the following unfavorable variances:

- Overall inpatient volume was under budget by 71 discharges.
- Outpatient volume was above budget and had higher Medicare patients and lower commercial insured patients.
- Home Care volume was under budget by 60 visits.

The net effect is Net Patient Revenue is under budget by ($1,053,752) or 23%.

Expenses

January's expenses were $4.6 million on a budget of $5.1 million or under budget by $538,966. The favorable variance this month is due to the new ER not opening in the month of January. The following is a summary of the operating expense variances for the month of January:

- Total productivity FTE's were under budget at 268 on a budget of 295, or $241,012 under budget. Med Surg was under budget by $76,285, IT, PFS, HIM and Quality had a net favorable variance of $40,952, Lab was under budget by $25,015, Recovery was under budget by $22,240, Labor & Delivery was under budget by $18,074, Radiology was under budget by $16,356 and CT Scan was under budget by $14,310.
- Medical and Prof Fees are over budget by ($33,329), ($39,250) is due to additional Prima Physician call.
- Supplies were under budget by $25,696 due to volume.
- Purchase Services were under budget by $40,255 due to projects in IT and Engineering that have been put on hold.
- Depreciation, Utilities and interest were all under budget due to the new ER not going into service until February.

Cash Collections on Patient Receivables:

For the month of January the cash collection goal was $3,144,398. The Hospital collected $3,252,903, or $108,505 above goal. Year to date the Hospital patient collections goal was $23,244,221, with actual collections of $23,344,032, or $119,811 above the goal.

RAC Activity

Sonoma Valley Hospital				
RAC Reserve				
Activity Through January 2014				

	Change in Reserve	Take Backs	Appeals Won	Reserve Balance
Jun-13				**715,383**
Jul-13		(54,655)		660,728
Aug-13		(115,900)	32,716	577,545
Sep-13	(230,000)	(199,693)		147,852
Oct-13	150,000	(5,886)		291,965
Nov-13		(223,810)		68,155
Dec-13	131,580	(16,617)		183,118
Jan-14	141,672	(19,384)		**305,406**
FY 2014 Net Change in RAC Reserve	**193,252**	**(635,945)**	**32,716**	**(409,977)**

Days in AR, AP, Days Cash on Hand

Days in Cash are at 7 and Days in Net A/R at 51.9.

In recent months AP Days have been increasing, while Cash Days have been decreasing, indicating deteriorating cash position. Currently AP Days are at 65 days, 5 days above target. Paying down AP Days to target is worth $373K and would result in deterioration of cash position by another 2 days (from 7 to 5). Cash on hand is currently at $1, 065K or 7 Cash Days. This is significantly below target of 30 days implying potential for liquidity problems in case of business downturn or large lump payments. If Operating Initiatives Plan to reduce Operating Expenses by $1,451K through the remainder of the year is successful, Cash Days will improve from 7 to 20 while AP Days will go down from 65 to 59 as a result of natural operating cycle (Graph 1 – 6.3% OIP Scenario). If Operating Initiatives Plan succeeds to reduce Operating Expenses by 5.0% through the remainder of the year, Cash Days will improve from 7 to 16 while AP Days will go down from 65 to 60, bringing AP Days to target level (Graph 2 – 5% OIP Scenario).

Capital Campaign Summary:

For the month of December, the Hospital received $281,546 in capital campaign donations. The total amount received from the Capital Campaign to date is $7,685,690 offset with spending of $6,724,814. The funds are included on line 17, Specific Funds on the Balance Sheet. Included on line 17 is also $21,469 for miscellaneous restricted funds, $114,552 received from the Foundation for the X-ray machine and $32,662 for the Health Round Table, all of which have been offset by spending of $121,782.

	Cash Receipts	Spending	Balance
Emergency Dept.	$1,511,046	$1,337,170	$173,876
Operating Room	$0	$0	$0
Art Work/Lobby	$400,000	$180,757	$219,243
General	$5,511,851	$5,206,887	$304,964
Children's Area	$250,000	$0	$250,000
Interest Earned	$12,793	$0	$12,793
Total Capital Campaign	**$7,685,690**	**$6,724,814**	**$960,876**
X-Ray Machine	$114,552	$114,552	$0
Misc. Restricted Funds	$21,469	$21,469	$0
Health Round Table	$32,662	$9,876	$22,786
Total Specific Funds	**$7,854,373**	**$6,870,711**	**$983,662**

These comparisons are for actual FY 2014 compared to actual FY 2013. These are not budget comparisons.

ER Visits

	ER – Inpatient				ER – Outpatient			
	CY	PY	Change	%	CY	PY	Change	%
July	**109**	**109**	**0**	**0%**	**641**	**729**	**-88**	**-12.1%**
Aug	**94**	**106**	**-12**	**-11.3%**	**695**	**778**	**-83**	**-10.7%**
Sept	**105**	**111**	**-6**	**-5.6%**	**690**	**677**	**13**	**1.9%**
Oct	**60**	**95**	**-35**	**-32.4%**	**671**	**706**	**-35**	**-5.2%**
Nov	**72**	**101**	**-29**	**-27.1%**	**593**	**631**	**-38**	**-6.0**
Dec	**95**	**100**	**-5**	**-4.2%**	**656**	**693**	**-37**	**-5.9%**
Jan	**81**	**141**	**-60**	**-64.5%**	**730**	**711**	**19**	**2.7%**
YTD	**616**	**763**	**-147**	**-19.3%**	**4,676**	**4,925**	**-249**	**-5.0%**

Sonoma Valley Hospital
Sonoma Valley Health Care District
January 2014 Financial Report

Board of Directors
March 6, 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

January Patient Volumes

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	91	162	-71	159
Acute Patient Days	389	540	-151	613
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Home Care Visits	1,040	1,100	-60	1,076
OP Gross Revenue	$9,095	$9,099	-$4	$8,805
Surgical Cases	113	139	-26	116

Summary Statement of Revenues and Expenses Month of January 2014

		Actual	Budget	Variance	Percentage	Prior Year
1	Total Operating Revenue	$ 3,772,147	$ 5,073,414	$ (1,301,267)	-26%	$ 4,825,276
2	Total Operating Expenses	$ 4,552,921	$ 5,091,887	$ 538,966	11%	$ 4,631,768
3	Operating Margin	$ (780,774)	$ (18,473)	$ (762,301)	-4127%	$ 193,508
4	NonOperating Rev/Exp	$ 512,562	$ 294,696	$ 217,866	74%	$ 299,699
5	Net Income before Restricted Cont.	$ (268,212)	$ 276,223	$ (544,435)	-197%	$ 493,207
6	Restricted Contribution	$ 281,546	$ 96,511	$ 185,035	192%	$ 43,788
7	Net Income with Restricted Contributior	$ 13,334	$ 372,734	$ (359,400)	-96%	$ 536,995
8	EBIDA before Restricted Contributions	$ (49,942)	$ 728,561	$ (778,503)		$ 758,833
9	EBIDA before Restricted Cont. %	-1%	14%	-16%		16%
10	Net Income without GO Bond Activity	$ (104,067)	$ 254,075	$ (358,142)		$ 413,439

Summary Statement of
Revenues and Expenses
Year to Date January 31, 2013 (7 months)

		Actual	Budget	Variance	Percentage	Prior Year
1	Total Operating Revenue	$ 29,129,122	$ 30,739,226	$ (1,610,104)	-5%	$ 28,690,430
2	Total Operating Expenses	$ 31,608,074	$ 32,216,723	$ 608,649	2%	$ 30,544,964
3	Operating Margin	$ (2,478,953)	$ (1,477,497)	$ (1,001,456)	-68%	$ (1,854,534)
4	NonOperating Rev/Exp	$ 2,312,329	$ 2,185,389	$ 126,940	6%	$ 2,240,938
5	Net Income before Restricted Cont.	$ (166,623)	$ 707,892	$ (874,515)	-124%	$ 386,404
6	Restricted Contribution	$ 3,260,990	$ 1,214,773	$ 2,046,217	168%	$ 448,709
7	Net Income with Restricted Contributior	$ 3,094,367	$ 1,922,665	$ 1,171,702	61%	$ 835,113
8	EBIDA before Restricted Contributions	$ 1,391,777	$ 2,630,174	$ (1,238,397)		$ 2,094,261
9	EBIDA before Restricted Cont. %	5%	9%	-3%		7%
10	Net Income without GO Bond Activity	$ (988,430)	$ (127,634)	$ (860,796)		$ (478,491)

9.

OFFICER AND COMMITTEE REPORTS

Sonoma Valley Hospital
FY 2015 Operating and Capital Budget Timeline

DRAFT

March 2014						
S	M	T	W	TH	F	S
23	24	25	26	27	28	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

April 2014						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 2014						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2014						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Budget Calendar to Finance Committee	Feb-25-2014
Budget Calendar to District Board	Mar-6-2014
Budget Calendar to Departments	Mar-7-2014
Budget Assumptions to Finance Committee	Mar-25-2014
Budget Assumptions to District Board	Apr-3-2014
Capital Budget Workbooks Completed by Managers	Apr-7-2014
Manager/Director Training Sessions	Apr-11-2014 (as needed)
Departments develop budget in IDEA	Apr-14-2014 - Apr-18-2014
Departmental meetings with Finance	Apr-21-2014 - Apr-25-2014
Budget rollup draft to Executive Team *	May-6-2014
Finalize departmental budgets	Apr-28-2014 - May-16-2014
Study Session for Finance Committee & District Board	Week of May 12-16
Proposed budget to Finance Committee for approval	May-27-2014
Proposed budget to District Board for approval	Jun-5-2014

* subsequent updates provided to Executive Team weekly

Northern California Health Care Authority

Reaching out in Collaboration

March 6, 2014

To: Members of the Board of Directors of the Sonoma Valley Health Care District

From: Bill Boerum, Board Member & Secretary, Sonoma Valley Health Care District;
Board Chair of the Northern California Health Care Authority (JPA)

Agenda Item Title:

Northern California Health Care Authority (JPA) – Conduit Issuer of Debt Obligations

Recommendation:

Amend the "Joint Powers Agreement" of the Northern California Health Care Authority to Enable Conduit Issuer Transactions

Background and Reasoning:

Last year following extensive interviews with the various stakeholders of the Northern California Health Care Authority (JPA) including the CEO's of the member district hospitals, it was decided to continue to maintain the existence of the Authority which, though it had had limited accomplishments, continued to hold the promise of potential future collaboration for the five district members.

Further, it was decided to scale back operations to fewer meetings and to a generally minimalist mode, awaiting opportunities which might arise. Additionally, in view of the fact that there were no immediate activities requiring action or funding, contributions by the members would not be requested for the foreseeable future. Nonetheless, it was recognized that given several regulatory requirements (e.g. annual audits and state agency filings) as well as internal requirements (e.g. basic administrative work and D&O insurance) that existing financial resources would be utilized though they would be depleted in two to three years.

Since that time it came to the attention of the JPA board of directors, through financial advisors known to us (Messrs. Gary Hicks and Brian Quint), that there was a business opportunity in the realm of our knowledge and mission and which could generate monies to extend the Authority's financial resources into the future and perhaps prompt undertakings which we might otherwise shy from. The business opportunity is serving as the "conduit issuer of debt obligations" for non-member agencies and institutions.

Following discussions by the JPA board as well as consideration of a business plan (informed by the financial advisors), it was decided to accept the Business Plan. It was recognized that the JPA "Agreement" would have to be amended to allow the Plan for the business opportunity initiative to go forward. Changes to the "Agreement" (as suggested by the financial advisors) were considered and recommended by the board. To undertake the initiative all the member districts need to approve an amended Agreement.

To reiterate, the purpose of the business initiative is to provide an on-going source for funding the Authority's operations in lieu of member contributions.

At December 31, 2013 the Authority's cash was $67,000. The budget (for the fiscal year ended June 30, 2014) projects six months' expenditures of $13,000. This would reduce cash to about $54,000. Anticipating budgets of approximately $25,000 annually for each of the next two years would bring cash resources to $29,000 at June 30, 2015 and to depletion at June 30, 2016.

Consequences of Negative Action/Alternative Actions:

The recommended business initiative cannot be implemented.

Financial Impact:

None to the budget of the District

Selection Process and Contract History: N/A

Board Committee: None – Direct recommendation from JPA Board of Directors

Attachments:

Business Plan and the "Amended Joint Powers Agreement" tracking changes to the Agreement.

Northern California Health Care Authority (the "Authority")

Business Plan: The Authority as a Conduit Issuer of Debt Obligations

January 21, 2014

Background

Through conversations with financial professionals with whom three of our five member districts have had experience, Bond Counsel Brian Quint and Financial Advisor, Gary Hicks it has come to our attention that there exists a business opportunity for the Authority to provide a broad scale financial intermediary service. The Authority, through its foundational Agreement and Bylaws already has been an issuer of Certificates of Participation (COP) for the Palm Drive and Northern Sonoma County Districts.

The proposed business opportunity is that the Authority extends its charter capabilities as a joint powers agency to selected borrowing entities which are not our members that is, to other governmental (district) entities and to non-profits, 501 (c) (3) public benefit corporations. By state law such borrowing entities must have a quasi-municipal entity such as a joint powers or state authority acting as a conduit.

The Business Opportunity

The purpose of the business is to generate revenues from non-member client fees to make the Authority largely self-sustaining (not requiring member district contributions) and thereby funding the organization's collaboration, communications, educational and administrative activities (such as applying for grants).

As a broad definition, the business activity would be as a "Conduit Issuer of Tax Exempt Obligations." The Authority's charter enables it to act as a public agency intermediary for selected borrowers in order to secure tax-exempt status for their debt obligations. This role provides lower financing costs for the borrower and improved access to a diverse market for the investor(s).

There are different types of transactions for which a conduit can facilitate through competitive sales or negotiated sales (e.g. private or direct placements) for new debt financings such as general obligation bonds, revenue bonds, certificates of participation and other debt forms.

Revenue Generation - Fees

There are several fees incident to such debt issuance. We believe that application and transaction fees would average between $5,000 and $15,000 per debt issue for public entities and between $5,000 and $30,000 for non-profit entities. Financial advisory fees and administrative fees can be negotiated. There can be recurring fees of $1,000 to $3,000 annually for on-going administration in behalf of the issuer. Non-profit healthcare entities such as clinics, senior housing, assisted living, skilled nursing facilities or hospitals may be the most frequent uses of conduit issuers. We do not believe our fees would need material discounts to attract business.

Fees for conduit transactions (just the issuance itself) range from $5,000 to $30,000 and average around $10,000 per debt issuance. These fees usually are based on the size of the debt issued, the perceived value brought to the transaction by the conduit issuer and the type of borrower involved. The two transactions for which the Authority served as a conduit for our members resulted in fees of $10,000 each.

Generally the administrative and legal fees associated with the conduit transaction are included in the debt instrument or bond indenture and paid by the borrower in addition to the above-referenced issuance fees. However, as our business starts up we may experience administrative and communications expenses depending on the due diligence involved. These activities might involve engaging or contracting with experienced, retired district trustees or hospital chief financial officers. We should not staff up for this business, but address the expenses piece meal.

Market Opportunity

According to Messrs. Hicks and Quint there definitely is a variety of conduit opportunities. Issuance size ranges from $5,000,000 to in excess of $50,000,000. There are 30 to 50 issues annually in California which require use of a conduit. (There are approximately 1,000 special districts in the state). Attracting at least three transactions the first year (at about a $10,000 fee per issuance), gross fee income of $20,000 to $25,000 would seem achievable.

Obviously clients would not be limited to health care districts. However starting in this domain which has more than 60 districts would be the first step in a word-of-mouth and networking campaign, including a web page, emails to investment bankers and financial advisors and presence at selected conferences. Additionally, there is the related domain of nonprofit health care owners and operators. According to Hicks a website and monthly email distributions would be essential for visibility for the business. The website would be a ready source of information for both borrowers and purchasers. It would add credibility for the Authority itself.

It may be that Hicks and Quint would be immediate sources of transactions since they know ready borrowers and the competitive landscape and could come to us with transactions which fit our legal authority and desired applicants. We understand that currently there is good interest on the part of

selected commercial banks as investors in the types of transactions for which the Authority could serve as a conduit.

Competition

There are several major conduit issuers active in the business which primarily service their members and constituencies. These include:

- The California Statewide Communities Development Authority (CSCDA) primarily assists the financing of county and city housing and energy projects but works with all types of borrowers;
- The Association of Bay Area Governments (ABAG) primarily sponsors financings of its municipal government members but also works with all types of borrowers;
- The California Municipal Finance Authority (CMFA) primarily sponsors underwritings to finance large educational projects and large hospitals but also works with all types of borrowers; and,
- The California Infrastructure and Economic Development Bank (successor to the Economic Development Financing Authority) supports public infrastructure projects in communities with broad statutory powers but also works with all types of borrowers to issue revenue bonds, make loans and provide credit enhancements.

In addition, cities and counties can act as conduit issuers as can the California Health Facilities Financing Authority (CHFFA) that only sponsors healthcare borrowers as a conduit issuer.

Meeting the competition would involve competitive (lower) fees, not charging an annual service fee and/or the willingness to do smaller size transactions. The latter could be a distinct competitive advantage. To the extent that bundling two or more small issues (commonly referred to as a pooled or composite issue) could be feasible, a future opportunity may lie there as well.

Liability

We have been told by our insurance provider (the California Special District Risk Management Authority) that our existing coverage would include risks associated with this new activity. We should obtain some form of acknowledgement to this effect in order to determine if in fact any risk management augmentation is needed which might require an additional premium expense.

The debt instrument documents and bond indentures incident to these financings routinely indemnify and hold harmless the conduit issuer from liability. We would insist upon it. Bond Counsel Quint characterizes the risk in conduit transactions as minimal. This does not mean that there is no risk. Any and all parties associated with a transaction that results in a claim of liability for a loss could be sued. Additionally it should be recognized that the constituent districts of the Authority may be held responsible for the Authority's actions. Neither Messrs. Hicks or Quint -or we are aware of any such contentions ever having been filed.

Next Steps

- If the business concept is approved by the Board of Directors, changes should be recommended immediately by the Board for amendments to the Joint Powers Authority Agreement and to the Bylaws. The proposed Agreement amendment(s) must be submitted for approval to each of the constituent member district boards of directors;
- All the member district boards need to approve the amendments;
- If the amendments are approved by the Districts, the Authority's Executive Committee should develop screening criteria and due diligence as well as policies and operating procedures (including perhaps some form of approving committee, if not the full Board itself) for consideration by the full Board of Directors at the June annual meeting;
- The Executive Committee should develop a budget for the business for the year 2014-2015 (to include development of a website) within the Authority's annual 2014-2015 budget to be considered by the full Board at the June meeting; and,
- The business should be launched immediately after the June meeting.

AMENDED AND RESTATED
JOINT POWERS AGREEMENT
ESTABLISHING A COORDINATED SYSTEM
FOR HEALTH CARE SERVICES

This JOINT POWERS AGREEMENT ESTABLISHING A COORDINATED SYSTEM FOR HEALTH CARE SERVICES (hereinafter, the "Agreement") is entered into by and between the undersigned parties ("Parties" or "Districts" or "Agencies") as of ~~July 1, 2007~~the date of the last execution hereof by all Parties, pursuant to the provisions of Title I, Division 7, Chapter 5, Article I (Sections 6500, et seq.) of the California Government Code (hereinafter, the "Act") relating to joint exercise of powers by public agencies.

Recitals

A. The Parties are all local health care districts organized pursuant to the Local Health Care District Law (California Health and Safety Code §§ 32000 *et seq.* hereinafter the "District Law") of the State of California (the "State"). The Districts own or operate licensed hospitals and/or other health care facilities and services in Northern California.

B. The Parties wish to form a joint powers authority entity (hereinafter, "JPA") pursuant to the Act to assist in pursuing the joint mission of providing health care services in their respective communities and to provide financing vehicle for the Districts, for other local health care districts organized pursuant to the District law ("Other Districts") and for nonprofit, public benefit corporations organized and existing under the laws of the State ("Nonprofits"). All of the Parties desire to establish a cooperative relationship for the following purposes:

i. To foster the development of, and expand, a system to deliver high quality health care services to the residents served by the Districts.

ii. To ensure a sufficient foundation of local support and financial stability to maintain a locally-owned health care delivery system.

iii. To create more efficient health care services by eliminating unnecessary duplication of services and resources.

iv. To establish a formal structure for business discussions and decisions ~~making~~ made leading to collaborative activities.

v. To establish a formal structure for the involvement of each District's Board of Directors.

vi. To develop and implement strategies and programs for meeting the needs of indigent residents in the areas served by the Districts.

vii. To undertake the financing and/or refinancing of projects of any nature, including, but not limited to, capital or working capital projects, insurance, liability or retirement programs or facilitating the Districts', Other Districts' and Nonprofits' use of existing or new financial instruments and mechanisms.

viii. To issue and execute bonds, notes, commercial paper or any other evidences of indebtedness, including leases or installment sale agreements or certificates of participation therein (herein "Bonds"), and to otherwise undertake financing programs under the Act or other applicable provisions of the laws of the State to accomplish its public purposes.

NOW, THEREFORE, THE PARTIES HEREBY AGREE TO THE TERMS AND CONDITIONS SET FORTH BELOW.

Agreement

1. **Recitals**. The Recitals set forth above are true and correct.

2. **General Purpose of Agreement**. The purpose of this Agreement is to establish a cooperative relationship by and among the Districts through the creation of a joint powers agency that efficiently and effectively provides opportunities to collaborate in the delivery of health care and financing services. The Parties intend that additional public agencies that provide health care services in Northern California, not presently executing this Agreement, may join the JPA in the future subject to the applicable terms and conditions stated in this Agreement. The Parties also intend to utilize flexible, cost effective, and efficient methods of providing coordinated health care and financing services. The methods used in future years to provide these services may differ from those initially established under this Agreement. Any such changes shall be determined by the Board of Directors of the JPA.

3. **Joint Powers Authority Created**. Pursuant to Section 6506 of the Act, the Parties create a public entity, separate and apart from the Parties to this Agreement, to be known as the Northern California Health Care Authority (hereinafter, the "Authority"). The debts, liabilities and obligations of the Authority shall not constitute debts, liabilities and/or obligations of any of the Parties .

4. **Joint Activities**.

A. **Joint Program Proposals**. The Districts shall collaborate in establishing joint program proposals which may be submitted to the Authority and shall, if approved by its Board of Directors, serve as a framework for the scope, operation and administration of that program by the Authority. The form of proposals for the financing and/or refinancing of projects as stated above shall be determined by the JPA to allow for an adequate assessment and evaluation of said proposals to the JPA. Only programs that receive approval by the Board shall be operated under the terms of this Agreement.

B. **Potential Projects**. The partied have identified the following specific projects as potential areas of joint activity under this Agreement:

i. Consolidated home care and ambulance services
ii. Emergency medical services;
iii. Joint warehousing;
iv. Joint benefits planning (employment and other);
v. Community benefits program;
vi. Provider sponsored network;
vii. Joint purchase or leasing of medical equipment and supplies;
viii. Physician recruitment and call services;
ix. Pooled financing, issuance of bonds and other funding vehicles (revenue, general obligation and other short term and long term);
x. Joint fundraising, philanthropy and sharing of gifts;
xi. Joint contracting negotiations with various third party and government payers inclusive of Medi-Cal managed care, commercial PPO, HMO, existing medical groups and JPA's;
xii. Such other projects as may be added in the future by agreement among the Parties;

xiii. Joint venture activities relating to inpatient and outpatient services;
xiv. Management activities;
xv. Development and implementation of insurance provider networks; and
xvi. Sharing and cross over of managed care contractual rates.

C. **Contents of Project Proposals**. Project proposals shall include the following elements:

i. A statement of the purpose of the joint program with a brief description.
ii. Contributions to be made by each District in cash or in kind (if permitted), including a statement as to the manner in which any surplus funds or assets on hand after the completion of its purpose shall be returned to the District.
iii. Any agreements or any obligations anticipated as part of the joint project, including the nature, anticipated scope and purpose of those agreements and obligations.
iv. Compensation, if any, to be paid to any party or parties implementing or administering the joint project.
v. Designation of a person or entity responsible for day-to-day administration of the joint project. In addition, the bonding requirements, if any, of any such person or entity as required by section 6505.1 of the Act shall be stated.
vi. Provisions, if appropriate, for the delegation of authority to independent contractors, consultants or committees.
vii. Disposition, division or distribution of any property acquired as a result of the joint exercise of power.
viii. Commencement and termination provisions.

5. **Powers and Duties**.

A. **Authority**. The Authority shall have the powers common to the Parties to this Agreement, to wit: the powers set forth in the District Law including, but not limited to, the powers set forth in section 32121 *et seq.* of the District Law. Such powers shall be exercised in the manner provided in the Act subject only to the restrictions set forth in this Agreement and those imposed upon the Parties in the exercise of similar power. The Authority is authorized in its own name to perform all acts necessary for the exercise of common powers, including, but not limited to, the powers to:

i. Engage in joint planning for health care services;
ii. Allocate health care services among the different facilities operated by the Parties;
iii. Engage in joint purchasing, joint development, and joint ownership of health care delivery and financing programs;
iv. Consolidate or eliminate duplicative administrative, managerial, clinical, and/or medical services;
v. Incur debts, liabilities or obligations, but no debt, liability or obligation of the Authority shall be a debt, liability or obligation of any of the Parties, except as otherwise provided herein;
vi. Receive gifts, contributions and donations of property and funds, services and other forms of financial assistance, from persons, firms and corporations and any governmental entity;
vii. Engage in joint contracting and negotiations with health plans;
viii. Take cooperative actions in order to provide for the health care needs of the residents of the communities they serve; and
ix. Make and enter contracts for goods and services, employ agents and employees, acquire, construct, manage, maintain or operate any building, works or

improvements, acquire, hold or dispose of property, incur debts, liabilities or obligations, and sue in its own name.

B. **Assessments**. Pursuant to Section 6504 to the Act, the Authority is empowered, and by this Agreement required, to assess the Parties to finance the entire operation of the Authority in the manner set forth in this Agreement.

C.**Bonds**. Without limiting the generality of the foregoing, the Authority may issue or cause to be issued Bonds, and pledge any property or revenues as security to the extent permitted under the Act, or any other applicable provision of law; provided, however, the Authority shall not issue Bonds with respect to any project unless the governing body of the District, Other District or Nonprofit, or its duly authorized representative, shall approve, conditionally or unconditionally, the project, including the issuance of Bonds therefor. Such approval may be evidenced by resolution, certificate, order, report or such other means of written approval of such project as may be selected by the District, Other District or Nonprofit, (or its authorized representative) whose approval is required.

The Bonds, together with the interest and premium, if any, thereon, shall not be deemed to constitute a debt of any District or pledge of the faith and credit of the Districts or the Authority. The Bonds shall be only special obligations of the Authority, and the Authority shall under no circumstances be obligated to pay the Bonds except from revenues and other funds pledged therefor. Neither the Districts nor the Authority shall be obligated to pay the principal of, premium, if any, or interest on the Bonds, or other costs incidental thereto, except from the revenues and funds pledged therefor, and neither the faith and credit nor the taxing power of the Districts nor the faith and credit of the Authority shall be pledged to the payment of the principal of, premium, if any, or interest on the Bonds nor shall the Districts or the Authority in any manner be obligated to make any appropriation for such payment.

No covenant or agreement contained in any Bond or related document shall be deemed to be a covenant or agreement of any Director, or any officer, employee or agent of the Authority in his or her individual capacity and neither the Board of the Authority nor any Director or officer thereof executing the Bonds shall be liable personally on any Bond or be subject to any personal liability or accountability by reason of the issuance of any Bonds.

6. **Governance**.

A. **Board of Directors**. The Authority shall be governed by a Board of Directors ("Board"). The Board of Directors, as the governing and administrative body of the Authority, shall formulate and set policy, and shall exercise the powers set forth in this Agreement to accomplish its purpose. Unless otherwise specified herein, each Party shall appoint one member of the Board ("Director"). Each Director shall be an elected or appointed official of the appointing Party.

B. **Normal Term of Office of Directors**. Each Director shall serve a two (2) year term of office. All Directors shall serve at the will and pleasure of their respective Agencies and may be replaced at any time and without cause by the member Agency that initially appointed the Director. Any replacement Director shall serve out the balance of the term of the Director being replaced.

C. **Alternates**. Any Director may, from time to time, appoint an alternate to serve in the Director's place at any meeting. Any such alternate shall be a government employee or official from the same District as the Director.

7. **Meetings of the Board of Directors**.

A. **Conducting Meetings**. The Board shall hold regular meetings at least quarterly and shall adopt bylaws for conducting their meetings and other business. All meetings of the Board, including without limitation regular, adjourned regular and special meetings, shall be called, noticed and conducted, in accordance with the provisions of the Ralph M. Brown Act (commencing with Section 54950 of the California Government Code).

B. **Quorum and Decision Making Methods**. A majority of voting members of the Board shall constitute a quorum. Each Director, or alternate, shall be entitled to one vote. Decisions shall be made by supermajority votes of at least 75% of the voting members present, except where otherwise required by law or established by Board bylaws or other provisions of this Agreement.

C. **Board Officers**. The Board shall have a Chair to preside at and conduct all meetings and a Vice Chair who shall succeed the Chair and preside in the absence of the Chair. The offices of Chair and Vice Chair shall rotate through each of the seats on the Board annually in a manner to be determined by the bylaws.

8. **Limitation on Powers**. Nothing in this Agreement shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the California Business and Professions Code.

9. **Appointed Officers**. Pursuant to section 6505.6 of the Act, the Board of Directors shall appoint an Auditor and a Treasurer for the Authority to perform the duties required by law as well as providing any other services that may be desired by the Authority. Should the County Auditor and County Treasurer be willing to serve, they may serve the Authority as Auditor and Treasurer, or the Authority may select another eligible Auditor and Treasurer to perform such duties. Such officers shall receive no compensation for holding the appointed office but shall be compensated for the cost of providing services as per written agreement with the Authority.

10. **Fiscal Year and Annual Budget/Financing**.

A. **Fiscal Year**. The Authority's fiscal year shall be the twelve (12) month period commencing each July 1, except if the effective date of this Agreement is other than July 1, the first fiscal year shall be the short year commencing the effective date and ending the following June 30.

B. **Annual Budget**. The Authority shall operate only under an approved fiscal year budget. The Authority may not operate at a deficit. The Parties shall pay for the · entire operation of the Authority, with the annual expenditure budget determining the total amount of assessment required. Once adopted annually for each fiscal year, the total annual expenditure budget may only be increased by unanimous vote of the Board of Directors. The Authority will adopt a preliminary annual budget no later than March 15 for the following fiscal year and will adopt a final budget prior to July 1.

C. **Budget Elements**. The Board of Directors, in adopting an annual budget, thereby fixes the assessment against the Parties which is binding thereon. The budget policy shall include, but is not limited to, the following components:

i. Operation and Maintenance Expenses. The costs of operating and maintaining a facility and the equipment housed therein shall include, but is not limited to, personnel salaries and benefits, office and computer supplies and other

consumables, payments to lease a facility, and replacement parts necessary to repair facility equipment due to normal wear and tear from ordinary usage; and

ii. Capital Expenditures. Capital expenditures shall include the costs of original purchase of equipment, hardware, software and other fixed asset type items typically having a useful life of more than one (1) year, including equipment improvements and additions, as opposed to replacement parts for ordinary maintenance during the useful life of the capital items. All costs · associated with such purchase, such as installation, shall be capitalized.

Replacement of equipment at the end of its useful life shall be a capital item. Capital expenditures shall be shared by the Parties in conformance with the cost formula established by this Agreement, except capital expenditures which are incurred for and are unique to a minority of the Parties, in which case such minorities shall share the expense equally.

D. **Assessments**. Upon adoption of the fiscal year budget by the Board of. Directors, and the forwarding thereof to the governing bodies of the Parties by the Board Secretary, unless otherwise specified by the order of the Board of Directors, the assessments fixed therein are automatically due and payable without further notice as follows:

July 15: 35% of total assessment
October 15: 25% of total assessment
January 15: 25% of total assessment
April 15: 15% of total assessment

The Board of Directors may set a different payment schedule to provide for adequate cash flow for operations and maintenance expenses and/or capital purchases, as needed. A five (5) percent late charge shall be imposed upon assessment payments not received by the Authority within thirty (30) calendar days following the scheduled dates for payment. An additional five (5) percent shall be imposed if payment is not made within an additional thirty (30) calendar days. If an assessment, including late charges, is not paid in full within seventy five (75) calendar days following any scheduled due date, the Party shall be in default and subject to immediate and automatic termination in accordance with this Agreement . .

E. **Annual Notification**. The Authority shall notify each participating Agency of its share of the Authority's annual cost for the following fiscal year no later than April 1.

F.**Fees Relating to the Issuance of Bonds**. The Board of Directors of the Authority shall, from time to time, establish a fee schedule for the issuance of Bonds, which schedule may vary if the Bonds are issued for District, Other Districts or Nonprofits.

11. **Funding and Cost Allocation**. The Authority's annual budget shall include a reasonable provision for contingencies as well as financing for the maintenance, upgrade, or ultimate replacement of key fixed assets and structures. The Authority shall endeavor to provide its services in the most cost effective manner available without compromising quality standards. The Authority shall endeavor to allocate all costs fairly and equitably to all participating agencies and approved providers. The Authority shall consider all available funding options to finance its costs. These shall include but are not limited to: charges to member Parties for baseline services, charges to member Parties, approved providers, and others to cover the costs of any enhanced, additional or contract services, taxes, bonds, and federal, state or private grants. The percentage allocations may also be revised at any time by the Board of Directors to accommodate the addition, if any, of new providers and any annexations or consolidations between members.

12. **Appeals to the Board of Directors**. Any member agency shall have the right to appeal any implemented or recommended policy or procedure to the Authority's Board of Directors for final determination should, in the opinion of the member agency, such policy or procedure pose a significant adverse impact on the member agency. In such cases, a unanimous vote of the Authority's Board of Directors (excluding the Director from the appealing agency) shall be required to approve the policy or recommendation.

13. **Term of Agreement and Termination Provisions**. This Agreement shall be deemed to go into effect on ~~July 1, 2007~~the date of approval by the last of the Districts (the "Effective Date"), and shall continue in full force and effect until rescinded or terminated, as set forth below.

A. **Termination of Individual Membership**. Any member may terminate its participation in this Agreement by giving written notice to the Board of Directors not less than one year before the start of the fiscal year, which termination shall be effective only on the beginning of the next fiscal year.

i. If a member terminates its participation in this Agreement, it shall pay its portion of the costs for which it is responsible up to the effective date of the termination. In addition, a terminating member shall be required to pay its proportionate share of remaining unpaid costs/debts related to any and all tangible and intangible property (including, but not limited to, costs of equipment, leases, facilities, improvements, etc.), as well as the actual costs associated with its membership termination (including, but not limited to, staff time). Any payments due under this section shall be paid within ninety (90) days after the effective date of termination.

ii. Termination of this Agreement by any Party shall not be construed as a completion of the purpose of this Agreement, and shall not require the repayment or return to the remaining Parties of all or any part of any contributions, payments, or advances made by the parties until this Agreement is rescinded or terminated as to all Parties. Further, the Board of Directors of the Authority has the discretion and authority to determine how to address any claims of ownership and/or possession of any property by a terminating party.

B. **Rescission of Agreement by All Parties**. At any time, this Agreement may be rescinded and terminated, and the Authority may be dissolved, by a unanimous vote of all Parties. In that event, the remaining assets and liabilities shall be apportioned among all Parties according to the relative assessments paid by those Parties, exclusive of late charges, from the inception of the JPA, up to the point of termination.

14. **Consolidations, Divisions and Annexations of Parties**. Consolidations of Parties with other Parties or with non-member agencies, divisions of Parties into two or more entities, and annexations of portions of Parties shall have no adverse effect on the cost assessments of uninvolved Parties. In the event that involved Parties cannot come to an agreement regarding adjustments to cost assessments between themselves, the Board of Directors shall resolve the matter after considering and hearing from the affected Parties.

15. **Membership**. Membership in the Authority shall be open to all cities, independent districts, and other public agencies which have an interest in providing health care services in Northern California.

A. **Admission of New Members**. The Board of Directors has the authority to admit new members to the Authority, after notice to existing members and an opportunity for them to be heard at a public meeting. The Board shall set the terms and conditions for admitting new members (either individually or generally) that it deems appropriate.

B. **Cost of Admitting New Members**. The Board of Directors shall determine the cost of admitting any new members to the Authority, including any buy-in costs, on? going assessments or charges that new members will be required to pay to the Authority. It shall have the discretion to charge new members less than the actual cost of admission as an initial incentive; however, ultimately the Board is responsible for assessing costs to new members based on the actual costs incurred and in the manner assessed to other member agencies.

C. **New Member Obligations**. Each agency accepted as a new member shall be required to pay all costs established by the Board of Directors, and sign a copy of this Agreement, or an acknowledgement that it is bound to all the terms and conditions herein (at the discretion of the Authority).

D. **Removal of Member**. The Board of Directors may remove any member from the Authority for good cause, including, but not limited to, failure to pay required costs or compromising the function or integrity of the Authority. Such removal can be effectuated only upon a 2/3 vote of the Board of Directors after providing the affected member (and all other members) with at least 30 days written notice of the intended removal and an opportunity to be heard. A member removed from the Authority pursuant to the provisions of this section will be deemed to have terminated its membership, and shall be required to comply with the payment provisions of section 13(A)(i) above, as well as all other applicable requirements.

16. **Amendments to Agreement**. This Agreement may be amended or modified only by a unanimous vote of the Member Agencies that are Parties to this Agreement. Any amendments to this Agreement shall be in writing and signed by all members.

17. **Severability**. Should any part, term, portion or provision of this Agreement, or the application thereof to any person or circumstances, be in conflict with any State or Federal law, or otherwise be rendered unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions, or the application thereof to other persons or circumstances, shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to continue to constitute the Agreement that the Parties intended to enter into in the first instance.

18. **Insurance**. The Authority shall be required to obtain insurance, or join a self insurance program in which one or more of the Parties participate, appropriate for its operations. Any and all insurance coverages provided by the Authority, and/or any self? insurance programs joined by the Authority, shall name each and every Party to this agreement as an additional insured for all liability arising out of or in connection with the operations by or on behalf of the named insured in the performance of this Agreement. Minimum levels of the insurance or self-insurance program shall be set by the Authority in its ordinary course of business. The Authority shall also require all of its contractors and subcontractors to have insurance appropriate for their operations.

19. **Indemnity**. The Authority shall indemnify, defend and hold harmless the Parties their officers, agents, servants, employees and volunteers from any and all claims, losses, costs or liability resulting to any person, firm or corporation or any other public or private entity for damages of any kind, including, but not limited to, injury, harm, sickness or death to persons and/or property from any cause whatsoever arising from or in any way connected with the performance of its operations and exercise of its powers, except from any such claim arising

solely out of acts or omissions attributable to the member Party or its officers, employees, volunteers or agents.

20. **Successors**. This Agreement shall be binding upon and shall inure to the benefit of the successors of the Parties hereto.

21. **Notice of Creation**. A notice of the creation of the Authority by this Agreement shall be filed by the Authority with the Secretary of State, pursuant to Section 6503.5 of the Act.

22. **Other Notices**. Notices to the Authority required or permitted to be given under this Agreement shall be in writing. Delivery of such notices shall be conclusively taken and sufficiently given forty-eight (48) hours after deposit in the United States Mail, return receipt requested, with the postage thereon fully prepaid, addressed to the Authority as follows:

[Insert address of principal place of business]

Notices to the Parties shall be provided in the same manner as above, addressed as set forth in the signature page hereto. The Authority may change its address above for notices by giving written notice as described above to all Parties. Any Party may change its address for notices by giving written notice as described above to the Authority.

23. **Counterparts**. This Agreement may be executed in any number counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

24. **Entire Agreement**. This Agreement contains the final and entire agreement between the parties and supersedes all other agreements, written or oral, heretofore made by the parties. The parties shall not be bound by any terms, conditions, statements, or representations, oral or written, not contained herein.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized, as of the day and year first above written.·

NORTH SONOMA COUNTY HOSPITAL DISTRICT

Name _____
Title _____
Date of Execution _____

PALM DRIVE HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

SONOMA VALLEY HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

MENDOCINO COAST HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT

Name _____
Title _____
Date of Execution _____

Medi-Cal Funding and Accountability Act of 2014
JOIN THE COALITION

Providing Billions in Federal Health Care Matching Funds that Will Ensure Access to Medical Care for Children, Seniors and Low-income Residents Without New Taxes

Name: Kelly Mather

Title: President & CEO

Organization/Occupation: Sonoma Valley HeathCare District

(For identification purposes only unless otherwise noted)

Official Organizational Endorsement (Y/N): YES

Address: 347 Andrieux Street,

City/State/Zip: Sonoma, CA 95476

Bus. Phone: (707) 935-5005 **Cell Phone:** NA

Email: kmather@svh.com

Twitter Handle:@ NONE **Facebook: (Y/N)** NO

Please contact me so I can participate in media activities (Y/N): NO

You may use my name as a coalition member and supporter of the Medi-Cal Funding and Accountability Act of 2014:

(Signature required)

Please return this form by email to CHA@randlecommunications.com or by fax to (916) 448-5872. Thank you for your support.

Paid for by Californians United for Medi-Cal Funding and Accountability, sponsored by California Association of Hospitals and Health Systems
455 Capitol Mall, Suite 600
Sacramento, CA 95814

Meeting Date: **March 6, 2014**

Prepared by: Peter Hohorst

Agenda Item Title: Media Relations Policy

Recommendations:
The Governance Committee recommends that the Board approve the Media Relations Policy.

Background:
At the January Board meeting the Board directed "the CEO, with the assistance of the Hospital's professional media relations consultant, to develop draft policies for the District/Hospital to bring to the Governance Committee (GC) no later than the February 2014 GC meeting. This draft policy shall include everything that the CEO, with the input of the media relations consultant, believes should be included in such a policy".
At the February 2014 Governance Committee meeting Bob Kenny, the media relations consultant presented a draft Media Relations Policy for review. The Policy with a few minor edits is recommended to the Board for approval by the Committee.

Consequences of Negative Action/Alternative Actions:
Without a policy all media communications will not be consistent and may not be transparent.

Financial Impact:
None

Attachment:
Draft Media Relations Policy

Sonoma Valley Health Care District And Hospital
Media Communications Policy

DRAFT (2/25/14)

POLICY #	POLICY NAME	ISSUE DATE	REVISION DATE	DEPARTMENT
	Media Communications			**Organizational**

1.0 PURPOSE

To identify procedures for communicating information to the public and stakeholders through the news media about the decisions, actions and programs undertaken by Sonoma Valley Health Care District and Hospital.

2.0 SCOPE

2.1 This policy applies to all media-based public communications for Sonoma Valley Health Care District and Hospital. For purposes of this policy, "news media" will be defined as:

- *2.1.1* Local, regional and national news and feature media, both print and electronic
- *2.1.2* Industry news media and websites
- *2.1.3* SVH/Board website
- *2.1.4* Social media (i.e. Facebook, Twitter)

3.0 POLICY

3.1 It is the policy of the Sonoma Valley Health Care District and Hospital to provide accurate and timely information to the media in order to foster and maintain open communications and provide transparency for the media and the public. The District and Hospital also believe it is important to regularly communicate information about Hospital programs and service offerings to community members and stakeholders.

- *3.1.1* The District and Hospital will be accessible to the media and public to respond to inquiries and address issues relevant to its mission, policies and decisions.
- *3.1.2* The District and Hospital will disseminate news and information to the media and public about its decisions, policies and activities in a timely manner.
- *3.1.3* The District and Hospital will respond to media inquiries in a timely manner but with the understanding that the District/Hospital may require time to formulate a response.
- *3.1.4* All District and Hospital communications will adhere to HIPAA guidelines. (A useful reference is the California Hospital Association publication, "Guide to Release of Patient Information to the Media.")

4.0 RESPONSIBILITIES

4.1 The CEO is responsible for ensuring that all communications are in compliance with the Media Communications Policy. The CEO will identify Staff and/or Consultants who will have responsibility for planning and executing District/Hospital communications through the media.

4.1.1 In this document, "Hospital Communications" refers both to Hospital Communications Staff and Communications Consultants designated by CEO to work with the media on behalf of District and Hospital.

4.1.2 Hospital Communications will ensure that District/Hospital external communications, including announcements and press releases, are communicated to the proper individuals and in the proper language that meets with District/Hospital goals, strategies, legal and regulatory requirements and policies. Hospital Communications will determine appropriate media distribution of announcements.

Hospital Communications duties will entail but are not limited to the following:

4.1.3 Plan, recommend, implement and report on public communications initiatives that enhance media and public understanding of the District and Hospital and the role each plays in serving the health and wellbeing of the community.

4.1.4 Develop and present to District Board an annual communications plan encompassing both public information and marketing communications strategies and initiatives. CEO will report results to District Board as part of monthly reports.

4.1.5 Disseminate news to all media about District/Hospital announcements, decisions and initiatives.

4.1.6 Maintain current list of local/regional media and key contacts, with information on deadline requirements, for dissemination of District/Hospital news.

4.1.7 Maintain Hospital's presence through online media including social media as appropriate.

4.1.8 Regularly update information on Hospital website and Facebook page.

4.1.9 Assist CEO or District Board members in preparing for media interviews.

4.1.10 Provide communications support to Hospital Foundation.

5.0 PROCEDURES

5.1 Board Chair will have responsibility for identifying and approving all media announcements related to Board decisions and actions.

5.2 Hospital CEO will have responsibility for approving all media announcements, including marketing communications, related to Hospital decisions and actions not directly related to District Board decisions or actions.

5.3 In matters dealing with issues of community and political sensitivity regarding District and/or Hospital policy or operations, CEO will obtain approval from Board Chair prior to releasing information to media. If media spokesperson is to be someone other than CEO or Chair, CEO will identify designated spokesperson to Board in advance of announcement.

5.4 In matters dealing with routine announcements and marketing activity related to Hospital, CEO will have discretion to release information to media through Hospital Communications procedures without District approval, but will provide information to District Board in a timely manner and not later than simultaneous with release of information.

5.4.1 For purposes of this document, routine news announcements include but are not be limited to the following: personnel news, new services, marketing communications, community health programs and participation in community events.

5.5 Hospital Communications personnel will be made available to the District Board at Chair's request to assist with developing and disseminating Board communications. These requests will be guided by the following:

5.5.1 Board requests for Hospital Communications support will be made to CEO.

5.5.2 Hospital Communications services will include but are not limited to: writing and disseminating press releases; analyzing issues and recommending strategies and actions; contacting media on Board's behalf; reporting results of media outreach.

5.5.3 Hospital Communications personnel will not serve as spokespersons for Board unless requested to do so by Board Chair or CEO.

5.5.4 District Board members contacted by the media can access Hospital Communications for assistance with CEO's approval.

5.5.5 Media inquiries received by Hospital Communications regarding District policies, activities and announcements will be communicated to the Board Chair and/or Hospital CEO. Hospital Communications will not speak for District Board unless authorized to do so by Chair/CEO. In relaying requests, Hospital Communications will suggest appropriate response to Chair/CEO.

6.0 EMPLOYEES

6.1.1 Hospital employees are not permitted to make statements to media or through media on behalf of the Hospital and/or Board without authorization from CEO.

6.1.2 Employees are not permitted to post materials on Hospital/Board website or Facebook page without authorization from the Hospital Communications member designated responsible for maintaining these media.

6.1.3 Employees are not prevented from making personal statements in social media as long as they do not represent themselves as Hospital/Board representatives. Employees must follow Hospital Social Media Policy (#HR8610-300) available from Human Resources.

Meeting Date: **March 6, 2014**

Prepared by: Peter Hohorst

Agenda Item Title: By Law Revision 2/25/14

Recommendations:

The Governance Committee recommends three changes to the District By Laws.

Page 1: A correction of a typo in the existing approved By Laws to change "is" to "its"

Page 12: Deletion of the Citizens Advisory Committee from the list of Standing Board Committees

Changes to the authorized membership of future Advisory Committees (Ad Hoc committees) to allow public members

Background:

The last Citizens Advisory Committee was disbanded in 2009 and with the earthquake compliance issue now resolved, there has not been a need for a permanent citizen's advisory committee. If a need arises in the future the committee or some reiteration of it can be reinstated by the Board.

The composition of Board Advisory Committees are currently restricted to two (no more, no less) Board members. They cannot have only one Board member and they cannot have three (Brown Act violation). They cannot have public members. This composition is unduly restrictive as it precludes public participation on any Advisory Committee and it precludes a committee with a single Board member and several public members.

The recommended wording would give the Board more flexibility in establishing and utilizing Advisory Committees.

This change in wording appears to be compliant with counsel's comments on the By Law revisions when they were reviewed in December, 2012.

> "a temporary advisory committee composed solely of less than a quorum of the legislative body that serves a limited or single purpose, that is not perpetual, and that will be dissolved once its specific task is completed is not subject to the Brown Act."

However counsel needs to be consulted to determine if the word "solely" in the above statement excludes non Board members.

Consequences of Negative Action/Alternative Actions:

Board Advisory Committees will not be as effective

Financial Impact:

None

Attachment:

Existing By Laws dated December, 2012

BYLAWS

of the

SONOMA VALLEY HEALTH CARE DISTRICT

Sonoma, California

BYLAWS

of the

SONOMA VALLEY HEALTH CARE DISTRICT

Approved by the Board of Directors December 1, 2011

Peter Hohorst, Chair

Kelly Mather, President and Chief Executive Officer

Orig. Date:	10.31.90
Revised:	02.27.91
	12.02.92
	01.05.94
	07.30.97
	01.08.03
	02.28.03
	02.25.04
	06.29.05
	09.27.06
	12.06.06
	05.30.07
	07.01.09
	11.05.09
	09.02.10
	10.07.10
	02.03.11
	12.01.12

TABLE OF CONTENTS

Article I Preamble

These District Bylaws are adopted by the Sonoma Valley Health Care District (the District) Board of Directors (the Board) pursuant to and consistent with Division 23 of the Health and Safety Code of the State of California, known as "The Local Health Care District Law." These District Bylaws are established to further enable the Board to faithfully exercise its powers and fiduciary duties in accordance with applicable law. The Board-approved Policy and Procedures Manual shall be used to assist further in implementing the responsibilities of the Board.

Section 1. Mission

The Mission of the Sonoma Valley Health Care District is to maintain, improve, and restore the health of everyone in our community.

This mission is pursued subject to available financial and human resources and leadership consistent with the Local District Health Care Law of California. The District sets forth Core Values as a framework to provide operational guidance for achieving its mission.

The Core Values of the Sonoma Valley Health Care District are that those who live in Sonoma Valley will experience outstanding health care because:

a. There will be direct access to appropriate care when needed and overall health will be coordinated in a comprehensive fashion.
b. Care will show respect and honor the dignity of everyone.
c. The available services will (a) match the needs of the community, (b) be fiscally sustainable, and (c) meet or exceed all quality standards.
d. Wise stewardship will be exercised regarding the District's financial resources to ensure stability, agility, and prudent growth.
e. Partnerships with physicians, other healthcare providers, and payers will extend the range of available services and conserve resources.
f. We will feel informed and proud of the quality of health care available in the District.

Section 2. Relationships

The Board recognizes that it is most effective in maintaining, improving, and restoring the health of everyone in our community when it works in collaboration with others. Among our partners are the community, the Hospital, the medical community, and other healthcare providers. Although the responsibilities of the Board are set forth in our public trust as the duties of fiduciary responsibility and care and in state law, it is the intent of the Board to maximize its impact on health by building strong, cooperative relationships.

a. The Community

The Board is publicly elected to represent the collective interests of all people in the District, regardless of whether they may be patients at the Hospital. That trust is exercised by inquiring and listening to the concerns of the entire community regarding health care expectations, community resources that might be available, and matters of good organizational citizenship. It is also the Board's responsibility to ensure that the public is informed about its own health and the operations of the Hospital and other healthcare services. The public is also welcome and encouraged to monitor District operations and policy and participate in the discussion of the public actions of the Board. It is the intent of the Board to honor the full spirit of transparency in its work.

b. The Hospital

The major resource available to the Board for serving the community's health needs is Sonoma Valley Hospital. This is an Acute Care, community hospital providing emergency care, in-patient and ambulatory acute care, skilled nursing, therapy, and related services. It serves the community by providing prompt response to acute health needs and coordination of care and by providing resources to the medical community.

c. The Medical Staff

Physicians are a self-governing community of peers who set standards for quality of care and professional conduct. Some of these professionals are Hospital employees; most are not. The community is best served when an appropriate mix of practitioners is free to reach professional excellence, with the Board providing required oversight and necessary resources.

d. Other Healthcare Providers

The District recognizes that maintaining, improving, and restoring the health of everyone in our community involves collaboration with the entire health care community. Individuals who have insurance plans that involve providers outside the Valley who use only the Hospital's emergency or diagnostic and support services are included in our mission. So are those who use the services of other local providers and are referred to Sonoma Valley Hospital for supportive care. Patients of the Hospital can expect that their care will include referral for advanced treatment at Bay Area hospitals that offer specialized services. The District works with local adjunctive services to ensure a supportive community environment.

Article II The Board as a Legal Entity

The name of the District shall be the Sonoma Valley Health Care District (the District).

The principal office for transacting business and maintaining records of the Sonoma Valley Health Care District shall be the Sonoma Valley Hospital (the Hospital), located at 347 Andrieux Street, Sonoma, California 95476. The district also maintains a Web site at http://www.svh.com/healthcare-district-information/.

Section 1. Powers

The Board shall have accountability and authority for those powers set forth in the Local Health Care District Law of California [California Health and Safety Code (H&S) 32,000] that are necessary for fulfilling its mission. These shall include, but are not limited to the following abilities to:

a. Form a medical staff to be known as "The Medical Staff of Sonoma Valley Hospital"; such medical staff shall be self-governing, subject to the District Board's final approval of members and their privileges, hospital rules for quality of patient health and safety, indemnification of practice, and Medical Staff Bylaws [California Health and Safety Code (H&S) 32128, 32129].
b. Form a service organization to be known as "The Sonoma Valley Hospital Auxiliary" whose bylaws are subject to approval by the Board.

c. Hire, direct, evaluate, and terminate if necessary the President and Chief Executive Officer of the Hospital and any other individuals neither working for the Hospital or reporting directly to the Chief Executive Officer but necessary for meeting the Mission of the District [H&S 32121].
d. Enter into contracts for provision of health care and make certain resources are available to medical staff members who are serving the community [H&S 32121, 32129].
e. Establish and maintain standards for quality of care in facilities under the District's direction [H&S 32125].
f. Create entities or enter into contractual relationships with existing entities useful for promoting the District's Mission [H&S 32121, 32131].
g. Acquire, lease, manage, and dispose of real assets for the purpose of meeting its Mission [H&S 32121, 32123, 32126].
h. Authorize the purchase, lease, management, and disposal of capital and other equipment needed to meet its Mission [California Health and Safety Code 32122, 32132].
i. Place before the public for vote parcel tax and bond measures to finance healthcare services and facilities [H&S 32127].
j. Sue and be sued and exercise related actions as a corporate entity [H&S 32121].
k. Manage its financial assets in a responsible fashion, including authorization for borrowing funds and letting of contracts [H&S 32127, 32130, 32132, 32133, 32136, 32138].
l. Create committees, policy, and take other actions necessary to enhance the mission of the District [H&S 32121].
m. Receive input from the public and inform the public regarding matters related to the operation of the District.

The Board exercises its responsibilities through setting goals, assessing the healthcare environment and performance of the hospital, and requesting responsive action. All District powers shall only be exercised pursuant to specific delegation by the Board of Directors.

Section 2. District Bylaws as Basis of Authority

a. Amendment

These District Bylaws shall be reviewed biannually at the beginning of even numbered years. They may be changed by an affirmative vote of at least three Board members at a regularly scheduled board meeting.

b. Relationship to Other Bylaws

The Bylaws of the Sonoma Valley Health Care District Medical Staff (the Medical Staff) are understood to be a subset of the District Bylaws with respect to their relationship with the District. Any action or procedure that is required, allowed, or prohibited in the Medical Staff Bylaws will also be required, allowed, or prohibited in the District Bylaws. The District Board and the Medical Staff shall consult on any proposed changes in either document that may affect both groups. Changes in the Medical Staff Bylaws shall be approved by the District Board; changes in District Bylaws that may affect the Medical Staff require corresponding revision of the Medical Staff Bylaws. The same relationship exists between the District Bylaws and the Bylaws of the Sonoma Valley Hospital Auxiliary (the Auxiliary).

In any case where there is a conflict between either the Medical Staff or Auxiliary with the District Bylaws, the District Bylaws shall be controlling.

Article III Board of Directors

Section 1. Members

a. Selection

The Board shall consist of five members, elected by the public from registered voters of the District in accordance with California Health and Safety Code Section 32100. Three members shall be elected in years evenly divisible by four and two members shall be elected in alternating even-numbered years. In the event of a Board vacancy, a new Board member shall be appointed to fill the

vacated position from applying individuals who meet qualification for election by vote of the remaining Board members in a publicly noticed and open meeting. The appointed Board member shall serve until the next general election returns are certified by the registrar of voters unless the vacancy occurs in the first half of the director's term, but less than 130 days prior to the next general election. In this case the appointed director shall serve the balance of the term (Section 1780 of the California Government Code).

b. Fiduciary Responsibilities

Board members have fiduciary responsibilities to the District. Those living in the District trust the Board to act on their behalf.

(1) The duty of care requires that Board members act toward the District with the same watchfulness, attention, caution, and prudence that a reasonable person in the circumstances would. The duty of loyalty requires that Board members not place their personal interests above those of the District.

(2) Board members shall comply with the District's Conflict of Interest Code as detailed in the Board Policy and Procedures Manual.

(3) The only actions of the Board are those agreed by a majority of Board members in publically noticed meetings that are consistent with state law and regulations. Diversity of informed and well-articulated opinion among Board members is expected while questions are open before the board.

(4) Board members respect privacy of information by not requesting or seeking to obtain information that is not authorized or necessary for conducting the business of the Board. Board members respect confidentiality by not revealing information to others who are not legally authorized to have it or which may be prejudicial to the good of the District. Board members respect information security by requesting and monitoring policies that protect the privacy of individuals served by or doing business with the District.

c. Personal Qualifications

In their service to the District, Board members are expected to:

(1) Actively promote the mission of the District: to maintain, improve, and restore the health of everyone in our community.

(2) Devote sufficient time to their duties to ensure they are fully knowledgeable regarding matters about which the Board deliberates.

(3) Provide respectful, positive, independent input into the group decision making process.

(4) Seek input from the community and represent the District to the community as ambassadors.

(5) Maintain a high level of personal integrity.

Section 2. Officers

The officers of the Board and their duties shall consist of the following:

a. Chair

(1) Serve as the Board's primary liaison with the Chief Executive Officer and with the press and the public
(2) Prepare the Board agenda and request necessary support materials for meeting
(3) Conduct meetings of the Board
(4) Sign documents as authorized by the Board
(5) Appoint members to committees subject to approval by a majority of the Board
(6) Coordinate the Board's performance evaluation of the President and Chief Executive Officer

b. First Vice Chair

(1) Serve in the capacity of the chair when necessary or as delegated.
(2) Serve as the permanent Board representative on the Joint Conference Committee of the Medical Executive Committee.

c. Second Vice Chair

(1) Serve as chair or member of the Board Quality Committee.
(2) Serve in the capacity of the chair when necessary or as delegated.

d. Secretary

(1) Direct that minutes, records, and other support material are prepared and made available in a timely fashion.
(2) Serve or cause to be served all notices of the Board.
(3) Sign documents as authorized by the Board.
(4) Serve as chair or member of the Board Governance Committee.

e. Treasurer

(1) Serve as chair or member of the Board Finance Committee.

Section 3. Elections

Beginning with the calendar year 2012 officers will be elected at the first regular Board meeting in December of each year. Election is by majority vote of the members of the newly-installed Board in even numbered years and by majority vote of existing members in odd numbered years. Officers may be elected to consecutive terms. In the event that the Board fills a vacant position, it may decide either to confirm the new Board member in the previous Board member's office or conduct a new set of elections.

Section 4. Committees

The Board may create committees in order to facilitate its business and to ensure access to expertise and citizen input. All committees shall be advisory to the Board and have no authority

to make decisions or take actions on behalf of the Board unless specifically delegated by the Board. A committee is created or disbanded by majority vote of the Board.

a. Types of Committees

(1) Standing Committees assist the Board by gathering information, evaluating proposals and policies, and make recommendations regarding key and continuous or regularly recurring functions of the District. The duties and responsibilities for the Board Standing Committees are contained in the Board Policy and Procedures manual. The Board standing committees shall be:

(a) Finance Committee
(b) Quality Committee
(c) Governance Committee
(d) Audit Committee
~~(e) Citizen Advisory Committee~~

(2) Advisory Committees ("Ad Hoc") may be established to study and make recommendations to the Board on specific matters. The scope of such committees shall be limited and shall not be of continuous or on-going nature. Upon determination by the Board that the period for advice has passed or upon acceptance of the Advisory Committee's written report by the Board, the Advisory Committee shall be disbanded. Advisory Committees shall be comprised of not more than two Board members and may include members of the public. Advisory committees are not subject to Brown Act provisions.

b. Types of Meetings

Meetings of the Board and its standing Committees are conducted in accordance with the Ralph M. Brown Act (the Brown Act). A quorum for the Board or for its standing committees shall consist of a majority. Agendas for regular Board and standing committee meetings will be available 72 hours in advance of meetings, and for special meetings 24 hours in advance, giving the date, time and location of meetings. No action will be taken concerning an item not previously noticed on the published agenda. Exceptions exist in the case of an emergency where the majority of the Board determines that an emergency exists (Government

Code 54956.5), in which case there is a need to take immediate action. The other exception is if a regular or special meeting is appropriately noticed and the need for urgent action came to the attention of the District subsequent to the agenda being posted. In that case, if two-thirds of the Board members present vote (or there is a unanimous vote if less than two-thirds are present) that there is a need to take immediate action. Public comment will be invited and considered at all open meetings (regular, emergency and special Board meetings and standing committee meetings), and meeting agendas, support materials, and minutes will be available to the public.

(1) Emergency Board meetings can be called on one hour's notice by the Chair or any Board member. News media that has submitted a prior written request for notification of emergency meetings shall be notified in advance of the meeting.

(2) Special Board meetings may be called by any two Board members with 24 hours notice and are subject to rules applying to regular meetings. News media that has submitted a prior written request for notification of special meetings shall be notified in advance of the meeting.

(3) Closed Board meetings may be held for purposes of considering the appointment, employment, evaluation of performance, discipline, dismissal or to hear complaints or charges concerning a Hospital employee or member of the Medical Staff; in consideration of pending litigation; or in matters of negotiations concerning real property, labor contracts, or discussion of trade secrets. Closed meetings shall be announced, conducted, and reported in accordance with the Brown Act, and the public may not participate. Standing committees may hold closed meetings if their charter or Board delegation includes issues allowing closed meetings.

c. Participation of Directors on Standing Committees

No more than two Board members shall be appointed to serve on any Standing Committee at one time. Other Board members may attend standing Committee Meetings as members of the public at any time. In the event of the absence of a regular Board member on a Standing Committee, the Chair of the Board, or in succession, the Chair of the Standing Committee may designate other Directors

to serve in the capacity of absent Board committee members. All appointed members of Board committees, including *ex officio* appointments and recognized alternates shall be voting members and shall count toward establishing a quorum. Board members who attend standing committee meetings as members of the public may not participate in the discussions to avoid a possible violation of the Brown Act.

Section 5. Compensation

a. Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

Section 6. Indemnification

a. Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee, of the District, or an individual (including a medical staff appointee or committee appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 et.seq. of the California Government Code.

b. Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 et.seq. of the California government Code.

c. Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession

Article IV Delegation of Authority

The Board honors the distinction between governance and management. The Board shall exercise its responsibilities for oversight by operating at the policy level, setting strategic direction and goals, monitoring key outcomes, and taking corrective action where needed.

Section 1. Chief Executive Officer

The District employs or contracts with a President and CEO for the Hospital who acts on behalf of the District within the constraints of the Board Bylaws and Board Policies set by the Board. The Board delegates to the President and CEO the authority to perform the following functions:

a. Manage the District's human, physical, financial, knowledge, and community good will resources in support of the District's Mission to maintain, improve, and restore the health of everyone in our community.
b. Manage the activities and resources of the Sonoma Valley Hospital.
c. Ensure that the hospital complies with applicable laws, regulations, and standards.
d. Provide supporting resources to the Board and its committees as requested.
e. Support the operations of the Board by providing reports, general information, staff support, and other resources.
f. Annually, create a draft update on the District's rolling Three -Year Strategic Plan and the Budget.
g. Promote awareness of the hospital, good will in the community, and philanthropic support.
h. Serve as the contact executive in affiliation agreements with other district hospitals, physician foundations, and other healthcare partners.
i. Negotiate, sign, monitor, and terminate or renegotiate contracts.
j. Sign checks to meet the District's financial obligations in accordance with Board Policy.
k. Discharge these functions in a positive, legal, and ethical fashion so as to bring respect to the District.
l. Carry out directives from the Board.

Section 2. Medical Staff

a. Establishment of a Medical Staff

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law [California Health and Safety Code (H&S) 32,000], whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit or care for patients in the Hospital. The Medical staff shall be an integral part of the Hospital. The District shall appoint the Medical Staff by approving their credentialing. The Medical Staff-shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the District.

The Medical Staff shall be represented as described in Article IV of these Bylaws and shall be afforded full access to the District through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the District for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies and as delegated by the District from time to time.

b. Bylaws, Rules, and Regulations

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the District. Whenever there is a reference in the Medical Staff Bylaws, Rules and Regulations, to the "Board of Directors" or "the District," that term shall refer to and be considered as the Sonoma Valley Health Care District as described in Article I of these Bylaws.

c. District Action on Membership and Clinical Privileges

(1) Medical Staff Responsibilities: The Medical Staff is accountable to the District for the quality of care, treatment and services rendered to patients in the Hospital. The Medical Staff shall be responsible for investigating and evaluating matters relating to Medical Staff membership status, clinical

privileges, and corrective action, except as provided in Section 3(d) in Article 4 of the Medical Staff bylaws. The Medical Staff shall adopt and forward to the District specific written recommendations, with appropriate supporting documentation, that will allow the District to take informed action. When the District does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the District renders a final decision. The District shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the District.

(2) Criteria for District Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(3) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(4) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, the District may take action subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

The Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

(5) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The hearing and appellate procedures employed by the District upon referral of such matters shall be consistent with the Local Healthcare

District Law [California Health and Safety Code (H&S) 32,150~~,~~ and those specified in the Medical Staff Bylaws, Rules and Regulations.

d. Accountability to the District

The Medical Staff shall conduct and be accountable to the District for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

e. Documentation

The District shall receive and act upon the findings and recommendations emanating from the activities required by Article IV, Section 2(d). All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the District can take appropriate action.

Section 3. Contractual Relationships

The District may enter into contractual relationships with other Districts, provider organizations, or consortia in order to share resources and improve access to care to better serve the needs of those in the Valley.

Meeting Date: March 6, 2014

Prepared by: Peter Hohorst

Agenda Item Title: Investment Policy

Recommendations:
Recommended that the Board approve the Investing Policy

Background:
Although the present financial condition of health care in general and Sonoma Valley Hospital in particular makes the adoption of an Investment Policy somewhat of a moot point, the District has had such a policy since 1980 and may conceivably need one in the future.
Accordingly, the Governance Committee has reviewed the existing Investment Policy and recommends that no changes be made to the existing Policy.

Consequences of Negative Action/Alternative Actions:
The existing policy, last reviewed in December, 2007 would continue to be in effect.

Financial Impact:
None

Attachment:
Investment Policy

Sonoma Valley Hospital Sonoma Valley Healthcare District Policy and Procedure **Organizational**	
Title: **Investment Policy**	Number: LD118 Page: 1 of 1

Carl Gerlach, CEO 01/22/08	Effective Date: November 24, 1980
Approved By Date	Revision Dates:
Signature	Review Dates: 6/89, 3/96, 3/99, 7/00, 12/01, 3/05, 12/07

POLICY

Until such time as surplus funds exceed $5,000,000, all investments shall be placed with the Local Agency Investment Fund (LAIF). If surplus funds exceed $5,000,000, an investment policy is to be developed and approved by the Finance Committee. Funds required under bond indentures which are invested by a trustee are not covered by this policy.

ACCOUNTABILITY/RESPONSIBILITY FOR REVIEW

Board of Directors

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

BOARD QUALITY COMMITTEE DASHBOARD 2013

The following are quality and patient safety indicators selected by the Board Quality Committee for quarterly reporting as part of the oversight mandate for ensuring the organization has an effective quality assurance and performance improvement program (QAPI).

1. Surgical Services Volumes by Service Fiscal Year 2013/2014

	Jul-Sept Q1.FY14		Oct-Dec Q2. FY14		Jan-Mar Q3.2013		Apr-Jun Q4.2013		Totals
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	
General	44	44	29	55	32	29	30	48	311
OBGYN	6	16	13	19	17	16	11	22	120
Ophthalmology	0	48	0	63	0	45	0	48	204
Orthopedic	55	111	40	106	55	106	57	101	631
Pain Management	0	49	0	45	0	37	0	39	170
Podiatry	1	8	1	7	0	15	3	4	39
Urology	0	5	2	17	3	3	1	5	36
Vascular Surgery	0	3	0	3	1	4	0	7	18
Endoscopy	9	76	21	79	24	66	14	82	371
Totals	**115**	**360**	**106**	**394**	**132**	**321**	**116**	**356**	**1900**

2. Emergency Department Patient Performance

a. **Time from presentation to the ED to time seen by MD based on a sampling of cases.**

Measurement:	Emergency Department Patient Throughput (Lower # is Better)
Category:	Patient Safety
Definition:	Time from arrival in ED to being seen by an MD in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
25.85	26.36	11.94	44.25	28.33		N/A	30	

Note: Reliable data collection in EMR is in development and will be ready for national reporting measures.

b. Time from decision to admit to bed on inpatient unit until patient departure from ED based on a sampling of cases.

Measurement:	Time from admit decision to depart to bed (Lower # is Better)
Category:	Patient Safety
Definition:	Time from decision to admit patient to departure to assigned bed in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
72.37	64.93	64.28	47.5	66.05		N/A	96	

3. Patient Satisfaction: Quality Patient Experience

Patient satisfaction is measured by the Press Ganey Patient Satisfaction Questionnaire that is mailed to the patient's home two weeks post discharge. There are many questions on the survey and the hospital has shown a significant improvement over the past two years. We chose 3 questions upon which to focus our attention.

Measurement:	Noise Level in and around rooms (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
75.3%	70.7%	71.9%	72%	76%		N/A	90.00%	

Measurement:	Explanations re: tests and treatments (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
87.1%	85.7%	86.1%	85.9%	90%		N/A	90.00%	

Measurement:	Likelihood to recommend SVH to others (Higher # is better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
89.6%	91.4%	88.7%	87.7%	88%		N/A	90.00%	

4. Readmissions Rates: Quality Patient Outcomes

Data is captured for patients who return to SVH within 30 days. The hospital focuses on four specific diagnostic groups as they are currently tied to Medicare pay-for-performance.

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days - All Diagnosis

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.20%	8.40%	4.2%	5.7 %	4.9%		N/A	16.0%	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with Same Diagnosis (DRG)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.40%	**2.00%**	**4.2%**	**1.53%**	**1.23%**		N/A	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with AMI (Heart Attack)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
6.00%	**0.00%**	**0.00%**	**0.00%**	**0.00%**		**N/A**	**18.0%**	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with CHF (Congestive Heart Failure)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.80%	**0.00%**	**0.00%**	**20.00%**	**16.67%**		N/A	**23.0%**	
			Small population **(1/ 5)**	*Small population* **(1/ 6)**				

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with PNE (Simple Pneumonia)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.50%	**11.11%**	**0.00%**	**0.00%**	**0.00%**		N/A	**17.6%**	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with COPD (Chronic Obstructive Pulmonary Disease)

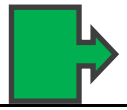
CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
0.00%	**16.50%**	**0.00%**	**0.00%**	**0.00%**		**N/A**	**TBD**	**TBD**

Chart Definitions:	Calendar Year	Average of all quarters previous year
	Q Change	Change from previous quarter/calendar year
	YTD Trend	Change from previous calendar year based on an average of the quarterly values this year
	Benchmark goal	External standard or internally set benchmark for quality performance
	Benchmark Perform	Most recent quarter performance against the benchmark goal
		Red means performance declined or does not meet the benchmark goal
		Green means improved performance or meeting the benchmark goal

5. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Infections are tracked for 16 different categories of infections are reported in detail only if quarterly or YTD performance does not meet the benchmark set and therefore potentially merits clinical and management remedial action. The following table summarizes those infection categories being tracked which are within benchmark.

Infection Category	Within Benchmark
Central line associated bloodstream infections	
Hospital acquired Cdiff infections	
Inpatient, MRSA infections	
VRE bloodstream infections	
Hip surgical site infections	
Knee surgical site infections	
Overall surgical site infections	
Class I SSI rate	
Class II SSI rate	
Total Joint SSI rate	
Ventilator Associated Events	
Hospital acquired Pneumonia	
Inpatient Hospital acquired Catheter associated urinary tract infections	
Home Care associated infections	
MRSA Active Surveillance cultures	
Flash sterilization measurements	