CAMARILLO HEALTH CARE DISTRICT

For your health & wellness

Regular Board of Directors Meeting
3615 E Las Posas Road, Suite 161
Camarillo, CA 93010
Tuesday, April 24, 2018
12:00 p.m.

2018 Board Meeting Calendar

January 23, 2018, 12:00 p.m.

February 27, 2018, 12:00 p.m.

March 27, 2018, 12:00 p.m.

April 24, 2018, 12:00 p.m.

May 29, 2018, 12:00 p.m.

June 12, 2018, 12:00 p.m. (Budget)

June 26, 2018, 12:00 p.m. (If Needed)

July 24, 2018, 12:00 p.m.

August – Dark

September 18, 2018, 12:00 p.m.

October 23, 2018, 12:00 p.m.

November - Dark

December 4, 2018, 8:30 a.m. (Board Work Study)

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AGENDA

April 24, 2018 12:00 p.m.

Camarillo Health Care District
Regular Meeting of the Board of Directors
3615 E. Las Posas Road, Suites 160 and 161, Camarillo, CA 93010

Board of Directors
Rod Brown, MBA, President
Christopher Loh, MD, Vice President
Richard Loft, MD, Clerk of the Board
Mark Hiepler, Esq., Director
Tom Doria, MD, Director

Staff
Kara Ralston, Chief Executive Officer
Sue Tatangelo, Chief Resource Officer
Sonia Amezcua, Chief Administrative Officer
Karen Valentine, Clerk to the Board

Participants
Rick Wood, *CSDA Financial Services*

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1. **Call to Order/Roll Call**

2. **Pledge of Allegiance – Director Doria**

3. **Amendments to the Agenda**
Requests to change the order of the agenda, delete, add any agenda item(s), or to remove any consent agenda items for discussion.

4. **Public Comment – Ca. GC Section 54954.3;** The Board reserves this time to hear from the public. Please complete a Speaker Card and submit to the Clerk of the Board. Your name will be called in order of the agenda item, or in order of received general topic Speaker Cards. Comments regarding items not on the agenda can be heard only; items on the agenda can be discussed. Three minutes per speaker are available, multiple speakers on the same topic/agenda item will be limited to 20 minutes total.

5. **Presentations –**

6. **Discussion/Action Items – Consideration, Discussion, and Decision:**

Discussion and consideration of Financial Reports and District Disbursements for the period ending March 31, 2018. **(Please See Section 6)**

Suggested Motion: Vote to approve District Financial Report and Disbursements for the period ending March 31, 2018.

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

7. Closed Sessions:

Pursuant to California Government Code 54957(b)(1) – Chief Executive Officer, Performance Evaluation.

8. Reconvene from Closed Session –

9. Announcement of Closed Session – Pursuant to Government Code §54957.1 – The legislative body of any local agency shall publicly report any reportable action taken in closed session and the vote or abstention on that action of every member present.

10. Consent Agenda – Consent Agenda items are considered routine and are acted upon without discussion, with one motion. If discussion is requested, that item(s) will be removed from the Consent Agenda for discussion and voted on as a separate item. If no discussion is requested, the Board Chairperson may request a motion to approve as presented.

A. Approve the Minutes of the Regular Board Meeting of March 27, 2018.
(Please see Section 10-A)

B. Approve the Minutes of the Executive Committee Meeting of April 10, 2018.
(Please see Section 10-B)

Suggested Motion: Vote to approve Consent Calendar as presented.

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

11. Discussion/Action Items

A. It is the recommendation of Administration that the Board of Directors approve Resolution 18-02, Requesting Consolidation of the Camarillo Health Care District General District Election with the Statewide General Election. **(Please see Section 11-A)**

Suggested Motion: Vote to approve Resolution 18-02, Requesting Consolidation of the Camarillo Health Care District General District Election with the Statewide General Election.

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

B. Discussion and consideration of the revised Pay Schedule, Attachment B, determining the amount of compensation earnable pursuant to California Code of Regulations (CCR) Title 2, Section 570.5. **(Please see Section 11-B)**

Suggested Motion: Vote to approve the revised Pay Schedule, Attachment B, determining the amount of compensation earnable pursuant to California Code of Regulations (CCR), Title 2, Section 570.5

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

C. It is the recommendation of Administration that the Board of Directors approve Resolution 18-03, Declaring May 2018 as "Older Americans Month". **(Please see Section 11-C)**

Suggested Motion: Vote to approve Resolution 18-03, Declaring May 2018 as "Older Americans Month".

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

D. It is the recommendation of Administration that the Board of Directors approve Resolution 18-04, changing the December 4, 2018 Board of Directors Meeting to December 11, 2018. The meeting time, 8:30 a.m. will remain the same. **(Please see Section 11-D)**

Suggested Motion: Vote to approve Resolution 18-04, changing the December 4, 2018 Board of Directors Meeting to December 11, 2018.

Motion_____Second_____Abstain_____Pass_____

Brown_____Loh_____Loft_____Hiepler_____Doria_____

12. Chief Executive Officer Report

13. Board President's Report

14. Board Members Interests and Concerns:

15. Future Meetings and Events:

Board of Directors

• Executive Committee (Brown/Loh)	Wednesday, May 9, 2018, 12:00 p.m.
• Full Board	Tuesday, May 29, 2018, 12:00 p.m.
• Executive Committee (Brown/Loh)	Tuesday, June 5, 2018, 12:00 p.m.
• Full Board– Budget Presentation – First Reading	Tuesday, June 12, 2018, 12:00 p.m.
• Executive Committee (Brown/Loh)	Tuesday, June 19, 2018, 12:00 p.m. (If Needed)
• Full Board– Budget Presentation – Second Reading Second reading may be waived	Tuesday, June 26, 2018, 12:00 p.m.
• Executive Committee (Brown/Loh)	Tuesday, July 17, 2018, 12:00 p.m.
• Finance Committee (Hiepler/Doria)	Tuesday, July 24, 2018, 11:00 a.m.
• Full Board	Tuesday, July 24, 2018, 12:00 p.m.

Events

• Business & Legislators Forum Camarillo Chamber of Commerce	May 18, 2018, 11:30 a.m. to 1:00 p.m. Spanish Hills Country Club
• Legislative Days – California Special Districts Association (CSDA) Sacramento, CA.	May 22-23, 2018

16. Adjournment – Having no further business, this meeting is adjourned at _____p.m.

Action Items not appearing on the Agenda may be addressed on an emergency basis by a majority vote of the Board of Directors when need for action arises.

ADA Compliance Statement – In Compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Clerk to the Board of Directors, Karen Valentine, at (805) 482-9382. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to this meeting.

Note: This agenda was posted at the Camarillo Health Care District Administrative Office and on our website, www.camhealth.com, on Friday, April 20, 2018, at 4:00 p.m.

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SECTION 6

ACTION ITEMS

SECTION 6
FINANCIAL REPORTS
DISCUSSION AND CONSIDERATION OF FINANCIAL REPORTS AND DISTRICT DISBURSEMENTS FOR PERIOD ENDING MARCH 31, 2018.

APRIL 24, 2018

Camarillo Health Care District
Statements of Activities
Comparison to Budget for the
Nine Months Ending March 31, 2018

REVENUES	Audited Actual 14 - 15	Audited Actual 15 - 16	Actual 16 - 17	Current Year-to-Date	Budget to-date	Annual Budget	Y-T-D vs Annual Budget
Tax revenue	$ 2,244,695	$ 2,375,896	$ 2,472,000	$ 2,072,980	$ 1,909,620	$ 2,546,160	81.42%
Program and facilities revenue	653,310	398,419	359,482	268,363	309,212	412,283	65.09%
Grants and agency funding	244,970	238,124	329,844	414,388	252,894	336,359	123.20%
Community Support and sponsorship	4,478	14,286	13,173	7,826	8,775	11,700	66.89%
Investment and interest income	144,126	155,200	161,872	164,625	156,000	158,000	104.19%
Other income	102,118	102,619	30,867	37,265	29,945	39,927	93.33%
Total Revenues	$ 3,393,696	$ 3,284,543	$ 3,367,239	$ 2,965,447	$ 2,666,447	3,504,429	84.62%
EXPENSES							
Personnel cost							
Wages and salaries	1,569,500	1,347,709	1,392,944	1,071,663	1,193,778	1,591,704	67.33%
Payroll taxes	562,284	110,164	111,521	90,240	91,324	152,960	59.00%
Benefits		189,450	291,397	233,276	276,107	336,947	69.23%
OPEB		233,378	233,005	174,358	151,351	201,802	86.40%
Retirement UAL		29,064	38,046	50,594	52,456	52,456	96.45%
Total personnel cost	2,131,785	1,909,765	2,066,912	1,620,131	1,765,017	2,335,869	69.36%
Other expenses							
Contractors and professional fees	276,798	300,824	395,721	274,853	246,173	325,789	84.37%
Facilities and related	244,652	238,656	230,961	166,879	196,979	262,638	63.54%
Depreciation	191,015	175,355	164,193	116,133	117,392	156,523	74.20%
Program related expense	98,098	80,067	71,985	56,392	55,997	74,663	75.53%
Advertising and promotion	120,082	77,736	83,139	63,565	74,813	99,750	63.72%
Supplies and office expense	69,349	68,046	71,473	59,694	47,705	63,606	93.85%
Board and staff	110,252	61,358	76,237	52,867	79,668	103,455	51.10%
Community partnerships	-	2,500	2,200	1,000	2,500	2,500	40.00%

Camarillo Health Care District
Statements of Activities
Comparison to Budget for the
Nine Months Ending March 31, 2018

	Audited Actual 14 - 15	Audited Actual 15 - 16	Actual 16 - 17	Current Year-to-Date	Budget to-date	Annual Budget	Y-T-D vs Annual Budget
Combined other expenses	25,835	30,007	22,506	15,002	18,264	24,352	61.60%
Total other expenses	1,136,081	1,034,549	1,118,416	806,385	839,490	1,113,276	72.43%
Operations Net	125,831	340,229	181,911	538,932	61,940	55,284	974.84%
Adjustments	1,193,105						
Total expenses	4,460,970	2,944,314	3,185,328	2,426,515	2,604,507	3,449,145	70.35%
Net position after adjustments	$ (1,067,274)	$ 340,229	$ 181,911	$ 538,932	$ 61,940	$ 55,284	974.84%

Camarillo Health Care District
Statements of Net Assets
As of March 31, 2018

ASSETS	Mar. 31, 2018	Mar. 31, 2017
Current Assets:		
Cash and Checking Accounts	$ 190,413	$ 311,229
Investment Accounts	2,964,748	2,217,365
Accounts and Grants Receivable	593,404	654,932
Total Current Assets	3,748,565	3,183,527
Noncurrent Assets:		
Property, plant and equipment - net	1,420,564	1,542,818
IS equipment - net	24,529	18,803
Transportation vehicles - net	57,791	84,165
Restricted GASB 75 OPEB	990,100	-
Prepaids	11,065	11,650
Total Noncurrent Assets	2,504,049	1,657,435
Deferred Outflows of Resources	431,775	264,803
Total Assets	$ 6,684,389	$ 5,105,765
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Accounts Payable	$ 63,809	$ 74,824
Construction Loan 2017	85,482	82,393
Employment costs	103,195	94,724
Accrued OPEB liability GASB 75	2,551,624	330,317
Scholarships	4,404	6,999
Deferred Revenue	16,867	9,983
Total Current Liabilities	2,825,381	599,241
Noncurrent Liabilities		
Construction Loan to 2021	276,166	361,648
Net Pension Liability GASB 68	1,203,554	821,635
Deferred Inflows of Resources	309,287	450,825
Total Noncurrent Liabilities	1,789,007	1,634,108
Net Assets:		
Unrestricted - prior	1,531,070	2,535,771
Unrestricted - current	538,932	336,645
Total Net Assets	2,070,002	2,872,416
Total Liabilities and Net Assets	$ 6,684,389	$ 5,105,765

Quick Ratio

Cash, Checking, Investment	
3,155,161	1.12

Current Ratio

Current Assets	
3,748,565	1.33

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Camarillo Health Care District
Statements of Net Assets
As of March 31, 2018

ASSETS	Mar. 31, 2018	Mar. 31, 2017	Mar. 31, 2016	Mar. 31, 2015	Mar. 31, 2014
Current Assets:					
Cash and Checking Accounts	$ 190,413	$ 311,229	$ 406,463	$ 182,744	$ 432,530
Investment Accounts	2,964,748	2,217,365	1,780,890	1,367,201	721,579
Accounts and Grants Receivable	593,404	654,932	416,808	423,565	576,371
Total Current Assets	$ 3,748,565	3,183,527	2,604,161	1,973,509	1,730,480
Noncurrent Assets:					
Property, plant and equipment - net	1,420,564	1,542,818	1,666,272	2,161,368	1,722,947
IS equipment - net	24,529	18,803	25,748	30,243	34,873
Transportation vehicles - net	57,791	84,165	110,538	161,882	196,846
Restricted GASB 75 OPEB	990,100	-	-	-	-
Prepaids	11,065	11,650	40,851	38,780	21,779
Total Noncurrent Assets	2,504,049	1,657,435	1,843,410	2,392,273	1,976,445
Deferred Outflows of Resources	431,775	264,803	112,553		
Total Assets	$ 6,684,389	$ 5,105,765	$ 4,560,124	$ 4,365,783	$ 3,706,925
LIABILITIES AND NET ASSETS					
Current Liabilities:					
Accounts Payable	$ 63,809	$ 74,824	$ 27,529	$ 47,492	$ 45,575
Construction Loan 2017	85,482	82,393	79,415	76,544	
Employment costs	103,195	94,724	97,831	174,259	198,322
Accrued OPEB liability GASB 75	2,551,624	330,317	206,830	183,810	152,350
Scholarships	4,404	6,999	20,335	7,380	10,762
Deferred Revenue	16,867	9,983	8,886	2,103	4,603

Total Current Liabilities	2,825,381	599,241	440,826	491,589	411,612

Camarillo Health Care District
Statements of Net Assets
As of March 31, 2018

	Mar. 31, 2018	Mar. 31, 2017	Mar. 31, 2016	Mar. 31, 2015	Mar. 31, 2014
Noncurrent Liabilities					
Construction Loan to 2021	276,166	361,648	444,041	523,456	
Net Pension Liability GASB 68	1,203,554	821,635	959,515		
Deferred Inflows of Resources	309,287	450,825	250,690		
Total Noncurrent Liabilities	1,789,007	1,634,108	1,654,246	523,456	
Net Assets:					
Unrestricted - prior	1,531,070	2,535,771	2,195,543	3,262,816	3,294,277
Unrestricted - current	538,932	336,645	269,510	87,922	1,036
Total Net Assets	2,070,002	2,872,416	2,465,053	3,350,738	3,295,314
Total Liabilities and Net Assets	$ 6,684,389	$ 5,105,765	$ 4,560,124	$ 4,365,783	$ 3,706,925
Quick Ratio (Cash, Checking & Investment Accounts divided by Total Current Liabilities)	1.12	4.22	4.96	3.15	2.80
Current Ratio (Total Current Assets divided by Total Current Liabilities)	1.33	5.31	5.91	4.01	4.20

Quick Ratio - measures the dollar amount of liquid assets available for each dollar of current liabilities. Thus a quick ratio of 1.5 means that a company has $1.50 of liquid assets available to cover each $1 of current liabilities.

Current Ratio - shows how many times over the firm can pay its current debt obligations based on its assets.

Camarillo Health Care District

Check Register (Checks and EFTs of All Types)

Sorted by Vendor

(Report period: March 1, 2018 to March 31, 2018)

Check Number	Date	EFT # / Vendor	Name	Net Amount	Type	Timing
Cash Account #4 [Bank of the West General]						
66060	3/8/2018	ACCESS	Access TLC Caregivers DBA	550.00	V	MO
66087	3/14/2018	ACQUA	Acqua Clear, Inc	578.18	V	QTLY
66126	3/27/2018	AFLAC	Aflac	1,089.54	V	MO
66088	3/14/2018	ANDERSON	Anderson Refrigeration dba	125.00	V	QTLY
66061	3/8/2018	ANDISITES	AndiSites, Inc	189.00	V	MO
66062	3/8/2018	ASLANIAN	Margaret Aslanian	175.00	F	
66089	3/14/2018	ASSISTED	Assisted Healthcare Services	1,677.75	V	MO
66063	3/8/2018	BANYAI	Danette Banyai	294.00	F	MO
66127	3/27/2018	BERRY	John Berry	10.00	refund	couldn't attend
66064	3/8/2018	BETA	Beta Healthcare Group	760.16	V	MO
66106	3/21/2018	BETA WC	Beta Healthcare Group	2,088.00	V	MO
66107	3/21/2018	BOTW	Bankcard Center	3,024.22	V	MO
66065	3/8/2018	BOWERS	Tracy Bowers	322.00	F	
66128	3/27/2018	BUCKLEY	Elizabeth Buckley	350.00	F	
66129	3/27/2018	BURNS	Anne Burns	10.00	refund	appt cancelled
66066	3/8/2018	C3 INTEL	C3 Intelligence, Inc	312.90	V	
66130	3/27/2018	CARD	Patricia Card	150.00	F	
66090	3/14/2018	CIPMA	CIPMA-HR	85.00	V	ANNUALY
66067	3/8/2018	CMH	CMH Centers for Family Health	320.00	V	
66108	3/21/2018	COLANTUONO	Colantuono, Highsmith, Whatley, PC	592.50	V	
66091	3/14/2018	COLITTI	Sydney Colitti	100.72	EE	MO
66124	3/27/2018	CPI	CPI Solutions, Inc	19,454.24	V	MO+SERVER
66092	3/14/2018	CRADDOCK	Blair Craddock	100.93	EE	MO
66068	3/8/2018	CRAWFORD L	Lorenzo Crawford	72.80	F	MO
66069	3/8/2018	DIGITAL	Digital Deployment, Inc	800.00	V	MO
66070	3/8/2018	DOS CAMINOS	Dos Caminos Plaza	4,538.38	V	MO
66071	3/8/2018	DOSCAMSTORA	Dos Caminos Plaza, Inc	50.00	V	MO
66072	3/8/2018	FARMER BROS	Farmers Bros. Co	226.12	V	
66125	3/27/2018	FERGUSON CAS	Ferguson, Case, Orr Paterson LLP	14,537.90	V	
66093	3/14/2018	FRONTIER	Frontier Communications	126.98	V	MO
66131	3/27/2018	HARMALA	Michelle Harmala	400.00	F	
66073	3/8/2018	HARTFORD	Hartford Life	1,052.40	V	MO
66094	3/14/2018	HARVEY	Lynette Harvey	104.64	EE	MO
66074	3/8/2018	HOME REMEDIE	Home Remedies dba	1,095.00	V	MO
66109	3/21/2018	ITS	Integrated Telemanagement Services, Inc	817.55	V	MO
66075	3/8/2018	IVEY	Jane Ivey	112.00	F	
66095	3/14/2018	IVEY	Jane Ivey	56.00	F	
66110	3/21/2018	JONES	Lynn Jones	107.91	EE	MO
66111	3/21/2018	JORDANO'S	Jordano's Food Service	143.19	V	MO
66076	3/8/2018	JOSE	Myka Jose	100.83	EE	MO
66077	3/8/2018	JTS	JTS Facility Services	3,555.82	V	MO
66096	3/14/2018	LEAF	Leaf	2,025.32	V	MO

Camarillo Health Care District

Check Register (Checks and EFTs of All Types)

Sorted by Vendor

(Report period: March 1, 2018 to March 31, 2018)

Check Number	Date	EFT # / Vendor	Name	Net Amount	Type	Timing
66097	3/14/2018	LONGOBART	Karen Longobart	45.00	refund	class cancelled
66098	3/14/2018	MCMULLEN	Don McMullen	59.00	refund	double pmt
66078	3/8/2018	MEDITECH	Meditech Health Services	550.00	V	
66099	3/14/2018	MEDITECH	Meditech Health Services	600.00	V	
66112	3/21/2018	MEDITECH	Meditech Health Services	760.00	V	
66079	3/8/2018	METLIFE	MetLife Small Business	746.58	V	MO
66080	3/8/2018	MORAN	Carmen Moran	303.02	EE	MO
66100	3/14/2018	MUSTANG	Mustang Marketing dba	2,275.00	V	MO
66081	3/8/2018	NUNN	Nunn Better, Inc	670.00	V	
66132	3/27/2018	PETTY	Petty Cash - Administrat	321.58		MO
66113	3/21/2018	PLATINUM	Platinum Tow & Transport	312.50	V	
66082	3/8/2018	ROGERS	Rogers & Partners, Inc	77.00	F	MO
66114	3/21/2018	SAFEWAY	Safeway Inc	183.36	V	MO
66115	3/21/2018	SHOEMAKER	Bonnie Shoemaker	500.00	F	
66133	3/27/2018	SO CA EDISON	Southern Ca. Edison Co.	1,661.13	V	MO
66101	3/14/2018	SO CA GAS	Southern California Gas	484.06	V	MO
66116	3/21/2018	SOMIS	Somis Thursday Club	35.00	V	ANNUALY
66117	3/21/2018	STAFF	Staff Assistance, Inc	1,801.00	V	
66118	3/21/2018	STAPLES	Staples Business Advantage	279.37	V	
66102	3/14/2018	TNT	TNT Automotive	844.48	V	
66134	3/27/2018	TNT	TNT Automotive	211.95	V	
66103	3/14/2018	TROPHIES	Trophies, Etc.	21.45	V	
66119	3/21/2018	TROPICAL	Tropical Car Wash	260.00	V	MO
66120	3/21/2018	US POST METR	United States Postal Svc	300.00	V	
66083	3/8/2018	USPOSTMASTER	U.S. Postmaster	6,800.00	V	QTLY
66121	3/21/2018	VALIC	VALIC	1,046.67	V	MO
66135	3/27/2018	VAUGHN	Carol Vaughn	150.00	F	
66122	3/21/2018	VCSDA	V C S D A	60.00		
66084	3/8/2018	VISION	Vision Services Plan	162.46	V	MO
66123	3/21/2018	VOYAGER	Voyager Fleet Systems Inc	1,083.98	V	MO
66085	3/8/2018	WIGGINS	Mary Wiggins	87.75	EE	MO
66104	3/14/2018	WYLY	Paulette Wyly	21.80	EE	MO
66105	3/14/2018	YOUNG	Jennifer Young	117.34	EE	MO
66086	3/8/2018	ZEPEDA	Monica Zepeda	90.47	EE	MO

Cash account Total	85,203.93
Report Total	85,203.93

Type: Board (B), Employee (EE), Facilitator (F), Vendor (V)

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SECTION 7

SECTION 7
CLOSED SESSION
PURSUANT TO CALIFORNIA GOVERNMENT CODE 54957(B)(1) –
CHIEF EXECUTIVE OFFICER PERFORMANCE EVALUATION.

APRIL 24, 2018

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SECTION 8

RECONVENE FROM CLOSED SESSION

APRIL 24, 2018

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SECTION 9

ANNOUNCEMENT OF CLOSED SESSION
GOVERNMENT CODE 54957.1

APRIL 24, 2018

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SECTION 10

CONSENT AGENDA

APPROVAL OF MINUTES OF
THE REGULAR BOARD MEETING OF MARCH 27, 2018

SECTION 10-A

APRIL 24, 2018

CAMARILLO HEALTH CARE DISTRICT

MINUTES March 27, 2018

Regular Meeting of the Board of Directors
3615 E. Las Posas Road, Suites 160 & 161, Camarillo, CA 93010

Board of Directors - Present
Rodger Brown, MBA, Board President
Christopher Loh, MD, Vice President
Richard Loft, MD, Clerk of the Board
Mark Hiepler, ESQ, Director
Thomas Doria, MD, Director

Staff - Present
Kara Ralston, Chief Executive Officer
Sonia Amezcua, Chief Administrative Officer
Renee Murphy, Accounting Manager
Karen Valentine, Clerk to the Board

Participants - Present
Michael Velthoen, Esq., *Ferguson Case Orr Patterson, LLP*
Rick Wood, *CSDA Financial Services*

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1. **Call to Order and Roll Call -** The Regular Meeting of the Camarillo Health Care District Board of Directors was called to order on Tuesday, March 27, 2018, at 12:04 p.m., by Rodger Brown, President.

2. **Pledge of Allegiance –** Director Loh

3. **Amendments to The Agenda** – None

4. **Public Comment –** Steve Waldron suggested that the Ferguson lawsuit be settled for $5,000 and the Rozanski lawsuit be settled for $10,000.

5. **Presentations –** None

6. **Discussion/Action Item -**

   A. CEO Ralston and Rick Wood presented the District's Disbursements and Financial Report for the period ending February 28, 2018.

   It was **MOVED** by Director Doria, **SECONDED** by Director Loh, and **MOTION PASSED** that the Board of Directors approve the District Disbursements and Financial Report for the period ending February 28, 2018.

Vote to Approve Financial Report For Period Ending February 28, 2018	
Director Brown	**Aye**
Director Loh	**Aye**
Director Loft	**Aye**
Director Hiepler	**Aye**
Director Doria	**Aye**

7. **Closed Session:** Entered Closed Session at 12:40 p.m.

A. Conference with Legal Counsel – Existing Litigation, one case, Government Code §54956.9(d)(1), Camarillo Health Care vs. Rozanski, Ventura County Superior Court Case No. 56-2016-00487601-CU-MC-VTA.

B. Conference with Legal Counsel – Existing Litigation, one case, Government Code §54956.9(d)(1), Ferguson vs. Camarillo Health Care, Ventura County Superior Court Case No. 56-2016-00478549-CU-BC-VTA.

8. **Reconvene from Closed Session:** Reconvened at 1:22 p.m.

9. **Announcement of Closed Session –** Pursuant to Government Code §54957.1 – The legislative body of any local agency shall publicly report any reportable action taken in closed session and the vote or abstention on that action of every member present.

A. Ventura County Superior Court Case No. 56-2016-00487601-CU-MC-VTA, Camarillo Health Care vs. Rozanski - The Board of Directors of the Camarillo Health Care District has entered into a provisional settlement agreement with Jane Rozanski. The District has agreed to accept Ms. Rozanski's offer of $173,000 payable on or before May 1, 2018.

Vote to Approve Provisional Settlement with Jane Rozanski, to be paid to the District on or before May 1, 2018.	
Director Brown	**Aye**
Director Loh	**Aye**
Director Loft	**Aye**
Director Hiepler	**Aye**
Director Doria	**Aye**

B. No Reportable Action

10. **Consent Agenda** – It was **MOVED** by Director Loh, **SECONDED** by Director Loft, and **MOTION PASSED** that the Board of Directors approve the Consent Agenda as presented.

Vote to Approve Consent Agenda	
Director Brown:	**Aye**
Director Loh:	**Aye**
Director Loft:	**Aye**
Director Hiepler:	**Aye**
Director Doria:	**Aye**

11. **A.** The Board of Directors reviewed and approved amendments to the District Investment Policy as follows:

Section 5.5 – Responsibilities of the Board of Directors

The Board of Directors shall annually review the written Investment Policy. As provided in the Policy, the Directors shall receive, review, and accept quarterly investment reports which will be included in the Consent Calendar of the ~~next~~ regularly scheduled meeting of the Board of Directors in the month following the meeting of the Finance/Investment Committee.

Section 6 – Reporting

Changes to numbering and formatting.

It was **MOVED** by Director Loft, **SECONDED** by Director Brown, and **MOTION PASSED**, to approve amendments to the District Investment Policy.

Vote to Approve Amendments to the District Investment Policy.	
Director Brown:	**Aye**
Director Loh:	**Aye**
Director Loft:	**Aye**
Director Hiepler:	**Aye**
Director Doria:	**Aye**

B. The Board of Directors reviewed the "Compensation Agreement for Hotel Conference Center" between the City of Camarillo and the Camarillo Health Care District, and heard further review conducted by District counsel Colantuono Highsmith & Whatley (CHW), which recommends adding a section; section 3.5. CHW review indicates the compensation agreement is lawful and that the City of Camarillo accepted the proposed section 3.5.

3.5 Nothing in this agreement amends or changes the existing constitutional and statutory allocations to each of the taxing entities of property, sales and use, and other taxes.

It was **MOVED** by Director Hiepler, **SECONDED** by Director Doria, and **MOTION PASSED** to approve the revised "Compensation Agreement for Hotel Conference Center".

Vote to Approve Revised Compensation Agreement	
Director Brown:	**Aye**
Director Loh:	**Aye**
Director Loft:	**Aye**
Director Hiepler:	**Aye**
Director Doria:	**Aye**

C. The Board of Directors reviewed and discussed District Policy Number 2001 – Compensation of the Chief Executive Officer.

It was **MOVED** by Director Doria, **SECONDED** by Director Hiepler, and **MOTION PASSED** to approve District Policy Number 2001 – Compensation of the Chief Executive Officer.

Vote to Approve District Policy Number 2001	
Director Brown:	**Aye**
Director Loh:	**Aye**
Director Loft:	**Aye**
Director Hiepler:	**Aye**
Director Doria:	**Aye**

12. **CEO Report -** Deferred.

13. **Board President's Report** – President Brown reported that electronic link to the CEO Evaluation materials would be sent to each Board Member no later than March 28, 2018. President Brown requested that all Directors have their evaluations completed and returned no later than April 15, 2018.

14. Having no further business, this meeting is adjourned at 1:41 p.m.

_____
Richard Loft
Clerk of the Board

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SECTION 10

CONSENT AGENDA

APPROVAL OF THE MINUTES OF THE EXECUTIVE/AGENDA PLANNING COMMITTEE MEETING OF APRIL 10, 2018

SECTION 10-B

APRIL 24, 2018

CAMARILLO HEALTH CARE DISTRICT

MINUTES

April 10, 2018

Executive/Agenda Building Committee Meeting
Camarillo Health Care District Board of Directors
3615 E Las Posas Road, Boardroom, Camarillo, CA 93010

Board Members Present:
Rod Brown, MBA, President

Staff Present:
Kara Ralston, Chief Executive Officer
Karen Valentine, Clerk to the Board

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1. **Call to Order –** The Executive Committee was called to order by Board President, Rod Brown, at 12:08 p.m.

2. **Public Comment** – No Public Comment

3. Reviewed the Minutes of the regularly scheduled Board Meeting of Tuesday, March 27, 2018.

4. Reviewed the proposed Agenda for the regularly scheduled Board Meeting of Tuesday, April 24, 2018.

5. Reviewed District Disbursements for period ending March 31, 2018. CEO Ralston proposed that staff prepare an addendum page to the disbursement report reflecting a month-by-month comparison, to present to the Finance Committee at their next meeting.

6. Reviewed the following Action Items:

   11A – Reviewed District Resolution 18-02, requesting consolidation of the Camarillo Health Care District General District Election with the Statewide General Election.

   11B – Reviewed District Resolution 18-03, declaring May 2018 as "Older Americans Month".

7. Discussed changing the date of the December 4, 2018 Regular Board Meeting to December 11, 2018. A Resolution will be presented to the Board at the April meeting requesting the date change.

8. Meeting adjourned at 12:51 p.m.

_____
Rod Brown
President

SECTION 11

ACTION ITEMS

IT IS THE RECOMMENDATION OF ADMINISTRATION THAT THE BOARD OF DIRECTORS APPROVE RESOLUTION 18-02, REQUESTING CONSOLIDATION OF THE CAMARILLO HEALTH CARE DISTRICT GENERAL DISTRICT ELECTION WITH THE STATEWIDE GENERAL ELECTION.

SECTION 11-A

APRIL 24, 2018

RESOLUTION NO. 18-02

REQUESTING CONSOLIDATION OF THE CAMARILLO HEALTH CARE DISTRICT GENERAL DISTRICT ELECTION WITH THE STATEWIDE GENERAL ELECTION

Resolution of the Board of Directors
Camarillo Health Care District
Ventura County, California

WHEREAS, an election shall be conducted for the Camarillo Health Care District pursuant to the Uniform District Election Law commencing with Section 10500 of the Elections Code every two years for the purpose of electing Board Members; and

WHEREAS, a statewide general election will be held within the County of Ventura on the same day;

WHEREAS, pursuant to Section 10400 et seq. of the Election Code, said election may be consolidated with other elections to be held on the same day; and

WHEREAS, whenever an election called by a district, city, or other political subdivision for the submission of a question, proposition, or office to be filled is to be consolidated with a statewide election, and the question, proposition, or office to be filled is to appear upon the same ballot as that provided for the statewide election, the district, city, or other political subdivision shall, at least 88 days prior to the date of the election, file with the board of supervisors, and copy with the elections official, a resolution of its governing board that requests that the Camarillo Health Care District election be consolidated with the statewide election, and acknowledges that the consolidated election will be conducted in the manner prescribed in Section 10418.

WHEREAS, the resolution requesting the consolidation shall be adopted and filed at the same time as the adoption of the ordinance, resolution, or order calling the election.

WHEREAS, various district, county, state and other political subdivision elections may be or have been called to be held on November 6, 2018; and

WHEREAS, the names of the candidates to appear upon the ballot where district, city, or other political subdivision offices are to be filled shall be filed with the county elections official no later than 81 days prior to the election.

NOW, THEREFORE BE IT RESOLVED by the Board of Directors of the Camarillo Health Care District as follows:

1. Whenever an election is to be held on the same day as a statewide election, a special election, or an election held pursuant to Section 1302 or 1303, the election may be consolidated with the statewide or special election, or the election held pursuant to Section 1302 or 1303, as applicable. If consolidated, the consolidated election shall be

held and conducted, election boards appointed, voting precincts designated, candidates nominated, ballots printed, polls opened and closed, voter challenges determined, ballots counted and returned, returns canvassed, results declared, certificates of election issued, recounts conducted, election contests presented, and all other proceedings incidental to and connected with the election shall be regulated and done in accordance with the provisions of law regulating the statewide or special election, or the election held pursuant to Section 1302 or 1303, as applicable.

2. The precincts used at the consolidation election shall be those used for the statewide, special, or regularly scheduled election and, where necessary, the county elections official may adjust precinct lines to coincide with the boundaries of the particular jurisdiction.

BE IT FURTHER RESOLVED AND ORDERED THAT THE governing body of the Camarillo Health Care District hereby orders an election be called and consolidated with any and all elections also called to be held on November 6, 2018 insofar as said elections are to be held in the same territory or in territory that is in part the same as the territory of the Camarillo Health Care District, and requests the Ventura County Board of Supervisors to order such consolidation under current Elections Code Section 10401 and 10403; and

BE IT FURTHER RESOLVED AND ORDERED that said governing body hereby requests the Board of Supervisors to permit the Ventura County Elections Department to provide any and all services necessary for conducting the election and agrees to pay for said services, and

BE IT FURTHER RESOLVED AND ORDERED that after a General District Board Member Election ending in a tie vote as defined in Elections Code 15651, the winner will be determined by lot and the District shall immediately notify the candidates who received the tie votes of the time and place where lots shall be cast to determine the winner; and

BE IT FURTHER RESOLVED AND ORDERED that the Ventura County Elections Department conduct the election for the following offices on the November 6, 2018 ballot:

SEATS OPEN	OFFICE	TERM
2	Director	4 Years
1	Director	2 Years

ADOPTED this 24th day of April, 2018.

_____
Rodger Brown, President
Board of Directors

Attest: _____
Richard Loft, Clerk of the Board
Board of Directors

STATE OF CALIFORNIA)

COUNTY OF VENTURA) ss

I, Richard Loft, Clerk of the Board of Directors of the Camarillo Health Care District

DO HEREBY CERTIFY that the foregoing Resolution 18-02 was duly adopted by the Board of Directors of said District at a regular meeting held on the 24th day of April, 2018 and it was adopted by the following vote:

AYES: _____

NAYS: _____

ABSENT: _____

_____
Richard Loft, Clerk of the Board
Board of Directors
Camarillo Health Care District

SECTION 11

ACTION ITEMS

CONSIDERATION AND REVIEW OF THE REVISED PAY SCHEDULE, ATTACHMENT B, DETERMINING THE AMOUNT OF COMPENSATION EARNABLE PURSUANT TO CALIFORNIA CODE OF REGULATIONS (CCR) TITLE 2, SECTION 570.5.

SECTION 11-B

APRIL 24, 2018

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Camarillo Health Care District
Pay Schedule -effective April 24, 2018

Classification	Time Base	Minimum	Maximum
Officers			
Chief Executive Officer	Annual	$ 151,840.00	$ 224,952.00
Chief Resource Officer	Annual	$ 74,880.00	$ 128,419.00
Chief Administrative Officer	Annual	$ 74,880.00	$ 128,419.00
*Clinical Services Officer	Annual	$ 74,880.00	$ 128,419.00
Directors			
Program & Operations Director	Annual	$ 70,000.00	$ 126,105.00
Clinical Services Director	Annual	$ 70,000.00	$ 126,105.00
*Care Services Director	Annual	$ 70,000.00	$ 126,105.00
Adult Day Center Director	Annual	$ 52,000.00	$ 72,072.00
Wellness & Caregiver Center Director	Annual	$ 52,000.00	$ 72,072.00
Managers			
Accounting Manager	Hourly	$ 18.00	$ 31.50
Adult Day Center Manager	Annual	$ 43,680.00	$ 63,336.00
Care Transitions Manager	Annual	$ 43,680.00	$ 63,336.00
Community Affairs Manager	Hourly	$ 18.00	$ 31.50
Community Education Manager	Hourly	$ 18.00	$ 31.50
Community Outreach Manager	Hourly	$ 18.00	$ 31.50
Community Services Manager	Annual	$ 39,520.00	$ 65,520.00
Health Promotion Manager	Annual	$ 39,520.00	$ 65,520.00
Senior Support Manager	Annual	$ 39,520.00	$ 61,152.00
Wellness & Caregiver Center Manager	Annual	$ 43,680.00	$ 63,336.00
Coordinators			
Adult Day Center Coordinator	Hourly	$ 17.00	$ 26.25
Care Coordinator	Hourly	$ 17.00	$ 26.25
Health Promotion Coordinator	Hourly	$ 17.00	$ 26.25
Senior Nutrition Coordinator	Hourly	$ 17.00	$ 26.25
Transportation Coordinator	Hourly	$ 17.00	$ 26.25
Assistants & all other positions			
Accounting Assistant	Hourly	$ 14.00	$ 21.00
Activity Leader I	Hourly	$ 13.00	$ 18.90
Activity Leader I (On-Call)	Hourly	$ 13.00	$ 18.90
Activity Leader II	Hourly	$ 13.50	$ 19.42
Administrative Assistant	Hourly	$ 13.00	$ 18.90
Administrative Assistant, HR	Hourly	$ 18.00	$ 27.16
Health Promotion Coach	Hourly	$ 18.00	$ 24.45
Driver	Hourly	$ 15.00	$ 18.90
Driver (On-Call)	Hourly	$ 15.00	$ 18.90
Executive Assistant	Hourly	$ 18.00	$ 27.30
Resource Specialist	Hourly	$ 13.00	$ 18.90
Senior Nutrition Assistant	Hourly	$ 13.00	$ 18.90

*Title change

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SECTION 11

ACTION ITEMS

CONSIDERATION AND REVIEW OF RESOLUTION 18-03,
DECLARING MAY 2018 AS
"OLDER AMERICANS MONTH"

SECTION 11-C

APRIL 24, 2018

RESOLUTION NO. 18-03

MAY 2018 – OLDER AMERICANS MONTH

Resolution of the Board of Directors
Camarillo Health Care District
Ventura County, California

Whereas, the City of Camarillo includes countless older Americans who enrich and strengthen our community; and

Whereas, the Camarillo Health Care District is committed to engaging and supporting older adults, their families, and caregivers; and

Whereas, the Camarillo Health Care District acknowledges the importance of taking part in activities that promote physical, mental, and emotional well-being—no matter your age; and

Whereas, the Camarillo Health Care District can enrich the lives of individuals of *every age* by:

- promoting home- and community-based services that support independent living;
- involving older adults in community planning, events, and other activities; and
- providing opportunities for older adults to work, volunteer, learn, lead, and mentor.

Now therefore, the Board of Directors of the Camarillo Health Care District do hereby proclaim May 2018 to be ***Older Americans Month***. The Camarillo Health Care District encourages the community to intentionally recognize older adults and the people who serve them as influential and vital members of our community, during this month of celebration.

ADOPTED, SIGNED AND APPROVED this 24th day of April 2018.

_____ Attest: _____

Rod Brown, President
Board of Directors

Richard Loft, Clerk of the Board
Board of Directors

STATE OF CALIFORNIA)

COUNTY OF VENTURA) ss

I, Richard Loft, Clerk of the Board of Directors of the Camarillo Health Care District

DO HEREBY CERTIFY that the foregoing Resolution 18-03 was duly adopted by the Board of Directors of said District at a Regular Meeting held on the 24th day of April 2018, and it was adopted by the following vote:

AYES: _____

NAYS: _____

ABSENT: _____

_____
Richard Loft, Clerk of the Board
Board of Directors
Camarillo Health Care District

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SECTION 11

ACTION ITEMS

IT IS THE RECOMMENDATION OF ADMINISTRATION THAT THE BOARD OF DIRECTORS APPROVE RESOLUTION 18-04, CHANGING THE DECEMBER 4, 2018 REGULAR BOARD MEETING TO DECEMBER 11, 2018

SECTION 11-D

APRIL 24, 2018

RESOLUTION NO. 18-04

Change the December 4 Meeting Date to December 11, 2018

Resolution of the Board of Directors
Camarillo Health Care District
Ventura County, California

WHEREAS, Camarillo Health Care District holds its Regular December Board of Directors meetings on the first Tuesday of December at 8:30 a.m.; and

WHEREAS, according to District By-laws, the District may, by resolution, change the day and time of its meetings; and

WHEREAS, in view of the Board's calendar of commitments, it is the recommendation of Administration that the regularly scheduled Board of Directors meeting be changed;

THEREFORE, BE IT RESOLVED, that the Board of Directors change the date of the December 4, 2018 meeting to December 11, 2018.

ADOPTED, SIGNED AND APPROVED this 24th day of April, 2018.

_____
Rod Brown, President
Board of Directors

Attest: _____
Richard Loft, Clerk of the Board
Board of Directors

STATE OF CALIFORNIA)

COUNTY OF VENTURA) ss

I, Richard Loft, Clerk of the Board of Directors of the Camarillo Health Care District

DO HEREBY CERTIFY that the foregoing Resolution 18-04 was duly adopted by the Board of Directors of said District at a Regular Meeting held on the 24th day of April, 2018, and it was adopted by the following vote:

AYES: _____

NAYS: _____

ABSENT: _____

_____
Richard Loft, Clerk of the Board
Board of Directors
Camarillo Health Care District

SECTION 12

CEO REPORT

APRIL 24, 2018

Building Relationships and Reducing Barriers Through Building Business Acumen

By Sue Tatangelo

The Camarillo Health Care District is involved in multiple productive partnerships with healthcare entities due to its planned, intentional approach.

To seize opportunity in the rapidly changing healthcare environment, a community-based organization (CBO) needs vision, leadership, business skills, strategy, and tenacity. For the Camarillo Health Care District, it has been a transformative journey. Vision alone was not enough to succeed, but success also required committed leadership, new business skills, strategic positioning, and resilient problem-solving.

The Camarillo Health Care District (the District) is a public agency established in 1969 and defined by the California Health and Safety Code, governed by an elected board, and created to provide a wide range of health services to the community. Nearly 24 percent of the total population of the District's assigned boundaries is older than age 60, and includes many people with multiple complex chronic health conditions, daily functional limitations, and families experiencing caregiver burden.

Given this scenario, the District developed a broad base of safety net services for older adults, such as adult daycare, a home-delivered meal program, a federally designated Family Caregiver Resource Center, transportation services, and evidence-based health promotions programs, but it did not yet have a fully formed vision of how to build relationships with health sector partners. In 2012, that changed with the launch of the Affordable Care Act's Triple Aim—to achieve better health, better care, and lower costs.

As did many others in the healthcare sector, the District then became acutely aware of the change afoot. For what seemed to be the first time, there was an opportunity for CBOs to be critical partners in the healthcare continuum. When the Centers for Medicare & Medicaid Innovation Center announced funding for a time-limited Community-Based Care Transitions Program Demonstration Project (CCTP), the District joined with its local area agency on aging in an application to reduce hospital readmissions through an evidence-based care transitions intervention, and was awarded the contract.

→**ABSTRACT** How can community-based organizations (CBO) prepare to seize contract opportunities in a changing healthcare environment? This article describes how one CBO became a high-value partner by increasing its business acumen, growing strategic partnerships, and reducing barriers through reciprocal learning, all of which resulted in multi-level health sector contracting. | **key words**: *business acumen, infrastructure capacity, strategic positioning, vulnerable populations, high-value partners, reciprocal learning, health sector contracts*

It soon became apparent that for the District to succeed in testing this new model of care, it would require new business skills, nimbleness, staffing ramp-up, the ability to manage data for real-time outcomes monitoring, value and quality measures, breakeven points, profit margin goals, rapid-cycle learning, and more. The District needed to acquire business acumen and the capacity to deliver its contract requirements.

The District applied to The SCAN Foundation's Linkage Lab and became one of six California CBOs in its first cohort, simultaneously with the District becoming a CCTP provider. Theory met practice at a most opportune time.

The Linkage Lab's assessment exposed the District's weaknesses, such as a lack of an enterprise-wide IT platform and a dearth of experience in contract negotiations. It also revealed its strengths, such as expertise in community-based services, a dedication to providing solutions for better health outcomes, and a passion for quality service delivery. The Linkage Lab experience, which was essential to the District's work, supported its development and articulation of a business plan, and guided the development of an infrastructure that could support health sector contracts and data management.

Planning for Post-CCTP Partnerships

Knowing the CCTP was temporary, the District's key objective from Linkage Lab was to establish at least one healthcare post-CCTP partnership, and to develop an integrated records management system with which to evaluate the District's future healthcare partnerships. Another key objective was to create a tool to evaluate and establish minimum contracting costs for the District's other traditional services, such as its evidence-based health promotion suite of programs and caregiver support services, to be ready for future partnership growth opportunities.

To promote a strategic approach to growth, the District also had to set criteria for evaluating and selecting new business opportunities, which included identifying potential clients (i.e., Accountable Care Organizations (ACO), hospitals, health plans, skilled nursing facilities, managed care organizations, and physician practices) and developing value propositions for each in order to articulate the business case to potential contractors.

During the CCTP Demonstration Project, a group of Southern California CBOs met regularly to share best practices. When the demonstration project ended, this informal group saw the value of formalizing a California CBO network in which each partner provides regional service, increasing the network's overall geographic reach, to attract large health plans to this specialty network. The Partners in Care Foundation championed that idea and the Partners At Home Network was born, offering to health plans high-value targeted home visits, including care transitions, medication adherence support, coaching for self-management, falls risk management, and person-centered care.

'Theory met practice at a most opportune time.'

The District recognized that being a member of a specialty network made good business sense, as it minimized contracting costs and provided substantial competitive advantage through such elements as shared IT and analytics costs, increased geographical reach, negotiating leverage, and broad best practices for quality improvement. This was the next "right" step for the District. It wasn't long before the Partners At Home Network secured a national health plan contract that is now in its third year of renewal. While being part of a California network made good business sense, the District also could see its future in developing contracts locally with health sector partners.

Next Steps: Building Ongoing Relationships

The optimistic assumption following the CCTP Demonstration Project was that at least one of

the District's partner hospitals would develop a continuing contract for those services. At the time, the average readmission rate at Ventura County hospitals was 16.8 percent, but for patients participating in the District's CCTP, the average readmission rate was reduced to 8.4 percent. The District was successful in substantially reducing avoidable hospitalizations and had proven its value proposition. Developing a contract for ongoing care transitions services seemed like the logical next step.

Community Memorial Hospital Systems (CMHS), in Ventura, California, was interested in exploring of this type of partnership. The hospital had just launched an ACO and, in an effort to continue building the relationship with the hospital, the District offered a six-month, no-cost pilot project. That pilot ended with a similar positive reduction in avoidable hospital readmission rates, and also highlighted the positive effects of having a community-based health coach embedded in the hospital to collaborate with clinical staff and improve the communication loop between the hospital, home health, and community-based care.

Also, patients in the pilot noted that the post-discharge home visits by the District health coach were helpful in managing their health conditions, and made them feel as if the hospital remained invested in their care long after discharge.

As a result of this successful ACO pilot, CMHS requested a full proposal. The District worked with hospital leadership to identify the pilot patients' group of conditions, and designed the intervention elements to ensure standards of care and quality improvement. The interventions included evidence-based health promotion programs such as the Stanford University Self-Management suite of programs, and leveraged patient access to a wide variety of other community-based services and supports. Although CMHS had originally submitted its priorities to the District during the proposal process, these had shifted (CMHS was anticipating an extensive building expansion); while not denied, the proposal went into CMHS's "not now" file.

Building the relationship with CMHS has proven to be invaluable. The hospital deepened its understanding of the District's value about how a skilled community partner can extend

The District successfully and substantially reduced avoidable hospitalizations, proving its value proposition.

quality care beyond hospital walls. The hospital has also broadened its idea of healthcare by intentionally and continually acknowledging the importance of having a partner that can address the social determinants of health in the home, including support for family caregivers.

Additionally, the hospital provided frank feedback on how the District could further increase its value as a partner by having a clinical program supervisor overseeing the intervention. The District hired a registered nurse with extensive experience in hospital, home health, and national health plan management, which distinguished the District's intervention from its competitors. The hospital had said that enhanced clinical review during the intervention would help identify a worsening health condition at home, should it occur. Having a clinician available to inform the hospital of a patient's health setback would mean greater opportunity to reduce avoidable hospital readmissions.

CMHS continues to champion community-based partnerships by creating pathways that allow the District to work with other health plans and providers for contracted services, inside its hospital. CMHS established a Memorandum of Understanding allowing the District to embed health coaches in the hospital, to determine patient eligibility, and to have patient bedside access to explore their interest in participating in the District's intervention. These pathways have facilitated contracts and grant

funding from Medi-Cal Managed Care and other health plans interested in expanding their members' care. To expand services, the District is now testing new care models for patients with cognitive impairments, as well as for patients with complex conditions, and those who are being discharged from skilled nursing facilities and/or completing their health plan's home health service.

New Partnerships Form

CMHS asked the District to join the Ventura County Hospital to Home Alliance, which proved to be a strategic move. Formed in 2014, the Alliance is a unique body of hospitals, home health organizations, skilled nursing facilities, and independent physician groups, all supported by the California quality improvement organization, Health Services Advisory Group. The District serves as its CBO representative. Historically, CBOs had not been part of the healthcare continuum and some Alliance members had difficulty relating to a social model of care in its network. The Alliance hospitals were very progressive in their vision by appointing the District to the Alliance's Steering Committee as an equal partner. The hospitals provided consistent messaging to Alliance members that social issues are health issues and emphasized the value of having a community-based partner. The District was also able to gain greater insight to health sector barriers for integrated care and take an active role in solutions.

Three years ago, the Alliance's mission made no mention of CBOs. Today, the mission is explicit in the integration of long-term services and supports (LTSS) into the healthcare continuum to improve health outcomes and reduce hospital admissions. Alliance members have become advocates who support policy changes for LTSS integration into the care continuum.

With Alliance member partnerships, the District has gained strategic positioning, which has resulted in innovative contracts and grants to test new approaches to care. CMHS, an Alliance hospital member, recently applied to the Hospital Association of Southern California to participate in a three-year Person-Centered Care Initiative, and selected certain Alliance partners to participate in the initiative, confident that these agencies shared a common vision of improving care. The District was included in this effort.

Dignity Health, an Alliance hospital member, is leading the development of a social innovations project and selected the District as a project partner. The project introduces students from a local university to the healthcare continuum in order to achieve the following: to promote older patients' productive recovery and greater self-determination as they are discharged from the hospital; to reduce inappropriate or over-use of care; to decrease isolation and increase self-empowerment; and to enhance geriatric competence in the future healthcare workforce. The District's role in this contract is to provide community resource education to the students and weekly student coaching.

'Continuous quality improvement accreditation increased the District's credibility as a quality care provider.'

Recently, Ventura County's Medicaid managed care program released funding to address the social determinants of health and increase access to quality care. The District was funded to test a new thirty to ninety-day intervention based on acuity of targeted older adults and persons with disabilities being discharged from skilled nursing facilities or from home health, and being at high risk of readmission to a higher level of care without linkages to critical social community supports. The District partnered with seven Alliance members based on their interest in building Medicaid capacity and testing new care models.

As the District increased its dialogue with health plans, it became aware that continuous quality improvement accreditation increased its

credibility as a quality care provider, and that it could better prepare itself for the needs of vulnerable Medicare-Medicaid populations, as well as distinguish itself from others entering the marketplace. When the National Committee for Quality Assurance developed accreditation in LTSS case management, the District became an early adopter.

The District's mission is to be a highly respected, preferred partner in Ventura County's healthcare continuum by providing valuable, effective, measurable, and integrated community-based health services. Today, the District's value as a CBO is demonstrated in its varied contracts as a subcontractor in a statewide network with a national health plan and a lead organization in a local network of evidence-based health promotion program providers. The District also has secured multiple sole contracts with local managed care, and has become the partner of choice in contracts with other local healthcare providers.

Looking back, it is amazing to see the distance the District has traveled from its initial experience with the Linkage Lab to now. This journey necessitated a fundamental grounding in business practices to map the vision, reciprocal learning from like-minded visionaries and fearless partners—as well as with the tenacity to navigate the detours along the way.

Sue Tatangelo has a master's degree in Organizational Management and is the chief resource officer at the Camarillo Health Care District in Camarillo, California. She can be contacted at statangelo@camhealth.com.

The Value of the Hospital–CBO Partnership in Achieving the Triple Aim

By Bonnie Subira

When a health system realized its gaps in knowledge and formed multiple partnerships, it learned the value of tackling the social determinants of health.

In the world of managed care, much has been written about the drivers of change that hospitals face, but less about the importance of partnering with community-based organizations (CBO) to meet these challenges. The Affordable Care Act led the Centers for Medicare & Medicaid Services (CMS) to develop regulatory programs such as Pay-for-Performance (P4P) and its Value-Based Purchasing (VBP) and Readmission Reduction initiatives. These programs' requirements seek to embed CMS's concept of value: better health, better care, and lower costs (or, the Triple Aim), and begin to push the evolution from volume-based reimbursement toward alternative payment value-based models.

As hospitals explore strategies to address these new regulations, they must consider that effecting better health, better care, and lower costs requires the combined services of healthcare and CBO communities. Hospitals and the healthcare community cannot achieve these aims by focusing only on clinical practice.

Concurrently, our country has a fast-growing aging population. The impacts of this demographic trend include seeing cohorts with a significantly higher rate of severe chronic health conditions and cognitive impairment; this means older people will have greater functional limitations and require more health and supportive services.

As an example, the California State Plan on Aging 2017–2021 (2017a; goo.gl/y1xuSX) describes the demographic changes as "an age wave" that will be felt in every aspect of society. The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the state's tremendous population growth, which continues to challenge its infrastructure planning. Demographers project that California's population, now nearly 38 million, could by 2050 reach 51 million. At the same time, residents ages 85 and older will have increased 310 percent (California Department of Aging, 2017b; goo.gl/wBsV68).

→**ABSTRACT** Given the impacts of social determinants of health, the goals of the Triple Aim can only be achieved if hospitals are willing to reach out and strengthen partnerships with their local networks of community-based organizations (CBO). Community Memorial Health System has endeavored to do that in forging their partnership with the Camarillo Health Care District, and in forming the Ventura County Hospital to Home Alliance. This article explores how CBOs can complement and enhance the healthcare community's effort to better manage illness and chronic disease in pursuing the Triple Aim. | **key words:** *Community Memorial Health System, Camarillo Health Care District, Hospital to Home Alliance, Triple Aim*

Where do hospitals begin to meet the daunting mandates imposed by this disruptive demographic, the P4P program, and the Triple Aim? Community Memorial Health System's (CMHS) journey to find an answer has led to the formation of some non-traditional partnerships.

How People Became Patients

Established in 1902, CMHS is a community-owned nonprofit health system serving Ventura County. CMHS operates two hospitals and sixteen community clinics throughout the county and in 2014 established an Accountable Care Organization (ACO).

In an effort to provide better care, the individual receiving care got lost.

The CMHS journey began with a process of self-examination and a look back to better understand how the healthcare industry, and healthcare delivery, had become so impersonal. Throughout the 1960s, as the Medicare program was being signed into law, 85 percent to 90 percent of medical school graduates across the nation were choosing specialty medicine (*What If Post*, 2009). Growth in specialized medicine added to significant advances in medical science in these years, while access to hospital care increased. Healthcare delivery began to change and with it the unintended consequence of people becoming "patients."

As care became more specialized within the hospital setting, the person (now "the patient") became the acute problem for which they received treatment: they were seen as "the heart," "the gallbladder," "the hip." Hospital care became more clinically sophisticated, involving multiple physicians, but at the same time, grew more impersonal. Hospitals were facilities that addressed illness, not wellness, and, in large part, problems, not people.

Somewhere along the line, and in an effort to provide better care, the focus shifted almost exclusively to an emphasis on clinical proficiency and technical excellence, while the individual receiving the care got lost. The healthcare industry established a boundary such that when a patient had a non-clinical need that could negatively impact health status, a common response was "that's a social issue." In its extreme, patients were categorized as non-compliant and judged unwilling to follow medical instruction, when in many cases the issue was the person's unassessed or unmet non-clinical need. This narrow clinical focus further impersonalized care and fostered silos in the healthcare industry.

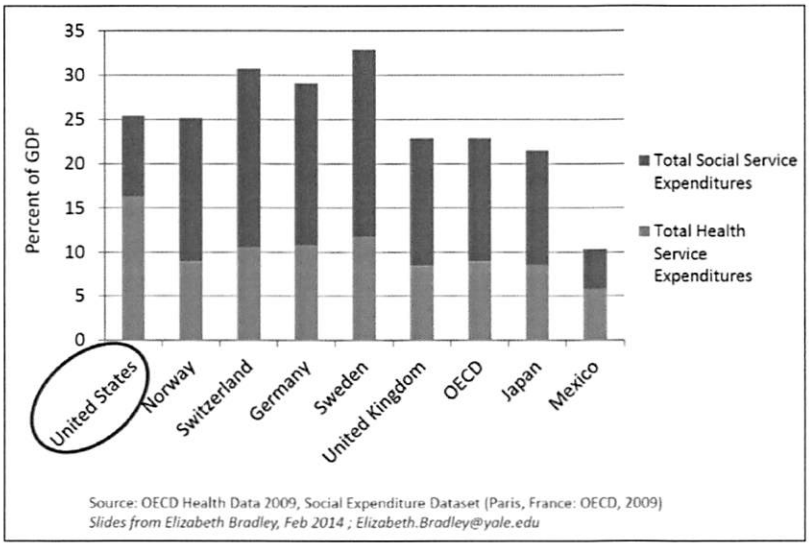
Today, although more than 95 percent of healthcare dollars is spent on direct medical services, as much as 70 percent of health outcomes can be attributed to the influence of non-clinical factors (Organisation for Economic Co-operation and Development, 2009). In the United States, the disparity between healthcare spending and social service spending is notable; America scores almost last among developed countries.

Answers Lie Beyond Hospital Walls

While continued clinical quality improvement is an essential component in achieving the Triple Aim, it is not enough on its own. Medical treatment alone does not create nor sustain good health. Thus, the starting point for CMHS was to expand the focus from the patient to the person and to consider the non-clinical or social determinants of health.

CMHS wondered how hospitals managed their accountability for health outcomes and costs beyond their scope of services and outside the hospital walls. They reached the conclusion that a hospital could not do it alone, but required improved partnerships with CBOs. Many healthcare colleagues report that they have formed such partnerships and offer as evidence long lists of community resources. While giving patients a list of phone numbers, dialing those numbers, setting up appointments, or providing "warm hand-offs" (in which a primary care provider conducts a face-to-face introduction of

Table 1. Incorporating Social Service Spending



Source: OECD Health Data 2009, Social Expenditure Dataset (Paris, France: OECD, 2009)
Slides from Elizabeth Bradley, Feb 2014 ; Elizabeth.Bradley@yale.edu

a patient to a behavioral health specialist) does demonstrate a hospital's ability to identify CBO resources and make referrals, there are distinct differences between maintaining a CBO referral list and cultivating a CBO partner.

Partnership is characterized by mutual cooperation and responsibility in the achievement of a specified goal. Over the past five years, CMHS has been fortunate to have formed such a partnership with the Camarillo Health Care District (the District).

The District is a local public agency established in 1969 and was created to provide a range of community-based programs and services designed to promote health and wellness in the community and at home. It offers a wide array of services, but specializes in programs that support the independence and dignity of older adults and people with disabilities through such programs as evidence-based health promotions services, falls mitigation, adult daycare, home-delivered meals, caregiver support services, care transitions, case management, and many others.

In 2012, the District, while known to CMHS, was severely underused. When District staff walked into our hospital and offered to provide care transitions services to our Medicare patients who were being discharged (as part of the CMS grant-funded Community Care Transitions Program), our response was a guarded yes.

How could a hospital turn down free help to strengthen care transitions? Frankly, we had concerns: What did this social service agency, The Camarillo Health Care District, know about chronically ill Medicare patients? In retrospect, we now know they knew significantly more than healthcare providers had given them credit for. Once our hospital realized the District was not there to provide clinical care, we began to see the value they brought in offering a broader view of a person's needs and the services necessary to address them.

The District has been instrumental in helping to identify the unmet community needs that drive poor health outcomes and increased costs. In our partnership thus far we have joined forces to better address family caregivers' needs and to provide early intervention against cognitive impairment and dementia—conditions that affect health status and thus increase healthcare costs.

'How could a hospital turn down free help to strengthen care transitions?'

Enter the Second Partnership

While CMHS began a relationship with the District, we invested in another new partnership in pursuit of the Triple Aim. For some time, CMHS had been meeting with local home health providers and skilled nursing facilities in an effort to strengthen transitions from the hospital, reduce unnecessary readmissions, and better manage chronic disease in the community. But we were not making the progress we had anticipated. In

concert with the regional CMS quality improvement organization, the Health Services Advisory Group, we reached out to other area hospitals and a large managed care organization to form a coalition to work with the District. The District was an integral part of the coalition, which has become known as the Ventura County Hospital to Home Alliance (Alliance). In its present form, the Alliance comprises ten home health agencies and seven skilled nursing facilities, as well as the District and CMHS.

CMHS's ability to reach beyond the hospital walls has reaped many early benefits.

The larger group did not immediately embrace the idea of including the District as a CBO participant in a predominantly clinical coalition. Initially, the clinical providers did not see the value of the CBO with respect to disease management, or how it might contribute to readmission reduction and care continuum quality. Several home health agencies were threatened by the District's presence, believing it to be a direct competitor for their services.

This scenario afforded the Alliance several opportunities for improvement. First, it needed to create equal understanding between partners about the mandates inherent in healthcare reform and the concept underlying the Triple Aim. Second, it needed to acknowledge the fact that Alliance partners generally work in isolation and are largely siloed by sector. As the group confronted the challenges of moving from business as usual to a value-based environment, it was able to see that many of the barriers it faced in caring for patients were social, not clinical.

When Alliance members realized that social issues did not release them from the responsibility for their patients' improved healthcare outcomes, they made significant progress on partnership goals. The Alliance membership began to understand the power of partnering with the District, a collaboration that could best address patients' social needs.

As was the case with CMHS, each Alliance member was relatively knowledgeable about community resources, but none had explored the value of community partners. Expanding the continuum of care to include the District allowed the group to engage in multiple process improvement projects that actively identified the social issues interfering with patient transitions and resulted in improved chronic disease management in the community.

Each Alliance member now makes use of the District's robust programing in the areas of caregiver support, cognitive impairment, and chronic disease management by proactively involving the District before patients leave their care setting. As a result, the District now has earlier access to patients and families to help them prepare for care transition and return to the community. Because they are working across the Alliance continuum, the District plays a key role in care coordination and has helped to improve communication and integration of the Alliance's services.

Apart from direct person care, the District has taught CMHS, as well as the Alliance membership, about the world of long-term services and supports (LTSS) that serves older adults and people with disabilities. Our healthcare community sorely lacked awareness about the breadth and depth of programming and advocacy that occurs in promoting health maintenance and wellness for older adults—a knowledge gap that directly contributed to community providers operating in silos. So while the District learns the language and acronyms of healthcare, CMHS and the Alliance are learning the language of the LTSS community: how they operate on national, state, and local levels, and the programs and work being done to benefit the populations we all serve. The District's participation in the Alliance has proven not only how much better we are together, but also that this partnership is essential for meeting the mandates of

providing better health and better care and lowering costs.

Conclusion: We Are Better Together!

CMHS's ability to reach beyond the hospital walls has reaped many early benefits. We have gained access to expertise, services, and programs that we cannot provide; we have a better understanding of caregivers' needs; we have access to care mangement programming for dementia patients and their families, along with improved access to other CBOs and social programs. As well, CHMS has a new orientation toward the LTSS community; better services integration; reciprocal and ongoing communication; and decreased siloed activities and services duplication.

The CMHS–District partnership has yielded powerful tools for achieving the Triple Aim. We look forward to building this relationship—and cultivating others—in order to provide the most effective and respectful care to the people we serve.

Bonnie Subira, M.S.W., is the former director of Case Management, Social Service and Palliative Care programs for Community Memorial Health System in Ventura, California. She now serves as the Health System's project manager for Population Health Programs.

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SECTION 13

BOARD PRESIDENT'S REPORTS

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SECTION 14

BOARD MEMBERS INTERESTS OR CONCERNS

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