MARIN HEALTHCARE DISTRICT

100B Drakes Landing Road, Suite 250, Greenbrae, CA 94904 **Telephone: 415-464-2090** **Fax: 415-464-2094**
Website: www.marinhealthcare.org ***Email:*** info@marinhealthcare.org

REGULAR MEETING @ 7:00 PM

CLOSED SESSION – FOLLOWING REGULAR MEETING

TUESDAY, DECEMBER 9, 2014

Board of Directors

Chair: Larry Bedard, M.D.
Vice Chair: Ann Sparkman, J.D.
Secretary: Harris Simmonds, M.D.
Directors: James Clever, M.D.
Jennifer Rienks, Ph. D.

Location:
Marin General Hospital, Conference Ctr.
250 Bon Air Road
Greenbrae, CA 94904

Staff:
Lee Domanico, CEO
Renee' Toriumi, Executive Assistant to CEO
Colin Coffey, District Counsel

AGENDA

REGULAR MEETING

		Tab
1. Roll Call	Bedard	
2. Approval of Agenda (action)	Bedard	
3. Approval of Consent Agenda		
a. Minutes of the Regular Meeting of November 11, 2014 (action)	Bedard	1
4. General Public Comment	Bedard	
Any member of the audience may make statements regarding any items NOT on the agenda. Statements are limited to a Maximum of three (3) minutes. Please state and spell your name if you wish it to be recorded in the minutes.		
5. Safety Update	Domanico	
6. Oath of Office for Newly Elected Board Members, Dr. Larry Bedard, Jennifer Hershon, Jennifer Rienks (action)	Bedard/Coffey	
7. Election of District Board Officers for 2014 (action)	Bedard	
8. Q3 2014 MGH Performance Metrics & Core Services Report	Domanico	2
9. MGH Employee Lease and Midlevel Services Agreement (action)	Domanico	3
10. Public Works Policy (action)	Domanico/Coffey	4
11. District 2015 Regular Board Meeting Schedule	Domanico	5
12. Committee Meeting Reports		
a. MHD Finance and Audit Committee (to meet on 12/16/2014)	Sparkman	
b. MHD Lease and Building Committee (met on 11/19/2014)	Simmonds	
13. Reports		
a. District CEO's Report	Domanico	
b. Hospital CEO's Report	Domanico	
c. Chair's Report	Bedard	
d. Board Members' Reports	All	
14. Adjournment of Regular Meeting Next Regular Meeting: Tuesday, January 13, 2015 @ 7:00 p.m.		

CLOSED SESSION

15. Call to Order	Bedard
16. Announcement – Purpose of Closed Meeting	Bedard
17. Conference with real estate negotiators, Government Code Section 54956.8 regarding negotiations with Marin County re terms of location of new Hillside Garage lot boundary. Negotiators: Domanico, Friedenberg	Domanico/Friedenberg
18. Adjournment of Closed Session	

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
American Sign Language Interpreters may be requested by calling (415) 464-2090 (voice) or (415) 464-2094 (facsimile) at least 48 hours in advance of this meeting.

Tab 1

MARIN HEALTHCARE DISTRICT
100B Drakes Landing Road, Suite 250
Greenbrae, CA 94904

SPECIAL STUDY SESSION and REGULAR MEETING MINUTES
Tuesday, November 11, 2014
Marin General Hospital, Conference Center

Call to Order – Special Study Session @ 6:00 pm
Chair Bedard called the Special Study Session to order at 6:00 pm.

Roll Call
BOARD MEMBERS PRESENT: Chair Larry Bedard, MD; Vice Chair Ann Sparkman; Secretary Harris Simmonds, MD; Director Jennifer Rienks, Director James Clever, MD

ALSO PRESENT: Lee Domanico, Chief Executive Officer; Colin Coffey, Counsel; Renee' Toriumi, EA to the CEO

6. Approval of Agenda
Director Simmonds moved to approve the agenda as presented. Director Sparkman seconded. Vote: all ayes.

7. Approval of Consent Agenda
a. Minutes of the Regular Meeting of October 14, 2014

After review of the Regular Meeting minutes of October 14, 2014 (following Tab 1), Director Simmonds moved to approve the minutes as presented. Director Rienks asked that more clarity be addressed on page 3, Section 14, Q2 2014 MGH Performance Metrics & Core Services Report. She asked that the first sentence of Section 14 read, "CEO Domanico reviewed … page 4 of 15, where the debt coverage ratio be changed from 5.16 to 2.62. Director Rienks seconded the motion to modify the minutes as stated above. Vote: all ayes, as amended.

8. General Public Comment
Public comment – Cindy Winter (Pedestrian Safety, Pedestrian Bridge to Park, Bike Parking)
Chair Bedard thanked Ms. Winter for her presentation and asked that she leave a copy of her notes with Ms. Toriumi.

9. Final MHD 2014-2013 Audit & Supplementary Information
CFO Ron Sperling reviewed the Marin Healthcare District Report of Independent Auditors and Financial Statements for the period of June 30, 2014 and 2013 (included following Tab 2).

The auditors, Moss Adams, presented their findings at the last Audit & Finance meeting a couple of weeks ago. The auditors reported an unqualified clean audit, which means that there were no concerns or changes from the information presented.

Director Simmonds moved to approve the 2014-2013 Audit & Supplementary Information. Director Sparkman seconded. Vote: all ayes.

CEO Domanico explained that Mr. Ron Sperling's last day would be on December 4th. Board members extended their thanks and appreciation to Mr. Sperling for his excellent work and ability to smoothly transition the accounting and finance processes.

Public comment – none.

10. Committee Meeting Reports

a. MHD Finance and Audit Committee (October 28, 2014)

Chair Sparkman reported the committee had reviewed the draft audit report, which was presented tonight. The committee also reviewed a draft of a Financial Procedures and Internal Control Policy, which will be finalized by legal counsel, Mr. Colin Coffey and presented to the full board for approval at a future meeting. Chair Sparkman reported $3.3M in the operating account, revenue on budget, and 1206b slightly below budget. Updates will be incorporated into the budget based on more current assumptions and operating procedures. The next meeting is scheduled for Tuesday, December 16, 2014.

Public comment – none.

b. MHD Lease and Building Committee

Chair Simmonds reported the next committee meeting will be held on November 19, 2014.

11. Reports

a. District CEO's Report

CEO Domanico reported Measure R received 78% in support, which was higher than any other measure or votes in support of Governor Brown. 68.5% for the Tax Measure supporting the rebuilding of the hospital signifies the public is generally pleased with the performance of the hospital in the past 4-5 years, supporting the governance in place.

Director James Clever was happy to report that his recommendation, eight (8) years ago, for the need of a two board structure (Hospital - operations/hospital management and District - financial control) was carried forth by KSA and implemented, which is working.

CEO Domanico agreed that the Hospital Replacement Building Team will address the pedestrian safety and bicycle parking locations planned in the current plans.

Director Rienks asked for the link to the Hospital Website be added back into the District Website. It was apparently removed in the recent upgrade.

b. Hospital CEO's Report

CEO Domanico stated that MGH is out in front of other Bay Area hospitals with the training of most of the caregivers who may have direct contact with Ebola patients. Staff from the Environmental Services and Maintenance Departments have also received training. CDC protective clothing and gear is onsite, with 250 units available for staff if necessary. A mock Ebola event has occurred with critiques shared to improve the patient flow process. Another mock event will be conducted in a week. Additional training has been provided in the prevention of droplet contagious diseases.

The Capital Campaign "Building Better Health" kickoff has taken place with first major gift received. MGH continues to be at or above operating budget and improving budget performance for the year.

Mr. Domanico stated that the gentleman who attended the last MHD BOD meeting has had conversations with Dr. Sklar and the issues he raised have been addressed.

MGH has received, 2nd year in a row, the distinguished award given to hospitals ranking in the top 5% of the country in clinical outcomes by HealthGrades. Safety has improved by 300% since the Operation Safety Program has been implemented.

c. Chair's Report

Chair Larry Bedard confirmed that nurses at Kaiser (reported by his spouse) are concerned with their Ebola training. Chair Bedard reported his attendance at a recent National Emergency Physician Conference, where 370 emergency leaders gather annually. There he received the High Kurmudgeon Award, recognizing his light-hearted annual participation seasoned with his humorous, clever and astute manner.

Chair Bedard reported on his attendance at El Camino Hospital where he discussed with others the MHD governance structure. He also expressed appreciation for attending the Estes Park Conference where he gained more knowledge of Value Based Purchasing.

Director Rienks reported her re-election to the MHD Board and emphasized the importance of continued communication about Measure R and the roles of the District and Hospital.

Chair Bedard acknowledged his re-election and congratulated Jennifer Hershon for her election to the Board. He confirmed she would be joining the District Board in December.

Chair Larry Bedard thanked Dr. James Clever for his eight (8) years of dedication and service to the Marin Healthcare District Board. A token of appreciation was presented.

12. Adjournment

Director Clever moved to adjourn the meeting. Director Rienks seconded. Vote: all ayes.

Next Regular Meeting: Tuesday, December 9, 2014 @ 7:00 pm.

Tab 2

MARIN GENERAL HOSPITAL

250 Bon Air Road, Greenbrae, CA 94904
t » 415-925-7000

Marin General Hospital

Performance Metrics and Core Services Report

3rd Quarter 2014

Prepared 11-21-2014

Marin General Hospital

Performance Metrics and Core Services Report: **3rd Quarter 2014**

TIER 1 PERFORMANCE METRICS

In accordance with Tier 1 Performance Metrics requirements, the MGH Board is required to meet each of the following minimum level requirements:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	1. MGH Board must maintain MGH's Joint Commission accreditation, or if deficiencies are found, correct them within six months.	Quarterly	In Compliance	Joint Commission granted MGH an "Accredited" decision with an effective date of 7/16/2013 for a duration of 36 months. Next survey to occur in 2016.
	2. MGH Board must maintain MGH's Medicare certification for quality of care and reimbursement eligibility.	Quarterly	In Compliance	MGH maintains its Medicare Certification.
	3. MGH Board must maintain MGH's California Department of Public Health Acute Care License	Quarterly	In Compliance	MGH maintains its license with the State of California.
	4. MGH Board must maintain MGH's plan for compliance with SB 1953.	Quarterly	In Compliance	MGH remains in compliance with SB 1953 (California Hospital Seismic Retrofit Program).
	5. MGH Board must report on all Tier 2 Metrics at least annually.	Annually	In Compliance	4Q 2013 (Annual Report) was presented to MGH Board and to MHD Board in May 2014.
	6. MGH Board must implement a Biennial Quality Performance Improvement Plan for MGH.	Annually	In Compliance	MGH Performance Improvement Plan for 2013 was presented for approval to the MGH Board in May 2014.
	7. MGH Board must include quality improvement metrics as part of the CEO and Senior Executive Bonus Structure for MGH.	Annually	In Compliance	CEO and Senior Executive Bonus Structure includes quality improvement metrics.
(B) Patient Satisfaction and Services	MGH Board will report on MGH's HCAHPS Results Quarterly.	Quarterly	In Compliance	**Schedule 1**
(C) Community Commitment	1. In coordination with the General Member, the MGH Board must publish the results of its biennial community assessment to assess MGH's performance at meeting community health care needs.	Annually	In Compliance	Community Health and Education Report was presented to the MGH Board and to the MHD Board in May 2014.
	2. MGH Board must provide community care benefits at a sufficient level to maintain MGH's non-profit tax exempt status.	Quarterly	In Compliance	MGH continues to provide community care and has maintained its tax exempt status.
(D) Physicians and Employees	MGH Board must report on all Tier 1 "Physician and Employee" Metrics at least annually.	Annually	In Compliance	Physician and Employee metrics were presented to the MGH Board and to the MHD Board in May 2014.
(E) Volumes and Service Array	1. MGH Board must maintain MGH's Scope of Acute Care Services as reported to OSHPD.	Quarterly	In Compliance	All services have been maintained.
	2. MGH Board must maintain MGH's services required by Exhibit G to the Loan Agreement between the General Member and Marin County, dated October 2008, as long as the Exhibit commitments are in effect.	Quarterly	In Compliance	All services have been maintained.
(F) Finances	1. MGH Board must maintain a positive operating cash-flow (operating EBITDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric.	Quarterly	In Compliance	**Schedule 2**
	2. MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.	Quarterly	In Compliance	**Schedule 2**

Marin General Hospital

Performance Metrics and Core Services Report: **3rd Quarter 2014**

TIER 2 PERFORMANCE METRICS

In accordance with Tier 2 Performance Metrics requirements, the General Member shall monitor and the MGH Board shall provide necessary reports to the General Member on the following metrics:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).	Quarterly	In Compliance	**Schedule 3**
(B) Patient Satisfaction and Services	1. MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.	Quarterly	In Compliance	**Schedule 1**
	2. MGH Board will report external awards and recognition.	Annually	In Compliance	External awards and recognition report was presented to the MGH Board and the MHD Board in May 2014
(C) Community Commitment	1. MGH Board will report all of MGH's cash and in-kind contributions to other organizations.	Quarterly	In Compliance	**Schedule 4**
	2. MGH Board will report on MGH's Charity Care.	Quarterly	In Compliance	**Schedule 4**
	3. MGH Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.	Annually	In Compliance	Community Health and Education Report was presented to the MGH Board and to the MHD Board in May 2014.
	4. MGH Board will report the level of reinvestment in MGH, covering investment in excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.	Annually	In Compliance	Reinvestment and Capital Expenditure Report was presented to the MGH Board and to the MHD Board in May 2014.
	5. MGH Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.	Annually	In Compliance	"Green Building" Status Report was presented to the MGH Board and to the MHD Board in May 2014.
(D) Physicians and Employees	1. MGH Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at MGH.	Annually	In Compliance	Physician Report was presented to the MGH Board and to the MHD Board in May 2014.
	2. MGH Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.	Annually	In Compliance	Physician and Employee metrics were presented to the MGH Board and to the MHD Board in May 2014.
	3. MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.	Quarterly	In Compliance	**Schedule 5**
(E) Volumes and Service Array	1. MGH Board will develop a strategic plan for MGH and review the plan and its performance with the General Member.	Annually	In Compliance	The updated MGH Strategic Plan was presented to the MGH Board on October 12, 2013
	2. MGH Board will report on the status of MGH's market share and Management responses.	Annually	In Compliance	MGH's market share and management responses report was presented to the MGH Board on October 12, 2013
	3. MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.	Quarterly	In Compliance	**Schedule 2**
	4. MGH Board will report on current Emergency services diversion statistics.	Quarterly	In Compliance	**Schedule 6**
(F) Finances	1. MGH Board will provide the audited financial statements.	Annually	In Compliance	The MGH 2012 Independent Audit was completed on April 29, 2014.
	2. MGH Board will report on its performance with regard to industry standard bond rating metrics, e.g., current ratio, leverage ratios, days cash on hand, reserve funding.	Quarterly	In Compliance	**Schedule 2**
	3. MGH Board will provide copies of MGH's annual tax return (form 990) upon completion to General Member.	Annually	In Compliance	The MGH 2011 Form 990 was filed on November 15, 2013.

Schedule 1: HCAHPS

(Hospital Consumer Assessment of Healthcare Providers & Systems)

- **Tier 1, Patient Satisfaction and Services**
  The MGH Board will report on MGH's HCAHPS Results Quarterly.
- **Tier 2, Patient Satisfaction and Services**
  The MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.

Marin General Hospital
Overall Hospital HCAHPS
Trending by Quarter

Scores displayed here are based on interviews from CMS submitted data for the selected time periods.
Mode adjustments and ESTIMATED Patient Mix Adjustments have been applied to the dimension scores.
Scores for the individual questions do not have adjustments applied.

FY 2016 VBP Thresholds				4Q 2013	1Q 2014	2Q 2014	3Q 2014
69.32	77.46	83.97	**Overall rating**	67.54	68.15	65.95	69.66
			Would Recommend	68.13	73.75	71.39	67.10
77.67	82.34	86.07	**Communication with Nurses**	74.61	74.55	75.09	73.50
			Nurse Respect	86.02	86.07	83.42	85.02
			Nurse Listen	70.76	78.28	76.72	74.04
			Nurse Explain	79.06	71.31	77.13	73.43
80.40	84.93	88.56	**Communication with Doctors**	78.45	79.62	83.57	79.39
			Doctor Respect	87.45	84.43	89.89	84.06
			Doctor Listen	76.92	80.25	81.48	83.25
			Doctor Explain	74.89	78.10	83.25	74.76
64.71	73.07	79.76	**Responsiveness of Staff**	57.01	58.39	59.25	59.16
			Call Button	57.00	60.99	57.58	61.05
			Bathroom Help	66.43	65.19	70.33	66.67
70.18	74.61	78.16	**Pain Management**	68.84	67.46	69.93	68.83
			Pain Controlled	68.29	66.48	67.16	68.63
			Help with Pain	78.79	77.84	82.09	78.43
62.33	68.13	72.77	**Communication about Medications**	51.31	58.41	56.15	56.00
			Med Explanation	76.00	75.00	75.86	71.90
			Med Side Effects	34.43	49.63	44.25	47.90
64.95	72.81	79.10	**Hospital Environment**	52.05	49.16	49.95	47.91
			Cleanliness	65.04	61.13	58.51	59.31
			Quiet	50.85	48.98	53.19	48.31
84.70	87.86	90.39	**Discharge Information**	81.49	83.52	80.99	84.09
			Help After Discharge	82.41	83.62	82.12	84.18
			Symptoms to Monitor	83.17	86.03	82.46	86.60
			Number of Surveys	236	247	192	210

Thresholds Color Key:
National 95th percentile
National 75th percentile
National average, 50th percentile

Scoring Color Key:
At or above 95th percentile
At or above 75th percentile
At or above 50th percentile
Below 50th percentile

Official VPB (Value-Based Purchasing) monthly trending HCAHPS results are distributed by MGH Quality Management on the 15th of each month.

Schedule 2: Finances

- **Tier 1, Finances**
  The MGH Board must maintain a positive operating cash-flow (operating EBITDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric. The MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.
- **Tier 2, Volumes and Service Array**
  The MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.

Financial Measure	1Q 2014 YTD	2Q 2014 YTD	3Q 2014 YTD	4Q 2014 YTD
EBIDA $	$5,621	$10,497	$14,279	
EBIDA %	6.81%	6.14%	5.59%	

Loan Ratios				
Current Ratio	2.82	2.61	2.85	
Debt to Capital Ratio	35.4%	32.6%	31.2%	
Debt Service Coverage Ratio	2.56	2.62	2.78	
Debt to EBIDA %	2.45	2.21	2.12	

Key Service Volumes, cumulative				
Acute discharges	2,308	4,611	6,842	
Acute patient days	10,129	20,065	29,856	
Average length of stay	4.39	4.35	4.36	
Emergency Department visits	9,014	18,299	27,533	
Inpatient surgeries	531	1,054	1,547	
Outpatient surgeries	958	1,964	2,868	

DEFINITIONS OF TERMS

EBIDA: Earnings Before Interest, Depreciation And Amortization. By adding back interest and amortization payments as well as depreciation (a non-cash outflow expense), it allows the measurement of the cash that a company generates.

Debt to Capital Ratio: A measurement of how leveraged a company is. The ratio compares a firm's total debt to its total capital. The total capital is the amount of available funds that the company can use for financing projects and other operations. A high debt-to-capital ratio indicates that a high proportion of a company's capital is comprised of debt.

Debt Service Coverage Ratio: A measurement of a property's ability to generate enough revenue to cover the cost of its mortgage payments. It is calculated by dividing the net operating income by the total debt service. For example, a property with a net operating income of $50,000 and a total debt service of $40,000 would have a debt service ratio of 1.25, meaning that it generates 25% more revenue than required to cover its debt payment.

Debt to EBIDA %: Measurement used to predict a company's ability to pay off the debt it already has. The ratio calculates the amount of time required for the business to pay off all debt, but does not take into considerations like interest, depreciation, taxes or amortization. Having a high debt/EBITDA ratio will often result in a lower credit score for the business.

Schedule 3: Clinical Quality Reporting Metrics

- **Tier 2, Quality, Safety and Compliance**
  The MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).

CLINICAL QUALITY METRICS DASHBOARD

Metrics are publicly reported on CalHospital Compare (www.calhospitalcompare.org), and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

Abbreviations and Acronyms Used in Dashboard Report

Term	Title/Phrase
Abx	Antibiotics
ACC	American College of Cardiology
ACE	Angiotensin Converting Enzyme Inhibitor
AMI	Acute Myocardial Infarction
APR DRG	All Patient Refined Diagnosis Related Groups
ARB	Angiotensin Receptor Blocker
ASA	American Stroke Association
C Section	Caesarian Section
CHART	California Hospital Assessment and Reporting Task Force
CLABSI	Central Line Associated Blood Stream Infection
CMS	Centers for Medicare and Medicaid Services
CT	Computerized Axial Tomography (CAT Scan)
CVP	Central Venous Pressure
ED	Emergency Department
HF	Heart Failure
Hg	Mercury
hr(s)	hour(s)
ICU	Intensive Care Unit
LVS	Left Ventricular Systolic
LVSD	Left Ventricular Systolic Dysfunction
NHSN	National Healthcare Safety Network
PCI	Percutaneous Coronary Intervention
PN	Pneumonia
POD	Post-op Day
Pt	Patient
SCIP	Surgical Care Improvement Project
ScVO2	Central Venous Oxygen Saturation
STEMI	ST Elevated Myocardial Infarction (ST refers to the EKG tracing segment)
VAP	Ventilator Associated Pneumonia
VHA	Voluntary Hospitals of America
VTE	Venous Thromboembolism

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

METRIC	CMS**	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q3-Qtr %	Q3-2014 Num/Den	Rolling %	Rolling Num/Den
Acute Myocardial Infarction (AMI) Measures																	
Aspirin prescribed at discharge	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	**98%**	41/42	99%	186/187
Beta blocker prescribed at discharge	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	**98%**	35/36	**99%**	157/158
Primary PCI within 90 minutes of arrival	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	**93%**	7/8	98%	40/41
Statin Prescribed at Discharge	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	42/42	100%	178/178
Heart Failure (HF) Measures																	
Evaluation of LVS Function	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	31/31	100%	156/156
ACEI or ARB for LVSD	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	9/9	100%	37/37
Pneumonia (PN) Measures																	
*Initial antibiotic selection for CAP in immunocompetent patient	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	97%	19/20	99%	103/104
Surgical Care Improvement Project (SCIP)Measures																	
Prophylactic antibiotic rec'd within one hr prior to surgical incision	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	99%	84/85	100%	317/318
*Prophylactic antibiotic selection for surgical patients: Overall rate	99%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	85/85	100%	317/318
*Prophylactic antibiotics discontinued within 24 hours after surgery end time: Overall rate	98%	96%	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	85/85	99%	312/315
Cardiac surgery patients with controlled postoperative blood glucose	97%	100%	100%	100%	67%	100%	100%	100%	100%	100%	86%	100%	100%	**95%**	18/19	97%	56/58
*Urinary catheter removed on post-op day 1 (POD 1) or post-op day 2 (POD 2), day of surgery being day zero (POD)	97%	93%	100%	100%	88%	94%	93%	93%	100%	100%	94%	100%	100%	98%	50/51	**96%**	187/194
*Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the periop period	98%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%	30/30	99%	104/105
*Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hrs prior to surgery to 24 hrs after surgery	98%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80/80	100%	323/324
Venous Thromboembolism (VTE) Measures																	
VTE prophylaxis	85%	97%	100%	95%	100%	95%	100%	100%	100%	100%	100%	98%	100%	99%	112/113	99%	486/492
ICU VTE prophylaxis	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	22/22	100%	79/79
VTE patients with anticoagulation overlap therapy	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	14/14	100%	48/48
VTE pts receiving unfractionated heparin with dosage/platelet monitoring	97%	100%	100%	100%	100%	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	8/8	100%	21/21
VTE warfarin therapy discharge instructions	75%	100%	100%	100%	40%	33%	67%	100%	100%	75%	100%	50%	100%	83%	5/6	76%	26/34
Hospital acquired potentially-preventable VTE +	10%	N/A	0%	N/A	0%	0%	0%	0%	0%	0%	0%	N/A	N/A	0%	0/1	0%	0/13
Global Immunization (IMM) Measures																	
*Influenza immunization	90%	86%	91%	90%	93%	83%	84%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/0	**88%**	452/514

* Performance period for CMS Value-Based Purchasing metric: 01-01-2014 through 12-31-2014 (shaded in blue)
** CMS Top Decile Benchmark
*** CMS National Median Benchmark (changed from top decile to national median effective 3rd Qtr 2013)
TJC: The Joint Commission measures, may be CMS voluntary
BTBE: Benchmark to be established
+ Lower Number is better

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
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METRIC	CMS**	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q3-Qtr %	Q3-2014 Num/Den	Rolling %	Rolling Num/Den
Stroke Measures																	
Venous thromboembolism (VTE) prophylaxis	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	37/37	100%	163/163
Discharged on antithrombotic therapy	99%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	31/31	99%	125/126
Anticoagulation therapy for atrial fibrillation/flutter	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6/6	100%	38/38
Thrombolytic therapy	66%	N/A	100%	N/A	100%	100%	N/A	N/A	N/A	N/A	67%	N/A	100%	83%	3/4	86%	6/7
Antithrombotic therapy by end of hospital day 2	98%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	100%	100%	99%	34/34	99%	142/143
Discharged on statin medication	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	97%	24/25	99%	92/93
Stroke education	88%	89%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	20/20	97%	72/74
Assess for rehabilitation	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	33/33	100%	156/156
Perinatal Care Measure																	
Elective Delivery +	6%	N/A	0%	0%	N/A	0%	0%	0%	0%	0%	0%	0%	0%	0%	0/6	0%	0/25
ED Inpatient (ED) Measures																	
Median time ED arrival to ED departure - Minutes	274***	299.00	291.50	312.00	318.00	304.00	347.50	314.00	295.00	276.50	285.00	280.00	257.50	**274.17**	174--Cases	**298.33**	698--Cases
Admit decision median time to ED departure time - Minutes	98***	165.00	150.00	134.00	168.00	170.00	165.00	149.00	127.50	137.50	116.50	125.00	135.00	**125.50**	102--Cases	**145.21**	451--Cases
ED Outpatient (ED) Measures																	
Median time ED arrival to ED discharge +	134***	138.00	144.00	138.50	168.50	149.50	121.50	122.00	205.50	129.00	121.00	102.00	140.00	121.00	103--Cases	**139.96**	444--Cases
Door to diagnostic evaluation by qualified medical personnel +	26***	23.50	30.00	37.00	31.00	31.00	36.00	28.00	48.00	22.50	18.00	35.50	26.00	**26.50**	101--Cases	**30.54**	437--Cases
Outpatient Pain Management Measure																	
Median time to pain management for long bone fracture - Mins +	57***	54.00	48.50	67.00	46.50	73.00	38.50	44.00	39.00	53.00	42.00	55.50	52.00	49.83	46--Cases	51.08	165--Cases
Outpatient Stroke Measure																	
Head CT/MRI results for stroke patients within 45 mins of ED arrival	57%	N/A	100%	100%	N/A	N/A	N/A	N/A	50%	N/A	N/A	N/A	N/A	N/A	0/0	75%	3/4
Outpatient Surgery Measures																	
Timing of antibiotic prophylaxis	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50/50	100%	195/195
Antibiotic selection	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50/50	100%	195/195

* Performance period for CMS Value-Based Purchasing metric: 01-01-2014 through 12-31-2014 (shaded in blue)

\+ Lower Number is better

** CMS Top Decile Benchmark

*** CMS National Median Benchmark (changed from top decile to national median effective 3rd Qtr 2013)

TJC: The Joint Commission measures, may be CMS voluntary

BTBE: Benchmark to be established

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
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	Benchmark					
♦ Surgical Site Infection						
METRIC	**National Standardized Infection Ratio (SIR)**	**Jan 2012 - Sep 2012**	**April 2012 - March 2013**	**July 2012 - June 2013**	**Oct 2012 - Sep 2013**	
*Colon surgery	1	Insufficient data to calculate SIR	**2.16**	0.80	**1.68**	No Different than U.S. National Benchmark
*Abdominal hysterectomy	1	Insufficient data to calculate SIR	Insufficient data to calculate SIR	0.00	not published	No Different than U.S. National Benchmark
♦ Healthcare Associated Infections (ICU)						
METRIC	**National Standardized Infection Ratio (SIR)**	**Jan 2012 - Sep 2012**	**April 2012 - March 2013**	**July 2012 - June 2013**	**Oct 2012 - Sep 2013**	
*Central Line Associated Blood Stream Infection Rate (CLABSI)	1	not published	**1.38**	0.85	**1.11**	No Different than U.S. National Benchmark
*Catheter Associated Urinary Tract Infection (CAUTI)	1	0.81	0.55	0.86	0.82	No Different than U.S. National Benchmark
♦ Healthcare Associated Infections (Inpatients)						
METRIC	**National Standardized Infection Ratio (SIR)**	**July 2012 - June 2013**	**Jan 2013 - Sep 2013**			
*Clostridium Difficile	1	**1.08**	1.03			No Different than U.S. National Benchmark
*Methicillin Resistant Staph Aureus Bacteremia	1	0.00	0.00			No Different than U.S. National Benchmark
♦ Heart Bypass Surgery Measures						
METRIC	**CA Hospital Assessment and Reporting Task Force (CHART) State Average**	**2006**	**2007**	**2008**	**2009**	
Internal mammary artery usage rate	95.00%	100.00%	**88.00%**	**94.00%**	not published	
Mortality rate	2.24%	1.81% (2005-2006)	1.91%	**4.35%**	not published	
Bilateral Cardiac Catheterization	2.14%	not published	not published	1.16%	not published	
♦ Surgical Complications						
METRIC	**CMS National Average**	**July 2009 - March 2012**				
Hip/knee complication: Hospital-level risk -- Standardized complication rate (RSCR) following elective primary total hip/knee arthoplasty	3.40%	**4.0%**				
METRIC	**CMS National Average**	**Oct 2010 - June 2012**				
*Serious Complications	0.61	**Worse than National Average**				
Deaths among patients with serious treatable complications after surgery	110.25 per 1,000 patient discharges	No different than National Average				
♦ Medicare Spending Per Beneficiary						
METRIC	**CMS National Average**	**Jan 2012 - Dec 2012**	**Jan 2013 - Dec 2013**			
*Medicare spending per beneficiary (All)	0.98	**1.02**	**1.01**			
♦ Mortality Measures - 30 Day						
METRIC	**CMS National Average**	**July 2006 - June 2009**	**July 2007 - June 2010**	**July 2008 - June 2011**	**July 2009 - June 2012**	
*Acute Myocardial Infarction Mortality Rate	15.2%	13.8%	13.7%	13.5%	13.30%	
*Heart Failure Mortality Rate	11.7%	10.6%	**12.1%**	**12.9%**	**13.8%**	
*Pneumonia Mortality Rate	11.9%	11.6%	11.1%	10.7%	10.9%	
COPD Mortality Rate	TBD					
Stroke Mortality Rate	TBD					

* Performance period for CMS Value-Based Purchasing metric: 01-01-2014 through 12-31-2014 (shaded in blue) + Lower Number is better

MARIN GENERAL HOSPITAL DASHBOARD
CLINICAL QUALITY METRICS
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♦ Acute Care Readmissions - 30 Day Risk Standardized

METRIC	CMS National Average	July 2006 - June 2009	July 2007 - June 2010	July 2008- June 2011	July 2009- June 2012
Acute Myocardial Infarction Readmission Rate	18.3%	18.0%	19.1%	18.0%	16.70%
Heart Failure Readmission Rate	23.0%	24.8%	24.5%	24.7%	22.60%
Pneumonia Readmission Rate	17.6%	17.7%	17.9%	17.9%	16.20%
COPD Readmission Rate	TBD				
Stroke Readmission Rate	TBD				
Total Hip Arthoplasty and Total Knee Arthoplasty Readmission Rate	5.4%				**5.80%**
METRIC	**CMS National Average**	**July 2011 - June 2012**			
Hospital-Wide All-Cause Unplanned Readmission	16.0%	15.2%			

♦ Current Performance Mortality Measures

METRIC	MGH	Q3-2013	Q4-2013	Q1-2014	Q2-2014
Acute Care Admission Mortality (APR DRG - Datavision)	1.00	0.90	0.98	**1.13**	**1.19**
Sepsis Mortality (APR DRG - Datavision)	1.00	**1.08**	0.61	**1.25**	1.00

♦ Outpatient Measures (Claims Data)

METRIC	CMS National Average	Jan 2011 - Dec 2011	July 2012 - June 2013		
Outpatient with low back pain who had an MRI without trying recommended treatments first, such as physical therapy	37.20%	Not available	Not available		
Outpatient who had follow-up mammogram, ultrasound, or MRI of the breast within 45 days after the screening on the mammogram	8.80%	7.70%	7.40%		
Outpatient CT scans of the abdomen that were "combination" (double) scans +	10.50%	6.00%	5.60%		
Outpatient CT scans of the chest that were "combination" (double) scans +	2.70%	1.40%	0.40%		
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery +	5.30%	**5.56%**	2.60%		
Outpatients with brain CT scans who got a sinus CT scan at the same time +	2.70%	1.70%	2.30%		

* Performance period for CMS Value-Based Purchasing metric: 01-01-2014 through 12-31-2014 (shaded in blue) + Lower Number is better

Schedule 4: Community Benefit Summary

- **Tier 2, Community Commitment**
  The Board will report all of MGH's cash and in-kind contributions to other organizations.
  The Board will report on MGH's Charity Care.

Cash & In-Kind Donations (these figures are not final and are subject to change)					
	1Q 2014	**2Q 2014**	**3Q 2014**	**4Q 2014**	**Total 2014**
Bread & Roses 40th Anniversary	$ 2,420	$ 0	$ 0		$ 2,420
Coastal Health Alliance	0	0	20,000		20,000
Healthy Aging Symposium	1,000	0	0		1,000
Homeward Bound of Marin	113,600	0	0		113,600
Hospice by the Bay (Ball)	0	0	2,200		2,200
Marin Brain Institute	0	630	0		630
Marin Community Clinics	53,151	18,610	55,830		127,591
Marin Community Clinics Summer Solstice	1,000	0	0		1,000
MHD 1206(b) Clinics	1,183,299	1,304,529	1,273,726		3,761,554
PRIMA Medical Foundation	950,000	950,000	1,732,727		3,632,727
Relay For Life	0	5,000	0		5,000
RotaCare San Rafael	0	0	15,000		15,000
RotaCare San Rafael (Refrigerator)	2,182	0			2,182
To Celebrate Life	0	0	15,000		15,000
Wine, Women & Song: Rock-n-Roll Breastival	0	0	5,000		5,000
Total Cash Donations	**$2,306,652**	**$2,278,769**	**$3,119,483**		**$7,704,904**

Total Cash & In-Kind Donations	**$2,306,652**	**$2,278,769**	**$3,119,483**		**$7,704,904**

Schedule 4, continued

Community Benefit Summary

(these figures are not final and are subject to change)

	1Q 2014	2Q 2014	3Q 2014	4Q 2014	Total 2014
Community Health Improvement Services	$41,854	$51,351	$78,854		$172,059
Health Professions Education	17,993	19,612	15,255		52,860
Research	0	0	5,105		5,105
Cash and In-Kind Contributions	2,306,652	2,278,769	3,119,483		7,704,904
Community Benefit Operations	1,640	1,640	2,830		6,110
Traditional Charity Care **Operation Access total is included in Charity Care*	1,063,745	731,530	555,312		2,350,587
Government Sponsored Health Care (includes Medi-Cal & Means-Tested Government Programs)	6,649,465	7,665,676	7,840,847		22,155,988
Community Benefit Subtotal (amount reported annually to state & IRS)	**$10,081,349**	**$10,748,578**	**$11,617,686**		**$32,447,613**
Community Building Activities	$ 0	$ 0	$ 0		$ 0
Unpaid Cost of Medicare	15,529,526	15,319,223	14,802,669		45,651,418
Bad Debt	526,391	590,145	857,451		1,973,987
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**$26,137,266**	**$26,657,946**	**$27,277,806**		**$80,073,018**

Operation Access

Though not a Community Benefit requirement, MGH has been participating with Operation Access since 2000. Operation Access brings together medical professionals and hospitals to provide donated outpatient surgical and specialty care for the uninsured and underserved.

	1Q 2014	2Q 2014	3Q 2014	4Q 2014	Total 2014
*Operation Access charity care provided by MGH (waived hospital charges)	$575,773	$114,687	$15,544		$706,004

Schedule 5: Nursing Turnover, Vacancies, Net Changes

- **Tier 2, Physicians and Employees**
  The MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.

Turnover Rate				
Quarter	Number of Clinical RNs	Terminated		Rate
		Voluntary	Involuntary	
4Q 2013	552	12	3	2.72%
1Q 2014	547	9	11	3.66%
2Q 2014	550	9	9	3.27%
3Q 2014	547	9	5	2.56%

Vacancy Rate									
Period	Per Diem Postings	Benefited Postings	Per Diem Hires	Benefited Hires	Benefited Headcount	Per Diem Headcount	Total Headcount	Benefited Vacancy Rate	Per Diem Vacancy Rate
4Q 2013	19	37	8	4	386	166	552	9.59%	11.45%
1Q 2014	14	25	4	11	393	154	547	6.36%	9.09%
2Q 2014	23	31	6	15	403	147	550	7.69%	15.65%
3Q 2014	13	19	2	10	402	145	547	4.73%	8.97%

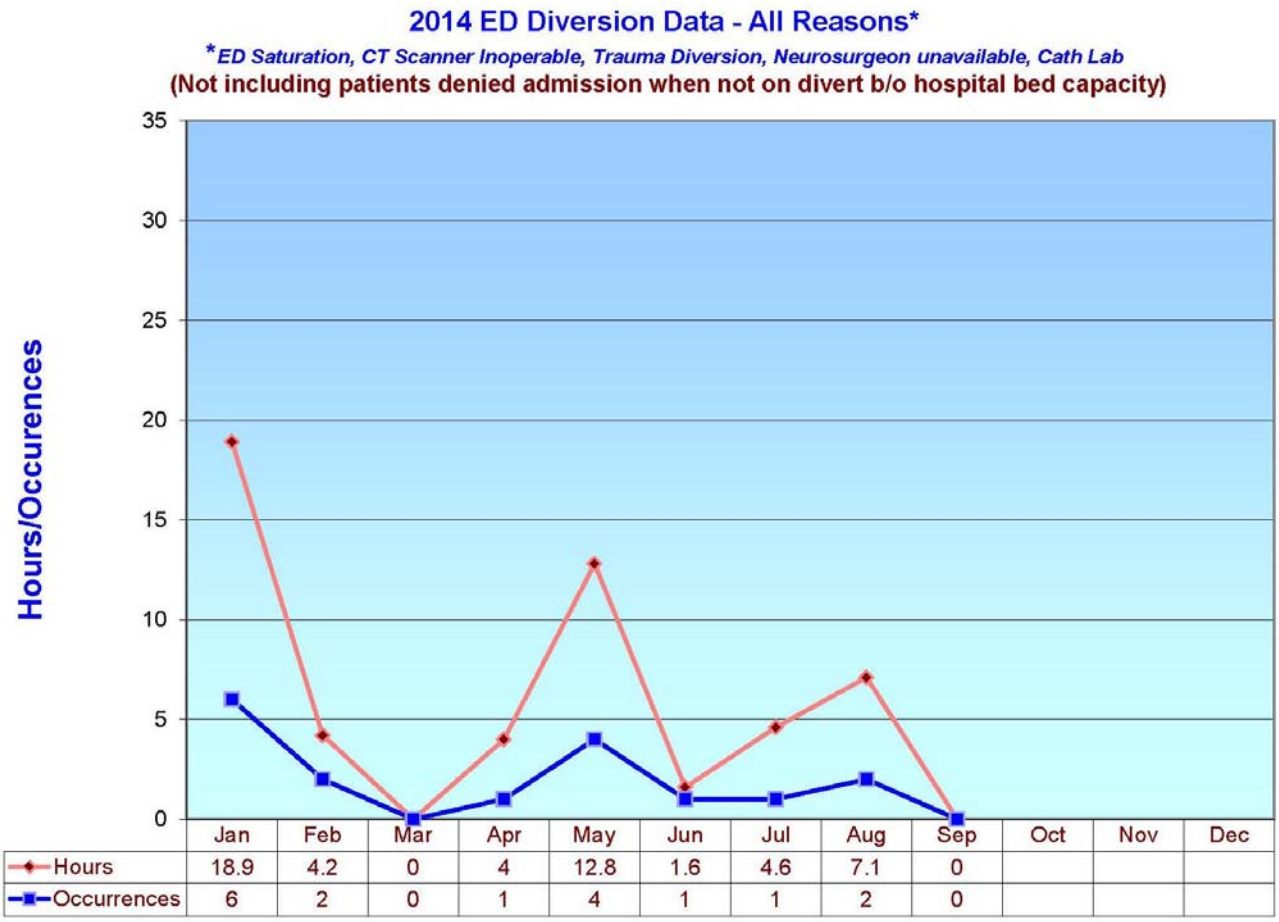
Hired, Termed, Net Change			
Period	Hired	Termed	Net Change
4Q 2013	12	15	(3)
1Q 2014	15	20	(5)
2Q 2014	21	18	3
3Q 2014	12	14	(2)

Schedule 6: Ambulance Diversion

- **Tier 2, Volumes and Service Array**
  The MGH Board will report on current Emergency services diversion statistics.

Quarter	Date	Time	Length of Time on Divert	Reason	ED Census	Waiting Room Census	ED Admitted Patient Census
1Q 2014	Jan. 2	1640 - 0039	8 hours	ED Saturation	25	10	5
1Q 2014	Jan. 3	1810 - 2005	1 hour, 55 min	Trauma Diversion	33	9	4
1Q 2014	Jan. 9	1805 - 2020	2 hours, 15 min	ED Saturation	31	10	5
1Q 2014	Jan. 14	1510 - 1706	2 hours	ED Saturation	22	5	12
1Q 2014	Jan. 15	1825 - 2105	2 hours, 20 min	ED Saturation	32	9	8
1Q 2014	Jan. 19	1417 - 1646	2 hours, 29 min	ED Saturation	24 (3 ICU Pts)	0	6
1Q 2014	Feb. 16	1905 - 2105	2 hours	ED Saturation	33	10	3 (2 ICU holds)
1Q 2014	Feb. 26	0000 - 0215	2 hours, 15 min	ED Saturation	17	6	6
2Q 2014	April 11	0115 - 0515	4 hours	ED Saturation	14	8	3 (ICU holds)
2Q 2014	May 2	1632 - 2320	6 hours, 48 mins	ED Saturation	36	9	8
2Q 2014	May 5	2040 - 2340	3 hours	ED Saturation	23	10	3
2Q 2014	May 11	1745 - 1845	1 hour	CT Scanner down	33	9	3
2Q 2014	May 11	1900 - 2100	2 hours	ED Saturation	23	5	1
2Q 2014	June 30	1930 - 2105	1 hour, 35 mins	ED Saturation	39	8	5
3Q 2014	July 3	1930 - 0005	4 hr 35 min	ED Saturation	25	15	7
3Q 2014	Aug. 2	1820 - 2004	1 hour 44 min	ED Saturation	36	12	4
3Q 2014	Aug. 20	2252 - 0414	5 hours 22 min	CT Scanner down	15	0	0

Schedule 6, continued



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hours	18.9	4.2	0	4	12.8	1.6	4.6	7.1	0			
Occurrences	6	2	0	1	4	1	1	2	0			

Tab 3

MARIN GENERAL HOSPITAL

250 Bon Air Road, Greenbrae, CA 94904
t » 415-925-7000

Date: December 9, 2014
To: MHD Board of Directors
From: Lee Domanico, CEO
Re: Recommendation for Approval of MGH Employee Lease and Midlevel Services Agreement.

Management recommends to the Board of Directors approval of the proposed Employee Lease and Midlevel Professional Services Agreement with the Hospital (the "Agreements"). The District owns and operates 1206(b) clinics located throughout the County (the "Clinic") which provide primary and specialty care. MGH manages and staffs the Clinic pursuant to the Management Services and Staffing Agreement with the District, including the provision of Clinic services to other providers, including MGH (e.g., the Diagnostic Testing Center "under arrangements" services).

Marin General currently employs a number of nurse practitioners and physician assistants ("midlevel" professionals) for Hospital based patient services. Services provided by these professionals are in some circumstances reimbursed by Medicare and Health Plans independently from Hospital charges or fees. When reimbursable, midlevel services are paid under Medicare Part B, the program for payment for professional services. MGH is paid for hospital services primarily under Medicare Part A and does not have a billing and collection structure available to bill and collect for midlevel services under Medicare Part B.

The District Clinic, on the other hand, has Part B billing and collection structures in place. Management consulted with HFS, a healthcare financial consulting firm familiar with the Clinic's operations, as well as expertise in healthcare provider reimbursement. HFS confirmed that the Clinic could lease these midlevels from the Hospital and, engaged then by the District, provide their services back to the Hospital for inpatient and outpatient services. The midlevels would also then be available for certain Clinic based services. Under its current billing and collection systems the District would capture existing and appropriate reimbursement that the Hospital is foregoing. The employee lease and professional services agreements would be performed subject to the terms of the Clinic Management Services and Staffing Agreement.

Under the Employee Lease of the MGH midlevels, MGH would cover 100% of the employee costs, offset by revenues received by the Clinic for the provision of the midlevels' services to Hospital and Clinic patients. Currently five midlevels would be involved, and others could be added in the future under the terms of the agreements.

Documentation
The following documentation is provided to the Board to support this requested action:

Transaction Summary of Key Terms of the Agreement

Requested Action by the Board

Motion based on management's recommendation: "To approve the terms of the Professional Services Agreement and Employee Lease for midlevel professionals with Marin General Hospital, as presented."

TRANSACTION SUMMARY
PHYSICIAN TRANSACTIONS AND ARRANGEMENTS
MARIN HEALTHCARE DISTRICT
EMPLOYEE LEASE AGREEMENT AND PROFESSIONAL SERVICES AGREEMENT
MARIN GENERAL HOSPITAL

A. Parties

Identify the contractor and indicate his or her specialty/practice area and administrative expertise.

Marin General Hospital ("MGH") and Marin Healthcare District ("MHD")

B. Purpose/Reasons to Pursue the Arrangement

Describe how the arrangement meets a community need.

MGH requires experienced and qualified nurse practitioners and physician assistants to provide professional services to hospital inpatients and outpatients and currently employs a number of these midlevel professionals. However, MGH does not have a billing and collection structure in place to properly bill and collect for these midlevel services under Medicare Part B. MHD, with its 1206B Clinic, does have such a billing and collection structure in place. Entering this Employee Lease Agreement ("Lease Agreement") and Personal Services Agreement ("PSA") would allow MHD to assume responsibility for billing and collection of midlevel services. In doing so, the MHD Clinic would get appropriate reimbursement that MGH is otherwise foregoing and would enhance patient care by assuring the continued availability of midlevel services to hospital inpatient and outpatients as well as patients at MHD clinics.

Indicate whether the arrangement is new or is a renewal of an existing arrangement.

This is a new arrangement.

C. Services to be Provided

Describe the services to be provided by the physician.

MGH will lease five of its midlevel employees to MHD pursuant to the Lease Agreement. MHD will then provide the midlevel personnel to MGH pursuant to the PSA in order to provide midlevel services for MGH inpatient and outpatient care. The midlevel personnel will also provide services to MHD clinic patients on an as needed basis. MHD will bill and collect for all services performed by the midlevel professionals.

Describe the time commitment of physician (e.g., FTE, part-time, # of hours)

The midlevel professionals will provide services on various days/schedules as agreed upon by MHD and MGH management.

D. Financial Terms

Describe the compensation methodology (hourly fee, monthly or annual salary, etc.). Indicate the aggregate compensation to be paid.

MHD will be responsible for the employment costs of the midlevel professionals under the Lease Agreement. Under the PSA, MGH will reimburse MHD in an amount equal to 100% of the employment costs paid by MHD, offset by any and all revenue received by MHD from collections for midlevel services performed at MGH inpatient/outpatient settings and/or MHD clinics.

Describe the methodology for determining that the financial terms meet Fair Market Value requirements.

The Agreements with MGH compel it to lease the employees to MHD at fair market value, established by the local market for such professional services.

E. Other Terms

Indicate whether the arrangement will be structured as an employment or independent contractor relationship.

The midlevel professionals will remain the employees of MGH. Their services will be provided to MGH by MHD as an independent contractor.

Indicate the term of the arrangement (dates) and describe the termination provisions.

The term of the PSA is two (2) year commencing on the effective date. The agreement may be terminated by either party upon 30 days' written notice or in case of material breach following an opportunity to cure. The agreement may be immediately terminated in the event of a loss of licensure or accreditation.

The term of the Lease is concurrent with the PSA.

Both the Lease and the PSA incorporate protections for the District (e.g., full MGH indemnity) from the Management Services and Staffing Agreement approved earlier this year by which MGH provides management and staff for the District Clinic.

Indicate insurance coverage arrangements.

MGH and MHD shall maintain professional liability insurance coverage in the amount of at least One Million Dollars ($1,000,000) per occurrence or claim and Three Million Dollars ($3,000,000) in the annual aggregate for acts and omissions of the midlevel personnel.

F. Business and Financial Risk

Identify any specific business and financial risks of the arrangement.

None.

G. Special Terms

List any special requests or conditions proposed by the physician.

None.

Tab 4

Marin Healthcare District

BOARD POLICY	Page of EFFECTIVE DATE:
SUBJECT: **Policy for Bidding for Public Works Contracts**	REVISED DATE: APPROVED BY:

BACKGROUND.

It is the intent of the Board of Directors ("Board") of the Marin 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 Marin General Hospital ("Hospital"). Consistent with the District's obligations, the Board desires to obtain the best value for all expenditures.

Health and Safety Code § 32132 requires healthcare districts to award to the lowest responsible bidder any contract up to established expenditure limits involving (i) materials and supplies furnished to the district and (ii) work to be done for the district. A number of exceptions apply, including a statutory exception for the Marin Health Care District permitting it to use a design-build method to assign contracts for construction or improvement of its facilities. (*Health and Safety Code § 32132.5.)*

Section 1. General Principle of the Bidding Policy.

1.1 Policy of the Board. As a general statement of policy, the Board declares that it shall endeavor to obtain the maximum value for all monies expended, consistent with the District's responsibility to provide the best health care to its patients.

Section 2. Lowest Bid Policy.

2.1 Definitions.

a. For purposes of this Memo, "Work" 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.

b. For purposes of this policy, "responsible bidder" means a bidder who has demonstrated the attribute of trustworthiness as well as quality, fitness,

capacity, and experience to perform the contract satisfactorily. (*Public Contract Code § 1103.*)

2.2 Application of Policy.

a. The Board shall award any contract for Work exceeding twenty-five thousand dollars ($25,000) to the lowest responsible bidder who shall give such security as the Board requires, or the Board shall reject all bids. (See *Health and Safety Code § 32132.*) Thereafter, the Board shall authorize the Hospital's Chief Executive Officer ("CEO") to enter into an agreement for the Work.

b. The Board shall award contracts for professional services of private architectural, landscape architectural, engineering, environmental, land surveying or construction management firms as provided in Section 5 of this Policy.

2.3 Exemptions to the Lowest Bid Policy. Subject to the provisions of this Section, the Board shall not be required to apply the lowest bid policy to (a) emergency contracts, (b) change orders, (c) energy services contracts, (d) public works project where the District has elected to follow the alternative statutory procedures, or (e) professional services.

a. The Board shall not be required to secure bids for emergency contracts. Notwithstanding anything to the contrary, the Board may award contracts for Work 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, and (ii) it is necessary to protect public health, safety, welfare or property. (See *Health and Safety Code § 32136.*)

b. The Board 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 amounts to more than five percent (5%) of the contract. (See *Health and Safety Code § 32132 (c)).*

c. *Public Contracts Code §§ 22030 et seq.* outline an alternative procedure for public works projects where a healthcare district's governing agency elects, by resolution, to become subject to the uniform construction cost accounting procedures set forth and has noticed the State Controller of that election. For additional information, please refer to Article 3, Chapter 2, Part 3, Division 2 of the *Public Contracts Code.*

d. The Board shall award contracts for professional services as provided in Section 5.

Section 3. Bidding Procedures for Work.

Bids for Work exceeding $25,000 submitted to the Board pursuant to Section 2.2(a) shall be subject to bidding procedures set forth in this Section 3 [Bidding Procedures for Work].

3.1 Preparation of Plans, Specifications, or Specifications of Proposed Work.

a. Upon determination that Work is required by the necessity or for the convenience of the District, the Board shall prepare plans, specifications or a description of general conditions ("Specifications"). The Specifications shall be in such detail and written with such specificity as the nature of the Work may require. In establishing the Specifications, the District 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. The Specifications document may be sold to potential bidders at cost or lent to potential bidders upon their furnishing such security as the replacement value of the Specifications may indicate.

b. If the nature or performance of the Work is such that prequalification of bidders is necessary or desirable, the District may establish a uniform prequalification system using a standard questionnaire to evaluate the ability, competency and integrity of bidders. In such event, the District may require each prospective bidder to complete and submit a standardized questionnaire and financial statements, subject to the provisions of *Public Contract Code §§ 20101 et seq.* The Specifications shall include procedures for such prequalification.

c. The Specifications shall include 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 director of the department under which the work is to be performed. 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.

d. When appropriate, the District may require 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. 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 contract.

e. The Specifications shall provide that the successful bidder to whom a contract involving an expenditure in excess of twenty-five thousand dollars

($25,000) for any public work is awarded shall furnish a payment bond approved by the Board. *(Civil Code § 9550.[1])* The labor and material bond shall be filed with the District pursuant to applicable laws of the State of California. The District shall not require a payment bond from an architect, engineer, land surveyor or other professional consultant.

f. When appropriate as determined by the Board, the Specifications may establish the time within which the whole or any specified portion of the Work shall be completed. (*Government Code § 53069.85.*)

g. When appropriate as determined by the Board, the Specifications may provide that for each day completion is delayed beyond the specified date, the contractor shall forfeit a specified sum of money. The Specifications may also provide for the payment of a bonus to the contractor for completion of the project prior to the specified time. (*Government Code § 53069.85.*)

h. When appropriate as determined by the Board, the Specifications may provide for a bonus to the contractor for completion of the project prior to a specified time. (*Government Code § 53069.85.*)

i. The Specifications shall provide that any prime contractor shall set forth 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 and (ii) the portion of Work to be performed by each such subcontractor. [Please see Section 3.7 for details.]

3.2 Notice Inviting Bids. Where formal bidding is required (or otherwise deemed desirable by the Board), the District shall publish a notice inviting formal bids ("Notice Inviting Bids").

a. The first publication or posting of the Notice Inviting Bids shall be 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 (or, if there is no such newspaper, then in a newspaper of general circulation which is circulated in the jurisdiction of the District. (*Public Contract Code § 20150.8.)*

b. In addition, the District may also publish Notice Inviting Bids in a trade publication, as specified in *Public Contract Code §* 22036. (*Public Contract Code § 20150.8.).*

[1] Civil Code § 9550 *et seq.* became operative July 1, 2012, replacing Civil Code § 3247 *et seq.*

c. The District may also give such other notice as it deems proper.

3.3 Requirements of Notice Inviting Bids. The Notice Inviting Bids shall:

a. Describe the contemplated Work;

b. Set forth the procedure by which potential bidders may obtain copies of the Specifications;

c. State the final time and date and 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. If applicable, include procedures for prequalification and information relating to bid guarantee;

e. State the date, time and place for opening of bids;

f. Set forth any bond requirements *(Civil Code § 9550*[2]*);*

g. If applicable as determined by the Board, establish the time within which the whole or any specified portion of the Work shall be completed (*Government Code § 53069.85);*

h. If applicable as determined by the Board, provide that for each day completion is delayed beyond the specified time, the contractor shall pay specified liquidated damages, provided such liquidated damages are reasonable (*Government Code § 53069.85*);

i. If applicable as determined by the Board, establish as extra compensation to the contractor a bonus for completion of Work prior to a specified time (*Government Code § 53069.85*); and

j. Set forth such other matters, if any, as would reasonably enhance the number and quality of bids.

3.4 Preparation and Submission of Bids. Each prospective bidder shall submit a written bid under sealed cover. Upon receipt, the bid shall be date and time stamped. All bids shall remain sealed until the date and time set forth 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.*)

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[2] See footnote 1, above.

3.5 Examination and Evaluation of Bids.

a. All bids requiring Board action shall be required to be sealed and then opened at a time and place stated in the Notice Inviting Bids. A member of the Board, or a person designated by the Board, will attend and officiate over the opening of bids ("Opening"). The bids will be made public for bidders and others properly interested parties who may be present at the Opening.

b. The Board 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.

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

3.6. Awarding of Contracts.

a. The Board shall award the contract to the lowest bidder, provided such bid is responsive and reasonable and meets the requirements and criteria set forth in the Notice Inviting Bids, as determined by the Board. Notwithstanding anything to the contrary, the Board is under no obligation to accept the lowest responsive and responsible bidder and reserves the right to reject all bids. *(Health and Safety Code § 32132.)* Factors which the District may take into account to determine whether a bidder is "responsible" include prior performance, financial capacity, technical expertise, reputation for reliability and satisfactory service, and other factors that may be set forth in the Specifications.

b. If the Board determines that the lowest bidder is not responsible, the Board may award the contract (i) to the next lowest responsible bidder, or (ii) to the lowest bidder on the condition that the lowest bidder furnish security other than or in addition to that set forth in the Specifications.

c. If the Board decides to award the contract for Work 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 Board's investigation, which reflects on such bidder's responsibility. The Board shall afford the low bidder an opportunity to rebut such adverse evidence and shall permit such bidder to present evidence that it is qualified to perform the Work. Such opportunity to rebut adverse evidence and to present evidence of qualification may be submitted in writing or at an informal hearing before the awarding body, committee and/or individual, as determined by the Board.

d. Any contract awarded by the Board shall be subject to all applicable provisions of federal, California and local laws, including without limitation laws relating to the performance of work for a public agency. In the event of a conflict between any contract documents and any applicable law, the law shall prevail.

3.7 Subcontractors. As provided in Section 3.1(j), the Specifications shall provide that any bidder shall set forth in his/her bid: the name and the location of the place of business of each subcontractor who will (a) perform labor or render service to the prime contractor in connection with the project or, (b) under subcontract to the prime contractor, specially fabricate and install a portion of the Work according to detailed drawings contained in the Specifications, in an amount in excess of one-half of one percent (0.5%) of the prime contractor's total bid. The bidder shall also specify in his/her bid the portion of the work that will be done 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 Contracts Code § 4104.)*

3.8 Construction Management Model. Construction management arrangements may be appropriate where District participation in the review and approval of subcontractor bids can lead to substantial cost savings and serve to cap maximum costs. The Board may adopt procedures designed to derive the benefits and advantages of using professional management oversight of a project consistent with the provisions of Section 5.5.

Section 4. Bid Conditions.

All formal bids shall be in writing and sealed and shall be subject to the following general conditions.

4.1 Three Bids. The Board shall consider a minimum of three (3) bids; however, where the Board cannot obtain three bids or when it decides that time will not permit obtaining three bids, it may consider a minimum of two (2) bids.

4.2 Reference Check. Contracts shall be awarded to the lowest responsible bidder meeting the applicable criteria established by the District, subject to a check of references and review of legal counsel, as applicable.

4.3 Multiple Bids. When bids for multiple items are solicited at the same time, the Board 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.

4.4 Minor Deviations. The Board reserves the right to waive inconsequential deviations from the specifications in the substance or form of bids received.

4.5 No Advantage. No illegal, unfair, unethical or otherwise improper advantage shall be accorded to any bidder by the District.

Section 5. Professional Services.

Bids for Work submitted to the Board pursuant to Section 2.2(c) shall be subject the procedures set forth in this Section 5.

5.1 No Competitive Bidding. The District 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 satisfactory performance of the services required. *(Government Code § 4526.)* No competitive bidding shall be required. *(Health and Safety Code § 32132(b).)* In the event the District determines that the services required are more of a technical nature and involve little professional judgment and that requiring bids would be in the public interest, the Board may employ a formal bidding procedure in awarding contracts for such professional services. *(Government Code § 4529.)*

5.2 Compensation for Services. The District may compensate persons or firms providing such services as it deems proper for the services rendered. The District may establish procedures that assure the professional services of private architectural, landscape architectural, engineering, environmental, land surveying and construction management firms are engaged at fair and reasonable prices. (*Government Code § 4526.*)

5.3 Notice Inviting Bids for Architectural and Engineering Services. Any Notice Inviting Bids for architectural or engineering 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." (For additional information, please refer to *Public Contract Code § 20103.6 and Civil Code § 2782.8.*)

5.4 Small Business Participation. In selecting firms and persons to provide private architectural, landscape architectural, engineering, environmental, land surveying or construction management services, the Board shall ensure that the selection process assures maximum participation of small business firms. (*Government Code §* 4526.) "Small business" means an independently owned and operated business that is not dominant in its field of operation, the principal office of which is located in California, the officers of which are domiciled in California, and which, together with affiliates, has one hundred (100) or fewer employees, and average annual gross receipts

of ten million dollars ($10,000,000) or less over the previous three years, or is a manufacturer with 100 or fewer employees. (*Government Code §* 14837.)

5.5 Construction Management Services. The Board may adopt procedures and award contracts for construction management services. Selection for professional services of a construction project management professionals shall be on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. The Board shall require that any individual or firm proposing to provide construction project management services provide evidence that the individual or firm and its personnel carrying out onsite responsibilities have expertise and experience in construction project design review and evaluation, construction mobilization and supervision, bid evaluation, project scheduling, cost-benefit analysis, claims review and negotiation, and general management and administration of a construction project. *(Government Code § 4529.5.)*

Section 6. Alternate Bidding Procedure: Design Build.

Notwithstanding any provision of this policy to the contrary, upon approval of the Board, the District may elect to utilize a design-build process in connection with certain construction projects. (*Health and Safety Code§ 32132.5.)*

6.1 Contracts for Construction of Hospital or Health Facility. Any project involving the construction or improvement of a hospital or health care facility may include both design and construction procured from a single entity, in accordance with *Public Contract Code § 22160 et.seq.*. (*Health and Safety Code§ 32132.5.)* The design-build entity ("Design-Build Entity") to which a contract is awarded shall be able to provide appropriately licensed contracting, architectural, and engineering services, as needed, pursuant to the applicable contract.

6.2 Design-Build Procedure. The District shall cause to be prepared by a design professional, duly licensed in California, a set of documents describing the scope of the project. Thereafter, the District shall prepare a request for proposal inviting qualified parties to submit competitive sealed proposals in the manner prescribed by the District, including the elements provided in *Public Contract Code § 22164(d).*

6.3 Prequalification Procedure. The District shall establish a procedure to prequalify Design-Build Entities using a standard questionnaire developed by the District. The questionnaire shall require the inclusion of the criteria set forth in *Public Contract Code § 22164(b)* and shall be verified under oath pursuant to *Public Contract Code § 22164(b)(4)(A).*

6.4 Contract Award. The District shall establish a procedure for final selection of the Design-Build Entity, and shall base its selection on either (a) a competitive bidding process resulting in lump-sum bids by the prequalified Design-Build

Entity, with awards made to the lowest responsible bidder; or (b) a competition based on best value and other criteria, in accordance with the provision of *Public Contract Code § 22160 et seq.* "Best value" means a value determined by objective criteria related to price, features, functions and life-cycle costs as described in *Public Contract Code §22161(a).*

Section 7. Miscellaneous Provisions.

7.1 Authority to Make Purchases. The CEO or the CEO's designee are hereby given authority to make all purchases and to execute all purchase orders or contracts for the District duly authorized pursuant to this Policy or other applicable policies referenced herein. All purchases and contracts shall be upon written order, whenever reasonably possible, and the District shall keep and maintain written records of the same.

7.2 Right to Direct Competitive Bidding. The Board reserves the right to direct competitive bidding (including but not limited to lowest bid) for any contract, regardless of whether or not competitive bidding is required by law or required by the terms of this Policy.

7.3 Electronic Transmission. The District may elect to receive bids and supporting materials over the Internet, provided it complies with the provisions of *Public Contract Code § 1601.*

7.4 Flexibility and Waiver of Policy Requirements. In recognition of the fact that the contracting and procurement needs of the District may, from time to time, render certain procedures or requirements set forth in this Policy impractical, the CEO or his/her designee is authorized to permit or waive deviations from this Policy, to the extent permitted by law, in consultation with the District's legal counsel and upon making a written finding that such deviations are in the best interest of the District.

7.5 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 under this Section which would subject those employees to the prohibition of *Government Code §* 87100.[3] (See *Government Code §* 4526.)

[3] Section 87100 provides, "No public official at any level of state or local government shall make, participate in making or in any way attempt to use his official position to influence a governmental decision in which he knows or has reason to know he has a financial interest."

Tab 5

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2015

Marin General Hospital

Our home. Our health. Our hospital.

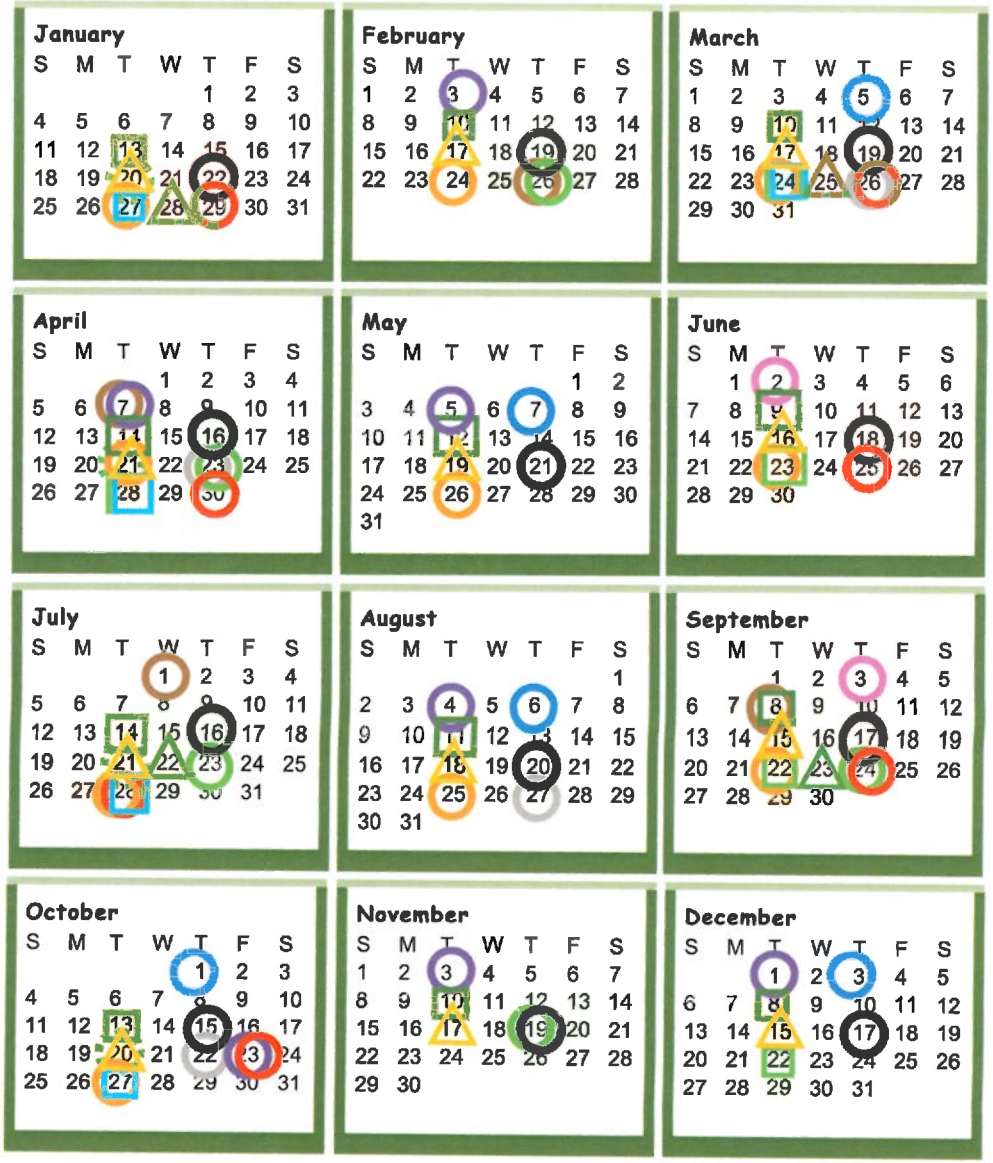
Audit	4th Thurs (6:00 pm)	3/26, 4/23(*), 8/27, 10/22 (*)=Joint Meeting w/Finance
Board Building	Quarterly (5:00 pm)	2/26, 4/7, 7/1, 9/8
Board of Directors	1st Tues (5:00 pm)	2/3, 4/7, 5/5, 8/4, 10/23 (R), 11/3, 12/1
Community Advisory	(To be scheduled)	
Compensation	(To be scheduled)	
Executive Committee	1st Thurs (4:00 pm)	3/5, 5/7, 8/6, 10/1, 12/3
Finance	4th Thurs (6:00 pm)	2/26, 4/23(*), 7/23, 9/24, 11/19(B) (*)=Joint Meeting w/Audit
Foundation Board	3rd Thurs (3:30 pm)	1/22, 2/19, 3/19, 4/16, 5/21, 6/18, 7/16, 8/20, 9/17, 10/15, 11/19, 12/17
Human Resources	1st Tues/Thurs (10 am)	6/2, 9/3
Interior Design Sub	(To be scheduled)	
Investment	3rd Tues (11:00 am)	1/20, 4/21, 7/21, 10/20
Nominating	(To be scheduled)	
Quality & Patient Safety	4th Tues (4:30 pm)	1/27, 2/24, 3/24, 4/21, 5/26, 6/23, 7/28, 8/25, 9/22, 10/27
Strategic Plg. & Mktg.	4th Tues (6 or 6:30 pm)	1/29, 3/26, 4/30, 6/25, 9/24, 10/23(R), 11/19, (R)=Retreat

Marin Healthcare District

Board of Directors	2nd Tues (7:00 pm)	1/13, 2/10(R), 3/10, 4/ 14, 5/12, 6/9, 7/14, 8/11, 9/8, 10/13, 11/10, 12/8
Finance & Audit	4th Tues (5:30 pm)	3/24, 4/28(B), 6/23, 9/22, 12/22
Lease & Building	4th Tues (4:00 pm)	1/27, 3/24, 4/28, 7/28, 10/27 (R)=Retreat (B)=Budget Review

Marin General Hospital & Marin Healthcare District

Community Benefit	4th Wed (6:00 pm)	1/28, 3/25, 7/22, 9/23
Employee Awards	3rd Fri (6:00 pm)	4/17
PMF Board of Directors	3rd Tues (6:00 pm)	1/20, 2/17, 3/17, 4/21, 5/19, 6/16, 7/21,



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