MARIN HEALTHCARE DISTRICT

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

TUESDAY, MARCH 9, 2021

5:00 PM: REGULAR OPEN MEETING

Board of Directors:
Chair: Jennifer Rienks, PhD
Vice Chair: Brian Su, MD
Secretary: Ann Sparkman, JD
Directors: Edward Alfrey, MD
Larry Bedard, MD

Staff:
David Klein, MD, CEO
Eric Brettner, CFO
Colin Coffey, District Counsel
Louis Weiner, Executive Assistant

Location:
Via Webex video conference:
https://marinhealth.webex.com
Meeting number: **187 409 4513**
Meeting password: **94930**
Or via Webex telephone conference:
1-408-418-9388

AGENDA

Tab #

5:00 PM: REGULAR OPEN MEETING

1.	Call to Order and Roll Call	Rienks	
2.	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.*		
3.	Approval of Agenda (action)	Rienks	
4.	Approval of Minutes of Regular Meeting of February 9, 2021 (action)	Rienks	#1
5.	MHD Response to Marin County Civil Grand Jury Report: "Opioid Misuse: Strengthening Marin County's Response"	Klein	#2
6.	Resolution MHD 2021-04: In Support of SB311: Compassionate Access To Medical Cannabis Act, "Ryan's Law" (action)	Bedard	#3
7.	Review of Q3 2020 Report of MarinHealth Medical Center Performance Metrics & Core Services	Klein	#4
8.	Report: MHMC Board Bylaws Review	Klein	
9.	COVID Report and Vaccine Administration	Klein	
10.	COVID Task Force Report	Su	

The agenda for the meeting will be posted and distributed at least 72 hours prior to the meeting.
In compliance with the Americans with Disabilities Act, if you require accommodations to participate in a District meeting please contact the District office at 415-464-2090 (voice) or 415-464-2094 (fax) at least 48 hours prior to the meeting.
Meetings open to the public are recorded and the recordings are posted on the District web site.

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TUESDAY, MARCH 9, 2021

5:00 PM: REGULAR OPEN MEETING

11. ACHD Governance Toolkit, Session 1: Community Engagement	Klein	#5
12. Committee Meeting Reports		
A. Lease & Building Committee *(did not meet, next meets March 24)*	Sparkman	
(i) MHD Community Health Webinar: COVID Vaccination (Feb. 10)		
B. Finance & Audit Committee *(did not meet, next meets March 16)*	Bedard	
13. Reports		
A. District CEO's Report	Klein	
B. Hospital CEO's Report	Klein	
C. Chair's Report	Rienks	
D. Board Members' Reports	All	
14. Agenda Suggestions for Future Meetings	All	
15. Adjournment of Regular Meeting	Rienks	

Next Regular Meeting: Tuesday, April 13, 2021, 5:00 p.m.

The agenda for the meeting will be posted and distributed at least 72 hours prior to the meeting.
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Tab 1

MARIN HEALTHCARE DISTRICT
BOARD OF DIRECTORS

REGULAR MEETING

Tuesday, February 9, 2021 @ 5:30 pm
Via Webex Teleconference

MINUTES

1. **Call to Order and Roll Call**
   Chair Rienks called the Regular Meeting to order at 5:30 pm.

   Board members present: Chair Jennifer Rienks; Vice Chair Brian Su, MD; Secretary Ann Sparkman; Director Edward Alfrey, MD; Director Larry Bedard, MD
   Staff present: David Klein, MD, CEO; Eric Brettner, CFO; Louis Weiner, Executive Assistant
   Counsel present: Colin Coffey

2. **Disclosure of Action Taken in Closed Session**
   Chair Rienks stated that there was no action to report.

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

4. **Approval of Agenda**
   Dr. Bedard moved to approve the agenda with moving Item #10 (Resolution MHD 2021-03) to be Item #9. Dr. Alfrey seconded, with the change. **Vote by roll call: all ayes.**

5. **Approval of Minutes of Regular Meeting of January 12, 2021**
   Dr. Alfrey moved to approve the minutes as presented. Ms. Sparkman seconded. **Vote by roll call: all ayes.**

6. **Appointment of District Board Committee Members 2021**
   a. *Finance & Audit Committee*
      Chair Rienks nominated Dr. Bedard as Chair of the Committee and Dr. Alfrey as Member. **Vote by roll call: All ayes.**
   b. *Lease & Building Committee*
      Chair Rienks nominated Ms. Sparkman as Chair of the Committee and Dr. Su as Member. **Vote by roll call: All ayes.**
   c. *MHD/MHMC Joint Nominating Committee*
      Chair Rienks nominated herself and Ms. Sparkman as Members of the Joint Committee. Dr. Alfrey, Dr. Su and Dr. Bedard expressed concern that both are UCSF-affiliated. After discussion, Chair Rienks amended the motion, nominating herself and Dr. Su as

Members of the Joint Committee. Dr. Alfrey seconded. **Vote by roll call: All ayes for Ms. Rienks and Dr. Su.**

7. **Approval of Resolution MHD 2021-01: Investment Authorization**
   Dr. Klein presented this resolution that brings current the names of the District Executive Officers for authority of signing for investing the assets of the District. Dr. Alfrey moved to approve as presented. Ms. Rienks seconded. **Vote by roll call: All ayes.**

8. **Support for The Improving Social Determinants of Health Act**
   Ms. Rienks asked the Board's support for the Federal "Improving Social Determinants of Health Act of 2021 (S.104/H.R.379)." The bill will authorize the CDC to create a program to improve health outcomes and reduce health inequities by coordinating CDC SDOH (social determinants of health) activities, and to improve capacity of public health agencies and community organizations to address SDOHs. To date there are 370 supporting organizations nationwide. Ms. Rienks would register MHD's support online; the support is expressed, not financial. There was no further discussion or public comment. Ms. Sparkman moved to approve registering support. Dr. Alfrey seconded. **Vote by roll call: All ayes.**

9. **Resolution MHD 2021-03: Continuing Medical Education Program on Medical Cannabis**
   Dr. Bedard presented Resolution MHD 2021-03 in support of educating the medical staff on the use of medical cannabis, and cited the statements made in the Resolution. He moved to approve the Resolution as presented. Dr. Alfrey seconded.

   Ms. Rienks noted, and Mr. Coffey agreed, that this Resolution does not authorize expenditures for a program. Discussion ensued that this Resolution is a recommendation, not a mandate, to MarinHealth Medical Center Medical Staff, as the District may not direct any actions of the Medical Staff. Ms. Rienks suggested that the conclusion of the Resolution be re-worded thus:
   "RESOLVED, that the Marin Healthcare District recommends that we work with the MarinHealth Medical Center, UCSF, and San Francisco Marin Medical Society to develop and/or provide a free Continuing Medical Education (CME) program on medical cannabis for our physicians and nurses."

   There was no public comment or further discussion. **Vote on the Resolution as amended, by roll call: Rienks, aye; Su, aye; Sparkman, aye; Alfrey, aye; Bedard, aye. The motion carried unanimously.**

10. **Resolution MHD 2021-02: Inpatient Use of Medicinal Cannabis**
    Dr. Bedard presented Resolution MHD 2021-02 in support of inpatient use of medical cannabis. He moved to approve the Resolution as presented. Dr. Alfrey seconded.

    Dr. Bedard cited the statements made in the Resolution, with additional comments. He noted that he is a member of the AMA/CMA Cannabis Task Force. He stated (as is included in the

Resolution) that the states of Maine, Connecticut and Minnesota allow the inpatient use of medical cannabis, and added that The Mayo Clinic allows it at their facilities.

Discussion ensued that cannabis is still Federally classified as a Schedule I drug, and that facilities risk loss of funding if in violation of the law. Ms. Sparkman stressed that legal issues must be faced in any consideration of inpatient use, and stated that this Resolution is premature. As more states approve recreational and therapeutic use, Federal classification may soon change. Dr. Su reiterated that such a medical policy would be an action of the Medical Executive Committee; Dr. Alfrey stated that it was discussed by MEC a couple of years ago that it's time for them to consider it again in advance of inevitable legalization. It was suggested to change the wording of this Resolution to recommend investigating, rather than approving, such a policy at MHMC.

Dr. Klein noted that MHMC and other hospitals and clinics often use DEA approved cannabis variants which are legal.

Ms. Sparkman asked that our legal counsel contact The Mayo Clinic's legal counsel to discover how they allow inpatient use in the face of Federal law. Mr. Coffey agreed.

There was no public comment.

Dr. Alfrey recommended that the conclusion of the Resolution be amended thus:
"RESOLVED: The Marin Healthcare District recommends that MarinHealth Medical Center administration and the Medical Staff investigate a policy allowing the inpatient use of medical cannabis.

Vote on the Resolution, as amended, by roll call: Rienks, aye; Su, aye; Sparkman, abstain; Alfrey, aye; Bedard, aye. The motion carried by majority.

11. <u>COVID Report and Vaccine Administration</u>

Dr. Klein reported that there are 4 COVID-positive patients in the hospital today, the lowest in months. The vaccination process is in place but is dependent on the supply of vaccine which is still less than expected. To date, 2,800 first and second doses have been given to staff and physicians, and 1,700 first doses to patients. Approximately 160 patients per day are vaccinated at the hospital currently. The County is partnering with Curative for public vaccination at the Larkspur Ferry site. The County next week is planning to open to age 65+, but supplies are still limited. Our in-hospital clinic will continue with as much allotment as we can get from the County. Of the hospital staff, nearly 80% have now been vaccinated, with some declining for various reasons. Staff education and testing continues, and those not vaccinated will be tested regularly.

12. <u>COVID Task Force Report</u>

Dr. Su reported that the Task Force met on January 26. Reimbursement application to FEMA has been submitted and it may be another 4 weeks before we know when the expected 75% ($275,000) will be received; we may receive 100%.

Vaccinations are dependent upon supply flow. The County's goal is to have everyone in Marin vaccinated by the end of June. Staffing is a challenge and clinical coordinators are needed; MHD may help fund that through the Task Force's budget.

At skilled nursing facilities in Marin, all patients and staff are now vaccinated. Some staff and residents at long-term care facilities have yet to be vaccinated.

The mobile team continues to provide aftercare at facilities.

450 triage kits (of 500) have been distributed. More may need to be purchased; costs have gone down and there is ample room in the budget. The kits have been beneficial and effective.

13. Committee Meeting Reports

A. Lease & Building Committee

Ms. Rienks reported that tomorrow is the next Community Health Webinar on COVID Vaccination (Tab #6). At its next meeting the Committee will plan for the next Webinar on Teen Mental Health in the Time of COVID.

B. Finance & Audit Committee

The Committee did not meet and there is nothing to report.

14. Reports

A. District CEO's Report

Dr. Klein reported that the MHMC Bylaws review is being completed. The consultant and done research and has interviewed MHD and MHMC Board members. Key topics being considered include: Role and authority of Executive Committee; Board composition, diversity, and term lengths; conflicts of interest; committee roles, responsibilities and membership; board meeting materials. The consultant will present recommendations, the MHMC Board will review and approve, and then the MHD Board will review any changes and approve in open meetings in the proper manner.

The search for additional District Counsel continues. Ms. Sparkman has helped in the process.

The new hospital's Certificate of Occupancy extension by is being completed and closed by OSHPDS's deadline of February 3, and the several remaining items to be completed will require a new project to be opened.

B. Hospital CEO's Report

Dr. Klein reported that the 2020 financials have closed. The year ended with a positive EBIDA but still unfavorable to budget. Current volumes are still down. Recovery will rely on growth initiatives, operational improvement, and clinical efficiencies.

The Medical Network leadership structure is being reorganized and has been approved by their Board; 2 candidates for Interim Executive Director are now being interviewed. Dr. Klein is holding a virtual town hall next week for all employees in the Network.

Joint Commission accreditation for the diabetes program is currently in process, with the survey in March.

Recent employee satisfaction pulse survey results preliminarily look favorable; the full annual survey will be in late spring. The recent physician satisfaction survey so far looks favorable.

The seismic survey of the older buildings continues, with the report expected in May.

The original alternative lobby construction plan is on hold due to other important funding needs, but plans for entryway and corridor modifications will begin soon.

The EPIC electronic health record steering committee has met and is proceeding for the rollout in early spring 2022.

The Strategic Planning steering committee has met, the full board committee meets next week, and the Strategic Plan will be presented to this Board when it is near final.

Ms. Rienks expressed concern about the fall-off in preventive screenings (e.g. cancer) being performed due to COVID. Dr. Klein stated that quality improvements in the Medical Network will include calling patients for scheduling preventive procedures.

C. Chair's Report

Ms. Rienks reported that she was contacted by a labor union representative regarding a hospital employee labor issue, and requested that the public be given the opportunity to address the Hospital Board during its virtual meetings. Dr. Klein agreed, and Mr. Weiner will arrange for that.

Association of California Healthcare Districts (ACHD) has a series of governance orientation videos for board members, and Dr. Klein will consider them for inclusion in this Board's meetings.

D. Board Members' Reports

There were no further reports.

15. <u>Agenda Items Suggested for Future Meetings</u>

There were no suggestions.

16. <u>Adjournment</u>

Chair Rienks adjourned the meeting at 7:03 pm.

Tab 2

Marin Healthcare District

Creating a healthier Marin together.

February 24, 2021

The Honorable Judge Andrew Sweet
Marin County Superior Court
P.O. Box 4988
San Rafael, CA 94913-4988

Lucy Dilworth, Foreperson
Marin County Grand Jury
3501 Civic Center Drive, Room #275
San Rafael, CA 94903

RE: Response to Grand Jury Report

Dear Judge Sweet and Ms. Dilworth,

Please find attached, the Marin Healthcare District response to the recent Grand Jury report, "Opioid Misuse: Strengthening Marin County's Response."

The response, research, documentation and reporting were completed by Ms. Rebecca Maxwell, LCSW, Director of Behavioral Health and Ms. Mary Hard, Director of System Budgeting and Reporting at MarinHealth Medical Center.

Please let me know if there are questions, concerns, or need for further clarification.

Sincerely,

David G. Klein, MD, MBA
Chief Executive Officer
Marin Healthcare District

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Response to Grand Jury Report

Report Title: Opioid Misuse: Strengthening Marin County's Response

Respondent/Agency Name: Marin Healthcare District

Your Name: David G Klein, MD, MBA Title: Chief Executive Officer

FINDINGS

- I (we) agree with the findings numbered: F3
- I (we) disagree *partially* with the findings numbered: N/A
- I (we) disagree *wholly* with the findings numbered: N/A

(Attach a statement specifying any portions of the findings that are disputed; include an explanation of the reasons therefor.)

RECOMMENDATIONS

- Recommendations numbered R5 have been implemented.

  (Attach a summary describing the implemented actions.)

- Recommendations numbered N/A have not yet been implemented, but will be implemented in the future.

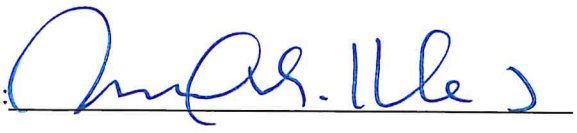
  (Attach a timeframe for the implementation.)

- Recommendations numbered N/A require further analysis.

  (Attach an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or director of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the grand jury report.)

- Recommendations numbered N/A will not be implemented because they are not warranted or are not reasonable.

  (Attach an explanation.)

Date: 2/24/21 Signed: 

Number of pages attached: 2

Marin Healthcare District

Creating a healthier Marin together.

Marin Healthcare District Response to Grand Jury Report
Findings and Recommendations
"Opioid Misuse: Strengthening Marin County's Response"
December 14, 2020

RESPONSE TO GRAND JURY FINDINGS

F3. Additional substance use navigators, who play a critical role in the hospital setting by guiding substance use disorder patients toward appropriate treatment, would enable more patients to obtain the follow-up support required for their recovery.

Response: Agree.

MarinHealth Medical Center, through grant funding, has employed a substance use navigator (SUN) in FY2019, 2020, and 2021. The substance use navigator has become an instrumental member of the interdisciplinary teams in the emergency department and inpatient clinical units and directly impacted over 300 individuals in 2020 who were referred to treatment after SUN intervention. Of those individuals referred to treatment, 31% made contact with a treatment facility. A successful SUN is able to develop relationships with community partners and clinical providers, and assist individuals beyond the walls of the hospital to connect with care to support recovery. SUNs are persistent, great problem solvers, and exceptional patient/client advocates who are helping to shift how those with substance use disorder are perceived and treated in the healthcare system and community at large. Through identification of patients impacted by substance use disorder, SUNs focus on harm reduction and low-threshold access to medication assisted treatment (MAT) in an effort to drive measurable positive impacts for patients, providers, and healthcare systems. Sixty percent of patients who received MAT at MarinHealth in 2020, either through induction or by prescription, and with the support and coordination by the substance use navigator, were connected with treatment facilities post hospital discharge.

RESPONSE TO GRAND JURY RECOMMENDATIONS

R5. Marin Healthcare District, through MarinHealth, should conduct a detailed cost-benefit analysis in fiscal year 2021–2022 to determine if additional substance use navigators are warranted and, if so, retain them.

Recommendation 5 has been implemented.

MarinHealth District, through MarinHealth, completed a cost-benefit analysis based on patient care costs and data from 2019 and 2020 with projected savings and added revenue directly impacted by the substance use navigator role. The analysis revealed that the work product was able to cover the cost of the substance use navigator position with an additional 15% to 43% margin depending on specific assumptions related to salary range, level of billable clinical intervention, and adjusted avoidable admission days. Additional benefits of the SUN that are not monetarily captured include: Streamlined patient care; Improving provider and staff satisfaction for caring for patients with substance use disorder; Reducing stigma and increasing access to post hospital care through low-barrier methods and harm reduction; Allowing other clinical staff such as

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social workers and nurses to dedicate their time to other patient care needs in the hospital; And, identifying individuals with substance use disorders with validated screening tools and implementing evidence-based care and treatment. In summary, with continued grant funding, MarinHealth would be able to add one additional substance use navigator. If no additional funding were to be secured for 2022, MarinHealth would be able to retain one substance use navigator. With additional projects and targeted efforts to reduce ED readmissions, inpatient length of stay, and increase care coordination post hospital discharge, MarinHealth will have additional data to assess throughout 2021 and will reassess the cost-benefit analysis to determine if additional SUNs are warranted. MarinHealth has demonstrated the ability to retain a substance use navigator since 2019. MarinHealth has a well-established behavioral health program that works in collaboration with the emergency department. The substance use navigator is supported by both these areas with direct clinical oversight by a physician and clinical social worker. The position has strong retention potential given the high quality training, supervision, community engagement, and professional growth afforded at MarinHealth.

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Tab 3

Creating a healthier Marin together.

MARIN HEALTHCARE DISTRICT
BOARD OF DIRECTORS

Resolution No. MHD 2021-04
SB 311 – Compassionate Access to Medical Cannabis Act, "Ryan's Law"

Whereas, in 1996 California became the first state to legalize the use of medical cannabis when citizens passed, the Compassionate Use Act; and

Whereas; in 1996 more than 70% of Marin County voters approved the Compassionate Use Act; and

Whereas, the fastest growing demography of people using medical cannabis is Medicare patients over the age of 65; and

Whereas, Marin County has one of the highest percentage of people on Medicare; and

Whereas, a large number of Medicare patient in Marin use medical cannabis as outpatient's; and

Whereas, On January 12, 2017 the National Academies of Science, Engineering & Medicine released a report entitled "Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for Research", which concluded there was conclusive or substantial scientific evidence that medical cannabis was an effective treatment for chronic pain in adults, anti-emetics in chemotherapy-induced nausea and spasticity symptoms in MS and moderate scientific evidence that medical cannabis was an effective treatment for obstructive sleep apnea and fibromyalgia; and

Whereas many terminally ill patients are admitted to the MarinHealth Medical Center with chronic pain and nausea due to chemotherapy; and

Whereas Hospitals in Israel, Germany, Canada and other countries have developed policy and procedures for inpatient use of medicinal cannabis; and

Whereas, the AMA Code of Ethics, Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship that states "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives." should apply to inpatients; and

Whereas, Senator Ben Hueso 40th District introduced SB 311, which allows terminal ill patients to use medical cannabis in hospitals; and

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Whereas, SB 311 specifically prohibit the smoking or vaping of medical cannabis for hospitalized terminally ill patients; and

Whereas, SB 311 allows any hospital investigated by the federal government for using a scheduled 1 drug to immediately prohibit the use of medical cannabis in the hospital; therefore

Be it resolved that the Marin Health District endorse and support the passage of SB 311 Ryan's Law.

ADOPTED this 9th day of March, 2021.

Ayes:

Nays:

Absent:

Abstain:

[Signatures on following page]

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MARIN HEALTHCARE DISTRICT
BOARD OF DIRECTORS

Signature Page
to
Resolution No. MHD 2021-04

ADOPTED this 9th day of March, 2021.

ATTEST:

_____
David G. Klein, MD
Chief Executive Officer

_____
Ann Sparkman, JD
Secretary

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

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

<INSERT LETTERHEAD>

<Month Day>, 2021

Senator Hueso,

I am writing to express my strong support for SB 311: Compassionate Access to Medical Cannabis Act, otherwise known as Ryan's Law. This legislation will provide relief, compassion and dignity to Californians during the most vulnerable time of their lives.

Due to the federal Drug-Free Workplace Act, which requires any institution receiving federal funds or grants to prohibit the use or distribution of "controlled substances" in the workplace, hospitals across the country have adopted policies prohibiting cannabis on their grounds. This means that, despite the state's approval of medical cannabis use for adults and children, and legalized recreational use for adults, California patients are currently unable to continue taking medical cannabis as part of their treatment plan while in the hospital – even if they possess a valid physicians' recommendation.

Ryan's Law seeks to close that gap by allowing those who most need compassion at the end of life to have access to medical cannabis in an in-patient setting. The bill would authorize a healthcare facility to reasonably restrict the manner in which a patient stores and uses medical cannabis to ensure the safety of other patients, guests, and employees of the healthcare facility. It does not apply to patients receiving emergency care, and smoking and vaping cannabis is expressly prohibited. Ryan's Law also provides a safe harbor clause allowing healthcare facilities to suspend the program if there is federal intervention.

For too long, Californians receiving treatment in healthcare facilities have been denied access to medical cannabis-related treatment methods, despite research demonstrating it to have innumerable benefits. As a result, individuals have been subjugated to unnecessary trials of pain and suffering. This is a simple yet critical step, which will have an abundance of benefits to ensure access to compassion and pain management for the most vulnerable Californians.

For these reasons, _____is (or I am) proud to join you in support of Ryan's Law.

Sincerely,

SB 311 – Ryan's Law: Compassionate Access to Medical Cannabis in Healthcare Facilities Act

Summary

Senate Bill 311 (Hueso) seeks to provide access to medical cannabis in healthcare facilities for Californians who are terminally ill. Specifically, the bill requires that hospitals and certain types of healthcare facilities in the State allow a terminally-ill patient to use medical cannabis for treatment and/or pain relief. Smoking or vaping cannabis is expressly prohibited, and the bill is not applicable to a patient receiving emergency services or care.

SB 311 would require a patient to provide the facility with a copy of their medical cannabis card or recommendation by a physician. Additionally, it would authorize a healthcare facility to reasonably restrict the manner in which a patient stores and uses medical cannabis to ensure the safety of other patients, guests, and employees of the healthcare facility, including requiring the medical cannabis to be stored in a locked container. For purposes of this bill, "terminally ill" is defined as having a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

To address concerns about federal intervention, Ryan's Law provides a safe harbor clause. In the case that the federal government takes one of the following actions below, a health care facility may be suspended from compliance with this bill until the federal government notifies the health care facility that it may resume permitting the use of medical cannabis within the facility:

- A federal regulatory agency or the US DOJ initiates enforcement action against a health care facility related to the facility's compliance with a state-regulated medical marijuana program.
- A federal regulatory agency, the US DOJ, or CMS issues a rule or otherwise provides notification to the health care facility that expressly prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

With these safeguards in place, this bill provides the necessary authority for hospitals to implement this law while ensuring the safety of other patients, medical staff and guests of the facility.

Background

Research has shown that medical cannabis possesses medicinal properties that can benefit a range of health conditions. It is most commonly used for pain relief, and is also used to improve appetite and reduce nausea. In certain cases it can be used as an alternative to heavy pain relievers like fentanyl and morphine.

Over two decades ago, California voters approved the Compassionate Use Act of 1996 (Proposition 215), which permitted patients with a valid doctor's recommendation to possess and cultivate cannabis for personal medical use. Subsequently, in 2016, California voters approved Proposition 64, which made it legal for Californians age 21 and older to grow, possess, and use cannabis for non-medicinal purposes, with certain restrictions. Proposition 64 also made it legal to sell and distribute cannabis through a regulated business as of January 1, 2018.

Although California has approved medical cannabis for adults and children, and recreational use for adults, federal law currently does not allow for a patient to take medical cannabis onto hospital grounds, even if the patient possesses a valid physician's recommendation. This is due to the federal Drug-Free Workplace Act of

1988, which requires entities receiving federal grants to establish and maintain drug-free workplace policies, including prohibiting the unlawful manufacture, distribution, dispensation, possession or use of prohibited controlled substances. Since cannabis remains a Schedule I drug at the federal level, hospitals and healthcare facilities receiving federal funds have consequently adopted policies prohibiting cannabis on their grounds.

Why this bill is needed

Hospitals and healthcare facilities are caught in the disjoint between state and federal medical cannabis laws and, as a result, patients suffer. Ryan's Law could greatly improve end-of-life treatment options for many patients receiving in-patient treatment by serving as an alternative to heavy pain killers like morphine and fentanyl.

For patients who use medical cannabis as part of their treatment, and who spend time in both in-patient and out-patient settings, questions arise as to the continuity and comprehensiveness of their care if they are taking a different medication regimen while in the hospital versus at home. This bill would allow for more effective transitions of care, while also removing a potential barrier to open communication between patients and doctors.

Ryan's Law would not require healthcare facilities to provide the medical cannabis; only to not interfere with its use, with certain restrictions. It is a simple, yet critical, step that will provide relief, compassion and dignity to Californians during the most vulnerable time of their lives.

Support:

Jim and Elaine Bartell (Parents of Ryan Bartell)
California NORML
Cannabis Nurses Network
Eaze
Bay Area Americans for Safe Access
Americans for Safe Access (National)

Staff Contact

Erin Hickey, Communications Director
Erin.Hickey@sen.ca.gov / (916) 651-4040

An act to add Chapter 4.9 (commencing with Section 1649) to Division 2 of the Health and Safety Code, relating to health care facilities.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Chapter 4.9 (commencing with Section 1649) is added to Division 2 of the Health and Safety Code, to read:

CHAPTER 4.9. COMPASSIONATE ACCESS TO MEDICAL CANNABIS ACT OR RYAN'S LAW

1649. (a) This chapter shall be known, and may be cited, as the "Compassionate Access to Medical Cannabis Act" or "Ryan's Law."

(b) It is the intent of the Legislature in enacting this chapter to support the ability of a terminally ill patient to safely use medicinal cannabis within specified health care facilities in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

1649.5. Unless the context requires otherwise, the following definitions shall apply to this chapter:

(a) "Compassionate Use Act of 1996" means the initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election and found at Section 11362.5, and any amendments to that act.

(b) (1) Except as provided in paragraph (2), "health care facility" means a health facility specified in subdivision (a), (c), (f), (i), or (n) of Section 1250.

(2) The meaning of "health care facility" shall not include a chemical dependency recovery hospital or a state hospital.

(c) "Medicinal cannabis" means cannabis or a cannabis product used in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

(d) "Patient" means an individual who is terminally ill.

(e) "Terminally ill" means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

1649.10. (a) A health care facility shall do all of the following:

(1) Not interfere or prohibit a patient from using medicinal cannabis within the health care facility.

(2) Prohibit smoking or vaping as methods to use medicinal cannabis.

(3) Include the use of medicinal cannabis within the patient's medical records.

(4) Require a patient to provide a copy of the patient's valid identification card, as described in Section 11362.715, or a copy of that patient's written documentation as defined in Section 11362.7.

(5) Develop and disseminate written guidelines for the use of medicinal cannabis within the health care facility pursuant to this chapter.

(b) This section does not apply to a patient receiving emergency services and care, as defined in Section 1317.1, or to the emergency department of a health care facility, as specified in subdivision (a) of Section 1250, while the patient is receiving emergency services and care.

1649.15. A health care facility may reasonably restrict the manner in which a patient stores and uses medicinal cannabis, including requiring the medicinal cannabis to be stored in a locked container, to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. A health care facility may specify that it is not

responsible for lost or stolen medicinal cannabis. A health care facility shall include all restrictions within the written guidelines required by Section 1649.10.

1649.20. This chapter does not require a health care facility to provide a patient with a recommendation to use medicinal cannabis in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 or include medicinal cannabis in a patient's discharge plan.

1649.25. (a) This chapter shall not be enforced by the department that licenses the health care facility.

(b) Compliance with this chapter shall not be a condition for obtaining, retaining, or renewing a license as a health care facility.

(c) This chapter does not reduce, expand, or otherwise modify the laws restricting the cultivation, possession, distribution, or use of cannabis that may be otherwise applicable, including, but not limited to, the Control, Regulate and Tax Adult Use of Marijuana Act, an initiative measure enacted by the approval of Proposition 64 at the November 8, 2016, statewide general election, and any amendments to that act.

1649.30. (a) If a federal regulatory agency, the United States Department of Justice (US DOJ), or the federal Centers for Medicare and Medicaid Services (CMS) takes one of the following actions, a health care facility may suspend compliance with Section 1649.10 until the regulatory agency, the US DOJ, or CMS notifies the health care facility that it may resume permitting the use of medicinal cannabis within the facility:

(1) A federal regulatory agency or the US DOJ initiates enforcement action against a health care facility related to the facility's compliance with a state-regulated medical marijuana program.

(2) A federal regulatory agency, the US DOJ, or CMS issues a rule or otherwise provides notification to the health care facility that expressly prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

(b) This section does not permit a health care facility to prohibit the use of medicinal cannabis due solely to the fact that cannabis is a Schedule I drug pursuant to the federal Uniform Controlled Substances Act, or other federal constraints on the use of medicinal cannabis that were in existence prior to the enactment of this chapter.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, Hueso.
General Subject: Compassionate Access to Medical Cannabis Act or Ryan's Law.

Existing law generally requires the licensure and regulation of various health care facilities, including, among others, a hospice facility. The Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election, prohibits specified criminal penalties from being imposed on a patient or a patient's primary caregiver who possesses or cultivates cannabis for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician. Existing law, known as the Medical Marijuana Program, requires counties to administer an identification card program for qualified patients and provides immunity from arrest to qualified patients with a valid identification card or designated primary caregivers, within prescribed limits.

This bill, the Compassionate Access to Medical Cannabis Act or Ryan's Law, would prohibit specified types of health care facilities from prohibiting or interfering with a terminally ill patient's use of medicinal cannabis within the health care facility, subject to certain restrictions. The bill would require a patient to provide the health care facility with a copy of their medical marijuana card or written documentation that the use of medicinal cannabis is recommended by a physician. The bill would authorize a health care facility to reasonably restrict the manner in which a patient stores and uses medicinal cannabis to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. The bill would prohibit the department that licenses the health care facility from enforcing these provisions, and compliance with the bill would not be a condition for obtaining, retaining, or renewing a license as a health care facility. The bill would authorize a health care facility to suspend compliance with these provisions if a regulatory agency, the United States Department of Justice, or the federal Centers for Medicare and Medicaid Services takes specified actions, including initiating an enforcement action against a health care facility related to the facility's compliance with a state-regulated medical marijuana program.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

Tab 4

MarinHealth Medical Center

Performance Metrics
and
Core Services Report

Q3 2020

March 2, 2021

250 Bon Air Road, Greenbrae, CA 94904 | O 1-415-925-7000

www.mymarinhealth.org

MarinHealth Medical Center (Marin General Hospital)

Performance Metrics and Core Services Report: **Q3 2020**

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 May 24, 2019 for a duration of 36 months.
	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 2019 (Annual Report) was presented to MGH Board and to MHD Board in June 2020.
	6. MGH Board must implement a Biennial Quality Performance Improvement Plan for MGH.	Annually	In Compliance	MGH Performance Improvement Plan for 2020 was presented for approval to the MGH Board in April 2020.
	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	Reported in Q4 2019
	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	Reported in Q4 2019
(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	At Risk	**Schedule 2**
	2. MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.	Quarterly	Not In Compliance	**Schedule 2**

MarinHealth Medical Center (Marin General Hospital)

Performance Metrics and Core Services Report: **Q3 2020**

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	Reported in Q4 2019
(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	Reported in Q4 2019
	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	Reported in Q4 2019
	5. MGH Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.	Annually	In Compliance	Reported in Q4 2019
(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	Reported in Q4 2019
	2. MGH Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.	Annually	In Compliance	Reported in Q4 2019
	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	Not In Compliance	The updated MGH Strategic Plan was presented to the MGH Board on March 5, 2019 and will be updated in **Q2 2021**.
	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 March 3, 2020.
	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 2019 Independent Audit was completed on April 24, 2020.
	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 2019 Form 990 was filed on November 13, 2020.

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.

FFY 2022 VBP Thresholds				Q4 2019	Q1 2020	Q2 2020	Q3 2020
73.37	81.04	87.18	**Overall rating**	**75.25**	**75.53**	**78.89**	**70.37**
			Would Recommend	**83.04**	**82.35**	**79.43**	**75.54**
83.38	88.02	91.73	**Communication with Nurses**	**77.56**	**78.76**	**81.80**	**77.52**
			Nurse Respect	83.67	84.40	86.53	84.33
			Nurse Listen	75.25	79.15	80.87	76.08
			Nurse Explain	73.75	72.73	78.00	72.15
82.52	87.04	90.65	**Communication with Doctors**	**83.60**	**81.23**	**80.26**	**82.10**
			Doctor Respect	88.33	84.81	83.95	84.69
			Doctor Listen	81.00	80.99	80.81	82.13
			Doctor Explain	81.46	77.89	76.01	79.46
66.75	75.27	82.09	**Responsiveness of Staff**	**68.20**	**67.19**	**71.05**	**68.71**
			Call Button	66.30	68.53	71.06	66.29
			Bathroom Help	70.11	65.85	71.04	71.12
65.29	71.25	76.01	**Communication about Medications**	**66.34**	**65.19**	**73.08**	**56.92**
			Med Explanation	82.00	81.12	90.74	66.90
			Med Side Effects	50.68	49.26	55.41	46.94
71.16	78.91	85.11	**Hospital Environment**	**59.67**	**59.47**	**67.18**	**61.00**
			Cleanliness	64.31	61.35	68.81	66.21
			Quiet	55.03	57.60	65.54	55.78
88.82	91.50	93.65	**Discharge Information**	**93.31**	**91.76**	**90.07**	**86.17**
			Help After Discharge	90.88	89.55	88.24	83.77
			Symptoms to Monitor	95.74	93.96	91.91	88.56
52.29	58.63	63.71	**Care Transition**	**54.72**	**52.61**	**50.74**	**47.50**
			Care Preferences	47.00	43.96	43.12	39.44
			Responsibilities	55.10	54.29	51.21	47.60
			Medications	62.06	59.57	57.89	55.46
			Number of Surveys	**302**	**288**	**301**	**301**

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 EBIDA) 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	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
EBIDA $ (in thousands)	(5,163)	(10,182)	(7,977)		(7,977)
EBIDA %	-4.77%	-5.10%	-2.6%		-2.6%
Loan Ratios					
Annual Debt Service Coverage	0.18	(1.31)	(0.97)		(0.97)
Maximum Annual Debt Service Coverage	0.15	(1.08)	(0.80)		(0.80)
Debt to Capitalization	51%	52.1%	52.5%		52.5%
Key Service Volumes					
Acute discharges	1,930	1,671	1,900		5,501
Acute patient days	9,705	7,976	9,200		26,881
Average length of stay	5.03	4.72	4.74		4.74
Emergency Department visits	6,763	4,833	10,338		21,934
Inpatient surgeries	375	303	340		1,018
Outpatient surgeries	955	505	896		2,356
Newborns	263	285	317		865

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.medicare.gov/care-compare/)

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

Hospital Inpatient Quality Reporting Program Measures

	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q3-2020 Num/Den	Rolling 2020 YTD	2020 YTD Num/Den
	♦ Stroke Measures									
STK-4	Thrombolytic Therapy	100%	**94%**	100%	100%	**56%**	N/A	5/9	**73%**	11/15
	♦ Sepsis Measure									
SEP-01	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	81%	**55%**	**53%**	**58%**	**47%**	N/A	40/85	**53%**	172/327
	♦ Perinatal Care Measure									
PC-01	Elective Delivery +	0%	**2%**	0%	0%	0%	N/A	0/25	0%	0/68
	♦ ED Inpatient Measures									
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients +	99***	**122.00**	**129.00**	**112.00**	**128.00**	N/A	158--Cases	**125.00**	521--Cases
	♦ Psychiatric (HBIPS) Measures									
IPF-HBIPS-2	Hours of Physical Restraint Use +	0.38	0.15	0.11	0.12	0.01	N/A	N/A	0.07	N/A
IPF-HBIPS-3	Hours of Seclusion Use +	0.29	0.11	0.03	0.00	0.00	N/A	N/A	0.03	N/A
IPF-HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	99%	**96%**	100%	**95%**	**93%**	N/A	14/15	**96%**	45/47
	♦ Substance Use Measures									
SUB-2	2-Alcohol Use Brief Intervention Provided or offered	100%	100%	100%	100%	100%	N/A	1/1	100%	5/5
SUB-2a	Alcohol Use Brief Intervention	100%	100%	100%	100%	100%	N/A	1/1	100%	5/5
	♦ Tobacco Use Measures									
TOB-2	2-Tobacco Use Treatment Provided or Offered	100%	**92%**	100%	100%	**93%**	N/A	14/15	**96%**	25/28
TOB-2a	2a-Tobacco Use Treatment	88%	**67%**	100%	100%	**86%**	N/A	12/14	93%	25/27
TOB-3	3-Tobacco Use Treatment Provided or Offered at Discharge	99%	**69%**	100%	100%	100%	N/A	13/13	100%	25/25
TOB-3a	3a-Tobacco Use Treatment at Discharge	71%	**23%**	100%	100%	86%	N/A	10/13	93%	19/25
	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q3-2020 Num/Den	Rolling 2020 YTD	Rolling Num/Den
	♦ Transition Record Measures									
TRSE	Transition Record with Specified Elements Received by Discharged Patients	99%	**93%**	**95%**	**92%**	**92%**	N/A	120/130	**93%**	360/387
TTTR	Timely Transmission of Transition Record	98%	**91%**	**91%**	**92%**	**91%**	N/A	118/130	**91%**	354/387
	METRIC	CMS**	2017	2018	2019				2020	Rolling Num/Den
IPF-IMM-2	Influenza Immunization	100%	88%	**98%**	**90%**				**92%**	279/302

** CMS Top Decile Benchmark CMS Reduction Program (shaded in blue) + Lower Number is better

Hospital Outpatient Quality Reporting Program Measures

	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q3-2020 Num/Den	Rolling 2020 YTD	2020 YTD Num/Den
	♦ ED Outpatient Measures									
OP-18	Median Time from ED Arrival to ED Departure for Discharged Patients +	142***	**168.50**	**191**	**169**	**166**	N/A	90--Cases	**177**	275--Cases
	♦ Outpatient Stroke Measure									
OP-23	Head CT/MRI Results for STK Pts w/in 45 Min of Arrival	72%***	85%	86%	**50%**	**50%**	N/A	2/4	**69%**	9/13

***** National Average + Lower Number is better**

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
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♦ Healthcare Personnel Influenza Vaccination

	METRIC	CMS National Average	Oct 2014 - Mar 2015	Oct 2016 - Mar 2017	Oct 2016 - Mar 2017	Oct 2017 - Mar 2018
IMM-3	Healthcare Personnel Influenza Vaccination	90%	**81%**	89%	89%	92%

♦ Surgical Site Infection +

	METRIC	National Standardized Infection Ratio (SIR)	Jan 2017 - Dec 2018	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019
HAI-SSI-Colon	Surgical Site Infection - Colon Surgery	1	not published**	not published**	not published**	not published**
HAI-SSI-Hyst	Surgical Site Infection - Abdominal Hysterectomy +	1	not published**	not published**	not published**	not published**

♦ Healthcare Associated Device Related Infections

	METRIC	National Standardized Infection Ratio (SIR)	Jan 2017 - Dec 2018	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019
HAI-CLABSI	Central Line Associated Blood Stream Infection (CLABSI)	1	**1.07**	0.54	0.57	0.71
HAI-CAUTI	Catheter Associated Urinary Tract Infection (CAUTI)	1	**1.17**	0.95	0.49	0.90

♦ Healthcare Associated Infections +

	METRIC	National Standardized Infection Ratio (SIR)	Jan 2017 - Dec 2018	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019
HAI-C-Diff	Clostridium Difficile	1	0.72	0.99	**1.01**	**1.22**
HAI-MRSA	Methicillin Resistant Staph Aureus Bacteremia	1	0.53	0.00	0.00	0.00

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

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2014 - Sept 2015	Nov 2015 - June 2017	July 2016 - June 2018	July 2017 - June 2019
PSI-90 (Composite)	Complication / Patient Safety Indicators PSI 90 (Composite)	0.9	No different than the National Rate	No different than the National Rate	No different than the National Rate	No different than the National Rate

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
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	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2014 - Sept 2015	Nov 2015 - June 2017	July 2016 - June 2018	July 2017 - June 2019
PSI-4	Death Among Surgical Patients with Serious Complications +	136.48 per 1,000 patient discharges	No different then National Average	No different then National Average	No different then National Average	No different then National Average
	♦ Surgical Complications +					
		Centers for Medicare & Medicaid Services (CMS) National Average	July 2014 - March 2016	April 2014 - March 2017	April 2015 - March 2018	April 2016 - March 2019
Surgical Complication	Hip/Knee Complication: Hospital-level Risk- Standardized Complication Rate (RSCR) following Elective Primary Total Hip/Knee Arthroplasty +	2.4%	2.7%	2.5%	**2.7%**	**3.0%**
	♦ Acute Care Readmissions - 30 Day Risk Standardized +					
	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2013- June 2016	July 2014- June 2017	July 2015 - June 2018	July 2016 - June 2019
READM-30-AMI	Acute Myocardial Infarction Readmission Rate	16.1%	15.20%	14.80%	14.09%	**16.30%**
READM-30-HF	Heart Failure Readmission Rate	21.9%	20.19%	19.80%	20.80%	21.60%
READM-30-PN	Pneumonia Readmission Rate	16.6%	16.80%	15.90%	15.10%	13.80%
READM-30-COPD	COPD Readmission Rate	19.60%	18.70%	**20.49%**	19.20%	19.60%
READM-30-THA/TKA	Total Hip Arthroplasty and Total Knee Arthroplasty Readmission Rate	4.00%	4.00%	4.10%	3.90%	**4.40%**
READM-30-CABG	Coronary Artery Bypass Graft Surgery (CABG)	12.70%	**14.30%**	**13.70%**	**13.80%**	11.70%
READM-30-STR	Stroke Readmission Rate		9.90%	10.40%	Not Published	Not Published
	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2015 - June 2016	July 2016 - June 2017	July 2015 - June 2018	July 2018 - June 2019
HWR Readmission	Hospital-Wide All-Cause Unplanned Readmission (HWR) +	15.6%	15.00%	**15.40%**	14.7%	13.7%

***** National Average + Lower Number is better**

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

♦ Mortality Measures - 30 Day +

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2013- June 2016	July 2014- June 2017	July 2015 - June 2018	July 2016 - June 2019
MORT-30-AMI	Acute Myocardial Infarction Mortality Rate	12.7%	12.90%	12.80%	12.50%	10.90%
MORT-30-HF	Heart Failure Mortality Rate	11.3%	11.70%	10.30%	9.70%	8.00%
MORT-30-PN	Pneumonia Mortality Rate	15.4%	**15.90%**	**15.90%**	15.30%	14.20%
MORT-30-COPD	COPD Mortality Rate	8.40%	7.96%	**9.30%**	**8.80%**	**9.20%**
MORT-30-STK	Stroke Mortality Rate	13.80%	11.70%	12.70%	13.70%	13.60%
CABG MORT-30	CABG 30-day Mortality Rate	3.00%	**3.46%**	**3.60%**	**3.40%**	3.00%

♦ Cost Efficiency +

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	Jan 2015 - Dec 2015	Jan 2016 - Dec 2016	Jan 2017 - Dec 2017	Jan 2018 - Dec 2018
MSPB-1	Medicare Spending Per Beneficiary (All)	0.99	**1.00**	**0.99**	0.98	0.97
			July 2013- June 2016	July 2014- June 2017	July 2015- June 2018	July 2016- June 2019
MSPB-AMI	Acute Myocardial Infarction (AMI) Payment Per Episode of Care	$25,526	$21,192	$21,274	$23,374	**$27,327**
MSPB-HF	Heart Failure (HF) Payment Per Episode of Care	$17,670	**$16,904**	**$16,632**	$16,981	$17,614
MSPB-PN	Pneumonia (PN) Payment Per Episode of Care	$18,322	**$17,429**	**$17,415**	$17,316	$17,717
	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average		July 2013 - June 2016	April 2014 - March 2017	April 2015 - March 2018
MSPB-Knee	Hip and Knee Replacement	$20,959		$22,502	$21,953	$20,263

***** National Average + Lower Number is better**

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

♦ Outpatient Measures (Claims Data) +

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019
OP-8	Outpatient with Low Back Pain who had an MRI without trying Recommended Treatments First, such as Physical Therapy	38.20%	Not Available	Not Available	Not Available	Not Available
OP-9	Outpatient who had Follow-Up Mammogram, Ultrasound, or MRI of the Breast within 45 days following a Screening Mammogram	8.90%	6.80%	7.00%	6.80%	Not Published
OP-10	Outpatient CT Scans of the Abdomen that were “Combination” (Double) Scans	6.40%	5.60%	4.80%	4.50%	6.10%
OP-11	Outpatient CT Scans of the Chest that were “Combination” (Double) Scans	1.40%	0.10%	0.20%	0.20%	Not Published
OP-13	Outpatients who got Cardiac Imaging Stress Tests Before Low-Risk Outpatient Surgery	4.20%	3.30%	3.50%	3.20%	3.20%
OP-14	Outpatients with Brain CT Scans who got a Sinus CT Scan at the Same Time	1.20%	0.40%	0.40%	0.30%	Not Published

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	Jan 2014 - Dec 2014	Jan 2015 - Dec 2015	Jan 2016 - Dec 2016	Jan 2018 Dec 2018
OP-22	Patient Left Emergency Department before Being Seen	2.00%	1.00%	1.00%	1.00%	2.00%

+ 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)					
	Q1 2020	**Q2 2020**	**Q3 2020**	**Q4 2020**	**Total 2020**
Buckelew	26,250	0			26,250
Community Action Marin	10,500	0			10,500
Community Development Corp of Marin	10,500	0			10,500
Community Institute for Psychotherapy	15,750	0			15,750
Homeward Bound	157,500	0			157,500
Huckleberry Youth Programs	10,500	0			10,500
Marin Center for Independent Living	26,250	0			26,250
Marin Community Clinics	105,000				105,000
MHD 1206B Clinics	6,524,273	8,692,426	5,623,735		20,840,434
North Marin Community Services	10,500	0			10,500
Operation Access	21,000	0			21,000
Ritter Center	26,250	0			26,250
RotaCare Free Clinic	15,750	0			15,750
San Geronimo Valley Community Center	5,250	0			5,250
Spahr Center	15,750	0			15,750
West Marin Senior Services	10,500	0			10,500
Whistlestop	15,750	0			15,750
Total Cash Donations	**7,007,273**	**8,692,426**	**5,623,735**		**21,323,434**
Meeting room use by community based organizations for community-health related purposes.	2,781	0			2,781
Food donations	987	987	987		2,961
Total In Kind Donations	**3,768**	**987**	**987**		**5,742**
Total Cash & In-Kind Donations	**7,011,041**	**8,693,413**	**5,624,722**		**21,329,176**

Schedule 4, continued

Community Benefit Summary

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

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
Community Health Improvement Services	43,643	33,516	39,634		116,793
Health Professions Education	517,015	350,811	77,510		945,336
Cash and In-Kind Contributions	7,011,041	8,693,413	5,624,722		21,329,176
Community Benefit Operations	0	0	1,397		1,397
Community Building Activities	0	0	0		0
Traditional Charity Care *Operation Access total is included	470,995	289,175	388,929		1,149,099
Government Sponsored Health Care (includes Medi-Cal & Means-Tested Government Programs)	6,784,847	6,734,333	8,794,129		22,313,309
Community Benefit Subtotal (amount reported annually to State & IRS)	**14,827,541**	**16,101,248**	**14,926,321**		**45,855,110**
Unpaid Cost of Medicare	20,131,921	16,777,396	18,216,928		55,126,245
Bad Debt	550,915	428,464	408,548		1,387,927
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**35,510,377**	**33,307,108**	**33,551,797**		**102,369,282**

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.

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
*Operation Access charity care provided by MGH (waived hospital charges)	5,513	191,460	754,668		951,641
Costs included in Charity Care	966	33,567	131,784		166,317

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				
Period	**Number of Clinical RNs**	**Separated**		**Rate**
		Voluntary	**Involuntary**	
Q4 2019	539	14	0	2.60%
Q1 2020	523	23	1	4.59%
Q2 2020	531	11	1	2.26%
Q3 2020	**521**	**17**	**8**	**4.80%**

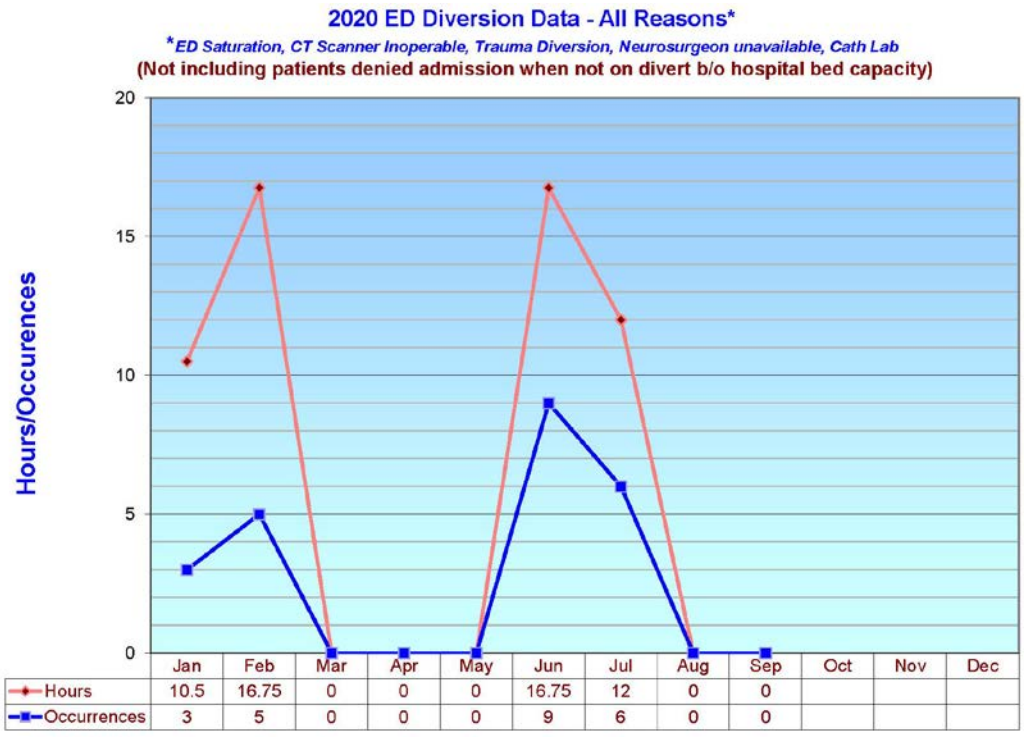
Vacancy Rate							
Period	**Open Per Diem Positions**	**Open Benefitted Positions**	**Filled Positions**	**Total Positions**	**Total Vacancy Rate**	**Benefitted Vacancy Rate of Total Positions**	**Per Diem Vacancy Rate of Total Positions**
Q4 2019	38	68	539	646	16.56%	10.53%	5.88%
Q1 2020	20	67	523	610	14.26%	10.98%	3.28%
Q2 2020	17	62	531	610	12.95%	10.16%	2.79%
Q3 2020	**22**	**72**	**521**	**610**	**14.59%**	**11.80%**	**3.61%**

Hired, Termed, Net Change			
Period	**Hired**	**Termed**	**Net Change**
Q4 2019	12	14	(2)
Q1 2020	8	24	(16)
Q2 2020	21	12	9
Q3 2020	**11**	**25**	**(14)**

Schedule 6: Ambulance Diversion

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

Quarter	Date	Time	Diversion Duration	Reason	Waiting Room Census	ED Admitted Patient Census
Q3 2020	July 3	19:18	2'01"	ED	8	6
	July 8	12:59	2'01"	ED	14	1
	July 13	19:18	1'56"	ED	6	7
	July 21	16:51	2'01"	ED	6	4
	July 21	19:26	2'01"	ED	8	7
	July 24	15:57	1'55"	ED	5	2



Tab 5

Session 1: Community Engagement Discussion Guide

Watch the **Community Engagement** Webinar Here

Download the Session Slides Here

Prepared by
James A. Rice, Ph.D.
Brian E. Rice, MHA

Series Preface:

This discussion guide is part of an "**ACHD Governance Toolkit**" composed of a series of six recorded webinars organized by the Association of California Healthcare District (ACHD) to encourage and support healthcare district boards of directors to further enhance the performance of their governance models and practices. The six topics addressed are:

1. Community Engagement
2. Balancing Governance & Management
3. Board Orientations
4. Strategic Planning
5. Board Self-Assessments
6. Board Education Programming

The six programs consist of an approximately 15-minute video with a downloadable slide deck, and a short discussion guide to stimulate healthy conversations between the CEO and the board about practical ways they can collaborate for more effective and efficient board decision making in each topic. The programs are also intended to help encourage healthcare districts to consider the successful completion of ACHD Certification.

The ACHD Certified Healthcare District Program promotes good governance for healthcare districts by creating a core set of accountability and transparency standards. This core set of ACHD standards is known as *Best Practices in Governance* and districts that demonstrate compliance are designated by ACHD as a **Certified Healthcare District** for a period of three years. Find more information on our website.

Each of the six webinars can be optimized when the Board Chair and CEO collaborate to organize a five-step program of education for the coming year.

The five-step process for your board-CEO conversation to address these topics is suggested to be:

1. The CEO and Board Chair reaffirm their shared commitment to the continuous enhancement of the board's education and capacity development. Jointly express this commitment at the beginning of each year.
2. Adopt a board policy of continuous board development that embraces:
    - Periodic CEO briefing materials on topics relevant to the strategic plans and challenges of the healthcare district.
    - A calendar of speakers in routine board meetings on hot topics to help the district's vitality.
    - Organization of a "Symposium" on board best practices with other community organizations and associations for joint learning and community leader networking.
    - Participation in small groups of district board members at ACHD or other state conferences on strategic issues and trends.
    - Organization of customized educational readings or mentors for each board member based on their unique needs and requests.
3. Organize a 30-minute educational session during a Spring and Fall board meeting to focus on one or more of the six Webinar topics. Ask one board member to team with a member of management and/or the staff to jointly present, and help guide the discussion around the webinar and this Discussion Guide. This team approach helps build interest, ownership and shared responsibility among the board for its ongoing development.
4. Encourage all board members to watch to the short video recording of the webinar before the scheduled discussion session. All should come to the discussion session ready to contribute in these ways:
    - Assess how well this topic is being addressed in your healthcare district;
    - Bring questions and ideas about how your district might better address this topic in the future; and
    - Bring some suggested resources that might help your healthcare district enhance its learning and planning for this topic.
5. Conduct a collegial assessment of each program to see how its value to your district could best be optimized in the coming year. Share your ideas with the ACHD staff.

Thank you again for all you do for the people of your healthcare district, and for the enhanced performance of your healthcare district board work!

Contact ACHD staff at any time with questions, or contact us at jim_rice@governakadimi.org

Let's begin moving though this discussion guide.

Community Engagement

Introduction

Thank you for your interest in exploring how your healthcare district board might better understand and develop its capacity for enhanced ***community engagement***. We see community engagement as a two-way street that both (a) invites the community into the work of your district's board, and (b) encourages your board to engage more effectively in the community through partnerships focused on community health gains and population health.

This discussion guide is not a stand-alone document. The guide is to be used in conjunction with the corresponding **recorded webinar** and **slide deck**. We encourage your board and CEO to collaborate for shared strategic thinking and planning to support your board members, individually and collectively, to be more effective in establishing and nurturing community partnerships by ***new strategies and structures of engagement***.

This Discussion Guide is organized to answer these questions:

1. What is "Community Engagement"?
2. Why is it important?
3. Common issues or challenges?
4. What can boards do to be more successful?
5. Where to secure resources for further educational insights on this topic?

Within each of these five sections, we pose a series of questions to guide your conversations about how to best enhance your work in developing and managing community engagement as a means to accomplish the mission of your healthcare district.

1. What is "Community Engagement"?

We have found that community engagement is a ***structured process*** to build and nurture ***partnership(s)*** with diverse players, such as:

1. Social Determinants of Health (SDOH) partners
2. Provider partners
3. Payer partners
4. Government, Civic and Business leaders
5. Supply Chain partners
6. Donor partners

Partnerships that deliver meaningful value resulting in ***health gain and health care*** in a resource constrained environment!

To strengthen your thinking and actions in this sphere of interest, please try to ask and answer these questions within a board retreat or board meeting:

- What do you mean by "**community**"? In addition to the above players in your region, what are the various segments in the population that make up your diverse community (ethnicity, race, gender, religions, age sub-groupings)? What do they need from you? What would you like from them? What actions should you consider taking to optimize the chance for your needs and theirs to best be met in the coming months?
- When we say "**engagement**" what does that mean? As both ***a noun*** (look the word up in the dictionary here and talk about how it applies to your healthcare district), and as ***a verb***, found here.
- If we are to build and nurture "**partnerships**" as an output of community engagement, what are the outcomes we desire from these partnerships? We partner to achieve what strategic goals or objectives?

2. Why is it important?

Our work in many communities and countries suggest there are many reasons to better master Community Engagement. First, as a healthcare district in California, we have no real choice as a community organization formed for and from the community! Other dimensions of its importance to us can be:

- The health care environment and landscape are more complex, riskier, and expensive than ever before.
- Because we cannot possibly have all the answers to most successfully engage or partner with the population segments in our district, it is not wise to do it alone; we need wisdom, leverage and resources of others in our journey to achieve our healthcare district's mission.
- Collaboration more than competition is now more likely to be an expected model from key stakeholders: payers, media, community leaders, providers, employees, donors, policy makers.
- Our journey to our mission needs intentional "mapping" rather than "drifting" for our sustained vitality.

How would you address these questions to improve your ability to leverage the importance of community engagement?

- What are 2-3 examples of the value of better community engagement for your healthcare district?
- You might ask your community partners how they measure the value of, or importance of better community partnering?

3. Common issues or challenges?

While many see the value of better community engagement and partnerships, it is not easy to accomplish and maintain these collaborative partnerships. Our work indicates these are some of the most important obstacles that constrain or frustrate good partnership opportunities:

- We must find new revenues to help us protect and promote community health compared to restoring health via acute care.
- New partnerships require new people, personalities, processes, priorities, and professions.
- Many distractions and competing priorities as U.S. and California policy constraints pull us from ***populations*** compared to ***patients.***
- Lack of experience and tools in community-based planning and "***Collaborative Governance***".
- Lack of resources to walk-the-talk.

What do you see as the key challenges to build enduring cooperation with these potential populations in your community?

- Physicians and other providers?
- Other community and civic organizations interested in health status and health care?
- Payers?
- Hispanic, African American, and other minority populations?
- Disabled populations?
- Homeless populations?
- Young families?
- Frail seniors?
- The younger generation?
- Others in your region?

4. What can Boards do to be more successful?

While your healthcare district board cannot do everything for every segment of the community, there is much you can do with careful study, listening and planning, such as:

- Invite education from community leaders on needs, barriers, and new strategies within new models of cooperation, and new sources of funds to catalyze and support collaboration and engagement.
- Study successful models of "Collective Impact" and "Collaborative Governance" across California, across the U.S., and in other countries.
- Experiment with "Community Plunges" (See Theda Care example).

Please discuss how you can best answer these related questions:

- What examples of community engagement and partnering have you already been using in your healthcare district? Why are they working well, or why not?
- How might you organize a ***community focus group or roundtable*** to listen to the needs the people and partners you wish/need to engage with, and then how would you use "***sincere inquiry***" to ask them how they might best engage with you to address their needs (and yours)?
- Pick one of the tough challenges in section 3 above. How should your board and executive team best remove, reduce or work around that obstacle?

5. Where to secure resources for further educational insights on this topic?

We encourage you to have a conversation about where you can turn for ideas and resources to build and sustain healthy community partnerships, and the processes of collaboration and engagement to build them. Our suggested sources are shown here:

- Foster McGaw Award winners
- Public Health Institute
- National Association of Counties
- Social Determinants of Health
- Association for Community Improvement
- Collective Impact

What do you find as suggested resources to use in your community engagement efforts?

Thank You

Thank you again for all you are doing to build community engagement.

Please click here to evaluate this board development discussion guide and webinar to help us improve support for your board's continuous development and effectiveness.

And thank you for all you do for the people you exist to serve in your healthcare district!

Governance Toolkit

Board Session 1:

The Board's Role in Community Engagement

Jim Rice: 1-612-703-4687 jim_rice@ajg.com

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

1

ACHD Governance Series

Effective Board Work for Enhanced Service and Performance

Six Short (15 minute) Programs for use by ACHD Members

1. **Community Engagement**
2. Balancing Governance & Management
3. Board Orientations
4. Strategic Planning
5. Board Self-Assessments
6. Board Education Programming

2

Jim Rice: Governance Adviser

Experienced. Practical. Responsive.

Jim Rice, PhD, FACHE is Senior Adviser with the Governance & Leadership service line of Gallagher's Human Resources & Compensation Consulting practice, and Chairman of the Akadimi Foundation. Having served on many boards, Jim focuses his consulting work on strategic governance structures and systems for high performing medical groups, hospitals, credit unions and integrated care systems. He is often engaged for enhanced strategic alliances and mergers for large and small not-for-profit organizations; as well as leadership development programming for Physicians, Boards and C-Suite Senior Leaders.

Dr. Rice holds a masters and doctoral degree in management and health policy from the University of Minnesota. He has received the University of Minnesota, School of Public Health Distinguished Alumni Leadership Award; a National Institute of Health Doctoral Fellowship; a US Public Health Service Traineeship in Hospital Management; a Bush Leadership Fellowship at Stanford and the National University of Singapore; and the American Hospital Association's Corning Award for Excellence in Hospital Planning. He is a Fellow in the American College of Healthcare Executives (ACHE) and has worked in over 35 countries in North America, Asia, Africa and Latin America.

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Community Engagement

Focus of Session:

1. What is "Community Engagement"?
2. Why is it important?
3. Common issues or challenges?
4. What can Boards do to be more successful?
5. Resources for further insights?

1. What is "Community Engagement"?

Structured process to build and nurture ***partnership(s)*** with diverse players:

1. Social Determinants of Health (SDOH) partners
2. Provider partners
3. Payer partners
4. Government, Civic and Business leaders
5. Supply Chain partners
6. Donor partners

Partnerships that deliver meaningful value/results for ***health gain and health care*** in resource constrained environment!

2. Why is it important?

1. No real choice as a community organization formed for and from the community!
2. Landscape is more Complex, Riskier, and Expensive
3. Not wise to go it alone: need wisdom, leverage and resources
4. Collaboration expected model from key stakeholders: payers | media | community leaders | providers | employees | donors | policy makers
5. Mission mapping demands engagement for vitality

3. Common Issues or Challenges?

- Few paying us to protect and promote community health compared to restoring health via acute care
- New partnerships require new People, Personalities, Processes, Priorities, and Professions
- Many distractions and competing priorities as US and California policy constraints pull us from ***populations*** compared to ***patients***
- Lack of experience and tools in community based planning and "***Collaborative Governance***"
- Lack of resources to walk-the-talk

4. What can Boards do to be more successful?

1. Invite education from community leaders on needs, barriers, and new strategies within new models and new money
2. Study successful models of "Collective Impact" and "Collaborative Governance" across California, across the US, and in other countries
3. Experiment with "Community Plunges"

5. Resources for further insights:

- Foster McGaw Award winners: https://www.aha.org/award/2017-12-11-foster-g-mcgaw-prize-winners-and-finalists
- Public Health Institute: https://www.phi.org/
- National Association of Counties: https://www.naco.org/topics/health
- Social Determinants of Health: https://www.cdc.gov/socialdeterminants/index.htm
- Association for Community Improvement https://www.aha.org/topics/association-community-health-improvement-achi
- Collective Impact: https://www.collectiveimpactforum.org/what-collective-impact
- Many Others

Thank you for all you do for the people in your healthcare district!

We hope this short program stimulates your continuous pursuit of enhanced board work to strengthen your healthcare district's support for ***health care*** and ***health gain*** in challenging times.

Please contact ACHD to access their many other board support resources.

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

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