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

TUESDAY, AUGUST 11, 2015

CLOSED MEETING @ 6:30 PM
REGULAR OPEN MEETING @ 7:00 PM

Board of Directors:
Chair: Harris Simmonds, MD
Vice Chair: Ann Sparkman, JD
Secretary: Jennifer Rienks, PhD
Directors: Larry Bedard, MD
Jennifer Hershon, RN, MSN

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

Staff:
Lee Domanico, CEO
Colin Coffey, District Counsel
Louis Weiner, Executive Assistant

AGENDA Tab #

CLOSED MEETING, 6:30 pm

1. Call to Order and Roll Call — Simmonds
2. General Public Comment — Simmonds

   Any member of the audience may make statements regarding any items 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.
3. Closed Session
   a. Approval of previous minutes of Closed Session (action) — Simmonds
   b. Conference with Legal Counsel: Potential litigation pursuant to Gov. Code Section 54956.9(d)(2) — Domanico
4. 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 (fax) at least 48 hours in advance of this meeting.
Meetings open to the public are audio-recorded. Recordings are posted on the District web site and retained for one (1) year.

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TUESDAY, AUGUST 11, 2015

CLOSED MEETING @ 6:30 PM
REGULAR OPEN MEETING @ 7:00 PM

AGENDA

Tab #

REGULAR MEETING, 7:00 PM

1.	Call to Order	Simmonds	
2.	Roll Call	Simmonds	
3.	General Public Comment	Simmonds	
	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.		
4.	Approval of Agenda (action)	Simmonds	
5.	Approval of Consent Agenda		
	a. Minutes of the Regular Meeting of July 14, 2015 (action)	Simmonds	#1
6.	MGH Performance Metrics and Core Services Report, 1Q 2015 (action)	Domanico	#2
7.	Review and approve Sublease of Office Space/Services at Cardiovascular Associates of Marin, 2 Bon Air Road, by UCSF (action)	Coffey	#3
8.	Bylaws Revision: Schedule of Board Officers Election and Board Committee Appointments (action)	Coffey	#4
9.	Report on MHD Bond Oversight Committee	Domanico	
10.	Committee Meeting Reports		
	a. MHD Finance and Audit Committee (met July 27)	Bedard	
	b. MHD Lease and Building Committee (met July 28)	Sparkman	
	(1) Review and approve Amended Policies and Procedures for MHD Board Meetings (action)	Coffey	#5
11.	Reports		
	a. District CEO's Report	Domanico	
	b. Hospital CEO's Report	Domanico	
	(1) Patient Satisfaction		
	c. Chair's Report	Simmonds	
	d. Board Members' Reports	All	
12.	Adjournment of Regular Meeting	Simmonds	
	Next Regular Meeting: Tuesday, September 8, 2015 @ 7:00 p.m.		

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
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Tab 1

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

BOARD OF DIRECTORS
REGULAR MEETING

MINUTES
Tuesday, July 14, 2015 @ 7:00 pm
Marin General Hospital, Conference Center

1. **Call to Order**
   Chair Simmonds called the Regular Meeting to order at 7:00 pm.

2. **Roll Call**
   BOARD MEMBERS PRESENT: Chair Harris Simmonds, MD; Vice Chair Ann Sparkman; Secretary Jennifer Rienks; Director Larry Bedard, MD; Director Jennifer Hershon

   ALSO PRESENT: Lee Domanico, Chief Executive Officer; Colin Coffey, District Counsel; Louis Weiner, Executive Assistant to the Boards; James McManus, Chief Financial Officer; Jon Friedenberg, Chief Administrative Officer

3. **Closed Session**
   Chair Simmonds announced the necessity of adjourning to Closed Session immediately, deferring to Counsel Coffey for explanation: This morning a legal issue arose that required immediate attention by the Board, concerning potential litigation pursuant to Government Code Section 54956.9(d)(2). This short-notice request for a Closed Session is compliant with the Brown Act's provision for "urgent matters" and requires a 4/5 vote of the Board for approval to adjourn to the Closed Session. There was no public comment. Vice Chair Sparkman moved to approve adjournment to Closed Session immediately. Secretary Rienks seconded. Vote: all ayes, unanimous.

   Chair Simmonds asked the public to exit for the Closed Session, to be invited back when the Regular Meeting reconvenes. He adjourned the Regular Meeting at 7:03 pm.

4. **Reconvening of Regular Session**
   Chair Simmonds invited the public to re-join, and called the Regular Meeting back to order at 7:21 pm.

5. **General Public Comment**
   There was no public comment.

6. **Approval of Agenda**
Secretary Rienks moved to approve the agenda as presented. Director Bedard seconded. Vote: all ayes.

7. **Approval of Consent Agenda**
To approve the minutes of the Special Study Session of June 9, 2015, the Regular Meeting of June 9, 2015, and the Minutes of the Special Study Session of June 10, 2015, Vice Chair Sparkman moved to approve the consent agenda as presented. Director Hershon seconded. Vote: all ayes.

8. **MHD Resolution 2015-04**
Counsel Coffey presented the Resolution requesting the Marin County Board of Supervisors to levy, enroll, collect and distribute property taxes authorized by public vote in November 2013 to support the debt service on the Marin Healthcare District's General Obligation Bonds that will begin issuance in November 2015. To be timed within the current tax year, the County needs this request submitted to them now, in mid-July.

There was no further comment from the Board. Secretary Rienks moved to approve MHD Resolution 2015-04. Vice Chair Sparkman seconded. There was no public comment. Vote: all ayes.

9. **MHD Bond Oversight Committee**
CEO Domanico reported that the passage of the Bond measure requires the formation of a District Bond Oversight Committee "to inform the public about the expenditure of Measure F bond funds and to ensure that proceeds are expended for the purpose described in Measure F." The proposed Charter (packet Tab #5) describes the Committee's background, purpose, duties, and operations.

The Committee will comprise 7 members the District community at large and will not include members of the Board of Directors. Members will serve a term of 4 years, meetings will most likely be quarterly, reports will be presented to the Board, and proceedings will be made public on the District's web site.

Chair Simmonds recommended the nominees be processed through the MHD members of the MHD-MGH Joint Nominating Committee (Chair Simmonds, Director Bedard) including application/conflict of interest forms to submit, and then brought to the full Board for action. James McManus, CFO, stated that the Committee should be seated by late October/early November, before or at the time the bonds are to be issued. He has already fielded 10 candidate nominations which he deems are qualified and will forward them to Chair Simmonds who will decide, with Director Bedard, whom to include for interview by the Board. Discussion ensued regarding methods of recruiting other qualified candidates.

Director Bedard moved to approve the MHD Bond Oversight Committee Charter. Vice Chair Sparkman seconded. There was no public comment. Vote: all ayes.

10. Committee Meeting Reports

a. MHD Finance and Audit Committee

The Committee did not meet in June, and there is no report.

b. MHD Lease and Building Committee

Vice Chair Sparkman reported that the Committee met on June 22. West Marin Senior Services (WMSS) had submitted a Community Health Grant Application to the District, and three representatives of WMSS were interviewed at this meeting. The Committee requested more information and a revised budget supporting the application which, when received, will be reviewed at the next meeting of the Committee.

11. Reports

a. District CEO's Report

CEO Domanico reported that MGH 2.0 construction continues to be on schedule and on budget.

He suggested an idea for a community program that the District might help fund, a volunteer program of first responders within their communities. He cited a successful program working in Israel, "United Hatzalah" (israelrescue.org) that could be used as a model. Public could be offered training in first response to time-critical events such as trauma, disaster, heart attack, dementia, etc. Other communities in the U.S. have varying degrees of first responder programs. The District may want to consider funding the establishing and training for such a volunteer program in the community and in the schools.

Public comment: Kerry Mazzoni.

b. Hospital CEO's Report

CEO Domanico reported that volume continued strong through June with solid operating performance. Two new linear accelerators are being installed in the Cancer Center. All nurses are being trained on central line and catheter infection prevention updates.

He has met with labor leaders to solve issues in the Sterile Processing Dept. The agreement with Radiology Associates is nearly complete. Three collective bargaining agreements will be settled soon; California Nurses Association is still in process. Nurses will stage informational picketing near the hospital on July 22.

The annual MGH Foundation Golf Tournament is Sept. 28, themed "A Taste of Italy."

c. Chair's Report

Chair Simmonds reported on the Special Study Session meeting on June 10 to revise "Policies and Procedures for MHD Board Meetings." Counsel Coffey will present revisions at the next meeting of the Lease & Building Committee, and when revisions are agreed upon would be recommended to the full Board for action.

Bylaws are to be amended to reflect a change in the calendar of when Board officers and committee members will be named. Counsel Coffey will submit the draft change of the Bylaws for approval.

d. Board Members' Reports

Director Hershon inquired as to MGH's relationships with public agencies providing patient support services and law enforcement. Jon Friedenberg, CAO, remarked that MGH provides medical directorship to EMS agencies and fire departments, is a key participant in the County disaster planning process, and works with the Sheriff's Dept. and with San Quentin; work with CHP and local police departments is as needed.

Director Bedard reported that he successfully completed the required biennial Public Service Ethics Education and encouraged the other Board members to do the same. AB 258, the Medical Cannabis Organ Transplant Act, was recently signed into law by Governor Brown.

Vice Chair Sparkman reported on her recent attendance at a conference of the American Health Lawyers Association.

Secretary Rienks met with a community member regarding the formation of "Ouchless ER" for children and is pursuing it further. She attended the annual Marin Community Clinics fundraising event. She suggested the MHD Board look into designating MHD as a Certified Healthcare District with the Association of California Healthcare Districts.

12. Adjournment of Regular Meeting

Chair Simmonds adjourned the meeting at 8:14 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

1st Quarter 2015

Prepared 07-31-2015

Marin General Hospital

Performance Metrics and Core Services Report: **1st Quarter 2015**

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 2014 (Annual Report) was presented to MGH Board and to MHD Board in April 2015.
	6. MGH Board must implement a Biennial Quality Performance Improvement Plan for MGH.	Annually	In Compliance	MGH Performance Improvement Plan for 2015 was presented for approval to the MGH Board in April 2015.
	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 April 2015.
	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 April 2015.
(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: **1st Quarter 2015**

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 April 2015.
(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 April 2015.
	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 April 2015.
	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 April 2015.
(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 April 2015.
	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 April 2015.
	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 September 12, 2014.
	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 September 12, 2014.
	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 2014 Independent Audit was completed on April 29, 2015.
	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, 2014.

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 2017 VBP Thresholds				2Q 2014	3Q 2014	4Q 2014	1Q 2015
70.02	78.12	84.60	**Overall rating**	65.95	69.66	75.03	61.82
			Would Recommend	71.39	67.10	78.01	70.27
78.19	82.87	86.61	**Communication with Nurses**	75.09	73.50	74.23	70.12
			Nurse Respect	83.42	85.02	84.47	86.04
			Nurse Listen	76.72	74.04	76.92	74.89
			Nurse Explain	77.13	73.43	73.30	68.33
80.51	85.12	88.80	**Communication with Doctors**	83.57	79.39	78.72	77.52
			Doctor Respect	89.89	84.06	86.64	86.04
			Doctor Listen	81.48	83.25	76.71	78.54
			Doctor Explain	83.25	74.76	76.71	78.18
65.05	73.36	80.01	**Responsiveness of Staff**	59.25	59.16	62.19	59.44
			Call Button	57.58	61.05	65.64	65.63
			Bathroom Help	70.33	66.67	68.14	68.46
70.28	74.75	78.33	**Pain Management**	69.93	68.83	70.37	66.70
			Pain Controlled	67.16	68.63	71.88	70.48
			Help with Pain	82.09	78.43	78.26	77.71
62.88	68.70	73.36	**Communication about Medications**	56.15	56.00	53.27	52.72
			Med Explanation	75.86	71.90	68.07	77.86
			Med Side Effects	44.25	47.90	46.28	38.58
65.30	73.13	79.39	**Hospital Environment**	49.95	47.91	52.42	47.04
			Cleanliness	58.51	59.31	62.56	62.44
			Quiet	53.19	48.31	54.09	45.95
85.91	88.60	91.23	**Discharge Information**	80.99	84.09	83.65	82.82
			Help After Discharge	82.12	84.18	83.01	83.25
			Symptoms to Monitor	82.46	86.60	86.89	87.38
			Number of Surveys	192	210	222	223

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 2015 YTD	2Q 2015 YTD	3Q 2015 YTD	4Q 2015 YTD
EBIDA $	$13,625			
EBIDA %	14.28%			

Loan Ratios				
Current Ratio	2.85			
Debt to Capital Ratio	29.7%			
Debt Service Coverage Ratio	3.60			
Debt to EBIDA %	1.61			

Key Service Volumes, cumulative				
Acute discharges	2,203			
Acute patient days	10,500			
Average length of stay	4.77			
Emergency Department visits	9,858			
Inpatient surgeries	539			
Outpatient surgeries	1,076			

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**	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1-Qtr %	Q1-2015 Num/Den	Rolling %	Rolling Num/Den
♦ Venous Thromboembolism (VTE) Measures																	
VTE prophylaxis	90%	100%	100%	100%	100%	98%	100%	100%	97%	83%	98%	83%	84%	**88%**	118/134	95%	471/497
ICU VTE prophylaxis	95%	100%	100%	100%	100%	100%	100%	100%	100%	86%	93%	100%	89%	**92%**	24/26	97%	88/91
VTE patients with anticoagulation overlap therapy	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	18/18	100%	60/60
VTE warfarin therapy discharge instructions	99%	100%	100%	75%	100%	50%	100%	100%	100%	67%	83%	100%	33%	**77%**	10/13	**84%**	31/37
Hospital acquired potentially-preventable VTE +	7%	0%	0%	0%	0%	N/A	N/A	N/A	0%	0%	N/A	0%	0%	0%	0/3	0%	0/11
♦ Global Immunization (IMM) Measures																	
* Influenza immunization	93%	N/A	N/A	N/A	N/A	N/A	N/A	87%	91%	85%	81%	90%	86%	**85%**	220/25/	**86%**	446/516
♦ Stroke Measures																	
Venous thromboembolism (VTE) prophylaxis	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	39/39	100%	159/159
Thrombolytic therapy	76%	N/A	N/A	N/A	67%	N/A	100%	N/A	N/A	0%	N/A	100%	100%	100%	3/3	**75%**	6/8
Discharged on statin medication	96%	100%	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%	100%	19/19	99%	94/95
Stroke education	92%	100%	100%	75%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	12/12	97%	70/72
♦ Perinatal Care Measure																	
* Elective delivery +	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0/6%	0%	0/32
♦ ED Inpatient (ED) Measures																	
Median time ED arrival to ED departure - Minutes	272***	314.00	295.00	276.50	285.00	289.00	257.50	284.50	295.00	291.50	326.00	269.50	305.00	**300.17**	181--cases	**290.71**	714--cases
Admit decision median time to ED departure time - Minutes	97***	149.00	127.50	137.50	116.50	124.00	135.00	100.00	131.00	152.00	140.00	119.00	132.00	**130.33**	124--cases	**130.29**	441--cases
♦ ED Outpatient (ED) Measures																	
Median time ED arrival to ED discharge +	139***	138.00	205.50	129.00	121.00	102.00	140.00	147.50	119.50	152.50	157.00	160.00	202.00	**173.00**	103--cases	**147.83**	412-cases
Door to diagnostic evaluation by qualified medical personnel +	25***	26.50	48.00	22.50	18.00	35.50	26.00	28.50	23.00	24.00	37.00	32.50	33.00	**34.17**	103--cases	**29.54**	408--cases
♦ Outpatient Pain Management Measure																	
Median time to pain management for long bone fracture - Mins +	54***	44.00	39.00	53.00	42.00	55.50	52.00	52.00	47.50	54.50	56.50	71.00	73.00	**66.83**	40--cases	**53.33**	184--cases
♦ Outpatient Stroke Measure																	
Head CT/MRI results for stroke patients within 45 mins of ED arrival	63%	N/A	50%	N/A	N/A	N/A	N/A	0%	0%	N/A	N/A	N/A	N/A	N/A	0/0	**20%**	1/5

* CMS Reduction Program (shaded in blue)
** CMS Top Decile Benchmark
*** Median Time
TJC: The Joint Commission measures may be CMS voluntary
+ Lower number is better

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/)

♦ Agency for Healthcare Research and Quality Measures (AHRQ-Patient Safety Indicators)

METRIC	CMS National Average	Oct 2010 - June 2012	July 2011 - June 2013		
* Complication / Patient Safety Indicators PSI 90 (Composite)	0.88	Worse than National Average	Worse than National Average		
METRIC	**MGH Goal**	**2012**	**2013**	**2014**	**Jan - March 2015**
Complication / Patient Safety Indicators PSI 90 (Composite)		0.37	0.42	0.43	0.15
Adult Pressure Ulcer		0.00	0.00	0.00	0.00
Iatrogenic Pneumothorax, Adult		0.67	0.71	1.21	0.61
Adult Central Venous Catheter-Related Bloodstream Infections		0.98	0.70	1.07	0.00
Adult Postoperative Hip Fracture		0.00	0.00	0.00	0.00
Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)		3.48	4.96	4.49	2.36
Adult Post-Operative Sepsis		17.31	0.00	5.98	16.94
Post-Operative Wound Dehiscence		3.32	0.00	0.00	0.00
Accidental Puncture or Laceration		2.96	2.34	2.19	0.00
METRIC	**CMS National Average**	**Oct 2010 - June 2012**	**July 2011 - June 2013**		
Death Among Surgical Patients with Serious Complications	118.52 per 1,000 patient discharges	No different than National Average	No different than National Average		

* CMS Reduction Program (shaded in blue)

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/)

♦ Acute Care Readmissions - 30 Day Risk Standardized

METRIC	CMS National Average	July 2007 - June 2010	July 2008- June 2011	July 2009- June 2012	July 2010 - June 2013
* Acute Myocardial Infarction Readmission Rate	17.8%	19.1%	18.0%	16.70%	15.90%
* Heart Failure Readmission Rate	22.7%	24.5%	24.7%	22.60%	**23.00%**
* Pneumonia Readmission Rate	17.3%	17.9%	17.9%	16.20%	15.00%
* COPD Readmission Rate	20.7%				19.00%
Stroke Readmission Rate	13.3%				12.10%
* Total Hip Arthoplasty and Total Knee Arthoplasty Readmission Rate	5.2%			**5.80%**	**5.30%**
Hospital-Wide All-Cause Unplanned Readmission (HWR)	15.6%				14.40%

♦ 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%		

* CMS Reduction Program (shaded in blue)

\+ Lower Number is Better

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/)

♦ Surgical Site Infection

METRIC	National Standardized Infection Ratio (SIR)	July 2012 - June 2013	Oct 2012 - Sep 2013	Jan 2013 - Dec 2013	July 2013 - June 2014	
* Colon surgery	1	0.80	**1.68**	**1.54**	**1.19**	No Different than U.S. National Benchmark
* Abdominal hysterectomy	1	0.00	not published	not published	not published	No Different than U.S. National Benchmark

♦ Healthcare Associated Infections (ICU)

METRIC	National Standardized Infection Ratio (SIR)	July 2012 - June 2013	Oct 2012 - Sep 2013	Jan 2013 - Dec 2013	July 2013 - June 2014	
* Central Line Associated Blood Stream Infection Rate (CLABSI)	1	0.85	**1.11**	0.54	0.27	No Different than U.S. National Benchmark
* Catheter Associated Urinary Tract Infection (CAUTI)	1	0.86	0.83	**1.10**	**1.10**	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	Jan 2013 - Dec 2013	July 2013 - June 2014	
* Clostridium Difficile	1	**1.08**	**1.03**	**1.06**	**1.16**	No Different than U.S. National Benchmark
* Methicillin Resistant Staph Aureus Bacteremia	1	0.00	0.00	0.00	**1.63**	No Different than U.S. National Benchmark

♦ Healthcare Personnel Influenza Vaccination

METRIC	CMS National Average	Oct 2013 - March 2014				
Healthcare Personnel Influenza Vaccination	79%	**71%**				No Different than U.S. National Benchmark

♦ Surgical Complications

METRIC	CMS National Average	July 2009 - March 2012	April 2010- March 2013			
Hip/knee complication: Hospital-level risk -- Standardized complication rate (RSCR) following elective primary total hip/knee arthoplasty	3.3%	**4.0%**	**4.4%**			

♦ Cost Efficiency

METRIC	CMS National Average	Jan 2012 - Dec 2012	Jan 2013 - Dec 2013	July 2010 - June 2013		
*Medicare spending per beneficiary (All)	0.98	**1.02**	**1.01**			
Acute Myocardial Infarction payment per episode of care	$21,292			$20,850		

♦ Mortality Measures - 30 Day

METRIC	CMS National Average	July 2007 - June 2010	July 2008 - June 2011	July 2009 - June 2012	July 2010 - June 2013	
* Acute Myocardial Infarction Mortality Rate	14.9%	13.7%	13.5%	13.30%	12.60%	
* Heart Failure Mortality Rate	11.9%	**12.1%**	**12.9%**	**13.8%**	**12.0%**	
* Pneumonia Mortality Rate	11.9%	11.1%	10.7%	10.9%	**12.2%**	
COPD Mortality Rate	7.8%				7.8%	
Stroke Mortality Rate	15.3%				15.2%	

* CMS Reduction Program (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 2015	**2Q 2015**	**3Q 2015**	**4Q 2015**	**Total 2015**
Hearth Walk	$ 2,500				$ 2,500
Marin Brain Institute	638				638
Marin Community Clinics	55,830				55,830
MHD 1206(b) Clinics	1,128,298				1,128,298
Prima Medical Foundation	1,550,000				1,550,000
Total Cash Donations	**$ 2,737,266**				**$ 2,737,266**
Compassionate discharge medications	$ 655				$ 655
Meeting room use by community based organizations for community-health related purposes.	2,568				2,568
Food donations	992				992
Total In Kind Donations	**$ 4,215**				**$ 4,215**
Total Cash & In-Kind Donations	**$ 2,741,481**				**$ 2,741,481**

Schedule 4, continued

Community Benefit Summary

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

	1Q 2015	2Q 2015	3Q 2015	4Q 2015	Total 2015
Community Health Improvement Services	$ 36,617				$ 36,617
Health Professions Education	1,206,980				1,206,980
Research	0				0
Cash and In-Kind Contributions	2,741,481				2,741,481
Community Benefit Operations	14,161				14,161
Traditional Charity Care *Operation Access total is included	322,987				322,987
Government Sponsored Health Care (includes Medi-Cal & Means-Tested Government Programs)	3,446,797				3,446,797
Community Benefit Subtotal (amount reported annually to State & IRS)	**$ 7,769,023**				**$ 7,769,023**
Community Building Activities	$ 2,813				$ 2,813
Unpaid Cost of Medicare	20,661,304				20,661,304
Bad Debt	526,063				526,063
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**$21,190,180**				**$21,190,180**

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)	$ 439,833				$ 439,833
Costs included in Charity Care	90,984				90,984

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	
2Q 2014	550	9	9	3.27%
3Q 2014	547	9	5	2.56%
4Q 2014	541	12	6	3.33%
1Q 2015	534	9	6	2.81%

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
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%
4Q 2014	12	34	2	9	402	139	541	8.46%	8.63%
1Q 2015	13	53	3	7	412	122	534	12.86%	10.66%

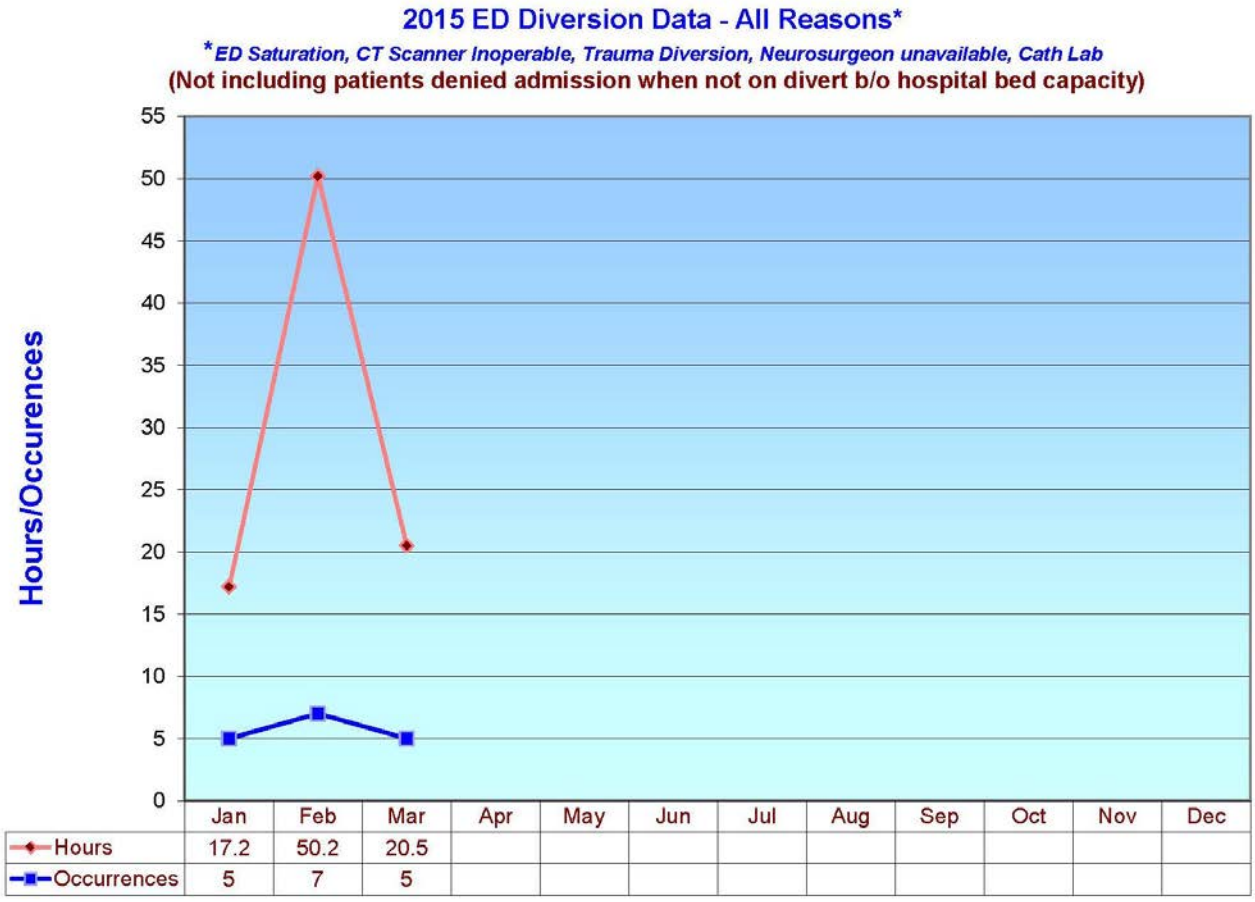
Hired, Termed, Net Change			
Period	Hired	Termed	Net Change
2Q 2014	21	18	3
3Q 2014	12	14	(2)
4Q 2014	11	18	(7)
1Q 2015	10	15	(5)

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 2015	Jan 12	21:10-02:00	4 hr 50 min	ED Saturation	24	12	6
1Q 2015	Jan 13	20:15-02:45	6 hr 30 min	ED Saturation	35	8	7
1Q 2015	Jan 15	15:53-17:24	1 hr 31 min	ED Saturation	37	10	6
1Q 2015	Jan 19	19:55-23:05	3 hr 10 min	ED Saturation	36	9	5
1Q 2015	Jan 28	14:47-15:58	1 hr 11 min	ED Saturation	27	6	4
1Q 2015	Feb 10	21:00-02:30	6 hr 30 min	ED Saturation	28	3	9
1Q 2015	Feb 11	11:50-01:15	13 hr 25 min	ED Saturation	24	1	8
1Q 2015	Feb 12	11:35-17:12	5 hr 37 min	ED Saturation	21	1	5
1Q 2015	Feb 17	21:58-05:56	7 hr 58 min	ICU Full	22	0	3
1Q 2015	Feb 25	10:50-11:45	55 min	Cath Lab Down			
1Q 2015	Feb 26	19:21-01:08	5 hr 47 min	ED Sat/ Hospital Sat	27	7	12
1Q 2015	Feb 27	09:20-19:20	10 hr	ED Saturation	21	0	11
1Q 2015	Mar 2	21:00-00:20	3 hr 20 min	ED Saturation	23	7	8
1Q 2015	Mar 3	19:13-23:05	3 hr 52 min	ED Saturation	24	5	5
1Q 2015	Mar 16	17:00-23:00	6 hr	ED Saturation	22	17	9
1Q 2015	Mar 19	18:30-23:45	5 hr 15 min	ED Sat/ HighCensus	25	4	7
1Q 2015	Mar 29	23:15-01:15	2 hr	ED Saturation	28	6	6

Schedule 6, continued



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hours	17.2	50.2	20.5									
Occurrences	5	7	5									

Tab 3

Marin Healthcare District

Creating a healthier Marin together.

TO: MHD Board of Directors

FROM: Lee Domanico

RE: Recommendation for Approval of sublease of office space/services at Cardiovascular Associates of Marin, 2 Bon Air Road, by University of California, San Francisco (for Dr. Scott Merrick)

DATE: August 11, 2015

The District owns and operates a 1206(b) clinic located at 2 Bon Air Road, Greenbrae (the "Clinic"), at which cardiovascular care services are provided to residents of the community through agreements with Cardiovascular Associates of Marin and San Francisco ("CAMSF").

MHD desires to sublease office space and shared support services at the Clinic to the University of California, San Francisco ("UCSF"), for the purpose of supporting an additional physician (Dr. Scott Merrick) specializing in cardiothoracic medicine and providing care to Clinic patients. UCSF currently employs Dr. Merrick to provide cardiothoracic medical director services and surgical call coverage at Marin General Hospital ("MGH"). Dr. Merrick requires access to Clinic facilities and services in order to provide necessary follow-up care to patients seen per the coverage agreement between UCSF and MGH and to meet the District community's local needs for outpatient cardiothoracic services.

Background

Because MHD Board members Ann Sparkman, J.D., and Jennifer Rienks, Ph.D., are employees of UCSF, prudent compliance practice suggests that District Board approval and adoption of Conflicts Findings be obtained.

Requested Action and Findings by the Board

Motion based on management's recommendation: "To approve the terms of the sublease of space at 2 Bon Air Road to UCSF, as presented in the Transaction Summary before the Board, along with the following findings:

- The proposed sublease arrangement is necessary to assist the District in the provision of locally accessible follow up care to MGH cardiothoracic patients of UCSF physician Scott Merrick, a qualified specialist. Additionally, the sublease provides space for UCSF physician Scott Merrick to offer specialty services in the communities served by the District and MGH, and the health and welfare of the residents of these communities require these provisions to assure the continued availability of a physician specializing in cardiothoracic medicine for patients of MHD and MGH.

- The sublease rate charged to UCSF for medical office space and shared support services is within the fair market range of reasonable rent per square foot in the San Rafael/Larkspur submarket based on the review of Jones Lang LaSalle, independent real estate appraisal consultants."

100 B Drake's Landing Road, Suite 250
Greenbrae, CA 94904

office 415-464-2090
fax 415-464-2094

TRANSACTION SUMMARY
PHYSICIAN TRANSACTIONS AND ARRANGEMENTS

SUBLEASE AGREEMENT
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; DR. MERRICK

MARIN HEALTHCARE DISTRICT 1206(b) CLINIC

The following are the proposed terms for the sublease to UCSF, to let office space in MHD's 1206(b) clinic located at 2 Bon Air Road, Greenbrae, California.

A. Parties

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

Marin Healthcare District ("MHD")
The University of California, San Francisco

B. Purpose/Reasons to Pursue the Arrangement

Describe how the arrangement meets a community need.

MHD operates a 1206(b) clinic located at 2 Bon Air Road, Larkspur, California (the "Clinic") which specializes in the provision of cardiology services to patients residing in the service area. MHD desires to contract with UCSF in order to allow UCSF employee and cardiothoracic specialist, Dr. Merrick, to provide cardiothoracic services to the communities served by MHD and Marin General Hospital ("MGH"), including necessary follow-up care to MGH patients. There is a demand or need in the community for an additional physician with experience in this specialty to provide services at the Clinic in order to ensure the continued availability of cardiothoracic care to patients of MHD and MGH.

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

This is a new arrangement.

C. <u>Terms of the Agreement</u>

1. <u>Agreement:</u>

MHD will sublease to UCSF a portion of the premises of Suite 100 at 2 Bon Air Road, Larkspur, CA.

2. <u>Term of Agreement</u>:

One (1) year.

3. Financial Terms:

Under the Sublease, MHD will receive $1,436.86 per month from UCSF for providing part-time use of two (2) exam rooms, non-exclusive use of the waiting room and the hallways to the two exam rooms (the "Sublease Premises"), and non-exclusive use of the services of one (1) registered nurse, the non-exclusive use of the receptionist and other non-clinical support staff, and basic supplies (gloves, wipes, masks, etc.) for use in seeing patients during the period of use of the Sublease Premises (the "Rent"). Use of Sublease Premises shall take place only between the hours of 2:00 P.M. Pacific Time and 6:00 P.M. Pacific Time on each Friday during the term of the Sublease. The Rent covers both UCSF's sublease of the premises (based on UCSF's approximate 1.74% share of the exclusive-use space/week used of the premises and use of the common area) and the leasing of MHD's staff and personnel.

4. Community Benefit/Need.

No alternative explored by management presents a better arrangement to ensure the situating of UCSF for continued availability of a physician specializing in cardiothoracic surgery for patients of MGH to provide locally available follow-up care and specialty outpatient services to the Marin community.

5. Fair Market Value Analysis.

The sublease price per square foot for $1,436.86 is within the fair market range of the fair market value data that was provided, as of June 20, 2014, by Jones Lang LaSalle, independent real estate appraisal consultants for the District and Hospital. Their findings indicate that the proposed sublease between UCSF and the Marin Healthcare District as summarized in this transaction summary is within fair market value, based on the location and size of the Sublease Premises and the scope of services to be provided and the proposed terms of the sublease.

Physician Transactions and Arrangements

Conflict of Interest Findings

Conflict findings are to be based on the terms and definitions in the Marin Healthcare District ("MHD") Conflicts of Interest Policy adopted by the Board of Directors.

1. Identify the contractor and the type or nature of the transaction or agreement.
The University of California, San Francisco; Sublease Agreement

2. Is the contractor a present officer or director of MHD? **No.**

3. Is any member of the Contractor's immediate family a present or former officer or director of any affiliate of MHD? **No**.

4. Does any present officer or director (including any immediate family member) of MHD have a financial interest in, or tie to, this transaction or arrangement, or to the contractor? **Yes**. If yes, describe the financial interest or relationship.

MHD Board members Ann Sparkman, J.D., and Jennifer Rienks, Ph.D. are employees of UCSF.

5. If any of items 2-4 were answered "yes", describe all the material facts, including:

- Alternatives to this transaction or arrangement investigated.

  Management investigated a number of alternative arrangements to this agreement with UCSF. This arrangement was the most optimal arrangement for the community and MHD for the reasons set forth above.

- How the transaction or arrangement better serves MHD's interests than alternatives would.

  This arrangement is designed to ensure continuity of care for patients seen by Dr. Merrick at MGH and to maintain the availability of cardiothoracic care services to District residents.

- How the determination was made that the transaction or arrangement is fair and reasonable.

  The sublease rate charged to UCSF for medical office space and shared support services is within the fair market range of reasonable rent per square foot in the San Rafael/Larkspur submarket based on the review of Jones Lang LaSalle, independent real estate appraisal consultants.

- The basis for concluding that MHD cannot obtain a more advantageous arrangement with reasonable efforts under the circumstances.

  The consensus among management is that a sublease agreement with UCSF provides the best option for the success of the cardiology services provided at the Clinic.

MARIN HEALTH CARE DISTRICT
PHYSICIAN TRANSACTIONS AND ARRANGEMENTS POLICY

Due Diligence Checklist for Board Approvals

UCSF Sublease at 2 Bon Air Road, Greenbrae

Basis for District Board review and approval: (check all that apply)

- ❒ New unbudgeted arrangement
- ❒ Transaction not covered in approved District Clinic operations or development budget
- X Conflict of Interest Issue in Transaction
- ❒ Transaction exceeds projected budget for physician staffing by 20%
- ❒ Transaction compensation exceeds FMV guidelines and needs specific consideration of compensation
- ❒ Transaction has term of more than two years without early termination
- ❒ Transaction involves the provision of services outside District boundaries
- ❒ Other: Recruitment Subsidies

□ Hospital CEO confirms MGH staff has completed its own due diligence and policy procedures as necessary for MGH funding of the proposed agreement and operational and capital needs associated with the transaction

- ❒ Hospital CFO has confirmed the transaction is financially viable and is consistent with Hospital's physician development plan to meet community physician access needs

X Hospital management confirms that all supporting documentation has been obtained supporting management due diligence covering legitimacy of the Physician and its business and license existence, its Medicare participation, and qualifications

- ❒ Hospital management confirms contract requirements based on its Physician Contracting Policy have been met

- X The Hospital has made a fair market value determination consistent with its Physician Contracting Policy

- ❒ Agreement / transaction has been approved by:

  - ❒ The Hospital Board since the matter involves a Board or senior management conflict of interest, or
  - ❒ The Board Executive Committee since the matter involves a matter with an annual value of $500K

- ❒ The Board Executive Committee since the matter involves more in funding or if funding exceeds an increase of 20% over the prior year
- ❒ The Board Executive Committee since the matter involves exceeds fair market guidelines
- ❒ The CEO since the matter involves routine arrangements or matters already authorized in Hospital Board approved budgets for physician development and operations
- ❒ Hospital Executive Committee: pursuant to IRS recruitment incentive guidelines

X Management confirms that all supporting documentation has been obtained supporting management due diligence covering legitimacy of the Physician and its business and license existence, its Medicare participation, and qualifications

❒ Management confirms consistency with Clinic business and strategic plan

❒ District Board reviewed Term Sheet

❒ District Board confirmed Fair Market Value determination

X District Board reviewed Conflict Findings, if any

❒ District Board made determinations supporting outside boundary services (if necessary)

❒ District Board approved material terms of agreement and authorizes execution of necessary documents concluding and supporting the arrangement

_____ _____

Larry Bedard, MD
Chair, District Management, Finance & Audit Committee — Date

_____ _____

Harris Simmonds, MD
Chair, District Board — Date

_____ _____

Lee Domanico
CEO, Marin General Hospital — Date

Tab 4

Proposed District Bylaw Amendment
Officer Election and Committee Appointments

Draft July 28, 2015

ARTICLE IV

OFFICERS

Section 1. Officers. The officers of the District shall be a Chair, a Vice Chair, and a Secretary. The Chair, Vice Chair and the Secretary shall be Directors. The officers shall be elected by the Board annually as the first order of business at the December **[January]** Regular Meeting of the Board. Each officer shall serve for a term of one (1) year. Officers shall not hold the same office for more than two (2) consecutive years**.** The Board may adopt policies and procedures designating one or more of its officers to sign checks drawn on the funds of the District, and to execute in the name of the District all contracts and conveyances and any other written instruments.

ARTICLE V

BOARD COMMITTEES

Section 1. General Provisions.

(a) Committees of the Board shall be standing or ad hoc. The committee members and chair shall be appointed by the Chair, subject to the approval of the Board. Standing Committee appointments and Board approval shall be made at the first **[February]** Regular Meeting of each calendar year.

Tab 5

POLICIES AND PROCEDURES FOR BOARD MEETINGS
MARIN HEALTHCARE DISTRICT
Adopted: March 8, 1994 Amended
September 13, 1994 Amended
June 13, 1995 Amended
April 15, 1997 Amended
August 10, 1999 Amended
February 12, 2002 Amended
June 14, 2005 Amended
June 13, 2006 Amended
July 10, 2007 Amended
August 11, 2015

I. GENERAL PROVISIONS.

SCOPE AND APPLICATION.

These Policies and Procedures for Board meetings apply to the Open Meetings of the Marin Healthcare District Board of Directors (the "Board") and do not apply to Closed Meetings or Committee Meetings. Nor do these Policies and Procedures apply to any study sessions that the Board sponsors, but are not formal meetings. Meetings of the District are governed by the Ralph M. Brown Open Meetings Act, which is hereby incorporated herein

II. PLACE AND TIME OF BOARD MEETINGS.

A. TIME OF BOARD MEETINGS.

1. Regular Meetings. Regular Meetings shall generally start at 7 p.m., and adjourn no later than 11 p.m. or upon the completion of the agenda item under discussion at 11 p.m., whichever is later, unless the Board votes to extend the time for adjournment. The Board may modify the start time and frequency of Regular Meetings as necessary to conduct the business of the District. The Board also may have a special meeting or closed meeting that starts and ends right before or after a regular meeting.

2. Special Meetings. Special Meetings shall start at the time stated in the notice thereof.

B. MEETING NOTICE AND AGENDA REQUESTS.

A written request to receive meeting notices and/or agendas shall be valid for 12 months from the date filed with the District. Unless a written renewal request is received by the District within 12 months of a prior request, no further meeting notices and/or agendas will be sent. The District may set a fee to cover costs of distributing meeting notices and/or agenda

III. THE AGENDA: CONTENT AND PREPARATION.

A. SETTING THE AGENDA.

The District Chief Executive Officer working in consultation with the Board Chair shall prepare the agenda. The Board Chair has the final authority to approve the agenda. This preparation includes determining what items need to come before the Board for the Board's information, action or both. Board Directors may also suggest items to the Board Chair and

Chief Executive Officer. The District Chief Executive Officer and Board Chair shall have sufficient backup documentation for every item that is to be included on the agenda.

Before an item is placed on the agenda, the agenda request shall contain a brief description of the item (not exceeding 20 words); appropriate documentation and supporting written materials; and a suggested motion if the agenda item requires Board action. If there is insufficient documentation, the Board Chair may exclude the item until such time as supporting documentation is received.

For pre-arranged presentations by non-Board Members (such as MGH Corporation, District consultants or a community group) that are specific to the business the Board is undertaking, the name of the group, the name and title of the individual or firm presenting, and an executive summary of the proposed presentation topic, shall be indicated on the agenda or provided in the meeting packet.

If any board members submit specific agenda items, as described next, their name will be listed next to the item(s).

The Board Chair shall endeavor before adjourning a Regular Meeting to ask for input from the Board on possible future agenda items.

B. REGULAR MEETINGS.

1. Board members requesting agenda items for a Regular Meeting shall submit their requests to the Chief Executive Officer at least eight (8) days before the meeting. The eight-day limit does not apply to referral by a Committee to the Board for the discussion and actions within the scope of items listed on the posted agenda of the Committee.

2. At the time of the request, each requested item shall include a description of the item to enable the Chief Executive Officer and Board Chair to determine its scope and its relation to the Board's responsibilities. Each Board member having requested an agenda item shall provide to the Executive Assistant any pertinent documentation related to each item with the item at least eight (8) days before the meeting. If the Board Member is seeking information or a staff report on an issue, the request should include a list of information sought by the member (if the item includes such a request) or a suggested motion for the consideration of the Board to authorize the resources necessary to research and complete the requested report.

3. Except for those matters which the Chief Executive Officer and Board Chair deem duplicative, appropriate for closed session, necessary to postpone to a future meeting or not germane to the mission, goals and objectives adopted by the Board, all requested items shall be included on the agenda. Should an item be deferred from the agenda, the Board Chair or the Chief Executive Officer will confer with the originator to discuss the reasons for the deferral. Should a Director disagree with the deferral, the Director may request a majority vote of the attending Board Members (at the next regular meeting where the Agenda is set) to have the item added to the next Board Meeting.

D. ORDER OF ITEMS ON THE AGENDA.

The general order of the agenda for a Regular Meeting shall be:

1. Call to Order

2. Roll Call

3. General Public Comment

4. Approval of Agenda

5. Approval of the Consent Agenda
    - Approval of the Minutes
    - Committee Meeting Minutes for review
    - Written reports, including updates and progress reports
    - Written correspondence

6. Action Items in Order of Priority

    a) Unfinished Business

    b) New Business

7. Special Presentations by MGH, Staff, Consultants or Other Guests

8. Committee Reports

9. Reports
    - District CEO Report
    - Hospital CEO Report
    - Chair's Report
    - Reports of Board Members

10. Items Suggested for Future Meetings

11. Adjournment

E. CHANGING THE ORDER AND TIME LIMITS OF THE AGENDA.

The Chair shall have the discretion to change the order of agenda items and to allocate time to deliberate on action items.

The Chair also shall have the discretion to limit the total time to be devoted to an item on the agenda, including limiting the time allowed for each person to speak on such item, including the public. The Chair is expected to exercise this discretion when it is necessary to complete consideration of the entire agenda in a timely fashion.

F. PURPOSE OF CLOSED SESSION FOR THE AGENDA.

If a closed session of the Board will be held before, during or after a Board meeting, the agenda shall describe the purpose of the closed session in compliance with the Brown Act.

G. ABOUT THE CONSENT AGENDA

The consent agenda lists routine items that the Board Members can act on with no individual presentation or discussion required. Any member of the Board may remove one or more items from the consent agenda and have it as a regular agenda item later in the meeting. No reason, rationale or discussion is required. The items remaining on the consent agenda shall then be enacted by one motion. Approval by the Board of Directors of consent items indicates that these items were approved together without any additional conditions.

After the Chair introduces the consent agenda and a Director moves to adopt the consent agenda, it is in order for a Director to remove one or more items for consideration later. It also is

in order for a member of the public to address any item on the consent agenda; however, only a Board member can request that an item be removed from the consent agenda.

Consent agenda items can include but shall not be limited to the items listed earlier in III.D.5.

IV. DISTRIBUTION OF THE AGENDA.

A. POSTING THE AGENDA.

1. Time for Posting.

   a) Regular Meetings. The agenda for a Regular Meeting shall be posted no later than 72 hours before the meeting.

   b) Special Meetings. The agenda for a Special Meeting shall be posted no later than 24 hours before the meeting.

2. Place and Manner of Posting.

   The agenda for a meeting shall be posted in a conspicuous place in the main lobby and in the glass cabinets opposite Greenbrae Grill of the Hospital that is freely accessible to all members of the public.

B. DISTRIBUTING THE AGENDA.

1. Board Members. The agenda packet for a Board meeting shall be delivered, mailed, or transmitted electronically to each Board Member the same day as the agenda is posted. If reports or supporting documents have been prepared on an item, such materials shall be distributed, if feasible, to the Board Members with the agenda packet. If a Board member requests a hard copy of the packet, the Executive Assistant will deliver or mail the packet to the Board member.

2. Media, Government and Libraries. At least three days before a Regular Meeting, the agenda shall be delivered, mailed, or transmitted electronically within the District to: newspapers of general circulation; the County government, city and town governments, and libraries for posting; and to other media upon request. The agenda for a Special Meeting shall be mailed or transmitted electronically to the same parties not less than 24 hours before the Board meeting. To encourage maximum community knowledge of District affairs, agenda packets will be provided to media representatives free of charge upon request.

3. Members of the Public. The agenda for Regular Meetings and Special Meetings shall be mailed or transmitted electronically on the schedule outlined above to all persons having submitted an annual request. Members of the public may make an appointment to visit the District office during established office hours to view the agenda and agenda packet without charge. The District may set a fee to cover costs of copying and distributing the agenda and agenda packet to the public. Documentation distributed to the Board at a meeting for public agenda items shall be made available to the public either at the meeting or within three working days of the meeting.

4. Website. The agenda shall be posted on the District website.

V. PROCESS FOR BOARD MEETINGS.

A. AGENDA ITEMS.

1. The Chair shall announce each agenda item.

2. For agenda action items the Board Member who has requested the item shall introduce it. Informal discussion of a topic is permitted while no motion is pending.
3. When the Chair believes that a motion is appropriate, the Chair shall seek a motion from the Board. The Chair shall ask for a second. If there is a second, the Chair shall state the name of the seconder. If there is no second, the Chair shall move to the next agenda item.

4. If there is a second to the motion, the Chair shall allow the Board Member who made the motion to discuss the matter further if desired. The other Board members may then discuss the motion.

5. The Chair shall allow the public to comment on the agenda item and motion as provided in VI of these Policies and Procedures.

6. The Chair shall allow the Board members to conclude discussion on the item and motion.

7. The Chair shall close discussion and if appropriate call for a vote on the item or motion.

8. The Board prefers a flexible form of meeting under the guidelines herein instead of formalized rules of procedure. However, if procedural questions arise that are not covered herein, except as stated in the District Bylaws, Sturgis, The Standard Code of Parliamentary Procedure, the most recent edition ("Sturgis"), **[or Robert's Rules ?]** shall be looked to as a general guideline for the Board's deliberations (such as the manner of debate, motions, amendments and voting) on matters not covered in these Policies and Procedures. The decisions of the Board Chair on such matters of procedure shall prevail unless challenged and overturned by a vote of the majority of the Board attending the meeting.

B. APPROVAL OF MINUTES

Board members are responsible for providing corrections to non-substantive, typographic, and grammatical errors to the preparer of the minutes before the Board meeting at which the minutes are to be approved—provided the Board members were able to receive a draft copy of the minutes in advance of being distributed to the public. In this case, Board members shall provide only substantive suggestions regarding the minutes during the meeting. If Board members were not able to receive a draft copy of the minutes in advance, they should provide all corrections, substantive and administrative, during the meeting.

VI. RIGHTS OF MEMBERS OF THE PUBLIC.

A. RIGHTS TO ATTEND AND SPEAK AT BOARD

1. General Public Comment Period at Regular Meetings. Each Regular Meeting agenda shall include a general public comment period for the public to address issues that are not on the agenda. In addition, members of the public can ask to address the board on particular agenda items during time allotted for such purpose.

2. Public Comment at Special Meeting. Special Meetings do not have a general public comment period unless the Board orders it. Public Comment limited to only the items on the agenda will be allowed at each Special Meeting.

VII. RECORDING OF BOARD MEETINGS.

A. RECORDING BY THE DISTRICT.

1. Minutes. Minutes of Board meetings shall be prepared by the Chief Executive Officer's office as soon as possible after each meeting and submitted to the Secretary of the Board. The minutes should summarize the actions taken on all items and the vote of the individual board members on those items. Minutes shall be made available on the District's web site.

2. Recording Board Meetings. Meetings of the Board shall be recorded under the supervision of the District staff. Recordings made of Board meetings shall be made available on the District's web site.

B. RECORDING BY MEMBERS OF THE PUBLIC.

Members of the public shall have the right to record or video record public Board meetings as long as they do not disrupt the meeting.

VIII. RULES OF DECORUM.

A. PRINCIPLES OF DECORUM

Meetings of the Board shall be conducted in an orderly manner to ensure that the Board may deliberate its business as well as allowing the public to listen and also be heard at appropriate times. The purpose of the meeting is for the Board to conduct its business in public, not to conduct a public meeting.

It is the responsibility of the Chair and the other members of the Board to maintain common courtesy and decorum and to show each other respect. Whoever is serving as Presiding Officer (generally the Board Chair but the Vice Chair in the Chair's absence) has overall responsibility for maintaining the order and decorum of the meetings, including the public in attendance.

B. RULES OF DECORUM

While any meeting of the Board is in session, the following rules of order and decorum shall be observed:

1. Board Members. The Board members shall preserve order and decorum, and a member shall not by conversation or other means delay or interrupt the Board proceedings or disturb any other member while speaking. Individual Board members have the right to disagree with ideas and opinions. However, once the Board votes to take action, the Board members shall support the action and not create impediments to the implementation of the action. Board members shall at all times conduct themselves with courtesy and respect to each other, to staff, and to members of the public.

2. Staff Members. Employees of the District shall observe the same rules of order and decorum as those which apply to the members of the Board.

3. Persons Addressing the Board. Public oral communications at the Board meetings should not be a substitute for any item that can be handled during the normal working hours of the District. The primary purpose of the oral communications is to allow citizens the opportunity to communicate formally with the Board as a whole, for matters that cannot be handled during the regular working hours of the District. Each person who addresses the Board shall not make personal, impertinent, slanderous or profane remarks to any member of the Board, staff or general public. Any person who makes such remarks, or who utters loud, threatening, personal or abusive language, or

engages in any other disorderly conduct which disrupts, disturbs or otherwise impedes the orderly conduct of any Board meeting shall be expelled from the meeting and may be barred from further audience before the Board during that meeting.

4. Members of the Audience. No person in the audience at a Board meeting shall engage in disorderly or boisterous conduct, including the utterance of loud, threatening or abusive language, whistling, hissing, and stamping of feet or other acts which disturb, disrupt or otherwise impede the orderly conduct of any Board meeting. Persons who conduct themselves in the aforementioned manner shall be barred from further audience before the Board during that meeting.

Even when Board meetings are not in session, Board members shall conduct themselves with courtesy and respect to each other, to staff and to members of the public if the Board members are representing themselves and the District.

Any complaints from any source directed toward District or Hospital employees, Board members, consultants or advisors to the District, shall first be discussed with the Chief Executive Officer or the Board Chair to resolve the issue at that level rather than at public meetings of the Board.

C. ADDRESSING THE BOARD.

A person wishing to address the Board may seek recognition by the Chair during discussion of any item during the time set aside for public comment. No person shall address the Board without first being recognized by the Chair. The following procedures shall be observed: Each person shall step to the microphone or specific area provided for the use of the public and will state his or her name when recognized by the Chair, unless anonymity is preferred.

1. During the general "Public Comment" portion of a Regular Meeting, the Chair shall request the speaker to terminate immediately any discussion on a subject which the Chair deems to be outside the subject matter of the District, or may be the subject of an agenda item at the meeting.

2. During the discussion of an agenda item, the Chair shall request the speaker to terminate immediately the discussion of a matter that the Chair deems to be outside the scope of the agenda item.

3. Each person shall limit any remarks to three (3) minutes, unless further time is granted by the Chair, or conversely, the time is limited as set forth by III.E. The time limits for public comment are not transferable.

4. Public comment is encouraged, but except as might be allowed by the Chair in connection with informational presentations, Board meetings are not forums for public or Board dialog or question and answer sessions. Questions may be responded to at the end of a public comment or public comments generally, or may be referred to staff for future response where appropriate.

IX. OTHER POLICIES AND PROCEDURES.

A. BROWN ACT.

The Board shall provide a copy or a summary of the Brown Act and these Policies and Procedures to each Board Member when revised, and to each Board Member Elect, upon election, who has not assumed the duties of District office.

B. AMENDMENTS.

These Policies and Procedures may be amended at any Board meeting by majority vote, assuming advance notification as an agenda item. These Policies and Procedures also may be suspended at any Board meeting by two-thirds vote, provided the suspension does not conflict with the Bylaws or the Brown Act or deprive any Board member of a fundamental right as set forth in parliamentary procedure.

C. SUPERCEDED BY CHANGES IN BROWN ACT.

These Policy and Procedures shall be superseded by any change in the provisions of the Brown Act that are in conflict with this Policy.