SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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BOARD OF DIRECTORS' MEETING
AGENDA
THURSDAY, MARCH 3, 2016, 6:00 P.M.

COMMUNITY MEETING ROOM
177 First Street West, Sonoma, CA

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District meeting, please contact the District Clerk, Gigi Betta at (707) 935.5004 at least 48 hours prior to the meeting.	**RECOMMENDATION**	
AGENDA ITEM		
MISSION STATEMENT The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.	*Hirsch*	
3. CONSENT CALENDAR A. Regular Board Minutes 2.4.16 B. FC Minutes 1.26.16 C. QC Minutes 1.27.16 D. GC Minutes 1.26.16 E. Policy and Procedures F. MEC Credentialing Report	*Hirsch*	Action
4.. SVH FOUNDATION UPDATE	*Dave Pier, Executive Director, SVH Foundation*	Inform
5. FINANCIAL REPORT FOR MONTH ENDING JANUARY 31, 2016	*Jensen*	Inform
6. ADMINISTRATIVE REPORT FOR FEBRUARY 2016	*Mather*	Inform
7. OFFICER & COMMITTEE REPORTS ➢ Policy Governing Bidding for Facility Contracts (Hohorst) ➢ ACHD Updates (Boerum)	*Board Committee Members*	Inform/Action
8. BOARD COMMENTS	*Board*	Inform
9. ADJOURN The next Regular Board meeting is April 7, 2016	*Hirsch*	

3.

CONSENT CALENDAR

SVHCD BOARD OF DIRECTORS
REGULAR MEETING MINUTES
Thursday, February 4, 2016
5:00 p.m. Closed Session
6:00 p.m. Regular Session
COMMUNITY MEETING ROOM
177 First Street West, Sonoma

	RECOMMENDATION	
MISSION STATEMENT The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.		
1. CALL TO ORDER • Closed Session called to order at 5:00pm • Regular Session called to order at 6:00pm • Board Member, Bill Boerum was excused from tonight's meeting. •	*Hirsch*	
2. PUBLIC COMMENT ON CLOSED SESSION	*Hirsch*	
3. CLOSED SESSION Calif. Government Code § 37606 & Health and Safety Code §32106 Report Involving Trade Secret regarding Business Strategy	*Hirsch*	
4. REPORT OF CLOSED SESSION FEBRUARY 4, 2016	*Hirsch*	
There was no report from the Closed Session.		
5. PUBLIC COMMENT SECTION	*Hirsch*	
No public comments.		
6. REPORT OF CLOSED SESSION JANUARY 19, 2016	*Hirsch*	Inform/Action
At the Closed Session on January 19, 2016 the Board approved the 4TH Amendment to the Funding Agreement between Prima Medical Foundation and Sonoma Valley Health Care District.		
7. CONSENT CALENDAR	*Hirsch*	Action
A. Regular Board Minutes 1.7.16 B. FC Minutes 11.17.15 C. GC Minutes 12.15.15 D. QC Minutes 11.18.15 E. MEC Credentialing Report		**MOTION** by Nevins to approve. Consent by and 2nd by Rymer. All in favor.
8. CALIFORNIA HOSPITAL ASSOCIATION PRESENTATION ON UPDATES AND PREDICTION OF HEALTHCARE IN THE STATE OF CALIFORNIA	*Anne McLeod, Senior VP of Health Policy & Innovation*	Inform
Ms. McLeod presented an update on the rapidly changing healthcare environment, both nationally and in California.		

9. RESOLUTION No. 327 1206(b) CLINIC FORMATION	*Hirsch*	Action
Michelle Donaldson recommended that the Board approve formation of a 1206b clinic to enhance patient access to primary and specialty care. Roll Call: Jane Hirsch-aye Peter Hohorst-aye Joshua Rymer-aye Sharon Nevins-aye Boerum-excused		**MOTION** by Hohorst to approve and 2nd by Rymer. All in favor.
10. SATELLITE HEALTHCARE LEASE	*Donaldson*	Action
Ms. Donaldson recommended the Board approve that SVHCD enter into an agreement with Satellite Healthcare, Inc. to lease space on Hospital premises in order to construct an outpatient dialysis unit. All Board Members were in favor.		**MOTION** by Hohorst to approve and 2nd by Nevins. All in favor.
11. RESOLUTION No. 326 UNION BANK LOC EXTENSION	*Jensen*	Action
Roll call vote: Jane Hirsch-aye Peter Hohorst-aye Joshua Rymer-aye Sharon Nevins-aye Boerum-absent		**MOTION** by Nevins to approve and 2nd by Rymer. All in favor
12. FY2016 CAPITAL SPENDING	*Jensen*	Inform
13. FINANCIAL REPORT MONTH ENDING DEC. 31, 2015	*Jensen*	Inform
After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net gain for December was $138,006 vs. a budgeted net loss of ($312,788). The total net income for December after all activity was $574,955 vs. a budgeted net income of $371,753. Mr. Hohorst commended SVH senior management for managing *total people cost* to within 1% of budget. Ms. Nevins commended the Finance Department for completing Year-End Projections by January 2015.		
14. ADMINISTRATIVE REPORT JANUARY 2015	*Mather*	Inform
Financially, December was a very good month for the Hospital and Ms. Mather is pleased to announce SVH is projected to meet budget goals in 2016. The Hospital's leadership team continues to do an outstanding job managing their expenses, even with a significant increase in physician expenses.		

15. OFFICER & COMMITTEE REPORTS	*Board*	Inform/Action
<u>Governance Committee</u> • Policy Governing Bidding for Facility Contracts (Hohorst) The policy is still in legal review and will be brought forward for approval at the March 3, 2016 Board meeting. • ACHD Update In Mr. Boerum's absence, Ms. Hirsch gave his report on the ACHD Leadership Academy in Sacramento, January 21-22, 2016.		
16. BOARD COMMENTS	*Board*	Inform
There were no Board comments.		
17. ADJOURN Regular Session was adjourned at 7:20pm	*Hirsch*	
The next Regular Board meeting is March 3, 2016 at 6:00pm		

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE MEETING
MINUTES
TUESDAY, January 26, 2016
Schantz Conference Room

Present	Excused/Absent	Staff	Public
Sharon Nevins, Chair Dick Fogg S. Mishra, M.D. (by phone) Peter Hohorst Mary Smith Steve Barclay Susan Porth Keith Chamberlin, M.D. (by phone)	Stephen Berezin	Kelly Mather Ken Jensen Gigi Betta	

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	*Nevins*		
	Meeting called to order at 5:00pm The new Finance Committee member, Susan Porth was introduced and welcomed to her first meeting.		
2. PUBLIC COMMENT SECTION	*Nevins*		
	Mr. McCandless informed the Committee that several national newspapers are running articles regarding the closure of several Obama Care clinics nationwide and feels that elderly poor are most		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	affected by this.		
3. CONSENT CALENDAR	*Nevins*	Action	
	• FC Minutes, 11.17.15 • No December 2015 Minutes	**MOTION** by Hohorst to approve Consent and 2nd by Fogg. All in favor.	
4. RESOLUTION No. 326 LINE OF CREDIT 3-YEAR EXTENSION	*Jensen*	Action	
	Resolution No. 326 proposes to extend the Union Bank Line of Credit by three years. The Finance Committee recommends that the Board approve the extension at the Board meeting on 2.4.16.	**MOTION** by Fogg to approve and 2nd by Smith. All in favor.	
5. ADMINISTRATIVE REPORT DECEMBER 2015	*Mather*	Inform	
	Ms. Mather presented the December Administrative Report summarizing the November Dashboard and trending results. Strategic updates on growth, service area optimization, time share, Satellite Dialysis, Sleep Lab, Parcel Tax renewal and philanthropy were also included in the report. All SVH employees with salaries below the maximum salary allowed for their position received a 3% salary increase effective 1.3.16. Those who are at or above the maximum salary allowed received a *longevity payment.* The longevity payment plan will pay 1.5% of salary biannually. The new longevity payment plan was not well received and Hospital Management will revisit salary increases in 2017.		
6. 2016 FC WORK PLAN	*Jensen*	Action	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	The Committee approved the 2016 Work Plan as presented by Mr. Jensen.	**MOTION** by Fogg to approve and 2nd by Hohorst. All in favor.	
7. FINANCE REPORT FOR MONTH ENDING DECEMBER 31, 2015	*Jensen*	Inform	
	December was another positive month for the Hospital. After accounting for all activity, the December net income was a gain of $574,955 vs. the budgeted net income of $371,753. The December EBIDA was 10.6% vs. a budgeted 0.3%. Year-to-date, the total net income is $731,107 better than budget with a year to date EBIDA of 6.6% vs. the budget of 6.6%. Ms. Porth asked for a description of the EHR and IGT programs. Mr. Jensen outlined the programs and added that funds from the IGT program will be available to the Hospital until 2018.		
8. PROJECTED BUDGET 2016	*Jensen*	Action	
	The Projected YTD Operating Projection was presented and was well received by the Committee. In order to stay on budget there are four major areas that must be closely monitored: volume, payer mix, contractual reserves and increases in medical staff stipends.		
9. FY16 QUARTERLY CAPITAL SPENDING	*Jensen*	Inform	
	The Finance Committee recommends that the Quarterly Capital Spending Plan be brought forward to the Board meeting on 2.4.16 for approval.		
10. MID-YEAR AUDIT 2016	*Jensen*	Inform	
	The auditors will be commencing their mid-year review focusing primarily on contractual adjustment categories.		
11. 1206(B) CLINIC FORMATION	*Nevins/Jensen*	Action	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	The Finance Committee recommends approval of Resolution No. 3327 at the Board meeting on February 4, 2016.		
12. ADJOURN Next meeting February 23, 2016	*Nevins*		
	Meeting adjourned at 6:15pm		

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, January 27, 2016
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Members Not Present	Admin Staff /Other
Jane Hirsch Carol Snyder Michael Mainardi Cathy Webber Ingrid Sheets Susan Idell Kelsey Woodward Brian Sebastian, M.D.		Joshua Rymer Howard Eisenstark	Leslie Lovejoy Robbie Cohen, M.D. Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 11.18.15 • No December 2015 Minutes		**MOTION** to approve Consent by Mainardi and 2nd by Idell. All in favor.
4. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Mr. Kobe presented the annual metrics for medication scanning rate, falls, pressure ulcer incidents, nursing turnover and RN certification.	
5. POLICY & PROCEDURES	*Lovejoy*	Action
• CNO Multiple October 2015 • HIM Multiple August 2015 • QS8610-106 Code Blue Management	Ms. Lovejoy and Mr. Kobe presented six policy revisions and one new policy. .	**MOTION** to approve P&Ps by Mainardi and 2nd by Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
• PC8610-306 De-clotting Central Venous Devices • LAB Multiple October 2015 • SNF Multiple December 2015 • PHARMACY ❖ MM8610-102 Controlled Substance ❖ MM8610-156 Electrolyte Replacement ❖ MM8610-157 Drug Supply Chain		Ms. Betta will change "due" to "do" on the summary sheet of the *De-clotting Central Venous Devices* policy.
6. QUALITY REPORT JANUARY 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy shared the priorities for December 2015/January 2016 including two new Quality & Risk initiatives (CHPSO and CALHEN 2.0) and the Leapfrog Action Plan implementation.	
7. REVIEW OF 2015 AND 2016 WORK PLANS		
	2015 Work Plan The Quality Committee met all goals on the 2015 Work Plan with the exception of the Palliative Care and Hospitalists educational presentations. The Annual Contract Evaluation Report was put on hold until the M.E.C. has approved it. 2016 Work Plan The following items will be added to the 2016 Work Plan: • IT Services Report in October • Hospitalists Presentation-June • Satellite Dialysis-September • Community Care Network (CCN)-TBD • Employer Direct Program-August	
8. CLOSING COMMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION	*Sebastian*	Action
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report	• Ms. Hirsch will approve the credentialing report via phone with Mr. Rymer.	

AGENDA ITEM	DISCUSSION	ACTION
• Board Quality Dashboard	• The Board Quality Dashboard will be brought forward to the next Quality Committee meeting on March 24, 2016.	
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:20pm	

SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE MEETING
MINUTES
TUESDAY, January 26, 2016
8:30AM

ADMINISTRATION CONFERENCE ROOM
347 ANDRIEUX STREET, SONOMA, CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS Meeting called to order at 8:35am	*Hohorst*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee 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 Committee consideration.*	*Hohorst*	
3. CONSENT CALENDAR • Minutes from 12.15.16	*Hohorst*	Action **MOTION** to approve by Hohorst. All in favor.
4. POLICY GOVERNING BIDDING FOR FACILITY CONTRACTS The policy is being review by attorney Colin Coffey. There may be minor revisions Under Section 5: Limit of Authority Delegated to CEO	*Hohorst*	Action
5. ADJOURN Meeting adjourned at 9:05am	*Hohorst*	

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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: **IC8610-131 Prevention Central-Line Assoc Infections, PC8610-120 Central Venous Access Catheter Management, PC8610-136 Implanted Port Access Management**	
APPROVED BY:	DATE: **1-27-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee — Date: 2-19-16

Douglas S Campbell, MD
Chair Medicine Committee — Date: 2/19/16

Leslie Lovejoy, RN PhD
Chief Quality Officer — Date: 2/19/16

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

Revision written by: **Bonnie Bernhardy**

Date of Document: **1-22-16**

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

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

IC8610-131 Prevention of Central-line Associated Bloodstream Infections Policy- Revision; added Appendix A Venous Access Device Adult Quick Reference Guidelines, added alcohol disinfecting port protectors; frequency of gauze dressing change from every 24 hours to every 48 hours; added "Full body sterile draping" for central venous catheter insertion; Central Venous catheters should be "evaluated daily for necessity". Removed: "evaluated routine; CLABSI rate data is reported to Quality "and the CDPH as required by law"

PC8610-120 Central Venous Access Catheter Management; Revision; flush central lines with 20ml NS instead of 10ml; Venous Access Device Adult Quick Reference Guidelines - Appendix A

PC8610-136 Implanted Port Access and Management; Revised; flush implanted ports with 20ml NS instead of 10ml; added Venous Access Device Adult Quick Reference Guidelines - Appendix A

Appendix A Venous Access Device Adult Quick Reference Guidelines-Revised outdated form to reflect current practice standards for venous access devices; added statement on Push-Pause flushing technique, Alcohol Cap change frequency and Stat Lock and change frequency

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	Bonnie Bernhardy to present
Medicine Committee	2/11/2016	Yes	Bonnie Bernhardy to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016	Yes	
Board Quality	2/24/2016	Yes	
Board of Directors	3/03/2016		

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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:

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- 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.

Departmental: PC6171-193 Sweet Success Policy – New Policy	
APPROVED BY:	DATE: **1-19-16**
Director's/Manager's Signature: Cynthia McAleer RN	Printed Name **Cynthia McAleer RN**

D. Paul Amara, MD
Birthplace Medical Director — Date: 2/19/16

Michael Brown MD
Chair Surgery Committee — Date: 2-19-16

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date: 2/17/16

Kelly Mather
Chief Executive Officer — Date: 2/23/16

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Birthplace Department Policy**

New Document or Revision written by: **Cynthia McAleer, RN**

Date of Document: **1-13-16**

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

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

PC6171-193 Sweet Success Program Policy- New Policy; Initiation of the Sweet Success program at SVH through The Birthplace requires a new policy outlining the program.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	Cynthia to present
Medicine Committee	2/11/2016	YES	Cynthia to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016	YES	
Board Quality	2/24/2016	YES	
Board of Directors	3/03/2016		

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SUBJECT: Sweet Success Program	POLICY #PC6171-193
	PAGE 1 OF 3
DEPARTMENT: The Birthplace	EFFECTIVE: 01/16
APPROVED BY: Director of Maternity Services	REVIEW/REVISED:

Purpose:
The purpose of the Sweet Success Program is to promote best practices of care for pregnant women who have preexisting or gestational diabetes. Sweet Success strives to optimize maternal and fetal birth outcomes, slow, or prevent ongoing diabetes among women with gestational diabetes, and reduce complications of diabetes among women with preexisting diabetes. The purpose of offering the Sweet Success program at this facility is to improve access, convenience and compliance for women in this community.

The goal of the Sweet Success program is to promote quality medical management and nutrition interventions for women with diabetes, or for women who develop diabetes during pregnancy so their pregnancy outcomes match those of women in the general population.

The program provides outpatient-based comprehensive education, nutrition, and medical services to the pregnant woman with diabetes to accomplish this goal. The intent is to achieve active participation by the woman in managing the meal plan, medications, exercise and other strategies necessary for optimal glycemic control.

Policy:
Management and care of this target group will be based on the CDAPP (California Diabetes and Pregnancy Program) Sweet Success Guidelines for Care and utilize a multidisciplinary team composed of physicians, registered nurses, registered dietitians, and other health care professionals as needed to provide preventive and health promoting strategies that are culturally appropriate and research-based.

The Medical Director of the Sonoma Valley Hospital Sweet Success affiliate will be a practicing physician who sees pregnant diabetic patients. The team will include a Registered Nurse as the Nurse Educator, and a Registered Dietitian (RD).

Procedure:
1. Physician referral required
    a. When referral received appointment with the RN will be made as soon as possible.
2. Interventions:
    a. Medical Nutrition Therapy (MNT)
        i. Use of a patient nutrition assessment to determine treatment strategies by the RD
            1. Make recommendations on kilocalorie and macronutrient needs, distribution of carbohydrates, and meeting nutrient requirements during pregnancy
            2. The basic objectives of MNT:
                a. Set appropriate weight gain goals

b. Determine caloric needs
c. Develop and individualized, nutritionally balanced meal plan
d. Recommend vitamin/mineral supplements as needed
e. Provide education concerning nutrition related issues
f. Evaluate adherence to the meal plan
g. Provide evidence based recommendations
h. Promote patient empowerment

ii. Encourage breastfeeding and provide guidelines.

b. Exercise:
   i. Educate on benefits and risks
   ii. Individualized exercise program discussed after medical clearance.
   iii. Use Sweet Success guidelines when proposing an exercise program.
   iv. Educate patient on symptoms signaling when to stop a specific exercise session and contraindication to exercise
c. Education on blood glucose testing:
   i. Provide Sweet Success and other diabetes education handouts as needed.
   ii. Provide instruction on self blood glucose monitoring.
      1. Provide starter kit for glucose monitoring with glucometer, test strips, and lancets.
         a. Ordered per physician order.
      2. Use glucometer with memory.
      3. Instruct on when to test blood glucose and recording of results using the blood glucose log.
      4. Discuss target capillary glucose values.
         a. Fasting: 60-89mg/dl.
         b. Postprandial (one hour from first bite): 100-129mg/dl.
d. Management of medications: (see Management of Blood Glucose in GDM addendum)
   i. When medication is indicated (based on the CDPP Sweet Success guidelines) the physician will initiate order
      1. If >20% of fasting glucose values are >89 & <120 AND/OR
      2. >20% of postprandial glucose values are >129 & <180
   ii. Use Sweet Success protocols and in collaboration with physician for management of oral hypoglycemic agents
   iii. Use Sweet Success protocols and in collaboration with physician for management of insulin therapy
      1. Education provided to patient
         a. Insulin injection technique, carbohydrate counting to control postmeal peak glucose levels, and prevention and treatment of hypoglycemia.

e. Additional education provided:
    i. Symptoms and treatment of hypoglycemia
    ii. Sick day guidelines
    iii. Preterm labor guidelines
f. Antenatal Testing
    i. Instructions on fetal kick count beginning at 28 weeks
        1. Kick counts are the only antenatal testing recommended for diet controlled GDM
    ii. Twice weekly NST and weekly AFI
        1. Starting at 28 weeks gestation if vasculopathy, hypertension, or uncontrolled DM
        2. Starting at 32 weeks gestation if utilizing oral medication or insulin.
g. Documentation
    i. Initial Intake Form per RN
    ii. Initial Nutrition Assessment per RD
    iii. Care Plan per RN and RD
    iv. Telephone order from physician for medication if indicated
    v. Copy of each visit to Medical Records to be included in patient's medical record.
h. Communication with provider
    i. A record of all visits will be provided to the physician provider, include:
        1. Plan of care
        2. Progress notes
        3. Nutrition Assessment per the RD
    ii. Notification of glucose levels indicating need to start medication therapy
        1. Obtain verbal order
    iii. Immediate communication with provider if higher level of care indicated
        1. If unable to maintain normoglycemia during the pregnancy refer patients to a Sweet Success affiliate which provides the higher level of care needed.

Reference:

CDAPP Sweet Success, Guidelines for Care. State Program Guide. California Department of Public Health, Center for Family Health, Maternal, Child & Adolescent Health Division, 2012.

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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 2016**	
APPROVED BY:	DATE: **1-27-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee — Date: 2/19/16

Douglas S Campbell, MD
Chair Medicine Committee — Date: 2/19/16

Leslie Lovejoy, RN PhD
Chief Quality Officer — Date: 2-19-16

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

Revision written by: **Multiple Policies Feb 2016**

Date of Document: **1-27-16**

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

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

GL8610-190 Smoking Policy - ~~Revision~~ NEW; Change "LD" to GL for compliance with nomenclature; Changed Reference to correct California Health and Safety Code Regulation; policy to prohibit patients from smoking and to move to a "Smoke-Free" campus effective March 1, 2016.

PC8610-157 Post-Mortem Protocol - Revision; changed policy name from Death Procedures; restricts the staff who may pronounce death on a DNR patient to nursing supervisors vs any staff RN

UR8610-100 Patient Status Determinations - ~~Revised~~ NEW; Change from a Case Management Observation Status Policy to an organizational policy; Added Categories of patient status and the correct order format including observation; Added responsibilities for order input and changing status documentation for physicians and admitting personnel.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/19/2016	Yes	
Surgery Committee	2/03/2016	YES	
Medicine Committee	2/11/2016	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	2/18/2016	yes	
Board Quality	2/24/2016	yes	
Board of Directors	3/03/2016		

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Healing Here at Home

SUBJECT: Smoking Policy	POLICY # GL8610-190
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 10/82
APPROVED BY: CEO	REVIEW/REVISED: 2/86, 6/89, 4/93, 3/99,12/01,11/07 3/11,2/14, 2/16

Purpose:
Sonoma Valley Hospital has a responsibility to its employees, patients, physicians and visitors to provide a safe and healthful environment. In addition, the mission of Sonoma Valley Hospital is to improve the health of the community and guide its healthcare team and community members towards optimal health and wellbeing. Research indicates that smoking and exposure to second hand smoke are significant health hazards for both smokers and non-smokers. Improperly discarded cigarette butts and other smoking and tobacco product residue are environmental pollutants that pose dangers to people and to wildlife. In addition to these hazards, smoking and discarded cigarettes may create fire hazards and increased cleaning, maintenance and repair costs; and exacerbate employee, patient and visitor illness. To address these interests and concerns, Sonoma Valley Hospital is issuing this Smoking Policy.

Definition:
For the purpose of this policy "smoking" means lighting, burning, carrying, inhaling, exhaling or holding a lit cigarette, cigar, bidi, pipe or other smoking or recreational vapor delivery apparatus containing tobacco or another substance. Substances and activities prohibited by this policy include use of other tobacco products such as smokeless tobacco, as well as the use of e-cigarettes and similar devices. Not prohibited by this policy are nicotine gum, patches, or other medically prescribed smoking cessation assistance devices.

Policy:
It is the policy of Sonoma Valley Hospital that smoking and other uses of tobacco products are prohibited on the hospital campus as well as at off-campus sites under hospital ownership or control, and in vehicles owned, leased or rented by Sonoma Valley Hospital.

Procedure:
A. Upon admission to the acute hospital, patients will be asked if they are currently smokers. If yes, the patient will be informed that this is a non-smoking campus and will be offered an alternative to cigarettes during their stay. Nursing staff will obtain the requisite order for a nicotine substitute unless contraindicated.

B. Residents in the Skilled Nursing Facility are exempted from this regulation and have the right to smoke in the area designated by signage or off-campus.

C. The transition from current hospital policy to a smoke free campus will become effective March 1, 2016.

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

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	PAGE 2 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 10/82
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D. Signage, complying with regulatory language, will be posted at all campus locations and cigarette butt containers will be available.
E. This policy and the restrictions within will be widely publicized to employees, physicians, visitors, contractors, vendors and the community at large.

F. Employees needing assistance should they decide to quit smoking are encouraged to contact their primary care physician for assistance.

G. The success of this policy depends on the thoughtfulness, civility and cooperation of all members of the Sonoma Valley Hospital community including patients and visitors. Compliance is grounded in an informed and educated community. As with all hospital policies, it is a standard and reasonable duty of all employees, volunteers, physicians and students to fully comply with this policy. Incidents related to this policy will be addressed through applicable administrative processes. Violators of this policy should expect to be approached and reminded of their obligation to comply with this policy.

H. See "Frequently Asked Questions" fact sheet for more information.

References:
California Health and Safety Code Section 1286.

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SMOKE-FREE CAMPUS - FREQUENTLY ASKED QUESTIONS

Q: Why are we becoming totally smoke-free?

A: The goal in implementing this policy is to provide a healthy, comfortable and productive work environment for all patients, visitors and staff. It is stated in the California Health and Safety Code, Section 1286 "Smoking shall be prohibited in patient care areas, waiting rooms, and visiting rooms of a health facility .... " and it is a best practice that nearly all healthcare facilities have implemented. As a Healing Hospital, it is imperative that we adhere to our advised practices. It will provide a healthier environment for employees, visitors and patients, and will underscore our commitment to support the health of our employees, patients and community.

Q: Who made the decision to implement the policy?

A: At the request of the Medical Staff, the Leadership Team decided to make Sonoma Valley Hospital smoke-free based on best practice of our Healing Hospital philosophy and the well being of our employees, patients and visitors.

Q: What does the policy mean?

A: All smoking and other use of tobacco or tobacco-like products are strictly prohibited within owned and leased buildings and on our property, including during breaks and meal times. This policy applies to all SVH properties including, but not limited to all staff, patients (with the exception of SNF residents), contractors and visitors. (Note: California Health and Safety Section 1286 clearly states "This section shall not apply to skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled".)

Q: Who is responsible for implementing and enforcing the policy?

A: We are all responsible for implementing and enforcing this policy. It is important that we all work to promote good health and support an environment free of tobacco or vapor products.

Q: How will the new policy be enforced?

A: Initially employees will be reminded of the new policy. If an employee continues to violate the policy, he/she may be subject to formal corrective action.

Q: Where can I smoke?

A: The goal of this policy is to make our work environment and property completely smoke-free. This policy does not apply to public property. Please respect our neighbors and refrain from smoking or discarding cigarette butts on their property.

Q: May I smoke in my car?

A: If your car is on SVH property – No. Cigarette butts are the most common type of litter. Reducing cigarette butt litter will beautify our campus and lower clean-up costs. Discarded cigarette butts contain all the carcinogens and nicotine that make tobacco use the leading cause of preventable death. Cigarette butts are also dangerous when consumed by wildlife, pets, or young children.

Q: Won't this policy just send the smokers to restrooms, stairwells and their cars?

A: While that potential exists, the hope is that all will embrace the efforts to sustain a healthier environment for patients, families and employees. The presence of smoke is unhealthy for everyone and the smell of smoke is a trigger for those trying to quit or remain smoke-free while they are here. It is our responsibility to help each other, our patients and visitors in this process.

Q: Why can't we have smoking shelters?

A: Providing a place to smoke doesn't support our goal and mission to be an advocate for health and wellness by providing a totally smoke-free environment for our patients, families and employees. We need to effectively eliminate the triggers (like smoking shelters) that make smoking cessation difficult. To spend money to erect or maintain such structures would be giving inferred approval of smoking, not the message we want to give to our community. There are no designated smoking areas on campus other than for the residents of the Skilled Nursing Facility as required by and stated in the California Health and Safety Code, Section 1286.

Q: I work at a building off-campus that allows smoking. May I smoke there?

A: Sonoma Valley Hospital staff may not use smoking products in any building or on property that is owned or leased by SVH.

Q: Will patients be able to smoke?

A: The same policy applies to patients – they are not permitted to smoke on SVH property (unless residents of the Skilled Nursing Facility as permitted by California Health and Safety Code, Section 1286). Signage will communicate information about the Smoke-free policy to all patients, visitors and employees.

Q: Won't this hurt patient volume?

A: It's extremely unlikely. The overall conclusion is that smoke-free policies in healthcare facilities do not lead to a loss of revenue or jobs and may even improve business. Research shows there are no negative economic impact or loss of income resulting from taking protective measures against tobacco or like substances. California Health and Safety Code, Section 1286 prohibits smoking in patient care areas, waiting rooms and visiting rooms of a health facility.

Q: How will we communicate to patients and visitors that we are smoke-free?

A: New signage and announcements through the media will help inform patients and visitors. SVH employees will also help explain the new policy.

Q: Are employees and managers expected to enforce this policy if they see someone smoking?

A: Employees may approach an individual who is violating the policy and voice a short, simple, friendly reminder that "SVH is now a smoke-free facility". If the person is a visitor he/she may not be aware of the policy. If the person is a fellow employee you need only remind the employee that "SVH is a smoke-free facility now" and move on. No one should feel that he/she should have to "confront" another employee. If employees see someone who is repeatedly violating the policy, they are encouraged to contact Human Resources or that employee's Supervisor. The employee's manager who is apprised of his/her employees' infractions should address this appropriately through the Corrective Action Process.

Q: What resources have been made available to employees who want to stop smoking?

A: On-line smoking cessation information is available through our wellness partner Viverae. Alternatively, any individual may consult with their private primary care physician for local classes or prescription medication to assist with smoking cessation.

Q: Will I be permitted to take longer for my smoke break, since I may have to go farther to take a smoke break?

A: Breaks (other than the unpaid meal break) are paid at SVH. As employees are permitted to take paid breaks in the department, employees who smoke will be afforded the same amount of time as employees who do not smoke.

All employees are encouraged to be supportive and respectful to co-workers who smoke, as the transition is made to the new policy. Smoking is a powerful addiction and people who smoke will have an adjustment time as the new policy goes into effect.

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

SUBJECT: Patient Status Determinations	POLICY # UR8610-100
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 10/12
APPROVED BY: Chief Quality Officer	REVIEW/REVISED: 8/14 2/16

PURPOSE:
This policy is intended to clarify the categories for registration status and patient placement determinations to facilitate appropriate utilization and billing of both inpatient and outpatient observation services in compliance with Centers for Medicare Services (CMS) regulations and guidelines.

POLICY:
Sonoma Valley Hospital will use the designated patient status determinations outlined below in order provide effective and efficient care of patients who require either an inpatient stay or a brief stay in the hospital as an outpatient for diagnosis and treatment.

PATIENT STATUS CATEGORIES:

1. Inpatient Acute
The electronic health record order for this status includes the following:
A. If the patient is being admitted as an inpatient from the Emergency Department, the Order should be one of the following.
1. Admit from the ED to the ICU;
2. Admit from the ED to the Medical/Surgical Unit
3. Admit from the ED to Telemetry
4. Admit from ED to Skilled Nursing

B. Electively scheduled inpatient surgery cases or urgent/emergent will use the following electronic order format and the order must be completed prior to the patient going to surgery as the patient is considered an inpatient. The patient's registration status is confirmed by patient registration and nursing prior to the patient going to surgery during the admission or pre-op preparation process (if emergent) and re-confirmed in the Ambulatory Care Unit prior to taking the patient to the OR suite.
1. Admit to the ICU
2. Admit to the Medical/Surgical Unit

2. Inpatient from a Skilled Nursing Facility or other Agency
A.. If the patient is a direct admission from an outside agency to the Acute Inpatient area or to the Skilled Nursing Unit, the order should be written as follows.
1. Admit to the ICU
2. Admit to the Medical/Surgical Unit
3. Admit to Skilled Nursing
4. Admit to Telemetry

3. Inpatient Transfers Between Units

B. The electronic order to transfer patients between patient care units only applies to the movement of an admitted patient between the Intensive Care and the Medical Surgical Units and a recorded as follows. No other "Transfer To" is accepted.

1. Transfer from ICU to Medical Surgical Unit
2. Transfer from Medical Surgical Unit to ICU

4. Observation and Outpatient Status

There are four outpatient/observation status determinations that are accepted and documented in the electronic record.

A. "Place in Observation": this determination is used when a patient requires a brief stay (generally 24 hours or less) to determine if a hospital inpatient admission is warranted based on medical necessity.

B. "Place patient as Outpatient in a bed": refers to a patient that can't be safely discharged from the Emergency Department because of patient safety or social issues that need to be addressed prior to discharge. This designation is used if medical necessity can't be met.

C. "Place in SCU for Same Day Surgery(Type 4)": refers to patients who are scheduled as an outpatient surgery or emergent same day surgery patients.

D. "Place Patient in Extended Recovery" refers to patients who remain in the hospital overnight following surgery for pain control and/or protracted nausea and vomiting..

PROCEDURE:

I. Patient Status Orders:

1. Patient Status Orders shall be entered by the Emergency Department Physician, Hospitalist or Surgeon.
2. Patients may not leave the Emergency Department without a patient status order.
2. All physician orders must be signed, dated, timed in accordance with hospital policy.
3. Hospital staff may take telephone orders for observation services or inpatient admission in accordance with hospital policy.
4. Only PBX and Admitting staff may change a patient status in the electronic record once the order is written by the physician.
4. The time and date of an inpatient admission is the time and date of the physician's admission order.
5. A physician can order an outpatient receiving observation services to be admitted as an inpatient at any time during the hospital stay , but not retroactively.
6. Reversing an inpatient admission order requires the "Condition Code 44" process for Medicare patients only. See policy & procedure 8750-103.

7. Patient Status Orders, once written, will print out in PBX/Admitting for all new admissions and reports are forwarded to the Nursing Administration Office and Case Management for continual confirmation of the correct patient status order entry.

II. Patient Status Determination

1. The determination of inpatient or outpatient status for any given patient is reserved to the admitting physician. Case Managers and Physician Advisors may advise the admitting physician on InterQual criteria and/or medical necessity of inpatient or observation admission, but the decision must be based on the physician's expectation of care that the patient will require. In general, the physician should order an inpatient admission for patients who are expected to need hospital care for 24 hours (over two midnights) or longer.
2. Case Managers should refer patients who do not fit into one InterQual admission category to a UR physician advisor(current contract is with Executive Health Resources).
3. Case Managers should validate that the patient's status matches physician orders as documented in the electronic record.
4. A patient should be admitted for a procedure when either the morbidity associated with the procedure or the co-morbidity associated with a particular patient suggests that a 24 hour or longer stay will be required.

III. Documentation

1. Nursing documentation for the observation patient must reflect the assessment and reassessment of the patient's condition and the performance of services ordered by the physician. The patient must be in the care of a physician during the period of observation, as documented in the medical record by registration, discharge and other appropriate progress notes that are timed, dated and legibly signed by the physician.

IV. Patient Status Communication

1, The Case Manager or Admitting Representative will notify all outpatients in beds that they are outpatients and may be responsible for a coinsurance payment. Notification is done through a letter or brochure explaining observations services.
2. The Case Manager or Admitting Representative will notify patients in writing when "Condition Code 44" is used to change them from an inpatient to an outpatient status because they have a right to appeal their change in status.

REFERENCES:

CIHQ Utilization Review: UR-4

4.

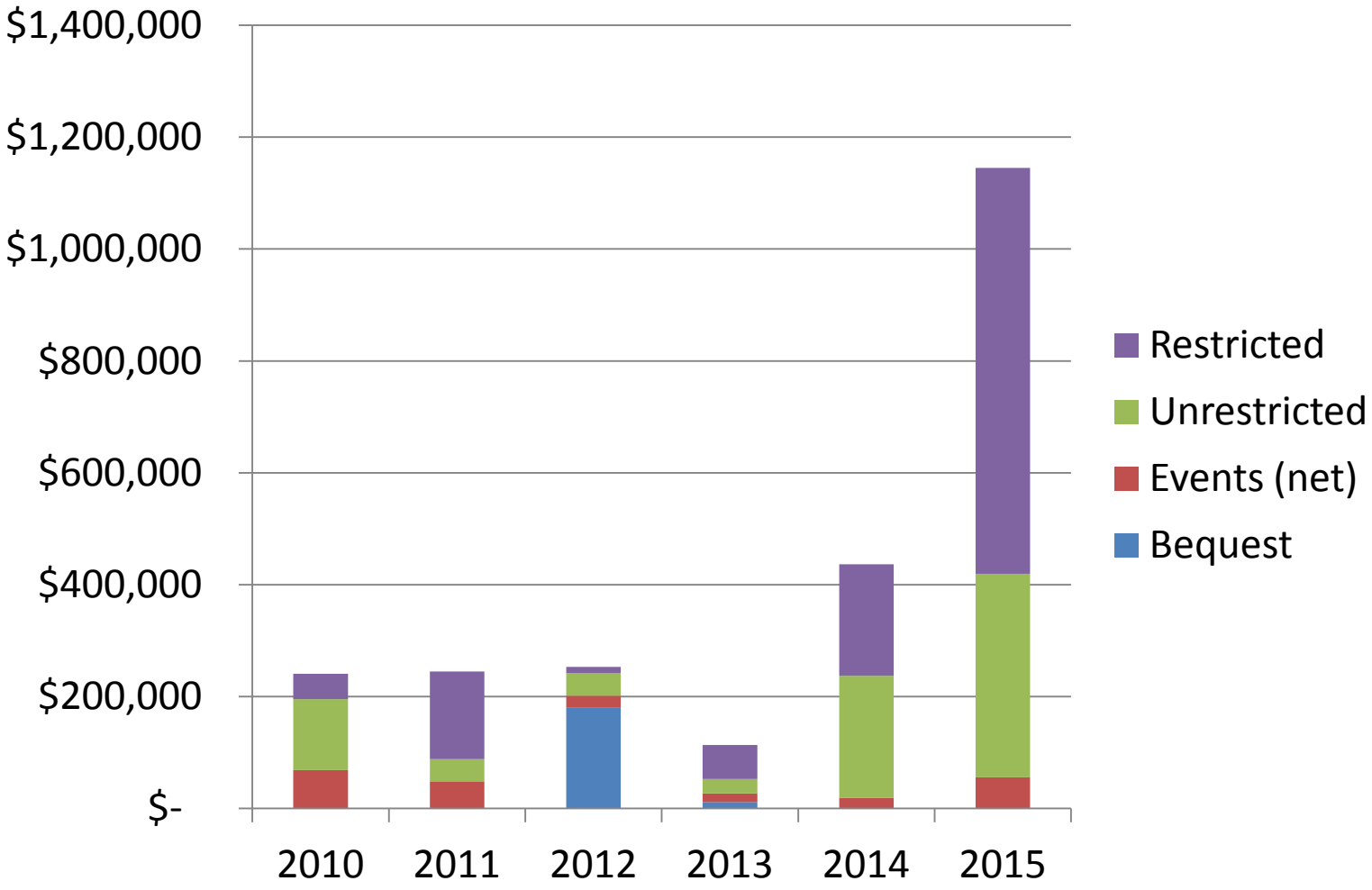
SVH FOUNDATION UPDATE

SVHF Progress & Goals

SONOMA VALLEY HOSPITAL
FOUNDATION
Inspiring Support for Sonoma Valley Hospital


EMERGENCY

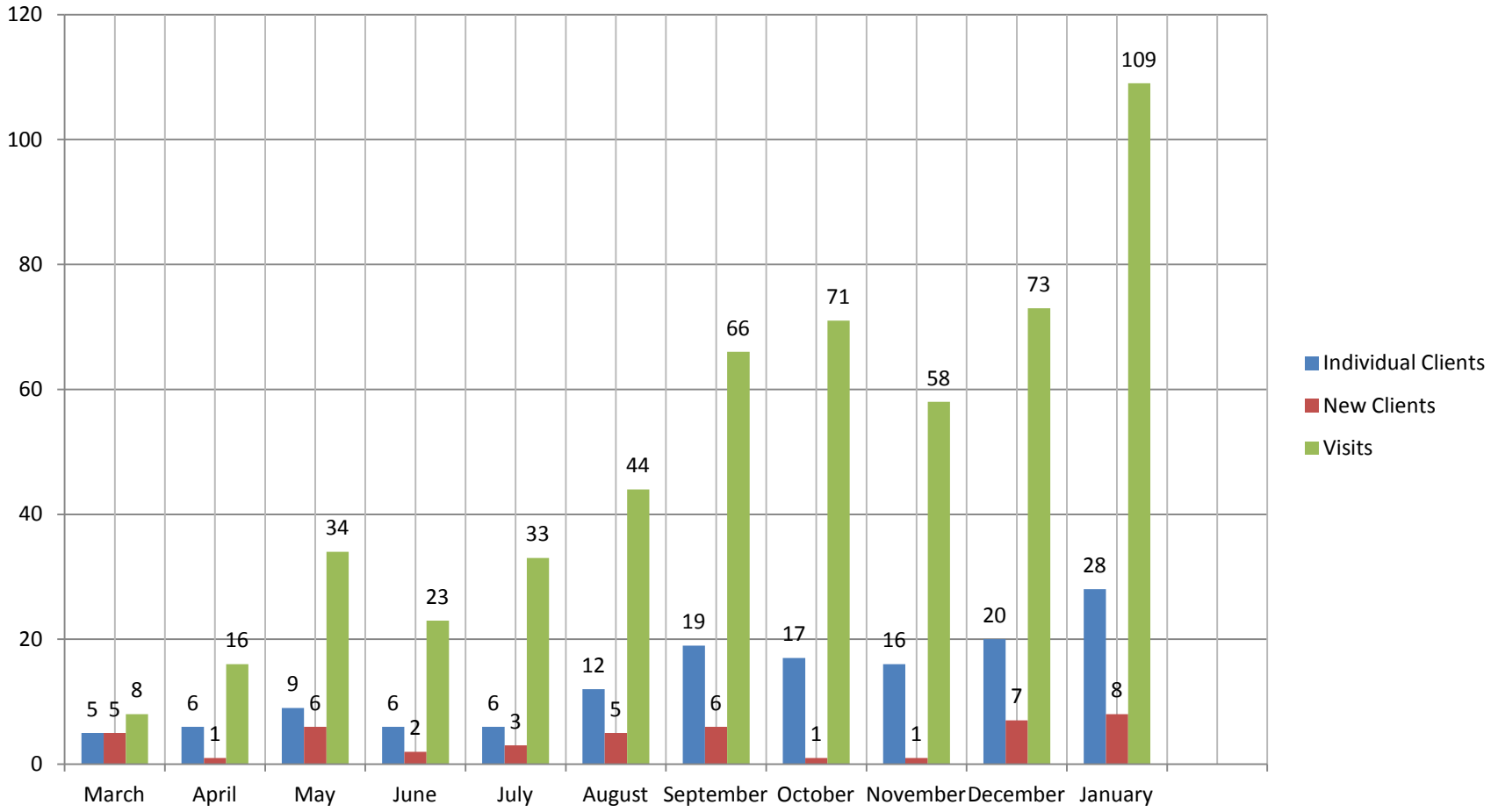
SVHF Historical Revenue



Recent Accomplishments

- $535,000 raised for 3D Mammography
- Collected $1.2M of Capital Campaign pledges
- Two Ultrasounds
- Cancer Support Sonoma Program
- Forceps for ER
- Free Mammograms for 85 women
- ABI Machine
- Flo-Lab
- Child Car Seat Certification training for Birthplace RN
- Continued Education for Nurses ($25k restricted donation)
- Continued Education and equipment for P/T ($10k restricted pledge)
- Universal Sling
- Phlebotomy Chair
- Surgical sponges with radio frequency detection
- 2016 budget includes $10,000 for SVH staff education

Cancer Support Sonoma



Foundation Focus

- Transitioning from capital-centric to sustained giving
- Focus on major gifts/significant foundations
- Stewardship
- Legacy Giving

Possible Upcoming Projects

Project	Description/Plans	Approximate Cost
Finish 3D Campaign	- Outstanding grant proposals	**$535,000**
Cancer Support Sonoma	- Second year of operations and management of CSS located on 3rd floor.	**$169,000**
OB Equipment for Birthplace	- Need 2 infant warmers, 2 fetal monitors, OB cart, and infant hearing screening system	**$130,000**
Welcome Center Upgrade	- Small scale remodel of the lobby to make it more welcoming and functional. - Goal to complete in summer 2016 - Could be ideal to focus ask to one donor who would be interested in Lobby naming recognition.	**$300,000**

Project	Description/Plans	Approximate Cost
Surgery Equipment Upgrades - Integrated System - Endosopes	- Final step for the new surgery rooms to use technology to integrate their systems and create more space in the rooms by removing the currently used/outdated towers. - Cost for upgrade (with installation and configuration) to Stryker's newest 1588 AIM camera platform for all three integrated ORs is $355,512.84. (Quote from Stryker). This will complete the transformation to full Stryker iSuites. - Endoscope replacement needed	**$500,000**
Mircogrid Renewable Energy Project	- Develop renewable energy source for SVH power. - Work with Mac McQuown and his team to design and implement a system that could include a fuel cell, solar, and other power sources. - Work with Mac on funding options - Timeline is TBD	**$2million+**
New Imaging Center and Upgraded Pharmacy	- Utilize the old operating rooms (currently vacant) to bring the MRI equipment inside (currently in trailer), and bring the pharmacy to the first floor (currently in basement). - Direct access from ER to CT - Updated imaging facility would create ease for patients and more space which is needed. - Updated pharmacy location will provide adequate space for current requirements.	**$2-3million**
Skilled Nursing Facility Refurbish	- Upgrade the common area in SNF - Refurbish space and equipment to bring to current standards	**$TBD**

5.

FINANCIAL REPORT FOR MONTH ENDING JANUARY 31, 2016

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

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **February 23, 2016**
Subject: **Financial Report for the Month Ending January 31, 2016**

January Operating Income for the hospital had a loss of ($391,212), unfavorable to budget by ($122,075). The year-to date actual loss from operations is ($1,919,970) which is favorable to the expected year-to-date loss of ($2,524,571). After accounting for all other activity, the January net income was $19,112 vs. the budgeted net income of $147,362. In January the hospital received notice that it will receive $236,000 resulting from an audit of the Medicare DRG transfer payments which reflects four prior years' short payments. This additional reimbursement was recorded in January and it lowered the Contractual Discounts by the additional amount. Without the additional supplemental reimbursement, January's loss from operations would have been ($627,212) or ($358,075) worse than budget. The January EBIDA was 3.9% vs. a budgeted 6.1%. Year-to-date, the total net income is $602,856 better than budget with a year to date EBIDA of 6.2% vs. the budget of 4.3%.

Gross patient revenue for January was $20,349,780, $456,427 better than expected. Inpatient gross revenue was over budget by $377,398 due to patient days being over budgeted expectations by 16 days. Outpatient revenue was under budget by ($76,824) due to a lower than budgeted volume for outpatient visits and procedures. The Emergency Room gross revenue is over budget by $156,966 due to a higher acuity of patients seen in the ER. SNF was over expectations by $55,386 due to a slight increase in volume. Home Health continues to be under budget due to purposely reducing services provided to Marin patients ($56,499).

Deductions from revenue were unfavorable to budgeted expectations by ($560,415) due to higher than expected use of the Emergency Room by Medi-Cal and Medicare patients. Medicare managed care accounts increased in January to 10.6% of gross revenue on budgeted expectations on 5.0%. Overall, Medi-Cal accounts were at budgeted expectations for January.

To offset the low reimbursement rates from Medi-Cal and Partnershsip, the hospital receives annual supplemental payments (AB 915) from Medi-Cal and Partnership based on our Medi-Cal volume. For FY 2015 we saw an increase in the supplemental payments due to the higher volume in the ER and we expect similar supplemental reimbursements for FY 2016.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budget by ($141,182).

Operating Expenses of $4,931,518 were under budget by $19,106. The significant negative variances were: Employee Benefits ($91,654), physician and professional fees ($18,611), supplies ($30,965), and interest expense (32,840). PTO was over budget in January by ($39,547) due to the following; paid sick leave for per diem employees ($14,145) and an increased use of PTO during January's holidays. Employee benefits are over budget by ($52,107) due to an increase in the cost of health benefits due to an increase in participation from open enrollment ($24,096) and an increase in the payroll tax FICA, which is typical in the month of January. Physician fees are over budget by ($54,668) due to an increase in the Sound Physician contract ($16,728), the cost of Locum Tenens for the hospitalists ($7,375), a newly contracted radiologist ($13,583), and an adjustment to Prima's general surgery call of ($20,800). The physician fees were offset by other professional fees being under budget by $36,057. Supplies were over budget due to higher inpatient volumes primarily in the OB, ER, and the laboratory. Interest expense is over budgeted expectations due to the true up of the Celtic lease.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for January was ($179,171) vs. a budgeted net loss of ($37,175). The total net income for January after all activity was $19,112 vs. a budgeted net income of $147,362.

EBIDA for the month of January was 3.9% vs. the budgeted 6.1%.

Patient Volumes – January

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	124	107	17	104
Newborn Discharges	16	12	4	11
Acute Patient Days	404	388	16	390
SNF Patient Days	710	654	56	654
Home Care Visits	933	1,196	-263	1,097
OP Gross Revenue	$12,184	$12,040	$144	$11,804
Surgical Cases	124	129	-5	129

Overall Payer Mix – January

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	48.6%	49.1%	-0.5%	46.9%	48.9%	-2.0%
Medicare Mgd Care	10.6%	5.0%	5.6%	7.4%	4.9%	2.5%
Medi-Cal	17.4%	17.7%	-0.3%	19.3%	17.6%	1.7%
Self Pay	0.4%	1.9%	-1.5%	1.0%	1.8%	-0.8%
Commercial	17.8%	20.2%	-2.4%	19.9%	20.5%	-0.6%
Workers Comp	2.4%	3.2%	-0.8%	2.8%	3.3%	-0.5%
Capitated	2.8%	2.9%	-0.1%	2.7%	3.0%	-0.3%
Total	100.0%	100.0%		100.0%	100.0%	

Cash Activity for January:

For the month of January the cash collection goal was $3,458,279 and the Hospital collected $3,422,134, or under the goal by ($36,145). The year-to-date cash goal is $24,242,297 and the Hospital has collected $24,335,061 or over the goal by $92,764. The cash collection goal is based upon net hospital revenue from 90 days ago. Days of cash on hand are 14 days at January 31, 2016. Accounts Receivable increased from December, from 51.2 days to 52.5 days in January. Accounts Payable has decreased by ($472,362) from December and Accounts Payable days are at 45.9.

ATTACHMENTS:

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

Sonoma Valley Hospital
Net Revenue by Payer for the month of January 31, 2016

ATTACHMENT A

	January-16				YTD			
Gross Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	9,931,738	9,718,070	213,668	2.2%	65,590,879	64,774,439	816,440	0.6%
Medi-Cal	3,542,912	3,518,159	24,753	0.7%	27,029,815	23,323,043	3,706,772	2.8%
Self Pay	72,487	368,427	-295,940	-80.3%	1,400,101	2,378,501	-978,400	-0.7%
Commercial	3,592,563	4,095,632	-503,069	-12.3%	28,077,570	27,847,813	229,757	0.2%
Medicare Managed Care	2,167,157	981,159	1,185,998	120.9%	10,363,645	6,435,296	3,928,349	3.0%
Worker's Comp.	481,627	642,317	-160,690	-25.0%	3,942,210	4,399,840	-457,630	-0.3%
Capitated	561,296	569,589	-8,293	-1.5%	3,730,100	3,970,320	-240,220	-0.2%
Total	**20,349,780**	**19,893,353**	**456,427**		**140,134,321**	**133,129,252**	**7,005,069**	

Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	1,695,378	1,778,407	-83,028	-4.7%	11,703,798	12,272,056	-568,258	-4.6%
Medi-Cal	531,437	481,988	49,449	10.3%	3,938,040	3,622,069	315,971	8.7%
Self Pay	26,088	134,476	-108,388	-80.6%	432,396	825,761	-393,364	-47.6%
Commercial	1,465,833	1,644,626	-178,793	-10.9%	10,339,104	10,281,526	57,578	0.6%
Medicare Managed Care	301,018	146,193	154,825	105.9%	1,478,407	1,015,416	462,990	45.6%
Worker's Comp.	116,795	166,360	-49,566	-29.8%	892,251	1,075,918	-183,667	-17.1%
Capitated	19,309	18,796	512	2.7%	132,612	139,985	-7,373	-5.3%
Prior Period Adj/IGT	236,000	125,000	111,000	88.8%	1,802,827	876,500	926,327	105.7%
Total	**4,391,858**	**4,495,846**	**(103,989)**	**-2.3%**	**30,719,435**	**30,109,230**	**610,205**	**2.0%**

Percent of Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	38.6%	39.6%	-1.0%	-2.5%	38.1%	40.8%	-2.8%	-6.9%
Medi-Cal	12.1%	10.7%	1.4%	13.1%	12.8%	12.0%	0.8%	6.7%
Self Pay	0.6%	3.0%	-2.4%	-80.0%	1.4%	2.7%	-1.3%	-48.1%
Commercial	33.4%	36.5%	-3.1%	-8.5%	33.7%	34.1%	-0.4%	-1.2%
Medicare Managed Care	6.8%	3.3%	3.5%	106.1%	4.8%	3.4%	1.4%	41.2%
Worker's Comp.	2.7%	3.7%	-1.0%	-27.0%	2.9%	3.6%	-0.7%	-19.4%
Capitated	0.4%	0.4%	0.0%	0.0%	0.4%	0.5%	-0.1%	-20.0%
Prior Period Adj/IGT	5.4%	2.8%	2.6%	92.9%	5.9%	2.9%	3.1%	106.9%
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**

Projected Collection Percentage:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	17.1%	18.3%	-1.2%	-6.7%	17.8%	18.9%	-1.1%	-5.8%
Medi-Cal	15.0%	13.7%	1.3%	9.5%	14.6%	15.5%	-1.0%	-6.2%
Self Pay	36.0%	36.5%	-0.5%	-1.4%	30.9%	34.7%	-3.8%	-11.0%
Commercial	40.8%	40.2%	0.6%	1.6%	36.8%	36.9%	-0.1%	-0.3%
Medicare Managed Care	13.9%	14.9%	-1.0%	-6.8%	14.3%	15.8%	-1.5%	-9.6%
Worker's Comp.	24.2%	25.9%	-1.7%	-6.4%	22.6%	24.5%	-1.8%	-7.4%
Capitated	3.4%	3.3%	0.1%	4.2%	3.6%	3.5%	0.0%	0.8%
Prior Period Adj/IGT	1.2%	0.6%	0.5%	84.6%	1.3%	0.7%	0.6%	95.4%

Sonoma Valley Health Care District **ATTACHMENT C**

Balance Sheet

As of January 31, 2016

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 2,077,644	$ 3,108,433	$ 2,509,913
2	Trustee Funds	2,970,872	2,970,872	2,533,185
3	Net Patient Receivables	8,216,147	7,864,567	7,573,521
4	Allow Uncollect Accts	(633,564)	(654,860)	(628,733)
5	Net A/R	7,582,583	7,209,707	6,944,788
6	Other Accts/Notes Rec	4,849,282	4,932,326	4,072,447
7	3rd Party Receivables, Net	647,488	1,122,720	1,033,286
8	Inventory	897,951	904,149	717,266
9	Prepaid Expenses	683,022	752,812	866,148
10	Total Current Assets	$ 19,708,842	$ 21,001,019	$ 18,677,033
12	Property,Plant & Equip, Net	$ 53,157,893	$ 53,415,047	$ 55,383,289
13	Specific Funds	584,122	275,657	420,163
14	Other Assets	143,691	143,691	143,164
15	Total Assets	$ 73,594,548	$ 74,835,415	$ 74,623,648
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	$ 3,259,693	$ 3,732,055	$ 3,877,757
17	Accrued Compensation	4,338,309	4,229,706	3,815,994
18	Interest Payable	685,537	571,281	707,574
19	Accrued Expenses	1,295,728	1,628,644	1,401,006
20	Advances From 3rd Parties	1,165,198	1,261,918	552,876
21	Deferred Tax Revenue	2,463,887	2,956,665	3,033,706
22	Current Maturities-LTD	1,708,979	1,706,832	1,708,979
23	Line of Credit - Union Bank	5,923,734	5,923,734	5,698,734
24	Other Liabilities	155,448	165,819	144,549
25	Total Current Liabilities	$ 20,996,514	$ 22,176,654	$ 20,941,175
26	Long Term Debt, net current portion	$ 36,825,822	$ 36,905,660	$ 39,524,098
27	Fund Balances:			
28	Unrestricted	$ 12,717,565	$ 12,768,215	$ 12,618,056
29	Restricted	3,054,648	2,984,886	1,540,319
30	Total Fund Balances	$ 15,772,213	$ 15,753,101	$ 14,158,375
31	Total Liabilities & Fund Balances	$ 73,594,548	$ 74,835,415	$ 74,623,648

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended January 31, 2016

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Volume Information					
1	124	107	17	16%	Acute Discharges	691	708	(17)	-2%	714
2	710	654	56	9%	SNF Days	4,428	4,292	136	3%	4,292
3	933	1,196	(263)	-22%	Home Care Visits	6,730	8,709	(1,979)	-23%	7,975
4	12,184	12,040	144	1%	Gross O/P Revenue (000's)	$ 87,686	$ 81,379	6,307	8%	$ 77,366
					Financial Results					
					Gross Patient Revenue					
5	$ 5,761,003	$ 5,383,605	377,398	7%	Inpatient	$ 37,029,633	$ 35,643,261	1,386,372	4%	$ 35,915,508
6	6,901,738	6,978,562	(76,824)	-1%	Outpatient	50,242,736	49,718,776	523,960	1%	45,659,102
7	4,945,454	4,788,488	156,966	3%	Emergency	35,486,057	29,650,085	5,835,972	20%	29,250,521
8	2,431,911	2,376,525	55,386	2%	SNF	15,168,101	15,452,823	(284,722)	-2%	14,684,493
9	309,674	366,173	(56,499)	-15%	Home Care	2,207,794	2,664,307	(456,513)	-17%	2,456,337
10	**$ 20,349,780**	**$ 19,893,353**	**456,427**	**2%**	**Total Gross Patient Revenue**	**$ 140,134,321**	**$ 133,129,252**	**7,005,069**	**5%**	**$ 127,965,962**
					Deductions from Revenue					
11	$ (16,114,922)	$ (15,412,179)	(702,743)	-5%	Contractual Discounts	$ (110,600,547)	$ (103,122,726)	(7,477,821)	-7%	$ (99,641,951)
12	(60,000)	(89,314)	29,314	33%	Bad Debt	(410,000)	(625,198)	215,198	34%	(740,000)
13	(19,000)	(21,264)	2,264	11%	Charity Care Provision	(207,166)	(148,848)	(58,318)	-39%	(133,600)
14	236,000	125,250	110,750	88%	Prior Period Adj/Government Program Revenue	1,802,827	876,750	926,077	0%	281,657
15	**$ (15,957,922)**	**$ (15,397,507)**	**(560,415)**	**4%**	**Total Deductions from Revenue**	**$ (109,414,886)**	**$ (103,020,022)**	**(6,394,864)**	**6%**	**$ (100,233,894)**
16	**$ 4,391,858**	**$ 4,495,846**	**(103,988)**	**-2%**	**Net Patient Service Revenue**	**$ 30,719,435**	**$ 30,109,230**	**610,205**	**2%**	**$ 27,732,068**
17	$ 129,971	$ 171,184	(41,213)	-24%	Risk contract revenue	$ 1,050,171	$ 1,198,288	(148,117)	-12%	$ 1,794,692
18	$ 4,521,829	$ 4,667,030	(145,201)	-3%	Net Hospital Revenue	$ 31,769,606	$ 31,307,518	462,088	1%	$ 29,526,760
19	$ 18,477	$ 14,458	4,019	28%	Other Op Rev & Electronic Health Records	$ 179,036	$ 101,206	77,830	77%	$ 480,164
20	**$ 4,540,306**	**$ 4,681,488**	**(141,182)**	**-3%**	**Total Operating Revenue**	**$ 31,948,642**	**$ 31,408,724**	**539,918**	**2%**	**$ 30,006,924**
					Operating Expenses					
21	$ 2,288,417	$ 2,300,825	12,408	1%	Salary and Wages and Agency Fees	$ 15,280,666	$ 15,265,066	(15,600)	0%	$ 14,058,712
22	887,198	$ 795,544	(91,654)	-12%	Employee Benefits	5,879,882	5,621,624	(258,258)	-5%	5,423,990
23	$ 3,175,615	$ 3,096,369	(79,246)	-3%	Total People Cost	$ 21,160,548	$ 20,886,690	(273,858)	-1%	$ 19,482,702
24	$ 360,216	$ 341,606	(18,611)	-5%	Med and Prof Fees (excld Agency)	$ 2,395,958	$ 2,475,155	79,197	3%	$ 2,475,099
25	532,161	501,196	(30,965)	-6%	Supplies	3,588,686	3,452,909	(135,777)	-4%	3,471,784
26	256,008	352,170	96,162	27%	Purchased Services	1,934,094	2,465,190	531,096	22%	2,331,532
27	287,563	283,132	(4,431)	-2%	Depreciation	2,034,222	1,981,921	(52,301)	-3%	2,024,047
28	77,875	98,958	21,083	21%	Utilities	678,384	692,706	14,322	2%	675,308
29	25,266	20,834	(4,432)	-21%	Insurance	176,740	145,838	(30,902)	-21%	134,785
30	70,805	37,965	(32,840)	-87%	Interest	362,739	284,318	(78,421)	-28%	316,530
31	146,009	155,895	9,886	6%	Other	1,169,215	1,111,068	(58,147)	-5%	351,553
32	0	62,500	62,500	100%	Matching Fees (Government Programs)	368,026	437,500	69,474	16%	645,940
33	**$ 4,931,518**	**$ 4,950,624**	**19,106**	**0%**	**Operating expenses**	**$ 33,868,612**	**$ 33,933,295**	**64,683**	**0%**	**$ 31,909,281**
34	**$ (391,212)**	**$ (269,137)**	**(122,075)**	**-45%**	**Operating Margin**	**$ (1,919,970)**	**$ (2,524,571)**	**604,601**	**24%**	**$ (1,902,358)**

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended January 31, 2016

	Month						Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Non Operating Rev and Expense					
35	$ (459)	$ 13,657	(14,116)	-103%	Miscellaneous Revenue	$ 20,377	$ 95,599	(75,222)	-79%	$ 85,089
36	-	5,805	(5,805)	-100%	Donations	-	40,635	(40,635)	100%	46,859
37	(37,500)	(37,500)	-	0%	Physician Practice Support-Prima	(262,500)	(262,500)	-	0%	(262,500)
38	250,000	250,000	-	0%	Parcel Tax Assessment Rev	1,751,954	1,750,000	1,954	0%	1,750,000
39	**$ 212,041**	**$ 231,962**	**(19,921)**	**-9%**	**Total Non-Operating Rev/Exp**	**$ 1,509,831**	**$ 1,623,734**	**(113,903)**	**-7%**	**$ 1,619,449**
40	**$ (179,171)**	**$ (37,175)**	**(141,996)**	**382%**	**Net Income / (Loss) prior to Restricted Contributions**	**$ (410,139)**	**$ (900,837)**	**490,698**	**-54%**	**$ (282,909)**
41	$ 69,762	$ 35,183	34,579	98%	Capital Campaign Contribution	$ 554,273	$ 246,281	307,992	125%	$ 533,198
42	$ -	$ 20,833	(20,833)	0%	Restricted Foundation Contributions	$ 450,000	$ 645,835	(195,835)	100%	$ -
43	**$ (109,409)**	**$ 18,841**	**(128,250)**	**-681%**	**Net Income / (Loss) w/ Restricted Contributions**	**$ 594,134**	**$ (8,721)**	**602,855**	**-6912%**	**$ 250,289**
44	242,777	242,777	-	0%	GO Bond Tax Assessment Rev	1,699,439	1,699,439	-	0%	1,067,970
45	(114,256)	(114,256)	-	0%	GO Bond Interest	(803,465)	(803,466)	1	0%	(889,089)
46	**$ 19,112**	**$ 147,362**	**(128,250)**	**-87%**	**Net Income/(Loss) w GO Bond Activity**	**$ 1,490,108**	**$ 887,252**	**602,856**	**68%**	**$ 429,171**
	$ 179,197	$ 283,922			**EBIDA - Not including Restricted Contributions**	$ 1,986,822	$ 1,365,401			$ 2,057,669
	3.9%	6.1%				6.2%	4.3%			6.9%

Sonoma Valley Health Care District **ATTACHMENT E**

Statement of Revenue and Expenses Variance Analysis

For the Period Ended January 31, 2016

	Description	YTD Variance	MONTH Variance	
	Volume Information			
1	Acute Discharges	(17)	17	
2	SNF Days	136	56	
3	Home Care Visits	(1,979)	(263)	
4	Gross O/P Revenue (000's)	6,307	144	
	Financial Results			
	Gross Patient Revenue			
5	Inpatient	1,386,372	377,398	Acute patient days were over budget by 16 days and inpatient surgeries were over budget by 4 cases.
6	Outpatient	523,960	(76,824)	Outpatient visits were under budget by 379 visits and outpatient surgeries were under budget by 9 cases.
7	Emergency	5,835,972	156,966	ER visits were under budget by 24 visits but had a higher than expected case mix (higher acuity).
8	SNF	(284,722)	55,386	SNF patient days were over budget by 56 days.
9	Home Care	(456,513)	(56,499)	Home Care visits were under budget by 263 visits.
10	**Total Gross Patient Revenue**	**7,005,069**	**456,427**	
	Deductions from Revenue			
11	Contractual Discounts	(7,477,821)	(702,743)	Commercial insurance was 17.8% vs. 20.2% budgeted. There was an increase in Medicare Managed Care in January, 10.6% on a budget of 5.0%.
12	Bad Debt	215,198	29,314	
13	Charity Care Provision	(58,318)	2,264	
14	Prior Period Adj/Government Program Revenue	926,077	110,750	Medicare supplemental payment for the DRG Transfer project
15	**Total Deductions from Revenue**	**(6,394,864)**	**(560,415)**	
16	**Net Patient Service Revenue**	**610,205**	**(103,988)**	
17	Risk contract revenue	(148,117)	(41,213)	Blue Shield capitation received was under budget.
18	Net Hospital Revenue	**462,088**	**(145,201)**	
19	Other Op Rev & Electronic Health Records	77,830	4,019	
20	**Total Operating Revenue**	**539,918**	**(141,182)**	
	Operating Expenses			
21	Salary and Wages and Agency Fees	(15,600)	12,408	
22	Employee Benefits	(258,258)	(91,654)	PTO was over budget in January by ($39,547) due to the following; unbudgeted paid sick leave for per diem employees ($14,145), and the true-up of the PTO liability. Employee benefits are over budget by ($52,107) due to an increase in the cost of health benefits ($24,096) due to increased participation during open enrollment and an increase in the payroll tax FICA, this expense will decrease in the coming months but was budgeted equally over the 12 months.
23	Total People Cost	**(273,858)**	**(79,246)**	
24	Med and Prof Fees (excld Agency)	79,197	(18,611)	Physician fees are over budget by ($54,668) due to an increase in the Sound Physician contract ($16,728), the cost of LocumTenens for the hospitalists ($7,375), a newly contracted radiologist ($13,583), and an adjustment to Prima's general surgery call of $20,800. The physician fees were offset by Other Professional fees being under budget by $36,057.
25	Supplies	(135,777)	(30,965)	Supplies are over budget due to higher inpatient volume in January.
26	Purchased Services	531,096	96,162	Budgeted Services not used during January.
27	Depreciation	(52,301)	(4,431)	
28	Utilities	14,322	21,083	
29	Insurance	(30,902)	(4,432)	Insurance premiums increased over budgeted expectations.
30	Interest	(78,421)	(32,840)	Variance due to the true up of the Celtic financing lease - true up being spread over 6 months.
31	Other	(58,147)	9,886	
32	Matching Fees (Government Programs)	69,474	62,500	There were no matching fees in January. This expense is offset from the revenue above from line 14.
33	**Operating expenses**	**64,683**	**19,106**	
34	**Operating Margin**	**604,601**	**(122,075)**	

Sonoma Valley Health Care District **ATTACHMENT E**
Statement of Revenue and Expenses Variance Analysis
For the Period Ended January 31, 2016

	Description	YTD Variance	MONTH Variance	
	Non Operating Rev and Expense			
35	Miscellaneous Revenue	(75,222)	(14,116)	
36	Donations	(40,635)	(5,805)	There were no unrestricted donations in January.
37	Physician Practice Support-Prima	-	-	
38	Parcel Tax Assessment Rev	1,954	-	
39	**Total Non-Operating Rev/Exp**	**(113,903)**	**(19,921)**	
			-	
40	**Net Income / (Loss) prior to Restricted Contributions**	**490,698**	**(141,996)**	
			-	
41	Capital Campaign Contribution	307,992	34,579	Capital campaign donations received from the Foundation were over budgeted expectations.
42	Restricted Foundation Contributions	(195,835)	(20,833)	There were no restricted donations in January
43	**Net Income / (Loss) w/ Restricted Contributions**	**602,855**	**(128,250)**	
44	GO Bond Tax Assessment Rev	-	-	
45	GO Bond Interest	**1**	-	
46	**Net Income/(Loss) w GO Bond Activity**	**602,856**	**(128,250)**	

6.

ADMINISTRATIVE REPORT MARCH 2016

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

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **3/3/16**
Subject: **Administrative Report**

Summary
Year to date results are at budget with a few unexpected, yet positive financial variances. While the healthcare environment continues to be volatile, SVH has been able to increase revenue and maintain expenses. The creative strategies such as our partnerships with the Employer Direct and Solano prison have just really begun this past month. In addition, the additions of many new specialists in Sonoma are resulting in increased surgeries and outpatient services.

Dashboard and Trended Results

The inpatient and emergency satisfaction goals were exceeded in December. In addition, we are back to the 90th percentile with the Value Based Purchasing score. The staff satisfaction survey is complete and we also exceeded the goal with 86% participation. The results will be shared in April with the staff and will be presented to the board in May. The EBIDA is looking very good as compared to our budgeted goal of 4%. We have also met our goal for community hours for the year.

Focused Updates

There are several departments that have been the focus for this fiscal year. The outpatient nutritional counseling service continues to grow and receive very positive feedback. Allison Evanson is an excellent speaker and her work is truly helping our community make more positive choices. Our partnership with the Ceres Project has resulted in sharing nutrient rich, healing food recipes that are now offered in our café. These recipes will also be included in our patient menu. Finally, this month we are purchasing a new information system for our food and nutrition services team to enhance our efficiency and effectiveness.

The Birth Place (obstetrics) has also been a major focus this year. Because of the generous donations to our foundation, several new pieces of new equipment such as fetal monitors will be purchased this month. This team has had several very busy months this year and the team has exceeded patient satisfaction. We hope to make several physical environment improvements in the near future to enhance the healing and experience for our patients.

The Wellness program has significantly enhanced the services in 2016. Spouses of staff are now eligible for the program and when they participate; their insurance premium costs are lowered. In order to increase participation and truly create a more healthy workplace, the program has increased the quarterly challenges and on site classes. We have improved our offerings to the night and weekend shifts. The Wellness program Kick-off this year was very well attended and included massage, aromatherapy, mindfulness, balance, a visit to our contemplation lounge and the opportunity to sample some of the healthy food options from the café. The wellness team also delivers tea through the Deep Breath Café and has created staff health baskets for the lounges.

I also have to mention that the rewards and recognition team continues to find creative ways to make our hospital a great place to work. They had a musical chairs contest last week that was a huge success.

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

DECEMBER DASHBOARD

PILLAR	PERFORMANCE GOAL	METRIC	ACTUAL RESULT	GOAL LEVEL
Service Excellence	Highly satisfied Inpatients	Maintain at least 5 out of 9 HCAHPS domain results above the 70th percentile	8 out of 9 in December	>7 = 5 (stretch) 6 = 4 5 = 3 (Goal) 4 = 2 <4=1
Service Excellence	Highly satisfied Emergency Patients	Maintain at least 5 out of 7 ERCAPS domain results above the 70th percentile	6 out of 7 in December	7 = 5 (stretch) 6 = 4 5 = 3 (Goal) 4 = 2 3 = 1
Quality	Excellent Clinical Outcomes	Value Based Purchasing Clinical Score at 50 or higher	53 (90TH percentile)	>55 = 5 (stretch) >52 =4 >50 =3 (Goal) >47=2 <40 =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	6.2%	>5% (stretch) >4.5%=4 >4.0% (Goal) >3/5%=2 <3.5%=1
	Efficiency and Financial Management	Meet FY 2016 Budgeted Expenses	$33,868,612 (actual) $33,933,295 (budget)	<2% =5 (stretch) <1% = 4 <Budget=3 (Goal) >1% =2 >2% = 1
Growth	Surgical Cases	Increase surgeries by 2% over prior year	892YTD FY2016 845 YTD FY2015	>2% = 5 >1% = 3 < 1% = 2
	Outpatient & Emergency Volumes	2% increase (gross outpatient revenue over prior year)	$87.7 mm YTD $77.5 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	1111 hours for 7 months	>1500 = 5 >1200 = 4 >1000 = 3 >750 = 2 >500 = 1

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

FY 2016 TRENDED RESULTS

MEASUREMENT	Goal FY 2016	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Inpatient Satisfaction	6/9	5	5	2	6	7	8						
Emergency Satisfaction	5/7	2	3	4	5	5	6						
Value Based Purchasing	>50	52	52.2	53.5	52.5	53					47	48	48
Staff Satisfaction	>75th	91	91	91	91	91	91	91	91	91	91	91	91
FY YTD Turnover	<10%	1.2	1.2	1.8	2.8	3.4	4.6	5.2	6.5	7.4	7.6	8	8.3
YTD EBIDA	>4%	8.2	7.6	7.7	7.3	5.7	6.6	6.2	6.2	5.4	4.7	4.2	3.8
Net Operating Revenue	>4.5m	4.48	4.6	4.7	4.7	4.1	4.7	4.5	4.6	4.1	4.1	4.1	4.5
Expense Management	<4.8m	4.7	4.8	4.9	4.9	4.6	4.8	4.9	5.0	4.7	4.8	4.6	5.1
Net Income	>50k	202	174	27.8	104	244	575	19	-211	-382	-278	74	139
Days Cash on Hand	>20	22	16	18	13	9	21	14	12	**15**	**20**	**17**	16
A/R Days	<50	46	45	49	47	53	51	53	48	47	47	43	47
Total FTE's	<315	313	310	312	327	322	317	319	303	310	304	307	309
FTEs/AOB	<4.0	3.6	3.77	3.65	3.77	4.1	3.77	3.57	3.46	3.79	4.05	3.91	3.36
Inpatient Discharges	>100	110	74	92	97	85	109	124	98	113	95	97	97
Outpatient Revenue	>$12m	12.6	12.9	12.7	13.1	11.9	12.2	12.1	10.5	11.8	11.2	10.7	12.0
Surgeries	>130	125	122	127	131	114	136	124	136	137	144	118	122
Home Health	>1000	981	917	948	948	1088	915	933	1109	1232	1154	963	1014
Births	>15	16	15	11	11	14	24	17	11	16	7	11	24
SNF days	>660	619	634	607	666	544	648	710	607	669	487	626	669
MRI	>120	143	131	119	132	109	113	102	116	157	138	125	144
Cardiology (Echos)	>65	66	62	63	77	41	50	46	56	67	61	63	66
Laboratory	>12.5	12.1	12.2	11.5	11.7	11.6	11.4	11.9	11.5	12.1	12.3	11.9	12.3
Radiology	>850	1036	1011	997	1018	875	907	904	1053	1156	1030	1014	965
Rehab	>2587	3014	2384	2773	2886	2297	3003	2815	2751	3113	3063	3008	2873
CT	>300	384	352	343	336	381	323	379	309	347	302	357	335
ER	>800	878	888	871	820	841	863	864	845	769	876	943	846
Mammography	>475	462	439	367	543	406	492	446	444	466	497	476	453
Ultrasound	>325	395	314	320	353	246	290	296	317	357	391	354	345
Occupational Health	>650	733	728	646	871	681	683	600	588	679	687	573	660

7.

OFFICER & COMMITTEE REPORTS

Meeting of the Governance Committee

Date: **3.3.16**

Prepared by: **Peter Hohorst**

Agenda Item Title: **POLICY GOVERNING BIDDING FOR FACILITY CONTRACTS**

Purpose:

It is the intent of the Board of Directors ("Board") of the Sonoma Valley Health Care District ("District") to provide an equal opportunity to all qualified and responsible parties wishing to participate in the bidding process with respect to the Sonoma Valley Health Care District ("District") and the Sonoma Valley Hospital ("Hospital").

It is the intent of the Board, consistent with the District's obligations, to obtain the maximum value for all expenditures.

It is the intent of the Board to clarify, with this policy, the authority granted to the President and Chief Operating Officer ("CEO") by the Board with regard to District and Hospital purchases and contracts. It is also the intent to clarify the authority retained by the Board.

In all instances where authority is granted to the CEO, it is understood that the CEO may in turn delegate this authority to a member of the CEO's staff. Responsibility for adherence to this policy, when the authority is delegated by the CEO to a staff member, remains with the CEO.

For purposes of this Policy "Facility Project" is defined as work relating to projects involving construction or improvement of a hospital or health facility (i.e. public works projects), but excluding routine or recurring maintenance.

Statement of Board Policy:

Section 1. Scope and Application of the Policy

1.1 Delegation of Authority

Except as specified in Section 5 of this policy, the Board hereby delegates to the CEO the authority to act on behalf of the Board in the implementation of the provisions of this Policy.

1.2 Bidding Threshold

The District, with certain exceptions, as covered in Section 2, (H&S Code 32132) shall award any contract exceeding twenty-five thousand dollars ($25,000) for projects relating to the construction or improvement of the Hospital or a facility owned by or leased to the District (Facility Projects) to the lowest responsible bidder using the "formal" bidding procedures provided in Section 3 [Formal Bidding Procedure]. Alternately, the District shall reject all bids.

1.3 Authority to Make Purchases.

The District's CEO is hereby given authority to make all purchases and to execute all purchase orders or contracts for the District duly authorized pursuant to this Policy. All purchases and contracts shall be upon written order.

1.4 Contract File

The CEO shall keep and maintain written or electronic records of all contracts. The contract file shall include a description of the method used to select the contractor or service provider, including a copy of the request for

proposal (RFP) or other form of solicitation, the amount of the contract, the expiration date of the contract, and the name of the contractor or service provider. The file shall also include a copy of the Notice of Bids and the names of all bidders and their proposals.

The contract file for all contracts awarded under the exceptions listed in section 2 shall include a description of the exception and an explanation of the method used to select the contractor or service provider.

The contract file shall include the names of any employ of the District, or any Board member who elected to recuse themselves from the award process because of a conflict of interest.

1.5 Conflict of Interest

With respect to all contracts covered by this Policy, any practices or procedures which might result in unlawful activity shall be prohibited, including practices which might result in rebates, kickbacks or other unlawful consideration. No employee of the District may participate in any selection process when such employee has a relationship with a person or business entity seeking a contract which would subject those employees to the prohibitions in *Government Code §* 87100

1.6 No Advantage.

No illegal, unfair, unethical or otherwise improper advantage shall be accorded to any bidder by the District, a Board member or an employee of the District/Hospital.

Section 2 Exceptions to Bidding and Lowest Bid Policy

The District shall not be required to apply the lowest bid policy to (a) emergency contracts, (b) emergency service contracts, (c) change orders to existing contracts that are less than 5% of the original contract, (d) routine and recurring maintenance, (e) professional services of private architectural, landscape architectural, engineering, environmental, land surveying, or construction project management firms for work on Facility Projects, and (f) Facility Projects where the District has elected to use a design-build method to select the contractor H&S Code 32132.b)

Section 2.1 Emergency Contracts.

Notwithstanding anything to the contrary, the Board may award contracts without following the lowest bid policy, if it first determines (i) an emergency exists that warrants such expenditure due to fire, flood, storm, epidemic or other disaster or equipment failure and (ii) it is necessary to protect public health, safety, welfare or property. (H&S Code 32136). In the event that the emergency requires immediate action, the CEO may make the determination that an emergency condition exists and award a contract without first receiving Board approval. The CEO shall inform the Board of the contract and the emergency at the next regularly scheduled Board meeting.

Section 2.2 Change Orders

Notwithstanding anything to the contrary, the CEO shall not be required to secure bids for change orders that do not materially change the scope of work set forth in a contract previously made, provided (i) the contract was made in compliance with bidding requirements, and (ii) no individual change order amounts to more than five percent (5%) of the contract (H&S Code 32132.c).

Section 2.3 Professional Services

Notwithstanding anything to the contrary, where required by facility projects, the CEO shall award contracts for professional services of private architectural, landscape architectural, engineering, environmental, land surveying or construction management firms on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. (Government Code § 4526.) No competitive bidding shall be required. (Health and Safety Code § 32132(b).)

If the CEO elects to solicit bids for architectural, landscape architectural, engineering, environmental, land surveying or construction management firms, the Notice Inviting Bids for these services shall contain the following statement in boldface type: **"Please be advised that the successful design professional will be required to indemnify, defend and hold harmless the District against liability for claims that arise out of or relate to the**

negligence, recklessness or willful misconduct of the design professional." (Public Contract Code § 20103.6 and Civil Code § 2782.8.)

The CEO shall establish procedures for verifying competence and professional qualifications and for determining fair and reasonable benchmark prices for these services (Government Code § 4526.).

Section 2.5 Design – Build Projects

Notwithstanding anything to the contrary, the Board may elect to use the Design – Build method to select a contractor for construction or improvement of the Hospital facility if the project amount will be greater than $1.0 million. (H&S Code 32132.5., Public Contract Code 20133.)

If the Board elects to use the design – build method, the Board shall follow the contracting provisions of Public Contract Code 20133 and shall award the contract based on "best value" as defined in section 20133. Because of their complexity the Design – Build contracting provisions have not been delineated in this policy.

Section 3. Formal Bidding Procedure

Section 3.1 Bid Packet

Where formal bidding is required, the CEO shall prepare a bid packet, including a notice inviting formal bids ("Notice Inviting Bids"). The packet shall include a description of the scope of Work in such detail and written with such specificity as may be required to allow all potential bidders to understand the need and give a level playing field to all bidders (Specifications). In establishing the Specifications, the CEO may consider the direct cost of the project as well as any requirement reasonably related to the quality, fitness and capacity of a bidder to perform the proposed Work satisfactorily.

(a) Prequalification

The CEO may establish a uniform prequalification system using a standard questionnaire to evaluate the ability, competency and integrity of bidders as outlined in Public Contract Code §§ 20101 et seq. In such event, the CEO may require each prospective bidder to complete and submit a standardized questionnaire and financial statement.

(b) Bidder's Security

The CEO shall include in the Specifications a requirement that all bids be accompanied by bidder's security in the form of cash, a cashier's check, certified check, or a bidder's bond executed by an admitted surety insurer made payable to the Hospital. The security shall be in an amount equal to at least ten percent (10%) of the amount bid. (Public Contract Code § 10167.) Any bid not accompanied by one of the applicable bidder's security shall be rejected as non-responsive. The District shall return to all unsuccessful bidders their respective bidder's security within five (5) working days after awarding the contract.

(c) Performance Bond

The CEO shall include in the Specifications, a requirement that the successful bidder furnish a performance bond in the amount of one hundred percent (100%) of the contract sum at the time of entering into the contract if the contract amount for the work is in excess of $500,000. The performance bond shall be filed with the District to insure the District against faulty, improper or incomplete materials or workmanship, and to insure the District of complete and proper performance of the contract.

(d) Payment Bond

The CEO shall include in the Specifications, a requirement that the successful bidder to whom a contract is awarded which is in excess of twenty-five thousand dollars ($25,000) shall furnish a payment bond acceptable to the District. (Civil Code § 9550) This labor and material bond shall be filed with the District pursuant to applicable laws of the State of California. The CEO shall not require a payment bond from an architectural, landscape architectural, engineering, land surveying or construction management firms.

(e) Completion Date

The CEO may include in the Specifications a time within which the whole or any specified portion of the Work shall be completed. (Government Code § 53069.85.)

The CEO may include in the Specifications a provision that the contractor shall forfeit a specified sum of money for each day completion is delayed beyond the date stated in the Specifications.

The CEO may include in the Specifications a provision for the payment of a bonus to the contractor for completion of the project prior to the specified date stated in the Specifications when such timely completion would be beneficial to the District. (Government Code § 53069.85.)

(f) Subcontractors

The CEO shall include in the Specifications a provision that any prime contractor include in his/her bid: (i) the name and address of each subcontractor who will perform labor or render service or fabricate or install a portion of the Work in excess of 5% of the total amount of the contract and (ii) a description of Work to be performed by each such subcontractor.

The bidder shall list only one subcontractor for each portion as is defined by the bidder in his/her bid. (Public Contract Code § 4104.)

A prime contractor whose bid is accepted may not substitute a new subcontractor in place of the subcontractor listed in the original bid except as allowed under Public Contract Code 4107.

3.2 Notice Inviting Bids.

Where formal bidding is required, the CEO shall publish the Notice Inviting Bids at least ten (10) days before the date of opening the bids. Notice shall be published at least twice, not less than five (5) days apart, in a newspaper of general circulation, printed and published in the jurisdiction of the District. (Public Contract Code 22037).

In addition, the CEO shall also publish Notice Inviting Bids in a trade publication, as specified in Public Contract Code § 22036.

3.3 Requirements of Notice Inviting Bids

The CEO shall include all of the following in the Notice Inviting Bids:

a. Description of the contemplated Work;

b. The procedure by which potential bidders may obtain electronic copies of the Plans and Specifications;

c. The final time, date and address (or e-mail address) for receiving and opening of bids (including designation of the appropriate District person or office) (Government Code § 53068; Public Contract Code § 4104.5, 22037)

d. The date, time and place for opening of bids;

e. The payment or performance bond amounts if required by the Specifications (Civil Code § 9550)

f. The time within which the whole or any specified portion of the Work shall be completed (Government Code § 53069.85)

g. The penalty amount, if required by the Specifications, for each day completion is delayed beyond the specified time. (Government Code 53069.85)

h The bonus amount payable to the contractor for completion of the work prior to the specified completion day if a bonus payment is included in the Specifications. (Government Code 53069.85)

3.4 Submission of Bids.

The CEO shall accept only written sealed bids from the prospective bidders. The CEO shall date and time stamp all bids upon receipt. All bids shall remain sealed until the date and time set forth for opening the bids in the Notice Inviting Bids. Any bid received by the District after the time specified in the Notice Inviting Bids shall be returned unopened. (Government Code 53068)

3.5 Examination and Evaluation of Bids.

On the date provided in the Notice Inviting Bids, the District shall publicly open the sealed bids. A person designated by the CEO, will attend and officiate over the opening of bids ("Opening"). The bids will be made public for bidders and other properly interested parties who may be present at the Opening.

The District reserves the right not to determine the low bidder at the Opening, to obtain the opinion of counsel on the legality and sufficiency of all bids, and to determine at a later date which bid to accept. Such determination shall be made within sixty (60) days of the Opening or unless a different period of time is specified in the Notice Inviting Bids.

In the event there are two or more identical lowest bids pursuant to any provision requiring competitive bidding, the CEO may determine by lot which bid shall be accepted. (Government Code 53064)

3.6. Award of Contract.

The CEO shall award the contract to the lowest bidder, provided the bidder is responsible as defined by section 3.7 and the bid is reasonable and meets the requirements and criteria set forth in the Notice Inviting Bids

Any contract awarded by the District shall be subject to all applicable provisions of federal, California and local laws. In the event of a conflict between any contract documents and any applicable law, the law shall prevail.

Notwithstanding anything to the contrary, the District is under no obligation to accept the lowest responsible bidder and reserves the right to reject all bids. (H&S Code 32132)

Section 3.7 Responsible Bidder

a. For purposes of this Policy, "responsible bidder" means a bidder who has demonstrated the attribute of trustworthiness and quality during prior service, a reputation for reliability and satisfactory service with other clients, sufficient financial capacity and the physical capability and the technical and non-technical expertise in order to perform the contract satisfactorily (Public Contract Code 1103).

b. If the CEO determines that the lowest bidder is not responsible, the Board may award the contract to the next lowest responsible bidder

c. If the Board decides to award the contract to a bidder other than the lowest bidder pursuant to subparagraph (b), the Board shall first notify the low bidder of any evidence, either obtained from third parties or concluded as a result of the District's investigation, which reflects on such bidder's responsibility. The District shall afford the low bidder an opportunity to rebut such adverse evidence and shall permit such bidder to present evidence that it is qualified. Such opportunity to rebut adverse evidence and to present evidence of qualification shall be submitted in writing to the District.

Section 4. Bid Conditions

All formal bids shall be subject to the following general conditions.

Section 4.1 Minimum Number of Bids.

The CEO shall consider a minimum of three (3) bids whenever possible; however, where the CEO cannot obtain three bids or when the CEO decides that time will not permit obtaining three bids, the CEO may consider a minimum of two (2) bids.

Section 4.2 Multiple Bids.

When bids for multiple items are solicited at the same time, the CEO may accept parts of one or more bids (provided the Notice Inviting Bids so indicates) unless the bidder has specified to the contrary, in which event the District reserves the right to disregard the bid in its entirety.

Section 4.4 Minor Deviations.

The CEO reserves the right to waive inconsequential deviations from the specifications in the substance or form of bids received.

Section 5. Limit of Authority Delegated to CEO

Section 5.1 District Contracts (Non Hospital)

Facility Project contracts or contracts regarding land purchases and leases which bind the District (but not the Hospital) to the terms of a contractual agreement shall be approved by the Board and shall be signed by the Chair of the Board unless the Board designates an alternate signer when the contract is approved.

Section 5.2 Capital Project Contracts

Facility Project contracts for capital projects that will financially obligate the Hospital to more than $100,000 shall be reviewed by the Finance Committee.

Facility Project contracts for capital projects that are included in the capital budget and will obligate the Hospital to more than $250,000 shall be approved by the Board.

Facility Project contracts for capital projects that are not included in the capital budget and will obligate the Hospital to more than $50,000 shall be approved by the Board.

Facility Project change orders that in aggregate increase the scope of the Facility Project by more than 20% shall be approved by the Board.

Section 5.3 Board Approval Process

For all Facility Project contracts where the approval of the Board is required (not delegated to the CEO) the project Specifications and the Notice Inviting Bids shall be approved by the Board before publication.

For all Facility Project contracts where the approval of the Board is required (not delegated to the CEO) the final contract shall be reviewed by the Finance Committee before submission to the Board for approval.