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

SONOMA VALLEY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
REGULAR MEETING AGENDA

Thursday, May 7, 2015
5:00 p. m. Closed Session
6:00 p.m. Regular Session

COMMUNITY MEETING ROOM
177 FIRST STREET WEST, SONOMA

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Nevins*	
2. PUBLIC COMMENT ON CLOSED SESSION	*Nevins*	
3. CLOSED SESSION Calif. Government Code § 54957 Performance Evaluation regarding Chief Executive Officer Calif. Government Code § 37606 and Health & Safety Code § 32106 Report Involving Trade Secret regarding Business Strategy	*Nevins*	
4. REPORT OF CLOSED SESSION	*Nevins*	
5. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.*		
6. CONSENT CALENDAR A. Regular Board Minutes 4.2.15 B. FC Minutes 4.28.15 C. QC Minutes 4.22.15 D. Three Year Rolling Strategic Plan FY2016-18 E. Policy & Procedures F. SB483 and AB850 Letters G. MEC Credentialing Report, 4.22.15	*Nevins*	Action
7. MARIN AFFILIATION AGREEMENT	*Domanico*	Inform/Action
8. ADVANCED DIRECTIVES	*Cohen*	Inform
9. FINANCIAL REPORT FOR MARCH 2015	*Jensen*	Inform
10. ADMINISTRATIVE REPORT FOR MAY 2015	*Mather*	Inform

11. OFFICER & COMMITTEE REPORTS A. Chair Report • Board Calendared Items and Educational Topics B. Quality Committee • Annual Review QA/PI Program C. Governance Committee • ACHD Legislative Days • Policy Governing Access to Public Records	*Committee Chairs*	Inform/Action
12. BOARD COMMENTS	*Board Members*	Inform/Discuss
13. ADJOURN The **Joint Finance Committee-Board Budget** meeting is on May 12, 2015 The next **Regular Board** meeting is on June 4, 2015.	*Nevins*	

6.

CONSENT CALENDAR

SVHCD BOARD OF DIRECTORS
REGULAR MEETING MINUTES
Thursday, April 2, 2015
Closed Session 5:00 p.m.
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 Regular Session called to order at 6:13 pm	*Nevins*	
2. PUBLIC COMMENT ON CLOSED SESSION	*Nevins*	
3. CLOSED SESSION Calif. Government Code § 54957–Public Employment–Executive Employment Agreement with CEO	*Nevins*	
4. REPORT OF CLOSED SESSION	*Nevins*	
5. PUBLIC COMMENT SECTION	*Nevins*	
At this time, members of the public may comment on any item not appearing on the agenda. It is recommended to keep 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 is invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.		
6. CONSENT CALENDAR	*Nevins*	Action
A. Regular Board Minutes 3.5.15 B. FC Minutes 2.26.15 C. QC Minutes 2.25.15 D. Policy & Procedure Approval: Nutritional E. MEC Credentialing Report, 3.25.15		**MOTION** to approve Consent Calendar by Boerum and 2nd by Hirsch. All in favor.
7. QUARTERLY GROWTH OVERVIEW AND YTD SUMMARY (2014-15)	*Donaldson*	Inform
Ms. Donaldson's presentation included Hospital accomplishments, lessons learned, revenue		.

trends, rolling margins, outpatient ancillary analysis and next steps.		
8. MARKETING ANNUAL REPORT	*Kenney*	Inform
Mr. Kenney presented the annual report for the marketing department and shared the department's goals, outreach, media and social media, community engagement and improving patient experience.		
9. DRAFT FY 2016-2018 ROLLING THREE YEAR STRATEGIC PLAN	*Mather*	Inform
Ms. Mather presented the 2016-2018 Strategic Plan which will be released online within the next few days. The Plan summarizes priorities, future goals, competitive and environmental assessments as well as detailed implementation plans for the strategic priorities above.		
10. FINANCIAL REPORT FOR FEBRUARY 2015	*Jensen*	Inform
After accounting for all income and expenses, the month of February's net loss was ($211,936) on a budgeted net loss of ($42,885). Net Hospital Revenue was favorable to budget by $595,380. Actual Net Hospital Revenue would have been unfavorable to budget by ($448,218) without the IGT Revenue. Expenses were unfavorable to budget by ($679,256). Actual Expense variance would have been unfavorable to budget by ($105,850) without the IGT fee.		
11. ADMINISTRATIVE REPORT FOR APRIL 2015	*Mather*	Inform
Ms. Mather shared her dashboard results and FY2015 trended results with the Board.		
12. 2015 STAFF SATISFACTION REPORT	*Mather*	Inform
A very positive and encouraging Staff Satisfaction Report (Employee Partnership Survey) was presented by Ms. Mather. Press Ganey Associates collects the data and compiles the report for the Hospital on an annual basis.		
13. OFFICER & COMMITTEE REPORTS	*Committee Chairs*	Inform/Action
A. Chair Report B. Quality Committee C. Finance Committee D. Governance Committee: Policy Governing Access to Public Records*		*Revisions will be made to policy 13.D. and brought back to the Board meeting on May 7, 2015.
14. BOARD COMMENTS	*Board Members*	Inform
None		
15. ADJOURN Meeting adjourned at 8:00pm	*Nevins*	

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
MEETING MINUTES
Tuesday, April 28, 2015
Schantz Conference Room

Voting Members Present	Members Excused/Absent	Staff	Public
Dick Fogg Sharon Nevins Phil Woodward S. Mishra (by phone) Peter Hohorst Mary Smith Stephen Berezin Shari Glago	Keith Chamberlin Steve Barclay	Kelly Mather Ken Jensen Jeannette Tarver Michelle Donaldson Gigi Betta	Sam McCandless

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION AND VISION STATEMENTS	*The mission of SVHCD is to maintain, improve and restore the health of everyone in our community. The vision of SVHCD is that SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community's health care journey.*		
1. CALL TO ORDER AND ANNOUNCEMENTS	*Fogg*		
	Meeting called to order at 5:00 p.m. A Joint Board/Finance Committee Budget Meeting is scheduled for Tuesday, May 12 at 5:00pm in the Basement Conference Room.		
2. PUBLIC COMMENT SECTION	*Fogg*		
	None		
3. CONSENT CALENDAR	*Fogg*		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
• FC Meeting Minutes, 1.27.15 (no quorum) and 3.24.15		**MOTION** by Woodward to approve Minutes and 2nd by Glago. All in favor.	
4. GROWTH OVERVIEW	*Donaldson*	Inform	
	Ms. Donaldson discussed the role of the Chief Revenue Officer (CRO) in Health Care and shared volume trends at SVH, lessons learned and next steps.		
5. CAPITAL SPENDING	*Tarver*	Inform	
	Ms. Tarver presented the FY2015 Capital Budget.		
6. SCAN UPDATE	*Jensen*	Inform	
	Mr. Jensen will bring back a more detailed SCAN report including payment data.		
7. OPERATING BUDGET STATUS	*Jensen*	Inform	
	The Operating Budget is in progress.		
8. AUDIT PLAN	*Tarver/Jensen*	Inform	
	Ms. Tarver distributed the Audit Schedule for FY 2014-15.		
9. MARCH 2015 FINANCIALS	*Jensen*	Inform	
	March activity was consistent with the experiences of the prior months. After accounting for all income and expenses, the net loss for March was ($382,610) vs. a budgeted gain of $27,392. The loss was offset by a Foundation Contribution of $286,913 restricted for the purchase of ultrasound equipment. The total loss after		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	all activity was ($58,801) vs. a budgeted gain of $123,627.		
10. CEO BOARD REPORT APRIL 2015	*Nevins/Mather*	Inform	
	Ms. Mather is delighted to announce that after recent changes in Leadership, staff satisfaction scores are at all time highs. Staff participation was 77% and SVH came in at the 91st percentile. Ms. Mather shared that the Three-Year Rolling Plan FY2016-18 is in its final stages and will go to the May 7, 2015 Board meeting for approval.		Send the FC the staff satisfaction report from the last Board Agenda Package (as a separate document)
11. ADJOURN/DISCUSSION	*Fog*		
	Ms. Nevins informed the Committee about an anonymous letter submitted to the editors at The Sonoma Sun and the Sonoma-Index Tribune. The letter alleges that SVH is being mismanaged. It is not known whether the letter will go to print. Meeting adjourned at 6:35pm		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, April 22, 2015
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Committee Members Excused	Admin Staff /Other
Jane Hirsch Carol Snyder Susan Idell Joshua Rymer Cathy Webber	M. Mainardi H. Eisenstark Ingrid Sheets Paul Amara MD	Kelsey Woodward Paul Amara MD	Leslie Lovejoy Gigi Betta Mark Kobe

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*		
	Meeting called to order at 5:05pm Ms. Hirsch shared that the Advanced Directives seminars given at Vintage House last week were very successful. They were well attending and the feedback was positive. More seminars are planned for the future.		
2. PUBLIC COMMENT	*Hirsch*		
	None		
3. CONSENT CALENDAR	*Hirsch*	Action	
• QC Minutes, 3.25.15 • Annual Review QA/PI Program		**MOTION** by Rymer to approve Consent and 2nd by Idell. All in favor.	
4. ANNUAL HOME CARE REPORT	*Lee*	Inform/Action	
	Ms. Lee presented *Healing at Home Annual Evaluation 2014.* Topics included management, staff and performance improvement assessments, department visit activity, patient satisfaction surveys, primary patient diagnoses and goals. Ms. Lee distributed the *Quality Assurance & Performance Improvement Plan 2015-16.*		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
5. PATIENT CARE SERVICES REPORT	*Kobe/Lovejoy*	Inform/Action	
	Mr. Kobe and Ms. Lovejoy share their report on *Nursing Services at Sonoma Valley Hospital*. Most significantly, the improvements implemented after the 2012 Strategic Planning Session were presented in detail. They also shared their plans for future improvements and developments 2015-16. Mr. Kobe will present on HCAHPS next month and will incorporate the Committees' areas of interest.		Board Clerk will send an email w/ HCAHPS survey to the Committee and ask for their feedback.
6. QUALITY REPORT FOR APRIL 2015	*Lovejoy*	Inform/Action	.
	Ms. Lovejoy presented the Quality Report for April covering priorities for the month, risk management, budget development and departmental functions.		
7. CLOSINGCOMMENTS	*Hirsch*		
			.
8. ADJOURN	*Hirsch*		
	Regular Session adjourned at 6:09 pm.		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*		
10. CLOSED SESSION	*Amara*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing/Peer Review Rpt.			
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action	
12. ADJOURN	*Hirsch* Closed Session adjourned at 6:12 pm.		

SONOMA VALLEY HOSPITAL

2016 Three-Year Rolling Strategic Plan

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

Executive Summary

Sonoma Valley Hospital ("SVH") has made great progress over the last few years toward becoming a model for the modern community hospital, one well prepared to succeed in the health care environment that is emerging. By all objective measures, SVH now demonstrates performance that is commensurate with or outperforms hospitals across the country. To continue this trajectory, SVH will focus on improving the health of our community and delivering the highest quality of care to patients. We also will continue to improve financial results in a dynamic and challenging market.

Patients and the industry have begun to recognize the extraordinary level of **safety and quality of service** that SVH provides. Feedback from patients through ongoing surveys confirms that SVH physicians and staff provide responsive, responsible and thoughtful care to those served. SVH is the preferred choice among Sonoma Valley residents for Emergency Services, Diagnostics, Rehabilitation, Skilled Nursing, Home Health Care and Occupational Health. On all measures of effectiveness, including safety and quality of health care delivered, SVH is a leading provider and scores well above industry averages, frequently ranking among the top 25 percent of hospitals in the nation. The Hospital has been recognized as one of the top 15 hospitals for safety in the country, quite an achievement for a small community hospital.

SVH has made great progress in recent years toward **financial stability** by reducing costs, paying down debt, upgrading the physical plant, improving technology, and growing service lines. SVH's new Emergency Department is a tremendous success, reporting increases in both volumes and excellent patient satisfaction. However, the type of insurance used by our patients is changing rapidly and has presented new challenges. The expansion of Medi-Cal has increased the volume of clients using the Emergency Department at very low reimbursement rates. Over the coming years, SVH must continue to identify and grow higher-margin services, review and adjust pricing, expand market share where possible – all while continuing to streamline services and maintaining a high level of quality and staff satisfaction.

The implementation of the Affordable Care Act, expansion of Medi-Cal, the secular decline in inpatient services, changes in payment or reimbursement models and levels, and increased regulations have all come together to create a volatile environment for hospitals and other health care providers. While no one knows exactly what the final **health care regulations and payment models** will be, SVH has been proactive by focusing on improving fundamentals: high patient safety and satisfaction, excellent quality outcomes such as reduced patient re-admissions, excellent staff and physician satisfaction, increased efficiencies, increased market share and revenues, and creating a

(continued)

Executive Summary *(cont.)*

modern and welcoming facility. That work will continue and will position SVH well no matter what shape changes to health care regulation and payment models may take. Ensuring a **healthy community** is a top priority for SVH and is critical for the Hospital's future. Industry incentives increasingly will be geared toward population health, continuing to emphasize disease prevention while adjusting to the shift away from inpatient care. SVH will continue to work closely with our excellent and efficient physicians to improve the health of our community. SVH also will continue to be a leader in developing and supporting community-wide programs that address awareness and early detection, keeping healthy people healthy, and leading healing for life.

While a great deal has been accomplished in recent years in upgrading the facility, including the addition of a state-of-the-art Emergency Department and Surgery Center, the Hospital continues to see volumes shift from inpatient to outpatient services. Sonoma Valley residents deserve a more efficient, easy-to-access and modern outpatient center in the future. In addition, SVH must continue to invest in the latest technology in order to continue to maintain high quality of care.

Sonoma Valley Hospital has become an example of "The New Community Hospital" and we will use its smaller size to nimbly adapt to the new health care environment by:

Strategic Priorities 2016-2018

1. CONTINUE TO PROVIDE THE HIGHEST LEVELS OF SAFETY AND QUALITY HEALTH CARE TO SONOMA VALLEY HOSPITAL PATIENTS: Transparency is now the norm in health care and SVH has excellent quality outcomes by most every measure. However, all hospitals are improving their results and therefore we will continue to improve our service excellence scores to above the 75th percentile, continue to meet or exceed national safety and quality measures, and continue to receive the Center for Medicare Services bonus payment due to an excellent Value Based Purchasing score. In addition, we will continue to maintain our staff satisfaction in the top decile, or above the 90th percentile.

2. IMPROVE HOSPITAL FINANCIAL STABILITY: SVH is a small hospital in a small community and must have a laser focus on financial management and efficiency. With new financial leadership and systems, we will enhance our reimbursement, collections and operational efficiency, improve our volumes through physician loyalty, and further increase our market share in several areas including surgery, outpatient diagnostics, rehabilitation and home health. In addition, we will begin to discuss continuation of the parcel tax which is due for renewal at the end of 2017.

3. ANTICIPATE AND PREPARE FOR CONTINUED CHANGES IN HEALTH CARE REGULATIONS AND PAYMENT MODELS: SVH currently uses many different types of payment systems and the incentives are competing with one another. Throughout the next year, we will evaluate each system and determine the best model for our organization. This includes working even more closely with our physician network and several large hospital partners which have leverage with health plans or with organizations which have many patient lives in our area.

4. SUPPORT SONOMA VALLEY IN BECOMING A HEALTHY COMMUNITY: We will continue to implement the Healing Hospital™ model whereby the Hospital focuses on having a "culture of health," encourages staff to serve as health role models and patients to participate in their healing in order to create a healthy community. SVH will lead population health in three ways: implement "Healthy Kids are Contagious™" initiatives, create health awareness and "Keep Healthy People Healthy," and help those with chronic disease "Lead Healing for Life." Also, we will expand the role of the SVH Foundation in community engagement.

The Future

Healing Here at Home

OUR VALUES: C.R.E.A.T.I.N.G **Compassion:** We show consideration of the feelings of others at all times. **Respect:** We honor and acknowledge the value of the people, places and resources in providing care. **Excellence:** We strive to exceed the expectations of the people we serve. **Accountability:** We are reliable, self-responsible owners of the outcomes of our organization. **Teamwork:** We are productive and participative staff members who energize others. **Innovation:** We seek new and creative solutions to deliver quality healthcare. **Nurturing:** We cultivate, develop and educate those with whom we work to achieve their highest potential. **Guidance:** We direct and lead our community members through their healthcare journey and in health improvement.

While great progress has been made, challenges remain. The focus on, and outstanding results in, safety and quality outcomes, and patient, physician and staff satisfaction will continue. New and sustainable sources of revenue are being developed to replace diminishing income from traditional inpatient services. Increased efficiency will continue to be key to our future. New models and sources of revenue must be identified such as regional expansion of selected services (e.g., Home Health), expanded outpatient services, and increased market share of inpatient procedures. In addition, continued increases in philanthropic support and the parcel tax revenue for capital expenditures will ensure our Hospital's success.

Sonoma Valley Hospital is uniquely positioned to succeed in the continually evolving landscape that is health care today and become a model for "The New Community Hospital." The old hospital model, in which the economics of health care was largely based on serving those who are acutely ill, is no longer viable. The "Future" is a hospital model growing from the need to serve the entire community as a place of healing, with a culture of safety and quality and excellent efficiency and financial stewardship. In proactively addressing these priorities, SVH is at the forefront in reimagining the role of the modern community hospital in the 21st century.

Environment Assessment: Trends in Hospital Health Care

Most hospitals in the United States are in the process of transitioning to a different business model. Health reform and increasing government mandates are reducing the utilization of hospital inpatient care in the health care delivery system, and hospitals must move from the model of providing inpatient and outpatient care into a team approach that coordinates care for defined populations. SVH is using a new decision support system to monitor and determine the best approach to these changes. While the role of a primary care hospital in smaller communities is still in question, and the new model is not yet fully formed, we are finding our way. Sonoma Valley Hospital is now breaking even on Medicare and is growing outpatient services, which is the first step to ensure our future.

Tighter integration of providers and hospital networks is required to deliver comprehensive and coordinated care to defined populations, including wellness/prevention, episodic care, management of chronic conditions, mental/behavioral health, and appropriate end-of-life care. This will be critical to ensure sustainable delivery systems, and payment will move toward capitation arrangements based on the wellness, outcomes and the health status of individuals. SVH is unique in that it offers almost the entire continuum of care including Skilled Nursing, Home Health Care and Outpatient Rehabilitation.

The implementation of the Affordable Care Act has stimulated a wide variety of changes: a decrease in the number of uninsured; restrictions on access to some physicians and hospitals (narrow networks); higher out-of-pocket costs for patients who selected certain options; and an increase in the numbers of individuals covered by Medi-Cal. In 2014, SVH experienced a 7% increase in Medi-Cal patients from 11% to 18%. As traditional commercial insurance continues to decrease, hospitals must continue to address the cost structure in order to adjust to the lower reimbursement from government payers.

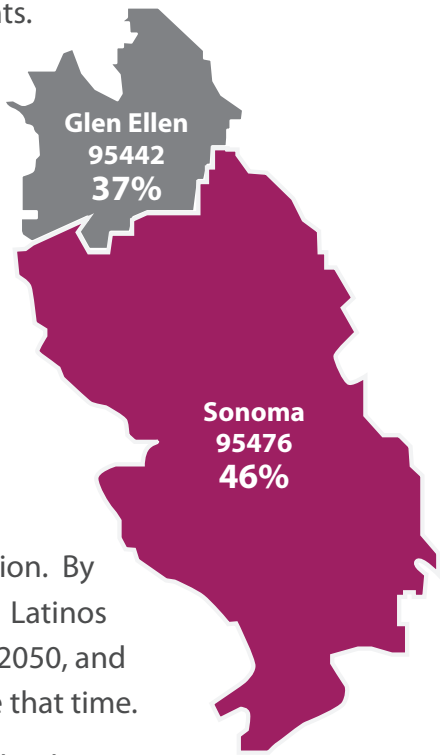
Finally, there is an increased emphasis, including transparency and public scrutiny, on quality, patient safety, and outcomes, as well as advances in information technology, electronic health records, and telemedicine. While positive and necessary, these contribute to rising health care expenditures and must be managed appropriately.

Human behavior (consumer-driven care based on increased involvement and responsibility for their health care and decision-making) and the aging of the population are becoming greater drivers of health care policy. This latter factor is important in the Sonoma Valley where a quarter of the population is over 65.

EVOLVING FROM	→	TO
MD/ HOSPITAL PARALLEL	→	MD/ HOSPITAL COLLABORATION
HOSPITAL- CENTRIC	→	INTEGRATED MANNER
DISEASE- EPISODIC CARE	→	CONTINUUM OF CARE
PAY FOR PROCEDURES	→	PAY FOR VALUE
FEE FOR SERVICE	→	CASE RATES/CAPITATION
INDIVIDUAL ILLNESS CARE	→	POPULATION/MAINTAIN HEALTH
SILO	→	SYSTEM

SVH Situation Analysis

- SVH serves a very small community. The primary service area is the 95476 zip code which includes the city of Sonoma. The secondary service area extends north and includes Glen Ellen, Boyes Hot Springs, Vineburg and El Verano. This area lines up with the SVHCD boundary and has a population of approximately 42,000 residents.



- SVH's service area has a disproportionate share of 50+ residents and is under-represented in younger age categories. Seniors make up a significant portion of the primary and secondary service area, representing one out of every four residents. This is significantly higher than the national average of 14%.

- Consistent with industry trends, SVH is experiencing an increase in Medi-Cal patients as a percent of total volumes. Due to the very low reimbursement for these patients, this is placing great pressure on margins.

- SVH's service area has a large and fast growing Latino population. By 2016, more than 32% of the Valley's population will be Hispanic. Latinos are expected to make up over 50% of California's population by 2050, and that benchmark could be reached in the SVH service area before that time.

- The nationwide patient satisfaction survey system monitored by the Center for Medicare Services uses eight domains to compare hospitals in service excellence. SVH ranks above the 50th percentile in 5 out of 8 of those domains, and often ranks above the 75th percentile. This means the patients rating SVH are happier with our care than with most other hospitals in the nation.

- The inpatient admissions for SVH went from 1,658 in 2010 to 1,168 in FY 2014 due to regulatory changes on how to qualify a patient for admission. This dramatic decrease had a major impact on revenue. The inpatient admissions for FY 2015 seem to have stabilized and are now projected to be over 1,200.

- There are 10 major service areas at SVH. The highest volume/highest margin areas are Outpatient Diagnostics (radiology, lab and cardiopulmonary), Emergency, Outpatient Surgery and Rehabilitation. Our low volume, high margin service is Inpatient Acute Services. Contributing high volume, low margin service include Occupational Health, Special Procedures and Home Health. Although Obstetrics and the Skilled Nursing Facility have low volumes and low margins, the efficiency has improved greatly in FY 2015, and we receive offsetting special supplemental payments because we offer these two services. Every service area has at least a positive direct margin now.

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SVH Situation Analysis *(cont.)*

- The Hospital is still mainly known and valued by the community for our Emergency Services with over 80% market share.

- The Hospital has a good share of the market in Radiology, Laboratory, Outpatient Rehabilitation, Home Health Care, Inpatient Rehabilitation/Skilled Nursing Facility, Medicine and Gynecology. Orthopedics has increased over the past two years. There is still a great opportunity to increase market share in inpatient services and outpatient surgery.

- We continue to monitor Primary Care for demand. We now have physicians covering almost every specialty, with new physicians in ENT, Urology, Orthopedic Spine Surgery and Pain Management. If there is a need for more providers in FY 2015, a mid-level practitioner will be considered to join Prima Medical Foundation.

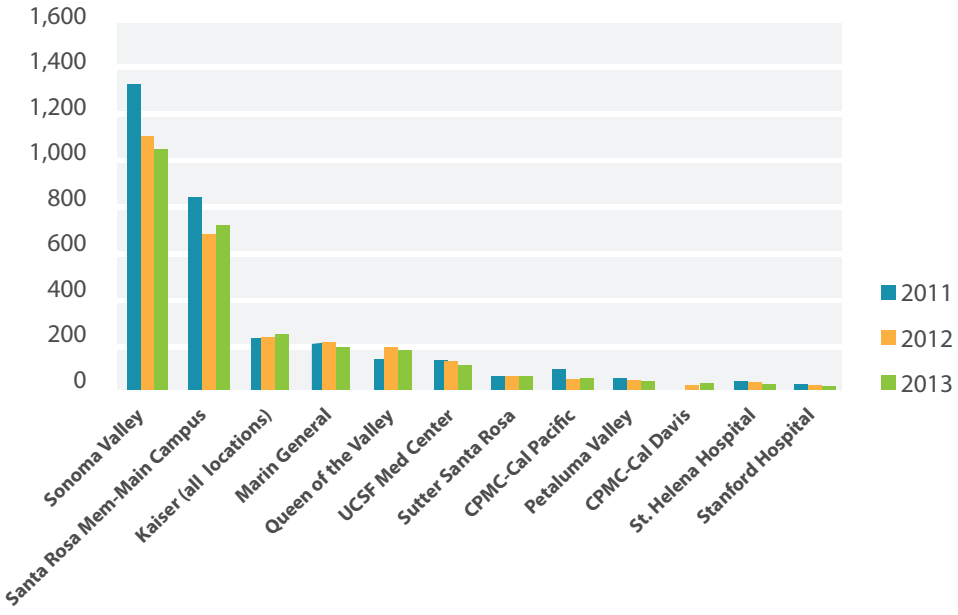
Competitive Assessment

SVH's continued improvement in operational strategy is critical, but it is not a substitute for strategically responding to competition. Many hospitals continue to make the strategic error of becoming more similar to their competition, rather than creating differentiation.

The SVH strategy is to move away from a narrow approach to service lines in order to capture the full continuum of care. Additionally, we are developing a regional strategy in certain services to reduce dependence on the local market. This is important to our future because of our competitive marketplace. SVH sits among 12 hospitals within a 50 mile radius, including three Kaiser facilities.

1. Sonoma Valley
   Total Beds 73
2. Petaluma Valley
   Total Beds 80 - 14 mi. West
3. Queen of the Valley Napa
   Total Beds 181 - 17 mi. East
4. Kaiser Santa Rosa
   Total Beds 173 - 23 mi. Northwest
5. Kaiser San Rafael
   Total Beds 116 - 25 mi. South
6. Santa Rosa Memorial
   Total Beds 256 - 21 mi. Northwest
7. Marin General
   Total Beds 218 - 30 mi. South
8. Novato Hospital (Sutter)
   Total Beds 47 - 20 mi. Southwest
9. UCSF Medical Center
   Total Beds 660 - 43 mi. South
10. Kaiser San Francisco
    Total Beds 236 - 43 mi. South
11. Healdsburg Hospital
    Total Beds 25 - 35 mi. Northwest
12. Sutter Santa Rosa
    Total Beds 120 - 44 mi. Northwest

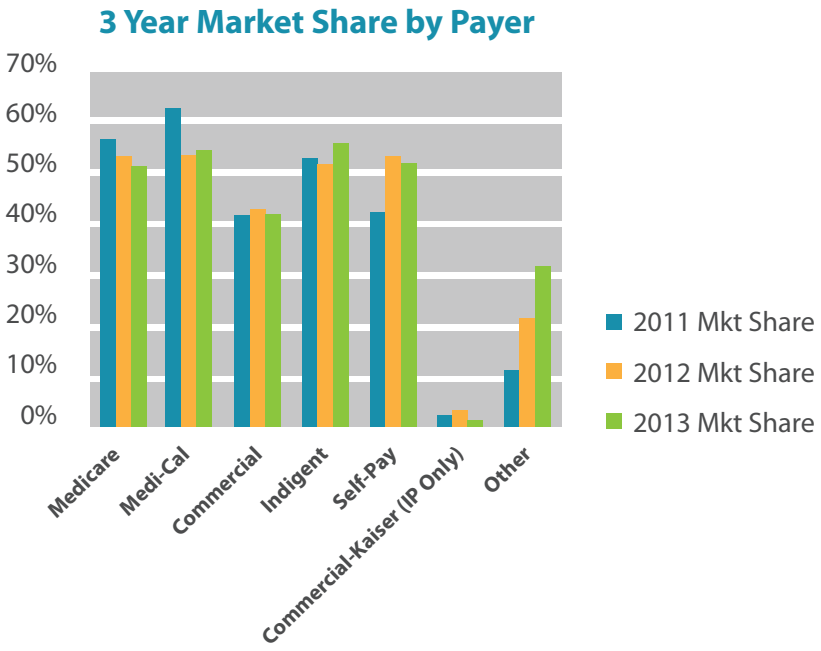
3 Year Market Share by Facility



Sonoma Valley Hospital Inpatient Market Position

Contractual shifting and reduction in governmental reimbursement, accompanied by a shift from inpatient to outpatient services, has resulted in a significant decline in inpatient volumes for all hospitals. In our service area, hospital admissions dropped from 3,436 to 2,871, a decrease of 16.4%. Sonoma Valley Hospital has 49.3% market share excluding Kaiser, and 37.1% market share including Kaiser hospitals. There are 1,096 inpatient admissions which go to other area hospitals with the first being Santa Rosa Memorial, followed by Marin General Hospital, then Queen of the Valley Medical Center, and finally UCSF Medical Center. Acting proactively, SVH is now partnering with these hospitals on health plan and physician alignment.

SVH market share by payer is still relatively high for all payers at above 50%, except for commercial insurance which is 40%. This data is the most recent available and reflects calendar year 2013; therefore the effect of the Affordable Care Act is not visible yet.



Implementation Plan for the Strategic Priorities

Continue to provide the highest levels of safety and quallity health care to Sonoma Valley Hospital patients

	QTR !	QTR2	QTR3	QTR4	FY 2017	FY 2018
Maintain staff satisfaction above 90th percentile through Healthy Culture initiatives	X	X	X	X	X	X
Improve Inpatient satisfaction above 50th percentile with hardwriting & verification	X	X	X	X	X	X
Maintain Emergency patient satisfaction above 75th percentile according to the new HCAHPS	X	X	X	X	X	X
Increase physician engagement through maintaining satisfaction, quality outcome & utilization alignment	X	X	X	X	X	X
Continue to receive national recognition and awards for excellence	X	X	X	X	X	X
Maintain a culture of safety and develop a patient harm score	X	X	X	X	X	X

Improve hospital financial stability

	QTR !	QTR2	QTR3	QTR4	FY 2017	FY 2018
Review physician outreach & loyalty to increase volumes through Cost Accounting initiatives	X	X	X	X	X	X
Maximize savings and margins with performance improvement process	X	X	X	X	X	X
Review and adjust pricing to attract more patients	X					
Increase Orthopedic and General Surgery volumes using CMA approach			X			
Implement a timeshare office for specialists in Sonoma	X					
Consider options for a new Outpatient Service Center			X	X	X	X
Begin the discussion of the parcel tax renewal for vote in 2017			X	X	X	X
Consider new options for the South Lot	X	X				

(continued)

Implementation Plan for the Strategic Priorities *(cont.)*

Anticipate and prepare for continued changes in health care regulations and payment models

	QTR !	QTR2	QTR3	QTR4	FY 2017	FY 2018
Continue to improve Medicare margins and ensure we are ready for regulatory changes	X	X				
Improve the reimbursement and partnership with Medi-Cal providers	X					
Review options to partner with large hospital systems and health plans	X	X	X	X	X	X
Work with physicians to increase alignment and consider new models of integration	X	X				
Study capitation versus other reimbursement options through modeling		X	X			
Complete ICD-10 readiness						
Hardwire use of the EHR to meet meaningful objectives						

Support Sonoma Valley in becoming a healthy community

	QTR !	QTR2	QTR3	QTR4	FY 2017	FY 2018
Continue Population and Community Health Awareness & Education Initiatives	X	X	X	X	X	X
Expand role of SVH Foundation in community engagement		X	X	X	X	X
Complete the Employer Wellness Program Pilot project		X				
Begin Community Care Network		X	X	X		
Implement a Disease Reversal Program			X	X		
Offer Wellness University to the community and complete the Healing Hospital Implementation	X		X		X	X
Provide Advanced Healthcare Planning education						
Complete a Community Opinion Survey						
Work with the SVHF on raising $750,000 or more						

Leading the health care district of Sonoma Valley in becoming and being known as a Healthy Community

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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

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

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

Organizational: Provision of Care-Central Venous Catheter Managment	
APPROVED BY **Leslie Lovejoy, Chief Nursing Officer**	DATE: **3/25/2015**
Director's/Manager's Signature	Printed Name **Leslie Lovejoy, RN, PhD**

Douglas S Campbell, MD
Chair Medicine Committee — Date

Michael Brown, MD
Chair Surgery Committee — Date

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

Kelly Mather
Chief Executive Officer — Date

Sharon Nevins
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**
Revision written by: **Mark Kobe/Bonnie Bernhardy**
Date of Document: **3-25-2015**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational: **X Clinical** **❑ Non-Clinical**	**❑ Departmental** **X Interdepartmental** (list departments effected) All

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

PC8610-266 **Central Venous Access Catheter Management:** Policy revised to update Central Venous Catheter flushing to CDC standards of care, eliminating usage of heparin for flushing. CVCs will be flushed with Normal Saline only.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	3/24/2015 ✓	Yes	
Surgery Committee	4/01/2015 ✓	Yes	
Medicine Committee	4/09/2015 ✓	Yes	
Medical Exec Committee	4/16/2015 ✓	Yes	
Board of Directors	5/07/2015		

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SUBJECT: Central Venous Access Catheter Management	POLICY #PC8610-266
	PAGE 1 OF 1
DEPARTMENT: Organizational	EFFECTIVE: 12/07
APPROVED BY: Chief Nursing Officer	REVIEW/REVISED: 12/07 3/10, 3/15

Policy:
Provide guidelines for the RN to effectively manage a patient with a central venous access catheter.

It is the responsibility of the RN caring for the patient with a central venous access catheter to maintain competency and skill level to provide safe care. The RN is expected to know why the patient has a central venous access catheter and its relevance to the patient's overall plan of care.

It is the responsibility of the MD to evaluate daily continued need of the central venous access catheter.

Procedure:
For general care of the patient with a central venous access catheter, refer to:
Lippincott: http://procedures.lww.com/lnp/procedureselect.do

Flushing Procedure:
Using a 10 ml syringe or larger, central venous access catheters will be flushed with 10 mls of preservative-free normal saline every 12 hours and PRN prior to and after medication administration. Flushing will also be performed prior to and after blood draws. The central venous access catheter will be flushed utilizing the push-pause technique to create turbulence. The catheter will be clamped while maintaining pressure on the syringe plunger and then the syringe will be disconnected.

For central venous access catheter insertion, disinfection of catheter hubs/injection ports and dressing changes, refer to SVH Prevention of Central-line Associated Bloodstream Infections Policy # IC8620-131 (SVH Intranet, Organization Policies, IC)

For PICC Line Insertion, refer to SVH PICC Line Insertion (Peripherally Inserted Central Catheter (PICC) POLICY # PC8610-201 (SVH Intranet, Organization Policies, PC)

For implanted port management refer to Implanted Port Management POLICY # 6010-7 (SVH Intranet, Organization Policies, PC)

Reference:
Lippincott: http://procedures.lww.com/lnp/procedureselect.do

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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

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

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

Organizational: Multiple Policies February List	
APPROVED BY:	DATE: **2/18/15**
Director's/Manager's Signature Leslie Lovejoy	Printed Name **Leslie Lovejoy, RN PhD**

D. Paul Amara, MD
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

SONOMA VALLEY HOSPITAL

Policy Submission Summary Sheet

Title of Document: Organizational-Multiple Departments

Type: **Revision**

February List	
Policy	**Notes**
ECHAZ8610-105 Battery Recycling (new)	new policy
ECHAZ8610-106 Hazardous Substances-Right to Know	retire; Part of ECHAZ8610-100 Haz Material & Waste Manage Plan
EC-SAF8610-120 Safety Committee	revised; minor changes to wording and updated roles
EC-SAF8610-103 Safety Program Action Plan	retire; Culture of Safety program replaces; not CIHQ requirement
EC-SAF8610-105 Summary of Illness and Injury Prevention Program	retire; refer to HR policies
EC-SEC8610-102 Aggressive Behavior Management-Code Grey	revised; added Non-Violent Crisis Training details, updated to current standard
EC-SEC8610-103 Non-Violent Crisis Intervention Training Program	Delete; added into Aggressive Behavior policy
EC-SEC8610-114 Care of Patients Under Legal Restriction	revised; changed to provision of care policy PC8610-360; updated to include Forensic Staff Information Sheet/Attestation
Forensic Staff Information Sheet (Form)	included in Care of Patients Under Legal Restriction
EC-SEC8610-110 Bomb and Telephone Threats Policy	revised; updated to include Bomb Threat information
EC-SEC8610-109 Management Bomb Threat Policy	retire; Combine with EC-SEC8610-110 Telephone Threats
Bomb and Telephone Threat Checklist	revised; updated protocol for PBX call, added Telephone Threat policy information
PC8610-209 AccuCheck Infrom II Glucose Monitoring System	revised; updated cleaning and disinfecting procedures
PC6171-171-Discharging the Newborn	revised; to include CCHD assessment with pulse oximetry
PC6171-185 Newborn Hearing Screen Policy	revised; to include entering data into the Data Management Service (DMS) and reporting NHSP Reports to the California Newborn Hearing Screening Program monthly.
MM8610-150 Vancomycin Protocol	revised; updated to separate from aminoglycoside protocol and include methodology that uses both manual and software based dosing methods
MM8610-153 Remote Pharmacist Services (new policy)	New policy outlining how we use the remote after hours pharmacy service
LD8610-131 Fixed Asset Disposal	reviewed; minor changes

Reviewed By:	**Date**	**Approved (Y N)**
Policy & Procedure Team	**2/17/15**	✓ Yes
Performance Improvement Committee	**2/26/15**	✓ YES
Medical Executive Committee 3/19 – NO	~~**3/19/15**~~	4/16/15 ✓ YES
Board of Directors	~~**3/05/15**~~	5/7/15

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April 9, 2015

The Honorable Ed Hernandez, O.D.
Chair, Senate Health Committee
State Capitol, Room 2080
Sacramento, CA 95814

SUBJECT: SB 483 (Beall) – OPPOSE

Dear Senator Hernandez:

I am writing today on behalf of Sonoma Valley Hospital, which represents approximately 445 employees, to express our opposition to SB 483. This bill would reduce the quality of patient care, place patient safety at risk, cause California hospitals to forego important Medicare reimbursement, impose burdensome reporting requirements, and increase the cost of health care. In addition, SB 483 would:

- Require hospitals to apply for approval from the California Department of Public Health to establish observation beds.
- Require hospitals to convert inpatient beds to outpatient observation beds, reducing the number of inpatient beds and resulting in bed shortages in some parts of the state.
- Require all observation patients to be placed only in observation beds. This requirement would be in direct conflict with the best practice of medicine, where the physician determines — based on patient needs — the appropriate type of bed in which to place a patient. For example, a physician may place a patient with symptoms of a stroke in the intensive care unit for observation, providing the most appropriate setting to monitor the patient.
- Prohibit an observation patient from being in an observation bed for more than 24 hours, which conflicts with high-quality patient care. Only a physician should determine how long a patient should remain in observation, not a one-size-fits-all rule.
- Conflict with the Centers for Medicare & Medicaid Services "two-midnight" rule, which — based on a physician assessment and documentation — allows patients to be placed in observation for a maximum of two midnights.
- Require hospitals to collect and process large volumes of additional data to report to the Office of Statewide Health Planning and Development.

For the reasons listed above, we respectfully ask for your **"NO" vote on SB 483** when it is heard in Committee.

Sincerely,

Kelly Mather
President and Chief Executive Officer

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April 15, 2015

The Honorable Roger Hernandez
Chair, Assembly Labor and Employment Committee
State Capitol, Room 5016
Sacramento, CA 95814

SUBJECT: AB 850 (Ridley-Thomas) – OPPOSE

Dear Assemblymember Hernandez:

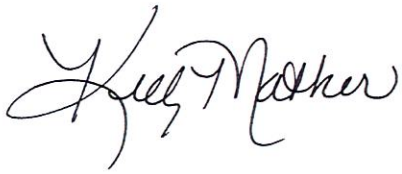
On behalf of Sonoma Valley Hospital, which represents approximately 445 employees, I am writing to express our opposition to AB 850.This bill addresses the employee safety requirements when certain potentially infectious patients are in the hospital. Unfortunately, the requirements proposed in the bill are not based on sound science to reduce infection contagion and could put our patients and employees at risk.

Our organization is opposed to AB 850 because:

- It would change the current Cal/OSHA aerosol transmissible disease regulations, requiring hospitals to provide personal protective equipment (PPE) consisting of a powered air purifying respirator and a full body hazmat suit for all staff who care for a patient under investigation for, or with a confirmed diagnosis of, a virulent aerosol transmissible disease.
- As written, this would apply to patients with risk factors but no symptoms of disease. Given the ambiguous nature of the term "virulent aerosol transmissible disease," this proposal could ultimately apply to an extremely high number of patients who do not have any symptoms of illness.
- The only exemption would be diseases for which there is an FDA-approved vaccine or medicine, such as an antiviral medication that neutralizes the pathogen.
- This is a significant change in the use of PPE for patients with a number of different viruses and diseases, including Ebola and possibly even tuberculosis.
- The bill would exceed current CDC recommendations and require hospitals to change current PPE policies. Therefore, hospitals will have to retrain staff, and California would become an outlier — without any scientific evidence of improved safety to patients or employees.
- The PPE mandated in this bill would be more difficult to use. Many of the materials are stiffer, more difficult to put on and take off. The highest risk of transmission of a virus is when the PPE is doffed, rather than a direct breach of the PPE. Furthermore, the stiffer suits are simply harder to work in, making patient care more difficult.

We respectfully urge your **opposition to AB 850**. This bill is not in line with CDC, science-based guidelines and could risk patient and employee health.

Sincerely,



Kelly Mather
President and Chief Executive Officer

7.

MGH-SVH AFFILIATION AGREEMENT

Meeting Date: May 7, 2014

Prepared by: Kelly Mather

Agenda Item Title: MGH-SVH Affiliation Agreement

Background: In 2011, Sonoma Valley Hospital entered into an agreement with Marin General Hospital for affiliation to work together on a physician strategy, regional strategic planning and payer relations. The current agreement is for $60,000 per year.

Recommendation: After four years of working together, it is clear that the affiliation portion of the agreement has been successful.

Consequences of Negative Action/Alternative Actions: Marin General Hospital agrees that the affiliation agreement is the best solution for our two hospitals to continue to gain benefits from our arrangement. If we do not affiliate with Marin General Hospital, we could lose our connection with Prima Medical Foundation and the shared risk pool with Western Health Advantage. In addition, Marin General Hospital and other larger hospitals are working together on several strategies to continue to be viable in the bay area.

Financial Impact: The previous cost for the management and affiliation agreement was $5,000 per month and this will continue until the end of calendar year 2015. There will be no future cost for this affiliation after January 1, 2016.

Attachment: Affiliation Agreement to follow.

8.

ADVANCED DIRECTIVES

ADVANCED HEALTHCARE DIRECTIVES

presented by Robert Cohen, M.D.,CMO, CMIO
May 7, 2015

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Advance Care Planning Continuum

Age 18

Complete an Advance Directive

C O N V E R S A T I O N

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness *(at any age)*

Complete a POLST Form

Treatment Wishes Honored

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

1331 Garden Highway, Suite 100
Sacramento, CA 95833
www.CoalitionCCC.org

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) choose a particular physician or health care facility, and 3) receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, I want my agent to make health care decisions for me immediately even though I am still able to make them for myself. ____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) **END-OF-LIFE DECISIONS**: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only: _____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):
Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician: _____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name: _____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of _____

On this _____ (date) before me _____,

Notary Public, personally appeared _____(name(s) of signer(s), who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. Seal

Signature of Notary _____

Values Checklist and Guide: My Choices Near the Ending of Life

1. Most important of all to me when thinking about end of life choices are:

___physical comfort ___relief of pain and suffering
___family/friends present ___to die naturally at home, if possible
___maintain my dignity & integrity ___live as long as possible no matter what
___other_____

2. In terms of living through serious illness and the ending of life, I define quality of life as:

___reflecting my values & beliefs ___the ability to direct my life decisions
___recognizing family & friends ___making my own decisions
___having a say about care needs ___maintaining my sense of independence
___able to do things I enjoy doing ___receiving palliative (supportive) care & hospice
___other_____

3. If I could choose where I would be when I am dying, I would want to be:

__ at home __ in the hospital __in the nursing home __other_____

4. What do you think about life-sustaining treatment? This means any medication, medical procedure or device that could be used to keep you alive when you otherwise would naturally die. This would include such things as: Cardiopulmonary resuscitation (CPR), using a breathing machine, using mechanical means to maintain blood pressure and heart rate, antibiotics, getting food or water by medical device (tube feeding), and other invasive treatments. What would you want to have in each situation below?

- If you could recover sufficiently to be comfortable and active? __use __don't use
- If you were near death with a terminal illness? __use __don't use
- If your brain's thinking function were destroyed? __use __don't use
- If you were moderately disabled by dementia e.g. Alzheimer's Disease? __use __don't use

5. What are some of the other things that are important to you?

___ nature of care should not devastate my family __ my religious beliefs and traditions
___ to be pain free and comfortable __ after death care issues
___ my spiritual care and well being __ to be in a comfortable peaceful setting
___ to be returned to my home land after I die, that being_____
___ other_____

6. Which family and friends would help you with your care when you are unable to care for yourself?

7. Do your loved ones know your wishes, values and beliefs about end of life care? __yes __no

8. Have you talked to:

(a) your doctor about these issues? __ yes __ no

(b) your pastor, minister, rabbi, priest or other spiritual leader about these issues? _yes __no

If you are using this as part of your Advance Care Plan please Print Name, Sign and Date below.

Print Name:_____/Sign:_____/Date:_____

Other Things to Consider Concerning My End of Life Wishes

(If you do not do this part now, it is a good idea to think about these things and complete later.)

9. I am a member of an organized church or religion? __yes __no
My specific faith, congregation or spiritual practice
is_____

10. To help attend to my spiritual needs as death approaches, I would call upon:
Name(s):_____Relationship:_____Phone_____
_____

11. When I am dying I would like my surroundings as follows and I would like to have with me these special possessions:

12. As I am near to the end of my life, I would like these people informed:

13. Following my death, I would like to also inform these people:

14. I have written or will write an announcement of death (obituary): ___yes ___no

15. My wishes for after-death care are for __ natural death care __ burial ___cremation

My wishes for memorial activity are as follows:

16. If I have made arrangements, the contact person/phone is_____

17. Other things important for someone to know about me, in the event that I become incapacitated or my death is close at hand?

18. _____ _____
(your signature/date) (optional - witness signature/date)

Please attach additional sheets if needed. When completed, copy and share this with your doctor, family and caregivers and make time for meaningful conversations in the process.
It also is important to properly complete an Advance Health Care Directive (AHCD) and distribute that to people who may need to guide your care if and when you become unable to make your wishes known and honored. When completing the AHCD, we recommend that you attach to your AHCD this completed Values Checklist and Guide (or something similar) and note in AHCD under "Special Instructions:" see Values Checklist attached. Advance Health Care Directive forms are available without charge from physicians, hospitals, social service providers, care homes and others.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Cardiopulmonary Resuscitation (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Medical Interventions: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — Information and Signatures:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Healthcare Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: **M F**

Healthcare Provider Assisting with Form Preparation ☐ N/A if POLST is completed by signing physician		
Name:	Title:	Phone Number:

Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone Number:

Directions for Healthcare Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

9.

FINANCIAL STATEMENTS MARCH 2015

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

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **April 28, 2015**
Subject: **Financial Report for the Month Ending March 31, 2015**

March activity was consistent with the experiences of the prior months. Gross patient revenue was better than budget by $1,436,132. However, there was a significant change in payer mix for the month compared with expectations. Medi-Cal was 18.6% (regular and managed care) of the revenue vs. a budgeted 11.5%. Commercial insurance, which now includes the lower paying Covered California patients, was 18.9% vs. the 24.2% budgeted. The net result was an increase to the contractual allowance expense of $1,583,938. Management is working with the Medi-Cal Managed care HMO to mitigate some of the losses due to their increased volume. Medicare was close to the budgeted 50.7% at 49.5%. The resulting net revenue was off budget by ($147,806).

Expenses were over budget by $94,497. The significant variances were employee benefits ($40,655), professional fees due to a true-up of the hospitalist costs ($21,270), and purchased services, mostly unanticipated IT costs ($70,828).

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for March was ($382,610) vs. a budgeted gain of $27,392. The loss was offset by a Foundation Contribution of $286,913 restricted for the purchase of ultrasound equipment. The total loss after all activity was ($58,801) vs. a budgeted gain of $123,627.

Below is a summary of significant variances for the month of March:

GROSS REVENUE was better than budget Inpatient revenue was favorable to budget by $247,140 and SNF was unfavorable by ($607,523). Outpatient revenue was better than budget by $892,250 and ER revenue was above budget by $885,946. Home Health had a positive budget variance of $18,319.	$ 1,436,132
Deductions from revenue are unfavorable to budget This is due to a significant change in payer mix this month compared to budget. Overall, Medi-Cal was 18.6% of gross revenue vs. a budget of 11.5%. Commercial insurances accounted for 18.9% of gross revenue vs. a budget of 24.2%.	$ (1,583,938)

Risk Contract Revenue was under budget	$ (91,026)	
This is due to zero inpatients from Napa State Hospital in March.		
Other Revenue was under budget	$ (65,619)	
due to the true-up of the E.H.R. Revenue received in January.		
Total Operating Revenue Variance		$ (304,451)
Total Staffing costs were over budget	$ (55,024)	
Productive FTE's were 284 vs. a budget of 278.		
Total FTE's were under budget by 2. The overage was due to a new Pharmacist being trained and registry from February of $19,300.		
Employee benefits were over budget	$ (40,655)	
primarily due to a required increase in the accrual of		
the State Unemployment insurance reserve of ($25,000).		
Professional fees were over budget	$ (21,270)	
due to a true-up of hospitalists costs from per contract.		
Purchased Services were over budget	$ (70,828)	
primarily due to unbudgeted IT costs ($56,181)		
All Other Operating Expenses were under budget	$ 93,280	
Total Expense Variance		$ (94,497)
Total Operating Margin Variance		$ (398,948)
Non-Operating Income was unfavorable to budget	$ (11,054)	
Capital Campaign and Restricted Contributions was favorable to budget	$ 203,163	
Net Variance		$ (206,839)

The net loss was ($93,197) vs. a budgeted net income of $113,642. After accounting for GO bond activity (which interest cost were better than budget by $22,326) the aggregated net loss was ($58,801) vs. a budgeted net income of $123,627.

Patient Volumes – March

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	113	113	0	117
Newborn Discharges	16	16	0	19
Acute Patient Days	401	418	-17	407
SNF Patient Days	669	712	-43	750
Home Care Visits	1,232	1,160	72	1,106
OP Gross Revenue	11,839	10,043	1,797	9,999
Surgical Cases	137	156	-19	156

Overall Payer Mix – March

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	49.5%	50.7%	-1.2%	47.4%	50.3%	-2.9%
Medi-Cal	18.6%	11.5%	7.1%	18.2%	11.4%	6.9%
Self Pay	1.2%	3.3%	-2.1%	1.6%	3.4%	-1.8%
Commercial	18.9%	24.2%	-5.3%	20.9%	24.5%	-3.6%
Managed MCR	7.0%	4.3%	2.8%	5.6%	4.4%	1.2%
Workers Comp	2.2%	3.1%	-1.0%	3.3%	3.2%	0.1%
Capitated	2.6%	2.9%	-0.3%	3.0%	2.8%	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 $3,249,826 and the Hospital collected $3,699,606 or over the goal by $449,780. The Year to date cash goal is $31,554,303 and the Hospital has collected $31,602,561 or over the goal by $48,259. The cash collection goal is based upon net hospital revenue from 90 days ago. Days of cash on hand are 15 days at March 31, 2015. Accounts Receivable decreased from February, from 50.2 days up to 47.3 days in March. Accounts Payable is up by $450,338 from February, of which $361,717 is attributable to the GE Ultrasound invoice posted and will be paid in April with the donation received from the Foundation. Accounts Payable days are at 49.0. Total Accounts Payable at the beginning of the fiscal year was $5,893,464 and at the end of March Accounts Payable is $3,708,759.

Year to Date:

The Hospital's YTD EBIDA is 5.4%. Our YTD expenses are over budget by ($1,435,887). This amount includes $120,000 of prior year expenses, the IGT program fee of $573,406, and $742,000 in operating expenses. Significant variances included in the $742,000 are attributable to inaccurate forecasting in anesthesia, Prima, utilities, hospitalists, lab, and IT services. Most of the operating expense variances were recognized in the first four months of the fiscal year.

Sonoma Valley Hospital
Sonoma Valley Health Care District
March 31, 2015 Financial Report

Finance Committee
April 28, 2015

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

Patient Volumes
Month of March 31, 2015

	Actual	Budget	Variance	Prior Year
Acute Discharges	113	113	0	117
Newborn Discharges	16	16	0	19
Acute Patient Days	401	418	-17	407
SNF Patient Days	669	712	-43	750
Home Care Visits	1,232	1,160	72	1,106
OP Gross Revenue	11,839	10,043	1,797	9,999

Summary Statement of Revenues and Expenses Month of March 31, 2015

	Actual	Budget	Variance	Percentage	Prior Year
1Total Operating Revenue	$ 4,184,340	$ 4,488,791	$ (304,451)	-7%	$ 5,547,231
2Total Operating Expenses	$ 4,782,662	$ 4,688,165	$ (94,497)	-2%	$ 5,005,960
3Operating Margin	$ (598,322)	$ (199,374)	$ (398,948)	-200%	$ 541,271
4NonOperating Rev/Exp	$ 215,712	$ 226,766	$ (11,054)	-5%	$ (268,444)
5Net Income before Rest.Cont. & GO Bond	$ (382,610)	$ 27,392	$ (410,002)	-1497%	$ 272,827
6Restricted Contribution	$ 289,413	$ 86,250	$ 203,163	236%	$ 56,417
7Net Income with Restricted Contributions	$ (93,197)	$ 113,642	$ (206,839)	-182%	$ 329,244
8Total GO Bond Rev/Exp	$ 34,396	$ 9,985	$ 24,411	244%	$ 71,825
9Net Income with GO Bond	$ (58,801)	$ 123,627	$ (182,428)	-148%	$ 401,069
10EBIDA before Restricted Contributions	$ (63,716)	$ 385,269	$ (448,985)		$ 1,556,218
11EBIDA before Restricted Cont. %	-2%	9%	-11%		28%

Operating Expenses
Month of March 31, 2015

		Actual	Budget	Variance	Percentage	Prior Year
	OPERATING EXPENSES					
1	Salary and Wages and Agency	$ 2,214,239	$ 2,159,215	$ (55,024)	-3%	$ 2,178,672
2	Employee Benefits	$ 806,935	$ 766,280	$ (40,655)	-5%	$ 760,936
3	Total People Cost	$ 3,021,174	$ 2,925,495	$ (95,679)	-3%	$ 2,939,608
4	Medical and Prof Fees (excld Agency)	$ 353,693	$ 332,423	$ (21,270)	-6%	$ 420,799
5	Supplies	$ 456,890	$ 495,635	$ 38,745	8%	$ 563,595
6	Purchased Services	$ 397,830	$ 327,002	$ (70,828)	-22%	$ 505,698
7	Depreciation	$ 282,296	$ 272,198	$ (10,098)	-4%	$ 248,464
8	Utilities	$ 76,184	$ 80,567	$ 4,383	5%	$ 89,720
9	Insurance	$ 19,298	$ 20,000	$ 702	4%	$ 18,888
10	Interest	$ 36,598	$ 85,679	$ 49,081	57%	$ 99,041
11	Other	$ 138,699	$ 149,166	$ 10,467	7%	$ 120,147
12	TOTAL OPERATING EXPENSE	$ 4,782,662	$ 4,688,165	$ (94,497)	-2%	$ 5,005,960

Sonoma Valley Health Care District
Balance Sheet
As of March 31, 2015

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 2,177,242	$ 1,739,015	$ 1,255,535
2	Trustee Funds	1,825,643	1,825,643	762,010
3	Net Patient Receivables	7,061,014	7,344,678	7,888,038
4	Allow Uncollect Accts	(620,633)	(599,908)	(1,740,680)
5	Net A/R	6,440,382	6,744,770	6,147,358
6	Other Accts/Notes Rec	3,932,731	3,991,709	2,980,819
7	3rd Party Receivables, Net	1,587,264	1,593,172	1,937,910
8	Due Frm Restrict Funds	-	-	-
9	Inventory	748,486	747,898	743,867
10	Prepaid Expenses	888,146	870,127	909,717
11	Total Current Assets	$ 17,599,894	$ 17,512,333	$ 14,737,216
12	Board Designated Assets	$ -	$ -	$ 5,399
13	Property,Plant & Equip, Net	55,341,279	55,611,181	20,667,608
14	Hospital Renewal Program	-	-	31,801,877
15	Unexpended Hospital Renewal Funds	-	-	4,024,455
16	Investments	-	-	-
17	Specific Funds	403,430	43,942	(3,459,216)
18	Other Assets	143,164	143,164	436,558
19	Total Assets	$ 73,487,766	$ 73,310,619	$ 68,213,897
	Liabilities & Fund Balances			
	Current Liabilities:			
20	Accounts Payable	$ 3,708,759	$ 3,258,421	$ 4,471,747
21	Accrued Compensation	4,145,169	3,808,448	3,892,725
22	Interest Payable	235,858	117,929	285,340
23	Accrued Expenses	1,041,494	1,377,813	1,261,871
24	Advances From 3rd Parties	668,079	501,283	(191,739)
25	Deferred Tax Revenue	2,229,055	2,631,380	1,317,172
26	Current Maturities-LTD	1,658,687	1,709,727	910,496
27	Line of Credit - Union Bank	6,273,734	6,273,734	3,973,734
28	Other Liabilities	144,549	144,549	230,806
29	Total Current Liabilities	$ 20,105,384	$ 19,823,284	$ 16,152,152
30	Long Term Debt, net current portion	$ 39,387,264	$ 39,433,416	$ 37,707,628
31	Fund Balances:			
32	Unrestricted	$ 12,092,301	$ 12,440,516	$ 13,229,305
33	Restricted	1,902,816	1,613,403	1,124,812
34	Total Fund Balances	$ 13,995,117	$ 14,053,919	$ 14,354,117
35	Total Liabilities & Fund Balances	$ 73,487,766	$ 73,310,619	$ 68,213,897

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended March 2015

		Month				Year-To- Date				YTD
		This Year		Variance		This Year		Variance		
		Actual	Budget	$	%	Actual	Budget	$	%	Prior Year
	Volume Information									
1	Acute Discharges	113	113	-	0%	925	956	(31)	-3%	883
2	SNF Days	669	712	(43)	-6%	5,568	5,598	(30)	-1%	5,672
3	Home Care Visits	1,232	1,160	72	6%	10,316	9,014	1,302	14%	8,054
4	Gross O/P Revenue (000's)	11,839	10,043	1,797	18%	$ 99,747	$ 88,507	11,240	13%	$ 85,126
	Financial Results									
	Gross Patient Revenue									
5	Inpatient	$ 6,222,894	$ 5,975,754	247,140	4%	$ 47,204,732	$ 50,454,012	(3,249,280)	-6%	$ 45,787,838
6	Outpatient	7,395,239	6,502,989	892,250	14%	59,609,379	56,834,014	2,775,365	5%	54,655,471
7	Emergency	4,071,288	3,185,342	885,946	28%	36,963,730	28,909,416	8,054,314	28%	27,991,214
8	SNF	2,172,164	2,779,687	(607,523)	-22%	18,782,816	22,558,074	(3,775,258)	-17%	21,711,187
9	Home Care	372,892	354,573	18,319	5%	3,173,456	2,763,076	410,380	15%	2,479,153
10	Total Gross Patient Revenue	$ 20,234,477	$ 18,798,345	1,436,132	8%	$ 165,734,114	$ 161,518,592	4,215,522	3%	$ 152,624,864
	Deductions from Revenue									
11	Contractual Discounts	$ (16,150,395)	$ (14,471,294)	(1,679,101)	-12%	$ (129,813,096)	$ (124,518,939)	(5,294,157)	-4%	$ (118,223,441)
12	Bad Debt	(100,000)	(174,924)	74,924	43%	(965,000)	(1,502,978)	537,978	36%	(1,808,255)
13	Charity Care Provision	(6,000)	(26,239)	20,239	77%	(161,100)	(225,448)	64,348	29%	(195,250)
14	Prior Period Adjustments	-	-	-	0%	1,325,255	-	1,325,255	0%	2,107,929
15	Total Deductions from Revenue	$ (16,256,395)	$ (14,672,457)	(1,583,938)	11%	$ (129,613,941)	$ (126,247,365)	(3,366,576)	3%	$ (118,119,017)
16	Net Patient Service Revenue	$ 3,978,082	$ 4,125,888	(147,806)	-4%	$ 36,120,173	$ 35,271,227	848,946	2%	$ 34,505,847
17	Risk contract revenue	$ 197,226	$ 288,252	(91,026)	-32%	$ 2,199,483	$ 2,594,268	(394,785)	-15%	$ 2,615,222
18	Net Hospital Revenue	$ 4,175,308	$ 4,414,140	(238,832)	-5%	$ 38,319,656	$ 37,865,495	454,161	1%	$ 37,121,068
19	Other Op Rev & Electronic Health Records	$ 9,032	$ 74,651	(65,619)	88%	$ 491,728	$ 671,859	(180,131)	-27%	$ 1,129,387
20	Total Operating Revenue	$ 4,184,340	$ 4,488,791	(304,451)	-7%	$ 38,811,384	$ 38,537,354	274,030	1%	$ 38,250,455
	Operating Expenses									
21	Salary and Wages and Agency Fees	$ 2,214,239	$ 2,159,215	(55,024)	-3%	$ 18,251,795	$ 17,963,499	(288,296)	-2%	$ 17,970,406
22	Employee Benefits	806,935	$ 766,280	(40,655)	-5%	7,010,563	6,831,151	(179,412)	-3%	6,607,326
23	Total People Cost	$ 3,021,174	$ 2,925,495	(95,679)	-3%	$ 25,262,358	$ 24,794,650	(467,708)	-2%	$ 24,577,732
24	Med and Prof Fees (excld Agency)	$ 353,693	$ 332,423	(21,270)	-6%	$ 3,163,018	$ 2,901,785	(261,233)	-9%	$ 3,893,893
25	Supplies	456,890	495,635	38,745	8%	4,380,390	4,289,438	(90,952)	-2%	4,544,513
26	Purchased Services	397,830	327,002	(70,828)	-22%	3,112,549	2,784,931	(327,618)	-12%	3,682,715
27	Depreciation	282,296	272,198	(10,098)	-4%	2,587,680	2,449,782	(137,898)	-6%	1,531,711
28	Utilities	76,184	80,567	4,383	5%	829,889	725,103	(104,786)	-14%	719,280
29	Insurance	19,298	20,000	702	4%	173,338	180,000	6,662	4%	169,988
30	Interest	36,598	85,679	49,081	57%	388,197	771,111	382,914	50%	298,619
31	Other	138,699	149,166	10,467	7%	1,840,289	1,405,022	(435,267)	-31%	1,514,806
32	Operating expenses	$ 4,782,662	$ 4,688,165	(94,497)	-2%	$ 41,737,709	$ 40,301,822	(1,435,887)	-4%	$ 40,933,257
33	Operating Margin	$ (598,322)	$ (199,374)	(398,948)	-200%	$ (2,926,326)	$ (1,764,468)	(1,161,858)	-66%	$ (2,682,802)
	Non Operating Rev and Expense									
34	Miscellaneous Revenue	$ 1,484	$ 933	551	59%	$ 87,783	$ 8,397	79,386	*	$ (142,784)
35	Donations	1,728	10,000	(8,272)	-83%	48,587	90,000	(41,413)	46%	3,374
36	Physician Practice Support-Prima	(37,500)	(34,167)	(3,333)	10%	(337,500)	(307,503)	(29,997)	10%	(521,723)
37	Parcel Tax Assessment Rev	250,000	250,000	-	0%	2,250,000	2,250,000	-	0%	2,136,135
38	Total Non-Operating Rev/Exp	$ 215,712	$ 226,766	(11,054)	-5%	$ 2,048,871	$ 2,040,894	7,977	0%	$ 1,475,002
39	Net Income / (Loss) prior to Restricted Contributions	$ (382,610)	$ 27,392	(410,002)	-1497%	$ (877,455)	$ 276,426	(1,153,881)	-417%	$ (1,207,800)
40	Capital Campaign Contribution	$ 2,500	$ 86,250	(83,750)	-97%	$ 608,782	$ 776,250	(167,468)	-22%	$ 3,706,098
41	Restricted Foundation Contributions	$ 286,913	$ -	286,913	0%	$ 395,489	$ -	395,489	100%	$ -
42	Net Income / (Loss) w/ Restricted Contributions	$ (93,197)	$ 113,642	(206,839)	-182%	$ 126,817	$ 1,052,676	(925,859)	-88%	$ 2,498,298
43	GO Bond Tax Assessment Rev	152,326	150,241	2,085	1%	1,372,622	1,352,169	20,453	2%	1,370,931
44	GO Bond Interest	(117,930)	(140,256)	22,326	-16%	(1,124,949)	(1,262,317)	137,368	-11%	(375,039)
45	Net Income/(Loss) w GO Bond Activity	$ (58,801)	$ 123,627	(182,428)	148%	$ 374,490	$ 1,142,528	(768,038)	67%	$ 3,494,190
	EBIDA	$ (63,716)	$ 385,269			$ 2,098,423	$ 3,497,319			$ 622,530
		-1.5%	8.6%			5.4%	9.1%			1.6%

10.

CEO ADMINISTRATIVE REPORT MAY 2015

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

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **4/29/15**
Subject: **Administrative Report**

Financial Summary

We are now 9 months into Fiscal Year 2015 and while we are still behind the budget, we have a positive EBIDA of $2,098,423. March and April volumes have been very erratic at both high and low for many areas. We have a few supplemental payments coming in that should also help us end the year much better than last year.

Dashboard Results

The great news is that inpatient satisfaction is back up and we have met the goal for ten out of twelve months. Staff satisfaction action plans are underway and many have been celebrating their high staff engagement scores with their teams. We have also provided over 1200 hours of community service.

Strategic Update

As we move into following our new strategic plan, I wanted to review the results from 2015's plan:

1) Re-design a Small Community Hospital for Viability:
   - Implement and leverage the new cost accounting system to improve revenues
   - Increased high margin surgeries, outpatient and emergency revenues.
   - Negotiated better reimbursements with most health plans, especially Partnership.
   - Optimized the Skilled Nursing Facility for a direct margin.
   - Completed the expansion of home care to Marin County
   - We did not achieve the goals of increasing SNF referrals
2) Inspire Sonoma Employers to Offer Health Plans that use SVH & our affiliated Physicians:
   - Create and launched an Employer Wellness program
   - Promote partner health plans to employers
   - We decided not to take risk in capitation pools, but instead joined larger hospitals
3) Facility and Technology Improvements to be a State of the Art Hospital
   - Purchased several new pieces of imaging equipment
   - Refurbish the 3rd floor for Cancer Support Sonoma and Pelvic Health services
   - Completed stage 2 meaningful use
   - Physician Electronic Health Record connections
   - We did not have the funding to further enhance the I.T. infrastructure
   - We are not launching a capital campaign for the Outpatient Services Center
4) Build a Healing Hospital and A Healthier Community
   - Healing Hospital implementation and preview as a best practice to other hospitals
   - Implement Health Awareness Programs with Compass, Girltalk and Education classes
   - Offered Wellness University to Health Round Table partners
   - We did not expand the Wellness program to family members

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

MARCH DASHBOARD

PILLAR	PERFORMANCE GOAL	METRIC	ACTUAL RESULT	GOAL LEVEL
Service Excellence	Highly satisfied Inpatients	Maintain at least 5 out of 8 HCAHPS domain results above the 50th percentile	6 out of 8 in February	>7 = 5 (stretch) 6 = 4 5 = 3 (Goal) 4 = 2 <4=1
Service Excellence	Highly satisfied Emergency Patients	Maintain a year to date average of at least 75th percentile	81st (rolling three month average)	>85th = 5 (stretch) >80th=4 >75th =3 (Goal) <75th = 2 <70th= 1
Quality	Excellent Clinical Outcomes	Value Based Purchasing Clinical Score at 68 or higher	52	>72 = 5 (stretch) >70 =4 >68 =3 (Goal) >66=2 <66 =1
People	Highly Engaged and Satisfied Staff	Press Ganey percentile ranking of 75th percentile or higher	79.6% mean score at 91st percentile	>80th = 5 (stretch) >77th=4 >75th=3 (Goal) >72nd=2 <70th =1
Finance	Financial Viability	YTD EBIDA	5.4%	>10% (stretch) >9%=4 >8% (Goal) >7%=2 <7%=1
	Efficiency and Financial Management	FY 2014 Budgeted Expenses (excluding IGT)	$41,737,709 (actual) $40,301,822 (budget)	<2% =5 (stretch) <1% = 4 <Budget=3 (Goal) >1% =2 >2% = 1
Growth	Surgical Cases	Increase surgeries by 2% over prior year	1181 YTD FY2015 1183 YTD FY2014	>3% = 5 >2% = 4 >1% = 3 (Goal)
	Outpatient & Emergency Volumes	2% increase (gross outpatient revenue over prior year)	$96.6 mm YTD $82.6 mm prior year	>5% = 5 (stretch) >3% = 4 >2% = 3 (Goal) <2% = 2
Community	Community Benefit Hours	Hours of time spent on community benefit activities per year	1298 hours for 8 months	>1500 = 5 >1200 = 4 >1000 = 3 >750 = 2 >500 = 1

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FY 2015 TRENDED RESULTS

MEASUREMENT	Goal FY 2015	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2014	May 2014	Jun 2014
Inpatient Satisfaction	5/8	5	6	5	6	4	5	3	6				
Emergency Satisfaction	>75th	79	79	80	76	78	81	82	81				
Value Based Purchasing Clinical Score	>68	68	71	70	70.88	69	68	78	78	52			
Staff Satisfaction	>75th	76	76	76	76	76	76	76	91	91			
FY YTD Turnover	<10%	1.6	1.9	2.6	3.6	4.6	4.9	5.5	6.5	7.4			
YTD EBIDA	>8%	7	7	4.9	7.3	6.5	6.7	6.9	6.2	5.4	9	4	3
Net Operating Revenue	>4.1m	4.26	4.6	3.8	4.7	4.0	4.1	4.4	4.6	4.1	3.9	3.9	4.9
Expense Management	<4.5m	4.6	4.7	4.4	4.6	4.4	4.3	4.6	5.0	4.7	4.4	4.4	4.8
Net Income	>75	-8	35	-381	304	67	-1	29	-211	-382	-360	**-240**	567
Days Cash on Hand	>15	14	12	14	11	10	13	17	12	15	17	8	7
A/R Days	<50	47	45	48	51	51	49	53	48	47	55	46	48
Total FTE's	<301	309	305	303	304	303	300	299	303	310	320	309	303
FTEs/AOB	<4.0	3.92	3.77	3.49	4.01	4.1	4.12	4.12	3.46	3.79	3.86	3.89	3.74
Inpatient Discharges	>100	105	104	87	107	96	111	104	98	113	94	100	91
Outpatient Revenue	>$10m	10.8	10.4	11.1	11.7	10.9	10.1	11.8	10.5	11.8	9.91	10.2	10.1
Surgeries	>130	135	133	122	155	118	117	129	136	137	147	142	121
Home Health	>1000	1146	1109	1111	1319	**1090**	1103	1097	1109	1232	1218	1135	992
Births	>15	16	9	21	13	16	18	11	11	16	6	16	11
SNF days	>660	651	687	597	527	580	596	654	607	669	674	605	613
MRI	>120	132	139	143	221	116	100	108	116	157	103	118	124
Cardiology (Echos)	>70	49	53	62	67	66	67	62	56	67	62	61	57
Laboratory	>12.5	12.6	12.8	13.0	13.0	11.5	11.4	12.5	11.5	12.1	12.4	13.1	13.9
Radiology	>850	968	988	900	1047	856	890	1111	1053	1156	868	918	888
Rehab	>2587	3030	2859	2468	3028	2634	3010	2478	2751	3113	3394	2877	2945
CT	>300	376	345	323	368	295	316	392	309	347	301	332	335
ER	>800	889	868	851	863	761	824	988	845	769	788	**909**	716
Mammography	>475	414	417	433	605	462	339	487	444	466	404	519	429
Ultrasound	>325	348	361	367	372	238	299	309	317	357	424	497	339
Occupational Health	>575	656	678	758	739	602	648	653	588	679	595	600	618

11.

COMMITTEE REPORTS

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UPDATED BOARD MEETING CALENDARED ITEMS 2015

January
- Board Member Committee Assignments

February
- Strategic Plan Update
- SVH Foundation Annual Report
- Information Technology Update

March
- Human Resources Annual Report
- Budget Assumptions

April
- Community Input for Strategic Plan
- Marketing Annual Report

May
- Three Year Strategic Plan (Mather)
- Draft FY 2016 Budget (Jensen)

June
- Operating Budget – 2015-16 (Jensen)
- Affiliation Agreement Annual Review (Mather)

July
- Capital Budget – 2016-2018 (Jensen)

August
- CEO Incentive Compensation Goals (Hirsch)

September
- Annual Nursing Report (Kobe)
- CEO Performance Evaluation (Hirsch)

October
- CEO Compensation (Hirsch)
- Strategic Plan Update (Mather)

November
- Audited Financial Statements (Jensen)
- 2014 – 2015 Annual Report (Mather)

December
- Election of District Officers (Nevins)

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UPDATED BOARD MEETING EDUCATIONAL TOPICS 2015

February Agenda
- Board Involvement in Quality Oversight

March Agenda

April Agenda
- Analysis of Service Lines by Market, Margin and Volume **AKA** Marketing Annual Report (Kenney)

May Agenda
- Advanced Directives (Cohen)

June Agenda
- Cancer Care (Koppel)

July Agenda
- Palliative Care (Lovejoy)

August Agenda
- Medicare Breakdown (Donaldson)
- Analysis of Capitation vs. Fee-for-Service Reimbursement (Jensen)

Proposed Issues for Future Board Meetings
- CHA/Hospital Council Update
- Geriatric Care
- Population Health (proposed)

Revised 4.23.15

Quality Assurance/Performance Improvement
Program Review 2014

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Findings

In 2014, the hospital had its first accreditation survey by the Center for Improvement in Healthcare Quality (CIHQ) which it successfully completed. Home Care successfully completed their state survey as did the Skilled Nursing Facility. Any and all deficiencies identified through these surveys have been resolved and added to departmental quality control monitoring. Over the past year there was a great deal of improvement in the development of a performance improvement infrastructure and department specific performance improvement such that each department identified the complexity of work flow processes and opportunities to improve based on some form of prioritization process, including considerations of risk, volume and problem proneness. The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified four projects: completion of Meaningful Use Stage 2; Skilled Nursing Performance Improvement Project; Functional Units of Service Cost Accounting Project; initiation of the ICD-10 Implementation Project. Three of the four projects were successfully implemented and have moved to continuing performance monitoring and refinement. Each of the prioritized projects aligned with both our strategic plan and with the hospital's overarching mission, vision and values.

This year, there was an increased use of the PDSA as Leaders have become more confident in the process and the expectations have been set that all projects will be reported using this process. Departmental quality monitoring and reporting has become uniform with the exception of those departments seeing changes in leadership this year. There is now an on-boarding process to help new leaders get up to speed and the organization held its first annual Performance Improvement Fair to continue to improve the organization's use of

performance improvement tools and to move towards data driven decision making. In addition, the implementation of a powerful and user friendly database tool that interfaces with Paragon and Midas Care Management and allows for sharing of data between departments such as finance and case management, has begun to break down silos and improve data sharing. We had thought to add a software tool that provides statistical process control analysis of data to enhance decision making around quality data. This was put on hold until this year.

There continue to be opportunities in the areas of: determining outcome measures continued monitoring once change has been implemented; leadership education regarding QAPI standards, and project development.

The organization clarified roles and responsibilities regarding project development and created a tracking process and a Project Review Team to coordinate projects of all scopes. The Project Review Team provides reports of new projects to the Administrative team where decisions are made regarding the availability of resources, including capital, and the project's alignment with the strategic initiatives and the hospital's mission. In an effort to more effectively manage all organizational projects, The Project Team and the IT Steering Committee aligned their projects into categories of: Quality Project only; IT Project only; and Combined Projects. As technology and the electronic health record have taken more of a center stage in continuous quality improvement, the IT Steering Committee has adjusted its focus and developed a subcommittee structure that includes non-clinical technology projects in one subcommittee and Clinical Informatics as the other. We are working on bring frontline staff into each of these committees and creating a charter for each. This will be more formalized in 2015.

Interdisciplinary collaboration was demonstrated through the Sorry Works process, Culture of Safety Program; Project Review Team, IT Steering Committee, Utilization Review Program; Pharmacy and Therapeutics Committee; Grievance Committee; departmental and cross departmental performance improvement projects and organization-wide performance improvement. Increasing the meetings of the Medical Staff Performance Improvement Committee and the further development of the Board Quality Committee allowed for more consistent and coordinated reporting of projects and mandated activities. The development and posting on the SVH website of the Board Quality Dashboard and Quality Scorecard by common medical conditions has increased public awareness of hospital performance.

The Performance Improvement Program does support the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety.

Assessment of Performance

The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. *Performance Improvement Infrastructure*

Performance Goal	Outcome
Annual Performance Improvement Fair: 95% of all leaders participate with effective PDSA Storyboard	95% of all leaders participated
Integration of survey deficiency citations into quality monitoring reports for 100% of citations by department	90%; still need some work here
Implement STATIT and train on statistical process control	On hold until January 2015
85% of all appropriate leaders now able to work on E-Notifications on Midas	71%; new leaders at end of year. Anticipate completion of training by end of 1st Q 2015
100% electronic submission of all QC reports to the shared drive; department files	75%; will monitor more closely in 2015
Implementation of Medical Staff QAPI and UR dashboards	Completed and full reporting in 2014
Re-establish Grievance Committee and reporting process	Completed; built reporting into Midas and reports are generated; committee meets regularly to review/discuss
.Project Management System Development	In process

II. *Performance Improvement, in addition to the prioritized organizational projects, efforts in 2014 focused on*:

Performance Initiative	Outcome
Improve Patient Satisfaction: move to 50th percentile rank for Inpatient HCAHPS for 5 of 8 domains	Changed vendors in September 2014; 4Q 2014: 5 of 8 at 50th percentile rank
Improve Patient Satisfaction: Emergency Department: 5 of 8 at 50th percentile rank	Changed Vendors in September 2014; 4Q 2014: 4 of 7 at 50th percentile rank
Employee Engagement Survey 2014 Goals: 80% Participation 75% Partnership Score	2014 Results: 76% Participation 76% Partnership Score 77th Percentile Rank
Organizational and Departmental policies & Procedures Updated and through committees 95% Organizational current 95% Departmental manuals current	• 97% of organizational P/Ps are current 393/406 • 23/28 departmental manuals are current 82%; currently working with department leaders
Surgical Services Transformation Project • Reduce Expenses by 10% • Increase fiscal year volume by 2% (total cases = 1619) • Reduce Supply Inventory by using PAR Levels • Move into New Wing: consolidate ACU & PACU	• Reduced by 6% YTD: expect to meet target by FY end • Fiscal year to date (2/15) Volume: 1317 • Par level established, supplies on budget • Completed; reduced FTE by 2 • Completed in March 2015

• Improve Scheduling & Preop process	
Culture of Safety Assessment • Improve by 5% over 2013 dimension scores • Meet or exceed AHRQ national benchmarks	• 6% improvement from 2013; opportunities to improve identified and education provided to leaders to coach staff. • 100% meet or exceed benchmark
Skilled Nursing PI Project • Reverse negative margin to positive contribution margin while maintaining high quality care • Reduce pharmacy costs • Decrease overutilization of lab, imaging and RT services • Improve financial counseling & billing	Decreased drug utilization by 23K; increased capture of RUG levels for therapy; timely and accurate billing; improved care coordination among physicians and decreased lab test over utilization by 60K; margin moved from -11% to a steady +2%-+8% depending on volume.
Outpatient Services: Primary Source Verification of non-medical Staff providers • Create workflow process & educate registration • Primary source verify licenses for current data base • Monthly review and updating of expireables	• Initial training page provided to registration clerks • 100% of 3,246 providers verification completed • 100%monthly review of current providers and updating of database through March 1 • Have identified some additional training needs and will work with team to refine process this year.
Development of an Emergency Department Transfer Record	Added EDIS program in the emergency department which allows for an ED transfer record to be generated. Completed.
Medical Staff Credentialing Process Project • Creation of workflow process • 100% primary sourced and fully complete credentialing and application documentation prior to privileging • Improve timeliness of credentialing/privileging as measured by # of expedited (Expedited = less than 5/yr)	• Completed • 100% • 3 expedited in CY 2014
Improved and standardized Brose low Pediatric Emergency Carts	100% of all crash carts are standardized
Improve Quality Outcomes, Utilization and Readmissions Prevention	Quality Core measures meet national benchmarks, with exception of flu vaccination documentation, there has been improved medical necessity documentation; and our readmission rate is below national and state benchmarks.

III. Accomplishments/Recognition

Skilled Nursing Facility	Silver Award for Quality
Healing at Home	Home Care Elite Award for quality outcomes

"A Grade"	Leapfrog Group
Listed the 11th Safest Hospital in US	Consumer Reports

Assessment of Effectiveness

The Performance Improvement Program is meeting the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2015 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2015 include the following:
   - Completion of the ICD-10 Project
   - Home Care Cost Accounting Project
   - Population Health/CCN/ Outpatient Services Project
   - Paragon 12.1 Update and preparation for Paragon 13

B. Performance Improvement Infrastructure Goals:

   - Provide an organized schedule of education for leaders to improve understanding and the quality of our program.
   - Implement STATIT.
   - Refine medical staff and board quality dashboards/scorecards to make them clinically relevant with meaningful data.
   - Refine Project Management process and infrastructure to better manage and communicate projects throughout the organization.

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Meeting Date: May 7, 2015

Prepared by: Peter Hohorst, SVH Board Director and Treasurer

Agenda Item Title: Thoughts on ACHD Legislative Days

My general impression was that ACHD listened to the critique from the February sessions and took steps to avoid similar instances during the Legislative Days. The meeting room was a good size for the attendees, hearing the speaker was easy and the power point screen visible.

The presentations on Monday were disappointing as far as relevance to our District:

- Sonoma is not a participant in the ALPHA fund and workmen's compensation costs are not a major problem for the District.
- Vaccination rates and communicable disease issues, while important from a community health standpoint, are not pressing issues for the District.
- The Legislative Briefing didn't have much focus. Perhaps because the legislature had just begun a new session with a large number of newly elected legislators it was not possible to discern what the principal issues would be.
- On the plus side the presentation on Telemedicine was informative and relevant. It could be a vehicle to retain patients who current leave the Valley for health services.

The Tuesday morning "meet the legislators" sessions did not seem to be productive. Only one of the five legislators was available, the other four sessions were with legislative aides. ACHD did do an impressive scheduling job and their inclusion of key legislative chairs as well as district legislators made good sense.

However, in my opinion the hand out would have been more effective if it contained more information on the Priority Bills and excluded many of the bills that probably will not see the light of day. For instance it does quantify the dollar impact of the Medi-Cal reductions if AB 366 were not passed. It was also concerning that two to the three Priority Bills related to workers' compensation. This seemed to be an over emphasis on workers' compensation because of the ALPHA fund.

Left unaddressed was the financial impact from the increase in the number of patients with Medi-Cal insurance which has an un-sustainable reimbursement rate.

POLICY GOVERNING ACCESS TO PUBLIC RECORDS

It is the policy of the Sonoma Valley Health Care District to encourage public participation in the governing process and to provide reasonable accessibility to all public records except those documents that are exempt from disclosure by express provisions of law or considered confidential or privileged under the law.

The following guidelines shall govern the accessibility for inspection and copying of public records of the Sonoma Valley Health Care District. These guidelines are to be administered by the President and Chief Executive Officer of the Hospital.

Reference, State of California, Government Code, Chapter 3.5 of Division 7, Section 6250, et. Seq. (The Public Records Act).

I. Purpose of Guidelines

The purpose of these guidelines is to serve as general rules to be followed by those persons charged with administration of the procedures concerning Inspection and Copying of Public Records of the Sonoma Valley Health Care District ("the District"). Certain requirements of law must be observed relating to disclosure of records and to the protection of the confidentiality of records. These guidelines set forth the general rules contained in such laws.

II. Definitions

- "Person" includes any natural person, corporation, partnership, firm or association.
- "Public Record" includes any writing containing information relating to the conduct of the business of the District prepared, owned, used or retained by the District regardless of physical form or characteristics.
- "Writing" means handwriting, typewriting, printing, emails, copying, photographing, and every other means of recording upon any form of communication or representation, including letters, words, pictures, sounds or symbols or combination thereof, and all papers, maps, magnetic or paper tapes, email, photographic films and prints, and other documents.

"Request for Public Record" refers to any written or verbal request.

III. Questions of Interpretation

In case of any questions as to the accessibility of the records of the District under these guidelines, records should not be made accessible to the public until such question has

been determined by the Chief Executive Officer of the Hospital. The decision of such officer is final unless overruled by the Board of Directors.

The District shall justify the withholding of any record by demonstrating that the record requested and withheld is exempt under paragraph IX of these guidelines or, that on the facts of the particular case, the public interest served by not making the record public outweighs the public interest served by the disclosure of such record.

In the case of any denial of an Application for Inspection or Copying of Records, the District shall notify the applicant of the decision to deny the application for records and shall set forth the names and positions of each person responsible for the denial of the request.

IV. Following Procedures for Inspection and Copying

The procedures referred to shall be followed in all of their specifics at all times. Records of inspections shall be accurately maintained.

V. Responding to Request for Public Records

Upon a determination as to whether the requested records are public records, a letter or email shall be sent to the individual requesting the public records within 10 days of the receipt of the request or 14 days if it is difficult to determine if the records exist. The letter or email shall include the following information:

- The date the request for public records was made.
- The date that the records will be made available, or in the case the requested records will not be made available for inspection or copying, the reasons therefore.
- If the copies of the records are requested, the response to the request shall include an invoice stating the total fee for such copies, and informing the individual that the copies will be made available once the fee has been deposited with the Administration of the Hospital. If the estimated cost for copying the records requested is less than $5.00 the invoice can be omitted.

VI Recording Requests for Public Records

A hard copy file or electronic file shall be kept in the Administration offices containing all information relating to request for public records received by the District.

The first page and or record of each request file shall be a log of all actions relating to the request for public records. The log for each request shall include:

- The name of the individual
- The date the request was received
- The date a response to the request was sent
- The action taken in response to the request

Upon receipt of a request for public records, the request shall be date stamped and filed in the Public Records Act Request file.

When a response to a request for public records is sent, a copy of the response and all attachments shall be copied and filed in the request file. Each response shall be stamped with the date it was sent.

VII Records Subject to Inspection Only with Authorization

All public records of the District are subject to inspection pursuant to these guidelines except as follows:

- Records set forth hereinafter as records subject to inspection only with authorization;
- Records NOT SUBJECT TO INSPECTION (unless by Court order); or
- Records which may be withheld by exercise of discretion.

If the District discloses a public record which is otherwise exempt from disclosure under the California Public Records Act, the disclosure shall constitute a waiver of the exemption otherwise applicable to such record.

VIII Records Subject to Inspection Only with Authorization

Any records relating to patients of the Hospital (including but not limited to the patient's records of admission and discharge, medical treatment, diagnosis and other care and services) shall only be made available for inspection and/or copying under the following conditions:

- Upon presentation of a written authorization therefore signed by an adult patient, by the guardian or conservator of his/her person or estate, or, in the case of a minor, by a parent or guardian of such minor, or by the personal representative or an heir of a deceased patient, and then only upon the presentation of the same by such person above named or an attorney at law representing such person.
- Where records relating to a minor patient are sought by a representative, and the minor is authorized by law to consent to medical treatment, or the District determines that access to the information would have a detrimental effect on the patient-provider relationship or the minor's physical or psychological well-being, the District shall not permit inspection of such records, absent a court order.
- Except when requested by a licensed physician, surgeon, or psychologist designated by request of the patient, if the District determines that access to records by the patient poses a substantial risk of significant adverse or detrimental consequences to the patient, the District may decline to permit inspection of mental health records sought by a patient or representative. The District must place a written record of the reason for refusal within the mental health records requested, including a description of the specific adverse or detrimental consequences, and a statement that refusal was made pursuant to Health and Safety Code Section 1975(b)(2).
- Upon presentation of a written order therefore issued by a Court of the State of California or the United States of America (see reference to Subpoena Duces Tecum hereinafter), which specifically commands the District disclose specified records.

- Upon subpoena, when permitted under Section XII below:

IX. Records Not Subject to Inspection (Unless by Court Order)

The following records of the District are not subject to inspection by any person without a written order issued by a Court of the State of California or of the United States of America (see reference to Subpoena Duces Tecum hereinafter):

- Records of the proceedings or other records of an organized committee of medical or medical-dental staffs in the Hospital having the responsibility of evaluation and improvement of the quality of care rendered in the Hospital.
- Records pertaining to pending litigation to which the District is a party, or to claims made pursuant to Division 3.6 commencing with Section 810 of Title 1 of the Government Code of California, until such litigation or claim has been finally adjudicated or otherwise settled.
- Personnel, medical or similar files of non-patients, the disclosure of which would constitute an unwarranted invasion of personal privacy of the individual or individuals concerned.
- Records of complaints to or investigation conducted by, or investigatory or security files compiled by, the District for correctional, law enforcement or licensing purposes.
- Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment or academic examination.
- The contents of real estate appraisals, engineering or feasibility estimate and evaluation made for or by the District relative to the acquisition of property, or to prospective public supply and construction contract, until such time as all the property has been acquired or all of the contract agreement obtained.
- Records the disclosure of which is exempted or prohibited pursuant to provisions of federal or state law, including, but not limited to, provisions of the Evidence Code of California relating to privilege. (Privileges conditionally provide for all communications between lawyer and client, physician and patient, and psychotherapist and patient).
- Records relating to any contract, or amendment thereof, for inpatient services governed by Articles 2.6, 2.8 and 2.91 of Chapter 7 of Division 9 of the Welfare and Institutions Code, pertaining to Medi-Cal provider contracting.
- Records relating to any contract with insurers or nonprofit hospital services plans for inpatient or outpatient services for alternative rates pursuant to Sections 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.
- Confidential documents relating to trade secrets of the District. Trade secrets are of unique value to the District, are important to the functioning of present or future District plans and are considered to be confidential documents.
- Records in the custody of or maintained by legal counsel to the District.

- A final accreditation report of the Joint Commission or other accrediting agency which has been transmitted to the State Department of Health Services pursuant to Subdivision (b) of Section 1282 of the Health and Safety Code.
- Computer software developed by the District is entitled to copyright protection and need not be disclosed as a public record.
- Any other records of the District that are not required to be disclosed pursuant to the California Public Records Act or other applicable statute as such statutes may be amended from time to time.

X. Records Submitted to Agencies Which are Exempted From Disclosure by the Health Care District

In addition to the limitations upon disclosure of public records otherwise set forth in these guidelines, the District is not required to disclose public records, or permit the inspection of public records pertaining to financial or utilization data other than such financial and utilization data as is filed with the California Health Facilities Commission and/or the Office of Statewide Health Planning and Development. It is sufficient compliance with the law to permit inspection of financial and utilization information reported to the Office of Statewide Health Planning and Development pursuant to Division 1, Part 1.8 of the California Health and Safety Code. In case of doubt, the District will consult with the District legal counsel before acting.

XI. Discretionary Withholding of Records

In addition to the limitation upon disclosure of records set forth in these guidelines, the District may, in its discretion, withhold inspection of any record or writing when the District determines, after reviewing the facts of the particular case, that the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record. Such discretion shall be exercised by the District by and through the Chief Executive Officer whose decision shall be final unless overruled by the Board of Directors.

XII. Compliance with Subpoena Duces Tecum

While a Subpoena Duces Tecum (a notice to appear and to bring records, or to produce records without appearance) is issued by a court, it is not an order of the court declaring that the particular records are subject to disclosure. Such records may still be subject to protection against disclosure by reason of the existence of a privilege or other legal reason. Therefore, receipt of such a subpoena does not permit disclosure of records in and of itself and the following rules shall be followed:

- Subpoena in Action where District is a party:
  Immediately consult with legal counsel representing the District as to the proper response.
- Subpoena in other actions:

If the records sought to be discovered (which are ordered to be produced) fall within one of the categories in Paragraphs VII, VIII or IX above, consult with the District's counsel prior to responding to the subpoena.

- If only a portion of the records may be disclosed or inspected:
  If only a portion of any requested records may be disclosed or inspected, the disclosable portions shall be segregated from the non-disclosable portions, and the segregated non-disclosable portions shall be withheld unless, and until, a court orders their productions.