SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS
REGULAR MEETING AGENDA
MAY 3, 2018

REGULAR SESSION 6:00 P.M.

COMMUNITY MEETING ROOM
177 FIRST STREET WEST, SONOMA

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact Interim District Clerk Vivian Woodall at (707) 935.5005 at least 48 hours prior to the meeting.	**RECOMMENDATION**	
AGENDA ITEM		
MISSION STATEMENT *The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Rymer*	
2. PUBLIC COMMENT *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.*	*Rymer*	
3. CONSENT CALENDAR *A.* Board Minutes 04.05.18 *Pages 3-5* *B.* Finance Committee Minutes 03.27.18 *Pages 6-8* *C.* Quality Committee Minutes 03.28.18 *Pages 9-10* *D.* Executed Policies and Procedures *Pages 11-29* E. Medical Staff Credentialing Report	*Rymer*	Action
4. CITY OF SONOMA PRESENTATION	*Capriola, Sackett*	Inform
5. HUMAN RESOURCES ANNUAL REPORT *Pages 31-59*	*McKissock*	Inform
6. GROWTH & BUSINESS DEVELOPMENT QUARTERLY REPORT *Pages 61-85*	*Donaldson*	Inform
7. FY 2019 ROLLING THREE-YEAR STRATEGIC PLAN *Pages 87-97*	*Mather*	Action
8. RESOLUTION NO. 339 ORDERING AN ELECTION FOR OPEN BOARD POSITIONS AND REQUESTING CONSOLIDATION WITH THE NOVEMBER 6, 2018, GENERAL DISTRICT ELECTION *Pages 99-102*	*Rymer*	Action
9. ADMINISTRATIVE REPORT MAY 2018 *Pages 104-106*	*Mather*	Inform
10. FINANCIAL REPORT MONTH ENDED MARCH 31, 2018 *Pages 108-122*	*Jensen*	Inform
11. BOARD COMMENTS A. AB 2798 Support Letter *Page 124* B. AB 1795 Support Letter *Pages 125-126* C. AB 3087 Oppose Letter *Pages 127-128*	*Board Members*	Inform
12. ADJOURN *The next Regular Board meeting is June 7, 2018.*	*Rymer*	

3.

CONSENT CALENDAR

BOARD OF DIRECTORS' MEETING
MINUTES
THURSDAY, APRIL 5, 2018
REGULAR SESSION 6:00 P.M.

COMMUNITY MEETING ROOM
177 First Street West, Sonoma, CA

	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER The meeting was called to order at 6:07 pm.	*Hirsch*	
2. PUBLIC COMMENT ON CLOSED SESSION		
None		
3. CLOSED SESSION Calif. Health & Safety Code § 32106: Trade Secrets Regarding Contract Negotiations		
4. REPORT ON CLOSED SESSION	*Hirsch*	
Ms. Hirsch reported that a meeting was held regarding contract negotiations but no decisions were made.		
5. PUBLIC COMMENT	*Hirsch*	
None		
6. CONSENT CALENDAR: A. Board Minutes 03.01.18 B. Finance Committee Minutes 02.27.18 C. Quality Committee Minutes 02.28.18 D. Executed Policies and Procedures E. Medical Staff Credentialing Report	*Hirsch*	**MOTION**: by Boerum to approve, 2nd by Hohorst. All in favor.
7. CHIEF OF STAFF REPORT	*Sebastian*	Inform
Dr. Sebastian reported the medical staff office is running very efficiently and the credentialing process is going well. There is good communication and good morale with the medical staff. There are quite a few new physicians; Dr. Lane is retiring; and Dr. Sawyer has closed his practice (but is staying as Chief of Surgery). The medical staff is looking forward to the UCSF affiliation. Current projects include working with the Quality department on the medication reconciliation process and proctoring of new physicians. Next quarter's focus will be on UCSF.		
8. SONOMA FIRE & RESCUE PRESENTATION	*Akre*	Inform
Mr. Steve Akre gave an overview of Sonoma Valley Fire & Rescue's formation, coverage area, capabilities and services, with six stations throughout the Valley. Fire services now cover Glen Ellen through Temelec, with ambulance services a slightly larger area. They employ firefighter/paramedics which provide flexibility for responding to		

additional calls. If needed, volunteers are called in and then crews from other towns and counties. In addition to structural and wildland firefighting and ambulance transport, services include high angle, swift water, and large animal rescue, as well as public education and fire prevention. There are county protocols which assess and designate to which hospital patients are transported. If transports do not hit the protocol and patients do not make a specific request, ambulances go to SVH because it is the closest.		
9. PATIENT CARE SERVICES ANNUAL REPORT 2017	*Kobe*	Inform
Mr. Kobe reviewed each of the patient care service areas and staffing structure, as well as the patient care services dashboard which is presented to the Quality Committee quarterly. The next dashboard will drop ED CAHPS data and use Rate My Hospital texting feedback. This tool provides instant feedback vs. waiting 60 days for data. The Rate My Hospital goal is 4.5 out of 5 in four departments; the actual average since inception has been 4.67. Mr. Kobe then reviewed expenses and direct margins. ER and inpatient services contribute quite a lot to the bottom line. ER cases grew in 2017. He also discussed staff satisfaction, funds allocated for nursing education and salary increases. Turnover challenges include new graduates who come to SVH to gain experience and then go elsewhere. Transfers have been trending up over the last 10 years, and management is looking at telemedicine services to keep these transfers at SVH.		
10. STRATEGIC PLAN FY 2019-2021	*Mather*	Inform
Ms. Mather reviewed the five strategies (major assumptions) which were similar to last year: 1) Achieve highest levels of safety and quality; 2) Preferred hospital for patients and physicians; 3) New revenue strategies and services; 4) Improve financial stability; 5) Lead progress toward a healthier community. Upcoming milestones include a public meeting on April 26th and approval at the May 3 Board meeting.		
11. ADMINISTRATIVE REPORT MARCH 2018	*Mather*	Inform
A CMO candidate will be interviewed April 11. Management is working closely with ER physicians and hospitalists to improve transfers and communication. The staff satisfaction survey will be presented to the Board in May. Opportunities exist in ER, ICU, inpatient rehab, and cardio. SVH is in the design phase for the Outpatient Diagnostic Center. 3D mammography is now open.		
12. FINANCIAL REPORT MONTH ENDED FEBRUARY 28, 2018	*Jensen*	Inform
Mr. Jensen reported that February had very low volumes and acuity dropped also, which lowered reimbursement. He reviewed the payer mix with Medicare 59.2% of the total. Commercial dropped to 16.7%. The cash goal was short by $456,000; year to date was better by $233,000. Accounts receivable were 46.5 days and accounts payable were 46.4 days. Employee costs and supplies were well managed. The operating margin was a $557,000 loss, and the net loss was $175,000.		

Most of this was attributable to lower volumes in February. March inpatient volumes were better.		
13. COMMITTEE REPORTS		
A. Governance Committee Report: i. Board Legislative and Regulatory Positions Policy #P-2018.04.05-1 ii. Board Gift, Ticket and Honoraria Policy #P-2018.04.05-2 iii. Board Gift Acceptance Policy #P-2013.06.06-3	*Hohorst*	Inform/Action
On the Legislative and Regulatory Positions Policy, the Governance Committee recommended cleaning up the wording to leave the policy as is. Regarding the Gift Ticket Policy, the only change was the dollar amount increased from $440 to $470. Regarding the Gift Acceptance Policy, Mr. Hohorst indicated the Foundation policy is identical in wording, so we are on the same page. He recommend no changes to the text. A new date would be added.		**MOTION:** by Hohorst, 2nd by Boerum. All in favor. **MOTION:** by Hohorst, 2nd by Boerum. All in favor. No action requested.
14. BOARD COMMENTS	*Board Members*	Inform
Mr. Rymer requested that the Board members have some discussion around identifying something new each learned at the recent Board Retreat. Mr. Hohorst was impressed by the role Mr. Rymer played in leading the retreat discussion. He thought the retreat one of the better sessions in focusing on problems faced as a District and not on personalities. Ms. Nevins agreed. It was one of the first opportunities we had to look outside of the hospital and look at trends in healthcare and how we fit or do not fit into that. There was good agreement by all present. Mr. Boerum agreed with his two colleagues. The retreat was well structured and well facilitated. New was the ability to face challenges with an optimistic point of view. He also learned a lot during the discussion about breast surgery. Ms. Hirsch learned a great deal in the UCSF affiliation discussion. Mr. Rymer also mentioned he was impressed by the amount of thought and planning that went into the affiliation. She also indicated an important new topic was how we can completely understand our financial parameters around patient volumes and the outpatient center. Ms. Mather: There was good discussion around things we don't all talk together about all the time. She appreciated the Board's understanding. She is proud of where SVH stands in terms of quality and safety. She also feels a great sense of urgency now.		
11. ADJOURN	*Hirsch*	
Meeting adjourned at 7:50 pm		

SVHCD
FINANCE COMMITTEE MEETING
MINUTES
TUESDAY, MARCH 27, 2018
Schantz Conference Room

Present	Excused	Staff	Public
Sharon Nevins Joshua Rymer Steve Berezin Susan Porth John Perez Keith Hughes via telephone Dr. Subhash Mishra via telephone		Kelly Mather Ken Jensen Sarah Dungan	Peter Hohorst

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION & VISION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*			
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	Called to order 4:59 pm		
2. PUBLIC COMMENT SECTION	*Nevins*		
	None		
3. CONSENT CALENDAR FC Minutes 02.27.18	*Nevins*	Action	
	Mr. Rymer requested a change to the minutes on the 1206b update. The intent is not to subsidize the clinic.	**MOTION:** by Rymer to approve with change, 2nd by Berezin. All in favor.	
4. REVENUE CYCLE PRESENTATION	*Denton*	Inform	
	Ms. Denton discussed the three phases of the revenue cycle (admitting, coding, claims processing) and the challenges which begin with the physician order. The goal is 98% accuracy, which has almost been reached. The Patient Financial Services department is working on improving physician		Rymer requested metrics and actual results for the future.

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	coding. The challenges of working with the various payers was also discussed.		
5. FINANCE COMMITTEE 2018 WORK PLAN	*Jensen*	Action	
	An evaluation of Finance Committee performance was added in May. Review of retirement plan management was added in October.	No action requested.	Benefit plan manager to attend October meeting.
6. REVIEW FINANCE COMMITTEE CHARTER	*Jensen*	Action	
	It was recommended that the charter include a "minimum of four district citizens." A pension review should be added to the charter. Ms. Nevins said the Committee may want to change its report to the Board on the performance of the Finance Committee. Suggested revisions to the charter will be brought to the next meeting.	No action requested.	
7. HEALING AT HOME UPDATE	*Jensen*	Inform	
	Mr. Jensen said a letter of intent will be discussed in closed session at the April Board meeting; then due diligence will begin.		
8. 1206(b) CLINIC UPDATE	*Jensen*	Inform	
	Ms. Mather said a position has been posted for a high-level practice manager for the clinics. SVH is hoping to start working with Sonoma Family Practice in the clinic July 1.		
9. ADMINISTRATIVE REPORT APRIL 2018	*Mather*	Inform	
	Ms. Mather hoped to have a draft of the Strategic Plan shortly, then a public input session will take place on April 26. The Hospital's anesthesia contract is up for renegotiation this spring. She planned to ask them to consider CRNAs for lower level cases. Dr. Lane has retired and SVH is working with his patients to stay in Sonoma. She indicated that Sonoma could use another primary care practitioner to see patients.		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
10. FINANCIAL REPORT FOR MONTH ENDING FEBRUARY 28, 2018	*Jensen*	Inform	
	Mr. Jensen reviewed volumes, which were significantly under budget in February, partly due to the loss of SDC and Napa State patients. The payer mix was also reviewed. The cash goal was short by $456,000 in February. Days' cash were 14.1, accounts receivable were 46.5, and accounts payable were 46.4. The balance of the parcel tax was expected in April. Gross patient revenue was under budget by $3.7 million, with total operating revenue under budget by $253,000. Salaries and benefits were under budget by $403,000; supplies were also better than budget. February's net operating loss was $557,000 and net income was a loss of $175,000.		
11. ADJOURN	*Nevins*		
	Meeting adjourned at 6:29 pm		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
March 28, 2018, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder Susan Idell Ingrid Sheets	Michael Mainardi, MD Michael Brown, MD	Howard Eisenstark, MD Cathy Webber Kelsey Woodward	Mark Kobe Danielle Jones Chris Kutza

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:02 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 02.28.18		**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
4. 340B DRUG DISCOUNT PURCHASING PROGRAM	*Kutza*	Inform
	Hospitals must recertify every year for the 340B program. Only eligible patients receive these drugs. This program resulted in a drug cost reduction of $355,000 in 2017 offset by additional expenses of $45,000 due to the complexity of the program. For ex., Remicade, which is an outpatient infusion drug for Crohn's disease used to cost over $1 million and the cost is now down to $200,000. Unfortunately, Crofab for rattlesnake bites is not covered.	
5. MED/SURG PATIENT CARE SERVICES REPORT	*Kobe*	Inform
	Mr. Kobe gave the Medical/Surgical report. The 20 bed unit is used for a variety of acute patients with	

AGENDA ITEM	DISCUSSION	ACTION
	respiratory, cardiac, gastro, and neuro conditions as well as surgical procedures. Outpatient infusion is also done here (using about four of those beds), often for antibiotic therapy. The unit can accommodate up to 10 cardiac telemetry patients. Inpatients have been averaging around 8-10 per day. He also discussed staffing on the unit and quality metrics. Patient satisfaction/HCAHPS scores are taken from surveys sent to Medical/Surgical patients who are discharged home.	
6. POLICIES & PROCEDURES	*Jones*	Action
	Ms. Jones reviewed each of the policies.	**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
7. QUALITY REPORT	*Jones*	Inform
	Ms. Jones and the Committee discussed the migration from manual quality dashboards to electronic. Committee members wanted to see the dashboard prior to the meeting, thought the screen was very difficult to see, and they also spent a great deal of time getting the dashboard where they wanted it. The electronic version would need to include those changes. It was agreed that both versions would be tried in April.	
8. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:25 p.m.	
9. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
		MOTION: by Mainardi to approve credentialing, 2nd by Idell. All in favor.
11. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:33 p.m.	

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

Policy and Procedures – Summary of Changes
The Board of Directors Meeting, May 3rd, 2018

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the appropriate 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 Sonoma Valley Health Care District Board.

ORGANIZATIONAL

NEW (Full Policies are attached)**:**

Code Neonate PC8610-174

We have recognized that there is an area of opportunity related to neonatal codes within our organization. This policy has outlined how to initiate a code neonate, who is to respond, what equipment to respond with, and what to do upon arrival.

Precipitous Birth in the ED PC8610-176

We have identified an opportunity for improvement within our organization with precipitous deliveries and neonatal resuscitations. This policy outlines that if delivery is imminent, the delivery and care will be provided in the Emergency Department until the Mother and Baby are deemed stable by a qualified physician for transfer. The policy also serves as a guideline for the delivery, resuscitation, and needed documentation, following NRP standards.

Water Management IC8610-178

The Centers for Medicare & Medicaid Services (CMS) posted a Survey and Certification letter (S&C 17-30 memo) on June 6, 2017, indicating that Medicare-certified healthcare facilities are expected to have water management policies and procedures to reduce the growth and spread of Legionella. Between 2000 and 2014, there was a fourfold increase in the number of cases of Legionnaires' disease according to the Center for Disease Control. 85% of all Legionnaires' disease outbreaks were attributed to water system exposures that could have been prevented by effective water management programs.

REVISIONS:

Authority Statement IC8610-102

Added "including microbial cultures of involved/effected staff, patients or the environment"-expecting to see this in a water management program

Color Coded Wristbands and Door Placards PC8610-126

A gray strip placed into the patient's door placard will be used to communicate to healthcare providers when a patient or visitor is at risk for violence. Use of the gray strip will be used to notify staff of this risk prior to entering a patient's room.

Contact Plus Enteric Isolation Precautions IC8610-128

Added: When a patient is receiving antibiotics and he/she has a liquid stool, the RN is authorized to immediately obtain a stool specimen and order C. difficile testing via protocol order. Patients who are taking antibiotics at the time of admission and have loose stool shall also be tested.

Rehabilitation Services with Patients in Contact Isolation Management of IC8610-136

"Patients with active diarrhea e.g., C. difficile, should not leave the isolation room" was added to the policy

DEPARTMENTAL

Skilled Nursing

Weighing and Measuring the Resident 6580-150

Policy amended to notify the Dietician of significant weight loss and document refusal of weight in EMR.

Surgical Services Departmental Manual

Table of Contents listing changes is attached

SUBJECT: Code Neonate	POLICY PC8610-174
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide a mechanism to assure that trained staff and equipment respond efficiently to a Code Neonate situation in a timely fashion to the proper department. To provide organized, standardized, and effective management of resuscitation emergencies. To promote the health and safety of patients under our care.

POLICY:

Code Neonate is activated by dialing 5-5-5-5, stating Code Neonate and providing location. Code Neonate is announced in all areas of the hospital, including the Emergency Department.

PROCEDURE:

A. Responsibilities of PBX:
   1. When alerted by 5-5-5-5 call, or by any other means, the operator will page the appropriate pagers/cellphones of the Code Response Team.
   2. The operator will announce Code Neonate and location on the overhead paging system three times in succession, pause 30 seconds and repeat announcement x 1

B. Neonatal Code paged in the Emergency Department:
   1. Deliver the Infant Warmer, and Broselow cart to the patient's room.
   2. OB RN will respond to ED.

C. Neonatal Code paged to A Women's Place:
   1. ED MD and one ED RN will respond to A Women's Place to assist if Code Neonate is paged to the A Women's Place and remain until cleared by OB personnel.

D. Neonatal Code paged to any other area of the Hospital, including the parking lot:
   1. ED RN responds to area with precipitous bassinet.
   2. The responding Neonatal Code Response Team will initiate the Precipitous Birth Protocol and immediately move the neonate to the Emergency Department to continue the resuscitation.

E. Neonatal Code Response Team:
-ED physician
-OB RN
-ED RN
-Respiratory Therapist
-Lab-Phlebotomist
-Nursing Supervisor
-XRAY Technician (respond to OB or ED, dependent on location of call)
-OB MD to be called immediately (By the ED Tech on duty)
-Pediatrician to be called immediately (By the ED Tech on duty)

REFERENCES:
CIHQ Nursing Services, 42 CFR; 482.23 except as permitted by law, the organization must provide 24-hour inpatient nursing services that are furnished or supervised by a registered nurse (RN).
ECC Guidelines, American Heart Association, 2011

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Deborah Bishop, ED & ICU Clinical Director
Sally Staples, A Woman's Place Manager
Mark Kobe, Chief Nursing Officer
Cynthia Lawder, M.D., Medical Director, Emergency Department

APPROVALS:
Policy & Procedure Team: 10/17/17
OB Task Force: 12/5/17
Safety Committee: 2/28/18
Code-Blue Committee: 2/28/18
Medicine Committee: 3/8/18
Medical Executive Committee: 3/15/18
Board Quality Committee: 3/28/18
The Board of Directors:

SUBJECT: Precipitous Birth in the Emergency Department	POLICY #PC8610-176
	PAGE 1 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines to the Emergency Department staff and A Women's Place on the care and management of obstetrical patients in whom delivery is imminent, while in the Emergency Department.

POLICY:

Patients presenting to the Emergency Department at Sonoma Valley Hospital who are pregnant where delivery is imminent will be cared for by qualified staff. After delivery in the Emergency Department and stabilization of mother and infant(s), mother and infant(s) will be transported by qualified staff to A Women's Place or another institution for admission and continuing care, whichever is deemed most appropriate by the attending physician on duty.

PROCUDURE:

(1) If delivery is imminent, delivery will occur in the Emergency Department, unless a cesarean section is known to be necessary, in which case the surgery team will be contacted immediately and the patient will be taken to surgery upon the team's arrival.

(a) **Code Neonate ED** will be paged overhead. RT, x-ray, House Supervisor, OB RN will respond immediately to the Emergency Department. If the OB MD and/or Pediatrician are already in house, they will also respond immediately to the Emergency Department.
(b) Initial examination will be conducted immediately by the ED attending Physician.
(c) The OB MD on-call at Sonoma Valley Hospital will be notified immediately of the patient and the delivery status. (If not in house).
(d) If the patient has an established OB physician, that physician will also be notified.
(e) The Pediatrician on-call at Sonoma Valley Hospital will be notified immediately of the patient and the delivery status. (If not in house).
(f) If the second OB RN is not in house, the Nursing Supervisor will call them in.

(2) Establish a Team Leader-Team Leader to have this protocol and NRP Protocol in hand (both located on bassinet).

(3) Delivery

(a) Bring Infant Warmer to bedside.
(b) Open precipitous delivery pack.
(c) Have Broselow cart brought to outside of room.
(d) Continually explain all that will be taking place to the patient, prior to treatments and procedures
(e) Mother will be placed on the cardiac monitor and vital signs obtained and documented, if time allows.
(f) Assess and document fetal heart tones.
(g) Start IV (preferably 18 gauge) of LR, obtain labs (CBC, Hold clot, PNC panel-rainbow).
(h) Administer 10L/min O2 via face mask, as needed.
(i) Prep as directed by the physician, as time permits.
(j) Assure newborn warmer has been delivered by OB RN and plugged in.
(k) Note time of delivery.
(l) Document time of placenta delivery and hold placenta for evaluation by OB MD.
(m) Clamp the umbilical cord at least 2 to 4 inches from umbilicus of baby and 2-4 inches from the placenta. Cut the cord between the clamps.
(n) If infant is moving/crying and well in appearance, dry and stimulate, if infant is full-term. If infant is premature, use extreme caution while drying and assessing. Stimulate by gently rubbing extremities only. Place infant skin to skin on mom's bare chest. *If you need to clear the airway, suction mouth w/bulb syringe.
(o) If infant is blue, not moving, appears to have no respiratory effort, initiate Neonatal Resuscitation. (Proceed to number 3).
(p) Perform and document APGAR score at 1 minute and 5 minutes. Continue to assess and document every 5 minutes until greater than 7.
(q) If possible and needed for medication administration, obtain and record the newborn weight.
(r) Perform ongoing assessment of maternal status including vital signs, bleeding and fundal checks.
(s) Administer medications, per MD order

(4) Neonatal Resuscitation-
(a) If neonate is gasping or apneic, or heart rate below 100 immediately initiate NRP protocol, located on Infant Warmer.
(b) If placenta still attached to Mother, Clamp cord 2-4 inches from umbilicus of baby, and 2-4 inches above that clamp, leaving clamps in place. Cut the cord between the clamps.
(c) Immediately take infant to another room within the ED for the resuscitation.
(d) Obtain and record the newborn weight. *Scale in triage room. Weigh in kg, remove the point (.) to have grams i.e. .323kg = 323gms

(e) Ensure infant is kept warm during resuscitation with warming bed or infant warmer.
*Current NRP Guidelines no initiation of resuscitation may be deemed ethical when the birth occurs prior to 22 weeks gestation.

(5) Disposition of Mother and/or Infant(s)
(a) If mother and/or infant(s) are to be transferred to another institution which provides obstetrical/neonatal services, they will be transported (ground or air) from the ED at the discretion of the responding OB MD and/or Pediatrician.
(b) All records, laboratory reports, initial radiological interpretations, and any other information obtained in the ED will be sent with the patient when transferred.
(c) If mother and/or infant(s) are to be kept at Sonoma Valley Hospital, they will be transferred to A Women's Place once they have been deemed **stable for safe transfer** between floors by both the ED MD and the OB MD and/or Pediatrician. Patients will be accompanied by appropriate staff members to maintain a safe transition to the floor.

(6) Birth Certificate
(a) Obtain the correct forms from A Women's Place.
(b) These papers must be completed prior to transfer to another institution.
(c) Birth certificate will be completed and signed by the Emergency Department attending or the physician/RN who actually delivered the infant(s)

(7) Emergency Department Medical Record – Mother and Infant(s)
(d) An Emergency Department medical record will be generated for the mother upon her arrival to the Emergency Department.
(e) The infant(s) will be registered using the time of delivery as the time admitted to the Emergency Department.
(f) An Emergency Department medical record will then be completed on each infant(s)

(8) Identification
(a) Mother and infant(s) identification bands will be made using the arm bands currently used in the Emergency Department
(b) Matching Mother Baby identification bands will be placed on mother and infant.

SUBJECT: Precipitous Birth in the Emergency Department	POLICY #PC8610-176
	PAGE 4 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

Supplies to be stocked in the Infant Warmer:

UVC Insertion Tray: expiration mo/yr
Precipt Tray
Sterile Gown
Sterile Towels x8
Straight Mayo Scissors
Mayo Clamps x2
Cord Clamps x2
Ring Forceps
Baby Blankets x2
Pkg 4x4 Bandage
Gel Warming Mattress exp:
Heel Warmers
Baby Blankets x2- extra
Baby Hat
IV packet: Earliest exp date on outside of pkt
Heplock
Saline Flush
3cc syringe x2
Pink lab tube x2
Green lab tube x2
23g Vacutainer
Blood transfer device
24g IV Catheter x2
IV Start Kit
Primary IV Tubing
Cord Blood Collection kit-purple top
Airway Drawer: Earliest exp date on outside
Bulb Syringe
Neonate OPA
Neonate BVM mask size 1
Infant BVM mask size 2

Hyperinflation System
Neo-Tee (Preferred for Ventilation)
Mini End Tidal CO2 Detector
Neonate ET Tubes 2.5, 3.0, 3.5
5Fr Stylet
Meconium Suction Device
Infant Pulse Oximeter

*Size 1 Miller Blade in Broselow cart Pink/Red Drawer, as well as, all full term supplies.

REFERENCES:

Besuner, P. (2007). AWHONN Templates for Protocols and Procedure for Maternity Services. 2nd edition.
The American College of Obstetrics and Gynecology; The American Academy of Pediatrics (2012). Guidelines for Perinatal care 7th edition.
Simpson, K. R. & Creehan, P. A. (2014). Perinatal Nursing 4th edition (AWHONN)

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Deborah Bishop, ED & ICU Clinical Director
Sally Staples, A Women's Place Manager
Cynthia Lawder, M.D., Medical Director, Emergency Department:
Mark Kobe, Chief Nursing Officer
PBX Staff

APPROVALS:
Policy & Procedure Team: 2/28/18
Surgery Committee: 3/8/18
Medicine Committee: 3/8/18
Medical Executive Committee: 3/15/18
Board Quality Committee: 3/28/18
The Board of Directors:

SUBJECT: Water Management	POLICY: IC8610-178
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To reduce the risk of healthcare associated Legionella and other pathogens associated with contaminated water.

POLICY:

SVH utilizes a water management program to reduce the risk of growth and spread of Legionella and other opportunistic pathogens associated with building water systems.

The water management program manager is the Director of Facilities. The Safety Committee reviews water management data and action plans. Infection Prevention reports to the Performance Improvement Committee on water management data and actions.

The hospital has conducted a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system.

The hospital Implements a water management program consistent with ASHRAE industry standards and the CDC Guidelines for the Prevention of Nosocomial Pneumonia.

The water management program includes physical controls, temperature management, disinfectant level control, visual inspection and environmental testing for pathogens when indicated. Note: In the absence of cases, the relationship between the results of water cultures and the risk for legionellosis remains undefined by the Centers for Disease Control. The CDC reports that the bacterium has been frequently present in water systems of buildings, often without being associated with known cases of disease. (1)

Background: Legionnaires Disease

Sonoma Valley Hospital has not identified any cases of hospital acquired Legionella. However, Legionella sp. are commonly found in various natural and man-made aquatic environments and may enter hospital water systems in low or undetectable numbers. Cooling towers, evaporative condensers, heated potable-water-distribution systems within hospitals, and locally produced distilled water can provide a suitable environment for legionellae to multiply. Factors known to enhance colonization and amplification of legionellae in man-made water environments include temperatures of 25-42 C, stagnation, scale and sediment, and the presence of certain free-living aquatic amoebae that are capable of supporting intracellular growth of legionellae.

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A person's risk for acquiring legionellosis after exposure to contaminated water depends on a number of factors, including the type and intensity of exposure and the person's health status. Persons who are severely immunosuppressed or who have chronic underlying illnesses, such as hematologic malignancy or end-stage renal disease, are at a markedly increased risk for legionellosis. Persons in the later stages of acquired immunodeficiency syndrome (AIDS) also are probably at increased risk for legionellosis, but data are limited because of infrequent testing of patients. Persons who have diabetes mellitus, chronic lung disease, or nonhematologic malignancy; those who smoke cigarettes; and the elderly are at moderately increased risk.

Definition of Nosocomial Legionnaires Disease:

The incubation period for Legionnaires disease is usually 2-10 days; thus, laboratory-confirmed legionellosis that occurs in a patient who has been hospitalized continuously for greater than or equal to 10 days before the onset of illness is considered a definite case of nosocomial Legionnaires disease, and laboratory-confirmed infection that occurs 2-9 days after hospital admission is a possible case of the disease.

Prevention Practices

The Centers for Disease Control recommends the following for hospitals without identified cases of Legionnaires Disease:

A. maintaining a high index of suspicion for legionellosis and appropriately using diagnostic tests for legionellosis in patients who have nosocomial pneumonia and who are at high risk for developing the disease and dying from the infection (385,445),
B. initiate an investigation for a hospital source of Legionella sp. upon identification of one case of definite or two cases of possible nosocomial Legionnaires disease, and
C. routinely maintain cooling towers and
D. using only sterile water for the filling and terminal rinsing of nebulization devices

General Infection-Control Strategies for Preventing Legionnaires Disease

A. Conduct an infection-control risk assessment to determine if patients at risk or severely immunocompromised patients are present.
B. Implement general strategies for detecting and preventing Legionnaires disease:
    1. Establish a surveillance process to detect health-care--associated Legionnaires disease e.g. periodic testing of hospital water for legionella and testing of patients who develop a hospital acquired pneumonia for Legionella.
    2. Inform health-care personnel (e.g., infection control, physicians, patient-care staff, engineering) regarding the potential for Legionnaires disease to occur and measures to prevent and control health-care--associated legionellosis.

3. Establish mechanisms to provide clinicians with laboratory tests (e.g., culture, urine antigen, direct fluorescence assay [DFA], and serology) for the diagnosis of Legionnaires disease.

C. Maintain a high index of suspicion for health-care--associated Legionnaires disease, and perform laboratory diagnostic tests for legionellosis on suspected cases, especially in patients at risk who do not require a PE for care (e.g., patients receiving systemic steroids; patients aged ≥65 years; or patients with chronic underlying disease (e.g., diabetes mellitus, congestive heart failure, or chronic obstructive lung disease)

D. Periodically review the availability and clinicians' use of laboratory diagnostic tests for Legionnaires disease in the facility; if clinicians' use of the tests on patients with diagnosed or suspected pneumonia is limited, implement measures (e.g., an educational campaign) to enhance clinicians' use of the test(s)

E. If one case of laboratory-confirmed, health-care--associated Legionnaires disease is identified, or if two or more cases of laboratory-suspected, health-care-associated Legionnaires disease occur during a 6-month period, certain activities should be initiated.
   1. Report the cases to state and local health departments.
   2. If the facility does not treat severely immunocompromised patients, conduct an epidemiologic investigation, including retrospective review of microbiologic, serologic, and postmortem data to look for previously unidentified cases of health-care--associated Legionnaires disease, and begin intensive prospective surveillance for additional cases.
   3. If no evidence of continued health-care--associated transmission exists, continue intensive prospective surveillance for ≥2 months after the initiation of surveillance.

F. If there is evidence of continued health-care--associated transmission (i.e., an outbreak), conduct an environmental assessment to determine the source of *Legionella* spp.
   1. Collect water samples from potential aerosolized water sources.
   2. Save and subtype isolates of *Legionella* spp. obtained from patients and the environment.
   3. If a source is identified, promptly institute water system decontamination measures per recommendations in accordance with the CDC recommendations.
   4. If *Legionella* spp. are detected in ≥1 culture (e.g., conducted at 2-week intervals during 3 months), reassess the control measures, modify them accordingly, and repeat the decontamination procedures; consider intensive use of techniques used in the initial decontamination, or a combination of superheating and hyperchlorination.

G. If an environmental source is not identified during a Legionnaires disease outbreak, continue surveillance for new cases for ≥2 months. Either defer decontamination pending identification of the source of *Legionella* spp. or proceed with decontamination of the hospital's water distribution system, with special attention to areas involved in the outbreak.

H. No recommendation is offered by the CDC regarding routine culturing of water systems in health-care facilities that do not have patient-care areas (i.e., PE or transplant units) for persons at high risk for *Legionella* spp. Infection.

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VII. Cooling Towers and Evaporative Condensers

A. When planning new construction, locate cooling towers so that the drift is directed away from the air-intake system, and design the towers to minimize the volume of aerosol drift.
B. Implement infection-control procedures for operational cooling towers)
   1. Install drift eliminators (ASHRAE 12-2000)
   2. Use an effective EPA-registered biocide on a regular basis. (ASHRAE 12-2000)
   3. Maintain towers according to manufacturers' recommendations, and keep detailed maintenance and infection-control records, including environmental test results from legionellosis outbreak investigations. (ASHRAE 12-2000)
      If cooling towers or evaporative condensers are implicated in health-care--associated legionellosis, decontaminate the cooling-tower system.

Water Sampling

A. When conducting any form of environmental sampling, identify existing comparative standards and fully document departures from standard methods
B. When sampling water, choose growth media and incubation conditions that will facilitate recovery of waterborne organisms

When environmental samples and patient specimens are available for comparison, perform the laboratory analysis on the recovered microorganisms down to the species level at a minimum, and beyond the species level if possible (*343*).

REFERENCES:
Guidelines for Environmental Infection Control in Health-Care Facilities, Lynne Sehulster, Ph.D., Raymond Y.W. Chinn, M.D, MMWR, June 6, 2003/52(RR10);1-42

OWNER:
Director of Quality & Risk

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APPROVALS:
Policy & Procedure Team: 2/20/18
Performance Improvement Committee: 2/22/18
Medical Executive Committee: 3/15/18
Board Quality Committee: 3/28/18
The Board of Directors:

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

POLICIES/PROCEDURES MANUAL
Surgical Services Department
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IC7471-103	Chemical Disinfection, High Level **What: no longer use this in our department** **Why: not our practice**	9/13
EC7420-115	Code Red in the Operating Room **What: references**	8/13
MM8610-108	Controlled Substance Distribution for Anesthesia **What: delete** **Why: duplicate policy, see MM7450-113**	8/13
PC7420-117	Cord Blood Gas Collection **What: Reviewed, no changes**	8/13
PC7420-119	Counts, Sponges, Sharps and Instruments **What: references, completed sentence on sponges, added verbiage regarding RFU sponge counts** **Why: Surgery acquired a radio-frequency unit and purchases sponges with radiopaque indicators for improved accuracy in assuring that no surgical sponges are left in body cavities from surgical procedures.**	8/13
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PC7430-104	Discharge of Patients Criteria from Surgical Care Unit (SCU) **What: references**	10/13
PC7430-105	Documentation in Surgical Care Unit (SCU) **What: Reviewed, no changes**	10/13
PC7420-146	Documentation in Surgery Briefly state changes and include reasons for making change(s). **What: references; deleted "The manual entry will be labeled as: LATE ENTRY. 2.1. If an employee on a previous shift failed to document, do not leave blank lines. They will be required to make a late entry as described as above."** **Why: delete obsolete content related to paper charting**	8/13
PC7420-147	Draping of the Patient in Surgery **What: Reviewed, no changes**	8/13
HR7471-108	Dress Code, Central Sterile **What: Reviewed, no changes**	9/13

MS7450-104	Duties and Responsibilities of the Chief of Anesthesia **What: references**	8/13
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EC7420-164	Electric Equipment Safety **What: references**	8/13
EC7420-124	Electrosurgical Units Safe Use of **What: DELETED ACCORDING TO OUR PRACTICE, REFERENCES** **Why: Cautery units live on rolling free standing carts so that they can be interchanged between the OR's**	8/13
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IC7471-114	Flexible Endoscopes, Reprocessing of **What: update to current practice, location of devices, procedure changes per manufacturer's recommendations** **Why: changed to location of areas of cleaning for best practice**	9/13
EC7420-148	Fluid Warmer Use **What: UPDATE TO CURRENT WARMER AND USE** **Why: changed brand and type of fluid warmer, updated for the device differences**	8/13
EC7420-125	Fluoroscan Use **What: changed to reflect newer model fluoroscan, added the record keeping of minutes of fluoro time, references** **Why: purchased newer model fluoroscan within past year; radiology recommends tracking minutes for patient exposure**	8/13
IC7471-115	Glidescope, Cleaning and Processing of **What: change way of processing, deleted all references to Cidex (no longer used)** **Why: no longer have Cidex**	8/13
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I.		
IC7471-138	Immediate Use Steam Sterilization **What: remove all references to 'flash' sterilization; update to current system in place "One Tray", with definitions of such. Added biologicals to criteria that much be monitored. Eliminated line regarding "insufficient surgical inventory"** **Why: current standard is for changing nomenclature from flash sterilization to immediate use steam sterilized (IUSS); Our IUSS system is called One Tray. Standard is to add biologicals to all loads along with the monitoring of such**	9/13

LD7420-149	Implant Reimbursement, Protocol for Surgical **What: references; updated sterilization technique to use current approved terminology, deleted "flash"; deleted unnecessary incomplete list of "possible" implantable items**	8/13
PC7420-129	Implantation of Medical Device **What: references; updated sterilization technique to use current approved terminology, deleted "flash"; deleted unnecessary incomplete list of "possible" implantable items**	8/13
IC7471-116	Infection Control for Sterilization **What: Reviewed, no changes**	9/13
IC7420-166	Infection Control in Surgical Services **What: references**	8/13
IC7471-118	Instruments, Cleaning and Processing of **What: Reviewed, no changes**	9/13
L.		
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MM8610-105	Malignant Hyperthermia , Management of Patient with **What: Reviewed, no changes**	8/13
IC7471-125	Monitoring of Sterilization Practices **What: Reviewed, no changes**	9/13
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PC7430-106	Nurse to Patient Ratios (in Phase I Recovery)in Surgical Care Unit (SCU) **What: REFERENCES**	10/13
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RI7420-134	Observers and Visitors in the Operating Room **What: references**	8/13
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PC7420-123	Pacemaker/ICD, Care of Patients Undergoing Surgery **What: references**	8/13
IC7471-123	Packaging Guidelines **What: Reviewed, no changes**	9/13
PC7420-136	Pathology Specimens: Handling Cultures and Specimens **What: references**	8/13
PC7420-138	Patient Positioning **What: references, updated to current equipment** **Why: no longer own an OEC fracture table; we own an OSI Hana fracture table**	8/13
RI7420-158	Patient Privacy **What: Reviewed, no changes**	
PC7420-147	Patient Safety in Surgery **What: references**	8/13

PC7420-111	Pediatric Patient in Surgery, Care of **What: references, updated for our unit name and practice** **Why: changed "will" to "may" regarding patients in room during induction; deleted "outpatient or pediatric unit" to SCU; deleted "encouraged' under comfort measures**	8/13
PC7430-103	Pediatric Patient in Surgical Care Unit (SCU), Care of **What: additional s/s respiratory distress**	10/13
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PC8610-201	PICC Line Insertion Peripherally Inserted Central Catheter **(Organizational Policy)** **What: Reviewed, no changes**	8/13
PC7430-107	Pre-Admission Evaluation, Surgical Care Unit (SCU) **What: additions to preop teaching re:medicationinstx for blood thinners, insulin and metformin**	10/13
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PC7420-142	Pre-Operative Skin Preparation of Patients **What: references, clipping of hair outside the OR** **Why: reflects current recommended practice per AORN standards**	8/13
PC8610-108	Procedural Sedation **(Organizational Policy)** **What: Reviewed, no changes**	8/13
R.		
EC7420-144	Radiological Safety **What: references**	8/13
PC7420-145	Rho-Gam Administration **What: references; to be done before discharge** **Why: to give time frame for patient receiving evidence of injection**	8/13
S.		
RI7420-151	Sales Representative in the Operating Room **What: current practice for check in using automated system** **Why: check in for vendors was done manually; now SVH has automated system**	8/13
EC7420-152	Sanitation in the Operating Room **What: deleted all references to glutaraldehyde (no longer use this method); added current mopping method for OR's;**	8/13
LD7420-157	Scheduling Surgical Procedures **What: changed charge nurse to clinical coordinator**	8/13
PC7420-153	Scope of Practice, Surgery **What: added licensure/required certifications of PACU RN, difference in shift PACU RN for on call**	8/13
PC7430-101	Scope of Service, Surgical Care Unit (SCU) **What: REFERENCES; REFERENCE STAFFING POLICY FOR AFTER HOURS PATIENTS**	10/13
HR7420-154	Staff Scheduling Practices **What: update to current staffing practices** **Why: establish guidelines and minimal requirements for taking call; d/t changing traffic patterns, allow additional time to arrive for after-hours case; circulator now required to stay as 2nd nurse for shorter recovery time; rotation of flexing off**	8/13
PC7430-108	Standardized Procedure for Patient Discharge from Surgical Care Unit (SCU) **What: Reviewed, no changes**	10/13
EC7471-127	Sterile Supplies, Storage of **What: Reviewed, no changes**	9/13
IC7471-128	Sterilization **What: eliminate ETO-not in use here; eliminate "Flash" and changed to IUSS**	9/13

	Why: ETO no longer commonly used in hospitals; current standard is change flash sterilization to Immediate Use Steam sterilization	
IC7471-136	Sterrad NX Sterilizer Usage **What: Reviewed, no changes**	9/13
IC7420-156	Surgical Hand Scrub/Antisepsis **What: references**	8/13
PC7420-155	Surgical/Invasive Procedure Site Confirmation/Verification **(Organizational Policy)** **What: update to current OR layout (Delete ACU and preop holding area) SCU unit, references**	8/13
T.		
PC7420-158	Tourniquet: Use of the Pneumatic Tourniquet in the Operating Room **What: references**	8/13
EC7420-159	Traffic Control in the Operating Room **What: references**	8/13
IC7471-134	Traffic Patterns, Central Sterile **What: Reviewed, no changes**	9/13
U.		
IC7471-135	Ultrasonic Cleaner **What: Reviewed, no changes**	9/13
PC7450-112	Unintended Intra-Operative Awareness During General Anesthesia **What: delete** **Why: was a JCAHO driven policy, no need for a scenario to be a policy**	8/13
PC8610-125	Universal Protocol **(Organizational Policy)** **What: Reviewed, no changes**	8/13
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PC7420-160	Vacuum Assisted Wound Closure **What: Reviewed, no changes**	8/13
	VAC Wound Closure Guide	
W.		
MM8610-112	Warming Fluids for IV and Irrigation Purposes, Storage and Handling of	8/13
PC7420-161	Wound Classification **What: references**	8/13
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Y.		
Z.		

Policy & Procedures Committee: 1/16/18
Surgery Committee: 2/8/18
Medical Executive Committee: 2/15/18
Board Quality Committee: 3/28/18
The Board of Directors:

5.

HUMAN RESOURCES ANNUAL REPORT 2017

Human Resources Department

Annual Report 2017

Prepared by: Lynn McKissock, Director of Human Resources

Introduction

The Human Resources department successfully managed another full year of essential projects, the largest one involving the implementation of a new Workplace Violence Prevention (WVP) Program, in compliance with the new Cal-OSHA regulations. The WVP Program implementation included creation a process to report incidents of violence to Cal-OSHA within defined timeframes by July of 2017, with a comprehensive written program and employee training completed by April 1, 2018. Happily, with the assistance of a WVP Taskforce, we were successful in meeting this new requirement. Other significant projects included: Total Compensation Statements for all benefited employees, managing the Employee Engagement Survey, completing the ACA annual reporting requirements, coordinating Sexual Harassment Training for all supervisory staff, conducting the annual employee health screening clinic, administering employee benefits and wellness program open enrollments (100% electronic), coordinating with the Rewards & Recognition Team in hosting the Employee Excellence & Service Awards luncheon, and processing of 100 new hires and 56 clinical students.

2017 Dashboard

Performance Indicator	2017	2016	2015
Employee Engagement Organizational Score (CY)	4.19 61st Percentile	4.24 74th Percentile	4.33 84th Percentile
Employee Engagement Survey Response Rate (CY)	81%	90%	86%
Turnover (CY)	13.6%	10.3%	8.1%
Salary Costs / % of Net Revenue (FY)	$26,169,737 / 47.54%	$25,970,061 / 44.4%	$23,760,793 / 43.5%
Benefit Costs / % of Net Revenue (FY)	$10,770,495 / 19.56%	$9,711,167 / 16.6%	$9,502,533 / 17.4%
Registry/Traveler Costs (FY)	$860,071	$993,822	$871,047
Leave of Absences (CY)	70	74	63
Number of Injuries (CY)	12	6	6
Number of Open WC Claims (CY)	10	11	12
Workers' Comp Costs (CY)	$156,921	$139,888	$154,478
Legal costs for Employee Issues (FY)	$39,772	$36,657	$30,255
Wellness Program Participation (CY)	216/322 – 67%	182/263 – 69%	162/260 – 62%

Employee Engagement Survey

We always look forward each year to see the results of our Employee Engagement Survey with hope of seeing scores reflective of Leadership's efforts to continually implement positive changes that affect the workplace environment. While we did see a slight decline in our overall engagement score (4.19 vs. 4.21 last year), I would like to draw attention to the survey items that showed the greatest improvements. You may recall that one of the top concerns from last year's survey was in regards to the employee's perception that their pay was fair compared to other healthcare employers in this area.

You may also recall that we implemented some significant compensation strategies during the previous year in response to this feedback. Happily, this specific survey item realized the greatest improvement over last year! Other items notable for the greatest improvement include: sufficient time to provide the best care; employees in a work unit helping each other accomplish their work; job responsibilities are clear; and employees enjoy working with their co-workers.

We did see a slight decline in our overall engagement score as well as participation this year as compared to last year. We do know that a few organizational changes/restructuring just prior to the survey may have negatively affected some individual's feelings, as change is oftentimes difficult to accept at first. As we begin our individual department meetings over the next couple of months, we look forward to continuing the conversation about change and look to gain a better understanding of this overall decline. As always, we will create relevant action plans to support our continuous improvement cycle. The following provides an overview of the scores, what they mean to us and some initial thoughts about our action planning response.

Starting with the Engagement Indicator score; this is a composite score of six (6) engagement indicator items reflecting the overall satisfaction our employees feel towards their workplace. Our score of 4.19, while slightly less than last year, is still 0.05 points higher than the National Healthcare Average as well as the National Community Hospital Average. Our participation rate of 81% is reflective of 326 responses out of 401 invitations (new hires that were still in their initial 90-days of employment and Per Diem staff that had worked less than 400 hours in the past 12 months were not included).

The Tier Distribution is based on responses to the items that most powerfully influence workforce engagement and indicates the level of work-unit action planning that may be required. Tier 1 groups require minimal action planning, meaning they can focus on some higher-level action plans or even focus on how they can continue to maintain what they are already doing well. Tier 2 groups will need to engage in some focused action planning and Tier 3 groups will need significant action planning and may need some additional training/resources to be successful. We will look to the Tier 1 groups to be such a resource and to share their best practices.

SVH' s Tier Distribution this year saw a slight increase in the number of Tier 1 work-units (57%) as compared to last year, which also correlates with the slight decline in the number of Tier 2 work-units (30%). Unfortunately, some of those Tier 2 units from last year also moved to the Tier 3 level (13%).

The Action Planning Readiness score assesses how well prepared the work-unit leader is to lead a workgroup through the action planning process. This key metric provides insight into the manager-employee relationship by measuring trust, respect, communication skills, and openness to discussing issues and solutions. This score is presented on a 100-point scale. Scores above 70 are a good indication that the work-unit is prepared to engage in action planning initiatives led by the manager/supervisor. As you can see, the majority of our work-units are in good standing and ready to proceed (86%). There are four (4) work-units whose action planning will need to focus on improving manager-employee relationships and we will provide additional support to those leaders in doing so.

Pulling this all together, there are three primary domains that are measured, in conjunction with the overall engagement score, tier score, and action planning readiness. These three domains, measured on a 5-point scale, include: Organization Domain – 3.99 (measures the degree to which employees feel connected to the overall organization), Manager Domain – 4.20 (measures the degree to which employees feel connected to their direct manager), and Employee Domain – 4.23 (measures the degree to which employees feel connected to their colleagues and jobs.

Finally, it's important that we first acknowledge and celebrate what is going well and then identify areas requiring our focus. Our highest performing survey items include: "I like the work I do;" "My work-unit provides high-quality care and service;" "I enjoy working with my coworkers:" "Employees in my work-unit follow proper procedures for patient care/customer service;" and "This organization contributes to the community." Conversely, our lowest performing survey items include: "This organization provides career development opportunities;" "I am satisfied with my job security;" "I am satisfied with my benefits;" and "Different levels of this organization communicate effectively with each other."

So, what's next – what do we do with this information? A few actions to consider include forming focus groups to better understand employee's perception of respect (a key driver of engagement), asking them to define what respect looks like to them and identify what's working well now and where are the areas needing improvement. We have a great opportunity to do this during our individual work-unit action planning activity. Additionally, we need to continue the conversation around job security and identify the cause of our employee's concerns and differentiate between fact and rumor, answer questions, and maintain open communication during organizational changes. We already have a great format for this with the CEO Employee Forums throughout the year. Finally, we need to determine individual work-unit support strategies, define support resources – particularly for those work-units in the Tier 3 or low action planning readiness categories – and reinforce ongoing improvement with an emphasis on recognition and sharing of best practices.

Turnover

We have experienced a gradual increase in turnover these past three years, with 2017 being the highest so far. Nursing experienced the greatest turnover in 2017, with clinical and support departments splitting the remaining difference. Nursing departments have continued to experience a gradual increase in turnover year-over-year, but 2017 did see a significant increase (from 10% - 11% up to 15%). It's possible that some of that increase was in direct response to some organizational changes in those departments, but with the majority of the turnover occurring in the third quarter, it could also be contributed to "seasonal" changes – the third quarter of the year is the most popular time for families to relocate. We have also experienced turnover in the nursing departments stemming from new graduates that are choosing to change employers once they have 6 – 12 months of experience with us. In response to this, HR is working with the nursing department to design a retention program focused on encouraging new graduates to stay at least 2-3 years. However, not all retention hinges on financial rewards. It is my belief that the employee's initial thoughts about staying or going develop during the most influential phase of their employment - the onboarding phase. The level of support,

guidance, communication, connection with co-workers as well as how their own values resonate with the organizational values are great influencers on the employee's decision about where they want to be. Therefore, any retention program we implement should include this dual approach.

Compensation & Benefits

We continue to see an increase, year-over-year, in our cost associated with salaries and benefits. In regards to salaries, this is primarily due to our efforts to remain regionally competitive and maintain an external equity with like-sized and similarly situated hospitals in Northern California, as well as our continuance of annual cost-of-living increases (2% - 3%). While we have been very conservative and reasonable in all of our salary adjustments, we do notice a gradual increase in cost of salaries as a percent of net revenues, with a significant jump in 2017. I believe this is primarily due to the additional salary adjustments made in 2017, as mentioned above (particularly in nursing), again in an effort to bring them closer to the market average for this area. This specific metric is a clear indicator that we need to continue evaluating our staffing and efficiencies in our overhead areas. Additionally, while we know we do a good job flexing nursing and clinical staff in response to volumes, we may need to evaluate this further and/or seek alternative solutions to managing these high expenses.

In regards to benefits, we made a number of cost-saving changes last year by increasing the employee contribution amount and successfully negotiating a smaller increase to premiums. Unfortunately, this year the insurance companies were less willing to reduce their premiums, which resulted in our selection of a lower-cost plan for medical, increasing the office visit copay, but keeping our cost of premiums level. However, we did have to absorb a larger increase for our dental plan, but also negotiated a decrease in premiums for employees enrolled in the Life & LTD plans. Given the trends of continuous, unforgiving increases in the cost of health insurance, we will be looking to make even more changes to our plans in the coming year.

Worker's Compensation

While what we see in the Dashboard as an increase in the number of new injuries in 2017 as compared to previous years, this is actually more reflective of the changes we have made to our reporting process and management of injuries, rather than an actual increase to injuries themselves. Therefore, we did experience twelve (12) new injuries this year, but we also closed thirteen (13) claims in the same time period, ending with just ten (10) open claims at the close of 2017. When reviewing the types of injuries we are experiencing, we learn that the primary cause of injury is from lifting (objects or patients), pushing/pulling, and patient assist, representing 50% of all injuries. Other categories include body motion, repetitive motion, and slips/trips. We did see our total cost of claims increase in 2017, but this can be attributable to the number of claims closed with corresponding compromise and release agreements.

Education

Our Education Coordinator was reduced to half time this year, but her valuable contributions to our staff and hospital quality have not suffered. Bonnie is passionate and committed to ensuring that staff are well prepared and skilled to deliver quality patient care. Her projects and initiatives this year included:

New Hire Skills Assessment: Bonnie meets with every nursing and clinical new hire to assess their current skills and knowledge. The list of twelve (12) topics are considered high-risk to patient safety and reviewed prior to working on the unit. In 2017 the list of topics covered were expanded to also include IV compounding when pharmacy is closed, central line care, cardiac monitor daily energy testing, and manual defibrillation with use of paddles.

Skills Lab: An annual event (with a lot of follow-up) committed to improving and maintaining the skill level of our staff for those low frequency/high-risk skills. In order to ensure that these high-risk skills meet our high level of standard. The competency verification process includes a hands-on return demonstration.

Workplace Violence Prevention Training: Cal-OSHA has required healthcare facilities to provide education on the recognition and prevention of workplace violence. All staff have reviewed an online workplace violence training module and have read the SVH Workplace Violence Prevention Program/Policy. Emergency staff and members of the Code Gray team participated in live classroom training that included verbal and hands-on techniques to manage individuals displaying aggressive behavior.

Workplace Violence Prevention competencies that were developed included Managing a Threat or Assault with a Weapon, Managing a Threat or Assault without a Weapon and Recognizing and Managing those at Risk for Threatening or Violent Behavior throughout the Assault Cycle. These competencies include staff roles and responsibilities and have been modified for those working in the hospital, Healing at Home or other off-site locations.

Advance Health Care Directives (AHCD): Hospital and community workshops continued to be conducted with the goal of having all staff and community members complete AHCD to ensure their wishes are honored during their end of life process.

Our education goals are to continue driving and supporting safe and high-quality patient care. While this is a big undertaking for a one-person department, we know Bonnie the one to do it. She most definitely is someone who seeks new and creative solutions to deliver quality healthcare!

Goals/Initiatives for 2018

Looking forward, Human Resources is focused on a couple of significant improvement projects, including continuous evaluation of overhead-reduction initiatives, starting with identifying cost-savings associated with our benefit and compensation programs/policies; improvements to our performance management programs, including both annual performance evaluations as well as performance correction plans; continuation of turnover analysis and a meaningful retention program in conjunction with a closer look at our current onboarding process, focused on finding opportunities for improvement; and last, but not least, a complete review and update to all HR-related policies and procedures, as well as a clear and meaningful Employee Handbook. Another very full year ahead!

Sonoma Valley Hospital

Human Resources Department

Annual Report – 2017

Sonoma Valley Health Care District
Board of Directors

May 3, 2018

Accomplishments

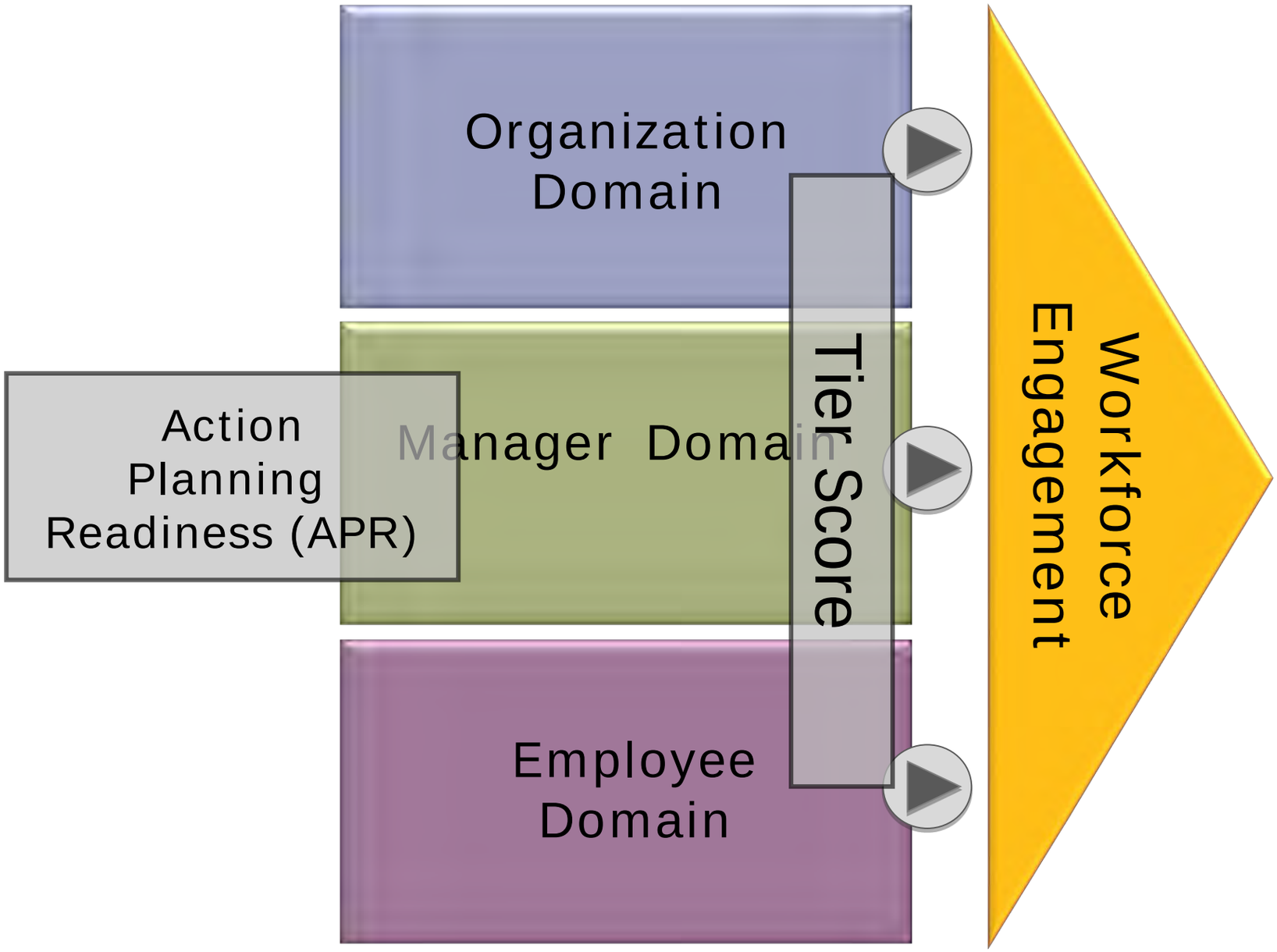
- Workplace Violence Prevention Program
- Sexual Harassment Training
- Total Compensation Statements
- ACA Reporting
- Employee Engagement Survey
- Annual Health Screening Clinic
- Benefits & Wellness Program Open Enrollment
- Employee Service & Excellence Awards
- 100 New Hires / 56 Clinical Students

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

Performance Indicator	2017	2016	2015
Employee Engagement Organizational Score (CY)	4.19 61st Percentile	4.24 74th Percentile	4.33 84th Percentile
Employee Engagement Survey Response Rate (CY)	81%	90%	86%
Turnover (CY)	13.6%	10.3%	8.1%
Salary Costs / % of Net Revenue (FY)	$26,169,737 / 47.54%	$25,970,061 / 44.4%	$23,760,793 / 43.5%
Benefit Costs / % of Net Revenue (FY)	$10,770,495 / 19.56%	$9,711,167 / 16.6%	$9,502,533 / 17.4%
Registry/Traveler Costs (FY)	$860,071	$993,822	$871,047
Leave of Absences (CY)	70	74	63
Number of Injuries (CY)	12	6	6
Number of Open WC Claims (CY)	10	11	12
Workers' Comp Costs (CY)	$156,921	$139,888	$154,478
Legal costs for Employee Issues (FY)	$39,772	$36,657	$30,255
Wellness Program Participation (CY)	216/322 – 67%	182/263 – 69%	162/260 – 62%

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

Employee Voice Model



High Performance Organization *

- Quality/Safety
  - Fewer Hospital Acquired Infections/Conditions
  - Shorter length of stay
  - Fewer readmissions
- Patient Experience
  - Higher scores across HCAHPS domains
- Finances
  - Higher net margins
  - Lower per-patient spend for readmissions
- Organizational Culture
  - Productivity
  - Retention/Talent Attraction
  - Community Image

*www.pressganey.com – Strategic Insights; Achieving Excellence: The Convergence of Safety, Quality, Experience and Caregiver Engagement

Greatest Improvements

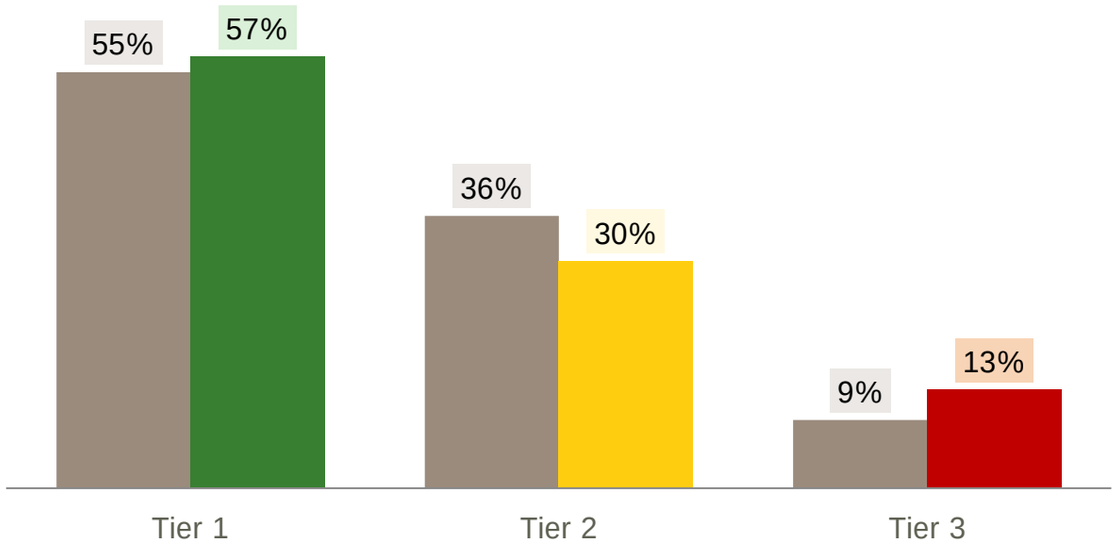
				Difference from:		
Item	Domain	2018 SVH	% Unfav	2017 SVH	Natl HC Avg	Natl Comm Hosp Avg
29. My pay is fair compared to other healthcare employers in this area.	ORG	3.44	24%	+.06	+.04	.00
53. I have sufficient time to provide the best care/service for our clients/patients.	EMP	3.99	7%	+.05	+.28	+.25
18. Employees in my work unit help others to accomplish their work.	EMP	4.37	3%	+.03	+.19	+.17
56. My job responsibilities are clear.	MGR	4.35	3%	+.03	+.12	+.06
4. I enjoy working with my coworkers.	EMP	4.51	1%	+.03	+.11	+.09

Results at a Glance

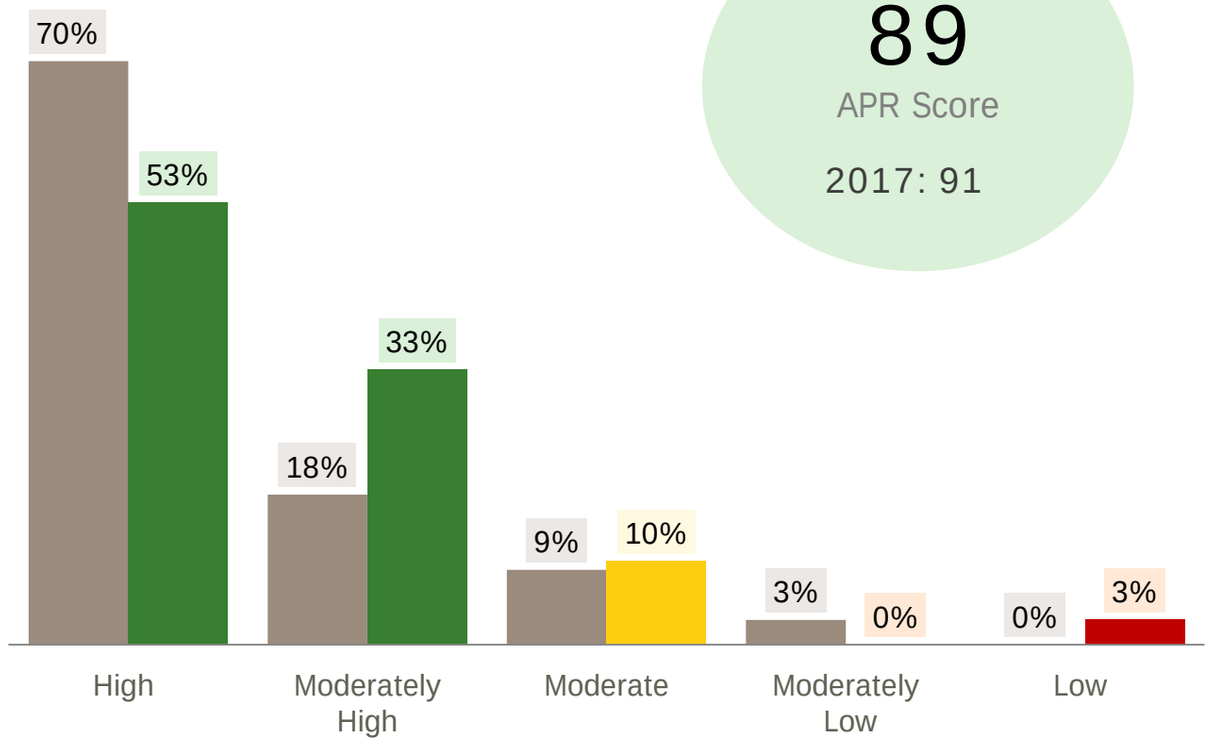
Survey Admin: January – February 2018

Year	Engagement Indicator	Natl HC Avg Percentile	Natl Comm Hosp Avg Percentile
2018 (n=326, 81%)	4.19	61st	54th
2017 (n=368, 90%)	4.24	74th	63rd

Tier



APR



PRESS GANEY®

Engagement

			Difference from:		
Engagement Item	2018 SVH	% Unfav	Natl HC Avg	Natl Comm Hosp Avg	2017 SVH
65. Overall, I am a satisfied employee.	4.24	2%	+.21	+.16	-.03
55. I would like to be working at this organization three years from now.	4.25	4%	+.09	+.06	.00
64. I would recommend this organization as a good place to work.	4.19	3%	+.06	+.05	-.09
42. I would stay with this organization if offered a similar position elsewhere.	3.96	6%	+.03	+.02	.00
41. I am proud to tell people I work for this organization.	4.31	1%	+.01	+.04	-.06
50. I would recommend this organization to family and friends who need care.	4.21	2%	-.06	-.02	-.08
2018 Engagement	4.19	-	+.05	+.05	-.05

Note – In this presentation GREEN / RED notes a statistically significant difference.

Natl HC Avg +/- .12 Natl Comm Hosp Avg +/- .12 History +/- .16

Press Ganey's Tier Approach

Tier 1

- Fewest Obstacles Less need for formal action planning
- Power Items scores ≥4.15

Tier 2

- Some Obstacles
  Would benefit from group action planning
- Power Item scores ≥3.80 and <4.15

Tier 3

- Greatest Obstacles
  Would benefit most from action planning support
- Power Items Scores <3.80

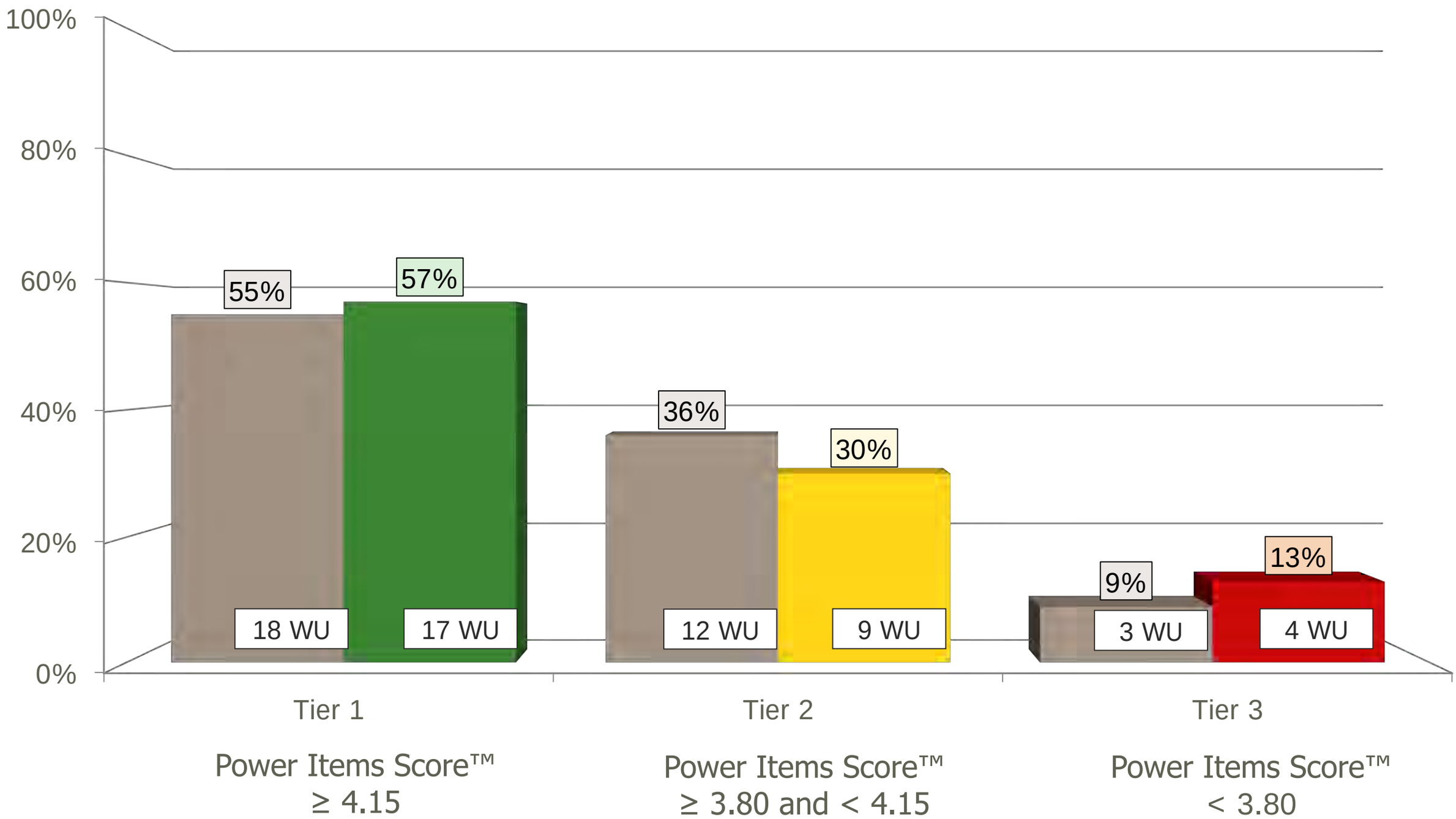
Tier helps organizations determine support /focus needed at the unit level

- Tier is a team score rather than simply a measure of manager performance
- Based on 15 Power Items (longstanding national drivers of engagement)
  - Used consistently across all PG clients
  - Includes items from all three survey domains (ORG, MGR, EMP)

Press Ganey's Tier Approach: Power Items

Power Item	Domain
My work unit works well together.	EMP
I like the work I do.	EMP
My job makes good use of my skills and abilities.	EMP
The person I report to treats me with respect.	MGR
I am satisfied with the recognition I receive for doing a good job.	MGR
I am involved in decisions that affect my work.	MGR
I respect the abilities of the person to whom I report.	MGR
The person I report to is a good communicator.	MGR
Different work units work well together in this organization.	ORG
This organization conducts business in an ethical manner.	ORG
This organization provides high-quality care and service.	ORG
This organization supports me in balancing my work life and personal life.	ORG
My pay is fair compared to other healthcare employers in this area.	ORG
This organization treats employees with respect.	ORG
This organization provides career development opportunities.	ORG

SVH Tier Distribution



Press Ganey's Action Planning Readiness Score™

High Readiness
APR scores
≥ 90

Moderately High Readiness
APR scores
80-89

- Group is ready to have discussions for improvement with manager

Moderate Readiness
APR scores 70 - 79

- Group may be ready for discussions– Manager may benefit from guidance

Moderately Low Readiness
APR Scores 60-69

Low Readiness
APR Scores below 60

- Build relationships between managers and employees prior to discussions

APR helps organizations determine support /focus needed in the manager-employee relationship

- Based on 6 Manager Domain Items
- Used consistently across all PG clients
- Reported on a 100 pt scale, similar to a grade in school

SVH Action Planning Readiness™

I respect the abilities of the person to whom I report.	92
The person I report to encourages teamwork.	92
The person I report to treats me with respect.	91
The person I report to cares about my job satisfaction.	90
The person I report to is a good communicator.	87
I am involved in decisions that affect my work.	80

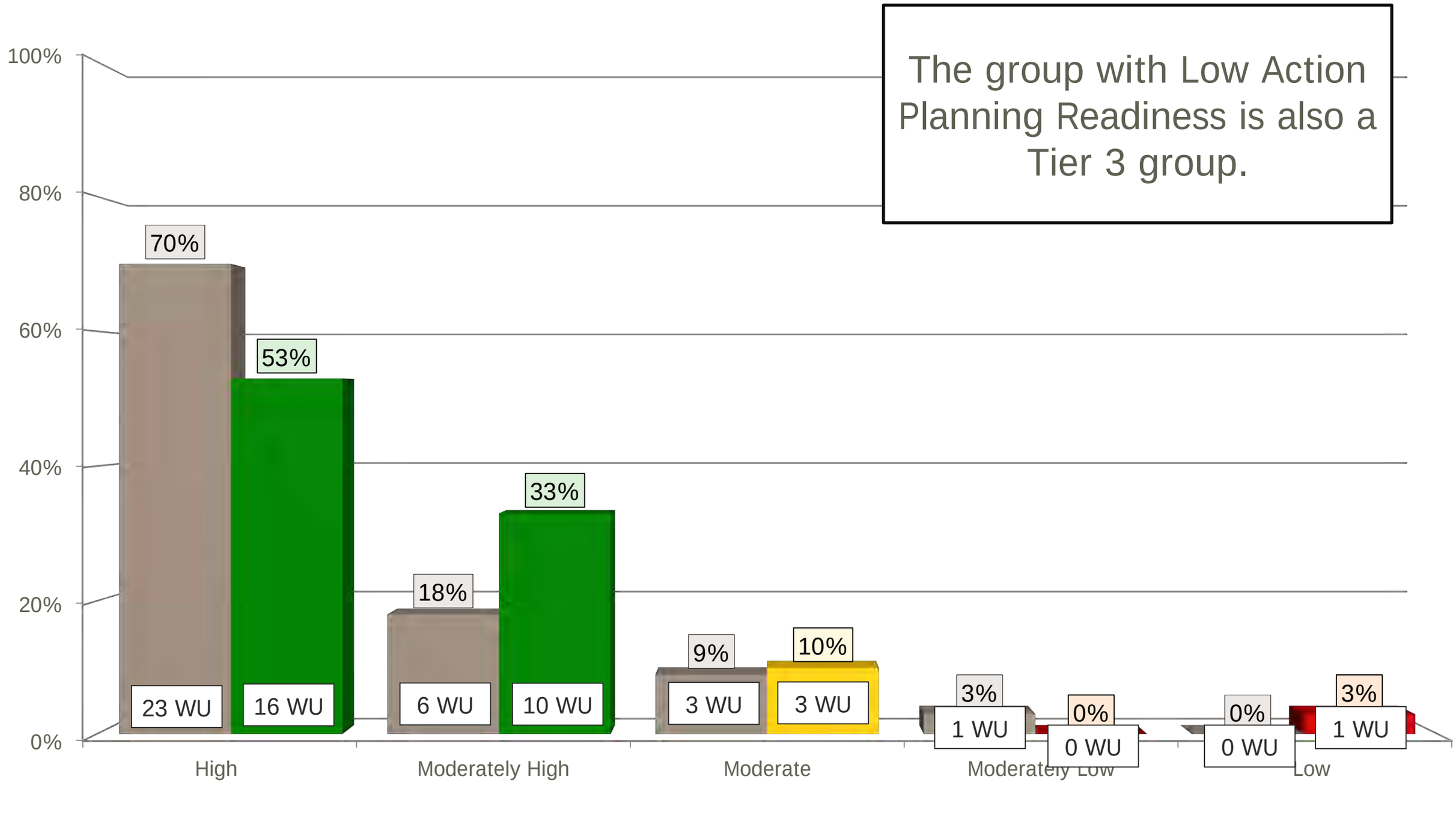
2018 SVH APR Score

89

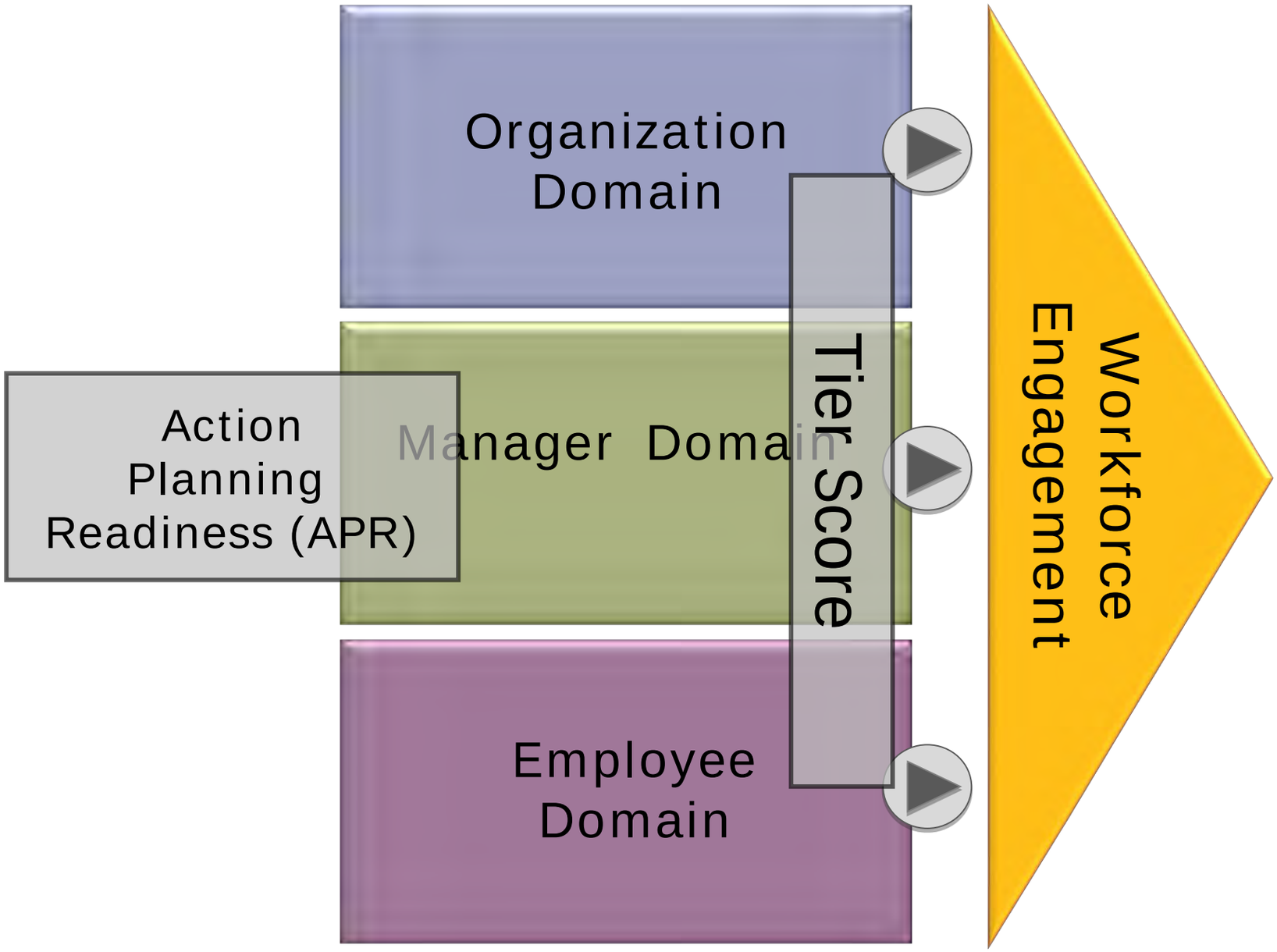
Moderately High Readiness APR 80-89

2017 SVH APR Score = 91

SVH Action Planning Readiness™ Distribution



Employee Voice Model



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*www.pressganey.com – Strategic Insights; Achieving Excellence: The Convergence of Safety, Quality, Experience and Caregiver Engagement

Highest Performing Items vs. Natl HC Avg

				Difference from:		
Item	Domain	2018 SVH	% Unfav	Natl HC Avg	Natl Comm Hosp Avg	2017 SVH
30. My work unit is adequately staffed.	ORG	3.72	14%	+.43	+.41	+.02
31. The amount of job stress I feel is reasonable.	EMP	3.84	10%	+.34	+.29	.00
53. I have sufficient time to provide the best care/service for our clients/patients.	EMP	3.99	7%	+.28	+.25	+.05
44. Employees who work here are seldom distracted from their work.	EMP	3.69	11%	+.26	+.22	-.01
49. Employees in my work unit are fully attentive to the needs of others.	EMP	4.24	3%	+.21	+.18	.00

Lowest Performing Items vs. Natl HC Avg

				Difference from:		
Item	Domain	2018 SVH	% Unfav	Natl HC Avg	Natl Comm Hosp Avg	2017 SVH
36. I am satisfied with my job security.	ORG	3.66	14%	-.34	-.33	-.28
47. This organization provides career development opportunities.	ORG	3.56	16%	-.25	-.26	-.04
21. I am satisfied with my benefits.	ORG	3.64	14%	-.06	-.01	-.09
33. I get the training I need to do a good job.	ORG	3.95	7%	-.05	-.09	-.10
15. This organization conducts business in an ethical manner.	ORG	4.08	5%	-.05	-.07	-.05

Keys for Improvement Success

- Communicate survey results
  - Share results in person
  - Thank team members for participating
- **Meet regularly with the goal to "solve work unit problems"**
  - The focus is not activity, but making things better for patients and caregivers
  - Involve team members in selection of issues and developing solutions
  - Implement solutions developed by team
- Report on progress and challenges
  - Continue meeting regularly to provide updates and discuss challenges or changes needed
  - Report through a cohesive chain of accountability:
    - Teams→ Managers→ Directors→ VP's→ Execs, etc.
- Continue problem solving cycle
  - Once sufficient progress is made on team priorities, choose next issues to solve

Turnover

- Nursing experienced largest increase
- Reasons for Turnover
  - Change in Leadership
  - New Graduates
  - Life Event
- Retention Program

COMPENSATION & BENEFITS

- Compensation
  - Rising cost of salaries
  - External equity adjustments
  - Overhead efficiencies

- Benefits
  - Medical plan change – avoid 4% increase
  - Dental plan – 11.5% increase
  - Continue to explore options

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Worker's Compensation

- 12 Injuries; 10 Open Claims
- Injuries by Cause
- Cost of Claims up
  - Closed 13 claims
- Self Insured Savings

Education

- New Hire Skills Assessment
- Skills Lab (hands-on return demonstrations)
- Workplace Violence Prevention Training & Written Competencies
- Advance Health Care Directive Education for Staff and Community

Goals/Initiatives 2017

- Cost-Saving Initiatives
- Performance Management
- Retention Program
- Clear & Effective Policies/Procedures

QUESTIONS?

6.

GROWTH & BUSINESS DEVELOPMENT QUARTERLY REPORT

Growth & Business Development Quarterly Review

FY 2018

Sonoma Valley Health Care District
Board of Directors

May 3, 2018

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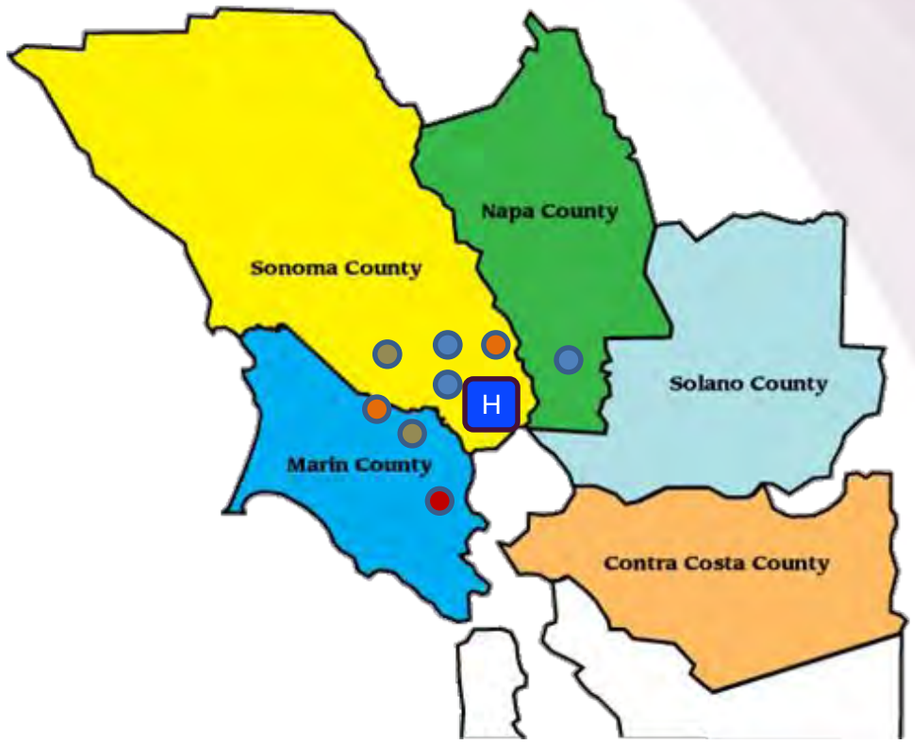
Agenda

- Positioned for Growth
- YTD Accomplishments FY 2018
- Growth Analysis
- Opportunities for Improvement
- Margin Analysis
- Planning Ahead

Positioned for Growth

- Unique position
- Physician Clinics
- Keeping patients local
- Additional services
- Expanded service lines
- Affiliation
- Innovative programs
- Focus on high margin services



- St. Joseph/ Providence
- Sutter Health
- Kaiser Permanent
- Marin General Hospital/UCSF

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Positioned for Growth

Why do we need growth initiatives?

- Revenue
- Defend against competition
- Long lasting niche strategies with low competition
- Set foundation for future

Review of FY 2018 Major Initiatives

Ambitious Goal: $1,450,000

Trending at $1,613,000 annualized

Major Initiatives

- Pain Management service margin
- Continued Bariatric expansion
- Develop Women's Services

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Review of FY 2018 Secondary Initiatives

Secondary Initiatives

- General Surgery regional expansion
- Ophthalmology Growth
- Enhance Urology, Vascular & Spine

Accomplishments

Pain Management

Increased reimbursement $390,600

Total service line margin $300,200

- 6 pain management Physicians
- Volumes increasing
- Regional expansion
- Collaboration with SVCHC and Bright Heart Health
- Clinics 3 days a week in Sonoma
- Service line under way

Accomplishments

Bariatrics: Whole Health Weight Loss

Increased reimbursement $134,000

Total service line margin $940,000

- Regional services
- Adding new procedures
- Collaborative marketing
- All ancillary services in hospital
- Educational seminars and support group
- All-in-one clinic day

Accomplishments

A Woman's Place:

A Woman's Place
Servicios de salud para la mujer
AT SONOMA VALLEY HOSPITAL

Margin projection of $300,000 YR 1

- Launched February 2018
- New patient clinic volumes doubled
- Increase in Breast & GYN surgeries
- Increase in pelvic rehab, ultrasounds and mammography
- Added Urogynecologist

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Accomplishments

General Surgery/Endoscopy

Increased reimbursement $552,000

Total service line margin $914,000

- Secondary increase of endoscopy cases
- Regional expansion
- Increased OR time
- Endoscopy increased due to outreach
- New General Surgeon

Accomplishments

Ophthalmology

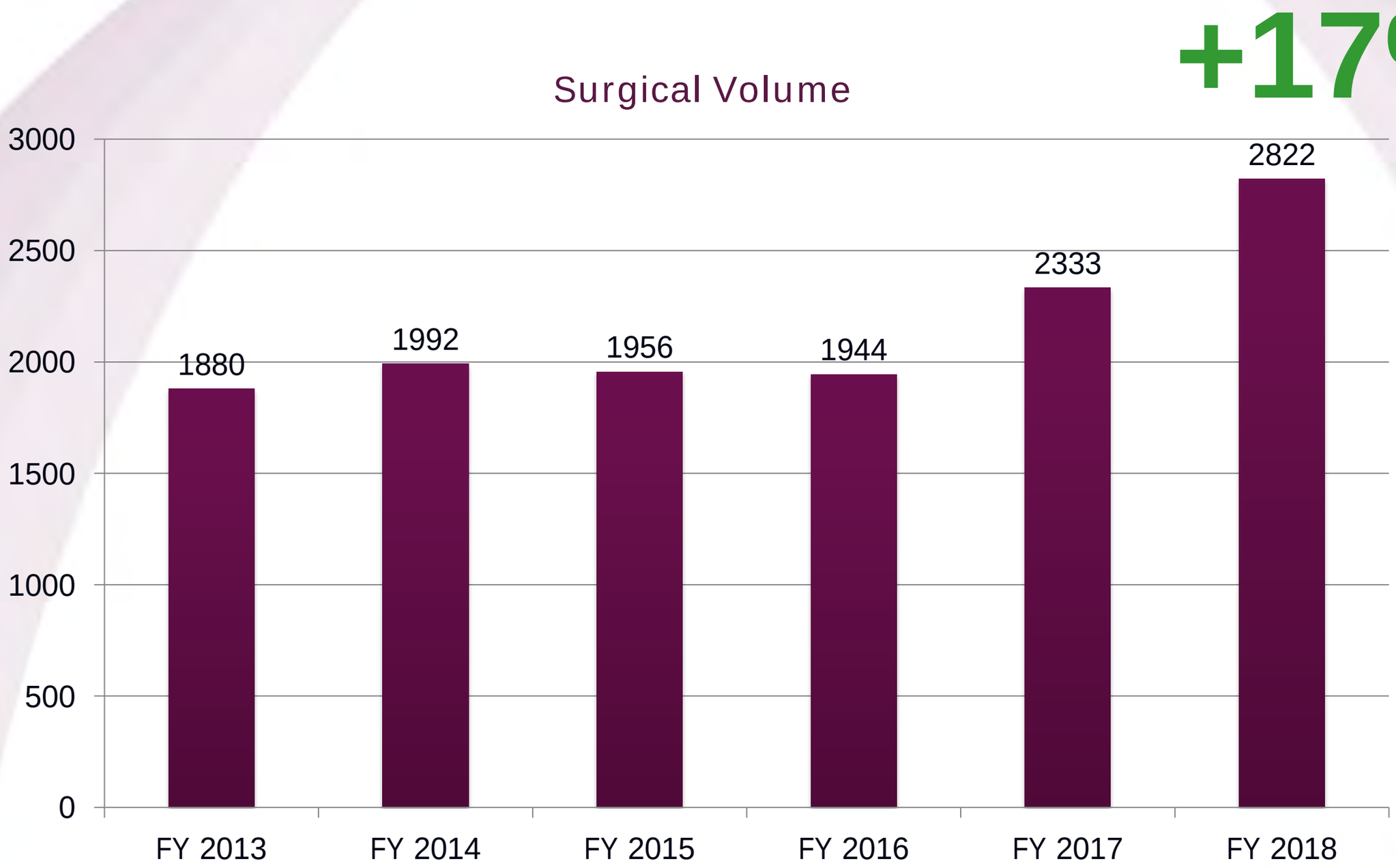
Increased reimbursement $232,700

Total service line margin $215,000

- Now have 3 Specialists
- Community outreach effective
- Full time clinic in Sonoma
- Increasing OR time 2x in last 3 months
- Added new high margin procedure

Accomplishments

+17%



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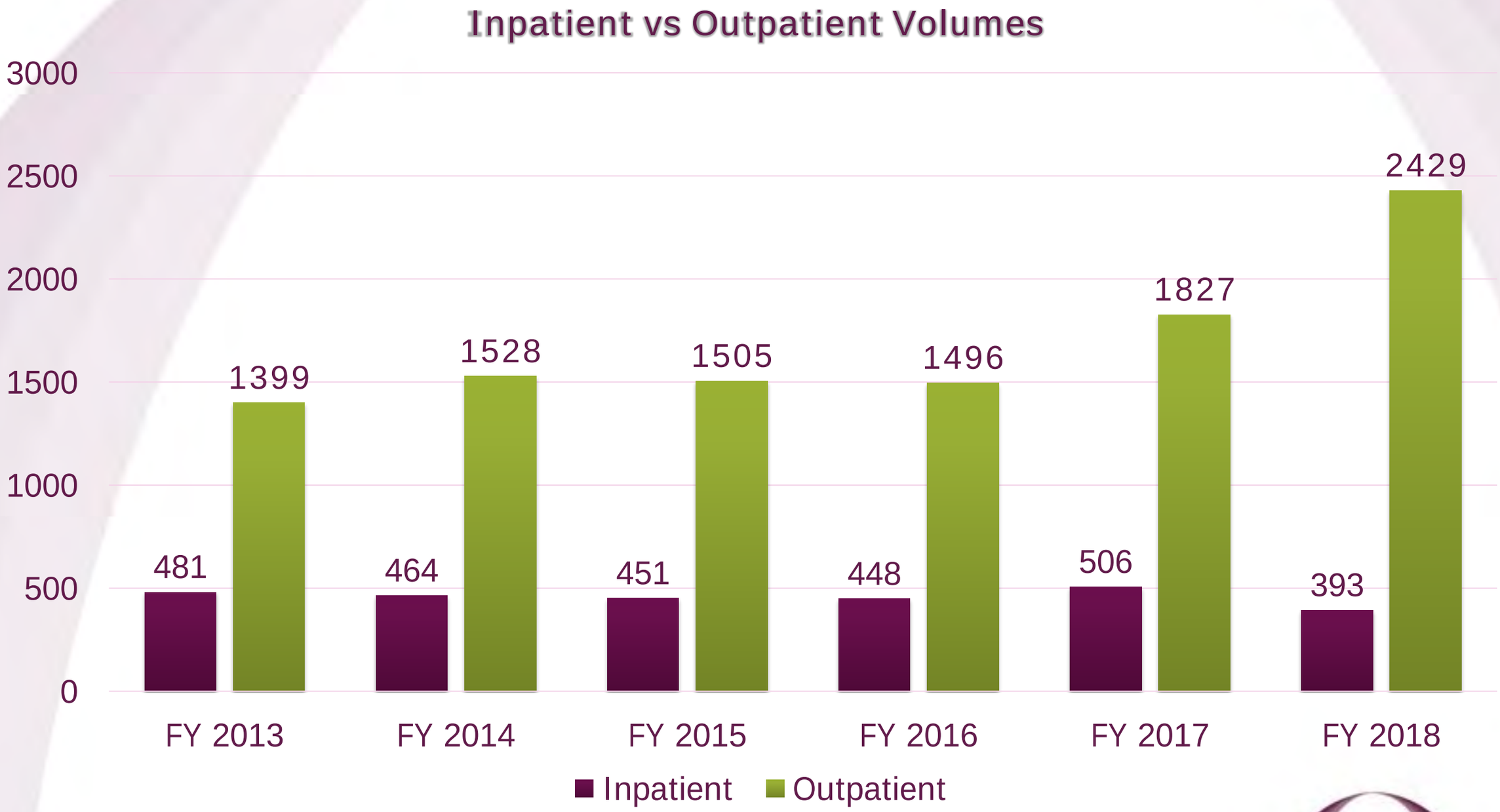
Inpatient vs Outpatient



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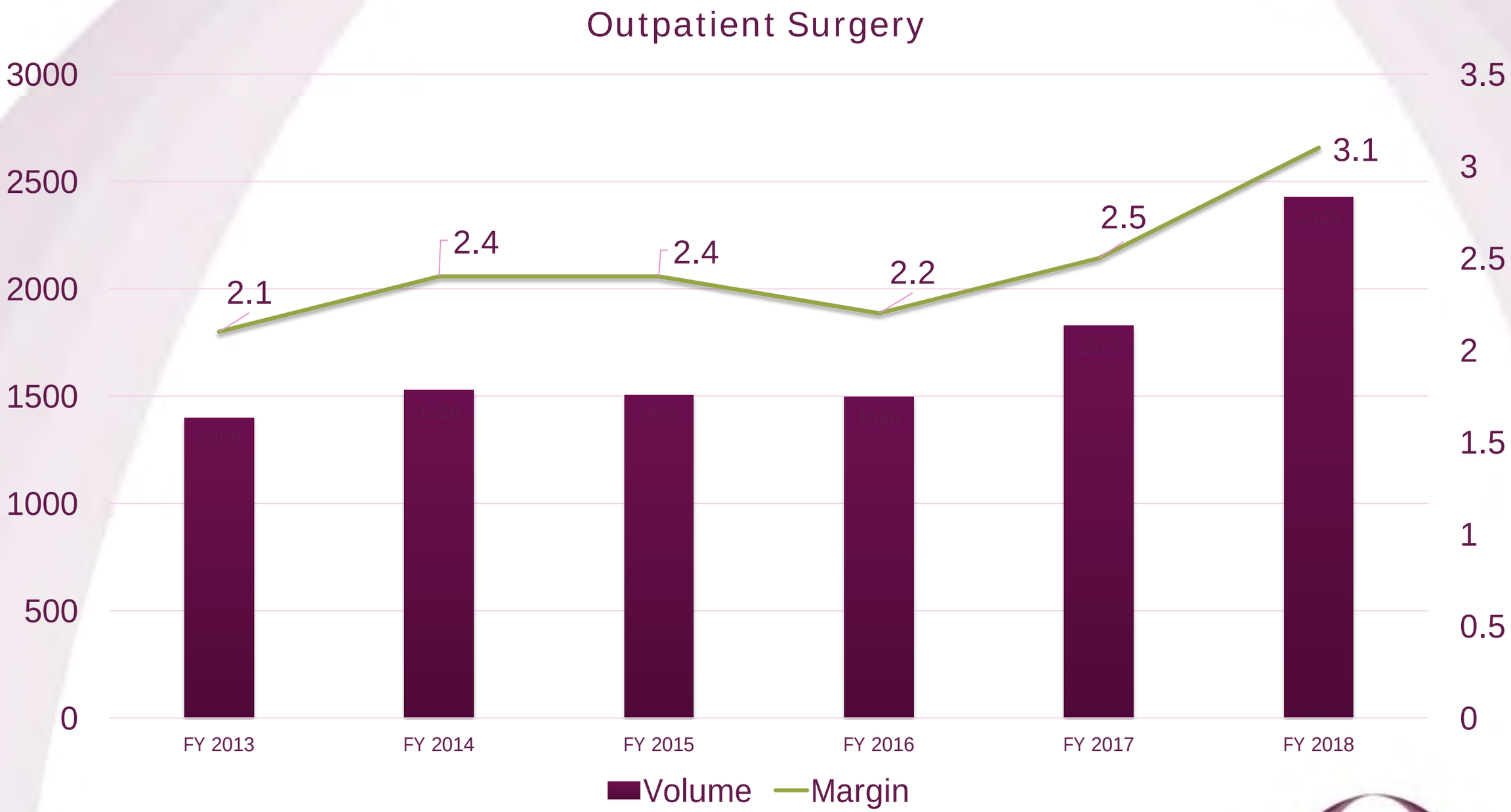
Outpatient Surgery



YTD Volume Analysis

Service	FY 17 YTD	FY 18 YTD	Increase
Pain Management	230	535	+57% 305 cases
Ophthalmology	124	174	+29% 50 cases
Endoscopy	408	661	+38% 253 cases
CDCR	156	181	+14% 25 visits
Bariatrics	44	50	+12% 6 cases

YTD Analysis

Surgical Service	FY 17 YTD	FY 18 YTD
Bariatrics	44	50
Pain Management	270	549
Ophthalmology	128	187
Endoscopy	431	707
Other	62	46
OBGyn	99	96
Total Joint Replacements	122	107
General Surgery	174	147
General Orthopedics	381	336
Urology	7	3
Total	1718	2228

Reimbursement per Case

Service Line	Average Reimbursement
Bariatrics	$22,000
ENT	$3,500
General orthopedics	$6,500
General surgery	$4,500
Joint replacements	$18,000
OB/Gyn	$3,800
Ophthalmology	$3,900
Pain management	$1,400
Breast surgery	$3,600
Podiatry	$4,400
Spine surgery	$8,600
Urology	$2,100
Vascular	$5,500
Endoscopy	$2,000

Changing Environment

- Total Joint Replacements
  - ConforMIS marketing
  - 23 hour joint replacements
- General Surgery
  - Regional outreach increasing clinic volumes
  - New General Surgeon increasing procedures
- General Orthopedics
  - Negative volumes increasing
  - Working with Surgeons to keep patients local

Opportunities

- OBGyn
  - 3 Specialists in Sonoma
- Urology
  - New Urologist starting
- Spine
  - Increase with pain medicine service line
- Vascular
  - MGH Physician in development

Service Line Analysis
(Direct Margin Percentages)

Date	ED	Surgery	SNF	Inpatient	Rehab	Outpatient Diagnostics	Occ Health	Special Procedures	OB
CY 2016	56%	43%	21%	32%	47%	61%	-7%	27%	2%
CY 2017	57%	45%	10%	28%	49%	59%	-22%	34%	-19%

Margin Analysis

Increasing/Maintained

- Emergency Room
  - Volumes remain stable
- Outpatient Surgery
  - Higher volume
- Rehabilitation
  - Support new services
- Outpatient Diagnostics
  - High volume low cost
- Special Procedures
  - Increase in Endoscopy

Declining

- SNF
  - Reduction in patient days
- Inpatient
  - Declining volumes
- Occupational Health
  - Workers Comp reduction
- OB
  - Declining volumes

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FY 2018 Optimization Initiatives

- SNF review

  Staffing, Payer Mix, Rehab minutes

- Occupational Health

  Downstream contribution, forecasting

- OB analysis of negative margins

  Cost per patient, impact of new services

- Surgery

  Efficiency staffing, maximize block time

Positioned for the Future

Current Initiatives

- A Woman's Place
- Bariatric growth-Orbera procedure
- Pain Management expansion and new procedures
- Expansion of CDCR Physicians
- Cardiology community outreach
- Adding 2 new Podiatrists
- ConforMIS regional expansion
- New Ophthalmology procedures
- Urologist starting in 3 months

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Planning for the Future

Due Diligence on New initiatives

- Bundled payment care initiative
- Telemedicine in 1206b clinic
- Plastic Surgery as a destination
- Outpatient total joint
- Chemotherapy
- Sleep lab/pulmonologist
- MDSave

QUESTIONS

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7.

FY 2019 ROLLING THREE-YEAR STRATEGIC PLAN

FY 2019 ROLLING THREE-YEAR STRATEGIC PLAN

I. Our Mission – why we exist – *To restore, maintain and improve the health of everyone in our community.*

II. Our Vision – what we always want to be - *A trusted resource for compassionate, exceptional healthcare.*

III. Our Values are always CREATING a Healthy Hospital:

C = Compassion (We show consideration for the feelings of others at all times)
R = Respect (We honor and acknowledge the value of people and resources in providing care)
E = Excellence (We strive to exceed the expectations of the people we serve)
A = Accountability (We are reliable, responsible owners of the outcomes of the organization)
T = Teamwork (We are productive and participative staff members who energize others)
I = Integrity (We seek new and creative solutions to deliver quality healthcare)
N = Nurturing (We inspire those with whom we work to achieve their highest potential)
G = Guidance (We direct our community members through their healthcare journey)

IV. Strategies for FY 2019 - 2021

1) Achieve the highest levels of healthcare safety, quality and value
2) Be the preferred hospital for patients, physicians, employers and health plans
3) Identify and implement new and enhanced revenue strategies and services
4) Continue to improve financial stability
5) Lead progress toward being a healthier community

V. Environmental Assessment

VI. Competitive Position

VII. SVH Situation Analysis

VIII. Strategic Tactics for FY 2019 - 2021

V. ENVIRONMENTAL ASSESSMENT

Trends In Hospital Healthcare

The traditional hospital model is under greater pressure than ever before, prompting some to ask, are hospitals becoming obsolete? This model, with the hospital as a central provider of broad inpatient and outpatient services, is challenged by both increased overhead and reduced reimbursement by government and commercial payers. In addition, new forms of competition are emerging, reflecting the continuing shift from inpatient to outpatient care.

The challenge facing small hospitals today is to continue providing essential services to a community in this quickly changing healthcare environment while improving or stabilizing operating margins. This has never been as urgent as it is today.

Decreased Payments: Changes in reimbursement are impacting all hospitals, notably the anticipated shift to a single payer system or health plans proposing payment at the same level of Medicare. Hospitals are increasingly dependent on government insurance programs. This is acutely felt by small hospitals, which tend to have a high mix of Medicare and Medi-Cal patients today. With the demographic trends, more patients are insured by Medicare and less have commercial insurance.

High Costs: The overhead required to be an acute care hospital, even a large one, is not sustainable. There is immense pressure to reduce total healthcare spending. At the same time, operating and capital costs are rising in many areas, from staffing and pharmaceuticals to mandated new technology. In California physicians cannot live on the reimbursements alone and are now a major part of the overhead expected to be covered by hospitals.

Inpatient Care: Acute inpatient volumes are decreasing despite the aging population. This has led to a corresponding reliance on providing outpatient care, which has lower margins. Most hospitals that have an average daily census of under 25 and are 30 miles from other facilities qualify as “Critical Access Hospitals” and get much better reimbursement from Medicare. In addition, home-based and non-hospital delivery of care is being used to meet an ever larger array of healthcare needs due to lower costs and perceived improved safety.

Regulations: Unfunded and unrecoverable federal and state mandates continue to drive up hospital costs, especially in California. Four federal agencies alone account for 629 regulatory requirements for hospitals, according to The American Hospital Association, which estimates that the regulatory burden alone costs hospitals $1,200 each time a patient is admitted.

Hospital Alternatives: This is an area of growing disruption as ambulatory and outpatient care is being addressed by smaller hospitals and, increasingly, hospital-alternative options. These include surgery and imaging centers and urgent care or physician outpatient clinics. More recently major retail pharmacies are moving to become community care centers, as evidenced by the recent announcement of the merger between CVS and Aetna. Some hospital systems and communities are experimenting with “neighborhood”

or “micro” hospitals that provide access to emergency care and outpatient services locally while transferring or referring more critical and complex cases to tertiary care hospitals in cities.

Home Health Care: Home-centered treatment is growing, along with virtual care ranging from telemedicine to mobile apps. Home health spending is projected to outpace all other types of care, reports *Home Health Care News*, citing CMS data that an estimated $103 billion will be spent on home health in the US this year, increasing to nearly $173 billion by 2026. However, very few hospitals today are involved in skilled home care due to the low reimbursement and high costs.

Technology and Equipment Costs. Keeping up with technology demands is a major and continuous overhead concern for hospitals. Updating Electronic Health Record systems and replacing very expensive imaging equipment are examples of multi-million-dollar investments that all hospitals must continuously make and which have a disproportionately greater impact on small hospitals.

Insurance Trends. There is a long-term trend by Medicare, Medi-Cal and commercial insurers to push more of the risks associated with care costs into the provider system. HMOs (such as Kaiser) and large healthcare systems increasingly are taking on these risks using data on patient outcomes and best practices to manage the total cost of care. Small hospitals will need to be part of a larger healthcare system to manage in this type of environment, as they will never have the scale and resources to assess and manage risks in smaller populations.

Emergency Services. Demographic trends and lack of mental health resources have driven up demand for emergency care. This has a mixed impact on small hospitals. An Emergency Department operating 24/7 is an expensive proposition, especially factoring in the support services required by government regulations. Emergency departments serve all patients and are often inundated with uninsured patients that continue to pose considerable financial risk.

VI. COMPETITIVE POSITION

Sonoma Valley Hospital is surrounded by several multi-hospital systems with provider networks and clinics in the North Bay. St. Joseph/Providence Healthcare manages or owns three hospitals: Petaluma Valley Hospital, Queen of the Valley Hospital and Santa Rosa Memorial. Kaiser Permanente has the largest market share in our area with several hospitals and provider clinics in Petaluma, Novato, Santa Rosa, Napa, Vallejo and San Rafael. Sutter Health has one hospital in Novato and another in Santa Rosa. Sutter also has a health plan in Sonoma County with a small physician network, but it does not have a major market share in Sonoma Valley's primary service area.

Given this competition, SVH maintains an advantage in its market due to the travel time required to drive to other hospitals. This advantage is most critical for emergency services and OB.

Hospital	**Peak travel time from Sonoma Valley**
Petaluma Valley Hospital	35 minutes
Queen of the Valley Medical Center	35 minutes
Novato Community Hospital	40 minutes
Santa Rosa Memorial Hospital	45 minutes
Kaiser Santa Rosa Hospital	50 minutes
Marin General Hospital	60 minutes
UCSF Health	75 minutes
Sutter Regional Medical Center of Santa Rosa	75 minutes

INSERT MAP WITH THIS LEGEND

SVH has recently affiliated with UCSF Health, a major and highly respected healthcare system in the Bay Area. We anticipate that this affiliation will provide the support and resources to improve market share for SVH in the years ahead. Marin General Hospital, which is a major partner for higher level care to SVH, has also recently affiliated with UCSF. UCSF currently has less than 5% of the market share in Sonoma Valley.

Kaiser is our biggest competitor with 46% of the commercial market in our region. It offers a low-cost solution for Medicare patients in Sonoma with Kaiser's Medicare Advantage Plan drawing more patients away from SVH. Even though there is competition for patients through the insurance plan, SVH continues to serve Kaiser members as their local Emergency Department. Kaiser represents 32% of our Emergency Department revenue.

Physician groups are the key drivers of SVH volumes, with a majority of patients coming from our local physicians. SVH provides support to Prima Medical Foundation, which has an office in Sonoma. In addition, SVH has started a 1206b clinic to help support other physicians. Meritage Medical Network manages most of the physician insurance contracts and manages risk contracts for the North Bay. SVH enjoys a high level of physician loyalty from this collaborative relationship and market share for our physicians is high. While St. Joseph and Sutter Health have large provider networks in close proximity to SVH, none of these physician practices have successfully migrated to Sonoma Valley.

SVH also works closely with health centers, such as Sonoma Valley Community Health Center, directing patient to both the hospital and our local specialists. There are several other organizations that direct patients to SVH including Partnership Health Plan and California Department of Corrections and Rehabilitation.

VII. SVH SITUATION ANALYSIS

The Community Served

SVH and the Sonoma Valley Health Care District serve a small community, running from Glen Ellen through the City of Sonoma, including Boyes Hot Springs, El Verano, Fetters Hot Springs and Agua Caliente, and also the Temelec area, Schellville, Eldridge and Vineburg. The two main zip codes served are 95476 and 95442, which identify the primary service area. The population of the district is approximately 42,000.

Age of Residents and Growth Rate of Seniors

SVH's service area has a disproportionate share of 50+ residents and is under-represented in younger age categories. In 2017 residents aged 65 and older made up 24.8% of the total population, and this segment of the population is growing the fastest. There are significantly more young people living in the Springs area compared to the rest of Sonoma Valley.

Growth of Latino Population

Over the past three years Sonoma Valley's Latino population has increased to 29% and is projected to grow to over 30% within the next several years. The Springs area has a significantly larger proportion of Latino residents at over 50%. In the Sonoma Valley overall, 35% of Latinos are uninsured. SVH continues to support the Latino population with increased access to healthcare services as well as bilingual health education and communication. Sonoma Valley Community Health Center is the major provider for our Latino population.

Payer Mix Trends

The dominance of government as the main reimbursement source underscores the need for additional sources of revenue and community support. Medicare volumes continue to represent over half of our payer mix. Medi-Cal has increased over the years to 17%. The percentage of patients with commercial insurance has decreased to approximately 19%, which is of great concern as commercial insurance was key to past financial viability. The hospital receives approximately $3.8 million per year from the parcel tax. The current parcel tax expires 2022.

Patient Experience

SVH has above-average patient satisfaction and continues to improve. The Centers for Medicare and Medicaid Services (CMS) measures satisfaction in 10 domains, and each domain is compared to a national percentile rank. SVH is consistently above the 60th percentile in almost every domain. This means that SVH has higher inpatient satisfaction than 60 percent of all hospitals in the country. In 2017 we added a satisfaction tool called "Rate My Hospital" for Emergency and Outpatient services and we rate above 4.5 on a 5.0 scale in all areas, which is very high.

Quality Outcomes

SVH is in the top 25 percent of hospitals in the nation based on quality of patient outcomes. We are also rated by CMS as a 4-star hospital. In addition to the CMS outcome measures, safety and quality indicators are regularly monitored and reported to the District Board Quality Committee and all exceed national benchmarks. SVH staff and our physicians strive to provide excellent care for all of our patients. We also maintain state-of-the-art technology and an excellent environment for the highest quality.

Emergency Care

Emergency services are the foundation for our community commitment. This is a significant community investment due to the high level of required expensive support services to be an Emergency Department. The Marcia and Gary Nelson Family Emergency Department was opened in 2014, and since then we have seen an increase in emergency visits. SVH's market share for our Emergency Department is over 70%. The volume has now stabilized with approximately 11,000 visits per year.

Surgical Services

While it took a couple of years to increase surgeries, SVH has enjoyed great success in the last two years with surgical procedures growing by 20%. However, the surgeries that have increased are not as intensive, which means less revenue. Ophthalmology, Endoscopy and Surgical Pain Management have increased dramatically. Bariatrics, General Surgery and Orthopedics have remained stable and continue to draw patients from outside the district. There is still opportunity to increase Breast Surgery, Gynecology, Vascular and Urology.

Inpatient, OB and Skilled Nursing Care

The overall trend over the past five years is a decline in inpatient discharges. Fewer patients are qualifying for an inpatient stay and are now treated as outpatients. With fewer inpatients the Skilled Nursing Facility census also decreases. The Skilled Nursing Facility average length of stay has significantly decreased from 16 to 12 days with very few patients staying for the long term, as in the past. Obstetrics continues to decrease each year as this corresponds to the trend of a lower number of births in the Valley. In early 2018 A Woman's Place was launched with several physicians with a focus on increasing OB, Breast Surgery and Gynecological services.

Outpatient Services

Outpatient services have remained flat, while in previous years we have seen increases of over 3%. SVH has high market share in Diagnostics, Occupational Health, Wound Care and Physical Therapy. However, visits are down in every service line due to insurance denials. There is an opportunity to increase Echocardiograms with the addition of another Cardiologist in the community who starts in June. The new 3D Mammography will also increase volumes. Observation and Special Procedures have declined a bit.

Partnerships/Affiliations

We work closely with many local health care providers to provide a seamless continuum of care to our patients. This year we took a big step in affiliating with UCSF Health, which ranks as the top hospital in California and one of the top five nationally. This relationship calls for us to work together to create a comprehensive, sustainable and integrated healthcare network to serve the needs of Sonoma Valley residents. It also strengthens our ability to service our community by providing access to the latest technology and specialized treatment options. SVH is also a part of the Prima Medical Foundation with five physicians in our community. Canopy Health is now the risk partner for Western Health Advantage, instead of Marin General Hospital. St. Joseph continues as the risk partner for SCAN at this time. Both hospital risk partners are managed by Meritage Medical Network.

Operational Efficiency

The trends in healthcare have challenged the hospital to manage costs effectively. We have developed new analytical tools allowing us to better understand margins by service line and identify ways to reduce overhead without compromising patient care. As a result, we are one of the few hospitals succeeding at the benchmark of Medicare reimbursement. We have nine service units at this time: Emergency, Inpatient (includes Med/Surg and ICU), Outpatient Surgery, Rehabilitation, Skilled Nursing, OB, Occupational Health, Special Procedures and Home Care. Home Care and OB costs exceed reimbursement at this time. Other service lines produce a direct margin, but these margins are shrinking due to increased hospital costs such as salaries. We will add a new service line – Physician Clinics (1206b) – in FY 2019. Occupational Health continues to be a complex, difficult service line to maintain.

Financial Stability

Despite managing the hospital very efficiently, the direct costs of salaries, supplies and physicians have increased. The cash on hand has improved but is still not stable. SVH has not added any significant debt and has almost paid off the Electronic Health Record investment from 2011. Much of the deferred maintenance from the past 30 years has been addressed, leaving only imaging equipment upgrades needed. SVH now owns the “South Lot” and has agreed to sell off a portion of this land to a developer. The hospital does not spend much on capital and usually relies on the SVH Foundation for support. The Foundation is now helping us replace the CT and MRI units and may fund a new Outpatient Diagnostic Center in the hospital.

Physicians

The shortage of Primary Care coverage is becoming more of a challenge for Sonoma Valley as physicians retire. In a recent survey 60% of our PCPs report they are not accepting new patients. In addition many of the physicians who remain in our community are not able to cover their practice costs and look to the hospital for support. We opened a 1206b clinic (District owned physician office) and plan to expand this clinic by adding Primary Care Providers in FY 2019.

Charity Care

Like all hospitals SVH serves all patients who require it, regardless of the ability to pay. As such, SVH provides substantial amounts of uncompensated care. When this care is provided to patients who lack the financial resources, it is classified as Charity Care. In FY 2017 the hospital provided $365,700 in Charity Care.

Community Benefit

The hospital leadership provides many innovative health improvement programs to the community. We participate in many community activities such as health fairs and providing educational events. Many of our programs are collaborative with organizations such as Vintage House, the Sonoma Valley Community Health Center and Integrative Health Practitioners. We provided over 1400 hours of community benefit in FY 2017.

IX. Strategic Tactics

Strategy	Tactic
Achieve the highest levels of healthcare safety, quality and value as measured by star ratings	• Achieve the "Highly Reliable Organization" goals • Become a stroke certified Emergency Department • Ensure we provide evidence based, advanced medicine with the new Chief Medical Officer • Continue to focus on patient experience to increase satisfaction for inpatients and outpatient surgery through CAHPS measurements • Maintain excellent outpatient satisfaction through Rate My Hospital • Continue to improve staff engagement throughout the hospital with emphasis on staff giving direct Inpatient and Emergency care • Continue our effective "Culture of Safety" program • Use the suggested Hospital Quality Institute scorecard and share it publicly
Be the preferred hospital for patients, physicians, health plans and employers as measured by volumes	• Work with UCSF to increase patient perception about the level of care we can provide here at home • Work with UCSF to increase physician loyalty • Complete the Outpatient Diagnostic Center with a new MRI, CT scanner and patient waiting areas • Increase the awareness of Canopy Health and direct patients to our facility • Recruit another primary care physician with a focus on Geriatrics • Meet with the major health plans, including Kaiser, to promote our high value (low cost/high quality) • Continue to work closely with physicians for retention and loyalty through outreach, marketing and innovative services • Expand telemedicine to offer neurology and psychology consults • Address the concern about lack of medical Gastroenterology

Identify and implement new and enhanced revenue strategies and services as measured by direct margins	• Work with UCSF to build programs of distinction, with a focus on inpatient and post-acute care • Open a Cardiology Center with the addition of the new Cardiologist • Grow the Women's Health service line with the new Breast Surgeon and additional OB/GYNs • Achieve designation as a Rural Health Center with most of our primary care physicians in the Valley • Work with the many pain management physicians to develop a pain network • Continue to support the expansion of the Whole Health Weight Loss Institute throughout Northern California • Continue to market Colorectal Surgery • Consider opening an Urgent Care center for after hours and weekends • Implement EPIC in the local physician offices with UCSF to give them affiliate status • Explore Medical Tourism strategies since Sonoma is a very popular destination • Educate the employers on their choices of health plans and how they affect their community hospital • Continue to increase the awareness of the primary care physicians and their availability, especially in pediatrics • Explore the next generation of our Information Technology and continue to improve our electronic health records • Facilitate discussions on a new Medical Office Building in Sonoma • Continue to recruit physicians to the Valley to increase access • Explore the needs of behavioral health with the County
Continue to improve financial stability as measured by EBDA	• Considering the urgency of what is facing small hospitals, find a model for financial stability • Using the Cost Accounting system, continue to improve margins by service line • Work with UCSF on opportunities to increase efficiency and/or reduce overhead • Complete the sale of the South Lot • Explore divesting the Healing at Home service line to a strong partner • Evaluate the future viability of Inpatient Services • Find a viable energy solution to reduce utility costs • Continue to improve the revenue cycle efficiency using technology • Ensure 1206b Clinics are financially stable • Consolidate the physician offices into one location for efficiency and better access • Implement an easy way for patients to access services through centralized scheduling with on-line capability • Evaluate the future of the OB service line if volumes do not increase • Evaluate the future of Occupational Health and the need by the community • Consider taking direct risk for SCAN patients with Meritage Medical Network working with UCSF • Continue to work with SVHF to raise funds for capital needs

Lead the progress toward being a healthier community as measured by health status	• Continue Health Education with GirlTalk, Conversation With A Doctor, Active Aging series and other well attended health education programs • Participate in the county-wide Community Needs Assessment • Continue to work with SVHF on community engagement and philanthropic support • In a new community perception survey, ask what we can do to improve health • Continue to work on Latino outreach and improve our perception of being supportive of diversity • Work with Bright Heart Health to reduce opioid dependency • Consider therapies, e.g., medical cannabis, for the community • Continue to inspire health and wellness through our culture and by providing a space for wellness ambassadors to lead others • Continue to attend local community events and work with groups spreading our positive message and inspiring good health • Continue to promote and support the Integrative Health Network with alternative therapies

8.

RESOLUTION NO. 339 ORDERING AN ELECTION

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

Meeting Date:	May 3, 2018
Prepared by:	Vivian Woodall, Clerk of the Board of Directors
Agenda Item Title:	Resolution No. 339 – Ordering an Election to be Held and Requesting Consolidation with the November 6, 2018, General District Election

Recommendation:
That the SVHCD Board approve and adopt Resolution No. 339.

Background:
Pursuant to Elections Code Section 10509, which requires notification prior to the 125th day before the election (July 4, 2018), the elected office holders of this district whose terms will expire in 2018, and/or their successors will be required to be elected at the upcoming election to be held on November 6, 2018. This resolution requests consolidation with the general election.

Consequences of Negative Action/Alternative Actions:
The incumbents interested in running for re-election will not be able to participate in the General Election in November 2018.

Financial Impact:
N/A

Attachments:
1. Resolution No. 339
2. Notice of Offices To Be Filled
3. Notice of District Boundaries

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS, COUNTY OF SONOMA, STATE OF CALIFORNIA

RESOLUTION NO. 339

ORDERING AN ELECTION TO BE HELD AND REQUESTING CONSOLIDATION WITH THE NOVEMBER 6, 2018, GENERAL DISTRICT ELECTION

WHEREAS, an election will be held on November 6, 2018, in the Sonoma Valley Health Care District for the purpose of electing District Directors to fill positions that will expire in 2018;

BE IT RESOLVED THAT, the District Directors of said district hereby request consolidation with any election that may be held on the same day, in the same territory or in territory that is in part the same.

THE FOREGOING RESOLUTION was introduced by Director _____, who moved its adoption, seconded by Director _____ and then adopted on roll call by the following vote:

Director Rymer	Aye	No	Abstain
Director Hirsch	Aye	No	Abstain
Director Hohorst	Aye	No	Abstain
Director Nevins	Aye	No	Abstain
Director Boerum	Aye	No	Abstain

AYES: _____ NOES: _____ ABSTAIN:_____ ABSENT:_____

WHEREUPON, the Chair declared the foregoing resolution adopted and **SO ORDERED.**

_____
Joshua Rymer, Chair

Dated: 3rd of May 2018

Attest:

_____
Bill Boerum, Secretary

seal

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

MEMORANDUM

TO: WILLIAM F. ROUSSEAU, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: Sonoma Valley Health Care District

SUBJECT: NOTICE OF OFFICES TO BE FILLED AND STATEMENT OF RESPONSIBILITY FOR STATEMENTS OF QUALIFICATIONS

DATE: May 3, 2018

Notice is hereby given that, pursuant to Elections Code Section 10509 (which requires notification prior to the 125th day before the election (July 4, 2018)), the following are the elected office holders of this district whose terms will expire in 2018, and/or their successors will be required to be elected at the upcoming election to be held on November 6, 2018.

DIRECTOR		LENGTH OF NEXT TERM (commencing 12.07.18)
1.	Joshua Rymer	Four Years
2.	Peter Hohorst	Four Years

1. The length of Statements of Qualifications shall not exceed **200** words.

2. The costs incurred in the printing of the optional Statements of Qualifications (English and Spanish, if requested by the candidate) in the Voter Information Pamphlet is the responsibility of the **Candidate**.

3. The District opts to **require payment in advance to the District Board Clerk**.

Note: It is the responsibility of the District to collect the costs of Statements of Qualifications from the candidates whether payment in advance or payment after the fact is required. **If advance payment is required, candidates must present a receipt from the District at the time the Statement of Qualifications is filed with the Registrar of Voters Office. Multi-county districts please be advised that the estimated cost reflects only the Sonoma County portion of the cost.**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND SUBMIT THIS STATEMENT IN COMPLIANCE WITH ELECTIONS CODE SECTIONS 10509 AND 13307.

SIGNED: _____ DATE: May 3, 2018
Vivian A. Woodall, District Board Clerk

seal

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

MEMORANDUM

TO: WILLIAM F. ROUSSEAU, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: Sonoma Valley Health Care District

SUBJECT: NOTICE OF DISTRICT BOUNDARIES/STATEMENT IN LIEU OF MAP

DATE: May 3, 2018

Pursuant to Elections Code Section 10522 (which requires notification prior to the 125th day before the election (July 4, 2018)) regarding district boundaries in the above named district, we are hereby notifying the Registrar of Voters Office that:

As of this date, there has been no change in the boundaries of this district since the date of the last election. A map of the district is already on file with your office; therefore this notice is in lieu of providing a duplicate map.

Submitted by _____ DATE: May 3, 2018
Vivian A. Woodall, District Board Clerk

seal

9.

ADMINISTRATIVE REPORT MAY 2018

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

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **4/26/18**
Subject: **Administrative Report**

Summary
The hospital is faced with a sense of urgency based on the revenues and volumes in FY 2018. The UCSF affiliation is a positive opportunity for our future and discussions on the best strategies are under way.

Strategic Update from FY 2018 Strategic Plan:

Strategic Priorities	Update
Highest levels of health care safety, quality and value	➢ Dr. Adrienne Green, CMO at UCSF, has agreed to fill in the UCSF Medical Director role until we find the best physician for the CMO role at SVH. ➢ SVH culture of embracing change using "100 day workouts." 75 day check-ins are now scheduled with excellent progress on 11 improvement projects. ➢ Emergency is working on the "Stroke Readiness" certification by the end of 2018. ➢ Quality Assurance/Performance Improvement plans are a focus to increase effectiveness. Leadership has been challenged to take these to the next level.
Be the preferred hospital for patients, physicians, employers and health plans	➢ Staff satisfaction results are being presented at the Board meeting and at the staff forums. The major concern is job security this year. ➢ We have a proposed design that is now being tested for the Outpatient Diagnostic Center. ➢ We have worked with Dr. Lane's office to retain as many of their patients as possible. Many of our local primary care physicians have taken new patients. ➢ We are working on an overall physician strategy which will include the plan for the Rural Health Center and aligning with UCSF.
Implement new and enhanced revenue strategies as measured by increased direct margins in each service unit	➢ The UCSF collaboration has begun. We are creating mutually beneficial strategic goals. ➢ The FY 2019 – 2021 Rolling Strategic Plan will be discussed 4/26 with any public input and then the Board will consider approval in May. ➢ The Woman's Place service line is on track with the goals. We have done a few breast surgeries now. 3D Mammography volumes were up 100 over average! ➢ A thorough analysis was completed on the contribution of Occupational Health. It does have a positive contribution margin and serves over 200 employers.
Continue to improve financial stability as measured by operating margin	➢ As the hospital volumes are decreasing, we are considering restructuring around our 5 most vital and utilized services starting with the ER. ➢ We will have a $1.3 million pickup from the South Lot sale in Fall 2018. ➢ We are working with a highly successful Home Care organization on a transfer of this service. ➢ Recommending changes in some of our pay practices and PTO accruals.
Lead progress toward being a healthier community as measured by community benefit	➢ Physicians are all doing a great job in their talks with the community. ➢ The Capital Campaign for the Outpatient Diagnostic Center is off to a great start. ➢ Celebration of Women is on May 10th. UCSF is a premier sponsor. ➢ We are working with Bright Heart Health in the ER to give support for patients with opioid addictions.

MARCH 2018

Patient Experience	Current Performance	FY 2018 Goal	National Benchmark
Would Recommend Hospital	98th percentile	> 60th percentile	50th percentile
Inpatient Overall Rating	99th percentile	>60th percentile	50th percentile
Home Health	92%	> 90%	> 80%
Outpatient Services	4.8	Rate My Hospital	4.5
Emergency	4.6	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Hospital Acquired Infections	5 of 6 <benchmark	5 of 6 <benchmark	6 of 6 < benchmark
30 Day All- Cause Readmissions	9.70%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Overall Surgical Site Infection Rate	0.43%	0.50%	n/a
Hand Hygiene	98%	>90%	>80%
Falls	1.6	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	7	< 10	17
Adverse Drug Events with Harm	1	0	0
C Section rate	11.3%	<20%	< 20%
Wound Care time to heal	22 days	< 30 days	< 31 days
Repeat Analysis in Radiology	3.25%	< 5%	< 5%
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Press Ganey Engagement Survey	61st percentile	75th percentile	50th percentile
Wellness Ambassadors	253	250	> 200
Turnover	14.2%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
EBDA	-1.7%	2.9%	3%
FTE's/AOB	4.17	4.3	5.3
Days Cash on Hand	6.7	20	30
Days in Accounts Receivable	43	49	50
Length of Stay	3.5	3.85	4.03
Cost per Medicare Beneficiary	$18,430	<$20,000	$20,473
Funds raised by SVHF	$7.95 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Inpatient Discharges	838/1117	1193	1225
Outpatient Visits	39,623/52,830	57,771	55,566
Emergency Visits	7,975/10,633	11,022	11,019
Surgeries	1379/1838	1,800	1,680
Births	82/109	132	120
Home Health Visits	6,977/9302	11,053	11,400
Community Benefit Hours	1036.5/1381	1200	1200

Note: Colors demonstrate comparison to National Benchmark

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

TRENDED MONTHLY RESULTS

MEASUREMENT	Goal FY 2018	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2017	May 2017	Jun 2017
FY YTD Turnover	<10%	.9	3.1	5.3	6.8	9.7	9.7	11.3	12.9	14.2	7.7	8.4	9
Leave of Absences	<12	10	10	11	11	11	9	10	15	13			
EBDA	>3%	.1	-.9	-1.1	.1	-1.2	-1.4	2.2	-.6	-1.7	3	3.1	3.6
Operating Revenue	>5m	5.0	4.8	4.6	4.6	4.5	4.5	4.9	4.7	4.2	4.9	5.3	5.2
Expense Management	<5m	5.1	5.3	5.2	4.8	5.3	5.1	5.3	5.2	5.1	5.3	5.6	5.2
Net Income	>50k	-197	-164	-230	62	-379	-226	125	-174	-395	-24	16	180
Days Cash on Hand	>20	16	10	9	12.5	14	17.4	23.5	14.1	6.7	11	19	20
A/R Days	<50	45	43	47	45	48	51	51	47	43	47	44	45
Total FTE's	<320	318	314	316	304	329	307	312	305	302	313	319	321
FTEs/AOB	<4.0	4.23	3.75	4.19	4.04	4.86	3.85	3.68	3.87	4.17	4.22	3.73	4.14
Inpatient Discharges	>90	76	94	87	87	99	96	111	82	106	89	100	87
Outpatient Revenue	>$13m	14.1	15.5	14.3	11.9	12.9	14.1	14.7	12.5	13.1	13.1	15.5	15.4
Surgeries	>150	162	164	187	120	155	160	141	139	151	171	173	197
Home Health	>950	870	713	789	871	630	798	801	821	684	934	966	940
Births	>11	6	10	5	12	11	10	7	11	8	11	7	15
SNF days	>550	528	500	479	624	468	563	646	494	566	512	559	458
MRI	>120	102	134	128	100	80	105	106	112	122	121	116	109
Cardiology (Echos)	>50	62	93	73	54	80	93	96	65	84	70	70	79
Laboratory	>12	11.9	12.2	11.6	10.8	12.0	11.4	12.9	10.6	12.3	12.1	13.6	11.8
Radiology	>850	881	966	870	757	882	891	1072	829	968	963	1142	1137
Rehab	>2700	2362	2872	2502	2078	2945	2884	2593	2773	3091	2748	2983	2802
CT	>300	326	390	354	271	272	386	346	288	305	385	407	376
ER	>900	920	894	921	827	816	919	996	811	871	921	1069	964
Mammography	>200	223	235	201	191	253	249	190	155	**363**	191	214	219
Ultrasound	>300	287	326	265	188	236	258	274	221	258	213	279	312
Occupational Health	>600	642	705	552	707	588	416	504	555	734	631	607	659
Wound Care	>200	226	263	287	287	203	277	204	122	182	239	203	307

10.

FINANCIAL REPORT
MONTH ENDED
MARCH 31, 2018

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

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **April 24, 2018**
Subject: **Financial Report for the Month Ending March 31, 2018**

During the month of March the hospital saw an improvement from February primarily in inpatient volume; patient days were still under budgeted expectations but inpatient surgeries were better than budget. As noted below, Emergency volume and acuity was below expectations. This negatively impacted Emergency Room revenue and the related Outpatient revenue. In previous years the month of March experienced higher volumes and this is reflected in the current budget. For the month of March the hospital accrued for a Hospital Quality Assurance Fee (HQAF) IGT for the fiscal year 16-17 which will net $147,386; the hospital expects this IGT payment in May or June.

The actual loss of ($947,303) from operations for March was ($675,528) unfavorable to the budgeted loss of ($271,775). After accounting for all other activity; March's net loss was ($395,401) vs. the budgeted net income of $140,722 with a monthly EBIDA of -8.3% vs. a budgeted 5.7%.

Gross patient revenue for March was $21,673,359; ($2,881,380) under budget. Inpatient gross revenue was under budget by ($308,815). Inpatient days were under budget by (69) days and inpatient surgeries were over budgeted expectations by 2 cases. Outpatient revenue was under budget by ($1,143,837). Outpatient visits were under budgeted expectations by (660) visits, and outpatient surgeries were under budgeted expectations by (12) cases. The Emergency Room gross revenue was under budget by ($1,533,514) with ER visits under budgeted expectations by (74) visits. The ER experienced lower overall acuity during March. SNF gross charges were over budgeted expectations by $146,505 and SNF patient days were at budget at 566 days. Home Health was under budget by ($41,719) with visits under budget by (170) visits which is due to seeing a reduced number of Kaiser HHA patients.

Gross revenue from surgical implants in March is $587,585 with $397,349 from inpatient surgeries and $190,236 from outpatient surgeries, and total implant costs were ($134,924). The net, before any revenue deductions, is $452,661.

Deductions from revenue were favorable to budgeted expectations by $1,884,967. Of the variance, $44,000 is from the accrual of the 16-17 HQAF IGT of $294,772 (net after matching fee is $147,386) and accrual of the Prime Grant of $62,500. Without the IGT variance, the deductions from revenue variance are favorable by $1,840,967 which is due to the gross revenue being under budgeted expectations.

The variance was also impacted by a continued negative shift in payer mix with Medicare and Medi-Cal volume increasing by 2.7 and 2.1 percentage points respectively over budget and Commercial volume dropping by 2.4 percentage points.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budgeted expectations by ($1,030,996).

Operating Expenses of $5,179,140 were favorable to budget by $355,468. ($60,953) of the variance is due to the matching fee of ($147,386) for the 16-17 HQAF IGT of which the hospital will receive $294,772 in May. Without the IGT matching fee, the operating expenses would have an overall positive variance of $416,421. The salaries and wages and agency fees were under budget by 212,460. Salaries and wages were under budget by $233,477 and agency fees were over budget by ($21,017). Professional fees were over budget by ($25,580) primarily due to non-budgeted consulting fees offset by lower administration and management salaries. Supplies and purchased services are both under budget in the month of March due to the hospital's lower volumes.

For the month of March, the hospital saved $96,039 attributable to the cost savings plan implemented January 1, 2018. See attachment I for details.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for March was ($685,912) vs. a budgeted net loss of ($23,013). The total net loss for March after all activity was ($395,401) vs. a budgeted net income of $140,722.

EBIDA for the month of March was -8.3% vs. the budgeted 5.7%.

Patient Volumes – March

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	**106**	**104**	**2**	**119**
Newborn Discharges	**8**	**15**	**-7**	**12**
Acute Patient Days	**335**	**404**	**-69**	**415**
SNF Patient Days	**566**	**580**	**-14**	**572**
Home Care Visits	**684**	**854**	**-170**	**849**
OP Gross Revenue	**$13,064**	**$15,784**	**($2,721)**	**$15,098**
Surgical Cases	**151**	**161**	**-10**	**189**

Gross Revenue Overall Payer Mix – March

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	45.0%	45.3%	-0.3%	44.2%	45.6%	-1.4%
Medicare Mgd Care	13.0%	10.0%	3.0%	12.9%	9.9%	3.0%
Medi-Cal	20.0%	17.9%	2.1%	18.0%	17.9%	0.1%
Self Pay	0.0%	1.2%	-1.2%	1.2%	1.2%	0.0%
Commercial	18.0%	20.4%	-2.4%	19.3%	20.4%	-1.1%
Workers Comp	2.4%	3.1%	-0.7%	2.2%	3.0%	-0.8%
Capitated	1.6%	2.1%	-0.5%	2.2%	2.0%	0.2%
Total	100.0%	100.0%		100.0%	100.0%	

Cash Activity for March:

For the month of March the cash collection goal was $4,030,553 and the Hospital collected $3,811,539 or under the goal by ($219,014). The year-to-date cash collection goal was $32,825,169 and the Hospital has collected $32,839,210 or over goal by $14,041. Days of cash on hand are 6.7 days at March 31, 2018. The days of cash on hand includes the unrestricted portion in our Money Market account of $719,563. Accounts Receivable decreased from February from 46.5 days to 43.0 days in March. Accounts Payable decreased by $251,093 from February and Accounts Payable days are at 43.5.

ATTACHMENTS:

-Attachment A is the Payer Mix Analysis which includes the projected collection percentage by payer.
-Attachment B is the Operating Indicators Report
-Attachment C is the Balance Sheet
-Attachment D (two pages) is the Statement of Revenue and Expense. The first page breaks out the hospital operations and page two includes all other activity.
-Attachment E is the Variance Analysis. The line number tie to the Statement of Revenue and Expense line numbers and explains any significant variances.
-Attachment F are the graphs for Revenue and Accounts Payable.
-Attachment G is the Statistical Analysis
-Attachment H is the Cash Forecast
-Attachment I is the Cash Savings from cost reduction plan implemented 1/1/2018

Sonoma Valley Hospital
Payer Mix for the month of March 31, 2018

ATTACHMENT A

	March-18				YTD			
Gross Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	9,751,058	11,109,532	-1,358,474	-12.2%	86,795,352	93,889,782	-7,094,430	-7.6%
Medicare Managed Care	2,805,181	2,459,706	345,475	14.0%	25,063,165	20,531,175	4,531,990	22.1%
Medi-Cal	4,327,642	4,378,033	-50,391	-1.2%	35,485,194	36,887,867	-1,402,673	-3.8%
Self Pay	-60	302,828	-302,888	-100.0%	2,148,150	2,551,898	-403,748	-15.8%
Commercial & Other Government	3,923,476	5,031,681	-1,108,205	-22.0%	37,537,315	42,156,067	-4,618,752	-11.0%
Worker's Comp.	522,905	769,327	-246,422	-32.0%	4,289,551	6,258,171	-1,968,620	-31.5%
Capitated	343,157	503,632	-160,475	-31.9%	4,233,405	4,193,690	39,715	0.9%
Total	**21,673,359**	**24,554,739**	**(2,881,380)**		**195,552,132**	**206,468,650**	**(10,916,518)**	

Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	1,377,595	1,588,375	-210,780	-13.3%	13,165,696	14,104,507	-938,811	-6.7%
Medicare Managed Care	430,180	315,790	114,390	36.2%	3,679,812	2,635,963	1,043,849	39.6%
Medi-Cal	678,185	639,836	38,349	6.0%	5,140,791	5,089,522	51,269	1.0%
Self Pay	-	111,490	-111,490	-100.0%	1,096,566	1,239,975	-143,409	-11.6%
Commercial & Other Government	1,158,018	1,931,556	-773,538	-40.0%	12,298,347	15,448,965	-3,150,618	-20.4%
Worker's Comp.	104,659	198,839	-94,180	-47.4%	914,451	1,542,537	-628,086	-40.7%
Capitated	13,167	16,331	-3,164	-19.4%	130,340	142,427	-12,087	-8.5%
Prior Period Adj/IGT	357,272	313,272	44,000	14.0%	4,087,838	2,819,448	1,268,390	45.0%
Total	**4,119,076**	**5,115,489**	**(996,413)**	**-19.5%**	**40,513,841**	**43,023,344**	**(2,509,503)**	**-5.8%**

Percent of Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	33.4%	31.1%	2.3%	7.4%	32.5%	32.8%	-0.4%	-1.2%
Medicare Managed Care	10.4%	6.2%	4.2%	67.7%	9.1%	6.1%	3.0%	49.2%
Medi-Cal	25.1%	18.6%	6.5%	34.9%	22.8%	18.4%	4.4%	23.9%
Self Pay	0.0%	2.2%	-2.2%	-100.0%	2.7%	2.9%	-0.2%	-6.9%
Commercial & Other Government	28.3%	37.7%	-9.4%	-24.9%	30.3%	35.9%	-5.6%	-15.6%
Worker's Comp.	2.5%	3.9%	-1.4%	-35.9%	2.3%	3.6%	-1.3%	-36.1%
Capitated	0.3%	0.3%	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**-0.1%**	**-0.1%**

Projected Collection Percentage:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	14.1%	14.3%	-0.2%	-1.4%	15.2%	15.0%	0.2%	1.3%
Medicare Managed Care	15.3%	12.8%	2.5%	19.5%	14.7%	12.8%	1.9%	14.8%
Medi-Cal	23.9%	21.8%	2.1%	9.6%	26.0%	21.4%	4.6%	21.5%
Self Pay	0.0%	36.8%	-36.8%	-100.0%	51.0%	48.6%	2.4%	4.9%
Commercial & Other Government	29.5%	38.4%	-8.9%	-23.2%	32.8%	36.6%	-3.8%	-10.4%
Worker's Comp.	20.0%	25.8%	-5.8%	-22.5%	21.3%	24.6%	-3.3%	-13.4%
Capitated	3.8%	3.2%	0.6%	18.8%	3.1%	3.4%	-0.3%	-8.8%

SONOMA VALLEY HOSPITAL
OPERATING INDICATORS
For the Period Ended March 31, 2018

ATTACHMENT B

	CURRENT MONTH				YEAR-TO-DATE			YTD
	Actual 03/31/18	Budget 03/31/18	Favorable (Unfavorable) Variance		Actual 03/31/18	Budget 03/31/18	Favorable (Unfavorable) Variance	Prior Year 03/31/17
				Inpatient Utilization				
				Discharges				
1	93	87	6	Acute	706	810	(104)	831
2	13	16	(3)	ICU	132	146	(14)	101
3	106	104	2	Total Discharges	838	956	(118)	932
4	8	15	(7)	Newborn	82	128	(46)	105
5	114	118	(4)	Total Discharges inc. Newborns	920	1,084	(164)	1,037
				Patient Days:				
6	238	303	(65)	Acute	2,174	2,799	(625)	2,788
7	97	101	(4)	ICU	756	902	(146)	890
8	335	404	(69)	Total Patient Days	2,930	3,701	(771)	3,678
9	11	30	(19)	Newborn	139	262	(123)	196
10	346	434	(88)	Total Patient Days inc. Newborns	3,069	3,963	(894)	3,874
				Average Length of Stay:				
11	2.6	3.5	(0.9)	Acute	3.1	3.5	(0.4)	3.4
12	7.5	6.2	1.3	ICU	5.7	6.2	(0.4)	8.8
13	3.2	3.9	(0.7)	Avg. Length of Stay	3.5	3.9	(0.4)	3.9
14	1.4	2.0	(0.7)	Newborn ALOS	1.7	2.0	0.4	1.9
				Average Daily Census:				
15	7.7	9.8	(2.1)	Acute	7.9	10.2	(2.3)	10.2
16	3.1	3.3	(0.1)	ICU	2.8	3.3	(0.5)	3.2
17	10.8	13.0	(2.2)	Avg. Daily Census	10.7	13.5	(2.8)	13.4
18	0.4	1.0	(0.6)	Newborn	0.51	0.96	(0.4)	0.72
				Long Term Care:				
19	566	580	(14)	SNF Patient Days	4,868	5,096	(228)	5,024
20	29	25	4	SNF Discharges	265	224	41	269
21	18.3	18.7	(0.5)	Average Daily Census	17.8	18.6	(0.8)	18.3
				Other Utilization Statistics				
				Emergency Room Statistics				
22	871	945	(74)	Total ER Visits	7,975	8,263	(288)	8,191
				Outpatient Statistics:				
23	4,713	5,373	(660)	Total Outpatients Visits	39,623	42,621	(2,998)	41,272
24	34	32	2	IP Surgeries	247	292	(45)	331
25	117	129	(12)	OP Surgeries	1,132	930	202	904
26	75	34	41	Special Procedures	603	281	322	375
27	684	854	(170)	Home Health Visits	6,977	8,293	(1,316)	8,277
28	340	363	(22)	Adjusted Discharges	2,989	3,034	(45)	3,082
29	2,272	2,759	(488)	Adjusted Patient Days (Inc. SNF)	21,136	22,617	(1,481)	22,294
30	73.3	89.0	(15.7)	Adj. Avg. Daily Census (Inc. SNF)	77.1	82.5	(5.4)	81.4
31	1.4458	1.4000	0.046	Case Mix Index -Medicare	1.5181	1.4000	0.118	1.6441
32	1.5115	1.4000	0.112	Case Mix Index - All payers	1.4757	1.4000	0.076	1.5583
				Labor Statistics				
33	279	296	17.5	FTE's - Worked	276	285	8.9	282
34	302	339	36.8	FTE's - Paid	312	326	14.2	318
35	43.93	42.71	(1.22)	Average Hourly Rate	42.66	42.61	(0.05)	40.39
36	23.5	21.7	(1.8)	Manhours / Adj. Pat Day	23.0	22.5	(0.5)	22.3
37	156.7	165.0	8.3	Manhours / Adj. Discharge	162.9	167.8	4.9	161.3
38	21.8%	21.1%	-0.7%	Benefits % of Salaries	22.5%	22.1%	-0.4%	23.1%
				Non-Labor Statistics				
39	11.5%	11.3%	-0.2%	Supply Expense % Net Revenue	11.8%	10.6%	-1.2%	12.5%
40	1,421	1,636	215	Supply Exp. / Adj. Discharge	1,639	1,539	(100)	1,693
41	15,694	15,705	11	Total Expense / Adj. Discharge	16,319	16,186	(133)	15,197
				Other Indicators				
42	6.7			Days Cash - Operating Funds				
43	43.0	50.0	(7.0)	Days in Net AR	46.5	50.0	(3.5)	49.8
44	95%			Collections % of Net Revenue	100%			107.5%
45	43.5	55.0	(11.5)	Days in Accounts Payable	43.5	55.0	(11.5)	21.4
46	19.5%	21.4%	-1.9%	% Net revenue to Gross revenue	21.3%	21.4%	-0.1%	21.2%
47	21.3%			% Net AR to Gross AR	21.3%			21.8%

ATTACHMENT C

Sonoma Valley Health Care District
Balance Sheet
As of March 31, 2018

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 375,086	$ 1,493,055	$ 2,559,444
2	Trustee Funds	3,625,045	4,041,283	2,700,058
3	Net Patient Receivables	7,760,498	8,440,995	8,113,757
4	Allow Uncollect Accts	(1,199,386)	(1,216,076)	(1,149,938)
5	Net A/R	6,561,112	7,224,919	6,963,819
6	Other Accts/Notes Rec	1,838,996	1,747,039	2,438,762
7	3rd Party Receivables, Net	1,488,696	1,350,988	900,158
8	Inventory	829,196	841,098	822,961
9	Prepaid Expenses	845,340	903,043	872,662
10	Total Current Assets	$ 15,563,471	$ 17,601,425	$ 17,257,864
12	Property,Plant & Equip, Net	$ 52,062,188	$ 52,296,982	$ 53,695,461
13	Specific Funds/ Money Market	919,563	1,019,441	479,089
14	Other Assets	-	-	-
15	Total Assets	$ 68,545,222	$ 70,917,848	$ 71,432,414
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	$ 3,357,467	$ 3,608,560	$ 2,693,685
17	Accrued Compensation	3,832,217	4,622,919	3,782,670
18	Interest Payable	211,545	525,747	220,532
19	Accrued Expenses	1,427,213	1,361,944	1,334,021
20	Advances From 3rd Parties	112,930	160,739	119,128
21	Deferred Tax Revenue	1,702,050	2,269,400	1,490,726
22	Current Maturities-LTD	1,226,184	1,245,911	1,286,950
23	Line of Credit - Union Bank	6,973,734	6,973,734	5,923,734
24	Other Liabilities	1,386	1,386	1,051,386
25	Total Current Liabilities	$ 18,844,727	$ 20,770,340	$ 17,902,832
26	Long Term Debt, net current portion	$ 35,141,312	$ 35,192,924	$ 37,544,929
27	Fund Balances:			
28	Unrestricted	$ 10,276,579	$ 10,817,584	$ 12,182,326
29	Restricted	4,282,604	4,137,000	3,802,328
30	Total Fund Balances	$ 14,559,183	$ 14,954,584	$ 15,984,653
31	Total Liabilities & Fund Balances	$ 68,545,222	$ 70,917,848	$ 71,432,414

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended March 31, 2018

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Volume Information					
1	106	104	2	2%	Acute Discharges	838	956	(118)	-12%	932
2	566	580	(14)	-2%	SNF Days	4,868	5,096	(228)	-4%	5,024
3	684	854	(170)	-20%	Home Care Visits	6,977	8,293	(1,316)	-16%	8,277
4	13,064	15,784	(2,721)	-17%	Gross O/P Revenue (000's)	$ 123,254	$ 126,087	(2,833)	-2%	$ 119,670
					Financial Results					
					Gross Patient Revenue					
5	$ 6,385,612	$ 6,694,427	(308,815)	-5%	Inpatient	$ 53,921,893	$ 61,875,132	(7,953,239)	-13%	$ 59,131,474
6	7,709,648	8,853,485	(1,143,837)	-13%	Outpatient	67,581,514	67,401,030	180,484	0%	62,658,408
7	5,123,733	6,657,247	(1,533,514)	-23%	Emergency	53,226,870	55,999,419	(2,772,549)	-5%	54,325,205
8	2,201,620	2,055,115	146,505	7%	SNF	18,269,817	18,340,583	(70,766)	0%	17,490,629
9	252,746	294,465	(41,719)	-14%	Home Care	2,552,038	2,852,486	(300,448)	-11%	2,899,601
10	**$ 21,673,359**	**$ 24,554,739**	**(2,881,380)**	**-12%**	**Total Gross Patient Revenue**	**$ 195,552,132**	**$ 206,468,650**	**(10,916,518)**	**-5%**	**$ 196,505,317**
					Deductions from Revenue					
11	$ (17,807,347)	$ (19,629,915)	1,822,568	9%	Contractual Discounts	$ (157,651,174)	$ (165,161,291)	7,510,117	5%	$ (157,003,622)
12	(100,000)	(100,000)	-	0%	Bad Debt	(1,353,000)	(900,000)	(453,000)	-50%	(1,065,000)
13	(4,208)	(22,607)	18,399	81%	Charity Care Provision	(121,955)	(203,463)	81,508	40%	(258,293)
14	357,272	313,272	44,000	14%	Prior Period Adj/Government Program Revenue	4,087,838	2,819,448	1,268,390	*	2,227,167
15	**$ (17,554,283)**	**$ (19,439,250)**	**1,884,967**	**-10%**	**Total Deductions from Revenue**	**$ (155,038,291)**	**$ (163,445,306)**	**8,407,015**	**-5%**	**$ (156,099,748)**
16	**$ 4,119,076**	**$ 5,115,489**	**(996,413)**	**-19%**	**Net Patient Service Revenue**	**$ 40,513,841**	**$ 43,023,344**	**(2,509,503)**	**-6%**	**$ 40,405,569**
17	$ 99,290	$ 128,521	(29,231)	-23%	Risk contract revenue	$ 1,072,293	$ 1,156,689	(84,396)	-7%	$ 1,168,960
18	$ 4,218,366	$ 5,244,010	(1,025,644)	-20%	Net Hospital Revenue	$ 41,586,134	$ 44,180,033	(2,593,899)	-6%	$ 41,574,529
19	$ 13,471	$ 18,823	(5,352)	**-28%**	Other Op Rev & Electronic Health Records	$ 146,197	$ 169,407	(23,210)	-14%	$ 295,108
20	**$ 4,231,837**	**$ 5,262,833**	**(1,030,996)**	**-20%**	**Total Operating Revenue**	**$ 41,732,331**	**$ 44,349,440**	**(2,617,109)**	**-6%**	**$ 41,869,637**
					Operating Expenses					
21	$ 2,342,930	$ 2,555,390	212,460	8%	Salary and Wages and Agency Fees	$ 20,777,146	$ 21,694,921	917,775	4%	$ 20,075,452
22	836,619	$ 925,523	88,904	10%	Employee Benefits	7,812,934	8,098,660	285,726	4%	7,917,480
23	$ 3,179,549	$ 3,480,913	301,364	9%	Total People Cost	$ 28,590,080	$ 29,793,581	1,203,501	4%	$ 27,992,932
24	$ 434,911	$ 409,331	(25,580)	-6%	Med and Prof Fees (excld Agency)	$ 3,763,141	$ 3,684,632	(78,509)	-2%	$ 3,480,499
25	483,502	593,138	109,636	18%	Supplies	4,899,361	4,669,893	(229,468)	-5%	5,215,888
26	371,068	376,471	5,403	1%	Purchased Services	3,292,473	3,387,335	94,862	3%	2,761,828
27	288,155	282,312	(5,843)	-2%	Depreciation	2,573,568	2,540,808	(32,760)	-1%	2,530,292
28	88,085	101,622	13,537	13%	Utilities	915,542	914,598	(944)	0%	891,966
29	31,819	27,614	(4,205)	-15%	Insurance	286,371	248,526	(37,845)	-15%	266,571
30	45,414	43,027	(2,387)	-6%	Interest	423,992	404,298	(19,694)	-5%	379,007
31	109,251	133,747	24,496	18%	Other	1,073,315	1,237,355	164,040	13%	1,218,235
32	147,386	86,433	(60,953)	*	Matching Fees (Government Programs)	1,491,827	777,897	(713,930)	-92%	747,361
33	**$ 5,179,140**	**$ 5,534,608**	**355,468**	**6%**	**Operating expenses**	**$ 47,309,670**	**$ 47,658,923**	**349,253**	**1%**	**$ 45,484,579**
34	**$ (947,303)**	**$ (271,775)**	**(675,528)**	**-249%**	**Operating Margin**	**$ (5,577,339)**	**$ (3,309,483)**	**(2,267,856)**	**-69%**	**$ (3,614,942)**

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended March 31, 2018

	Month						Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Non Operating Rev and Expense					
35	$ (1,320)	$ (13,222)	11,902	-90%	Miscellaneous Revenue/(Expenses)	$ (45,488)	$ (116,991)	71,503	*	$ (89,229)
36	2,810	-	2,810	0%	Donations	25,966	-	25,966	0%	96,009
37	(56,766)	(54,683)	(2,083)	4%	Physician Practice Support-Prima	(510,894)	(492,147)	(18,747)	4%	(337,500)
38	316,667	316,667	-	0%	Parcel Tax Assessment Rev	2,850,003	2,850,003	-	0%	2,250,378
39	0	0	-	0%	Extraordinary Items	(26,875)	0	(26,875)	0%	
40	**$ 261,391**	**$ 248,762**	**12,629**	**5%**	**Total Non-Operating Rev/Exp**	**$ 2,292,712**	**$ 2,240,865**	**78,722**	**2%**	**$ 1,919,658**
41	**$ (685,912)**	**$ (23,013)**	**(662,899)**	**2881%**	**Net Income / (Loss) prior to Restricted Contributions**	**$ (3,284,627)**	**$ (1,068,618)**	**(2,189,134)**	**205%**	**$ (1,695,284)**
42	$ 32,583	$ 18,828	13,755	73%	Capital Campaign Contribution	$ 140,664	$ 142,984	(2,320)	-2%	$ 204,566
43	$ 113,021	$ -	113,021	0%	Restricted Foundation Contributions	$ 262,806	$ -	262,806	100%	$ -
44	**$ (540,308)**	**$ (4,185)**	**(536,123)**	**12811%**	**Net Income / (Loss) w/ Restricted Contributions**	**$ (2,881,157)**	**$ (925,634)**	**(1,955,523)**	**211%**	**$ (1,490,719)**
45	250,683	250,683	-	0%	GO Bond Tax Assessment Rev	2,256,147	2,256,147	-	0%	2,222,181
46	(105,776)	(105,776)	-	0%	GO Bond Interest	(956,474)	(956,474)	-	0%	(1,008,037)
47	**$ (395,401)**	**$ 140,722**	**(536,123)**	**-381%**	**Net Income/(Loss) w GO Bond Activity**	**$ (1,581,484)**	**$ 374,039**	**(1,955,523)**	**-523%**	**$ (276,575)**
	$ (352,343)	$ 302,326			**EBIDA - Not including Restricted Contributions**	$ (287,067)	$ 1,876,488			$ 1,214,015
	-8.3%	5.7%				-0.7%	4.2%			2.9%
	$ (397,757)	$ 259,299			**EBDA - Not including Restricted Contributions**	$ (711,059)	$ 1,472,190			
	-9.4%	4.9%				-1.7%	3.3%			

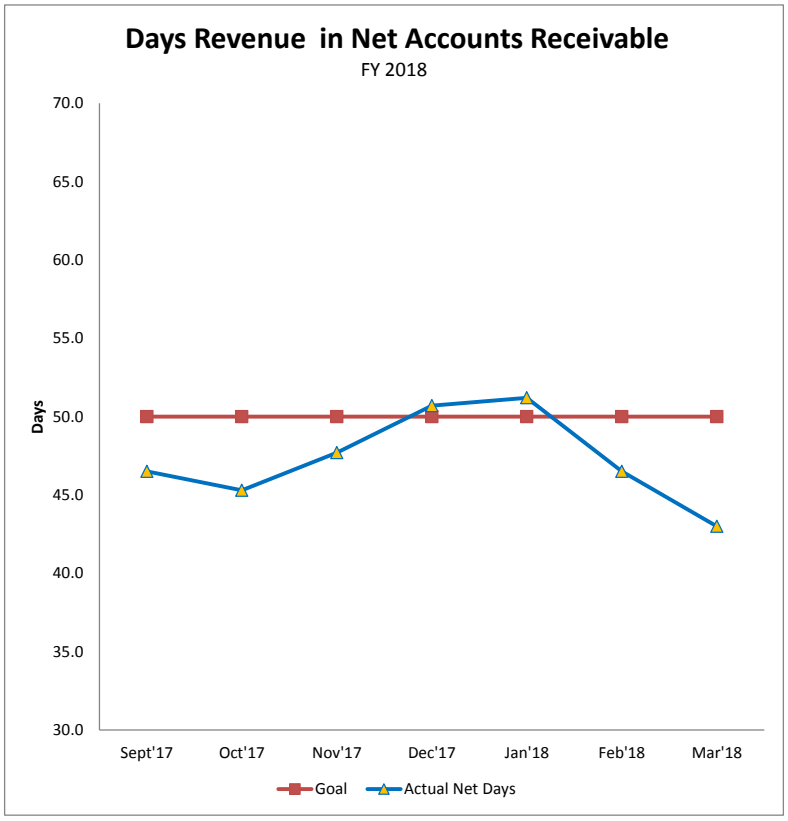
Sonoma Valley Health Care District **ATTACHMENT E**
Statement of Revenue and Expenses Variance Analysis
For the Period Ended March 31, 2018

		YTD	MONTH	
	Description	**Variance**	**Variance**	
	Volume Information			
1	Acute Discharges	(118)	2	
2	SNF Days	(228)	(14)	
3	Home Care Visits	(1,316)	(170)	
4	Gross O/P Revenue (000's)	(2,833)	(2,721)	
	Financial Results			
	Gross Patient Revenue			
5	Inpatient	(7,953,239)	(308,815)	Inpatient days are 335 days vs. budgeted expectations of 404 days and inpatient surgeries are 34 vs. budgeted expectations 32.
6	Outpatient	180,484	(1,143,837)	Outpatient visits are 4,713 vs. budgeted expectations of 5,373 visits and outpatient surgeries are 117 vs. budgeted expectations 129.
7	Emergency	(2,772,549)	(1,533,514)	ER visits are 871 vs. budgeted visits of 945.
8	SNF	(70,766)	146,505	SNF patient days are 566 vs. budgeted expected days of 580.
9	Home Care	(300,448)	(41,719)	HHA visits are 684 vs. budgeted expectations of 854.
10	**Total Gross Patient Revenue**	**(10,916,518)**	**(2,881,380)**	
	Deductions from Revenue			
11	Contractual Discounts	7,510,117	1,822,568	
12	Bad Debt	(453,000)	-	
13	Charity Care Provision	81,508	18,399	
14	Prior Period Adj/Government Program Revenue	1,268,390	44,000	Accrued $62,500 for the prime grant, and $294,772 for 16-17 HQAF IGT (Matching fee in line 32, net $147,386).
15	**Total Deductions from Revenue**	**8,407,015**	**1,884,967**	
16	**Net Patient Service Revenue**	**(2,509,503)**	**(996,413)**	
17	Risk contract revenue	(84,396)	(29,231)	
18	Net Hospital Revenue	**(2,593,899)**	**(1,025,644)**	
19	Other Op Rev & Electronic Health Records	(23,210)	(5,352)	
20	**Total Operating Revenue**	**(2,617,109)**	**(1,030,996)**	
	Operating Expenses			
21	Salary and Wages and Agency Fees	917,775	212,460	Salaries and Wages are under budget by $233,477 and the Agency fees are over budget by ($21,017).
22	Employee Benefits	285,726	88,904	PTO is under budget by $47,646 and employee benefits are under budget by $41,258.
23	Total People Cost	**1,203,501**	**301,364**	
24	Med and Prof Fees (excld Agency)	(78,509)	(25,580)	Chief Revenue Officer was moved from employee to consultant ($17,680) and dietary consultant ($16,900) .
25	Supplies	(229,468)	109,636	Supplies services are under budgeted expectations due to lower volume in March.
26	Purchased Services	94,862	5,403	
27	Depreciation	(32,760)	(5,843)	
28	Utilities	(944)	13,537	
29	Insurance	(37,845)	(4,205)	
30	Interest	(19,694)	(2,387)	
31	Other	164,040	24,496	
32	Matching Fees (Government Programs)	(713,930)	(60,953)	Matching fees for 16-17 HQAF IGT of $147,386
33	**Operating expenses**	**349,253**	**355,468**	
34	**Operating Margin**	**(2,267,856)**	**(675,528)**	
	Non Operating Rev and Expense			
35	Miscellaneous Revenue	71,503	11,902	
36	Donations	25,966	2,810	Foundation grants for employee education
37	Physician Practice Support-Prima	(18,747)	(2,083)	
38	Parcel Tax Assessment Rev	-	-	
39	Extraordinary Items	(26,875)	-	
40	**Total Non-Operating Rev/Exp**	78,722	12,629	
			-	
41	**Net Income / (Loss) prior to Restricted Contributions**	**(2,189,134)**	**(662,899)**	

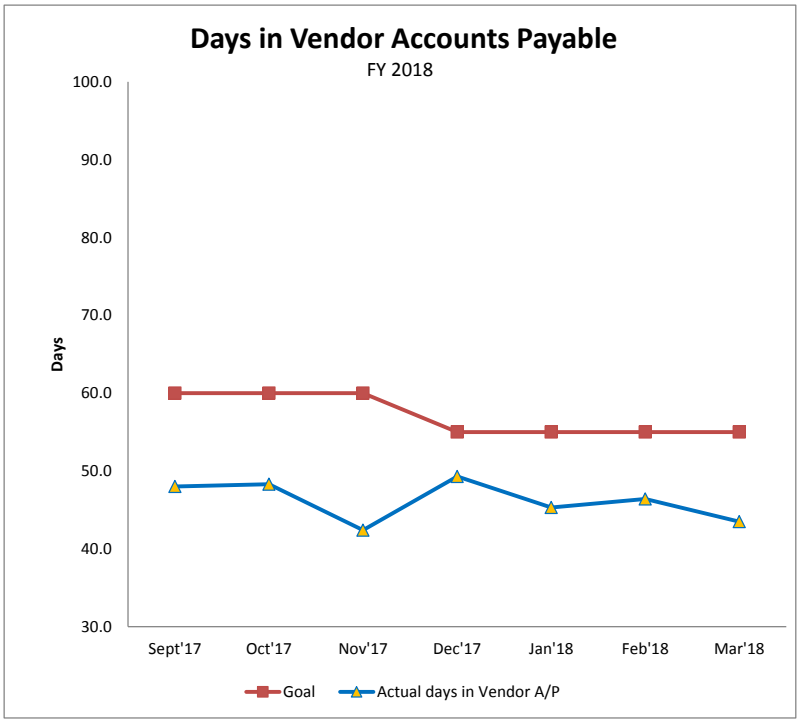
Sonoma Valley Health Care District
Statement of Revenue and Expenses Variance Analysis
For the Period Ended March 31, 2018

ATTACHMENT E

	Description	YTD Variance	MONTH Variance	
			-	
42	Capital Campaign Contribution	(2,320)	13,755	Capital Campaign donations and OP Diagnostic Center donations over budgeted expectations
43	Restricted Foundation Contributions	262,806	113,021	Foundation donations (3D Mammography - $64,426.92) and A Women's Place ($48,593.62)
44	**Net Income / (Loss) w/ Restricted Contributions**	**(1,955,523)**	**(536,123)**	
45	GO Bond Tax Assessment Rev	-	-	
46	GO Bond Interest	-	-	
47	**Net Income/(Loss) w GO Bond Activity**	**(1,955,523)**	**(536,123)**	



Days in A/R	Sept'17	Oct'17	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18
Actual days in A/R	46.5	45.3	47.7	50.7	51.2	46.5	43.0
Goal	50.0	50.0	50.0	50.0	50.0	50.0	50.0



Days in A/P	Sept'17	Oct'17	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18
Actual days in Vendor A/P	48.0	48.3	42.4	49.3	45.3	46.4	43.5
Goal	60.0	60.0	60.0	55.0	55.0	55.0	55.0

Sonoma Valley Hospital
Statistical Analysis
FY 2018

ATTACHMENT G

	ACTUAL	BUDGET	ACTUAL												
	Mar-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17
Statistics															
Acute															
Acute Patient Days	335	404	289	394	386	321	315	325	325	240	346	388	368	415	415
Acute Discharges (w/o Newborns)	106	104	82	111	96	99	87	87	94	76	87	100	89	119	97
SNF Days	566	580	494	646	563	468	624	479	500	528	458	559	512	572	607
HHA Visits	684	854	821	801	798	630	871	789	713	870	940	966	934	849	922
Emergency Room Visits	871	945	811	996	919	816	827	921	894	920	964	1,069	921	941	851
Gross Outpatient Revenue (000's)	$13,064	$15,784	$12,519	$14,741	$14,051	$12,952	$11,864	$14,364	$15,524	$14,175	$15,454	$15,523	$13,168	$15,098	$12,189
Equivalent Patient Days	2,272	2,759	2,212	2,629	2,471	2,030	2,334	2,266	2,591	2,332	2,328	2,654	2,227	2,537	2,553
Births	8	15	11	7	10	11	12	5	10	6	15	7	11	12	12
Surgical Cases - Inpatient	34	32	16	32	24	34	23	33	22	29	36	30	47	40	26
Surgical Cases - Outpatient	117	129	123	109	136	121	97	154	142	133	161	143	124	149	101
Total Surgical Cases	151	161	139	141	160	155	120	187	164	162	197	173	171	189	127
Total Special Procedures	75	34	75	65	59	73	52	75	77	52	66	58	44	36	41
Medicare Case Mix Index	1.45	1.40	1.34	1.50	1.57	1.55	1.49	1.54	1.57	1.65	1.66	1.69	1.64	1.45	1.52
Income Statement															
Net Revenue (000's)	$4,218	$5,244	4,590	4,909	4,466	4,474	4,543	4,518	4,775	4,988	5,188	5,330	4,924	5,283	4,266
Operating Expenses (000's)	$5,179	$5,535	$5,270	$5,357	$5,122	$5,332	$4,872	$5,206	$5,380	$5,592	$5,250	$5,678	$5,308	$5,395	$4,803
Net Income (000's)	($395)	$141	$ (175)	$ 125	$ (226)	$ (380)	$ 62	$ (230)	$ (165)	$ (198)	$ 690	$ 16	$ (24)	$ 304	$ 308
Productivity															
Total Operating Expense Per Equivalent Patient Day	$2,280	$2,006	$2,382	$2,038	$2,073	$2,627	$2,087	$2,297	$2,076	$2,398	$2,255	$2,139	$2,383	$2,127	$1,881
Productive FTEs	279	296	274	276	255	316	246	289	279	271	278	291	285	294	294
Non-Productive FTE's	23	43	31	36	52	13	58	27	35	47	43	28	28	28	28
Total FTEs	302	339	305	312	307	329	304	316	314	318	321	319	313	322	322
FTEs per Adjusted Occupied Bed	4.17	3.81	3.87	3.68	3.85	4.86	4.04	4.19	3.75	4.23	4.14	3.73	4.22	3.93	3.54
Balance Sheet															
Days of Expense In General Operating Cash	6.7		14	24	18	14	12	9	11	16	20	19	11	16	27
Net Days of Revenue in AR	43	50	47	51	51	48	45	47	43	45	45	44	47	44	46

Sonoma Valley Hospital
Cash Forecast
FY 2018

ATTACHMENT H

		Actual July	Actual Aug	Actual Sept	Actual Oct	Actual Nov	Actual Dec	Actual Jan	Actual Feb	Actual Mar	Forecast Apr	Forecast May	Forecast Jun	TOTAL
	Hospital Operating Sources													
1	Patient Payments Collected	4,502,585	4,253,229	4,093,599	4,253,616	3,890,115	3,814,761	4,401,932	3,677,850	4,283,702	4,422,606	4,357,338	4,451,807	50,403,141
2	Capitation Revenue	133,404	128,220	128,530	131,210	128,781	122,912	93,640	106,306	99,290	99,290	99,290	99,290	1,370,163
3	Napa State	39,561	4,166	35,361	26,125	5,181	21,341	30,259	-		20,762	20,762	20,762	224,280
4	Other Operating Revenue	10,971	25,415	37,380	30,930	42,863	35,092	33,639	57,291	45,083	18,823	18,823	18,827	375,136
5	Other Non-Operating Revenue	26,914	38,081	68,232	33,898	48,014	43,511	47,501	9,459	32,528				348,139
6	Unrestricted Contributions		8,478	150			19,590	835		2,810	390,000			421,863
7	Line of Credit													-
	Sub-Total Hospital Sources	**4,713,435**	**4,457,589**	**4,363,253**	**4,475,779**	**4,114,954**	**4,057,207**	**4,607,806**	**3,850,906**	**4,463,413**	**4,951,481**	**4,496,213**	**4,590,686**	**53,142,721**
	Hospital Uses of Cash													
8	Operating Expenses	5,146,037	5,273,336	5,040,006	4,799,145	5,326,497	4,701,617	4,944,257	4,794,729	5,813,204	4,790,340	4,837,721	4,770,733	60,237,622
9	Add Capital Lease Payments	52,503	186,389	69,999	179,596	109,938	70,502	45,558	181,715	71,338	103,364	103,786	169,180	1,343,868
10	Additional Liabilities								375,000					375,000
11	Capital Expenditures	15,965	56,034	1,755	88,906	88,829	59,065	546,421		37,792				894,767
	Total Hospital Uses	**5,214,505**	**5,515,759**	**5,111,761**	**5,067,647**	**5,525,264**	**4,831,184**	**5,536,236**	**5,351,443**	**5,922,334**	**4,893,704**	**4,941,507**	**4,939,913**	**62,851,257**
	Net Hospital Sources/Uses of Cash	**(501,070)**	**(1,058,171)**	**(748,508)**	**(591,868)**	**(1,410,310)**	**(773,977)**	**(928,430)**	**(1,500,538)**	**(1,458,921)**	**57,777**	**(445,294)**	**(349,227)**	**(9,708,535)**
	Non-Hospital Sources													
12	Restricted Cash/Capital Donations		527,977	(727,205)	(100,755)	382,167	417	551,467	-	227,056	734,900	(697,244)	18,828	917,608
13	Parcel Tax Revenue	152,275		1,500,000			482,664	532,571			1,267,429			3,934,939
14	Payment - South Lot				(25,205)		(25,205)			(24,658)			(24,932)	(100,000)
15	Other:													-
16	IGT (Net)				1,877,696							1,242,582		3,120,278
17	IGT - AB915							811,535		138,554		162,259		1,112,348
18	PRIME					1,350,000							150,000	1,500,000
	Sub-Total Non-Hospital Sources	**152,275**	**527,977**	**772,795**	**1,751,736**	**1,732,167**	**457,876**	**1,895,573**	**-**	**340,952**	**2,002,329**	**707,597**	**143,896**	**10,485,173**
	Non-Hospital Uses of Cash													
19	Matching Fees		509,543	266,212	675,000						716,072	75,000		2,241,827
	Sub-Total Non-Hospital Uses of Cash	-	509,543	266,212	675,000	-	-	-	-	-	716,072	75,000	-	2,241,827
	Net Non-Hospital Sources/Uses of Cash	**152,275**	**18,434**	**506,583**	**1,076,736**	**1,732,167**	**457,876**	**1,895,573**	**-**	**340,952**	**1,286,257**	**632,597**	**143,896**	**8,243,346**
	Net Sources/Uses	**(348,795)**	**(1,039,737)**	**(241,925)**	**484,868**	**321,857**	**(316,101)**	**967,143**	**(1,500,538)**	**(1,117,969)**	**1,344,034**	**187,303**	**(205,331)**	
	Cash and Equivalents at beginning of period	3,166,281	2,817,486	1,777,750	1,535,825	2,020,693	2,342,550	2,026,449	2,993,592	1,493,055	375,086	1,719,120	1,906,423	
	Cash and Equivalents at end of period	**2,817,486**	**1,777,750**	**1,535,825**	**2,020,693**	**2,342,550**	**2,026,449**	**2,993,592**	**1,493,055**	**375,086**	**1,719,120**	**1,906,423**	**1,701,092**	

Sonoma Valley Hospital **ATTACHMENT H**
Cash Forecast
FY 2018

		Actual July - Dec	Actual Jan	Actual Feb	Forecast Mar	Forecast Apr	Forecast May	Forecast Jun	TOTAL
	Hospital Operating Sources								
1	Patient Payments Collected	24,807,906	4,401,932	3,677,850	4,283,702	4,422,606	4,357,338	4,451,807	50,403,141
2	Capitation Revenue	773,056	93,640	106,306	99,290	99,290	99,290	99,290	1,370,163
3	Napa State	131,735	30,259	-	-	20,762	20,762	20,762	224,280
4	Other Operating Revenue	182,650	33,639	57,291	45,083	18,823	18,823	18,827	375,136
5	Other Non-Operating Revenue	258,651	47,501	9,459	32,528	-	-	-	348,139
6	Unrestricted Contributions	28,218	835	-	2,810	390,000	-	-	421,863
7	Line of Credit								-
	Sub-Total Hospital Sources	**26,182,217**	**4,607,806**	**3,850,906**	**4,463,413**	**4,951,481**	**4,496,213**	**4,590,686**	**53,142,721**
	Hospital Uses of Cash								
8	Operating Expenses	30,286,638	4,944,257	4,794,729	5,813,204	4,790,340	4,837,721	4,770,733	60,237,622
10	Add Capital Lease Payments	668,927	45,558	181,715	71,338	103,364	103,786	169,180	1,343,868
11	Additional Liabilities			375,000	-	-	-	-	375,000
12	Capital Expenditures	310,554	546,421		37,792				894,767
	Total Hospital Uses	**31,266,120**	**5,536,236**	**5,351,443**	**5,922,334**	**4,893,704**	**4,941,507**	**4,939,913**	**62,851,257**
	Net Hospital Sources/Uses of Cash	**(5,083,903)**	**(928,430)**	**(1,500,538)**	**(1,458,921)**	**57,777**	**(445,294)**	**(349,227)**	**(9,708,535)**
	Non-Hospital Sources								
13	Restricted Cash/Capital Donations	82,601	551,467	-	227,056	734,900	(697,244)	18,828	917,608
14	Parcel Tax Revenue	2,134,939	532,571	-	-	1,267,429	-	-	3,934,939
15	Payment - South Lot	(50,410)		-	(24,658)	-	-	(24,932)	(100,000)
16	Other:	-		-	-	-	-	-	-
17	IGT	1,877,696		-	-	-	1,242,582	-	3,120,278
18	IGT - AB915 (Net)	-	811,535	-	138,554	-	162,259	-	1,112,348
19	PRIME	1,350,000			-	-	-	150,000	1,500,000
	Sub-Total Non-Hospital Sources	**5,394,826**	**1,895,573**	**-**	**340,952**	**2,002,329**	**707,597**	**143,896**	**10,485,173**
	Non-Hospital Uses of Cash								
20	Matching Fees	1,450,755				716,072	75,000	-	2,241,827
	Sub-Total Non-Hospital Uses of Cash	1,450,755	-	-	-	716,072	75,000	-	2,241,827
	Net Non-Hospital Sources/Uses of Cash	**3,944,071**	**1,895,573**	**-**	**340,952**	**1,286,257**	**632,597**	**143,896**	**8,243,346**
	Net Sources/Uses	**(1,139,832)**	**967,143**	**(1,500,538)**	**(1,117,969)**	**1,344,034**	**187,303**	**(205,331)**	
	Cash and Equivalents at beginning of period	3,166,281	2,026,449	2,993,592	1,493,055	375,086	1,719,120	1,906,423	
	Cash and Equivalents at end of period	**2,026,449**	**2,993,592**	**1,493,055**	**375,086**	**1,719,120**	**1,906,423**	**1,701,092**	

0.267082793

Sonoma Valley Hospital

ATTACHMENT I

Schedule of Cash Savings from Cost Reduction Plan

For the months of January Through March 2018

			Savings				
Department	**Department**	**Job Code**	**Jan-18**	**Feb-18**	**Mar-18**	**Total**	**Notes**
7290	Home Health	Total department	$ 23,660	$ 34,779	$ 14,939	$ 73,378	Cost reduction, net
7721	Respiratory Therapy	0000 - Management	727	909	257	1,893	Cardiopulmanary Manager
7770	Rehab	0000 - Management	9,431	9,008	6,754	25,193	Consolidation of Rehab managers (New hire in February)
8361/8750	CareTransitions/Quality	0000 - Management	2,872	3,015	3,317	9,204	Chief of Quality
8480	IT	0000 - Management	10,523	10,390	8,719	29,632	IT Manager
8510	Accounting	0000 - Management	8,386	6,828	6,997	22,211	Controller
8610	Administration	0000 - Management	6,120	6,243	6,733	19,096	CFO (.8 to .5)
8710	Medical Staff	0000 - Management	13,807	12,178	13,445	39,430	CMO/CMIO (To be replaced by UCSF CMO)
9550	Community Health	0000 - Management	3,787	3,602	3,787	11,176	Wellness Coordinator
		Gross Salary savings	**$ 79,313**	**$ 86,952**	**$ 64,948**	**$ 231,213**	
		Employer portion FICA	**6,067**	**6,652**	**4,968**	**17,688**	
		Health Benefits	**16,511**	**22,948**	**26,123**	**65,582**	
		Total Savings	**$ 101,891**	**$ 116,552**	**$ 96,039**	**$ 314,482**	

11.

BOARD COMMENTS

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

April 2, 2018

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

SUBJECT: AB 2798 (Maienschein) – Support

Dear Assemblymember Wood:

I am writing today on behalf of Sonoma Valley Hospital, which represents nearly 450 employees, to voice our support for AB 2798 (Maienschein). This bill would establish specific time frames for the California Department of Public Health (CDPH) to review and complete hospital applications. If the time frames are not met, the application would subsequently be deemed approved. AB 2798 would also require CDPH to develop an assistance unit to help hospitals with the application process, to fully automate the application process and to publish performance metrics. Delays in processing and approving applications mean that patients lack access to critical, and potentially lifesaving, services.

Backlog in CDPH's Centralized Applications Unit has reached the point of endangering the health of California citizens. One hospital waited more than six months to expand its existing cardiac catheterization laboratory. During the wait, its two additional beds remained empty while 9-1-1 ambulances had to find another hospital with an open cardiac catheterization bed, thus delaying time-sensitive treatment for those patients. Nearly every region in this state has a hospital that has experienced delays in application approval. These delays are occurring as CDPH proposes, in the 2018-19 state budget, to raise hospital licensing fees for the fourth consecutive year. If this fee increase is approved, fees will have been raised 103 percent in four years.

Our hospital submitted an application for our new 3D Mammography system and space in May 2017 to the Central Applications Unit (CAU). We are pleased that this service was approved, but we did not hear back from anyone until March 2018. Due to the delay, we were one of the hospitals whose application was sent to the local office. The local office was able to process the application and license the system for us within one month. If we had to continue to rely on the CAU, we would likely still be waiting.

Without the passage of AB 2798, hospitals will have to wait eight to 10 months for an application to be assigned an analysist and an additional four to five months for approval. Please vote "AYE" when the bill is heard in committee.

Sincerely,

Kelly Mather
President and Chief Executive Officer

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

April 2, 2018

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

SUBJECT: AB 1795 (Gipson) – Support

Dear Assemblymember Wood:

I am writing today on behalf of Sonoma Valley Hospital, which represents nearly 450 employees, to voice our support for AB 1795 (Gipson). This bill would authorize a local emergency medical services agency to allow specially trained paramedics to triage patients who meet specific criteria to a locally designated behavioral health treatment facility or sobering center. AB 1795 would allow for more direct access and appropriate care to patients while increasing efficiency for local response systems.

As our emergency medical systems strive to become more efficient, it is evident that many of the current 9-1-1 calls are not best served by advanced life support-level transportation or by hospital emergency department (ED) care. Many emergency medical services systems are developing formal sobering and behavioral health facility alternative ED destination programs to redirect 9-1-1 patients from a hospital emergency department after they have been evaluated by a paramedic.

Patients experiencing an acute behavioral health crisis, with or without psychiatric holds, comprise an increasing proportion of emergency medical services calls. To help address the issue, the Office of Statewide Health Planning and Development and the Emergency Medical Services Authority established a workforce pilot project on community paramedicine. For more than two years, Stanislaus County has participated in this pilot, resulting in no adverse patient outcomes, decreased emergency department usage and costs, and enhanced public safety. Law enforcement officers called to a scene are able to transfer responsibility to paramedics and return to their duties.

Our ER and ICU are both often filled with inebriated and mental health crisis patients. We have no psychiatrists in the region that can help us facilitate mental health evaluation and/or a 5150 hold. Consequently, the patient may languish in the ED for more than 72 hours and ultimately be placed in the inpatient unit. In 2017, one patient was in the hospital for more than 180 days due to lack of mental health placement. Inebriated patients present similar problems as mental health issues are often the basis for chronic inebriation. Ultimately, these patients are admitted for withdrawal symptoms, extensive uncompensated lengths of stay, and then discharged to the community at large, only to often return again. We are not a rehabilitation center and only deal with acute crisis intervention.

Passage of AB 1795 will improve treatment and access by transporting patients directly to behavioral health facilities or sobering centers, where medically trained personnel — including nurses, psychiatrists and community resource workers — can connect recovering patients to supportive services that will lead to long-term care, housing and self-sufficiency.

Please vote "AYE" when the bill is heard in committee.

Sincerely,

Kelly Mather
President and Chief Executive Officer

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

April 17, 2018

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

SUBJECT: AB 3087 (Kalra) – OPPOSE

Dear Assemblymember Wood:

I am writing today on behalf of Sonoma Valley Hospital, which represents nearly 450 employees, to voice our opposition to AB 3087 (Kalra) which would create the California Health Care Cost, Quality and Equity Commission. The commission's primary role would be to set commercial payments to hospitals, doctors and other health care providers.

Establishing a rate-setting process that will unilaterally determine the payment rates to hospitals, doctors and other providers without understanding the underlying drivers of health care costs is a simplistic and dangerous solution to a complex problem. California hospitals face the highest labor costs in the country, and nearly 60 cents of every dollar spent by California hospitals goes to employee wages and benefits. Further, AB 3087 does not solve the fundamental problems of the health care payment system. Because the legislation does not apply to Medicare or Medi-Cal, hospitals and other providers will continue to be underpaid by these government programs.

The end result of AB 3087 will be massive cuts in hospital services, massive loss of jobs, and large numbers of hospitals being forced to close. Sonoma Valley Hospital is a small, relatively rural provider serving a community of around 40,000 residents. The payer mix is 55% Medicare and 15% Medi-Cal. The hospital is subsidized to some extent by a parcel tax which barely covers the unreimbursed costs of the government programs. The hospital has the only emergency room in the community. Any further restriction on reimbursement would substantially affect financial survival.

California hospitals work hard to reduce costs and have long been leaders in innovative approaches to delivery system reforms, care coordination and clinical efficiencies. Because of our state's long history with managed health care and other operational and clinical efficiencies, hospital costs in the Golden State are already significantly lower than in the rest of the nation. Hospital costs today represent roughly 33 percent of all health care expenditures, down from more than 40 percent almost four decades ago. According to 2016 data from the American Hospital Association, the average hospital cost per 1,000 Californians is $2,285, compared to the U.S. average of compared to the U.S. average of $2,537.

Please vote "NO" when the bill is heard in committee.

Sincerely,

Kelly Mather
President and Chief Executive Officer