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MARK TWAIN
HEALTH CARE DISTRICT

P. O. Box 95
San Andreas, CA 95249
(209) 754-4468 Phone
(209) 754-2537 Fax

Meeting of the Board of Directors
Wednesday April 24, 2019
7:30 am
Mark Twain Medical Center Classroom 2
768 Mountain Ranch Rd,
San Andreas, CA

Agenda

Mark Twain Health Care District Mission Statement

"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. **Call to order:**
2. **Roll Call:**
3. **Approval of Agenda:** Action
4. **Public Comment on matters not listed on the Agenda:**

   The purpose of this section of the agenda is to allow comments and input from the public on matters within the jurisdiction of the Mark Twain Health Care District not listed on the Agenda. (The public may also comment on any item listed on the Agenda prior to Board action on such item.) **Limit of 3 minutes per speaker**. The Board appreciates your comments however it will not discuss and cannot act on items not on the agenda.

5. **Consent Agenda:** Action

   All Consent items are considered routine and may be approved by the District Board without any discussion by a single roll-call vote. Any Board Member or member of the public may remove any item from the Consent list. If an item is removed, it will be discussed separately following approval of the remainder of the Consent items.

   A. Un-Approved Minutes:

   - Un-Approved Finance Committee Meeting Minutes for March 19, 2019
   - Un-Approved Board Meeting Minutes for March 27, 2019:

B. Correspondence:

- Dakota Butzler iPad - Thank you 4-15-2019:

6. MTHCD Reports:

A. President's Report:……:……Ms. Reed

- Special Presentation:
- Association of California Health Care Districts (ACHD):
- ACHD Annual Meeting – Oct 9-11 – District Initiatives:

B. Chief Executive Officer's Report: ……..……..……..……..Dr. Smart

- Community Out-Reach:
- VS H&W Center - Draft Policies: Action

  Punctuation & Grammar Changes – Please Submit to District Office Staff:

  1. Draft Use of Gloves
  2. Draft EMERGENCY RELEASE OF PATIENT RECORDS
  3. Draft Medication Reconciliation
  4. Draft Radiology Department Safety Guidelines
  5. Draft RADIOLOGY SAFETY
  6. Draft Monitoring Inspection of Medication Inventory
  7. Draft MEDICATION WASTE STREAM
  8. Draft Medication Management – Storage of Multi-Use Containers
  9. Draft Look-Alike Sound-Alike Medications
  10. Draft FORMULARY
  11. Draft Drug Samples
  12. Draft TRANSFER OF PATIENT – CHART INFORMATION
  13. Draft RETENTION OF RECORDS
  14. Draft MEDICAL RECORD TRANSFER
  15. Draft SECURITY AND RETENTION OF MEDICAL RECORDS
  16. Draft MEDICAL RECORDS RELEASE
  17. Draft MEDICAL RECORDS FORMS AND FEES
  18. Draft Correction of Information in Medical Record 112118

- Strategic Plan Matrix (Last Updated 3-19-2019):
- Personnel Manual - 2000 Hiring Process (Last updated 4-6-2019) Action:
- County Health Report:

C. **Corp. Board Report**:……Ms. Reed / Ms. Atkinson

D. **Stay Vertical Calaveras:**……..Steve Shetzline

E. **Ad Hoc Real Estate**: ……..Ms. Reed / Ms. Al-Rafiq

- **Update on the Valley Springs Health & Wellness Center**:……Dr. Smart
  - Construction:……Dr. Smart
    - Project Manager:……..Pat Van Lieshout
  - Operations and Development:……Dr. Smart
    - USDA Form 271:
- **Update on Valley Springs Property - Phase II**:……Ms. Reed / Ms. Al-Rafiq

7. **<u>Committee Reports</u>:**

A. **Finance Committee**:……Ms. Atkinson / Ms. Radford

- Budget Update- Reimbursements……..Ms. Atkinson
- Financial Update:…….. Mr. Wood
- Financial Statements (Mar. 2019) Recommendation-Approval: Action……...Ms. Atkinson
- Fixed Asset - Capitalization Policy No. 30: Action……Dr. Smart
- Investment Activities:……..Mr. Wood
  - Review Investment Authority - CA Govt. Code 53607 Policy No. 22: Action

C. **Ad Hoc Lease Review Committee**:……..Ms. Reed / Ms Atkinson

D. **Ad Hoc Policy Committee**:……Ms. Atkinson / Ms. Al-Rafiq

E. **Personnel Committee:**

- CEO Contract**:** Action**:**

F. **Ad Hoc Community Grant**: Action……Ms. Radford / Ms. Sellick

- Recommendation for Awarding Grants:

8. Board Comment and Request for Future Agenda Items:

A. Announcements of Interest to the Board or the Public:

9. Next Meeting:

A. Will not be on the usual Wed. and has been rescheduled to Friday May 31, 2019:

10. Adjournment: Action

MARK TWAIN
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P. O. Box 95
San Andreas, CA 95249
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Phone (209) 754-2537 Fax

Special Finance Committee Meeting
Tues. March 19, 2019
9:00am
Mark Twain Medical Center Education Center - Classroom 5 San Andreas, CA

Un- Approved Minutes

Mark Twain Health Care District Mission Statement

"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. **Call to order:**

The meeting was called to order by Treasurer Susan Atkinson at 9:00am.

2. **Roll Call:**

Present for roll call was Ms. Atkinson and Ms. Radford.

3. **Approval of Agenda:** Action

Ms. Radford moved to approve the Agenda. Ms. Atkinson provided her second and the motion passed 2-0.

4. **Public Comment On Matters Not Listed On The Agenda:**

Hearing none.

5. **Consent Agenda:** Action

   A. **Un-Approved Minutes:**

      - No Finance Committee Meeting in February:

B. Bank and Investment Statements:

Dr. Smart: Explained the purpose for each of the bank accounts as follows;

- Bank of Stockton: Is a pass-through account for USDA to use to service the loan.
- Umpqua Bank: The original and long-standing District accounts i.e.; checking, money market and investment.
- Five-Star Bank: VS Clinic, operations and money market.
- US Bank: Required by Athena Health for billing services.
- Cal Trust: Investment account.

Ms. Radford moved to approve the Consent Agenda as discussed. Ms. Atkinson provided her second and the motion passed 2-0.

6. Accountant's Report: Action

- Financial Status, Trends, Long-Term Views and Cashflow:

Dr. Smart: Estimated USDA interest payments would be $75k but in fact the first payment was $16k. The next payment will be due in Sept./Oct. To service the loan in 2020 will likely be $400k.

- February Financials Will Be Presented to The Committee:

Mr. Wood: Is nearing his review of the financials and which documents will be presented to the Committee.

- Investment – Update: Action

Mr. Wood: Handed out his narrative and stated the Balance Sheet shows a strong cash position; per Government Code 53646 it will be necessary to reaffirm (annually) who is delegated to monitor and make changes in the investments of the District and suggest that it be included on the April agenda; he will also be doing an investment spread sheet; reserve funds will be in his report and amounts will be added as appropriate and can stay at Cal Trust in short or long term options; as the Umpqua investments mature they will be moved to a higher paying position; he will also be adding a credit card report to the financials; new to the financials is the expenses for the VS H&W Center which will become its own report as it develops; he is also giving new life to the MOB Lease schedule and will include it in each pkt. he explained journal entries are in a category excluding writing a check, deposits, accounts payable/receivable i.e. they have no supporting documentation yet needs to be included for the books to balance.

Ms. Radford moved to approve the Financial report. Ms. Atkinson provided her second and the motion passed 2-0.

7. Executive Director's Report:

- **USDA (SF 271) Outlay Report (Feb. 28, 2019):** As presented.

- **Update on MTHCD and MTMC/Dignity Lease:**

Dr. Smart: Attended a meeting along with Dignity staff at the Attorney General's Office in LA. The AG representative stated it wasn't within the AG's jurisdiction; she expressed her pleasure with the District including women's health and for the all-women Board and gave her well-wishes for the agreement. Additional documents will follow for the District' review. The lease is due to close at the end of April.

8. Treasurer's Report:

- **Update on Community Member**: Action

Dr. Smart: Made reference to the District's Policy No. 5.3 wherein a community member can be selected by the Finance Committee and then recommended to the Board for approval. He then introduced Lori Hack (CV included in pkt).

Ms. Hack: Told about her career, having a second home in Arnold, wanting to give back to her local community so has a desire to serve on the Finance Committee.

Ms. Radford moved to recommend Ms. Hack to the Board as the Finance Committee member. Ms. Atkinson provided her second and the motion passed 2-0.

- **Budget Cycle Planning and Input:**

He'll email the Committee Chairs the budget so they can begin the process with an April 15th due date for their submissions. The Committee can expect to see a draft 2019-20 budget at the May Finance Committee meeting.

9. Comments and Future Agenda Items:

Mr. Wood: CSDA distributed 18k copies of their California Special Districts (1969 – 2019) magazine. The Jan-Feb 2019 addition celebrates their 50th anniversary and includes a piece on Stay Vertical Calaveras (pg.47).

10. Next Meeting:

- The next meeting will be April 10, 2019.

11. Adjournment: Action

Ms. Radford moved to adjourn the meeting. Ms. Atkinson provided her second and the meeting was adjourned at 10:23am.

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MARK TWAIN
HEALTH CARE DISTRICT

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Meeting of the Board of Directors
Wednesday March 27, 2019
7:30 am
Mark Twain Medical Center Classroom 2
768 Mountain Ranch Rd,
San Andreas, CA

Un- Approved Minutes

Mark Twain Health Care District Mission Statement
"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. **Call to order:**

The meeting was called to order President Lin Reed at 7:34am.

2. **Roll Call:**

Present for roll call was Lin Reed, MBA OTR/L; Ann Radford, FNP: Susan Atkinson, MSW; Debbie Sellick CMP and Talibah Al-Rafiq.

3. **Approval of Agenda:** Action

Ms. Atkinson moved to approve the agenda as amended to accommodate the schedules of speakers. Ms. Radford provided her second and the motion passed. 5-0

4. **Public Comment on matters not listed on the Agenda:**

Stay Vertical Calaveras instructors thanked the Board for the Stay Vertical Program and expressed the good it is doing in the Community.

Public member would like to Calaveras Government, School Districts, hospital and other large organizations in the County adopt the same service animal policy to avoid unpleasant circumstances. The District will amend policy, as needed, to conform with regulations/law.

5. Consent Agenda: Action

A. Un-Approved Minutes:

- The Finance Committee Was Unable to Meet in February:
- Un-Approved Special Board Meeting Minutes for February 6, 2019:
- Un-Approved Board Meeting Minutes for February 27, 2019:

Ms. Radford moved to approve the Consent Agenda. Ms. Sellick provided her second and the motion passed 5-0.

6. MTHCD Reports:

A. President's Report:

- **Association of California Health Care Districts (ACHD):**

Ms. Reed: The ACHD Board met and decided on financial changes to stay solvent after the ALPHA BETA support ends i.e.: this is the last year for Legislative Days however they will send a representative to support specific bills.

- **Board Self-Assessment:**

After discussion of the Self-Assessment it was suggested to discuss items of importance at the next Strategic Planning meeting.

B. Chief Executive Officer's Report: ……..……..……..……..Dr. Smart

- **VS H&W Center - Draft Policies: Action**

1. DRAFT Universal Precautions

Amend: (pkt. pg. 41) General Guidelines Item 1 first line: change practices to "practical"

2. DRAFT STERILE SUPPLIES AND INSTRUMENTS
3. DRAFT Sterile Shelf Life
4. DRAFT STERILE FIELD
5. DRAFT Infection Control – Overview

Amend: (pkt. pg.52) Implementation: Item 2.d. ……it is acceptable "to" use alcohol….

6. DRAFT INFECTION CONTROL
7. DRAFT HAZARDOUS WASTE
8. DRAFT Handwashing 112018

Amend: (pkt. pg.57) Handwashing (hand hygiene) with "waterless" antiseptic…….

9. DRAFT Fit Testing 112018
10. DRAFT Exposure Control Plan

Amend: (pkt. pg. 63) Item iii. Protective clothing shall be provided to employee ~~and~~……

Amend: (pkt. pg. 64) Item iii. …….shall not be picked up directly with "their" hands.

Amend: (pkt. pg. 64) Change all references of "Mantoux" to read "QuantiFERON Gold" Test.

11. DRAFT Exam Table and Exam Room Cleaning and Disinfecting 112018
12. DRAFT Contagious Patient 112018
13. DRAFT CLEANING DUTIES
14. DRAFT Blood Borne Pathogen Exposure 112018

Amend: (pkt. pg. 75) General (2nd bullet) change clean-p to "cleanup"……..

Amend: (pkt. pg. 76) Waste (3rd bullet)…….; container lids must ~~be~~ fit tightly and properly….

Amend: (pkt. pg. 76) Environment (4th bullet)…….by a mechanical means, not "by" hand.

15. DRAFT Biohazard Material Management 112018
16. DRAFT Aseptic Procedures 112018
17. DRAFT Medical Assistant Scope of Practice 111918
18. DRAFT Information Technology Rules of Use 111918
19. DRAFT ePHI Policy 111918
20. DRAFT Demonstrated Competency 111918

Amend: (pkt. pg. 96) Item 7. The ~~Radiology~~ "Clinic" Supervisor will……..

21. DRAFT Marketing Policy 111218
22. DRAFT Compliance Policy 111218
23. DRAFT Volunteer Deployment 111918
24. DRAFT Unscheduled Downtime of Electronic Medical Record 111918
25. DRAFT Transfer Of Patient To A Hospital 111918
26. DRAFT Threatening or Hostile Patient 111918

- **Strategic Plan Matrix (Last Updated 3-19-2019):**

Dr. Smart: Complimented the Board on having accomplished 15 of the 17 items.

- **MTMC Amended Parcel Map:**

Dr. Smart: Has been in the process of reviewing the escrow documents presented with the new lease package and discovered the District owns parcel one (pkt. pg. 110-111) which gives the District future possibilities for more opportunities to provide health care in the community.

C. Corp. Board Report:

Ms. Reed: Introduced Doug Archer as the new Pres/CEO of MTMC.

Mr. Archer: Expressed he has received a great welcome from staff and he's glad to be back in the foothills, the Joint Commission is on site so will get a fresh start in that process; he wants to partner as there is an increasing demand for services.

Ms. Reed: Thanked Mr. Philipp for his most-recent 8-month interim CEO visit; the Joint Commission team was at the Corp. Board meeting and it was positive; the hospital had a good month financially; surgery numbers have increased; staff is still needed in the clinics, but Copper will soon be welcoming a provider.

Ms. Atkinson: The Corp. Board approved the 3rd set of by laws for the lease; the Angels Camp clinic expects has a new completion date for early Sept; Cerner EHR is on target for this July; the new CFO, John Chivers will start in mid-April.

D. Stay Vertical Calaveras:

Mr. Shetzline: With the help of instructors led the group in a Tai Chi exercise and expressed the success of the program; there will be Spring and Summer classes; newly opened Better Together will start a class on April 8th.

Dr. Smart: The District has been receiving lots of good feedback about the program which is an in-house program.

E. Ad Hoc Real Estate:

- **Update on the Valley Springs Health & Wellness Center**:

General Comments: To address the local query advertise what services the VS H&W Center will provide.

  - **Construction:**

Dr. Smart: Mr. Van Lieshout was on vacation and called in for the site meeting; the project is on budget; Mr. Van Lieshout helps with budget items; purchases have begun for furniture and IT which is part of the $600k budget.

Ms. Al-Rafiq: Windows were installed, and the contractors are good about answering questions regardless of simplicity.

- **Project Manager:**

Mr. Van Lieshout: The construction contract was for 300 days and to end in early July; the rain has cause for some delay in the site work and could push the completion date into Sept; the contractor hopes to make up lost time come dryer weather.

- **Operations and Development:**

Dr. Smart: Took Cheryl Duncan, Consultant to see the project giving her an inside perspective of the flow that's planned for the clinic; he has been training with Athena and likes the EHR very much.

- **VS H&W Center Manager:**

Dr. Smart: There is a Personnel Ad Hoc meeting today; he expects to advertise for a manager that will report to the CEO in May/June and hire in July.

- **Employee Benefit and Wages:**

Dr. Smart: Has been meeting with the consultant and employee benefit plan vendors to develop an employee benefit package.

- **Update on Valley Springs Property – Phase II:**

Ms. Al-Rafiq and Ms. Reed visited a PACE project in Stockton and found it to be an amazing program; the open concept allows for community gathering and provides PT, exercise, clinic options etc.; the program is for the 55+ year-old person that lives at home; it's a day facility for Lodi, Stockton and part of Stanislaus County residents; upon joining the program each person receives an individual case management program designed for their care; there is a doctor on site and the focus is to keep those that belong to the program out of the emergency rooms; the Stockton facility is newly built where as the other 5 locations are in a remodeled space.

Ms. Al-Rafiq: Is also working with a Sacramento developer that is interested in what the District is considering for the VS property; she is also having conversations with USDA for what might be possible at the VS Property.

General Comments: Would like to see a PACE or similar program in Calaveras; there is a real need for elderly care; need to encourage respite care for the caregivers.

7. <u>Committee Reports</u>:

A. Finance Committee:

- **Financial Update**:

Mr. Wood: Reviewed his Feb. Financial narrative saying eight months into the budget-year the District looks good; clinic equipment will be capitalized and be on the balance sheet.

Dr. Smart: Along with Kelly Hohenbrink, Consultant, are working on the VS H&W Center budget.

- **Financial Statements (Feb. 2019) Recommendation-Approval**: Action

Ms. Atkinson moved to approve the financial statements. Ms. Radford provided her second and the motion passed 5-0

- **Investment Activities**:

Mr. Wood: A Cal Trust account was opened in March and $250k was deposited at 2.56% which is better than the industry standard Local Agency Investment Fund (LAIF) at 2.4%; he will be updating the balance sheet; per Government Code 53646 and 53607 he will be preparing a spread sheet to show investments; he suggested the District add to their April Agenda (and do annually) to delegate who will be making the investment transactions; he recommends it be the CEO.

- **Community Member:** Action:

Ms. Atkinson: Introduced Lori Hack stating her 25 years' experience in the field and with her own firm, Object Health LLC, (pkt. pg.116-118) and how she wanted to serve on the Finance Committee.

Dr. Smart: Initially met Ms. Hack six or seven years ago when she was a consultant to his private practice. That experience was a positive one.

Ms. Hack: Recently moved to the Arnold area, saw the District's ad, was surprised to hear Dr. Smart was the CEO. She wants to be supportive of her community and join the Finance Committee.

MS. Radford moved to approve Ms. Hack to join the Finance Committee. Ms. Sellick provided her second and the motion passed 5-0.

F. Ad Hoc Lease Review Committee:

- **Bylaws – Oversite Committee:** Action

Ms. Reed: After four years of negotiating the new lease it is scheduled to close on April 30th and starting the new lease on May 1st, 2019.

Dr. Smart: The Bylaws before the Board is the ninth document in the lease package. The lease process has taken the District to the California State Attorney General's office as well as to the Vatican. The Amended and Restated Bylaws of the Designated Procedures Oversite Committee (pkt. pg. 119-127) has to do with the election to have sterilization procedures. It has no bearing on the District but states the difference in the Catholic and non-Catholic hospitals. There are 12 Catholic hospitals. MTMC is the 12th of 12 non-Catholic hospitals and does have providers that perform sterilization procedures. The bylaws have no consequence to the District which is the landlord however it is part of the lease documents and needs the Board's approval.

Ms. Atkinson moved to approve the bylaws. Ms. Al-Rafiq provided her second and the motion passed 5-0.

G. Ad Hoc Policy Committee:

Ms. Atkinson: The Committee didn't meet this month, but members have three policies to review before the next meeting.

H. Ad Hoc Community Grant:

- **Recommendation for Awarding Grants:**

Ms. Radford: The Community Grants Committee met and reviewed 28 applications; the Committee budget is $135k; Board members have until April 20th to review an office copy and make a recommendation to the Committee; a May reception will be planned for the recipients.

8. Board Comment and Request for Future Agenda Items:

A. Announcements of Interest to the Board or the Public:

9. Next Meeting:

A. Wed. April 24, 2019

11. Adjournment: Action**:**

Ms. Radford moved to adjourn the meeting at 9:58am. Ms. Atkinson provided her second and the motion passed. 5-0.

From: Butzler, Dakota <BUTZLER@hartford.edu>
Sent: Monday, April 15, 2019 8:36 AM
To: Peggy Stout <pstout@mthcd.org>
Subject: Dakota Butzler Scholarship Recipient Follow-Up

Hi Peggy,

My mom Caprice mentioned that you had asked her if I would be able to send you a follow-up email regarding my college experience, my plans and how the iPad played a part in my academic success. I am still so thankful that I was chosen to receive the iPad scholarship 4 years ago and would be more than happy to give you an update.

I have been attending the University of Hartford in Connecticut since I graduated from Calaveras High School in 2015. I am in an accelerated 5 year undergraduate and graduate program majoring in prosthetics and orthotics. From the fall semester of 2015 through the spring semester of 2018 I was a full time undergraduate student while also playing on the university's Division I women's volleyball team. However, due to the accelerated academic program, I had to stop playing volleyball when I became a full-time graduate student in the summer of 2018.

In December of 2018, I graduated Summa Cum Laude with a Bachelor of Science from the University of Hartford. I am now one full year into the master's portion of the program. In May of 2020, I will graduate with a Masters of Science in Prosthetics and Orthotics. After graduation, I will have to complete a 2 year residency before I can sit to take my board exams in order to become a certified clinician.

The iPad has played a huge role in my academic success. Especially while being a student-athlete, having the iPad gave me the opportunity to do school work virtually anywhere. Even while traveling, I never missed a beat in any of my classes. It also allowed me to video chat with my family and keep in touch with them from all the way across the country. For my busy lifestyle, the iPad truly was an indispensable tool.

Thank you so much for your generosity 4 years ago and I hope that you can continue to award high school graduates for many years to come. Please email or call me if you have any further questions or need any more information.

Best,

Dakota Butzler
dakotabutzler@gmail.com
209-981-7914

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

ACHD Advocate
April 2019

In This Edition:

From the Desk of Ken Cohen, Chief Executive Officer

Weeks like this one remind me just how proud I am to lead our organization and work with each of you to promote the profound role Healthcare Districts play in responding to the specialized health needs of all Californians while also having direct accountability to the communities you serve.

ACHD Members gathered Monday and Tuesday for our 2019 Legislative Day where we were joined by Assemblymember Cecilia Aguiar-Curry, who encouraged Districts to share stories of how their Districts are helping to provide care for Californians. We also heard from Michelle Baass, Undersecretary for the California Health and Human Services Agency, who provided insight on the Agency's priority issues and Governor Newsom's health care agenda. You can watch a recap video of our event here.

As ACHD members headed to the Capitol to meet with their legislators, Valerie Lakey with Mayers Memorial Hospital District took time to voice support for AB 890 before the Assembly Business & Professions Committee on behalf of ACHD. This bill, by Assemblymember Jim Wood, would authorize nurse practitioners to practice to the full extent of their education and training without the involvement of physicians. ACHD believes it is one solution to the workforce shortages many of our Districts grapple with as they provide care for Californians. You can learn more about this bill in a story by the Los Angeles Times this week.

Certainly, we continue to see that it's a busy year in Sacramento and that makes our collective advocacy work essential. Thank you for your contributions to the ACHD Team.

Scenes from Legislative Day

Legislative Update

Legislative Day served as a great way to connect members with their legislators and advocate on legislation that will improve the health and infrastructure of your communities.

Post Legislative Day, the ACHD Advocacy Team continues to engage with legislation that may impact Healthcare Districts this year. April 11 marked the beginning of Spring Recess. When the Legislature returns on April 22, bills will face a policy deadline of April 26. You can view our current Legislative Reports here. Additionally, you can view committee hearings and floor sessions on CalChannel.

ACA 1:
ACHD continues to focus on ACA 1 (Aguiar-Curry) that would give local governments improved options for funding critical infrastructure projects by creating a new voter approved mechanism with a vote threshold of 55% to approve local general obligation (G.O.) bonds and special taxes. The constitutional amendment was approved by the Assembly Local Government Committee on a 5-2 vote and will be heard next in the Assembly Appropriations Committee. If approved by both houses with a 2/3 vote, ACA 1 will be placed on the next general election ballot for a vote of the people.

AB 890:
AB 890 (Wood) would expand the scope of nurse practitioners, allowing them to practice to the full extent of their education and training. This measure is essential to ensuring Districts can reach everyone who needs health care, especially in rural and underserved areas of the state. ACHD continue to work in the Legislature to educate and advocate on this measure. The measure passed 16-0 out of Assembly Business and Professions and will be herd next in the Assembly Appropriations Committee.

ACHD continues to advocate on bills as they move through policy committees. For a full report of legislation ACHD is engaged on visit achd.org.

Calling Community Leaders - James Irvine Foundation Leadership Awards

The James Irvine Foundation

Do you know a leader in your community who is advancing breakthrough solutions to critical issues facing California? Every year, the James Irvine Foundation Leadership Awards recognize individuals who are doing such work, granting each recipient's organization $250,000, and helping them share their solutions with policymakers and peers.

Nominations are now open and will be accepted until April 26, 2019. Leaders can be from the nonprofit, private, or public sector. More about the selection criteria and a link to the online nominations form can be found at https://irvine.ly/nominate.

Webinar Education Series

Satisfying Capital Requirements for Seismic Retrofitting Compliance
April 25, 2019 at 10:00AM

Join us and learn more about California hospital construction costs and the status of state mandated requirements that could impact your balance sheet. Anthony J. Taddey of WIPFLi CPAs and Consultants will present this webinar.

Register Here

To access webinars on demand, click here.

The Association of California Healthcare Districts (ACHD) represents Healthcare Districts throughout the state's urban, suburban and rural areas. California is home to 79 Healthcare Districts that play a profound role in responding to the specialized health needs of local communities by providing access to essential health services to tens of millions of Californians while also having direct accountability to the communities that Districts serve. In many areas, Healthcare Districts are the sole source of health, medical and well-being services in their communities.

Learn more at www.achd.org.

Association of California Healthcare Districts
www.achd.org

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Use of Gloves	REVIEWED: 11/30/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Use of gloves

Objective: To ensure staff and patient safety and to support infection control protocols, staff members will wear gloves when it is possible they will come in contact with blood, other body fluids, contagious organisms and/or disinfecting and sterilizing agents.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. In the Clinic, gloves must be worn when:

   a. Touching blood and body fluids/secretions, mucous membranes, or non-intact skin of all patients (cuts, scratches, rashes, scaling, lesions, etc.) (Some examples of body fluids include: urine, feces, saliva, blood, semen, vaginal secretions, perspiration, tears, sputum, infectious discharge from any area of body, menstrual fluids, amniotic fluid, oozing from a burn, or under a scab etc.)

   b. When handling items or surfaces soiled with blood or body fluids. (See above)

   c. The healthcare worker has cuts, scratches, or other breaks in the skin.

   d. The healthcare worker judges that contamination may occur (i.e. uncooperative or fearful patients or children, or patients with poor personal hygiene).

   e Performing finger and/or heel sticks on infants and children or adults.

   f. Performing phlebotomy.

   g. Cleaning up where body fluids contaminate surfaces.

   h. Working with patients with communicable disease symptoms.

   i. Performing any type of procedures where the intended procedure will

break intact skin, i.e. injections, etc.

j. Performing waived testing or securing lab specimens.

k. The healthcare worker is in any situation when possible contamination with body fluids may occur, as deemed possible by healthcare worker.

2. In the Clinic, gloves need not be worn when contact with the patient is unlikely to result in exposure to blood or other body fluids. Examples include:

a. Shaking hands/greeting patient(s).

b. Delivering *oral* medications.

c. Giving prescriptions and other educational/handout information.

d. Taking blood pressure, pulse.

f. Taking patient chief complaint or history.

g. Handling of medical record (patient chart).

3. Rationale for why to use gloves

a. Provide protective barrier to employee.

b. Reduce the likelihood of personnel to transmit organism(s) to another patient or other employees.

c. Reduce likelihood of transmission from contaminant to healthcare worker.

(Gloves are disposable single use, and must be disposed of after a single use.)

4. Gloves must always be changed after handling blood/body fluids before continuing care of the SAME patient to prevent cross-contamination from one site to another site on that same patient.

5. Gloves are disposable; single use only!.

6. Hands are to be washed ***before*** putting gloves on and ***immediately after*** removing them.

7. Alcohol-based hand sanitizing gel is to be used only when hands are known to not be visibly soiled. If hands are VISIBLY soiled, alcohol gel is not to be used, and hands are to be washed under running water with soap, water, and plenty of friction.

RESOURCE:

- World Health Organization. Glove Use Information Leaflet. August 2009. Retrieved 3/11/15 from http://www.who.int/gpsc/5may/Glove_Use_Information_Leaflet.pdf

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: EMERGENCY RELEASE OF PATIENT RECORDS	REVIEWED: 11/30/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Emergency release of patient medical records

Objective: For the purpose of continuity of Clinic patient care, the Clinic will act immediately on a request for patient records from a requesting emergency room in lieu of standard medical record release procedures.

Response Rating:

Required Equipment:

Procedure:

1. On request from a hospital emergency room, Clinic employees will immediately respond to fulfill the request for transfer of patient medical records to the emergency physician.

2. In lieu of the procedure for release of patient information, the staff member receiving a request for patient records from an emergency room shall immediately notify the Clinic staff member responsible for release of medical records.

3. The employee assigned to transfer the medical record will prepare chart notes to reflect what the hospital emergency room has requested from the medical record, the name of the physician requesting the information and the date and time of the request.

4. The records requested will be faxed to a secure fax number provided by the requesting emergency department. A notation will be recorded indicating the date and time the medical records were sent, as well as the fax number to which the records are sent.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Medication Reconciliation	REVIEWED: 11/30/18
SECTION: Patient Care	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Medication reconciliation

Objective: In order to maintain and communicate accurate patient medication information, care providers will create an accurate list of a patient's medications at time of intake to the clinic, reconcile discrepancies, and ensure update with any medication additions/changes made during the encounter. A copy of the list will be available to the patient upon discharge from the clinic.

Response Rating:

Required Equipment:

Definitions:

Medication: for the purposes of this policy, the term medication denotes any of the following:

- Prescription medications
- Sample medications
- Herbal remedies, nutriceuticals, vitamins, and over-the-counter medications
- Diagnostic and contract agents
- Radioactive medications
- Vaccines
- Respiratory therapy-related medications
- Parenteral nutrition
- Blood derivatives
- Intravenous solutions either plan or with additives
- Any agent classified by the F.D.A. as a drug

Procedure:

1. Patients should be encouraged to bring their medication vials and/or a list from their pharmacy to each clinic visit.

2. During the intake process, which is completed in the examination or procedure room, the Medical Assistant will obtain a list of the patient's current medications. This list will include medication name, dose, route, and frequency.

3. Refer to the list above to ensure all medications are included.

4. The medication list will reside in the Electronic Medical Record, if in use. If the clinic utilizes a paper medical record, the medication reconciliation form will be utilized. Two patient identifiers will be placed on the paper form.

4. The physician will review the list, include any changes to current medications and medications added to the patient's regimen as a result of the current examination/treatment. The list will be signed and dated by the physician.

5. The patient will be offered a copy of the current medication reconciliation upon discharge from the clinic.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Radiology Department Safety Guidelines	REVIEWED: 11/21/18
SECTION: Safety	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Radiology Department Safety Guidelines

Objective: To outline radiology department guidelines to support patient and staff safety in accordance with California Radiation Control Regulations.

Response Rating: Mandatory

Definitions:

A.L.A.R.A. – As low as reasonably achievable; limiting radiation exposure to patients by ensuring that proper procedures and techniques are followed to prevent the need for repeated imaging because of sub-optimal image quality.

Procedure:

1. No x-ray worker shall be used to hold patients or films except in an emergency and no person shall be regularly used for this service. If an individual must hold the patient, that individual shall be protected with appropriate shielding devices such as protective gloves and apron and they shall be so positioned that the useful beam will strike no part of their body. [17 CCR §30308 (b)(1)].

2. Only individuals required for the radiographic procedure shall be in the radiographic room during the exposure, and except for the patient, all such persons shall be equipped with appropriate protective devices. [17 CCR §30308 (b)(2)].

3. The radiographic field shall be restricted to the area of clinical interest. [17 CCR §30308 (b)(3)].

4. Gonadal shielding of not less than 0.5mm lead equivalent shall be used for patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the direct beam, except for cases in which this would interfere with the diagnostic procedure. [17 CCR §30308 (b)(4)].

5. The operator shall stand behind the barrier provided for their protection during radiographic exposures. [17 CCR §30308 (b)(5)].

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: RADIOLOGY SAFETY	REVIEWED: 11/21/18
SECTION: SAFETY	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Radiation Safety

Objective: Safety of personnel and patients in Radiology Department

Response Rating: Mandatory

Procedure: Radiation Safety and Protection Program

Organization and Administration

1. Supervising Radiological Technician will be responsible for the implementation and enforcement of all Radiation Safety and Protection procedures.

ALARA Program

1. The radiology department shall use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).

2. All technicians working in the radiology department will be required to use tested and approved techniques posted at the x-ray console in the radiology department to achieve the principles of the ALARA program.

Dosimetry Program

1. All technicians will be required to wear approved film badges that will monitor their doses of radiation while working within the radiology department.

a. Film badges will be left in the radiology office upon end of shift. Badges are NOT to be taken out of the radiology department.

b. A Control film badge will be kept in the radiology department at all times conspicuously located on the bulletin board.

2. Film badges will be monitored, checked, and documentation will be provided on a quarterly basis.

3. Radiation dosimetry reports will be reviewed and initialed by the supervising radiologist on a quarterly basis. Copies of these reports will be made available to all technicians involved in the dosimetry program.

4. Technicians will be instructed on the proper use of individual monitoring devices including consequences of over exposure to radiation.

Radiological Controls

1. Entry and Exit Controls

    a. The two doors entering the radiology department will be locked at all times when an exam is in progress.

2. Posting Requirements

    a. The two doors entering the radiology department will be posted with a sign indicating a radiologic exam is in progress and to Not Enter

    b. A current copy of Department Form RH-2364 (Notice to Employees) will be posted in the radiology department office for all employees to read.

    c. A copy of the CCR 17 with a copy of operating and emergency procedures applicable to work will be available to employees in the radiology department for review.

Disposal of Equipment

1. Any sale, transfer, or discontinuance of use of any reportable source of radiation will be reported in writing to the Department.

Other Controls

1. Positioning aids, gonadal shielding, protective aprons, and protective gloves are available within the radiology department for shielding patients from over exposure to radiation.

    a. These aids will be tested annually and logged to ensure the integrity of the devices.

Record Keeping and Reporting

1. Supervision of all record keeping will be the responsibility of the Supervising Radiologic Technician.

2. Records kept on hand are in the Radiology Department:

    a. Daily log of patients and exams
    b. Records release forms (disc's of digital images for patients)
    c. Radiation Dosimetry Reports
    d. Digest of new regulations to CCR 17
    e. Log of testing of Radiation Protection devices

Training

1. Operating and Safety Procedures

    a. Safety Procedures for radiology equipment are delineated in the Operational Manual provided by Fujifilm Corporation on the FDE D-EVO (DR-ID 600). These procedures are located in the Radiology Department.

2. On a quarterly basis all radiological technicians will be instructed in the health protection problems associated with exposure to radiation, in precautions or procedures to minimize exposure, instruct such individuals in, and instruct them to observe, to the extent within their control, the applicable provisions of Department regulations for the protection of personnel from exposures to radiation occurring in the radiology room.

    a. These training sessions will be documented and that documentation will be kept in the radiology department office.

3. Technicians will be reminded of their responsibility to report promptly to the administrative staff of the Health Care District any condition that may lead to or cause a violation of department regulations or unnecessary exposure to radiation.

4. Technicians will be instructed in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation and advise them as to the radiation exposure reports which they may request.

Quality Assurance Programs

1. Every six (6) months the radiology equipment will be subjected to a preventative maintenance inspection by qualified radiological maintenance personnel.

    a. Any repairs necessary to maintain the safety and functionality of the equipment will be documented and that documentation will be kept in the radiology department office of later review.

    b. It will be the responsibility of the Radiology Supervisor to keep and maintain these records.

Internal Audit Procedures

1. This procedure will be reviewed on an annual basis.

    a. The procedure will be reviewed by the Supervising Radiologic Technician.

b. All Radiologic Technicians in the Radiology Department will review and sign the procedure after each annual review.

2. A copy of this procedure will be available in the Radiology Department for review by personnel.

3. This procedure will also be placed in the Policy and Procedures manual of the West Side Health Care District.

Reference: California Code Regulations, Title 17

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Monitoring Inspection of Medication Inventory	REVIEWED: 11/21/18
SECTION: Medication Management	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Monitoring inspection of Clinic medication inventory

Objective: To ensure that medications are properly stored throughout the Clinic, the designated staff member shall inspect every nursing station, medication room, cart or other area where medications are stored, at least once each month, document their findings and share those findings with Clinic Manager, Medical Director and/or designee.

Response Rating: Mandatory

Required Equipment:

Definitions:

Procedure:

The designated person shall:

1. Insure that antiseptics or other drugs for external use, and disinfectants, are stored separately from medications intended for internal or injectable use.
2. Insure that special storage conditions are met when necessary to assure stability.
3. Identify outdated medications and remove them from the Clinic inventory to prevent inadvertent administration.
4. Check the supply of emergency medications for correctness and remove outdated medications.
5. Check that metric and apothecary conversion charts are posted.
6. Review and document refrigerator, freezer, and medication room temperatures and submit that information as a part of the ongoing Quality Assurance/Performance Improvement program.
7. Review each area where medication is stored for cleanliness, presence of non-stock medications and samples, adequate security and other conditions deemed necessary by the District and Medical Staff and submit documentation of the review as a part of the ongoing Quality Assurance/Performance Improvement program.

8. Areas out of compliance will be reviewed and corrected by the Clinic Manager.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: MEDICATION WASTE STREAM	REVIEWED: 11/21/18
SECTION: MEDICATION MANAGEMENT	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Management of medication waste stream

Objective: The secure management of medication waste, including outdates and less than full dose amounts.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Non-scheduled drugs are placed in the medication disposal bucket that can be found in the Medication Room.
   a. Outdated medications or less than one dose quantities.
   b. Waste is documented by the Clinic Manager, or designee, on the current Medication and Supply Waste Documentation form. The completed form is submitted to the Medical Director for inclusion in the QAPI review.
   c. The non-scheduled drug waste stream vendor is XXXXXX.
   d. When the bucket is full, follow directions provided by the vendor for the return of the bucket.
   e. Upon receipt of the full bucket, the vendor will return a new, replacement bucket to the Clinic.
   f. Under no circumstances are outdated or less than one dose medications diverted from the approved waste stream.

2. Scheduled drugs are placed in the secure medication disposal bucket, which can be found in the freezer located in the Medication Room. Scheduled medication waste must be witnessed as demonstrated by a co-signature in the manual system under the patient's name
   a. Outdated medication or less than one dose quantities
   b. Waste is documented by the Clinic Manager, or designee, on the current Medication and Supply Waste Documentation form. The completed form is submitted to the Medical Director for inclusion in the QAPI review.
   c. Scheduled drugs are documented in the XXXXXX online narcotic medication inventory. All required fields, including NDC number and specific quantity will be submitted.
   d. The controlled substance waste stream vendor is XXXXXX.

e. When the bucket is full, the Clinic Manager, or designee, will contact the vendor and request return instructions and will follow those instructions in order to safety forward the wasted medications to the vendor.

f. A new secure medication disposal bucket will be placed in the freezer, which can be found in the Medication Room to accommodate new wasted medications.

g. Under no circumstances are outdated or less than one dose medications diverted from the approved waste stream.

3. Wasted injectible schedule medications cannot be placed in the secure medication disposal bucket.

a. With a witness present, draw up amount to be wasted into a syringe.
b. Discharge the medication from the syringe into the sink drain and run tap water down the drain.
c. Dispose of the used syringe in the sharps container.
d. This medication waste must be witnessed demonstrated by a co-signature in the XXXXXX system under the patient's name

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Medication Management – Storage of Multi-Use Containers	REVIEWED: 11/21/18
SECTION: Medication Management	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Medication management and storage of multi-use containers

Objective: To utilize multiple dose vials appropriately; to store and manage open multiple dose vials in a safe and appropriate manner.

Response Rating: Mandatory

Required Equipment:

Definitions:

Procedure:

1. Upon opening of a multiple dose container/vial (with preservatives), nursing staff shall affix a "vial open" label to the container. Label will include expiration date for each vial that has been opened and will also state "MV" to indicate multi-dose vial.
2. For sterile medications: when staff has used aseptic technique, the shelf life of the open vial will be twenty-eight (28) days or the manufacturer's expiration date, if shorter. The vial will then be discarded regardless of the expiration date of the medication.
3. For non-sterile medications, the expiration/discard date shall be one year from the date of opening or the manufacturer's expiration date, if shorter. This policy includes hydrogen peroxide and betadine.
4. Single-dose vials (without preservatives) shall be discarded after initial puncture
5. Immuno-compromised patients should not have medications administered from previously used multi-dose vials.
6. If suspected contamination has occurred with any open container/vial of medication, that container/vial will be discarded immediately.
7. Opened multi-dose vials will remain in the medication room. Opened multi-dose vials removed from the medication room will be disposed of immediately after use.
8. Wasted/discarded vials will be documented in the medication management waste stream, as well as the medication management machine to ensure accurate inventory management and timely replacement of inventory.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Look-Alike Sound-Alike Medications	REVIEWED: 11/21/18
SECTION: Medication Management	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Look-Alike Sound-Alike Medications

Objective: To reduce medication errors, the Clinic will use the ISMP List of Confused Drug Names to indicate and delineate Look-Alike Sound-Alike medications.

Response Rating: Mandatory

Required Equipment:

Definitions:

Procedure:

1. Existing policy requires that the Clinic will maintain a formulary that represents the medications to be maintained for use in patient care.
2. The formulary will be compared to the ISMP's List of Confused Drug Names and any medications found on that list will be renamed on the formulary.
    a. To reflect the recommended "tall man" lettering.
    b. If no "tall man" lettering option is available, the medication name will be listed in bold font to indicate its Look-Alike Sound-Alike status.
3. The medication storage system will be labeled using the recommended "tall man" lettering" and/or bold font to indicate its Look-Alike Sound-Alike medications
4. The medication library in the Electronic Medical Record will be prepared utilizing the recommended "tall man" lettering for any Look-Alike Sound-Alike medications.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: FORMULARY	REVIEWED: 11/21/18
SECTION: MEDICATION MANAGEMENT	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Formulary

Objective: A formulary for the Clinics will be developed, followed and updated.

Response Rating:

Required Equipment:

Procedure

1. A Clinic formulary will be developed, followed and updated after consultation with the Medical Director, Clinic practitioners, and other appropriate personnel, as required.

2. Additions, deletions, revisions to the formulary will be managed through the use of a chargemaster management form, as required by policy. At a minimum, the form will document who requested the change, item details, CPT code, charges, addition to chargemaster, staff training.

2. Clinic formulary will be approved by the Medical Director.

3. Strengths of medications will be limited to the smallest number of variations required to appropriately address patient needs.

4. Additions, deletions, and other changes to the Formulary will be discussed at the Clinic Medical Director meeting(s).

5. A copy of the current formulary will be available in the Clinic for review by practitioners, at their request.

6. A copy of the current formulary will be available in the Clinic in the medication management area.

7. Monthly Medication Management surveys of the Clinic will include inventory review using the Formulary as a resource.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Drug Samples	REVIEWED: 11/21/18
SECTION: Medication Management	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: In order to ensure compliance with approved formulary and medication management policy, drug samples are not permitted in the Clinic.

Objective: Mandatory

Response Rating:

Required Equipment:

Definitions:

1. Drug Sample: a unit of a drug, which is not intended to be sold and is intended to promote the sales of the drug.

Procedure

1. Drug samples are not allowed in the Clinic.
2. Medical Director and Clinic Director will ensure no drug samples exist in the Clinic.
3. Drug samples found will be confiscated by Clinic Manager and placed in the medication waste stream, after being removed from their packaging.
4. Drug company sales representatives who present themselves to the Clinic will be advised that they must have an appointment to meet with the Medical Director and may leave printed materials, but no drug samples or drug sample vouchers.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: TRANSFER OF PATIENT – CHART INFORMATION	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Transfer of Patient – Chart Information

Objective: To provide required documentation in support of continuity of care.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. A copy of current visit note should accompany a patient being transferred to a higher level of care. Receptionist staff will begin printing/copying documentation when notified to do so by nursing staff.

2. Patient Consent to Transfer Form must be signed if the patient is able to do so. If the patient is unable to sign and a family member is with them, the family member may sign the Transfer Consent form. If the patient is unable to sign and is unaccompanied, the content will be marked "Patient unable to sign" and will be signed and dated by the Clinic staff member.

3. The following information should accompany the patient to the hospital:

    a. Patient demographic sheet
    b. Current visit note
    c. Any additional nursing or physician notes
    d. Copies of current lab results
    e. Copy of EKG monitor strips, if applicable
    f. Copy of x-rays, if applicable

4. If the visit note is not completed prior to transfer of the patient, the practitioner will ensure the note is completed and direct staff to transmit the same to the receiving hospital using either a secure fax number for the EMR interface capabilities.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: RETENTION OF RECORDS	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Retention of medical records

Objective: Inactive paper medical records will be retained in a secure location and inactive electronic medical records will be archived and retrievable in accordance with HIPAA and other relevant standards.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Electronic medical records will be archived when the patient has not been seen in the Clinic for three years.

2. Paper files will be checked for inactive status each year in January.

3. A log of medical records that have been archived will be developed, maintained and updated as follows:

    a. Annually, when new records are moved from active to archived status.
    b. On a case-by-case basis, when archived records are returned to active status due to a patient returning to the Clinic after a hiatus of three (3) years or more.

4. Inactive medical records will be retained as follows:

    a. Pediatric to the age of majority plus one year or seven years after the last discharge date, whichever is longer
    b. Adults for seven years after the last discharge date.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: MEDICAL RECORD TRANSFER	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Transfer of medical records

Objective: A patient or his/her representative is entitled to access to the patient's health record. Record transfers shall be done upon appropriate request.

Response Rating:

Required Equipment:

Procedure:

1. A release of information form will be signed and dated by the patient or their legal representative.

2. Release of information will include the patient's name, date of birth, and destination of the records.

3. Confidentiality of records will be stressed to all patients or legal custodians who hand carry records.

4. Records will not be transferred without patient or legal representative signature (telephone requests from medical offices, insurance companies or other parties will not be accepted).

5. At no time will records be transferred or released if there is a question regarding legality and/or legitimacy of the requesting individual.

6. The medical records personnel will be responsible for monitoring the transfer of records.

7. When records are being transferred to an entity other than an affiliated Clinic or recognized health care entity, a charge will be made to the patient. The copied records will not be released until payment has been received.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: SECURITY AND RETENTION OF MEDICAL RECORDS	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Security and retention of medical records

Objective: Patient medical records will be maintained in an Electronic Medical Record application (EMR). Should downtime processes be required, all paper medical records in the Clinic shall be kept in a secure locked location until they can be scanned into the EMR.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. The Clinic will utilize an Electronic Medical Record (EMR) to record patient demographics, problem list, medication list, and documentation of treatment rendered.

2. Should the EMR be unavailable due to downtime of the system, power failure or other unexpected event, paper forms will be used to document patient demographics, problem list, medication list, and treatment rendered.

3. Any paper records generated will be stored in the secure, locked location (drawer, cabinet, desk) located in the receptionist work area until Clinic staff can scan those paper records into the EMR.

4. After being scanned into the EMR, the paper records will be forwarded to the Administrative Medical Assistant to ensure claims are created for each patient encounter.

5. Medical records may be handled only by providers involved in the care of the patient, designated Clinic employees and employees of copy services who have signed authorizations to duplicate records.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: MEDICAL RECORDS RELEASE	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Release of medical records

Objective: To ensure that authorization for release of patient medical information is valid, requirements for patient authorization under the Confidentiality of Medical Information Act will be followed.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. To be valid, authorization for a provider to release patient medical information must be:
   a. In writing.
   b. Executed by a signature that serves no purpose other than to execute the authorization.
   c. Signed and dated by one of the following:
      1. The patient.
      2. The legal representative of the patient, if the patient is a minor.
      3. The legal representative of the patient, if the patient is an adult with a guardian.
   d. The limitations, if any, on the types of medical information to be disclosed.
   e. The name of the health care provider that may disclose the medical information.
   f. The name of the person or entities authorized to receive the medical information.
2. The designated employee will give a medical records release form to the person requesting records.
3. The form must be completed and signed before a witness, who will also sign the document.
4. The signed, completed document will be kept in the medical record and the requested records will be released to persons requesting them or their designee.
5. A copy of the signed, completed request form will accompany the records being sent.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: MEDICAL RECORDS FORMS AND FEES	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Medical Records Forms and Fees

Objective: To cover the costs of document production and printing, in some instances fees will be assessed to complete forms on behalf of the patient and to provide copies of some documents.

Response Rating:

Required Equipment:

Procedure:

1. The following forms will be completed at the patient's request upon receipt of payment by the patient

    a. Personal disability insurance forms (income, mortgage, credit)
    b. Supplemental forms related to State or Federal disability insurance
        1. Initial forms will be completed without charge
        2. Supplemental or secondary forms will be completed at a cost of $10 per form, due and payable at the time the form is brought to the Clinic.

2. Forms will be completed within 7 business days

    a. Form may be completed by the RN or designee, for approval by the physician
    b. All forms must be reviewed, signed, and dated by the physician
    c. The completed form must be scanned into the patient's EMR
    d. If the EMR is not available, a paper copy of the form will be made and retained until such time as the EMR is available, at which time the document will be scanned into the EMR and the paper copy destroyed.

3. The patient will be notified by telephone that the form is completed.

    a. The form may be mailed to the patient's home address, if they request.
    b. The completed form may be picked up by the patient, after they provide photo ID or to their designee with written permission and a photo ID.

4. Patients requesting copies of their medical record may be charged for those copies unless those copies are requested and transmitted via the Patient Portal:

    a. Copies of current laboratory results will be provided at no charge.
    b. Copies of the medical record being sent to a referral physician will be sent at no charge.
    c. Copies of the medical record being sent when the patient is moving their care to another practice will be sent at no charge.
    d. Copies of the patient's immunization card will be provided at a cost of $5, due and payable at the time the copy is made.
    e. Copies of the patient's medical record, for the patient's use and not for transfer to another physician, will be provided at a cost of $0.25 per page but not to exceed $25.00, due and payable at the time the copy is made.
    f. A current signed medical records release form must be submitted at the time of the request and payment.

4. Subpoenas will be forwarded to the medical records office and responded to by the Medical Records Clerk.

5. A fee of $35.00, payable in advance, will be collected for each subpoenaed record.

6. Patient requests for medical records will be forwarded to the medical records office and responded to by the Medical Records Clerk.

    a. Exceptions will be processed in the clinic
    b. Exceptions will be limited to: immunization card, most recent lab results, most recent physical examination report, most recent discharge/visit summary

7. A medical records release form will be required for each request.

8. All requests will be logged upon receipt and all records sent, released, or mailed will be logged when leaving the clinic.

9. Funds collected for records copies will be logged upon receipt.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: CORRECTION OF INFORMATION IN THE MEDICAL RECORD	REVIEWED: 11/21/18
SECTION: MEDICAL RECORDS	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Correction of information in the medical record

Objective: Information placed in the medical record will be accurate.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. All entries into a paper medical record (chart) will be made in blue or black ink.

2. Should it be necessary to correct information in a paper medical record, the following steps will be taken:

   a. Draw a single fine line through the error
   b. Print "error" on the cross out and initial and date
   c. Enter the correct information adjacent to the correction and initial and date

3. Corrections to the Electronic Medical Record (EMR) will be documented as correcting entries or late entries, depending upon the reason for the additional information and/or revision.

Mark Twain Health Care District
Strategic Matrix 2018

	A	B	C	D
1	**Strategic Action Item**			
2		**Person Resonsible**	**Expected Date**	**Completed**
3				
4	**Valley Springs RHC**	**Real Estate Com**		
5	Develop Budget /Operational Plan for VS RHC 1206B	Smart		10/2/2018
6	Electronic Medical Records linked to billing & compatib	Smart	12/20/2018	Completed
7	Explore leasing ancillary functions from MTMC	Smart	on going	
8	Gantt Chart From Walter	Smart		3/12/2018
9	Physical Address (Pending Name for Access Street)	Stout		6/14/2018
10				
11				
12	**MTHCD Public Image and Communication**			
13	District Name Change			
14	Public Relations Strategy			
15	In-Kind Funding			
16	Doodle Scheduling On-Line	Stout		4/28/2018
17	Explore Options as District "convener" of County Care			
18				
19	**Accounting Service**	Finance Comm		
20	Plan/Contract for New District Accounting Services			11/1/2018
21	Written Plan for reserve accounts (ex. Seismic Retrofit)	Smart & Krieg		12/20/2018
22	Storage boxes	Smart		1/1/2019
23	Financial Report Dashboard	Wood		3/27/2019
24				
25	**District Records**			
26	Fine-Tune District Records Disaster Plan	Stout & Computer		Nov-18
27	Develop Record retention plan (state law) Attny	Policy Committee		1/1/2019
28	District Records-Back UP	Stout		6/14/2018
29				
30	**Committee Structure**	Reed		
31	Executive Committee			
32	Community Advisory Committee			
33				
34	**Phase II Development**	Al-Rafiq		
35	Pace Program - Welbe Health - July Open House Set up	Al-Rafiq		TBD
36	Senior Living Opportunities	Al-Rafiq		on-going
37				
38	**Explore Potential Partnerships in County**	Sellick & Reed		
39	Behavioral Health-Proposal to Follow	Sellick & Reed		
40	Veterans - On Hold	Atkinson & Radford		6/5/2018
41	Opioid Coalition	Radford		Nov. 2018
42				
43				
44				
45				

2000 HIRING PROCESS

The ~~Executive Director~~ Chief Executive Officer is responsible for initiating and completing the hiring process. The ~~Executive Director~~ CEO shall review applicants and their applications / resumes. When the applicant is applying for a position in the Valley Springs Health & Wellness Center, or other District health care facilities, and the position applied for is not the Center CEO, Center Manager or the Center Medical Director, the review and hiring process may be delegated by the ~~Ex. Dir~~. CEO to the Center Manager, or reside with the ~~Executive Director~~ CEO, and does not require any participation from the District Board or its committees. An appropriate screening process, including evaluation criteria, interview process, and reference checks shall be established. No screening device, application procedure, or evaluation criteria shall discriminate on the basis of any non-job-related factor as delineated in this manual.

In the case of the VS H&W Center manager and medical director and upon completion of the ~~hiring~~ application and interview process, with the exception noted in the above paragraph, the ~~Executive Director~~ CEO will make a recommendation regarding his/her choice(s) for the position(s) relevant Board Committee (if in existence) and the Board for approval. ~~The Board or Committee reserves the right to conduct additional interviews or seek additional information. Once the Board makes the final determination, the Executive Director shall offer the position to the candidate and complete any final negotiations~~. Applicants not selected for the position shall receive a written notice of their status as soon as possible.

When hiring the ~~Executive Director~~ CEO, the Board shall appoint an ad hoc Personnel Committee composed of members of the Board. The Board will make the final hiring decision.

All resumes, application forms, monitoring forms (including information regarding age, race, and sex), test results, interview notes, and any other documentation of the selection process relative to all applicants, will be archived for at least twelve months following final selection.

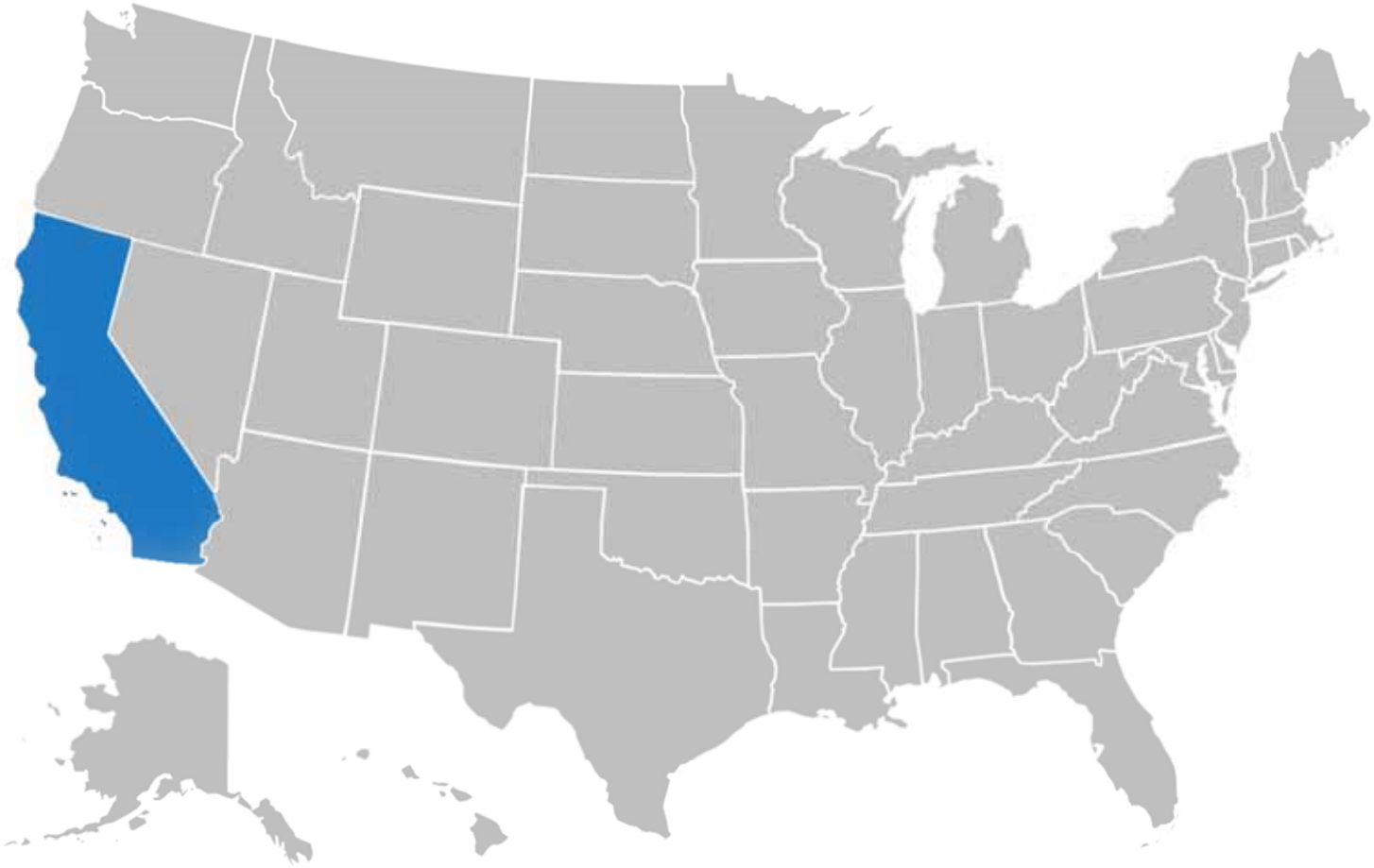
To RS (Last updated 4-6-2019 (To Board 4-24-2019)

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

California



2019 County Health Rankings Report

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

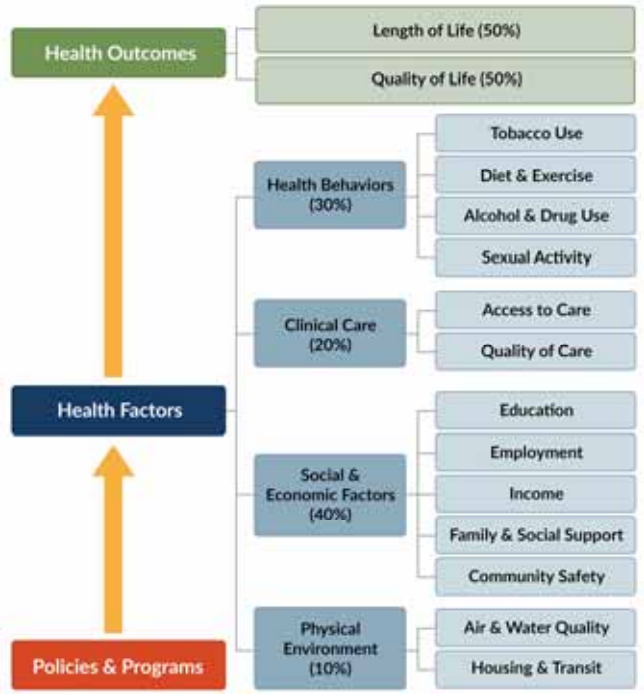
Support provided by
Robert Wood Johnson Foundation

The County Health Rankings & Roadmaps (CHR&R) brings actionable data, evidence, guidance, and stories to communities to make it easier for people to be healthy in their neighborhoods, schools, and workplaces. Ranking the health of nearly every county in the nation (based on the model below), CHR&R illustrates what we know when it comes to what is keeping people healthy or making them sick and shows what we can do to create healthier places to live, learn, work, and play.

What are the County Health Rankings?

Published online at countyhealthrankings.org, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings are unique in their ability to measure the current overall health of each county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births.

Communities use the Rankings to garner support for local health improvement initiatives among government agencies, health care providers, community organizations, business leaders, policymakers, and the public.



Moving with Data to Action

The Take Action to Improve Health section of our website, countyhealthrankings.org, helps communities join together to look at the many factors influencing health, select strategies that work, and make changes that will have a lasting impact. Take Action to Improve Health is a hub of information to help any community member or leader who wants to improve their community's health and equity. You will find:

- What Works for Health, a searchable menu of evidence-informed policies and programs that can make a difference locally;
- The Action Center, your home for step-by-step guidance and tools to help you move with data to action;
- Action Learning Guides, self-directed learning on specific topics with a blend of guidance, tools, and hands-on practice and reflection activities;
- The Partner Center, information to help you identify the right partners and explore tips to engage them;
- Peer Learning, a virtual, interactive place to learn with and from others about what works in communities; and
- Action Learning Coaches, located across the nation, who are available to provide real-time guidance to local communities interested in learning how to accelerate their efforts to improve health and advance equity.

The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

Opportunities for Health Vary by Place and Race

Our country has achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking and infectious diseases. But when you look closer, there are significant differences in health outcomes according to where we live, how much money we make, or how we are treated. The data show that, in counties everywhere, not everyone has benefited in the same way from these health improvements. There are fewer opportunities and resources for better health among groups that have been historically marginalized, including people of color, people living in poverty, people with physical or mental disabilities, LGBTQ persons, and women.

Differences in Opportunity Have Been Created, and Can Be Undone

Differences in opportunity do not arise on their own or because of the actions of individuals alone. Often, they are the result of policies and practices at many levels that have created deep-rooted barriers to good health, such as unfair bank lending practices, school funding based on local property taxes, and discriminatory policing and prison sentencing. The collective effect is that a fair and just opportunity to live a long and healthy life does not exist for everyone. Now is the time to change how things are done.

Measure What Matters

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health and in the conditions and resources needed for optimal health. This report provides data on differences in health and opportunities in California that can help identify where action is needed to achieve greater equity and offers information on how to move with data to action.

Specifically, this report will help illuminate:

1. Differences in health outcomes within the state by place and racial/ethnic groups
2. Differences in health factors within the state by place and racial/ethnic groups
3. What communities can do to create opportunity and health for all

Differences in Health Outcomes within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Outcomes?

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (percent of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the % of low birth weight newborns. Detailed information on the underlying measures is available at **countyhealthrankings.org**

The green map above shows the distribution of California's **health outcomes**, based on an equal weighting of length and quality of life. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 10 at the end of this report.

How Do Health Outcomes Vary by Race/Ethnicity?

Length and quality of life vary not only based on where we live, but also by our racial/ethnic background. In California, there are differences by race/ethnicity in length and quality of life that are masked when we only look at differences by place. The table below presents the five underlying measures that make up the Health Outcomes rank. Explore the table to see how health differs between the healthiest and the least healthy counties in California, and among racial/ethnic groups.

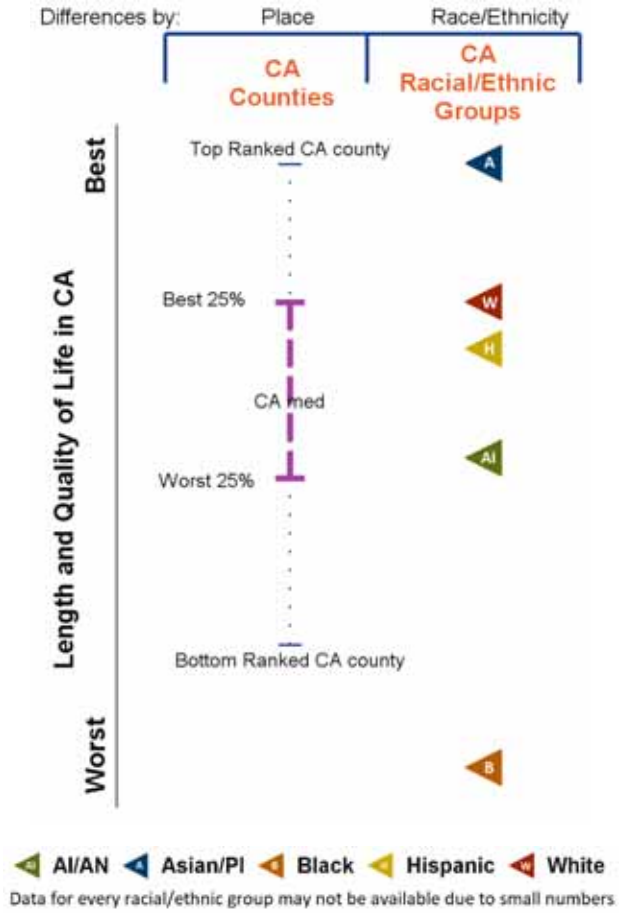
Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in California

	Healthiest CA County	Least Healthy CA County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	3,100	11,600	9,300	3,100	9,700	4,700	5,700
Poor or Fair Health (%)	11%	18%	16%	10%	16%	31%	10%
Poor Physical Health Days (avg)	3.0	4.2	4.3	2.1	4.7	3.8	3.4
Poor Mental Health Days (avg)	3.3	4.4	2.0	2.4	4.4	3.2	3.9
Low Birthweight (%)	6%	7%	7%	8%	12%	6%	6%

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

N/A = Not available. Data for all racial/ethnic groups may not be available due to small numbers

Health Outcomes in California



The graphic to the left compares measures of length and quality of life by place (Health Outcomes ranks) and by race/ethnicity. To learn more about this composite measure, see the technical notes on page 14.

Taken as a whole, measures of length and quality of life in California indicate:

- American Indians/Alaskan Natives are most similar in health to those living in the middle 50% of counties.
- Asians/Pacific Islanders are healthier than those living in the top ranked county.
- Blacks are less healthy than those living in the bottom ranked county.
- Hispanics are most similar in health to those living in the middle 50% of counties.
- Whites are most similar in health to those living in the middle 50% of counties.

(Quartiles refer to the map on page 4.)

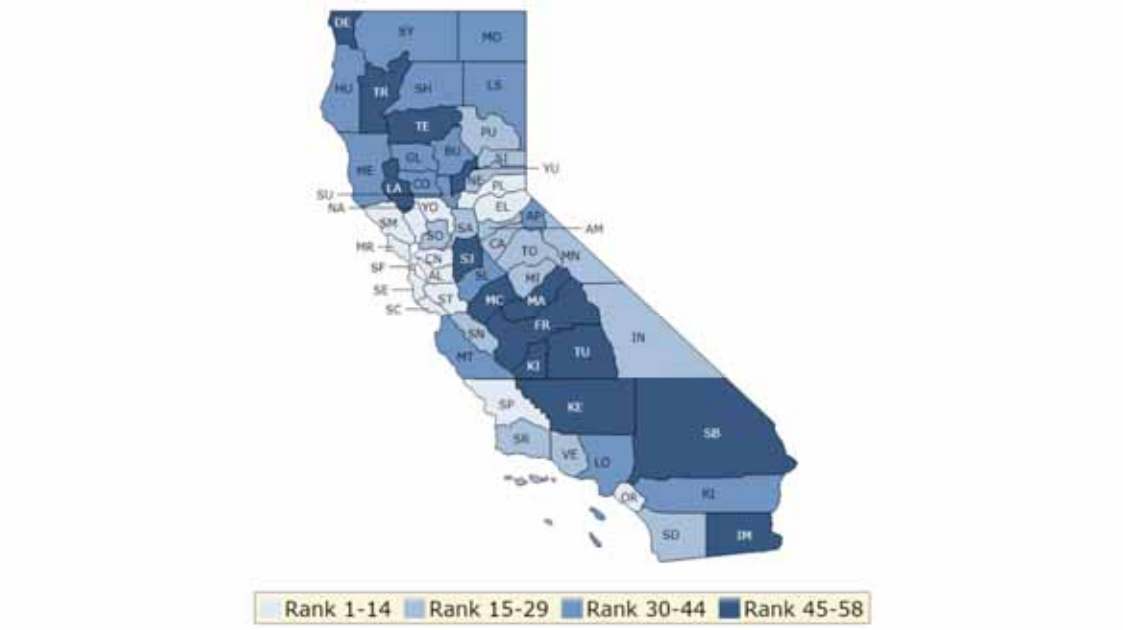
AI/AN -American Indian/Alaskan Native/Native American
Asian/PI - Asian/Pacific Islander

Across the US, values for measures of length and quality of life for Native American, Black, and Hispanic residents are regularly worse than for Whites and Asians. For example, even in the healthiest counties in the US, Black and American Indian premature death rates are about 1.4 times higher than White rates. Not only are these differences unjust and avoidable, they will also negatively impact our changing nation's future prosperity.

Differences in Health Factors within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Factors?

Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family & social support, community safety), and the physical environment (air & water quality, housing & transit).



The blue map above shows the distribution of California's **health factors** based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Detailed information on the underlying measures is available at **countyhealthrankings.org.** The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 10.

What are the Factors That Drive Health and Health Equity and How Does Housing Play a Role?

Health is influenced by a range of factors. Social and economic factors, like connected and supportive communities, good schools, stable jobs, and safe neighborhoods, are foundational to achieving long and healthy lives. These social and economic factors also interact with other important drivers of health and health equity. For example, housing that is unaffordable or unstable can either result from poverty or exacerbate it. When our homes are near high performing schools and good jobs, it's easier to get a quality education and earn a living wage. When people live near grocery stores where fresh food is available or close to green spaces and parks, eating healthy and being active is easier. When things like lead, mold, smoke, and other toxins are inside our homes, they can make us sick. And when so much of a paycheck goes toward the rent or mortgage, it makes it hard to afford to go to the doctor, cover the utility bills, or maintain reliable transportation to work or school.

How Do Opportunities for Stable and Affordable Housing Vary in California?

Housing is central to people's opportunities for living long and well. Nationwide, housing costs far exceed affordability given local incomes in many communities. As a result, people have no choice but to spend too much on housing, leaving little left for other necessities. Here, we focus on stable and affordable housing as an essential element of healthy communities. We also explore the connection between housing and children in poverty to illuminate the fact that these issues are made even more difficult when family budgets are the tightest.

What can work to create and preserve stable and affordable housing that can improve economic and social well-being and connect residents to opportunity?

A comprehensive, strategic approach that looks across a community and multiple sectors is needed to create and preserve stable, affordable housing in our communities. The way forward requires policies, programs, and systems changes that respond to the specific needs of each community, promote inclusive and connected neighborhoods, reduce displacement, and enable opportunity for better health for all people. This includes efforts to:

Make communities more inclusive and connected, such as:

- Inclusive zoning
- Civic engagement in public governance and in community development decisions
- Fair housing laws and enforcement
- Youth leadership programs
- Access to living wage jobs, quality health care, grocery stores, green spaces and parks, and public transportation systems

For more information about evidence-informed strategies that can address priorities in your community, visit What Works for Health at countyhealthrankings.org/whatworks

Facilitate access to resources needed to secure affordable housing, particularly for low- to middle-income families, such as:

- Housing choice vouchers for low- and very low-income households
- Housing trust funds

Address capital resources needed to create and preserve affordable housing, particularly for low- to middle-income families, such as:

- Acquisition, management, and financing of land for affordable housing, like land banks or land trusts
- Tax credits, block grants, and other government subsidies or revenues to advance affordable housing development
- Zoning changes that reduce the cost of housing production

This report explores statewide data. To dive deeper into your county data, visit Use the Data at countyhealthrankings.org

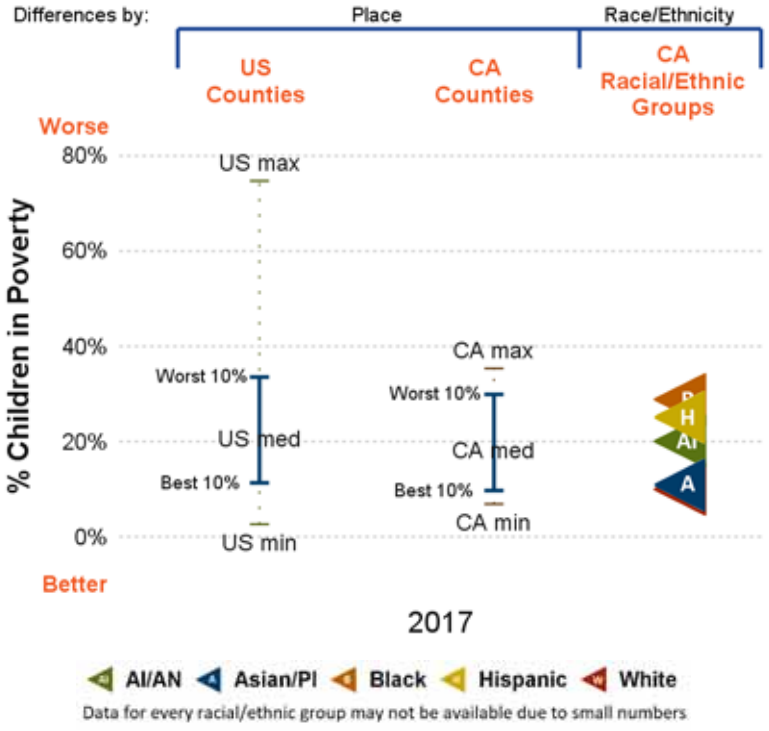
Consider these questions as you look at the data graphics throughout this report:

- What differences do you see among counties in your state?
- What differences do you see by racial/ethnic groups in your state?
- How do counties in your state compare to all U.S. counties?
- What patterns do you see? For example, do some racial/ethnic groups fare better or worse across measures?

Children in Poverty

Poverty limits opportunities for quality housing, safe neighborhoods, healthy food, living wage jobs, and quality education. As poverty and related stress increase, health worsens.

- In California, 18% of children are living in poverty.
- Children in poverty among California counties range from 7% to 35%.
- Child poverty rates among racial/ethnic groups in California range from 10% to 29%.



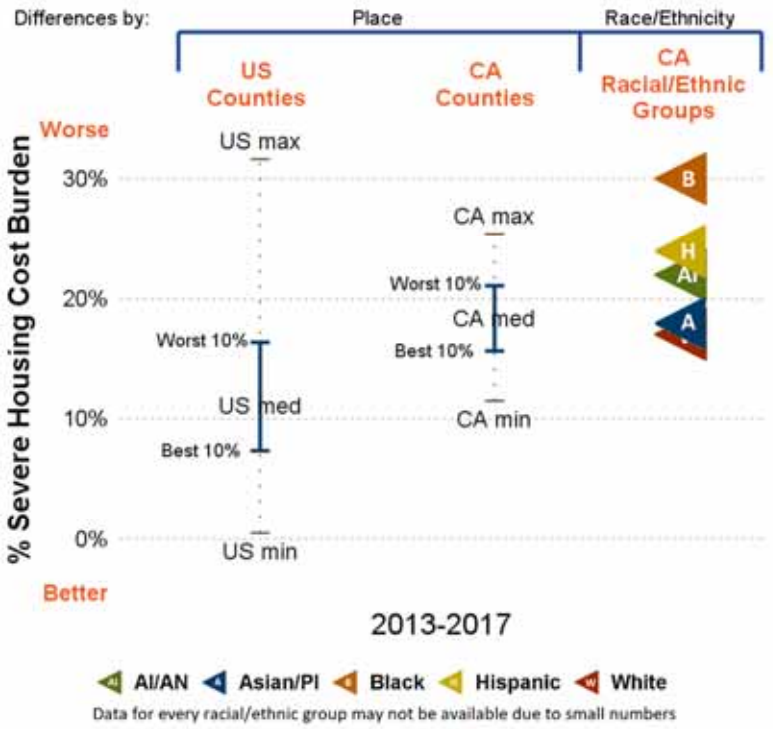
US and state values and the state minimum and maximum can be found in the table on page 12

American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

Severe Housing Cost Burden

There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs.

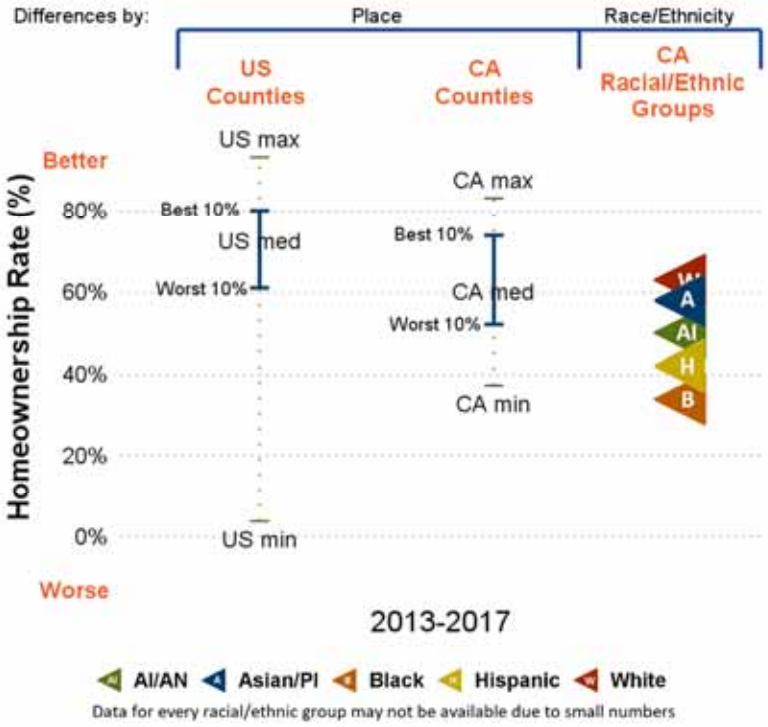
- In California, 21% of households spend more than half of their income on housing costs.
- Across California counties, severe housing cost burden ranges from 12% to 25% of households.
- Severe housing cost burden ranges from 17% to 30% among households headed by different racial/ethnic groups in California.



Homeownership

Homeownership has historically been a springboard for families to enter the middle class. Owning a home over time can help build savings for education or for other opportunities important to health and future family wealth. High levels of homeownership are associated with more stable housing and more tightly knit communities.

- In California, 55% of households own their home.
- Homeownership rates among California counties range from 37% to 83% of households.
- Homeownership rates among racial/ethnic groups in California range from 34% to 63%.



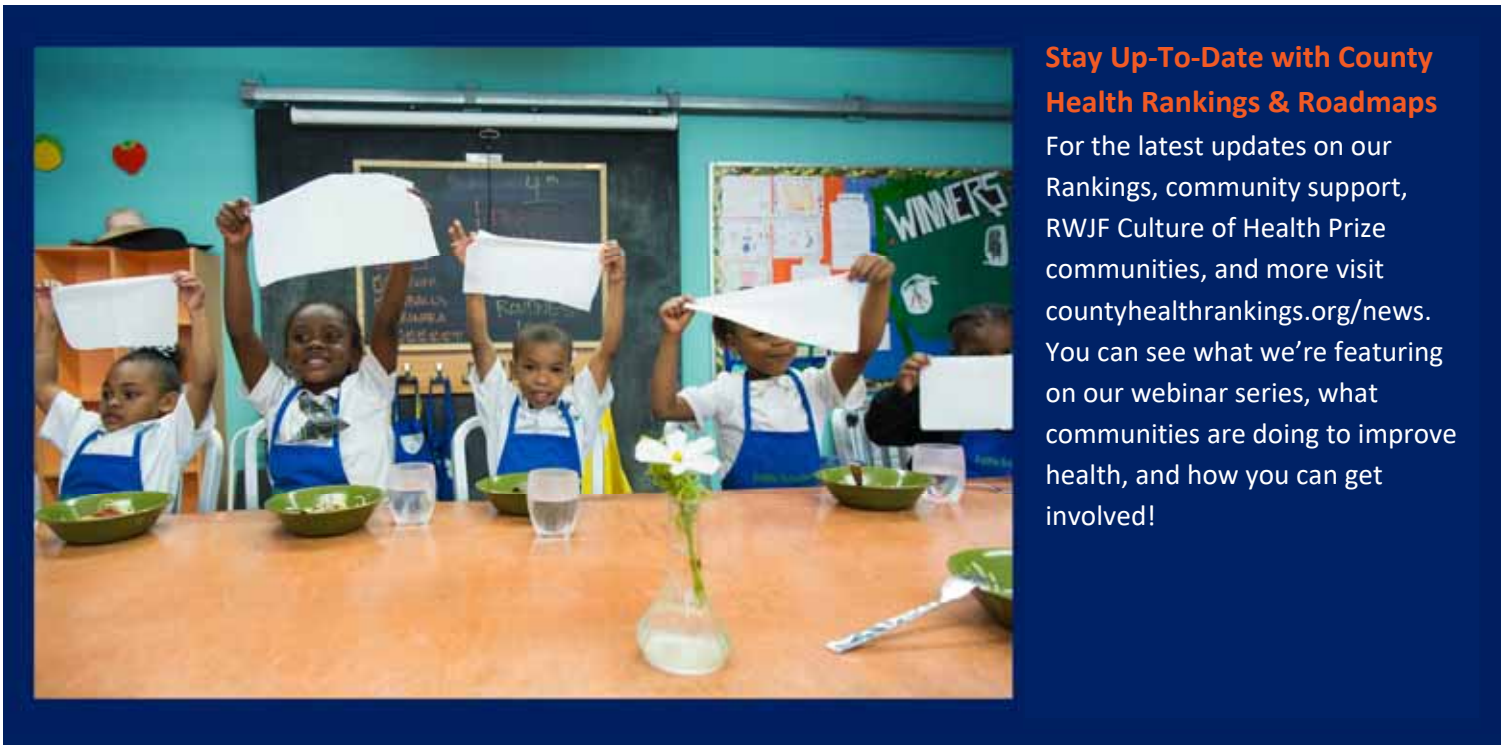
2019 County Health Rankings for the 58 Ranked Counties in California

County	Health Outcomes	Health Factors
Alameda	12	6
Alpine	34	43
Amador	25	16
Butte	35	32
Calaveras	24	23
Colusa	27	41
Contra Costa	11	10
Del Norte	45	50
El Dorado	17	7
Fresno	50	52
Glenn	40	44
Humboldt	49	37
Imperial	31	56
Inyo	43	24
Kern	52	57

County	Health Outcomes	Health Factors
Kings	30	53
Lake	58	54
Lassen	39	38
Los Angeles	23	30
Madera	36	51
Marin	1	1
Mariposa	42	27
Mendocino	41	39
Merced	47	55
Modoc	56	40
Mono	18	21
Monterey	21	33
Napa	7	12
Nevada	14	15
Orange	5	9

County	Health Outcomes	Health Factors
Placer	4	3
Plumas	54	29
Riverside	26	35
Sacramento	29	25
San Benito	20	22
San Bernardino	38	47
San Diego	10	20
San Francisco	6	5
San Joaquin	44	46
San Luis Obispo	15	8
San Mateo	2	2
Santa Barbara	19	17
Santa Clara	3	4
Santa Cruz	13	14
Shasta	48	31

County	Health Outcomes	Health Factors
Sierra	37	28
Siskiyou	57	36
Solano	22	26
Sonoma	8	11
Stanislaus	33	42
Sutter	32	34
Tehama	46	45
Trinity	55	48
Tulare	51	58
Tuolumne	28	19
Ventura	9	18
Yolo	16	13
Yuba	53	49



Stay Up-To-Date with County Health Rankings & Roadmaps

For the latest updates on our Rankings, community support, RWJF Culture of Health Prize communities, and more visit countyhealthrankings.org/news. You can see what we're featuring on our webinar series, what communities are doing to improve health, and how you can get involved!

2019 County Health Rankings for California: Measures and National/State Results

Measure	Description	US	CA	CA Minimum	CA Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	6900	5,300	3,100	11,600
Poor or fair health	% of adults reporting fair or poor health	16%	18%	11%	27%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	3.5	2.7	4.5
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.5	2.9	4.4
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	7%	5%	9%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	11%	8%	16%
Adult obesity	% of adults that report a BMI ≥ 30	29%	23%	17%	34%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.7	8.9	5.7	9.4
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	22%	17%	12%	25%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	84%	93%	43%	100%
Excessive drinking	% of adults reporting binge or heavy drinking	18%	18%	16%	24%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	29%	30%	0%	70%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	497.3	506.2	191.8	945.3
Teen births	# of births per 1,000 female population ages 15-19	25	22	7	44
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	10%	8%	5%	11%
Primary care physicians	Ratio of population to primary care physicians	1,330:1	1,270:1	1,070:0	640:1
Dentists	Ratio of population to dentists	1,460:1	1,200:1	1,120:0	670:1
Mental health providers	Ratio of population to mental health providers	440:1	310:1	1,010:1	120:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	4,520	3,507	1,710	5,327
Mammography screening	% of female Medicare enrollees ages 65-74 that receive mammography screening	41%	36%	29%	46%
Flu vaccinations	% of Medicare enrollees who receive an influenza vaccination	45%	40%	17%	48%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	85%	83%	36%	100%
Some college	% of adults ages 25-44 with some post-secondary education	65%	64%	36%	87%
Unemployment	% of population aged 16 and older unemployed but seeking work	4.4%	4.8%	2.7%	19.1%
Children in poverty	% of children under age 18 in poverty	18%	18%	7%	35%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.9	5.3	3.0	7.1
Children in single-parent households	% of children that live in a household headed by a single parent	33%	31%	17%	45%
Social associations	# of membership associations per 10,000 population	9.3	5.8	3.4	16.1
Violent crime	# of reported violent crime offenses per 100,000 population	386	421	162	787
Injury deaths	# of deaths due to injury per 100,000 population	67	49	35	149
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	8.6	9.5	5.6	19.7
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	N/A	N/A	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	18%	27%	12%	34%
Driving alone to work	% of workforce that drives alone to work	76%	74%	34%	82%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	35%	40%	8%	56%

2019 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2015-2017
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2016
	Poor physical health days	Behavioral Risk Factor Surveillance System	2016
	Poor mental health days	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	National Center for Health Statistics – Natality files	2011-2017
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2016
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2015
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2015 & 2016
	Physical inactivity	CDC Diabetes Interactive Atlas	2015
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & U.S. Census Files	2010 & 2018
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2016
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2013-2017
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB	2016
	Teen births	National Center for Health Statistics – Natality files	2011-2017
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2016
	Primary care physicians	Area Health Resource File/American Medical Association	2016
	Dentists	Area Health Resource File/National Provider Identification file	2017
	Mental health providers	CMS, National Provider Identification file	2018
Quality of Care	Preventable hospital stays	Mapping Medicare Disparities Tool	2016
	Mammography screening	Mapping Medicare Disparities Tool	2016
	Flu vaccinations	Mapping Medicare Disparities Tool	2016
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	State-specific sources & EDFacts	Varies
	Some college	American Community Survey	2013-2017
Employment	Unemployment	Bureau of Labor Statistics	2017
Income	Children in poverty	Small Area Income and Poverty Estimates	2017
	Income inequality	American Community Survey	2013-2017
Family and Social Support	Children in single-parent households	American Community Survey	2013-2017
	Social associations	County Business Patterns	2016
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2014 & 2016
	Injury deaths	CDC WONDER mortality data	2013-2017
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution – particulate matter*	Environmental Public Health Tracking Network	2014
	Drinking water violations	Safe Drinking Water Information System	2017
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2011-2015
	Driving alone to work	American Community Survey	2013-2017
	Long commute – driving alone	American Community Survey	2013-2017

*Not available for AK and HI.

2019 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Life expectancy	National Center for Health Statistics - Mortality Files	2015-2017
	Premature age-adjusted mortality	CDC WONDER mortality data	2015-2017
	Child mortality	CDC WONDER mortality data	2014-2017
	Infant mortality	CDC WONDER mortality data	2011-2017
Quality of Life	Frequent physical distress	Behavioral Risk Factor Surveillance System	2016
	Frequent mental distress	Behavioral Risk Factor Surveillance System	2016
	Diabetes prevalence	CDC Diabetes Interactive Atlas	2015
	HIV prevalence	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2015
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2016
	Limited access to healthy foods	USDA Food Environment Atlas	2015
Alcohol and Drug Use	Drug overdose deaths	CDC WONDER mortality data	2015-2017
	Motor vehicle crash deaths	CDC WONDER mortality data	2011-2017
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2016
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2016
	Uninsured children	Small Area Health Insurance Estimates	2016
	Other primary care providers	CMS, National Provider Identification File	2018
SOCIAL & ECONOMIC FACTORS			
Education	Disconnected youth	American Community Survey	2013-2017
Income	Median household income	Small Area Income and Poverty Estimates	2017
	Children eligible for free or reduced price lunch	National Center for Education Statistics	2016-2017
Family and Social Support	Residential segregation - black/white	American Community Survey	2013-2017
	Residential segregation - non-white/white	American Community Survey	2013-2017
Community Safety	Homicides	CDC WONDER mortality data	2011-2017
	Firearm fatalities	CDC WONDER mortality data	2013-2017
PHYSICAL ENVIRONMENT			
Housing and Transit	Homeownership	American Community Survey	2013-2017
	Severe housing cost burden	American Community Survey	2013-2017
DEMOGRAPHICS			
All	Population	Census Population Estimates	2017
	% below 18 years of age	Census Population Estimates	2017
	% 65 and older	Census Population Estimates	2017
	% Non-Hispanic African American	Census Population Estimates	2017
	% American Indian and Alaskan Native	Census Population Estimates	2017
	% Asian	Census Population Estimates	2017
	% Native Hawaiian/Other Pacific Islander	Census Population Estimates	2017
	% Hispanic	Census Population Estimates	2017
	% Non-Hispanic white	Census Population Estimates	2017
	% not proficient in English	American Community Survey	2013-2017
	% Females	Census Population Estimates	2017
	% Rural	Census Population Estimates	2010

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that “race” is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 14. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under Rankings Methods.

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit What Works for Health.

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that “darker is bad”.
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

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What Works for Health
Community Transformation
Operations
RWJF Culture of Health Prize

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The Centers for Disease Control and Prevention for providing us with key health indicators
Burness for supporting our communication efforts
Forum One for website design and support

This work is possible thanks to a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Calaveras (CA)

Show areas to explore Show areas of strength

County Demographics +

		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Health Outcomes							24
Length of Life							41
Premature death	(Click for info)	7,300		6,300-8,400	5,400	5,300	
Quality of Life							5
Poor or fair health	(Click for info)	13%		12-13%	12%	18%	
Poor physical health days	(Click for info)	3.4		3.3-3.6	3.0	3.5	

County Demographics +

		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Poor mental health days	(Click for info)	3.7		3.5-3.9	3.1	3.5	
Low birthweight		6%		5-7%	6%	7%	
Additional Health Outcomes (not included in overall ranking) +							
Health Factors							23
Health Behaviors							23
Adult smoking	(Click for info)	12%		11-12%	14%	11%	
Adult obesity		25%		18-31%	26%	23%	
Food environment index		8.1			8.7	8.9	

County Demographics +

		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Physical inactivity		22%		16-30%	19%	17%	
Access to exercise opportunities		54%			91%	93%	
Excessive drinking	(Click for info)	18%		18-19%	13%	18%	
Alcohol-impaired driving deaths		40%		33-47%	13%	30%	
Sexually transmitted infections		191.8			152.8	506.2	
Teen births		**15**		12-17	14	22	
Additional Health Behaviors (not included in overall ranking) +							
Clinical Care							19
Uninsured		6%		5-7%	6%	8%	

County Demographics +

	Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
	Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Primary care physicians	2,050:1			1,050:1	1,270:1	
Dentists	2,400:1			1,260:1	1,200:1	
Mental health providers	630:1			310:1	310:1	
Preventable hospital stays	**2,477**			2,765	3,507	
Mammography screening	**42%**			49%	36%	
Flu vaccinations	**37%**			52%	40%	
Additional Clinical Care (not included in overall ranking) +						
Social & Economic Factors						27
High school graduation	90%			96%	83%	

County Demographics +

	Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
	Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Some college	56%		49-63%	73%	64%	
Unemployment	4.7%			2.9%	4.8%	
Children in poverty	**21%**		16-26%	11%	18%	
Income inequality	4.9		4.3-5.5	3.7	5.3	
Children in single-parent households	36%		27-46%	20%	31%	
Social associations	8.6			21.9	5.8	
Violent crime	327			63	421	
Injury deaths	95		82-108	57	49	

Additional Social & Economic Factors (not included in overall ranking) +

Physical Environment	21

County Demographics +

		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
		Calaveras County	Trend(Click for info)	Error Margin	Top U.S. Performers	California	Rank (of 58)(Click for info)
Air pollution - particulate matter	(Click for info)	9.0			6.1	9.5	
Drinking water violations		No					
Severe housing problems		21%		17-24%	9%	27%	
Driving alone to work		**79%**		77-81%	72%	74%	
Long commute - driving alone		56%		49-63%	15%	40%	

Additional Physical Environment (not included in overall ranking) +

Note: Blank values reflect unreliable or missing data

OUT LAY REPORT AND REQUEST FOR REIMBURSEMENT

Draw Request Number:	Mark Twain Health Care District			Construction of New Health Clinic				
	768 Mountain Ranch Road, San Andreas, CA 95249			Payment Requested				
#8	**Initial Budget**	**Current Budget**	**Previous Paid to Date**	**#8**	**Paid to Date**		**Balance Remaining**	**%**
Misc. Soft Costs								
Administrative/Legal	530,075.00	530,075.00	538,475.14		538,475.14		(8,400.14)	-1.58%
Financing/Cost of issuance	325,000.00	275,000.00	233,124.25		233,124.25		41,875.75	15.23%
Land Acquisition	890,000.00	890,000.00	890,000.00		890,000.00		-	0.00%
Furniture Fixtures/Equipment	350,000.00	350,000.00	-		-		350,000.00	100.00%
Structured cabling/IT	250,000.00	250,000.00	-		-		250,000.00	100.00%
			-		-			
			-		-			
			-		-			
Architectural design/other architectural			-		-			
Architect/Engineer fees	433,600.00	480,665.00	434,765.54	11,549.24	446,314.78		34,350.22	7.15%
Other architectural and engineering fees			-		-			
			-		-			
3rd party project management	157,725.00	269,820.00	202,886.20	12,383.84	215,270.04		54,549.96	20.22%
Monument sign		30,000.00	-		-		30,000.00	100.00%
Construction w/ sales tax								
			-		-			
			-		-			
			-		-			
			-		-			
Construction Contract	3,587,575.00	5,555,000.00	316,727.11	522,864.10	839,591.21		4,715,408.79	84.89%
					-			
sidewalks	25,000.00				-			
					-			
Contingency	713,837.00	634,895.00		9,898.00	9,898.00		624,997.00	98.44%
Contingency as a Percent of Total	20.00%	11.00%						
Total	**7,262,812.00**	**9,265,455.00**	**2,615,978.24**	**556,695.18**	**3,172,673.42**		**6,092,781.58**	65.76%
PROJECT FUNDING BREAKDOWN								
Mark Twain Health Care District (applicant)	1,062,812.00	1,205,455.00	1,205,455.00		1,205,455.00		-	0.00%
Mark Twain Health Care District (applicant)	600,000.00	600,000.00	-	115,634.84	115,634.84		484,365.16	80.73%
USDA Loan, Series A	5,600,000.00	6,782,000.00	2,158,506.14	556,695.18	2,715,201.32		4,066,798.68	59.96%
USDA Subsequent Loan, Series B		678,000.00	34,000.00		34,000.00		644,000.00	94.99%
Total	**7,262,812.00**	**9,265,455.00**	**3,397,961.14**	**672,330.02**	**4,070,291.16**		**5,195,163.84**	56.07%
FUNDS - DIFFERENCE								

Date of Outlay Report	**4/7/2019**
APPROVAL AND SIGNATURE SECTION	
OWNER'S APPROVAL:	
Executive Director or Board President	DATE
ENGINEER/ARCHITECT APPROVAL:	
Architect	DATE
USDA RURAL DEVELOPMENT	
CONCURRENCE:	
Tonja Galentine	DATE

OWNER CERTIFICATION: I certify that to the best of my knowledge and belief the billed costs or disbursements are in accordance with the terms of the project and that the reimbursement represents the Federal share due which has not been previously requested and that an inspection has been performed and all work is in accordance with the terms of the award.

Invoices will be approved by the borrower and their engineer, as appropriate, and submitted to the processing office for concurrence. The review and acceptance of project costs, including construction pay estimates, by USDA Rural Development does not attest to the correctness of the amounts, the quantities shown or that the work has been performed under the terms of the agreements or contracts.

Notes:

MARK TWAIN
HEALTH CARE DISTRICT

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Agenda Item:	**Financial Reports (as of March, 2019)**
Item Type:	**Action**
Submitted By:	**Rick Wood, Accountant**
Presented By:	**Rick Wood, Accountant**

BACKGROUND:
The DRAFT March 31, 2019 financial statements are attached. This presentation provides a comparison against the three previously completed years, the previous month, and a Year-to-Date comparison to the 2018/2019 budget.

- Nine months into the current fiscal year, with the exception of the items related to the revenues from the new lease, the District appears on track with the Budget.
- For the April Finance Committee meeting, the “Minority Interest” for March 2019 had not yet been provided to the District. This information, along with the Umpqua investment numbers, are now recorded in the financials.
- Like the revenue section, expenses are tracking well compared to Budget.
- The Valley Springs Clinic expenses will continue to be broken out at the bottom of the statement. As this continues to grow, we will add a separate page for this report. The District did pre-pay some items, $115,631.84, in March that will likely be capitalized on the Balance Sheet. Currently they show as “Prepaid – Valley Springs Clinic”. Once these items are paid in full, a determination will be made as to the capitalization versus expense, based on the current policy.
- The Balance Sheet shows a strong cash position, and the expected growing debt related to the new clinic.
- We did open an investment account with CalTRUST, and deposited $250,000 – A “DRAFT” “Investment & Reserves Report” is included for your review.

Mark Twain Health Care District
Profit & Loss
Through March 31, 2019

Revenues	Actual 2015/2016	Actual 2016/2017	Actual 2017/2018	Actual 31-Mar	Year-to-date 2018/2019	Budget 2018/2019	Actual vs Budget
District Taxes	905,711	935,421	999,443	82,667	744,365	992,000	75.04%
Rental Revenue	319,089	319,039	313,039	26,587	239,279	728,633	32.84%
Land Rental Revenue	5,777	5,777	5,296	481	4,333	5,777	75.00%
MOB Rental Revenue	214,814	217,159	219,794	18,794	168,243	227,181	74.06%
Lease Interest Income	3,698	1,982	2,428	0	0	397,712	0.00%
Intrest and Other Income	2,696	4,423	5,045	1,741	17,673	120,000	14.73%
Total Revenue	**1,451,785**	**1,483,801**	**1,545,045**	**130,270**	**1,173,893**	**2,471,303**	**47.50%**

Expenses	Actual 2015/2016	Actual 2016/2017	Actual 2017/2018	Actual 31-Mar	Year-to-date 2018/2019	Budget 2018/2019	Actual vs Budget
Salaries, wages				19,240	156,434	220,000	71.11%
Payroll Expense	33,587	68,794	235,531	1,499	7,057	16,184	43.61%
Benefits			663			5,300	0.00%
Insurance	14,889	16,578	17,043	1,250	14,901	20,000	74.50%
Legal Fees	44,309	15,195	20,179		11,052	60,000	18.42%
Audit	10,790	13,945	18,090		13,635	11,500	118.57%
Operational Consulting	262,634	392,908	332,287		22,969	60,000	38.28%
Accounting Services	805	1,304	1,141	2,251	48,988	70,000	69.98%
Community Education & Marketing	11,949	10,895	5,488	0	1,720	20,000	8.60%
Medical office rent	215,243	220,659	226,237	19,332	173,987	233,024	74.66%
Depreciation and amortization	85,769	35,556	26,582	2,032	18,276	36,045	50.70%
Valley Springs Rental		11,198	57,593	530	2,184	5,000	43.68%
Board Stipends				500	2,400	6,000	40.00%
Dues & Subscriptions	12,343	12,554	14,731	500	12,365	19,000	65.08%
Outside Training/Conferences	2,906	1,920	3,030	0	9,821	15,000	65.48%
Travel, Meals & Lodging	7,983	6,758	17,363	1,545	6,489	15,000	43.26%
Office Supplies & Expense	1,365	4,310	19,685	464	13,937	30,000	46.46%
Other Misc Expenses	10,958	65,595	28,745	18	3,342	5,000	66.84%
Utilities	559,265	387,974	0	475	8,252	675,000	1.22%
Grants & Sponsorships	154,969	74,159	47,413	5,000	63,407	635,000	9.99%
Valley Springs Clinic				6,351	46,529	50,000	93.06%
Debt Service				21,608	21,608	88,772	24.34%
Total Expenses	**1,429,764**	**1,340,302**	**1,071,801**	**82,594**	**659,354**	**2,295,825**	**28.72%**
Excess of revenues over expenses	**22,021**	**143,499**	**473,244**	**47,676**	**514,539**	**175,478**	**293.22%**

Valley Spring Clinic Expenses		
Marketing	248	794
Office Supplies & Expenses	0	2,644
OP Consultant	5,810	21,122
IT/EMR	0	3,675
Physcian/Provider Recruiting	0	18,000
Admin.	293	293
Total - Valley Springs Clinic Expenses	**6,351**	**46,529**

Investment & Reserves Report
31-Mar-19

Reserve Funds	Minimum Target	12/31/2018 Balance	2019 Allocated	2019 Interest	3/31/2019 Balance	Annual Funding Goal
Valley Springs HWC - Operational Reserve Fund	2,200,000	0	0	0	0	
Capital Improvement Fund	12,000,000	0	0	0	0	
Technology Reserve Fund	1,000,000	0	0	0	0	
Lease & Contract Reserve Fund	3,000,000	0	0	0	0	
Loan Reserve Fund	1,300,000	0	0	0	0	
Reserves & Contingencies	19,500,000	0	0	0	0	0

CalTRUST	3/31/2019	2019 Interest Earned	Annualized Rates	Duration
Valley Springs HWC - Operational Reserve Fund	0	0		
Capital Improvement Fund	0	0		
Technology Reserve Fund	0	0		
Lease & Contract Reserve Fund	0	0		
Loan Reserve Fund	0	0		
Total CalTRUST	**250,614**	**614**	2.54% - 2.73%	1 Year or Less
Five Star				
General Operating Fund	152,545	123.33		
Money Market Account	735,799	5,798.98		
Valley Springs - Checking	16,336	3.60		
Total Five Star	**904,680**	**5,925.91**	2.32%	1 Year or Less
Umpqua Bank				
Checking	359,231	0.00		
Money Market Account	2,300	0.00		
Investments	721,399	3,444.79	1.60%	
Total Savings & CD's	**1,082,930**	**3,444.79**		
Bank of Stockton	**322,303**	**0**	0.00%	1 Year or Less
Total in interest earning accounts	**2,560,528**	**9,985**		
Potential Unrealized Loss		**0**		
Total Without Unrealized Loss		**9,985**		

Mark Twain Health Care District's (District) Investment Policy No. 22 describes the District's commitment to managing risk by selecting investment products based on safety, liquidity and yield. Per California Government Code Section 53600 et. seq., specifically section 53646 and section 53607, this investment report details all investment-related activity in the current period. District investable funds are currently invested in Umpqua Bank, Five Star Bank, and the CalTRUST investment pool, all of which meet those standards; the individual investment transactions of the CalTRUST Pool are not reportable under the government code. That being said, the District's Investment Policy remains a prudent investment course, and is in compliance with the "Prudent Investor's Policy" designed to protect public funds. The report for this period does reflect any deviation from the District's Investment Policy .

Mark Twain Healthcare District

BALANCE SHEET

As of March 31, 2019

	TOTAL	
	AS OF MAR 31, 2019	AS OF MAR 31, 2018 (PY)
ASSETS		
Current Assets		
Bank Accounts		
100.30 Umpqua Bank Checking	359,231.42	51,344.60
100.40 Money Market - Umpqua	2,300.43	920,558.53
100.50 Stockton Bank of	322,302.77	
100.60 Five Star Bank	152,545.31	
100.70 Five Star Bank - MMA	735,798.98	
100.80 Five Star Bank - Valley Springs Checking	16,335.88	
Total Bank Accounts	**$1,588,514.79**	**$971,903.13**
Accounts Receivable		
1200 Accounts Receivable	52,922.23	62,491.01
Total Accounts Receivable	**$52,922.23**	**$62,491.01**
Other Current Assets		
101.00 Umpqua Investments	721,398.61	705,034.65
103.00 CalTRUST	250,614.11	
115.05 Due From Calaveras County	148,657.18	199,763.65
130.00 Prepaid Expenses		
130.20 Prepaid Malpractice	4,144.61	2,543.61
130.30 Other Prepaid Expenses	0.00	436.80
130.40 Prepaid Valley Springs Clinic	115,631.84	
Total 130.00 Prepaid Expenses	**119,776.45**	**2,980.41**
Total Other Current Assets	**$1,240,446.35**	**$907,778.71**
Total Current Assets	**$2,881,883.37**	**$1,942,172.85**
Fixed Assets		
150.00 Land and Land Improvements	0.00	0.00
150.10 Land	1,189,256.50	1,189,256.50
150.20 Land Improvements	150,307.79	150,307.79
Total 150.00 Land and Land Improvements	**1,339,564.29**	**1,339,564.29**
151.00 Buildings and Improvements	0.00	0.00
151.10 Building	2,123,677.81	2,123,677.81
151.20 Building Improvements	2,276,955.79	2,276,955.79
151.30 Building Service Equipment	168,095.20	168,095.20
Total 151.00 Buildings and Improvements	**4,568,728.80**	**4,568,728.80**
152 CIP	1,760,875.48	
152.1 CIP Consulting Services	4,646.25	
152.10 Fixed Equipment	698,156.25	698,156.25
152.92 CIP - VS Clinc Land Costs	1,117,376.81	463,639.38
160.00 Accumulated Depreciation	-5,336,329.00	-5,313,099.00
Total Fixed Assets	**$4,153,018.88**	**$1,756,989.72**
Other Assets		

	TOTAL	
	AS OF MAR 31, 2019	AS OF MAR 31, 2018 (PY)
170.00 Minority Interest in MTMC	14,195,018.00	14,975,253.00
180.00 Bond Issue Costs		
180.10 Bond Issue Costs	141,088.00	141,088.00
180.20 Accumulated Amortization	-141,088.00	-141,088.00
Total 180.00 Bond Issue Costs	**0.00**	**0.00**
180.30 Intangible Assets	0.00	0.00
180.50 Land Lease Legal Fees	28,081.11	28,081.11
180.55 Accumulated Amortization-LLLF	-26,876.11	-25,748.11
180.60 Capitalized Lease Negotiations	392,901.39	323,586.92
Total 180.30 Intangible Assets	**394,106.39**	**325,919.92**
Total Other Assets	**$14,589,124.39**	**$15,301,172.92**
TOTAL ASSETS	**$21,624,026.64**	**$19,000,335.49**
LIABILITIES AND EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		
2000 Accounts Payable	569,150.04	0.00
Total Accounts Payable	**$569,150.04**	**$0.00**
Other Current Liabilities		
200.00 Accts Payable & Accrued Expenes		
200.10 Other Accounts Payable	5,692.34	-20.00
200.40 Accrued Utilities	35,719.52	33,793.70
Total 200.00 Accts Payable & Accrued Expenes	**41,411.86**	**33,773.70**
210.00 Deide Security Deposit	2,275.00	2,275.00
211.00 Valley Springs Security Deposit	1,000.00	1,000.00
220.10 Due to MTMC - Rental Clearing	23,729.01	55,367.85
226 Deferred Rental Revenue	38,393.35	38,289.91
24000 Payroll Liabilities	5,893.81	12,790.71
Total Other Current Liabilities	**$112,703.03**	**$143,497.17**
Total Current Liabilities	**$681,853.07**	**$143,497.17**
Long-Term Liabilities		
250.00 Notes Payable - Long Term		
250.10 USDA Loan - VS Clinic	2,192,506.14	0.00
Total 250.00 Notes Payable - Long Term	**2,192,506.14**	**0.00**
Total Long-Term Liabilities	**$2,192,506.14**	**$0.00**
Total Liabilities	**$2,874,359.21**	**$143,497.17**
Equity		
290.00 Fund Balance	648,149.41	648,149.41
291.00 PY - Minority Interest MTMC	19,720,638.00	19,720,638.00
3000 Opening Bal Equity	0.03	0.03
3900 Retained Earnings	-1,485,827.71	-1,373,588.30
Net Income	-133,292.30	-138,360.82
Total Equity	**$18,749,667.43**	**$18,856,838.32**
TOTAL LIABILITIES AND EQUITY	**$21,624,026.64**	**$19,000,335.49**

Mark Twain Healthcare District

JOURNAL

March 2019

DATE	TRANSACTION TYPE	NUM	NAME	MEMO/DESCRIPTION	ACCOUNT #	ACCOUNT	DEBIT	CREDIT
03/01/2019	Journal Entry	11449		USDA Interest Loan Draw	736	736 Debt Financing Costs	$638.90	
				USDA Interest Loan Draw	736	736 Debt Financing Costs	$20,969.46	
				USDA Interest Loan Draw	100.50	100.50 Stockton Bank of		$21,608.36
							$21,608.36	**$21,608.36**
03/07/2019	Journal Entry	11448		Loan Draw #7	100.50	100.50 Stockton Bank of	$88,017.60	
				Loan Draw #7	250.10	250.10 Notes Payable - Long Term:USDA Loan - VS Clinic		$88,017.60
							$88,017.60	**$88,017.60**
03/31/2019	Journal Entry	11447		Mar Rental pymt from DH/MTMC	100.30	100.30 Umpqua Bank Checking	$38,545.42	
				Mar Rental pymt from DH/MTMC	550.10	550.10 Rental Revenue		$23,200.00
				Mar Rental pymt from DH/MTMC	550.30	550.30 MOB Rental Revenue		$15,345.42
							$38,545.42	**$38,545.42**
03/31/2019	Journal Entry	11450		To accrue 1 month property tax per budget	115.05	115.05 Due From Calaveras County	$82,667.00	
				To accrue 1 month property tax per budget	560.10	560.10 District Tax Revenue		$82,667.00
					220.10	220.10 Due to MTMC - Rental Clearing	$2,636.57	
					550.10	550.10 Rental Revenue		$2,636.57
				depreciate 1 month	735.72	735.72 Depreciation & Amortization:D & A - Buildings	$1,938.00	
				depreciate 1 month	160.00	160.00 Accumulated Depreciation		$1,938.00
				amortize 1 mo	710.81	710.81 Insurance:Insurance - D & O	$1,250.00	
				amortize 1 mo	130.20	130.20 Prepaid Expenses:Prepaid Malpractice		$1,250.00
				amortize 1 mo	735.75	735.75 Depreciation & Amortization:Amortization of Intangible	$94.00	
				amortize 1 mo	180.55	180.55 Intangible Assets:Accumulated Amortization-LLLF		$94.00
				Mar 2019 Rent - Resource Connection	550.10	550.10 Rental Revenue		$750.00
				Mar 2019 Rent - Resource Connection	100.30	100.30 Umpqua Bank Checking	$750.00	
							$89,335.57	**$89,335.57**
03/31/2019	Journal Entry	11451		Payroll Tax Expense	66000	66000 Payroll Expenses	$667.98	
				Direct Deposit Fee	66000	66000 Payroll Expenses	$5.25	
				Total Wages	65000	65000 Salaries and Benefits	$8,677.71	
				EDD/IRS	24000	24000 Payroll Liabilities		$3,353.74
				Net Pay	100.60	100.60 Five Star Bank		$5,997.20
				EDD/IRS	24000	24000 Payroll Liabilities	$2,727.68	
				EDD/IRS	100.60	100.60 Five Star Bank		$2,727.68
				EDD/IRS	24000	24000 Payroll Liabilities	$626.06	
				Net Pay	100.60	100.60 Five Star Bank		$626.06
				Payroll Tax Expense	66000	66000 Payroll Expenses	$820.14	

DATE	TRANSACTION TYPE	NUM	NAME	MEMO/DESCRIPTION	ACCOUNT #	ACCOUNT	DEBIT	CREDIT
				Direct Deposit Fee	66000	66000 Payroll Expenses	$5.25	
				Total Wages	65000	65000 Salaries and Benefits	$10,562.46	
				EDD/IRS	24000	24000 Payroll Liabilities		$4,190.64
				Net Pay	100.60	100.60 Five Star Bank		$7,197.21
				EDD/IRS	24000	24000 Payroll Liabilities	$3,394.06	
				EDD/IRS	100.60	100.60 Five Star Bank		$3,394.06
				EDD/IRS	24000	24000 Payroll Liabilities	$796.58	
				EDD/IRS	100.60	100.60 Five Star Bank		$796.58
							$28,283.17	**$28,283.17**
03/31/2019	Journal Entry	11453		March 2019 Minority District Share of MTMC Loss	750.03	750.03 Minority Interest MTSJ Ops	$652,570.00	
				March 2019 District Share of MTMC Investment gain	750.04	750.04 Minority Interest MTSJ Invest		$24,857.50
				March 2019 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC		$627,712.50
							$652,570.00	**$652,570.00**
03/31/2019	Journal Entry	11454		Correct Oct 2018 District adjustment to Minority Interest	3901	3901 CY - Minority Interest MTMC	$119,209.50	
				Correct Oct 2018 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC		$119,209.50
				Correct Nov 2018 District adjustment to Minority Interest	3901	3901 CY - Minority Interest MTMC	$174,254.00	
				Correct Nov 2018 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC		$174,254.00
				Correct Dec 2018 District adjustment to Minority Interest	3901	3901 CY - Minority Interest MTMC	$95,818.00	
				Correct Dec 2018 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC		$95,818.00
				Correct Jan 2019 District adjustment to Minority Interest	3901	3901 CY - Minority Interest MTMC		$538,953.50
				Correct Jan 2019 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC	$538,953.50	
				Correct Jan 2019 District adjustment to Minority Interest add on	3901	3901 CY - Minority Interest MTMC		$50,500.00
				Correct Jan 2019 District adjustment to Minority Interest add on	170.00	170.00 Minority Interest in MTMC	$50,500.00	
				Correct Feb 2019 District adjustment to Minority Interest	3901	3901 CY - Minority Interest MTMC		$112,297.50
				Correct Feb 2019 District adjustment to Minority Interest	170.00	170.00 Minority Interest in MTMC	$112,297.50	
							$1,091,032.50	**$1,091,032.50**
TOTAL							**$2,009,392.62**	**$2,009,392.62**

Mark Twain Healthcare District

BILL PAYMENT LIST

March 2019

DATE	NUM	VENDOR	AMOUNT
100.60 Five Star Bank			
03/05/2019	15229	Outlet Tek	-120.00
03/05/2019	15230	Expeditor Systems	-15,410.83
03/05/2019	15231	Suburban Propane-Ortho	-666.77
03/05/2019	15232	Calaveras Public Utility District	-1,314.92
03/05/2019	15233	City of Angels	-170.40
03/05/2019	15234	PG&E 46578486352 VS Clinic # 10	-120.09
03/05/2019	15235	PG&E 46995152991 VS Clinic # 9	-241.64
03/05/2019	15236	California Special District Assn	-1,665.48
03/05/2019	15237	J.S. West	-781.48
03/05/2019	15238	Arnaudo Bros., L.P.	-19,331.89
03/05/2019	15239	Calaveras Telephone	-467.42
03/05/2019	15213	Dr. Randall Smart	-52.20
03/05/2019	15240	Helen Foraker Advertising	-247.50
03/05/2019	15241	The Valley Springs News	-26.00
03/05/2019	15242	Streamline	-200.00
03/12/2019	15243	MTMC Nutritional Services	-248.00
03/12/2019	15244	Cheryl Duncan Consulting	-3,847.50
03/12/2019	15245	Streamline	-200.00
03/12/2019	15246	AT&T 248 134-7000	-37.35
03/12/2019	15247	AT&T 457-7	-4.64
03/12/2019	15248	AT&T OneNet	-1,076.42
03/12/2019	15249	AT&T 754-9362	-892.80
03/12/2019	15251	Ebbetts Pass Gas Services	-35.10
03/12/2019	15252	PG&E 74021406306 SAFMC	-466.96
03/12/2019	15253	PG&E 39918320076 Cancer	-313.36
03/12/2019	15254	PG&E 71068388090 Pain Mgmt	-695.37
03/12/2019	15255	PG&E 11152462708 SOMO	-10,806.66
03/12/2019	15256	Suburban Propane-Ortho	-306.34
03/12/2019	15257	Calaveras Power Agency	-19,636.50
03/12/2019	15258	PG&E 2306121143-1 ortho	-546.15
03/12/2019	15259	PG&E 42630399709 Hospital	-14,346.87
03/12/2019	15260	Tribble and Ayala	-109.02
03/12/2019	15261	PG&E 89195984003 Cancer/Infusion	-710.23
03/13/2019	15262	J.M. Keckler Medical Sales, Inc.	-61,395.31
03/12/2019	ACH 4	Umpqua Bank	-1,239.82
03/20/2019	15263	Aspen Street Architects	-11,549.24
03/20/2019	15264	Best Best & Krieger, LLP	-15,663.90
03/20/2019	15265	Susan Atkinson	-151.38
03/20/2019	15266	Campora Propane	-341.89
03/27/2019	15267	San Andreas Sanitary District	-15,240.86
03/27/2019	15268	The Valley Springs News	-40.00
03/27/2019	15269	De Lage Landen Public Finance LLC	-38,825.70
03/27/2019	15270	Suburban Propane-Ortho	-361.77

DATE	NUM	VENDOR	AMOUNT
03/27/2019	15271	Mobile Modular	-383.84
03/27/2019	15272	Ebbetts Pass Gas Services	-1,407.83
03/27/2019	15273	Gateway Press	-25.74
03/27/2019	15274	Ann Radford	-100.00
03/27/2019	15275	Debbie Sellick	-100.00
03/27/2019	15276	Lin Reed	-100.00
03/27/2019	15277	Susan Atkinson	-100.00
03/27/2019	15278	Talibah Al-Rafiq	-100.00
03/27/2019	15279	Debbie Sellick	-76.56
Total for 100.60 Five Star Bank			**$ -242,299.73**

Mark Twain Healthcare District

TRANSACTION REPORT

February 2019

DATE	TRANSACTION TYPE	NUM	NAME	MEMO/DESCRIPTION	ACCOUNT	SPLIT	AMOUNT	BALANCE
02/28/2019	Bill	Feb 2019 6507	Umpqua Bank	Office supplies purchased	740.89 Miscellaneous:Office Supplies and Expense	2000 Accounts Payable	1,099.82	1,099.82
02/28/2019	Bill	Feb 2019 6507	Umpqua Bank	2 Hotel Stays at Hyatt Regency Sacramento	840.89 New Valley Springs Clinic:Office Supplies and Expenses - New Valley Springs Clinic	2000 Accounts Payable	140.00	1,239.82
TOTAL							**$1,239.82**	

Mark Twain Health Care District Policy No. 30

Fixed Asset Capitalization: Draft – All New

1. Policy:

The scope of this policy defines the parameters of items that can be included as capital purchases and recorded as assets.

2. Purpose:

This policy defines Mark Twain Health Care District requirements for the capitalization of assets.

3. Definitions:

Capitalization is defined as the process of recording the purchase of a fixed asset or the collection of costs related to an internally produced project as an asset. Examples of capital expenditures include the purchase of land, buildings, machinery, office equipment, leasehold improvements and vehicles. An example of an internally produced project is internally developed software or a construction project.

4. Principally Affected Departments:

Primarily, Finance Committee and Accounting Departments.

5. Procedures:

A. Effective _____(date) all assets with a useful life of greater than two years and falling into one of the following categories shall be capitalized**.**

- An individual item with a cost greater than $2,500 (including personal computers).
- Items purchased in bulk with an individual cost exceeding $2,500,

B. When replacement parts are purchased, or repairs and maintenance are made to an asset for a cost of $2,500 or more, a decision must be made about capitalizing or expensing the cost.

- If the cost was incurred to restore or maintain the original useful life of the asset, then the cost should be expensed.
- If the cost was incurred to extend the asset's useful life, increase capacity, or improve the efficiency or safety of the property, then the cost would be added to the carrying amount of the related asset and the existing useful life should be extended in accordance with the cost incurred.

C. If the asset has component parts that must be replaced at regular intervals, those parts may be recorded as separate assets because their useful lives are different than the useful life of the asset as a whole. When those parts are replaced, the original component may be written off (and a loss on disposition is recorded, if needed) and a new asset may be recorded for the cost of the replacement part.

D. The cost basis of furniture and equipment assets will include all charges relating to the purchase of the asset including the purchase price, freight charges, sales taxes and installation, if applicable.

E. Leasehold improvements including painting are to be capitalized if they relate to the occupancy of a new office or major renovation of an existing office. Expenditures incurred in connection with maintaining an existing facility in good working order should be expensed as a repair.

F. The cost of buildings should include all expenditures related directly to their acquisition or construction. These costs include materials, labor and overhead incurred during construction and fees, such as attorneys, architects and building permits.

G. The cost of building should also include the amount of retention payable to construction contractors, if applicable. In most construction labor and material contracts, the contractor will request payment each month for labor and materials supplied during that month. However, the contractor will receive payment for only 90 percent or 95 percent of those labor and materials supplied. The remaining 5 percent or 10 percent will not be paid monthly but will be “retained” until the entire project is completed. Retention is usually set up in the construction contract to ensure prompt and thorough completion of the project. Retention will motivate tradesmen working for the contractors to return to the project to complete small unprofitable punch-list items in order to complete the project successfully. Retention provides the owner and general contractor with money to correct defective work if a sub-contractor abandons the project, and provides funds to pay the mechanics lien claims of unpaid suppliers, etc. Retention and retainage are terms both used for the same concept.

H. Start-up costs are to be expensed as incurred (excluding those costs associated with getting fixed assets into a condition whereby they can be placed into service).

I. During construction or development of a capital project. There may be certain costs incurred that should not be capitalized to an asset. Examples of the costs that should not be capitalized as apart of the cost of the asset are as follows;

- General and administrative costs and overhead costs should be charged to expense as incurred. Such costs include rent, depreciation, and other occupancy costs associated with the physical space occupied by employees, and all costs (including payroll and payroll benefit-related costs) of support functions, which may include executive management, corporate accounting, acquisitions, purchasing, corporate legal, office management and administration, marketing, human resources and information systems.

- Costs related to training (learning) in any manner or at any time (e.g., IT system or application) should be charged to expense. Time spent training (learning), even if the tools are “on-the-job”, cannot be considered a future economic benefit (i.e., a

capitalized asset) since the Mark Twain Health Care District has no control over the length of time an employee will stay with the District.

J. The cost of the asset should not be reduced by any amount for salvage value. Typically, salvage values will be nominal or offset by the cost of removing the assets (since the salvage value will not be realized without incurring costs of removal) and, thus, can be ignored.

Mark Twain Health Care District Policy No. 22

Investments: Changes are in Yellow

22.1 Policy

It is the policy of the Mark Twain Health Care District ("District") to provide guidelines for the prudent investment of District funds and to maximize the efficiency of the District's cash management. The ultimate goal is to enhance the economic status of the District consistent with the prudent protection of the District's investments. This investment policy has been prepared in conformance with all pertinent existing laws of the State of California including California Government Code Sections 53600, *et seq.*

22.2 Scope

This policy covers all funds and investment activities of the District except for (1) the proceeds of bond issues, which are invested in accordance with provisions of their specific bond indentures, and (2) funds invested in retirement or deferred compensation plans. All funds covered by this policy are defined and accounted for in the District's audited annual Basic Financial Statements Report. Further, any new funds created shall be covered by this policy unless specifically excluded by District management and the Board of Directors.

22.3 Prudent Investor Standard

The District operates its investment portfolio under the Prudent Investor Standard (California
Government Code Section 53600.3) which states, that "when investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the District, that a prudent person in a like capacity and familiar with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principle and maintain the liquidity needs of the District."

This standard shall be applied in the context of managing the overall portfolio. Investment officers, acting in accordance with written procedures and this investment policy and exercising the above standard of diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control adverse developments.

22.4 Investment Objectives

A. When investing, reinvesting, purchasing, acquiring, exchanging, selling or managing the District's funds,

1. The primary objective is to safeguard the principle of the funds.
2. The secondary objective is to meet the liquidity needs of the District.
3. The third objective is to achieve a reasonable market rate of return on invested funds.

It is the policy of the District to invest public funds in a manner to obtain the highest yield obtainable with the maximum security while meeting the daily cash flow demands of the District as long as investments meet the criteria established by this policy for safety and liquidity and conform to all laws governing the investment of District funds.

B. Safety of Principle

Safety of principle is the foremost objective of the District. Each investment transaction shall seek to first ensure that capital losses are avoided, whether they arise from securities defaults, institution default, broker-dealer default, or erosion of market value of securities. The District shall mitigate the risk to the principle of invested funds by limiting credit and interest rate risks. Credit Risk is the risk of loss due to the failure of a security's issuer or backer. Interest Rate Risk is the risk that the market value of the District's portfolio will fall due to an increase in general interest rates.

1. Credit risk will be mitigated by:

a. Limiting investments to only the most creditworthy types of securities;

b. Prequalifying the financial institutions with which the District will do business, using a questionnaire or other screening tool (see exhibit A); and

c. Diversifying the investment portfolio so that the potential failure of any one issue or issuer will not place undue burden on the District.

2. Interest rate risk will be mitigated by:

a. Structuring the District's portfolio so that securities mature to meet the District's cash requirements for ongoing obligations, thereby reducing the possible need to sell securities on the open market at a loss prior to their maturity to meet those requirements; and
b. Investing a portion of the portfolio in shorter-term securities.

C. Liquidity

Availability of sufficient cash to pay for current expenditures shall be maintained in money market funds, local government investment pools that offer daily liquidity, repurchase agreements, or short-term securities that can easily be converted into cash because they have secondary markets. The accounting management system of the District shall be designed to accurately monitor and forecast expenditures and revenues to ensure the investment of monies to the fullest extent possible.

D. Rates of Return

Yield on investments shall be considered only after the basic requirements of safety and liquidity have been met. The investment portfolio shall be designed to attain a market average rate of return throughout economic cycles, taking into account the District's risk constraints, the composition and cash flow characteristics of the portfolio, and applicable laws.

22.5 Delegation of Authority

A. Responsibilities of the Accounting Department

As delegated on an annual basis by the Board of Directors, and in accordance with California Code Section 53607, Tthe Accounting Department is charged with the responsibility for maintaining custody of all public funds and securities belonging to or under the control of the District, and for the deposit and investment of those funds in accordance with principles of sound treasury management and with applicable laws and ordinances.

B. Responsibilities of the Chief Financial Officer, or contracted financial services vendor

The Chief Financial Officer, or contract financial services vendor, shall perform the monthly review and reconciliation of accounting investments as well as be responsible

for the conduct of all Accounting Department functions.

C. Responsibilities of the ~~Executive Director~~ Chief Executive Officer (CEO)

The ~~Executive Director~~ CEO is responsible for directing and supervising the assigned designee and is responsible further to keep the Board of Directors fully advised as to the financial condition of the District.

D. Responsibilities of the District's Auditing Firm

The District's auditing firm's responsibilities shall include but not be limited to the examination and analysis of fiscal procedures and the examination, checking and verification of accounts and expenditures. A review of the District's investment program is a part of the responsibility described above.

E. Responsibilities of the Board of Directors

The Board of Directors shall annually review and approve the written Investment Policy. As provided in the Policy, the Directors shall receive, review, and accept quarterly investment reports, as identified in California Code Section 53646 et seq, and monthly investment reports as identified in California Code Section 53607, which may be included in the Consent Calendar of the regularly scheduled meeting of the Board of Directors. ~~in the month following the meeting of the Finance/Investment Committee~~.

F. Responsibilities of the Finance/Investment Committee

There shall be a Finance Committee consisting of two (2) members of the Board of Directors and no more than two (2) citizens having experience in accounting, banking, or financial investments. No members of the Finance/Investment Committee shall profit in any way from activities of the Committee. The ~~Executive Director~~ CEO and assigned designee(s) shall serve as staff liaison to the Committee. The Committee shall meet monthly ~~no less than quarterly~~ to discuss the monthly ~~quarterly~~ investment reports, investment strategy, investment and banking procedures, as well as the anticipated cash flow projection and any other significant investment-related activities being undertaken. The Committee's meetings will be summarized in minutes, which are distributed to the Board of Directors with the monthly ~~quarterly~~ investment report. In the event that a monthly Finance Committee meeting is not held, the Accounting Department will prepare an investment report and send it to the full Board of Directors.

22.6 Ethics and Conflicts of Interest

Officers and employees involved in the investment process shall refrain from personal business activity that could conflict with proper execution of the investment program or which could impair their ability to make impartial investment decisions. Employees and

investment officers shall disclose any material financial interest in financial institutions that conduct business with this District, and they shall further disclose any large personal financial / investment positions that could be related to the performance of the District's portfolio.

22.7 Authorized Financial Dealers and Institutions

A. The ~~Executive Director~~ CEO will establish and maintain a list of the financial institutions and broker / dealers authorized to provide investment and depository services to the District. The District shall initially send a copy of its current Investment Policy to all financial institutions and broker / dealers approved to do business with the District. Receipt of the Investment Policy including confirmation that it has been received and reviewed by the person (s) handling the District's account, shall be acknowledged in writing within thirty (30) days. The District's investment status shall be reported to the Board at least annually by participating investment institutions.

1. Depositories

In selecting depositories, the creditworthiness of institutions shall be considered, and the ~~Executive Director~~ CEO shall conduct a comprehensive review of prospective depositories' credit characteristics and financial history as part of the application process.

2. Brokers and Dealers

To become a broker or dealer qualified to do business with the District, a firm must respond to the District's "Broker Dealer Questionnaire" and submit related documents relative to eligibility. Required documents include a current audited financial statement, proof of state registration, proof of FINRA registration, and a certification that the firm has received and reviewed the District's Investment Policy and agrees to offer the District only those securities that are authorized by the Investment Policy. The ~~Executive Director~~ CEO may establish any additional criteria deemed appropriate to evaluate and approve any financial services provider.

If a third-party investment advisor is authorized to conduct investment transactions on the District's behalf, the investment advisor may use its own list of approved broker/dealers and financial institutions. The investment advisor's approved list must be made available to the District upon request.

22.8 Diversification and Risk

The District recognizes that investment risks can result from issuer defaults, market price changes, or various technical complications leading to temporary illiquidity. To minimize the District's exposure to these types of risk, the portfolio should be diversified among several types of institutions, instruments, and maturities. The ~~Executive Director~~ CEO with the Finance Committee shall minimize default risk by prudently selecting only instruments and institutions, which at the time of placement have been evaluated for their financial viability and compliance with this policy. No individual investment transaction shall be undertaken that jeopardizes the total capital position of the overall portfolio.

22.9 Performance Standards

The investment portfolio will be managed in accordance with the standards established within this Investment Policy and should obtain a market rate of return throughout budgetary and economic cycles, taking into account the District's investment risk constraints, cash flow needs, and maturities of the investments. The basis to determine whether market yields are being achieved shall be the total return of the portfolio. The Bank of America Merrill Lynch 1-5 Year U.S. Government/Corporate AAA-A Index is the benchmark that will be compared to the portfolio's sector composition, maturity structure, current investment strategy, and total return. The Finance Committee will periodically review the District's portfolio performance against the benchmark.

22.10 Reporting

The District has adopted California Government Code 53607 and 53646 et seq to define the District's reporting responsibilities.

EMPLOYMENT AGREEMENT

CHIEF EXECUTIVE OFFICER

This employment agreement (the "**Agreement**") is made and entered into as of April 1, 2019 (the "**Effective Date**") by and between the Mark Twain Healthcare District, a political subdivision of the State of California (the "**District**") and Randall Smart, M.D. (the "**Employee**").

RECITALS

The District desires to employ the Employee from the Effective Date until expiration of the term of this Agreement, and Employee is willing to be employed by District during that period, on the terms and subject to the conditions set forth in this Agreement. In consideration of the mutual covenants and promises of the parties, the District and Employee covenant and agree as follows:

AGREEMENT

1. Duties

(a) During the term of this Agreement, Employee will be employed by the District to serve as the Chief Executive Officer of the District. This is a *1.0 FTE* position generally requiring forty (40) hours of service each week. Employee will devote such amount of business time to the conduct of the business of the District as may be reasonably required to effectively discharge Employee's duties under this Agreement and, subject to the supervision and direction of the District's Board of Directors (the "Board"). The employee will perform those duties and have such authority and powers as are customarily associated with the office of the Chief Executive Officer of a healthcare district engaged in a business that is similar to the business of the District and shall include oversight and managerial duties related to the Valley Springs Clinic. Employee shall be provided a copy of the Job Description for the Chief Executive Officer position, which Job Description may change from time to time at the discretion of the District.

(b) Unless the parties agree otherwise in writing, during the term of this Agreement, Employee will not be required to perform services under this Agreement other than at District's principal place of business in Calaveras County, California provided, however, that District may, from time to time, require Employee to travel temporarily to other locations on the District's business. Notwithstanding the foregoing, nothing in this Agreement is to be construed as prohibiting Employee from continuing to serve as a director, officer or member of various professional, charitable and civic organizations in the same manner as immediately prior to the execution of this Agreement.

2. Term of Employment

2.1 At Will Status

Employment with District is voluntarily entered into and shall be considered "at-will". Employee is free to resign at any time, with our without notice, and with or without cause. Similarly,

District may terminate the employment relationship at any time, with or without notice, and with or without or cause, so long as there is no violation of applicable federal or state law. Nothing in this Agreement or in any document or statement shall limit the right of District to terminate the employment relationship "at-will" at any time, with or without cause. Only the Board of Directors of the District has the authority to make any such agreement altering the "at-will" nature of this Agreement, and then only in writing.

2.2 Basic Term

The term of employment of Employee by the District will commence on the Effective Date and will extend for a period of one (1) year until March 31, 2020. Notwithstanding the forgoing, Employee shall remain at all times an "at will" employee of the District and both Employee and the District shall have the right to terminate the employment relationship, without or without cause, and with or without notice at any time, without penalty.

3. Salary, Benefits and Other Compensation

3.1 Compensation

As payment for the services to be rendered by Employee as provided in Section 1, District agrees to pay to Employee compensation in the amount of one hundred and five dollars ($105) per hour.

3.2 Vacation, Holidays and Sick Leave

During the term of this Agreement, Employee will be entitled to vacation, holidays and sick leave in accordance with the normal and customary practices of the District.

3.3 Health and Retirement Benefits

During the term of this Agreement, Employee will be entitled to health and retirement benefits in accordance with the normal and customary practices of the District.

3.4 Expenses

During the term of this Agreement, District will reimburse Employee for Employee's reasonable out-of-pocket expenses incurred in connection with District's business, including travel expenses, food, and lodging while away from the District offices. This shall include, but not be limited to, Employee's attendance at ACHD and other associations deemed useful to the performance by Employee of his job duties for not more than five (5) days per year. Expenses, not to exceed Five Thousand Dollars ($5,000) per year, shall be reviewed and approved by the Board Chair, or a board member designated by the Chair.

4. Confidentiality

Because of Employee's employment by District, Employee will have access to trade secrets and confidential information about District, its products, its customers, and its methods of doing

business (the "Confidential Information "). During and after the termination of Employee's employment by the District, Employee may not directly or indirectly disclose or use any such Confidential Information; provided, that Employee will not incur any liability for disclosure of information which (a) is required in the course of Employee's employment by the District, (b) was permitted in writing by the Board or (c) is within the public domain or comes within the public domain without any breach of this Agreement.

In consideration of Employee's access to the Confidential Information, Employee agrees that for a period of two (2) years after termination of Employee's employment, Employee will not, directly or indirectly, use such Confidential Information to compete with the business of the District, as the business of the District may then be constituted, within any state, region or locality in which the District is then doing business or marketing its products. Employee understands and agrees that direct competition means development, production, promotion, or sale of products or services competitive with those of District. Indirect competition means employment by any competitor or third party providing products competing with District's products, for whom Employee will perform the same or similar function as he performs for the District.

5. Miscellaneous

5.1 Waiver

The waiver of any breach of any provision of this Agreement will not operate or be construed as a waiver of any subsequent breach of the same or other provision of this Agreement.

5.2 Entire Agreement; Modification

Except as otherwise provided in the Agreement, this Agreement represents the entire understanding among the parties with respect to the subject matter of this Agreement, and this Agreement supersedes any and all prior understandings, agreements, plans, and negotiations, whether written or oral, with respect to the subject matter hereof, including without limitation, any understandings, agreements, or obligations respecting any past or future compensation, bonuses, reimbursements, or other payments to Employee from District. All modifications to the Agreement must be in writing and signed by the party against whom enforcement of such modification is sought.

5.3 Notice

All notices and other communications under this Agreement must be in writing and must be given by personal delivery, telecopier or telegram, or first class mail, certified or registered with return receipt requested, and will be deemed to have been duly given upon receipt if personally delivered, three (3) days after mailing, if mailed, or twelve (12) hours after transmission, if delivered by telecopies or telegram, to the respective persons named below:

If to District:

Mark Twain Healthcare District
P.O. Box 95
San Andreas, CA 95249-0095

If to Employee:

Dr. Randall Smart
P.O. Box 306
Murphys, CA 95247-0306

Any party may change such party's address for notices by notice duly given pursuant to this Section.

5.4 Headings

The Section headings of this Agreement are intended for reference and may not by themselves determine the construction or interpretation of this Agreement.

5.5 Governing Law

This Agreement is to be governed by and construed in accordance with the laws of the State of California applicable to contracts entered into and wholly to be performed within the State of California by California residents. Venue shall be in Calaveras County.

5.6 Attorney's Fees

If either party brings an action for any relief or collection against the other party, declaratory or otherwise, arising out of the arrangement described in this Agreement, the losing party shall pay to the prevailing party a reasonable sum for attorneys' fees and costs actually incurred in bringing such action, including fees incurred at trial, in an arbitration, on appeal and on any review therefrom, all of which shall be deemed to have accrued upon the commencement of such action and shall be paid whether or not such action is prosecuted to judgment. Any judgment or order entered in such action shall contain a specific provision providing for the recovery of attorneys' fees and costs incurred in enforcing such judgment. For the purpose of this section, attorneys' fees shall include fees incurred in connection with discovery, post judgment motions, contempt proceedings, garnishment and levy.

5.7 Survival of District's Obligations

This Agreement will be binding on, and inure to the benefit of, the executors, administrators, heirs, successors, and assigns of the parties; provided, however, that except as expressly provided in this Agreement, this Agreement may not be assigned either by District or by Employee.

5.8 Counterparts

This Agreement may be executed in one or more counterparts, all of which taken together will constitute one and the same Agreement.

5.9 Enforcement

If any portion of this Agreement is determined to be invalid or unenforceable, that portion of this Agreement will be adjusted, rather than voided, to achieve the intent of the parties under this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on April 3, 20 19, in San Andreas, California.

Mark Twain Healthcare District

By: _____
Its: Chair, Board of Directors

Dr. Randall Smart
Employee

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