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

CLOSED SESSION AGENDA @ 5:30 PM
OPEN SPECIAL STUDY SESSION @ 6:30 PM
OPEN REGULAR MEETING REVISED AGENDA @ 7:00 PM
TUESDAY, OCTOBER 14, 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. (excused due to travel)
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

			Tab
CLOSED Session Call to Order @ 5:30 pm			
1.	Announcement – Purpose of Special Meeting	Bedard	
2.	Roll Call	Bedard	
3.	Discussion involving trade secrets pursuant to H&S Code Section 32106, concerning strategic planning for new programs, services and facilities. • Community Health Grant Process	Domanico	
4.	Conference with Legal Counsel: Pending litigation pursuant to Government Code Section 54956.9(d)(1), Marin Superior Court, matter number CV 1403531	Domanico	
5.	Conference with Legal Counsel, potential litigation pursuant to Government Code Section 54956.9 (e)(1)	Domanico	
6.	Adjourn to Open Special Study Session		
OPEN Special Study Session @ 6:30 pm			
7.	Hospital Replacement Project Presentation by Jason Haim, Architect	Domanico	1
8.	Adjourn to Open Regular Session @ 7:00 pm		
OPEN Regular Meeting @ 7:00 pm			
9.	Approval of Consent Agenda		
	a. Minutes of the Regular Meeting of September 9, 2014 (action)	Bedard	2
10.	General Public Comment *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.*	Bedard	
11.	Measure R Campaign Update	Friedenberg	
12.	Hillside Parking Structure plan, project budget of $25.9M, and Plan of Finance through Union Bank – Presentation by Paul Kirincic, Chair of the MGH Board of Directors (action)	Kirincic	3
13.	Proposition 46 - Medical Malpractice Lawsuit Cap and Drug Testing of Doctors (action)	Bedard	4
14.	Q2 2014 MGH Performance Metrics & Core Services Report (action)	Domanico	5
15.	Committee Meeting Reports (no new meeting reports)		
	a. MHD Finance and Audit Committee (8/26/14-reported 9/9/14)	Sparkman	
	b. MHD Lease and Building Committee (8/21/2014-reported 9/9/14)	Simmonds	
16.	Reports		
	a. District CEO's Report	Domanico	
	b. Hospital CEO's Report	Domanico	
	c. Chair's Report	Bedard	
	d. Board Members' Reports	All	
17.	Adjournment Next Regular Meeting: Tuesday, November 11, 2014 @ 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.
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 Board Meeting

Marin General Hospital

October 14, 2014

Agenda

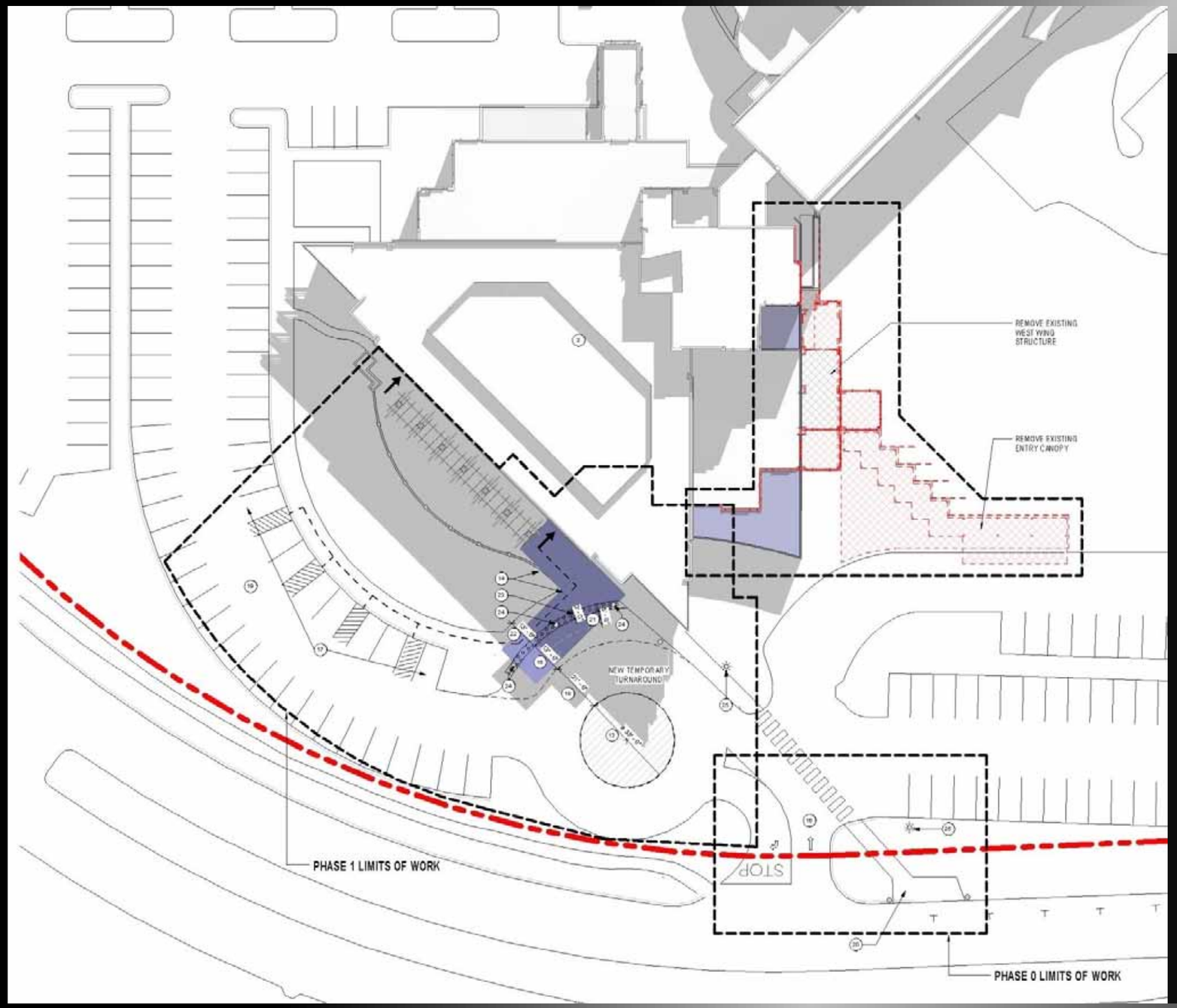
- *West Wing Make Ready*
- *Hospital Replacement Building (HRB)*
- *Hillside Parking Structure: Update, Budget Review and Approval*

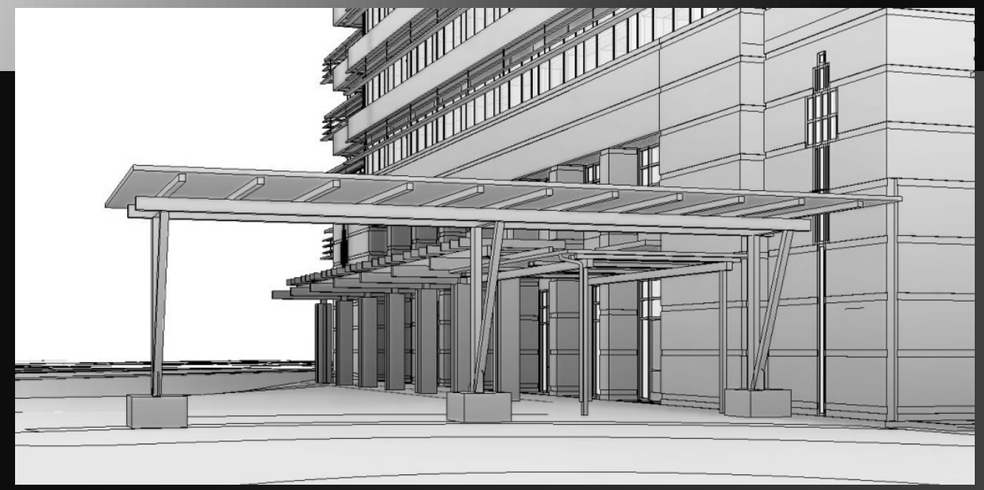
West Wing Make Ready

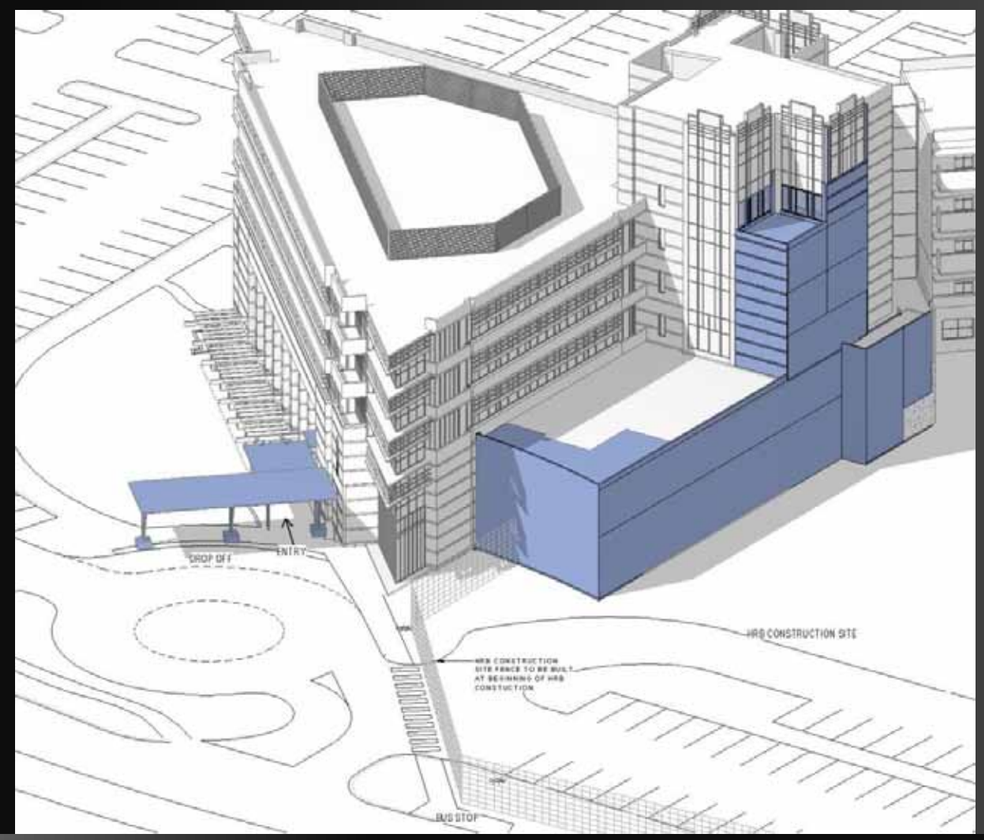
West Wing Make Ready

- This scope of work prepares the West Wing to accept the Hospital Replacement Building
- Plans submitted to OSHPD 9/26/14 – Anticipate getting permit in June-July 2015
- Hospital Operations is starting to prepare for the impacts to the Lobby and Interventional Platform (Surgery) Levels
- Construction duration is 12 months
- We will be requesting Board Budget approval starting in December 2014

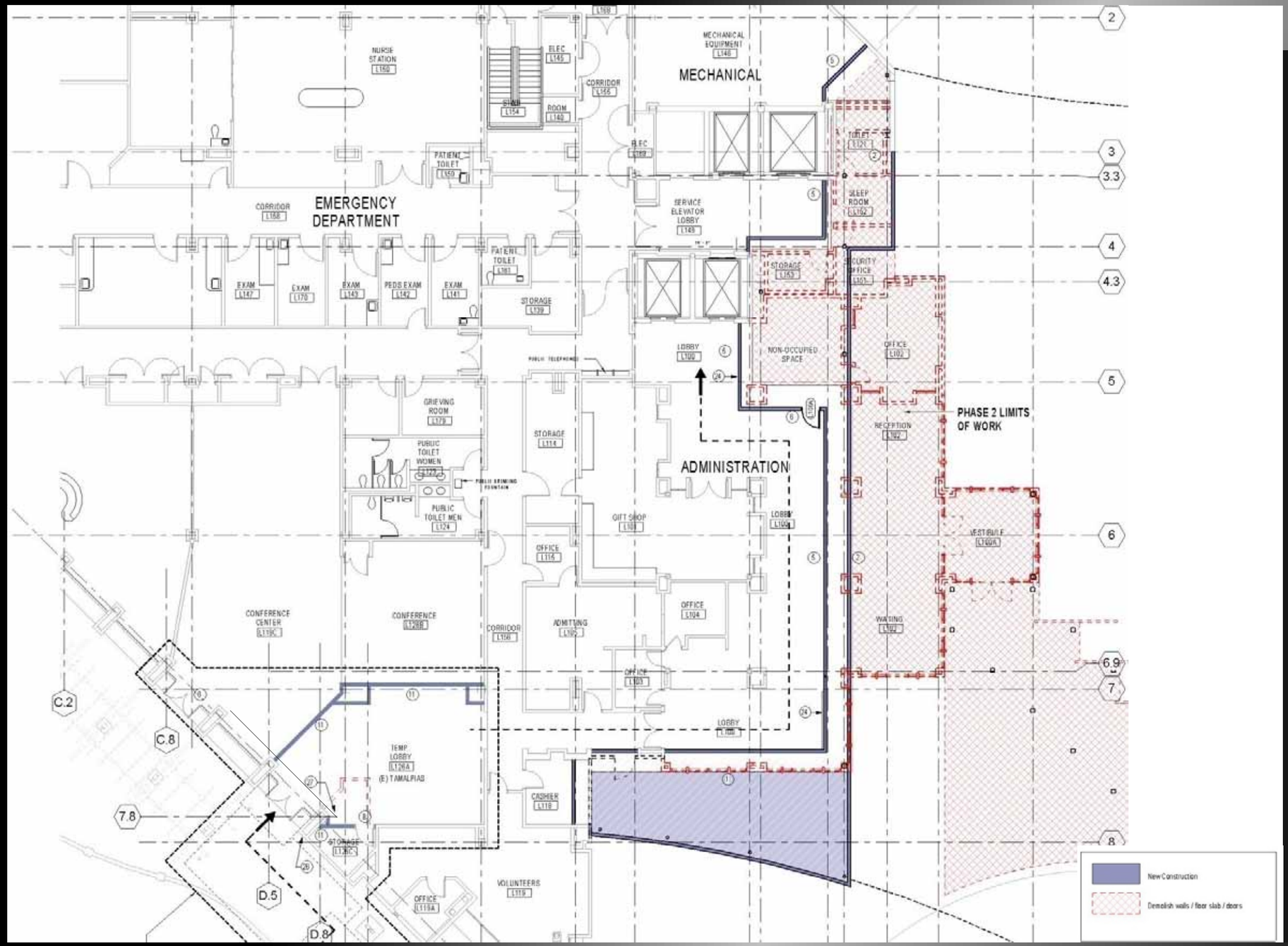
West Wing Make Ready – Temporary Site

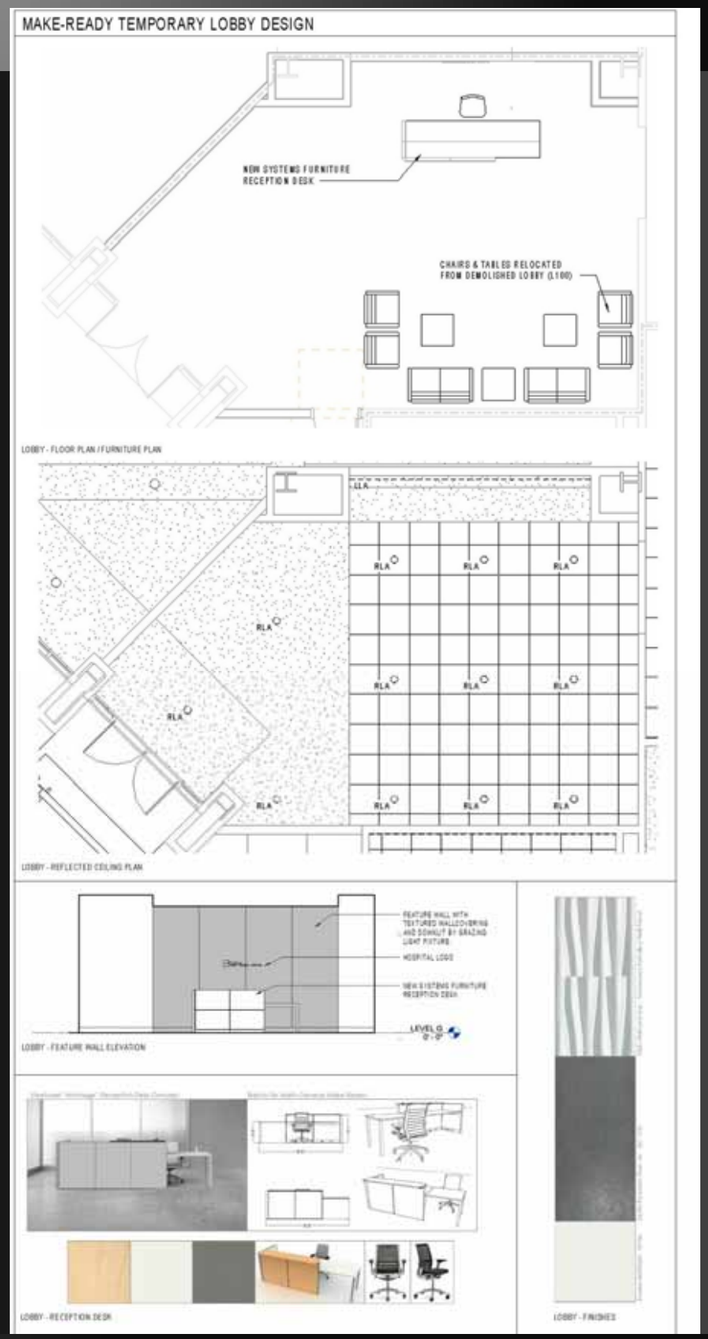






West Wing Make Ready – Ground Floor / Temporary Lobby





HRB Update

Hospital Replacement Building (“HRB”)

- Design Development is 50% complete w/ 3-month LEAN process review
- Meetings conducted with both hospital management and staff / leave behind boards in each department for additional staff input
- Continue to develop detailed departmental planning and room-by-room requirements w/ staff
- Medical Equipment Planning is 65% complete
- An Interior Design Subcommittee has been identified
- Exterior Skin Design is in development and review with MGH Board Building Committee
- Coordination meetings being held with the County regarding required permits and timing
- EIR Addendum for Lobby Addition at West Wing is in progress – anticipate EIR Addendum approval in Q1 2015
- Senate Bill 785 allowing Marin Healthcare District to proceed using the Design Build procurement process was approved in September

HRB Exterior

Exterior Options

Option A – Horizontal Architectural Sunshading (Original Option)

Option C – Metal Panel with Vertical Sunshades

Option B – Reduced Architectural Sunshades

Option D – Exterior Plaster & Horizontal Overhangs

Option A – Horizontal Architectural Sunshading (Original Option)

Option A – Horizontal Architectural Sunshading (Original Option)

Connection to West Wing

Option A – Horizontal Architectural Sunshading (Original Option)

Typical Module with Solarium

Option A – Horizontal Architectural Sunshading (Original Option)

Architectural Precedents

RMP_Rothschild Tower
Horizontal Louvered Sun Shading

Jesolo-Lido-Condo
Horizontal Sun Shading

Edward-P.-Evans-Hall

Edward-P.-Evans-Hall
Curved Glass Wall

RMP_UCLA Art Institute
Horizontal Sun Shading

Option B – Reduced Architectural Sunshades

Option B – Reduced Architectural Sunshades

Connection to West Wing

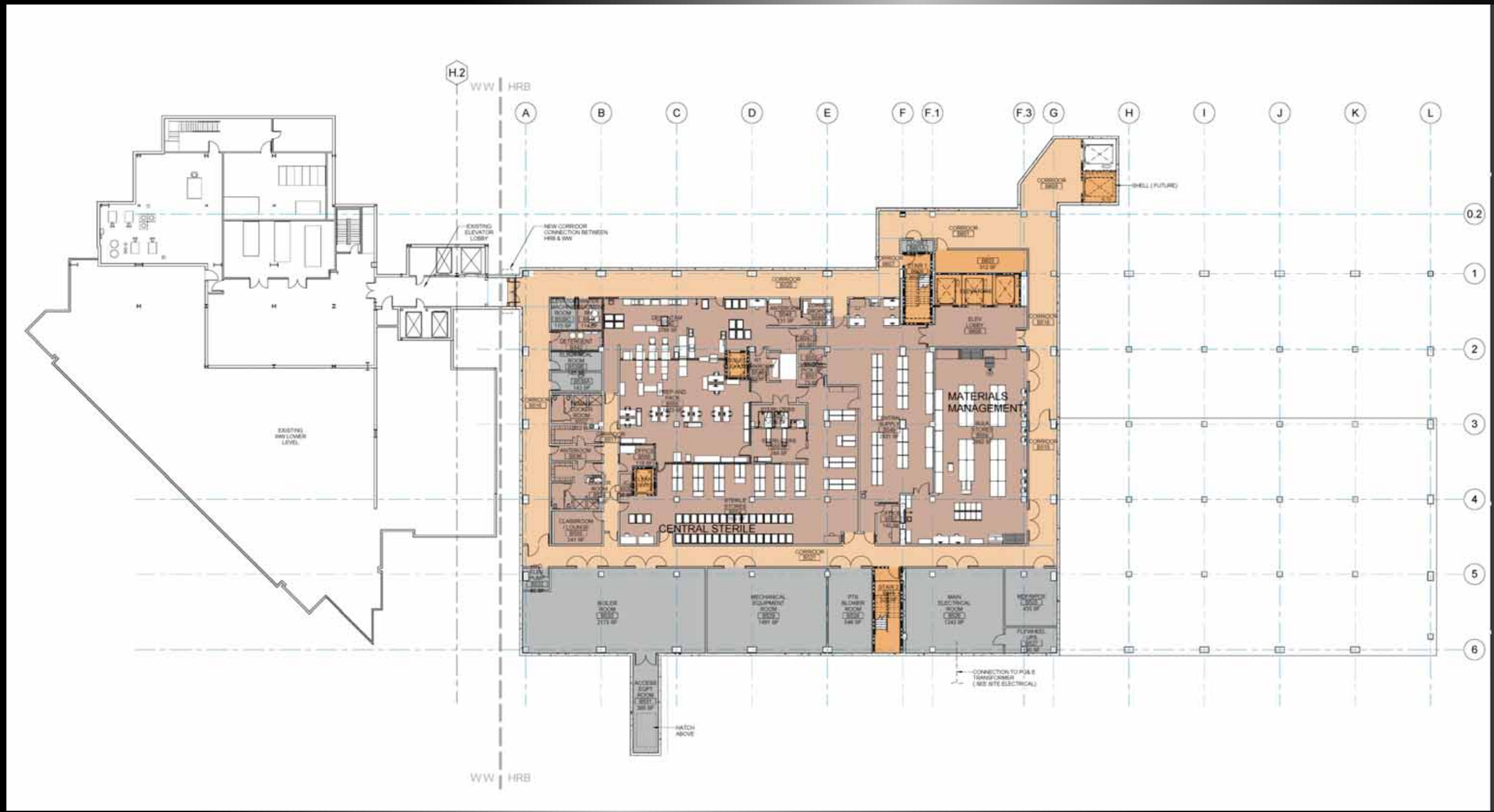
Option B – Reduced Architectural Sunshades

Typical Module with Solarium

Preferred Option: Combination A &B

HRB Floor Plan Development

Basement Floor Plan



Ground Floor Plan

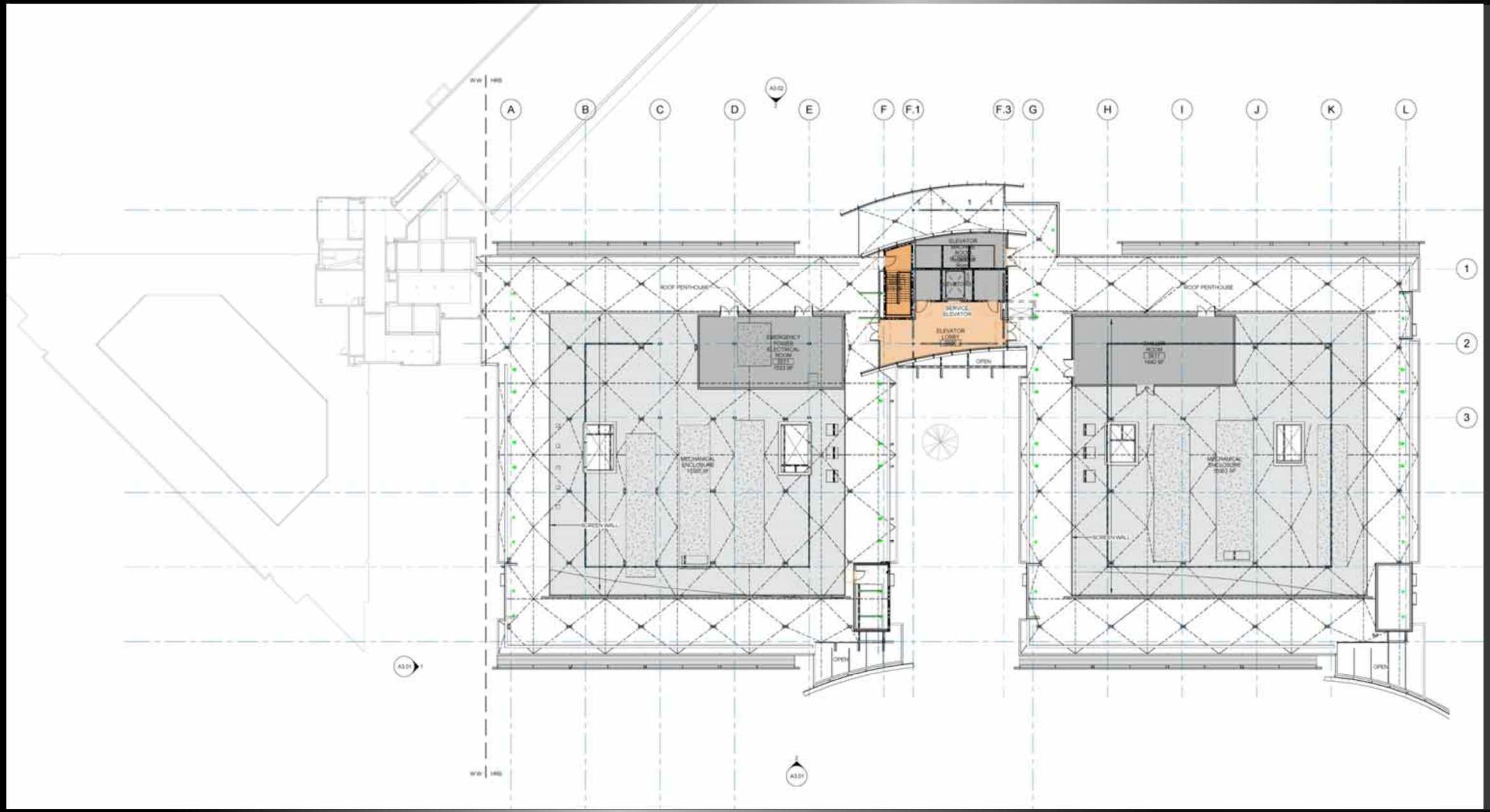
Ground Level

Ground Floor Plan

Level 2S Floor Plan

Level 4 Floor Plan

Roof Floor Plan



HRB Interior Design

Interior Design – Cost Level Summary – Ground Floor

Interior Design – Cost Level Summary

High Cost

West Wing = 26,106 SF
HRB = 102,136 SF

Specialty Ceiling/Lighting
- High-end ceiling systems such as Ceilings Plus
- High-end Lighting
  - custom length linear fixtures
  - LED Accent Lighting

Architectural Elements
- Feature walls with specialty applications
- Additional Layers of drywall/reveals
- Column Covers/Wraps

High-end finishes
- Stone Flooring
- Specialty Wall/Floors Tiles (Restrooms)
- Custom Carpet/Area Inserts
- Wood Veneers
- Graphics/Way-finding

Custom Millwork

Systems furniture (or) modular units

High-end Ancillary Furniture

High/Medium Cost

West Wing = 16,084 SF
HRB = 63,824 SF

Upgraded Ceiling Grid+ Specialty Lighting

<u>Upgraded Finishes</u>

Patient/Staff Corridors/Interior Rooms
- Hard Surface Floor Tiles
- Wall Paint
- Wall Protection by Acrovyn (or similar)
- Rubber Base
- Door Finish Upgrade

Stairwells
- Drywall Ceilings
- Upgraded Lighting
- Wall Paint
- Rubber base
- Upgraded hard surface flooring

Medium Cost
West Wing = 13,006 SF
HRB = 35,796 SF

Standard Ceiling Grid/Drywall Ceiling + Lighting

<u>Standard Finishes</u>

General Areas
- Hard Surface Floor Tiles
- Wall Paint
- Rubber Base

Offices + Meeting Spaces
- Carpet Tile
- Wall Paint
- Rubber Base

Restrooms
- Porcelain Tile Flooring
- Subway Wall Tile
- Solid Surface Counters

Standard Systems Furniture

Standard Ancillary Furniture

Low Cost
West Wing = 4,097 SF
HRB = 44,217 SF

Economic Ceiling Grid + Lighting

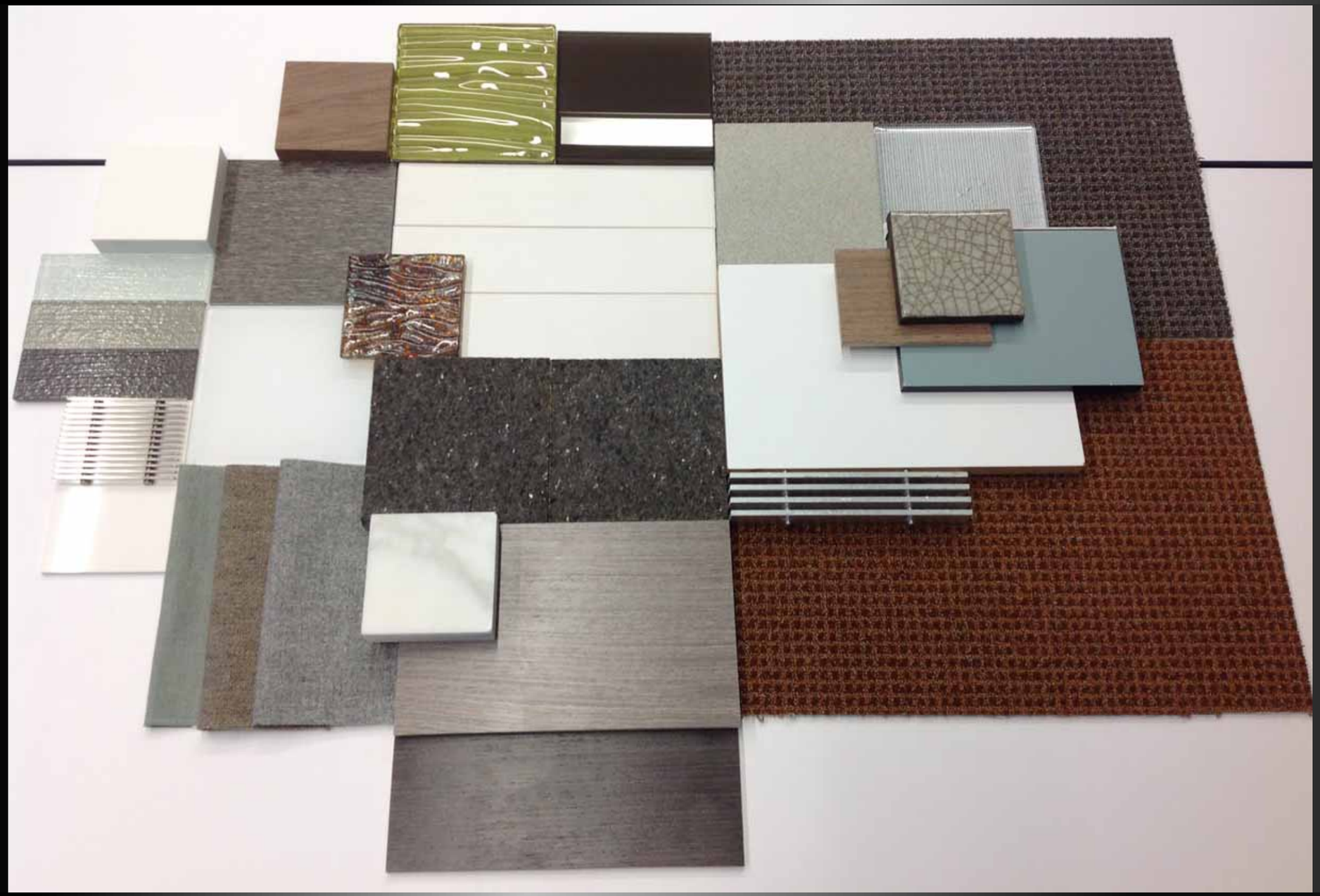
Economic Finishes
- Wall Paint
- VCT Flooring
- Rubber Base
- Wall Protection, as required

Economic Systems Furniture

Economic Ancillary Furniture

HRB Finish Pallet (3 Options)

HRB Preferred Pallet

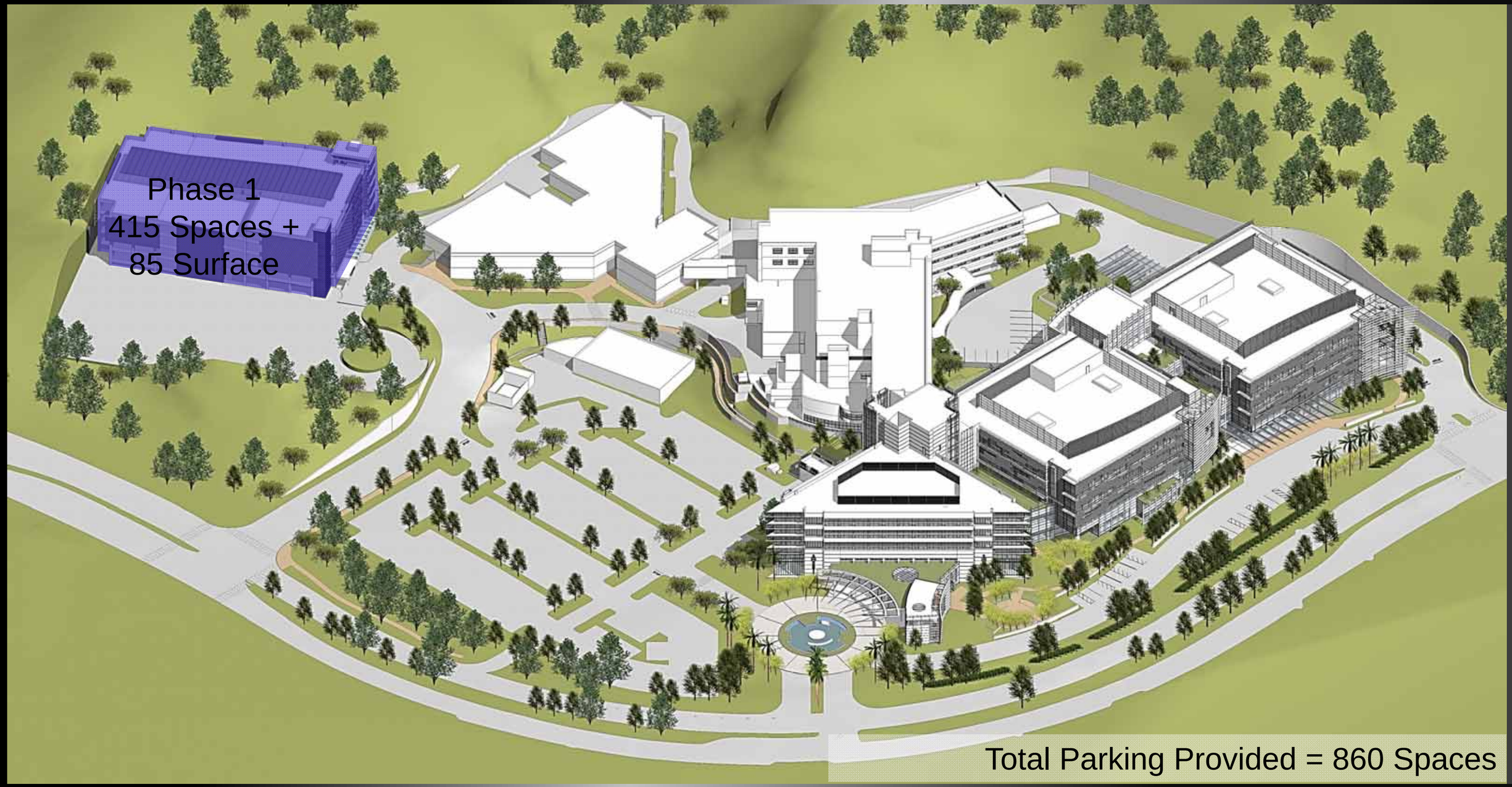


Hillside Parking Structure

Parking Structure Status

- Design Review Board Submittal III went to the County on 10/6/14
- Design Review Board Meeting with Marin County Planning Commission is anticipated for mid December
- 60% Construction Documents complete 10/6/14
- 100% Construction Documents complete Mid November 2014
- Garage anticipated construction start date - Q1-2015
- Project is within the budget at $25,962,000

Proposed Hillside Parking – Phase I



Hillside Parking Structure – Phase 1

Tab 2

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

REGULAR MEETING MINUTES
Tuesday, September 9, 2014
Marin General Hospital, Conference Center

1. Call to Order
Chair Bedard called the meeting to order at 7:15 pm.

2. 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; Jon Friedenberg, Chief Administrative Officer and Renee' Toriumi, EA to the CEO

Public Comment – The public was given the opportunity to comment on the Closed Session Agenda. There being no comment, the public exited the room.

3. Closed Session
The closed session was adjourned at 7:15 pm.

4. Public Session - Approval of the Agenda
Director Simmonds moved to approve the agenda as presented. Director Sparkman seconded. Vote: all ayes.

5. Approval of the Consent Agenda
Director Simmonds moved to approve the consent agenda and minutes from the Special Meeting on July 30, 2014 at the San Rafael City Hall. Director Sparkman seconded. Vote: all ayes.

Minutes of the Regular Meeting of August 5, 2014 (included following Tab 2):
Director Rienks requested a change be made to page 3, Section 11, paragraph 3, last sentence to read, "This question is not one of the required CMS metrics; however, it is a required metric as stated in the Bylaws and will be included in the quarterly report in the future."

Director Rienks requested a change be made to page 3, Section 11, paragraph 4, first sentence to read, "Director Rienks asked if this quarterly report could be presented to this Board more timely."

Secretary Simmonds seconded the revisions as requested by Director Rienks. Vote: all ayes.

6. General Public Comment

Public comment – none

7. Revision of the Conflict of Interest Code

Simmonds moved to approve the revision of the Conflict of Interest Code, as stated on page 4 (included following Tab 3), reflecting the correct title of "Chief Administrative Officer" rather than the Chief Fund & Business Development Officer. Director Sparkman seconded. Vote: all ayes

Public comment - none

Chair Bedard requested there be a change in the meeting agenda to allow Dr. Catherine Guitfreund to speak earlier in the evening to present her information in support of voting no on Proposition 46.

8. California Proposition 46, Medical Malpractice Lawsuits Cap and Drug Testing of Doctors – Presentation by Katherine Gatfrand, CMA Trustee (materials included following tab 8)

Dr. Guitfreund left materials for distribution, which the Board will review and consider for distribution at their next meeting in October. She explained the process for drug and alcohol testing and use of Cures Issue Database. She reviewed several situations where patients would be adversely if Proposition 46 were to be passed.

Public comments – several questions were asked of Dr. Guitfreund, but no names were provided.

9. Optimizing Marin General (OMG) MedAssets Presentation

Mr. Jon Friedenberg reviewed the cost savings aspects of Optimizing Marin General (OMG):

Supply Chain Initiatives
Revenue Cycle
Process Optimization
Financial Impact Pipeline

Public comments – none

10. MGH New Brand Launch – Presentation by Jamie Maites

Ms. Jamie Maites reviewed the new MGH Brand Launch (included following Tab 4):

Role of Marketing & Communications (Share of Mind/Share of Heart/Share of Market)
Primary Research (Core-Target Consumers, Employee/Physician, Executives)
Consumer Choice (Personal Need/Best Physicians/Overall Reputation)
Marin County Health Statistics

Align MGH Brand with Marin County Attributes
New Branch Positioning
Print Ad Example
Bus Shelter/Wallscape
Bus Kings
Broadcast (radio and television)
Paid Media (Pandora Station)
Media Detail

Director Rienks requested that Ms. Maites research and report back on what specific areas would be covered in the broadcast searches.

Public comment – none

11. Marin Healthcare District Brochure – Presentation by Jamie Maites

Mr. Jon Friedenberg reviewed a draft brochure (Included following Tab 5) which was created a year ago, and recently reviewed at the last L&B committee meeting.

Director Rienks moved to allocate $25,000 for the cost of sending out the brochure materials to targeted audiences. The motion was debated and due to a lack of a second, a vote was not taken.

Chair Bedard moved to include the brochure information on the website. Director Clever seconded. Vote: all ayes

Public comment – Steve Lamb (benefits of advertising)

Director Rienks agreed that listing the brochure on the website was beneficial, but expressed that the inclusion of information on the website was inadequate in distributing the information to the general public, who may not visit the website.

12. MHD Budget for Printing & Mailing Expenses

Mr. Jon Friedenberg briefly reviewed the two options (included following Tab 6). However, since it was agreed that the information be listed on the website, the necessity of the expense quotes was moot.

13. Measure R Ballot Arguments / Lease Campaign Update

Mr. Jon Friedenberg reviewed (included following Tab 7) the Measure R Statement; County Counsel's Impartial Analysis of Measure R; Argument in Favor of Measure R; Rebuttal to Argument in Favor of Measure R; Argument Against Measure R and Rebuttal to Argument Against Measure R, with arguments and for and against as submitted to the Registrar.

Public comment – none.

14. Committee Meeting Reports

a. MHD Finance & Audit Committee (met on August 26, 2014)

Chair Sparkman reported that the committee was pleased to report that the District is in excellent financial health, with approximately $3M in revenue, favorable to budget by $30,000 in the first month of the year. 1206b clinics are operating below budget by $58,000. Urology practice is continuing to build volume, da Vinci equipment volume has not grown as anticipated. Cardiac Clinic and Associates is continuing to exceed expectations. Ms. Jamie Maites reviewed the Community Health Grant Benefit Policy. The next meeting is scheduled for October 28th. No meeting will be held in September.

Public comment – none.

b. MHD Lease & Building Committee (met on August 21, 2014)

Chair Simmonds reported that the committee had discussed the District's participation in the promotion of Measure R; Marin Healthcare District brochure; and Inspection of the facility, reserve funds and clarification about statements made in the Lease. Chair Simmonds stated that there are many opportunities and regulations that require the inspection of facilities, which clearly addressed the public concerns.

Public comment – none.

15. Reports

a. District CEO's Report

CEO Lee Domanico reviewed the ongoing legislation in place to allow a Design Build Process for the hospital. He stated that this process will be a more efficient in the building of the replacement hospital.

Board and Public comments – none.

b. Hospital CEO's Report

CEO Lee Domanico reported favorable operating results due to labor and expense controls. In some cases, MGH is slightly ahead of budget. The work to improve the throughput in the Emergency Department has been concluded, which will minimize diversion and wait times for patients.

Mr. Domanico reviewed the various management education classes that are being offered at MGH. A program is being discussed and developed with the Dominican University of California (DUOC) in San Rafael for management classes to be jointly taught by a DUOC professor and management executive.

The Hospital Board will hold their Annual Strategic Retreat on 9/12-13/2014. This information will be shared with the District Board in early 2015.

The transition from Xerox to McKesson has been successful, enhancing the speed of computer system performance and dramatically reducing wait times and processing of

medications through the Paragon system. There have also been significant improvements in help desk turnaround time. Employee badges will be implemented in the future to enhance computer access and improve speed in utilizing systems.

Board and Public comments – none.

c. Chair's Report

Chair Bedard stated that there was no additional information to report.

d. Board Members' Reports

Director Clever mentioned that physicians should consider a fist bump as an alternative to hand shaking to avoid the transmission of illness and disease. Others agreed that sometimes the tapping of elbow to elbow has also been an alternative practice.

There were no other board member reports.

16. **Adjournment**

Director Sparkman moved to adjourn at 8:40 pm.

Tab 3

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

HILLSIDE PARKING GARAGE PROJECT

To: Marin Healthcare District, Board of Directors

From: Paul Kirincic, Chair, Board of Directors, MGH

Date: October 14, 2014

Recommendation

On behalf of the Board of Directors of Marin General Hospital, we wish to convey this report and recommendation to the District Board in support of the construction and financing of the Hillside Parking Project as currently designed. The Project design and construction program has been developed by the District's architects and construction management consultants, and the financing developed under the guidance of the overall project financing recommendations of the District's financial advisor. The Hospital Board recommends approval of this project and its funding at this time in order to continue to make progress on the hospital replacement project.

Description of Project

The Hillside Garage will consist of a structure which will include 415 spaces. Funding for the first phase of the garage project is estimated to be $26 million.

The project will consist of a 5 ½ story parking garage. The North service entrance will be redesigned to add a traffic signal, widen the road up to the garage from two to four lanes, excavate the hillside to accommodate this garage and also allow for a 2nd parking garage that could be associated with an Ambulatory Services Building (if and when built), build the first phase garage with 415 spaces and create a surface parking lot with 85 spaces.

This parking garage is necessary as the current patient parking in the front of the hospital will be eliminated by the foot print of the two new nursing towers.

Project Cost

Design, Permits, & Fees	$2,257,000
Construction	20,687,000
Project Management & Other Costs	768,000
Contingency	2,250,000
Total Project Costs	$25,962,000
Total Estimated Capitalized Interest	454,000
	$26,416,000

Note to Project Cost Estimate:

1. MGH will be responsible for an ADA path from the garage to the hospital. To accommodate this requirement, we may need to add an elevator in the Mental Health Building which would cost $250,000.

Project Financing

The financing for this project will come from a $30 million credit facility previously negotiated with Union Bank. This agreement was finalized in February, 2014. It is considered bridge financing until the first GO bond issue is completed. The credit facility is available to us beginning October 1st, 2014 and is due on January, 2017. However, the bank has indicated a willingness to extend the due date to accommodate the timing of the first GO bond issue. (It should be noted that the existing term loan ($30 million) and the line of credit ($40 million) come due at the same time).

The loan can be drawn down in as many as 5 tranches and bears interest at LIBOR + 2.5%. While this interest rate is on the high side, the financial advisor has agreed that that it was not worth re-opening the entire negotiation process with Union Bank, given the short duration of the facility.

Per the loan document, the construction cost and related debt will not be included in the computation of any of the loan covenants, therefore, this project will not be "dilutive" from a loan compliance perspective for MGH.

Your approval, therefore, is sought for both the Hillside Garage Construction Project and the MGH debt financing arrangement as presented.

Date: October 14, 2014

To: Marin Healthcare District Board of Directors

From: Kevin Coss, Hospital Replacement Project Director

Re: Hillside Parking Structure – Schematic Design Summary

The hospital currently has a total of 1,126 full-time equivalent (FTE) employees; approximately 190 acute care visitors and patients visit the hospital daily, with approximately 700 ambulatory and 100 mental health visitors and patients daily. Marin General Hospital currently has substantial parking shortages for its patient/visitor population as well as staff. Currently its patient/visitors and staff compete for close convenient parking to the main hospital entrance given limited parking availability onsite. The Hillside Garage project will resolve the parking shortages for the campus. The Hillside Garage consists of two separate structures adjacent to and abutting one another. Each structure will include 415 spaces and will be constructed in separate phases. The first phase of the project will resolve the current parking shortage and the second phase of the garage will accommodate new staff and visitors associated with a future Ambulatory Services Building. We are requesting funds for the first phase of the garage project.

Currently there are a total of 768 surface parking spaces utilized by the existing hospital. Of this total, 605 parking spaces are located throughout 18 surface parking lots on the project site; 73 are on-street parking spaces along Bon Air Road fronting the project site; and 90 are off-street spaces in the neighboring St. Sebastian Church to the north, across Bon Air Road. Most of the existing on-site parking results from Marin County's approvals of the 1985 Marin General Hospital Master Plan and a subsequent 1995 plan amendment, which together required at least 750 permanent on-site spaces (with a practical capacity of 675 spaces).

The County of Marin has an easement for parking on a plat of land in the surface parking lot on the campus that includes 37 parking spaces for the employees of the Community Mental Health Facility along with three additional reserved spaces in the Community Clinic parking lot for a total of 40 spaces.

Valet parking is offered onsite to employees and visitors. A valet stand is located near the lobby entrance of the East Wing and at the Emergency Department Parking lot at the West Wing. During a typical weekday, three valet attendants are available to park and retrieve vehicles from the three parking lots within the project site that are used for valet operations. Parking at the

hospital is currently free of charge and will remain free of charge upon completion of the parking structure.

The existing vehicular entrance/exit at the northern quadrant of the project site services primarily emergency vehicles, service vehicles, and hospital employees. This North Service road provides direct vehicle access to Bon Air Road and is currently an un-signalized intersection. At this intersection of the project site Golden Gate Transit has a bus shelter that provides bus service directly to the hospital.

The first phase parking garage is a major initial component of the proposed campus project to ensure adequate on-site parking is provided during and after construction of the project. The Hillside Garage will be constructed on the hillside at the northeast portion of the project site, adjacent to the existing Community Mental Health Facility. The Hillside Parking Structure will be located in the footprint of the Marin Community Clinic trailers. The parking structure will provide 415 parking spaces and will primarily service staff parking. This phase will construct a 5 ½ story parking garage, tucked within the contours of the hillside and involves excavating 60,000 cubic yards of the hillside. The excavation includes the footprint for both phase one and phase two parking garages so that we won't impact the hospital site when it becomes time to build the phase two garage. The top deck of the garage will rise 57 feet but will be minimally visible from neighboring properties since it will be cut into the hillside. The South elevation of the garage will be visible from the existing hospital and the façade will include design features that make it consistent with the look of the West Wing and Hospital Replacement Building. Façade design features include a concrete precast shear panel, louvers, and glass curtain walls at the elevator and stair towers. The elevator and stair tower at the southwest and southeast corners of the garage will rise to 70 feet. In addition to the 415 space garage, we will create a surface parking lot with 85 spaces in the footprint of the phase two structure. We will also construct retaining walls ranging from approximately 3 to 25 feet tall will be required for terracing in the northernmost area of the site, near the Hillside Garage.

The retaining walls that will be hidden behind the garage will have a steel rod finish. The other retaining walls around the site and surrounding the surface lot will have a boulder finish with stain to give it an aesthetic look of a boulder rock wall. The structure will incorporate dense vegetation zone around the structure where feasible. The parking structure will be accessed from Bon Air Road using the North Service entrance. The project will reconstruct the North Service entrance to add a traffic signal, widen the road up to the garage from two to four lanes. Water, storm drain, sanitary sewer, electricity, and telecommunication utilities will be extended from Bon Air Road through the north access road to the parking structure. All water drained from the garages will be treated in an oil/grease separator prior to being discharged into the storm drain. These improvements to the access road to and from the structure will remove 12 parking spaces from service but the net total of new spaces added to the campus will be 403 after the Hillside Parking Structure is complete.

Consistent with typical conditions associated with development projects in Marin County, fire lane access will be maintained in accordance with latest fire and building codes and will be a requirement of the construction of the Hillside Parking Structure. Fire hydrants will be left online during construction or until new hydrants have been tested and approved to be operational by the Marin County Building Department and Marin County Fire. The project will require approval of a phased fire protection plan, which Marin Healthcare District will be required to maintain throughout the construction process by the Building and Fire District.

The second phase of the garage project will be required to accommodate staff and visitors for the future Ambulatory Services Building (ASB). Prior to opening the ASB, the second 5 ½ story parking garage will have to be completed. The second garage will abut the first garage in the footprint of the 85 space surface lot. This phase will also include a round-about drop off area at the front of the garage and a pedestrian bridge from the round-about area to the ASB.

100B Drakes Landing Road, Suite 250
Greenbrae, CA 94904
415/464-2090
fax: 415/464-2094

Tab 4

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

September 16, 2014

TO: Member Hospital Chief Executive Officers

FROM: C. Duane Dauner, President/CEO

SUBJECT: Proposition 46

CHA and the Regional Associations are strongly opposed to Proposition 46, the trial lawyers' initiative to raise the Medical Injury Compensation Act of 1975 (MICRA) cap on non-economic loss (pain and suffering) from $250,000 to $1.1 million, indexed annually.

Until the November 4 General Election, hospitals will regularly receive Proposition 46 information similar to the enclosed materials. These materials are also available at www.NoOn46.com.

To ensure hospitals comply with California laws pertaining to ballot initiatives, guidelines for public hospitals and 501(c)(3) tax-exempt hospitals are attached. For-profit hospitals are not bound by similar limitations, but to the extent contributions or expenditures are made (monetary or non-monetary) to oppose Proposition 46, they may be required to file a major donor committee campaign finance report. Also attached is a CHA summary of labor relations considerations that apply to all private hospitals.

For additional information on the guidelines or reporting, please contact Lois Suder, executive vice president/chief operating officer, at lsuder@calhospital.org or (916) 552-7622.

For specific questions about Proposition 46, please contact Bill Emmerson, senior vice president, state relations & advocacy at wemmerson@calhospital.org or (916) 552-7540, or me at cddauner@calhospital.org or (916) 552 7547.

CDD:rf

enclosures

Guidelines for Ballot Measure Education By California Public Hospitals

This document sets forth general guidelines to assist California public hospitals making public communications that reference policy and operational issues impacted by ballot measures attempting to or actually qualified for consideration by voters. This guidance is not a substitute for advice applicable to your specific circumstances or activities, and you are encouraged to consult with your compliance counsel before engaging in any communications that related to ballot issues.

Public Funds and Tax Issues

Public hospitals are tax exempt pursuant to Section 115 of the Internal Revenue Code, which does not address prohibitions or limits on lobbying or political activities. Public hospitals may be subject to state law restrictions on lobbying expenditures.

State law prohibits using public resources for any campaign activity, which means any activity that constitutes a *contribution* or an *expenditure* under the Political Reform Act. Public agencies are permitted, however, to provide information to the public about the possible effects of any ballot measure on state activities, operations, or policies, so long as: the informational activities are otherwise authorized by state law and the information provided constitutes an accurate, fair and impartial presentation of relevant facts to aid the electorate in reaching an informed judgment regarding the ballot measure.

Examples of Permissible Informational Activities

— Public hospital may evaluate the merits of a proposed ballot measure and make its views known to the public, either at a public meeting or at a private organization meeting at the organization's request
— Public hospital governing board may discuss in an open forum and adopt a resolution expressing the board's position regarding a ballot measure
— Fair presentation of the facts in response to a citizen's request for information
— Dispassionate language

cont.

Examples of Prohibited Campaign Activities

— Public hospital cannot expend public funds to mount a campaign on a ballot measure
— Type of activity: any material of the kind that campaign committees typically distribute, such as bumper stickers, posters, television or radio, billboards, door-to-door canvassing
— Style and tenor: use of terms of express advocacy (vote for / against, support / oppose, cast your ballot, defeat, reject, don't / sign petitions); use of exhortatory tone of persuasion; unambiguously urging a particular result in an election
— Timing: whether a campaign is underway at the time of the communication, special edition of newsletter or other communication

cont.

BELL, McANDREWS, & HILTACHK, LLP
Attorneys and Counselors at Law
455 CAPITOL MALL, SUITE 600
SACRAMENTO, CA 95814
(916) 442-7757
FAX (916) 442-7759
www.bmhlaw.com

Examples of Permissible Informational Activities

— Use of website, articles in a regular edition and usual circulation of a newsletter, to distribute educational materials, such as posting text of measure, title and summary, arguments for and against, governing board's resolution taking a position and minutes of the meeting at which the resolution was adopted
— Statements of fact such as the name of a proposal on the ballot, when on the ballot, the subject matter and description of the measure, report or recommendations for dealing with potential impacts of ballot measures (such as a finance director's recommendations for service and program reductions to comply with a measure), encourage public to get educated on the subject of the ballot measure
— Publishing list of potential cuts or other impacts if measure passes or fails, such as closing departments or suspending services, eliminating jobs or positions, or suspending or revising building projects

Examples of Prohibited Campaign Activities

— Audience to which the communication is directed: communications targeting the electorate specifically or expanded circulation of a regular communication

Campaign Finance Issues

The Political Reform Act applies to public agencies that make *contributions* or *expenditures*. Any *express advocacy* by a public agency pertaining to a ballot measure will trigger the Political Reform Act reporting and disclaimer rules. Because *express advocacy* by a public agency is prohibited and should be avoided, this guidance does not detail the Political Reform Act compliance issues that apply to such activity.

Guidelines for Ballot Measure Advocacy By IRC § 501(c)(3) Hospitals

This document sets forth general guidelines relating to advocacy supporting or opposing ballot measures in California by hospitals that are tax exempt under Section 501(c)(3) of the Internal Revenue Code. This guidance is not a substitute for tax or campaign finance advice applicable to your specific circumstances or activities, and you are encouraged to consult with your compliance counsel before engaging in any ballot measure advocacy.

Campaign Finance Issues

The Political Reform Act rules apply only to *express advocacy,* communications that *unambiguously urge* a particular result regarding a *clearly identified* ballot measure, targeting the general public. Communications, even to the general public, that do not urge a particular result and/or refer to a clearly identified ballot measure are not regulated by the Political Reform Act (not reportable, no disclaimer required).

Clearly identified means reference to a proposition number, official title or popular name of a measure, the subject matter of the measure and states that the measure is circulating or before the people for a vote.

Unambiguously urge a particular result means uses express words of advocacy (vote for/against, support, defeat, reject, sign petitions), or is susceptible of no reasonable interpretation other than as an appeal to support or oppose a specific measure; communications that do not mention an election, voting or the merits of a ballot measure may satisfy the non-express advocacy "safe harbor."

Campaign Reporting: A hospital that is "coordinating" with CAHHS and its sponsored primarily formed recipient committees is making a non-monetary contribution to the committee(s) when it pays for general public communications. A hospital that develops its own materials is making *independent expenditures*. Reportable costs include payments to consultants (non-employees), any hard costs such as design, printing or postage, community events, pro-rata salary of any employee who spends more than 10% in any month on campaign work (the employee's name is not disclosed on the campaign report – only the total of any reportable prorate salaries for employees meeting the time threshold). Consult separate guidance from CAHHS Political Reform Act outside counsel for reporting deadlines and related parameters.

Disclaimers: All public communications *expressly advocating* for or against a ballot measure must have a "Paid for by" disclaimer. Font size and other rules vary depending on the communication medium. Consult separate guidance from CAHHS Political Reform Act outside counsel for specific disclaimer requirements.

Exception—Communications to Hospital Employees: Communications restricted to a hospital's employees and their families are exempt from the Political Reform Act's campaign reporting and disclaimer rules. A hospital may incur costs (including hard costs, such as printing or postage, and in-house resources, such as employee time or email infrastructure) to hold meetings, send newsletters, flyers, emails, and make phone calls to employees and their family members *expressly advocating* support of or opposition to a ballot measure, and such efforts do not require a disclaimer and are not reportable on a campaign finance report. A hospital may not include campaign materials in the same envelope as an employee's paycheck, may not coerce or influence employees by means of actual or threat of discharge or other adverse action impacting employment, and may not otherwise reward or punish employees for political activities or beliefs.

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SACRAMENTO, CA 95814
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FAX (916) 442-7759
www.bmhlaw.com

Guidelines for Ballot Measure Advocacy By IRC § 501(c)(3) Hospitals

Examples of communications that are reportable / disclaimer required

- Any communications to the general public that urge a particular result on a clearly identified ballot measure
  - Using traditional campaign advertising mediums, such as door-to-door canvassing, television, radio, billboard, internet (website, blogs, twitter, YouTube, facebook)
  - Message advocates vote for / against, don't / sign the petition, references to the merits of a ballot measure, references to petition circulation, references to an election, references to voting

Examples of communications that are non-reportable / no disclaimer required

- Communications limited to hospital employees, including vote for / against, don't / sign the petition
- Communications to the general public limited to accurate, fair and impartial statement of facts regarding a hospital's assessment of the impacts of a proposed ballot measure on a hospital's operations, including how a hospital would respond to implementing the law, such as specific budget cuts, department cuts or reorganization, reduction or elimination of capital improvements

Tax Issues

Ballot measure advocacy is "direct lobbying" under the tax code. 501(c)(3)s are not prohibited from lobbying but are subject to a limit. Exceeding the applicable lobbying nontaxable limit can result in imposition of an excise tax or loss of tax exemption. Expenditures and other activities related to communications to employees and their families apply towards a hospital's lobbying nontaxable limit the same as general public communications and activities.

The limit that applies depends on whether or not the hospital has filed Form 5768 with the IRS to avail itself of the "501h expenditure" test limit on lobbying.

Filing a 501h election provides a precise limit on lobbying nontaxable expenditures, and is based on a sliding scale of total exempt purpose expenditures, but the maximum lobbying nontaxable expenditure under the 501h election is $1,000,000, regardless of a hospital's total annual exempt purpose expenditures.

If Form 5768 is not in effect for any fiscal year or if the hospital is not eligible to file Form 5768, then the "insubstantial part" test evaluates all of the "facts and circumstances" including the percentage of the organization's total budget spent on lobbying, the overall objectives of the organization, time spent by officers, directors, employees and volunteers. This is a balancing test, not a bright line test, and the IRS has avoided providing any type of expenditure or time threshold, though experienced practitioners counsel that annual lobbying expenditures up to 5% of a hospital's exempt purpose expenditures will not incur adverse tax consequences. Hospitals with exempt purpose expenditures in the tens of millions annually, or more, will have a higher lobbying nontaxable expenditure limit under this insubstantial part test than the limit set by filing a 501h election.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Labor Relations Considerations in Ballot Measure Advocacy

September 16, 2014

When hospitals participate in ballot measure advocacy, they should consider a number of associated labor issues, identified below. Each hospital has to make its own decision about participating, and each should consult with its labor counsel.

In general, the National Labor Relations Act ("NLRA") permits a private health care employer to maintain a policy prohibiting solicitation by its employees during their work time or, at any time, in immediate patient care areas. Distribution of literature and other items generally can be prohibited by employees during their work time or in work areas.

Under the NLRA, private employers generally can prohibit all non-employee solicitation and distribution on the premises. Most hospitals have such rules incorporated in their solicitation and distribution policies. If employers allow select third parties access to the property to communicate, however, they may be required to allow other third parties similar access to the property.

Solicitation and distribution by the MICRA campaign and independent contractor physicians presumably would fall under the non-employee rules. These rules would cover distribution of literature, wearing buttons and oral communication. Whether and when such advocacy could be allowed is a hospital-specific analysis based on the language of the hospital's policy as well as how the policy has been enforced.

Under the NLRA, employers have a right to free speech on matters they deem business related. Thus, hospitals can articulate their view on Proposition 46. If a hospital wants to express its opposition to Proposition 46, it should consider having its own materials on its own letterhead (subject to nonprofit and public hospital legal considerations).

Tab 5

MARIN GENERAL HOSPITAL

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

Marin General Hospital

Performance Metrics and Core Services Report

2nd Quarter 2014

Prepared 09-19-2014

Marin General Hospital

Performance Metrics and Core Services Report: **2nd 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: **2nd 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				3Q 2013	4Q 2013	1Q 2014	2Q 2014
69.32	77.46	83.97	**Overall rating**	65.53	67.54	68.15	65.95
			Would Recommend	72.10	68.13	73.75	71.39
77.67	82.34	86.07	**Communication with Nurses**	74.41	74.61	74.55	75.09
			Nurse Respect	83.11	86.02	86.07	83.42
			Nurse Listen	76.79	70.76	78.28	76.72
			Nurse Explain	75.34	79.06	71.31	77.13
80.40	84.93	88.56	**Communication with Doctors**	79.38	78.45	79.62	83.57
			Doctor Respect	87.73	87.45	84.43	89.89
			Doctor Listen	78.54	76.92	80.25	81.48
			Doctor Explain	75.78	74.89	78.10	83.25
64.71	73.07	79.76	**Responsiveness of Staff**	57.17	57.01	58.39	59.25
			Call Button	54.74	57.00	60.99	57.58
			Bathroom Help	69.00	66.43	65.19	70.33
70.18	74.61	78.16	**Pain Management**	65.17	68.84	67.46	69.93
			Pain Controlled	64.24	68.29	66.48	67.16
			Help with Pain	75.50	78.79	77.84	82.09
62.33	68.13	72.77	**Communication about Medications**	57.01	51.31	58.41	56.15
			Med Explanation	72.22	76.00	75.00	75.86
			Med Side Effects	49.59	34.43	49.63	44.25
64.95	72.81	79.10	**Hospital Environment**	53.80	52.05	49.16	49.95
			Cleanliness	62.39	65.04	61.13	58.51
			Quiet	50.71	50.85	48.98	53.19
84.70	87.86	90.39	**Discharge Information**	82.68	81.49	83.52	80.99
			Help After Discharge	80.77	82.41	83.62	82.12
			Symptoms to Monitor	87.19	83.17	86.03	82.46
			Number of Surveys	224	236	247	192

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		
EBIDA %	6.81%	6.14%		

Loan Ratios				
Current Ratio	2.82	2.61		
Debt to Capital Ratio	35.4%	32.6%		
Debt Service Coverage Ratio	5.16	2.62		
Debt to EBIDA %	2.45	2.21		

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

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**	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Q2-Qtr %	Q2-2014 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%	100%	100%	100%	100%	37/37	100%	203/203
Beta blocker prescribed at discharge	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	30/30	100%	172/172
Primary PCI within 90 minutes of arrival	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	8/8	100%	43/43
Statin Prescribed at Discharge	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	34/34	100%	190/190
Heart Failure (HF) Measures																	
Evaluation of LVS Function	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	38/38	100%	154/154
ACEI or ARB for LVSD	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	9/9	100%	39/39
Pneumonia (PN) Measures																	
*Initial antibiotic selection for CAP in immunocompetent patient	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	28/28	100%	94/94
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%	100%	100%	81/81	100%	307/307
*Prophylactic antibiotic selection for surgical patients: Overall rate	99%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	81/81	100%	306/307
*Prophylactic antibiotics discontinued within 24 hours after surgery end time: Overall rate	98%	100%	100%	95%	96%	96%	100%	100%	100%	96%	100%	100%	100%	100%	79/79	99%	300/304
Cardiac surgery patients with controlled postoperative blood glucose	97%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	14/14	98%	52/53
*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%	95%	100%	100%	93%	100%	100%	88%	94%	93%	93%	100%	100%	98%	44/45	**96%**	191/198
*Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the periop period	98%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	24/24	99%	103/104
*Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hrs prior to surgery to 24 hrs after surgery	98%	96%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	84/84	99%	324/326
Venous Thromboembolism (VTE) Measures																	
VTE prophylaxis	85%	94%	100%	100%	97%	100%	95%	100%	95%	100%	100%	100%	100%	100%	122/122	99%	493/500
ICU VTE prophylaxis	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	22/22	100%	70/70
VTE patients with anticoagulation overlap therapy	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	12/12	100%	54/54
VTE pts receiving unfractionated heparin with dosage/platelet monitoring	97%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	100%	100%	100%	100%	4/4	100%	21/21
VTE warfarin therapy discharge instructions	75%	100%	100%	100%	100%	100%	100%	40%	33%	67%	100%	100%	75%	92%	9/10	83%	34/41
Hospital acquired potentially-preventable VTE +	10%	N/A	0%	0%	N/A	0%	N/A	0%	0%	0%	0%	0%	0%	0%	0/4	0%	0/16
Global Immunization (IMM) Measures																	
*Influenza immunization	90%	N/A	N/A	N/A	86%	91%	90%	93%	83%	84%	N/A	N/A	N/A	N/A	0/0	**88%**	453/515

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\+ 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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METRIC	CMS**	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Q2-Qtr %	Q2-2014 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%	40/40	100%	168/138
Discharged on antithrombotic therapy	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	28/28	100%	136/136
Anticoagulation therapy for atrial fibrillation/flutter	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	9/9	100%	39/39
Thrombolytic therapy	66%	100%	N/A	100%	N/A	100%	N/A	100%	100%	N/A	N/A	N/A	N/A	100%	0/0	100%	7/7
Antithrombotic therapy by end of hospital day 2	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	35/35	100%	147/147
Discharged on statin medication	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	21/21	100%	98/98
Stroke education	88%	100%	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	75%	92%	17/18	97%	75/77
Assess for rehabilitation	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	38/38	100%	166/166
Perinatal Care Measure																	
Elective Delivery +	6%	0%	0%	0%	N/A	0%	0%	N/A	0%	0%	0%	0%	0%	0%	0/14%	0%	0/28
ED Inpatient (ED) Measures																	
Median time ED arrival to ED departure - Minutes	274***	300.00	353.00	309.00	299.00	291.50	312.00	318.00	298.00	347.50	314.00	295.00	276.50	**295.17**	192--Cases	**309.46**	705--Cases
Admit decision median time to ED departure time - Minutes	98***	160.00	165.00	154.50	165.00	150.00	134.00	168.00	170.00	165.00	149.00	127.50	137.50	**138.00**	119--Cases	**153.79**	468--Cases
ED Outpatient (ED) Measures																	
Median time ED arrival to ED discharge +	134***	168.00	147.00	142.00	138.00	144.00	138.50	168.50	149.50	121.50	138.00	205.50	129.00	**157.50**	104--Cases	**149.13**	443--Cases
Door to diagnostic evaluation by qualified medical personnel +	26***	33.00	23.00	28.00	23.50	30.00	37.00	31.00	31.00	36.00	26.50	48.00	22.50	**32.33**	104--Cases	**30.79**	436--Cases
Outpatient Pain Management Measure																	
Median time to pain management for long bone fracture - Mins +	57***	46.00	48.00	75.00	54.00	48.50	67.00	46.50	73.00	38.50	44.00	39.00	53.00	45.33	44--Cases	52.71	155--Cases
Outpatient Stroke Measure																	
Head CT/MRI results for stroke patients within 45 mins of ED arrival	57%	100%	0%	N/A	N/A	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A	50%	1/2	**57%**	4/7
Outpatient Surgery Measures																	
Timing of antibiotic prophylaxis	98%	95%	92%	91%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	44/44	98%	198/202
Antibiotic selection	99%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	44/44	100%	201/202

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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**	**20007**	**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**				
*Medicare spending per beneficiary (All)	0.98	1.02				
♦ 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%			

♦ 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 mammorgram, 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			$ 2,420
Healthy Aging Symposium	1,000	0			1,000
Homeward Bound of Marin	113,600	0			113,600
Marin Brain Institute	0	630			630
Marin Community Clinics	53,151	18,610			71,761
Marin Community Clinics Summer Solstice	1,000	0			1,000
MHD 1206(b) Clinics	1,183,299	1,304,529			2,487,828
PRIMA Medical Foundation	950,000	950,000			1,900,000
Relay For Life	0	5,000			5,000
RotaCare San Rafael (Refrigerator)	2,182	0			2,182
Total Cash Donations	**$2,306,652**	**$2,278,769**			**$4,585,421**

Total Cash & In-Kind Donations	**$2,306,652**	**$2,278,769**			**$4,585,421**

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			$93,205
Health Professions Education	17,993	19,612			37,605
Cash and In-Kind Contributions	2,306,652	2,278,769			4,585,421
Community Benefit Operations	1,640	1,640			3,280
Traditional Charity Care **Operation Access total is included in Charity Care*	1,063,745	731,530			1,795,275
Government Sponsored Health Care (includes Medi-Cal & Means-Tested Government Programs)	6,649,465	7,665,676			14,315,141
Community Benefit Subtotal (amount reported annually to state & IRS)	**$10,081,349**	**$10,748,578**			**$20,829,927**
Community Building Activities	$0	$0			$0
Unpaid Cost of Medicare	15,529,526	15,319,223			30,848,749
Bad Debt	526,391	590,145			1,116,536
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**$26,137,266**	**$26,657,946**			**$52,795,212**

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			$690,460

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	
3Q 2013	556	9	5	2.52%
4Q 2013	552	12	3	2.72%
1Q 2014	547	9	11	3.66%
2Q 2014	550	9	9	3.27%

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
3Q 2013	24	29	3	6	387	169	556	7.49%	14.20%
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%

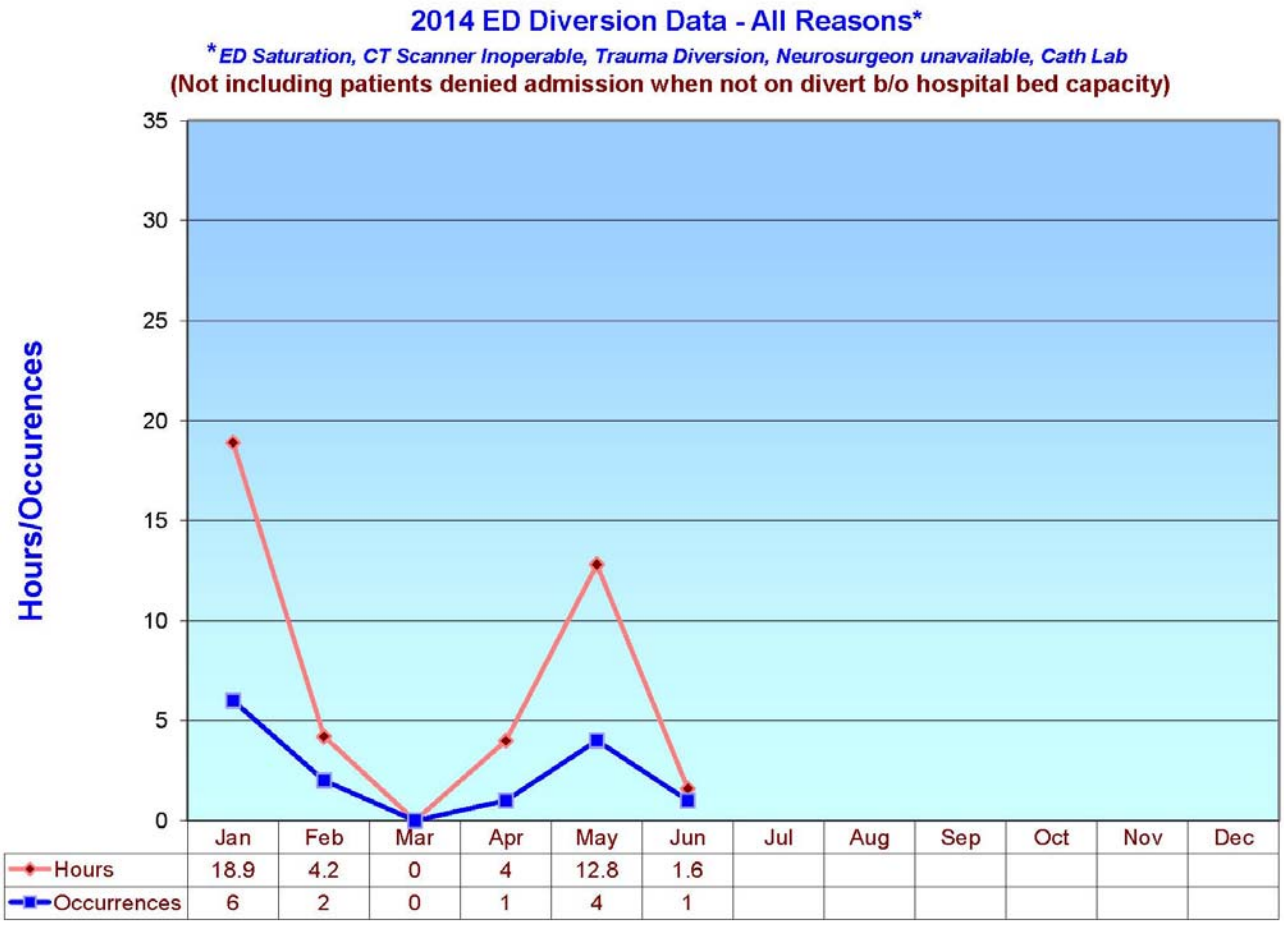
Hired, Termed, Net Change			
Period	Hired	Termed	Net Change
3Q 2013	10	14	(4)
4Q 2013	12	15	(3)
1Q 2014	15	20	(5)
2Q 2014	21	18	3

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

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						
Occurrences	6	2	0	1	4	1						