DOCTORS
MEDICAL CENTER

West Contra Costa Healthcare District
Doctors Medical Center
Governing Body
Board of Directors

Monday, November 26, 2012
4:30 PM
Doctors Medical Center Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS
MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
NOVEMBER 26, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

AGENDA

1. **CALL TO ORDER** — E. Zell

2. **ROLL CALL**

3. **APPROVAL OF OCTOBER 24, 2012 MINUTES** — E. Zell

4. **PUBLIC COMMENTS** — E. Zell
   [At this time persons in the audience may speak on any items not on the agenda and any other matter within the jurisdiction of the of the Governing Body]

5. **QUALITY AND PATIENT SAFETY REPORT** — K. Taylor
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION:* *1. Acceptance of the Quality and Patient Safety Report*
      2. Approval of Release of Information Policy

6. **PATIENT SATISFACTION RESULTS** — R. Redlo
   a. Presentation
   b. Discussion
   c. Public Comment

d. *ACTION: For information only*

7. **HUMAN RESOUCES REPORT – INFLUENZA VACCINE POLICY** L. Yee
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of Influenza Vaccine Policy*

8. **FINANCIALS – OCTOBER 2012** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the October 2012 Financials*

9. **PRESENTATION OF 2013 BUDGET** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of 2013 Capital and Operating Budget*

10. **APPOINTMENT OF AUDIT FIRM** J. Boatman
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of TCA Partners, LLP for Audit*

11. **REVENUE CYCLE CONSULTING SUPPORT** J. Boatman
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of Contract to Retain Huron Consulting Group for Revenue Cycle Consulting*

12. **CEO REPORT** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: For Information Only*

13. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION:*
       1. *Approval of Lexiscan Administration During Radionuclide Myocardial Perfusion Imaging Policy*
       2. *Approval of revised Metered Dose Inhaler Therapy Policy*
       3. *Approval of Medical Record Suspension Policy*

4. Acceptance of the Medical Staff Report and Approval of Appointments, Reappointments.

ADJOURN TO CLOSED SESSION

A. Reports of Medical Staff Audit and Quality Assurance Matters Pursuant to Health and Safety Code Section 32155.

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: Bob Redlo, VP of Patient Relations, Labor Relations & Workforce Development, John Hardy, Vice President of Human Resources: California Nurses Association, NUHW, PEU Local One and Local 39.

C. Discussion involving Trade Secrets Pursuant to Health and Safety Code Section 32106. Discussion will concern new programs, services, facilities.

ANNOUNCEMENT OF REPORTABLE ACTION(S) TAKEN IN CLOSED SESSION, IF ANY.

DOCTORS
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MINUTES

TAB 3

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WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
OCTOBER 24, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

MINUTES

1. **CALL TO ORDER**

The meeting was called to order at 4:35 P.M.

2. **ROLL CALL**

Quorum was established and roll was called:

Present: *Eric Zell, Chair*
Supervisor John Gioia, Vice Chair
Irma Anderson
Nancy Casazza
Sharon Drager, M.D.
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace

Excused: *Wendel Brunner, M.D*
Deborah Campbell
Pat Godley

3. **APPROVAL OF SEPTEMBER 26, 2012 MINUTES**

The motion made by Director Anderson and seconded by Director Wallace to approve the September 26, 2012 minutes passed unanimously.

4. **PUBLIC COMMENTS**

Seven members of NUHW spoke regarding their concerns and frustrations in securing a long term contract, and lack of confidence in the management team negotiating that agreement. Specific concerns were voiced regarding pay that is below market, and changes

in health care benefits that will limit access to other hospitals. Supervisor Gioia and Director Zell stated that the Board and the Hospital are committed to reaching an agreement.

5. QUALITY REPORT

Ms. Karen Taylor Director of Quality and Risk Management presented and sought acceptance of the Quality Management Report. Ms. Taylor provided an update on The Joint Commission Survey Results, reporting that Doctors Medical Center was reaccredited as a result of the survey conducted October 2-5, 2012.

Ms. Taylor highlighted the Direct and Indirect Impact Standards:

- Received "Direct Impact Standards" – a plan of correction is due in 45 days: There were 5 findings
- Also – There were 8 findings for the "Indirect Impact Standards" – requires a plan of correction is due in 60 days

She indicated that both of those are pretty minor and the surveyor gave us accolades, especially in the Environmental Cure area.

Ms. Taylor provided an update on the Compliance Program. She indicated that the program will be implemented in mid-November with Ethics Point as our third-party vendor. We will have a hotline and web based tools for issues reporting, education for the staff, a Compliance Committee that will meet quarterly, and an annual report to the Governing Body.

Ms. Taylor also provided Highlights of Hospital Compare Report:

- Healthcare Compare is a publically available web site for patients and others to access information regarding performance in clinical quality measures
- Core Measures, Patient Satisfaction (HCAHPS), Mortality and Readmission Data, and Patient Safety Indicators are compared to national and state experiences. (Some information also on Joint Commission web site)
- For the reporting period currently available (through 1st Quarter October 2012) on 18 Core Measure indicators:
    - DMC is at or better than national and state performance in 8 indicators, and slightly below in 10 indicators
    - For those below, we are above 90% (our threshold) and within 1-2% of state and national performance
    - Only significant outliers include "Discharge Instructions for Heart Failure Patients" and in the past years we have had "Administration of Pneumococcal Immunization" – because we began the program late in the year. Patients discharged after October 1st or after need to receive vaccines earlier - which should have improved this year.
- As reported in the past, on the HCAHPS scores DMC is below national and state performances on all indicators
- For mortality measures, DMC is at or better than the national scores on all measures

- For readmissions and all patient safety indicators, DMC performance is consistent with national performance on all indicators
- Diagnosis with greatest improvement opportunity continues to be care for patients with congestive heart failure
- Lack of documented discharge instructions remains an ongoing problem – the complexity of navigation of the EMR is a driving issue and a problem identified in TJC survey as well.

Director Nancy Casazza asked if there are discharge instructions electronically available. Ms. Taylor replied that while discharge instructions are available through the electronic record, the process remains complex and difficult to use. Improving this process is a key priority area for the hospital.

Director Eric Zell inquired about an Action item on the Agenda - Approval of release of information policies. Ms. Taylor replied that the documentation was not in the meeting packet, so it was agreed to defer it to the next meeting.

The motion made by Doctor Drager and seconded by Supervisor Gioia to accept the Quality report passed unanimously.

6. **FINANCIALS – SEPTEMBER 2012:**
Mr. James Boatman, Chief Financial Officer presented and sought acceptance of the September 2012 Financial Report. The net loss for the month was $2.9 million, with operating revenue $1.7 million under budget and expenses $502,000 over budget. The most significant negative variance in revenue was commercial/PPO/HMO insured patients. The largest variance in expenses was salaries and benefits, with a $610,000 negative variance due to increased outpatient volume (particularly in the Emergency Department) and overtime related to Joint Commission preparation. Mr. Boatman further reported that Accounts Receivable significantly increased in September, and he presented the status of the capital budget. We have $247,000 remaining the in 2012 budget for capital items.

In response to a question from Director Beverly Wallace, Mr. Boatman and Ms. Gideon reported that the financials do not include the entire payment expected from Chevron, and we are presently working with them to address the billing for patient presenting to the Emergency Department as a result of that incident. We do not currently know the exact timeframe for Chevron payment, but hope to resolve within the next 30-60 days. We have made it clear to Chevron that we expect payment by the end of the calendar year.

The motion made by Director Casazza and seconded by Director Anderson to accept the September 2012 Financial report passed unanimously.

7. **CAPITAL EXPENSE: PRISMA FLEX**

Ms. Kaminsky presented a proposal and sought approval of the PRISMA FLEX for Continual Renal Replacement Therapy (CRRT) at a total cost of $47,950. Doctor Sharon Drager asked Mc. Kaminsky and Dr. Pagtaluman, a member of the audience, to explain Renal Replacement. Dr. Pagtalunan responded that Doctors Medical Center was the first

hospital in the East Bay to start the program and became the standard of care with acute renal failure in the ICU. The two existing units are over 10 years old and will no longer be supported by March 31, 2013. Purchasing by December 21, 2012 will afford a discount of $13,000

The motion made by Director Anderson and seconded by Vice Chair Gioia to approve the proposal for the PRISMA FLEX passed unanimously.

8. LOCAL 39 OPERATING CONTRACT

Mr. Redlo, Vice President of Workforce Development and Patient and Labor Relations acknowledged the NUHW staff that spoke in the Public Comment portion of the meeting and thanked the entire NUHW negotiating team for their dedication to the hospital and to our patients. He and the administrative team have the utmost respect for all of our staff, and he apologized if his words or behavior have offended anyone.

Mr. Redlo presented the West Contra Costa Health District dba Doctors Medical Center, San Pablo and Stationary Engineers Local No. 39 proposed Memorandum of Understanding ("MOU") for the approximately twelve employees represented by this union. The MOU will be in effect to March 31, 2015, with a total cost of approximately $70,750 for the term of the contract.

The motion made by Supervisor Gioia and seconded by Director Anderson to approve West Contra Costa Health District dba Doctors Medical Center, San Pablo and Stationary Engineers Local No. 39 Memorandum of Understanding passed unanimously.

9. CHIEF EXECUTIVE OFFICER REPORT

Ms. Gideon, Chief Executive Officer, presented the West Contra Costa Healthcare District Update of 2012 Strategic and Operating Priorities. Ms. Gideon referred to the Development of a Strategic Plan and stated that discussions and an active search for a partner was on-going, but in the early stages. Ms. Gideon stated that you can't look at the financials presented by Mr. Boatman and realize anything other than this organization needs a partner As there is more to report, we will obviously be doing so within the community and within this room as well.

DMC was recognized and honored by the Board of Supervisors at its October 23, 2012 meeting for the outstanding efforts during the August Chevron incident. Several Emergency Room physicians and employees, on behalf of the many employees that have stepped up under really extraordinary circumstances, were in attendance at the meeting to accept a plaque and resolution presented by the Board of Supervisors.

Ms. Gideon reported that Executive Assistant Lani Cantu had resigned effective October 26 to accept another opportunity. The Governing Body members thanked Lani for your support of the Board and the Governing Body and wished her well in her new position.

10. MEDICAL EXECUTIVE REPORT

Dr. Hodgson stated that while at the County Board Supervisors, Chair Gioia spoke "from the heart" in particular about Doctors Medical Center, which felt good to be recognized after all the really hard work. She also publically recognized a long term DMC volunteer, Nell Trudell upon the celebration of her 98th birthday. Nell has been an active and important member of the DMC family for 35 years, and continues to volunteer in our Gift Shop.

Dr. Hodgson began her report on non-action items:

1) Medical Staff Bylaws which are currently under Legal review. She stated that upon completion the committee will convene for final review and then submit it to the medical staff for a vote. They have 30 days to vote, after which she will present the Bylaws to the Governing Body for approval.

2) Privilege and Delineations Both major departments (Medicine and Sugary) have developed many subspecialties, but they are working on the others.

Dr. Hodgson sought approval of the following action items:

3) Policy regarding Do Not Use Abbreviations List – One change was made to reflect that the Joint Commission no longer considers using "cc" instead of "ml", removed from the list.

4) Privileges – both in Department of Medicine. Both voluntary (opportunities closer to home). She called attention to the Initial Appointments and Reappointments and sought approval.

The motion made by Dr. Walker and seconded by Dr. Wallace to approve the policy and the credentials passed unanimously.

The meeting adjourned to closed session and there were no reportable actions from closed session to report.

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QUALITY REPORT

TAB 5

QUALITY MANAGEMENT REPORT

Karen Taylor, Director Integrated Quality Services & Compliance

Patient Falls
April - June 2012

- 24 Falls compared to 32 in 2011
- No Patient injuries in 2012
- DMC fall rate per 1000 patient days = 2.24 compared with CalNoc Benchmark 2.94
- Reducing Patient Falls is a priority for 2013
- Current Falls Protocol will be reviewed and revised to reduce falls in 2013.

Hospital Acquired Pressure Ulcers(HAPU) April - June 2012

- 16 reported skin breakdown events
- 3 HAPU were Stage 3 or 4 requiring a report to CDPH with action plans
- 2012 indicates that the number is reduced from prior years
- Actions taken: Formed a Wound Assessment Team to review documentation & processes related to recognition of high risk patients. Implementation of the "turning buddy" system in MICU.

Organ Donation (CTDN) April – June 2012

- 67 Deaths
- 3 Tissue Donors; No potential organ donors
- 100% referral rates
- CTDN is educating the community about donation opportunities
- Focus for 2012 & 2013 is to improve timeliness of reporting to assist with organ donation potential

Vendor Tracking by Materials Management

- Regulatory requirement to track visits from vendor reps and to insure compliance on required credentialing and certifications.
- DMC began in March 2010
- 2227 vendor reps have registered with Reptrax and linked to our facility
- No cost to DMC; vendors pay fees to Reptrax
- Ensures that vendors are compliant with regulatory requirements including Flu vaccine

HOSPITAL PERFORMANCE IMPROVEMENT COMMITTEE (HPIC) REPORTING FORM

MATERIALS MANAGEMENT

Report is for November 2012

SITUATION :

Regulatory Requirement to track visits from vendor reps and to insure compliance on required credentialing and certifications.

BACKGROUND:

DMC joined Reptrax in March 2010 at no cost to the facility. Vendor reps register to our facility, pay fees and supply required documentation directly to Reptrax. Depending on which category the vendor rep falls in will determine what types of credentialing they need to provide.

ACTION TAKEN & RESULTS:

Since March 2010: 2227 vendor reps have registered with Reptrax and linked to our facility.

Since January 2012: 510 new vendor reps have registered.

Since January 2012: 1152 vendor rep visits to our facility.

It was announced at the Director Meeting that all vendor reps are required to come to Materials Management to check-in when they enter the facility as well as the flu shot is required for all reps effective 11/1/12.

RECOMMENDATIONS/FOLLOWUP:

Continue to track compliance through Reptrax to insure vendor reps remain compliant with the Regulatory Requirement as well as our hospital policy.

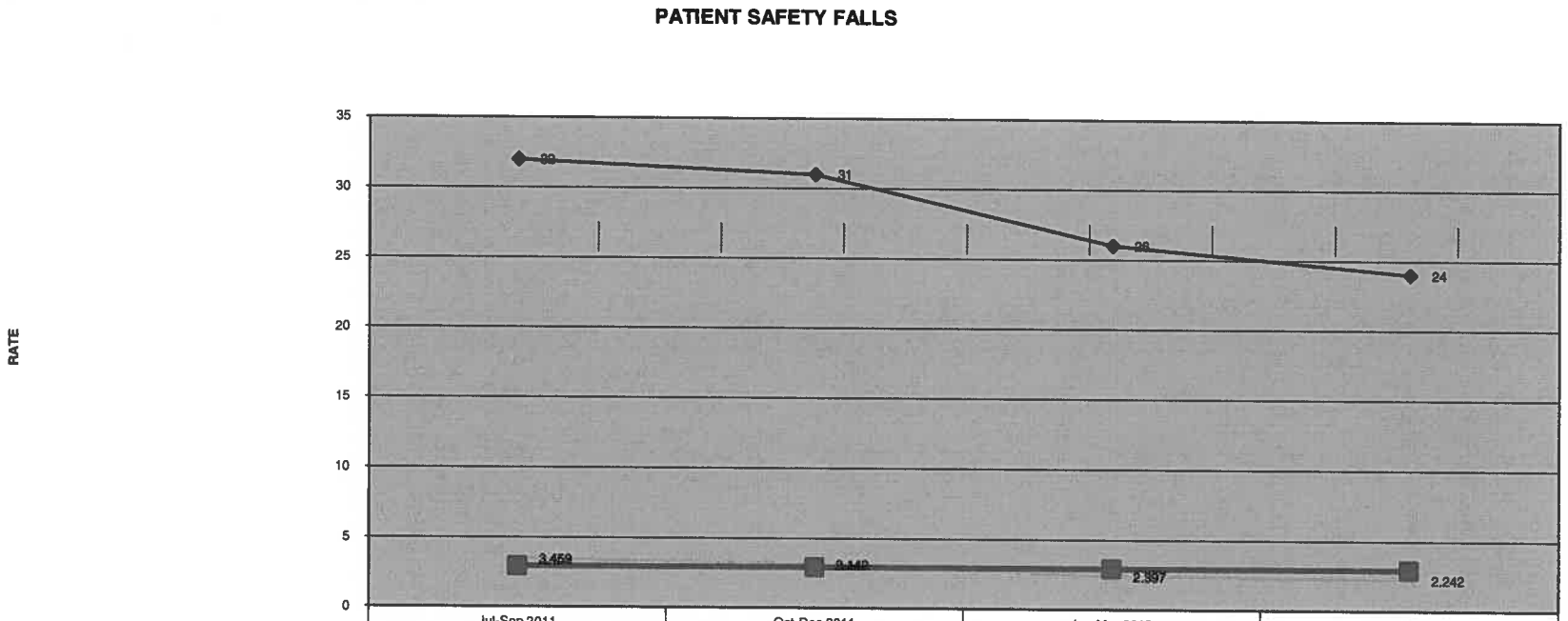
Submitted by: Jennifer Viramontes/DMM **Date:** 11/14/12

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Patient Safety: Falls

Indicator	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Total
Total Falls	32	31	26	24	113
Total Falls With Injury	0	0	0	0	0
% Falls with Injury	0	0	0	0	0
Total Falls per 1,000 Patient Days (APD)	3.459	3.142	2.397	2.242	11.240
Total Falls w/Injury per 1,000 Patient Days (APD)	0	0	0	0	0
CALNOC Benchmark	2.94	2.94	2.94	2.94	
CALNOC Benchmark (Falls with Injury)	0.1	0.1	0.1	0.1	



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DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

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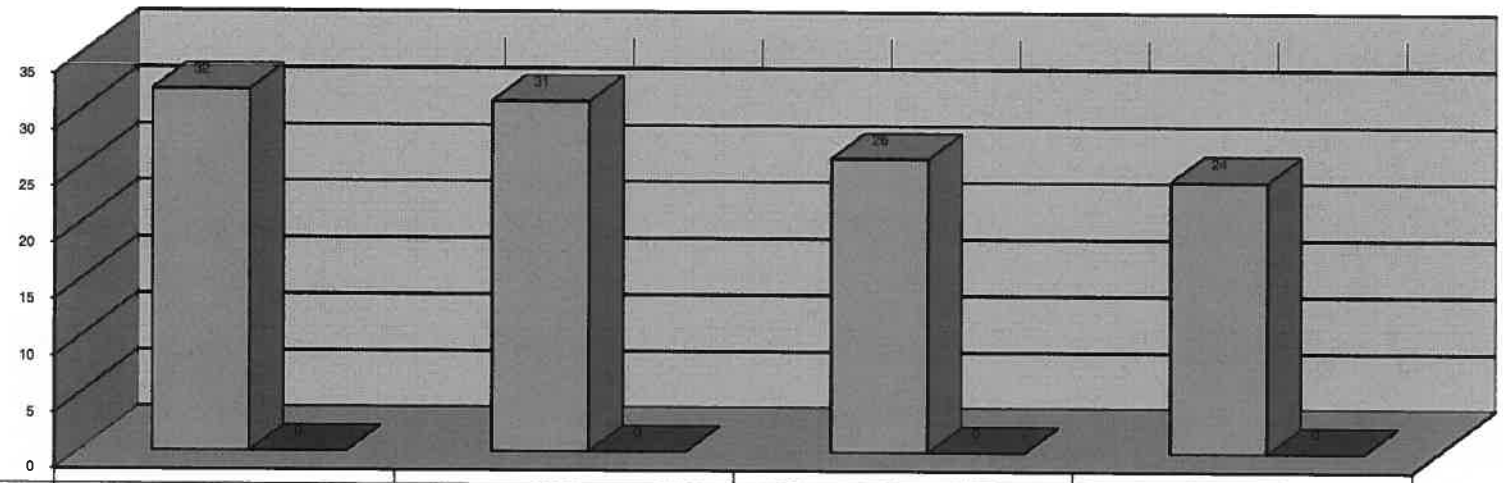
Total Falls w/Injury per 1,000 Patient Days (APD)	0	0	0	0	0
CALNOC Benchmark	2.94	2.94	2.94	2.94	
CALNOC Benchmark (Falls with Injury)	0.1	0.1	0.1	0.1	

Fall vs Injury



	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012
Total Falls	32	31	26	24
Total Falls With Injury	0	0	Rate 0	0

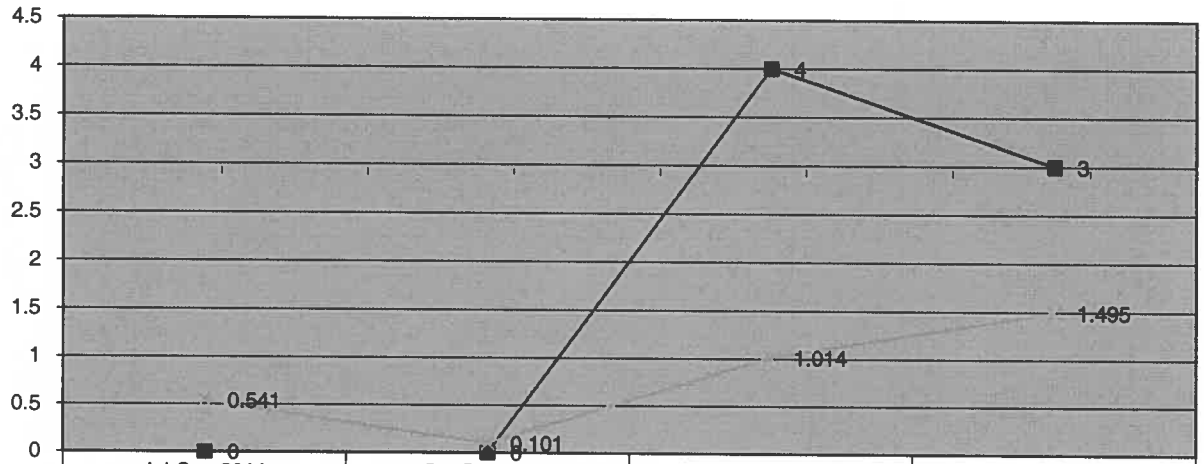
DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Patient Safety: Pressure Ulcers

Indicator	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Total
Total HAPU Events	6	2	11	16	35
HAPU EVENTS: Stage 3, Stage 4, Unstageable	0	0	4	3	7
Skin Integrity Events by Location	49	47	53	41	190
HAPU Rate: Adjusted Patient Days	0.541	0.101	1.014	1.495	3.151

Patient Safety: Pressure Ulcers



	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012
HAPU EVENTS: Stage 3, Stage 4, Unstageable	0	0	4	3
HAPU Rate: Adjusted Patient Days	0.541	0.101	1.014	1.495

Rate

California Transplant Donor Network

CONTACT
Kari Cluff
Donation Services Liaison
Cell: 510-301-8866
FAX: 510-251-7018
kcluff@ctdn.org
http://www.ctdn.org

Hospital Combined Donation & Referral Scorecard

Doctors Medical Center San Pablo Q2 2012

YTD Donation/Referral Counts	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
All Deaths	40	18	33	28	21	18							158
Eligible Deaths	0	0	0	0	0	0							0
Hospital Referrals	40	18	33	28	21	18							158
Missed Referrals	0	0	0	0	0	0							0
Organ/Tissue Referrals	1	0	0	0	0	0							1
Timely Organ Referrals	0	0	0	0	0	0							0
Organ Donors	0	0	0	0	0	0							0
Eligible Donors	0	0	0	0	0	0							0
Non-Eligible Donors	0	0	0	0	0	0							0
Organs Transplanted	0	0	0	0	0	0							0
Tissue Donors	3	0	1	1	0	2							7

YTD Donation/Referral Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Adjusted Conversion Rate	-	-	-	-	-	-							0%
Overall Referral Rate	100%	100%	100%	100%	100%	100%							100%
Timely Organ Referral Rate	0%	-	-	-	-	-							0%
Organ Donor FPA Rate	-	-	-	-	-	-							0%
OTPD	-	-	-	-	-	-							0.00
Death to Tissue Donor Rate	7.5%	0.0%	3.0%	3.6%	0.0%	11.1%							4.4%
Tissue Donor FPA Rate	0%	-	0%	0%	-	0%							0%

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

All items marked with † must be completed, and or required routing

†TITLE: Release of Information	**†CHECK ONE: ☐ ☐Reviewed** **X☐ Revised : X ☐ Major ☐Minor**

† ☐ Administrative ☐Clinical ☐Department __HIM

†SUBMITTED BY: Jody Popke

†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC x Other
Recommendation from mock survey "Meaningful Use Requirements"

†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:

.
Added 3 new sections for Meaningful Use Requirements
Producing a patient their own records on CD-when requested by patient
Producing discharge instruction on CD-when requested by patient
Producing Clinical Care Document on CD-when requested by patient

	MEETING DATE	APPROVAL
x☐ **Manager or Department Director†**		Jody Popke
x☐ **Administrative Policy Review Committee (APRC)†** (Determine committee routing) **Send electronic copy with tracked revisions to PI**	9/26/2012	X
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☐ P&T Committee		
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)†**	9/26/2012	X
☐ **Executive Leadership**		
☐ **Medical Executive Committee (MEC)**		
X☐ **Board of Trustees**		
☐ **Final version routed to PI for posting to MCN** (notification to submitter of approval)		

DOCTORS MEDICAL CENTER

Manual: ADMINISTRATION	Sub Folder:
Title: Release of Information	Reviewed: 10/97 Revised: 10/96, 8/00, 4/03, 10/05, 8/06, 1/08, 3/09, 1/10, 1/11, 8/12
Effective Date: 7/94 Expiration Date: 8/15	Page 1 of 2

POLICY:

The medical record is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. It is the responsibility of the hospital to safeguard both informational content and the patient chart against loss, defacement, tampering or use by unauthorized individuals. All medical records are confidential and shall not be disclosed except in accordance with policies and procedures of Doctors Medical Center San Pablo.

In April 2003, HIPAA (Health Insurance Portability & Accountability Act of 1966) became law, regulating the use and disclosure of PHI (Protected Health Information). General guidelines are listed below. For additional information see separate HIPAA POLICY BINDER LOCATED IN THE HIM DEPARTMENT.

General Guidelines:

1. Records may be readily released for TPO (Treatment, Payment or Health Care Operations).
2. Identify the individual who is making a request
    a. If patient: by driver's license, photo ID or comparing signature to signature on hospital stay
    b. If another healthcare provider: by asking for information only they would know (e.g.: what lab tests were ordered)
    c. If for payment: by verifying they are responsible for payment on the face sheet
    d. If for health care operations: employees should be identified by job description their role
3. If authorization is required, have patient complete either "Access Request" or "Authorization to Use & Disclose Health Information."
4. Release minimally necessary information.
5. For faxing medical records
    a. Submit via HPF if it is available in HPF, so there is a permanent tracking.
    b. If done manually because it is not yet in HPF, it must always be sent with a cover sheet – see attached.
    c. Verify fax number and if used often, pre-program fax machine with number.
6. Please refer all requests for information that are beyond TPO to the Health Information Department.
7. An electronic version via CD of the patient's medical record can be produced within 3 day upon request.
8. A Continuity Care Document "CCD" can also be produced electronically via CD within 3 day up request.

9. An electronic copy of the patients discharge instruction can also be produced immediately upon request by the HIM via CD during working hours and produced by the nursing supervision during non working hours of the HIM department.

Responsible for review/updating (Title/Dept)	Title: Director	Dept: Health Information Management

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PATIENT SATISFACTION RESULTS

TAB 6

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Patient Satisfaction (HCAHPS)

INDICATOR	Threshold	Target	Goal	4th Qtr 2011	1st Qtr 2012	2nd Qtr 2012	3rd Qtr 2012	1st to 2nd Qtr 2012	2nd Qtr 2012
Patient Satisfaction -Top Box Scores(HCAHPS)	US Average	CA Average	DMC	Top Box	Top Box	Top Box	Top Box	%Change	PG Database Ranking
Number of Surveys Returned	CMS Required Minimum= 300+ Annually			231	232	250	233	N/A	N/A
Mean Score (Related to Press Ganey Supplemental Questions)	Unavailable	Unavailable	80%	75%	77%	76%	78%	↑ 2%	–
Patients who gave DMC a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	67%	63%	63%	44%	49%	45%	49%	↑ 4%	1%
Patients who reported YES, they would definitely recommend the hospital.	69%	67%	67%	46%	46%	45%	52%	↑ 7%	1%
Patients who reported that their nurses "Always" communicated well.	76%	71%	70%	60%	59%	59%	66%	↑ 7%	1%
Patients who reported that their doctors "Always" communicated well.	80%	76%	76%	70%	68%	73%	74%	↑ 1%	3%
Patients who reported that they "Always" received help as soon as they wanted.	64%	57%	57%	40%	42%	42%	41%	↓ 1%	1%
Patients who reported that their pain was "Always" well controlled.	69%	66%	65%	55%	55%	55%	63%	↑ 8%	1%
Patients who reported that staff "Always" explained about medicines before giving it to them.	61%	56%	56%	46%	48%	50%	54%	↑ 4%	–
Patients who reported that the area around their room was "Always" quiet at night.	58%	48%	47%	41%	33%	33%	40%	↑ 7%	1%
Patients who reported that their room and bathroom were "Always" clean.	71%	68%	67%	55%	53%	51%	60%	↑ 9%	1%
Patients who reported that YES, they were given information about what to do during their recovery at home.	81%	79%	79%	71%	69%	71%	68%	↓ 3%	1%

Definitions

Top Box- HCAHPS response rates of patients who provided the highest score in each domain or stand alone question. Example: Definitely Yes, Always and 9-10

Mean Score- An average of all Press Ganey Supplemental question responses based on a 0-100 scoring system. Example: Very Poor=0, Poor=25, Fair=50, Good=75, Very Good=100

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INFLUENZA POLICY

TAB 7

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

All items marked with † must be completed, and or required routing

†**TITLE:** Influenza Vaccine	†**CHECK ONE:** ☒ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor
† ☒ Administrative ☐ Clinical ☐ Department _____	
†**SUBMITTED BY:** Human Resources/Employee Health	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other County Mandate	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** .	

	MEETING DATE	APPROVAL
☐ **Manager or Department Director**†		
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☒ Infection Control Committee ☐ IDP Committee	11/16/12	approved
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee		OK'd by Therese Helser
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☒ EOC/Safety Committee ☐ Other:	9/19/12	approved
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☒ **Administrative Policy Review Committee (APRC)**†	10/24/12	approved
☒ **Executive Leadership**	10/2012	approved
☐ **Medical Executive Committee (MEC)** (as applicable)		
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual: HOSPITAL WIDE	Sub Folder:
Title: INFLUENZA VACCINE	Reviewed: Revised:
Effective Date: Draft pending Governing Board Approval Expiration Date:	Page 1 of 2

PURPOSE:

To help protect staff, non-employees, patients, and families of Doctors Medical Center, San Pablo from acquiring seasonal influenza disease and to help prevent the unnecessary spread of the influenza virus between employees, non-employees, patients and families. The influenza vaccination coverage is a measure of safety and quality.

DEFINITION:

The Health Officer of Contra Costa County has defined health care workers as persons, paid and unpaid, working in licensed health care settings who have direct patient contact or who work in an acute care environment including, but not limited to corridors, stairwells, lobbies, waiting areas, et cetera.

Influenza season has been designated by the County Health Officer each year as November 1 through March 31. The Health Officer may extend the injection and mandatory masking period if surveillance data demonstrate an unusually late peak and continued widespread influenza activity in the spring. Health care workers should be offered influenza vaccine before influenza season starts, as it can take up to two weeks to develop protection.

POLICY:

In compliance with the Contra Costa County Department of Health order, employees will receive an Influenza flu vaccine during flu season; those who refuse Influenza immunization will be required to wear a mask while working in an acute care environment.

PROCEDURE:

Education will be provided to address the potential consequences of influenza for employees, co-workers, patients, and families. The epidemiology and modes of transmission, diagnosis, treatment, and infection control strategies and the benefits of influenza vaccination will also be addressed. This information will be available to health care workers via E-Mail, at department meetings, in writing, and verbally one on one.

Doctors Medical Center will provide inactivated vaccine by injection to employees, volunteers, and licensed independent practitioners. The annual immunization programs will begin in fall and extend through the winter. Influenza vaccines will be available at the Employee Health Clinic, at designated sites throughout the hospital at designated times, and on roving flu carts. Employee Health will use strategies to accommodate all health care workers in order to increase influenza vaccine availability during all shifts. A legible, written record of current flu vaccine administration from outside providers will be accepted as proof of vaccination. Health care workers who receive the Influenza vaccine will receive an annual DMC sticker for their name badge as proof they have received the vaccine.

The number of participants, including the facility and department, will be monitored and the information will be distributed to managers of said departments. If vaccination has not occurred by November 1st of each year, Health Care Workers (HCW's) of DMC will be required to wear a mask while working in this acute care environment.

HCW's who do not receive the Influenza vaccine *and* who do not wear a mask while working in the acute care environment will be considered non-compliant with the Contra Costa County mandate, and Doctors Medical Center will remove those staff from duty without pay until they comply with these requirements.

References:

California Department of Public Health: Increasing Influenza Vaccination Rates Among the California Health Care Personnel statement 12/5/11

Contra Costa Regional Medical Center Infection Prevention and Control Program Influenza or Wear a Mask Policy August 2012

Contra Costa Health Officer Influenza Vaccination and Masking Order FAQ 9/11/12

Contra Costa County Director & Officer Order. August 27, 2012

CDC Influenza Vaccine Information Statement July, 2012

Colorado Hospital Association Guide to Developing Influenza Vaccination Policy for Healthcare Personnel, 2011

American Hospital Association Quality Advisory – July, 2011

Responsible for review/updating (Title/Dept)	Title: Director	Dept: Human Resources

DOCTORS
MEDICAL CENTER

FINANCIALS
OCTOBER 2012

TAB 8

Board Presentation

October 2012

Financial Report

Financial Report Key Points

- Net Loss was $573K in October.
- Operating revenue was over budget by $747K due to the receipt of $1.4M for EHR
- Expenses $481K over budget.

Statement of Activity - Summary

For the Period Ending

October 31, 2012

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
11,276	10,529	747	**Net Operating Revenues $**	102,520	109,044	(6,524)
12,517	12,036	(481)	**Total Operating Expenses $**	124,366	123,834	(532)
(1,241)	(1,506)	265	**Income/(Loss) from Operations $**	(21,846)	(14,790)	(7,056)
668	876	(208)	**Income from Other Sources $**	6,951	6,329	622
(573)	(631)	58	**Net Income / (Loss) $**	(14,895)	(8,461)	(6,434)

2,167	2,410	(243)	**Patient Days**	22,858	25,194	(2,336)
504	500	4	**Discharges**	5,047	5,167	(120)
6,757	6,582	175	**Outpatient Visits**	67,872	65,894	1,978
646	618	(28)	**Worked FTE's**	629	636	6
1.51	1.59	0.08	**Medicare CMI**	1.54	1.59	0.05

Budget Variances – Net Revenue

- Medi-Cal / Medi-Cal HMO - ($413)K.
- Medicare / Medicare HMO - $307K.
- Government / Workers Comp - ($368K).
- Commercial / PPO /HMO - ($193K).

Budget Variances – Expenses

- Salaries & Benefits ($469K) – Salaries are over primarily in nursing areas collection costs and Paragon training. Benefits are over in employee benefit costs claims and sick pay.
- Professional Fees ($90K) – Unbudgeted consultants and offsetting decrease in legal costs.
- Supplies $229K – Underutilization of implants and pharmaceuticals cost reductions.

Cash Position

October 31, 2012

(Thousands)

	October 31, 2012	December 31, 2011
Unrestricted Cash	$4,507	$13,972
Restricted Cash	$14,272	$29,847
Total Cash	$18,779	$43,819
Days Unrestricted Cash	11	33
Days Restricted	37	72
Total Days of Cash	48	106

California Benchmark Average	34
Top 25%	82
Top 10%	183

Accounts Receivable

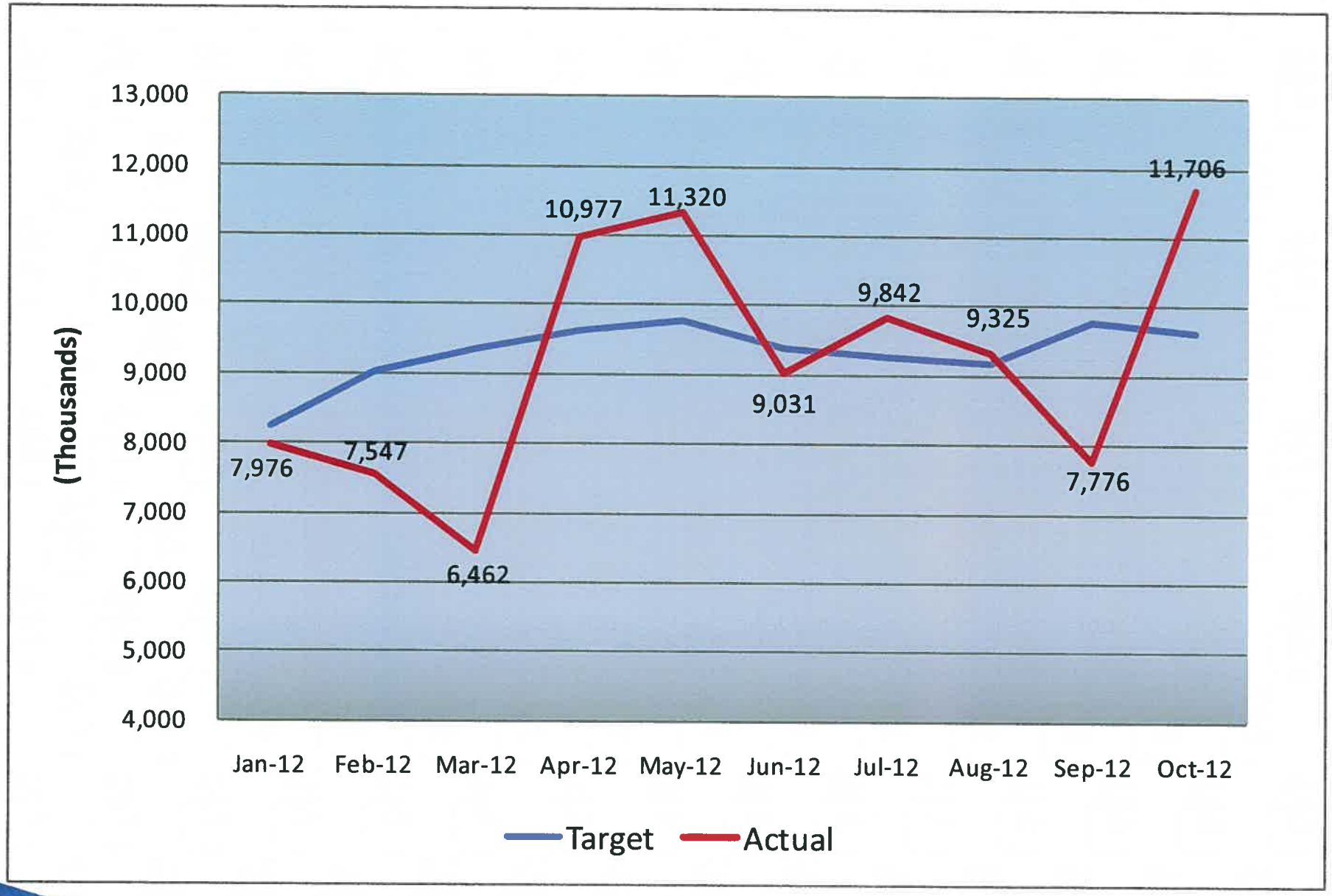
October 31, 2012

(Thousands)

	October 31, 2012	December 31, 2011
Net Patient Accounts Receivable	$27,662	$19,177
Net Days in Accounts Receivable	84.5	60.7

California Benchmark Average	65.7 days
Top 25%	45.2 days
Top 10%	35.5 days

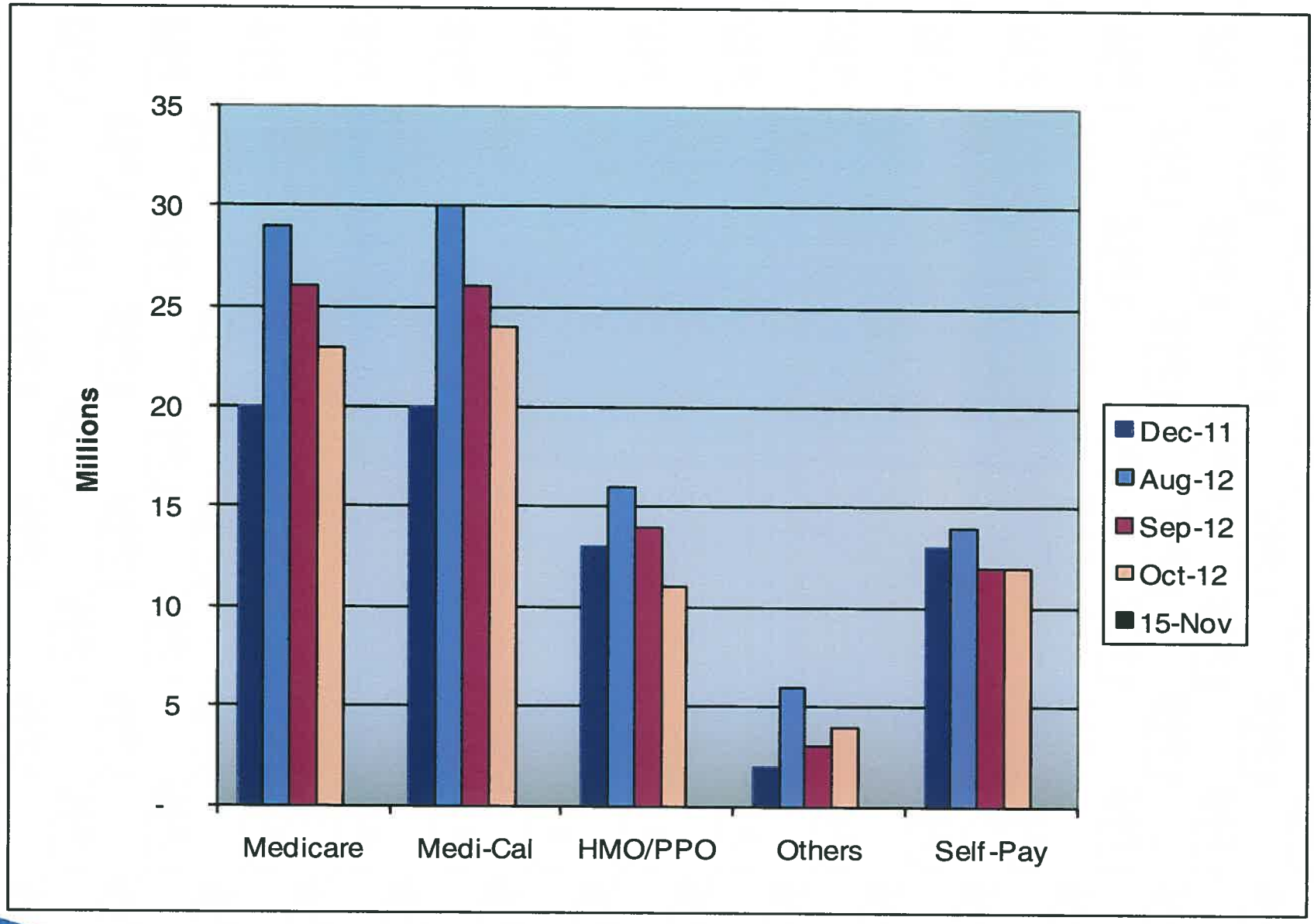
Cash Collections YTD



Capital Budget 2012

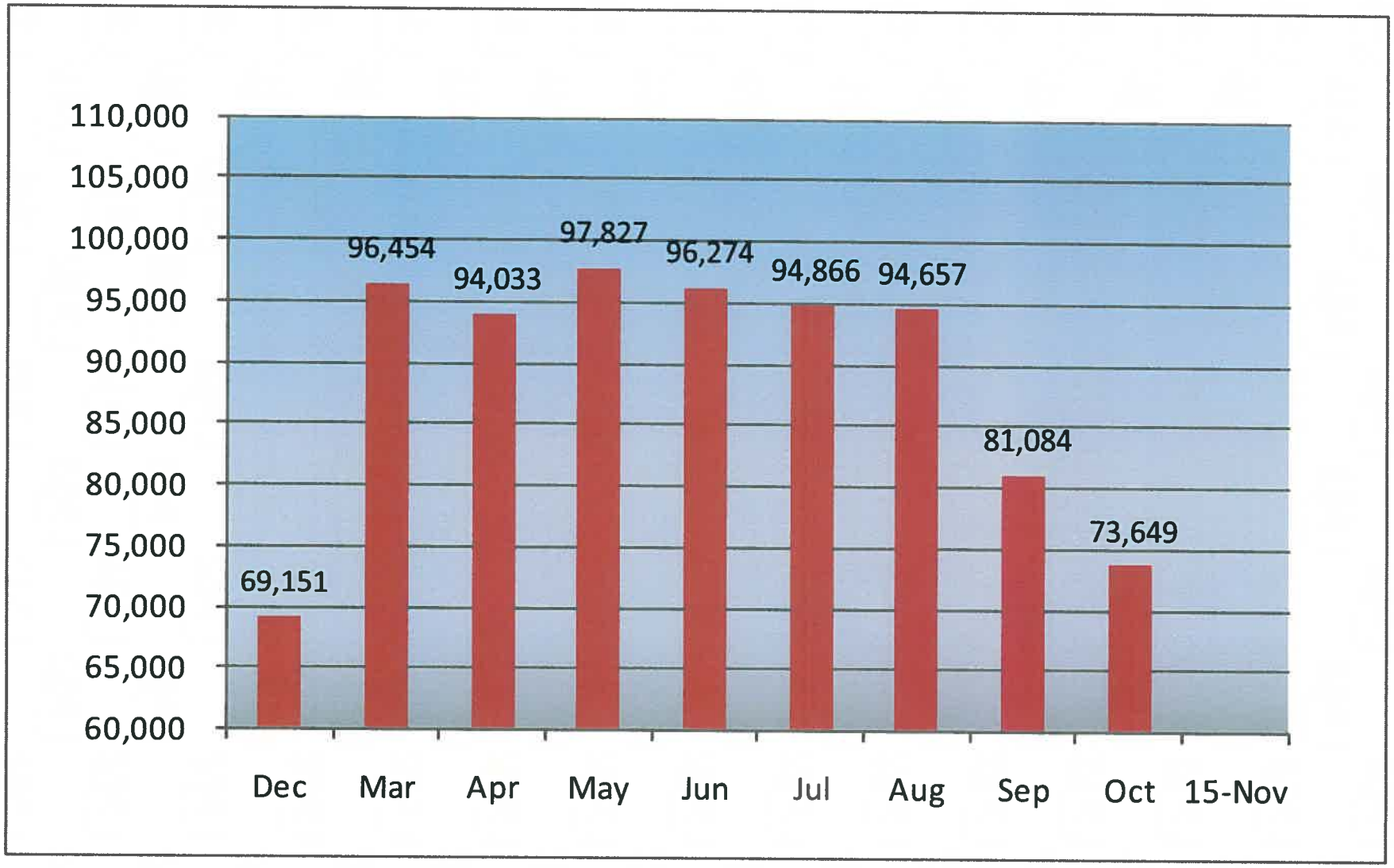
Paragon	$1,757,000
Other	1,000,000
Total Capital Budget:	$2,757,000
Commited To Date:	$2,732,477
Subtotal Remaining	$24,523
Foundation Support	175,000
Remaining Capital	$199,523

AR By Payor


35
30
25
20
15
10
5
-
Millions
Medicare
Medi-Cal
HMO/PPO
Others
Self-Pay
Dec-11
Aug-12
Sep-12
Oct-12
15-Nov

Accounts Receivable

(Thousands)



WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2012
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
1	9,727	10,171	(444)	-4.4%	8,321	Net Patient Service Revenue	99,090	106,264	(7,174)	-6.8%	98,296
2		222	(222)	-100.0%	-	Collaboration Savings		1,554	(1,554)	-100.0%	
3	1,549	136	1,413	1040.9%	80	Other Revenue	3,430	1,225	2,205	180.0%	1,022
4	11,276	10,529	747	7.1%	8,401	**Total Operating Revenue**	102,520	109,044	(6,524)	-6.0%	99,318
						OPERATING EXPENSES					
5	5,339	5,154	(185)	-3.6%	4,645	Salaries & Wages	53,852	52,235	(1,617)	-3.1%	51,749
6	2,851	2,567	(284)	-11.1%	2,704	Employee Benefits	27,189	27,591	402	1.5%	28,804
7	932	842	(90)	-10.7%	909	Professional Fees	9,542	8,715	(827)	-9.5%	9,058
8	1,475	1,704	229	13.4%	1,257	Supplies	14,584	17,105	2,521	14.7%	16,256
9	990	965	(25)	-2.6%	825	Purchased Services	9,226	9,665	439	4.5%	8,707
10	198	268	70	26.0%	271	Rentals & Leases	2,473	2,675	202	7.6%	2,509
11	419	370	(49)	-13.3%	349	Depreciation & Amortization	4,044	3,692	(352)	-9.5%	3,467
12		(222)	(222)			Collaboration Savings	-	(1,554)	(1,554)		
12	313	389	76	19.5%	379	Other Operating Expenses	3,456	3,710	254	6.8%	3,408
13	12,517	12,036	(481)	-4.0%	11,339	**Total Operating Expenses**	124,366	123,834	(532)	-0.4%	123,958
14	(1,241)	(1,506)	265	-17.6%	(2,938)	**Operating Profit / Loss**	(21,846)	(14,790)	(7,056)	47.7%	(24,640)
						NON-OPERATING REVENUES (EXPENSES)					
15	-	-	-	0.0%	-	Other Non-Operating Revenue	1,200	-	1,200	0.0%	5,443
16	1,124	1,131	(7)	0.6%	258	District Tax Revenue	9,204	8,761	443	-5.1%	7,123
17	15	4	11	253.8%	708	Investment Income	226	42	184	433.0%	39
18	(471)	(260)	(211)	0.0%	2	Less: Interest Expense	(3,679)	(2,475)	(1,204)	48.6%	(1,261)
19	668	876	(208)	-23.7%	968	**Total Net Non-Operating**	6,951	6,329	622	9.8%	11,344
20	(573)	(631)	58	-9.2%	(1,970)	**Income Profit (Loss)**	(14,895)	(8,461)	(6,434)	76%	(13,296)
						Profitability Ratios:					
21	-11.0%	-14.3%	35.6%		-35.0%	Operating Margin %	-21.3%	-13.6%	108.2%		-24.8%
22	-5.1%	-6.0%	0.9%		-23.4%	Profit Margin %	-14.5%	-7.8%	-6.8%		-13.4%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2012
(Amounts in Thousands)

23	2,388	2,131	(256)	-12.0%	2,277	SWB / APD	2,258	2,139	(119)	-5.6%	2,269
24	65.4%	64.1%			64.8%	SWB / Total Operating Expenses	65.2%	64.5%			65.0%
25	3,649	3,323	(326)	-9.8%	3,513	Total Operating Expenses / APD	3,466	3,319	(147)	-4.4%	3,492
26	35,520	38,848	(3,328)	-8.6%	33,861	I/P Gross Charges	349,045	414,600	(65,555)	-15.8%	386,109
27	20,705	19,543	1,162	5.9%	20,024	O/P Gross Charges	198,936	199,426	(490)	-0.2%	198,752
28	**56,225**	**58,391**	**(2,166)**	**-3.7%**	**53,885**	**Total Gross Charges**	**547,981**	**614,026**	**(66,045)**	**-10.8%**	**584,861**
						Payor Mix (IP and OP)					
29	44%	40%	4%		39%	Medicare %	43%	40%	3%		40%
30	4%	15%	-11%		10%	Medi-Cal %	5%	15%	-10%		13%
31	13%	12%	1%		15%	Managed Care HMO / PPO %	13%	12%	1%		11%
32	10%	9%	1%		10%	Medicare HMO %	10%	9%	1%		9%
33	15%	9%	6%		11%	Medi-Cal HMO %	15%	9%	6%		11%
34	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
35	1%	1%	0%		2%	Worker's Comp %	1%	1%	0%		1%
36	3%	3%	0%		3%	Other Government %	3%	3%	-1%		3%
37	10%	10%	0%		10%	Self Pay /Charity %	11%	10%	1%		10%
						STATISTICS					
38	511	488	23	4.7%	503	Admissions	5,092	5,162	(70)	-1.4%	5,116
39	504	500	4	0.8%	492	Discharges	5,047	5,167	(120)	-2.3%	5,120
40	2,167	2,410	(243)	-10.1%	2,028	Patient Days	22,858	25,194	(2,336)	-9.3%	23,436
41	69.9	77.7	(7.8)	-10.1%	65.4	Average Daily Census (ADC)	74.9	82.6	(7.7)	-9.3%	77.1
42	4.30	4.82	0.52	10.8%	4.12	Average Length of Stay (LOS)- Accrual Based	4.53	4.88	0.35	7.1%	4.58
43	31	31			31	Days in Month	305	305			304
44	798	752	46	6.2%	783	Adjusted Discharges (AD)	7,924	7,652	271	3.5%	7,756
45	3,430	3,622	(192)	-5.3%	3,227	Adjusted Patient Days (APD)	35,886	37,313	(1,427)	-3.8%	35,500
46	111	117	(6)	-5.3%	104	Adjusted ADC (AADC)	118	122	(5)	-3.8%	117
47	85	89	(4)	-4.5%	85	Inpatient Surgeries	769	913	(144)	-15.8%	902
48	97	115	(18)	-15.7%	94	Outpatient Surgeries	933	974	(41)	-4.2%	996
49	**182**	**204**	(22)	-10.8%	**179**	**Total Surgeries**	**1,702**	**1,887**	(185)	-9.8%	**1,898**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2012
(Amounts in Thousands)

50	3,229	2,794	435	15.6%	3,068	ED Outpatient Visits	35,032	28,040	6,992	24.9%	29,677
51	3,431	3,673	(242)	-6.6%	3,547	Ancillary Outpatient Visits	31,907	36,880	(4,973)	-13.5%	36,872
52	97	115	(18)	-15.7%	94	Outpatient Surgeries	933	974	(41)	-4.2%	996
53	**6,757**	**6,582**	175	2.7%	**6,709**	**Total Outpatient Visits**	**67,872**	**65,894**	1,978	3.0%	**67,545**
54	425	409	16	3.9%	480	Emergency Room Admits	4,625	4,482	143	3.2%	4,539
55	13.2%	14.6%			15.6%	% of Total E/R Visits	13.2%	16.0%			15.3%
56	83.2%	83.8%			95.4%	% of Acute Admissions	90.8%	86.8%			88.7%
57	646	618	(28)	-4.6%	583	Worked FTE	629	636	6	1.0%	652
58	733	687	(46)	-6.7%	676	Paid FTE	730	724	(6)	-0.9%	763
59	5.84	5.29	(0.55)	-10.4%	5.60	Worked FTE / AADC	5.35	5.24	(0.11)	-2.0%	5.58
60	6.63	5.88	(0.75)	-12.7%	6.49	Paid FTE / AADC	6.20	5.99	(0.21)	-3.6%	6.53
61	2,836	2,808	28	1.0%	2,578	Net Patient Revenue / APD	2,761	2,848	(87)	-3.0%	2,769
62	16,391	16,119	272	1.7%	16,697	I/P Charges / Patient Days	15,270	16,456	(1,186)	-7.2%	16,475
63	3,064	2,969	95	3.2%	2,985	O/P Charges / Visit	2,931	3,026	(95)	-3.2%	2,943
64	1,556	1,423	(134)	-9.4%	1,439	Salary Expense / APD	1,501	1,400	(101)	-7.2%	1,458
64	4.8	5.7	0.94	16.5%	4.4	Medicare LOS - Discharged Based	4.9	5.8	0.91	15.7%	5.1
65	1.51	1.59	0.08	5.1%	1.41	Medicare CMI	1.54	1.59	0.05	3.1%	1.6
66	3.16	3.58	0.43	12.0%	3.12	Medicare CMI Adjusted LOS	3.17	3.64	0.47	12.9%	3.26
67	4.4	4.8	0.38	7.9%	4.12	Total LOS - Discharged Based	4.6	4.8	0.27	5.6%	4.53
68	1.531	1.509	(0.02)	-1.5%	1.36	Total CMI	1.492	1.481	(0.01)	-0.7%	1.48
69	2.88	3.17	0.29	9.3%	3.03	Total CMI Adjusted LOS	3.05	3.25	0.20	6.3%	3.06

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
October 31, 2012
(Amounts in Thousands)

		Current Month	Dec. 31, 2011
	ASSETS		
70	Cash	4,507	13,959
71	Net Patient Accounts Receivable	27,662	19,177
72	Other Receivables	2,693	1,160
73	Inventory	2,060	2,109
73	Current Assets With Limited Use	14,272	29,859
74	Prepaid Expenses and Deposits	1,316	999
75	**TOTAL CURRENT ASSETS**	**52,510**	**67,263**
76	**Assets With Limited Use**	**642**	**642**
	Property Plant & Equipment		
77	Land	12,120	12,120
78	Bldg/Leasehold Improvements	29,432	33,733
79	Capital Leases	10,926	10,926
80	Equipment	43,104	34,074
81	CIP	1,224	3,130
82	Total Property, Plant & Equipment	96,806	93,983
83	Accumulated Depreciation	-53,060	-49,200
84	**Net Property, Plant & Equipment**	**43,746**	**44,783**
85	**Intangible Assets**	**1,465**	**1,517**
86	**Total Assets**	**98,363**	**114,205**
87	Current Ratio (CA/CL)	***1.35***	***1.89***
88	Net Working Capital (CA-CL)	***13,507***	***31,749***
89	Long Term Debt Ratio (LTD/TA)	***0.62***	***0.55***
90	Long Term Debt to Capital (LTD/(LTD+TE)	***1.09***	***0.87***
91	Financial Leverage (TA/TE)	***-18.8***	***11.8***
92	Quick Ratio	**0.82**	**0.93**
93	Unrestricted Cash Days	**11**	**33**
94	Restricted Cash Days	**37**	**72**
95	Net A/R Days	**84.5**	**60.7**

		Current Month	Dec. 31, 2011
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,695	1,634
97	Accounts Payable and Accrued Expenses	16,206	16,021
98	Accrued Payroll and Related Liabilities	16,951	13,639
99	Deferred District Tax Revenue	2,880	2,880
100	Estimated Third Party Payor Settlements	1,271	1,340
101	**Total Current Liabilities**	**39,003**	**35,514**
	Other Liabilities		
102	Other Deferred Liabilities	3,242	6,105
103	Chapter 9 Bankruptcy	0	0
	Long Term Debt		
104	Notes Payable - Secured	61,175	62,067
105	Capital Leases	1,791	2,481
106	Less Current Portion LTD	-1,625	-1,634
107	**Total Long Term Debt**	**61,341**	**62,914**
108	**Total Liabilities**	**103,586**	**104,533**
	EQUITY		
109	Retained Earnings	9,672	28,400
110	Year to Date Profit / (Loss)	-14,895	-18,728
111	**Total Equity**	**-5,223**	**9,672**
112	**Total Liabilities & Equity**	**98,363**	**114,205**

DOCTORS
MEDICAL CENTER

October 2012 Executive Report

Doctors Medical Center had a Net Loss of $573,000 in the month of October. As a result, net income was slightly over budget $58,000. The following are the factors leading to the Net Income variance:

Net Patient Revenue Factors	**Positive / (Negative)**
Government/ Workers Compensation	($368,000)
Medi-Cal / Medi-Cal HMO	($413,000)
Medicare / Medicare HMO	$307,000
Managed Care, Commercial, PPO	($193,000)
Expenses	
Salaries & Benefits	($469,000)
Professional Fees	($ 90,000)
Supplies	$229,000

Net patient revenue was under budget by $444,000. Inpatient gross charges were under budget by 8.6%. Patient days were 10.1% under budget with discharges at 0.8% over budget. Outpatient gross charges were over budget in October by 5.9%. Ancillary outpatient visits were 6.6% under budget and outpatient surgeries were 15.7% under budget, while emergency department visits were 15.6% over budget. Total Medi-Cal days were under budget by 24.4% with 74% of Medi-Cal days coming to us as managed Medi-Cal days. Days from both the Government programs and Workers Compensation also remain under budget as total budgeted days were 224 compared to the actual in October of 51. Managed Care, Commercial and PPO combined days were 3.5% under budget as total budgeted days were 200 compared to 193 actual days in October. The Medicare case mix index for October was 1.51 versus a budget of 1.59 and Medicare discharges were 8.0% over budget.

Salaries and Benefits combined were over budget $469,000 in October. Worked FTE's per adjusted average daily census was unfavorable to budget by 10.4% with salaries and wages at 3.6% over budget. Patient days were 10.1% under budget and outpatient visits were 2.7% over budget. Salaries for October were over budget by $185,000 in the nursing areas, unbudgeted collection costs for the billing department and Paragon training. Benefit costs were over budget in October by $284,000 due to an overage in health insurance and sick pay. Year to date salaries and benefits combined are $1,215,000 over budget.

Professional Fees were over budget in October by $90,000 due to unbudgeted consultants and offsetting decrease in legal costs.

Supplies were under budget in October by $229,000 under budget as a result of the continued underutilization of implants of and pharmaceutical cost reductions.

Budgeted collaboration revenue and expense reductions have not been achieved resulting in a $444,000 negative effect on October and a year to date negative effect of $3,108,000

DOCTORS
MEDICAL CENTER

2013 BUDGET PRESENTATION

TAB 9

2013 Budget

November 26, 2012

Goals of 2013 Budget

- Improve current operational performance
- Increase ownership and accountability of DMC's Department Leadership in the 2013 Budget
- Increase commitment to quality & patient safety
- Improve operational support for clinical services

2013 Budget Process

The intent was to create a budget that reflects our current operations with changes that streamline costs and maintains our patient safety and quality standards. To do this we:

- Met with each Department Director to review volume and revenue assumptions and expenses.
- Created detailed work plans for changes needed to each department.
- Looked to each Department Director for efficiencies in delivering services.

Revenue Changes

Chevron Event	($5,000)
Decrease in Volume	(1,800)
Increase in Medicare Rate	1,360
Change in Commercial Rates	1,660
Chargemaster Increase	1,500

2013 Budget – Expense Changes

Flexing of Staff for Volume Decrease	($3,442)
Wage Increase (1% plus 1%)	1,690
New Leadership Team	538
Reduction of Interim Leadership	(1,773)
Soriant	(811)
Supply Reductions	(1,170)
Employee Development	500
Emergency Department Contract	670
Intensivists	475

2013 Budgeted Statement of Revenues and Expenses
Amounts in Thousands

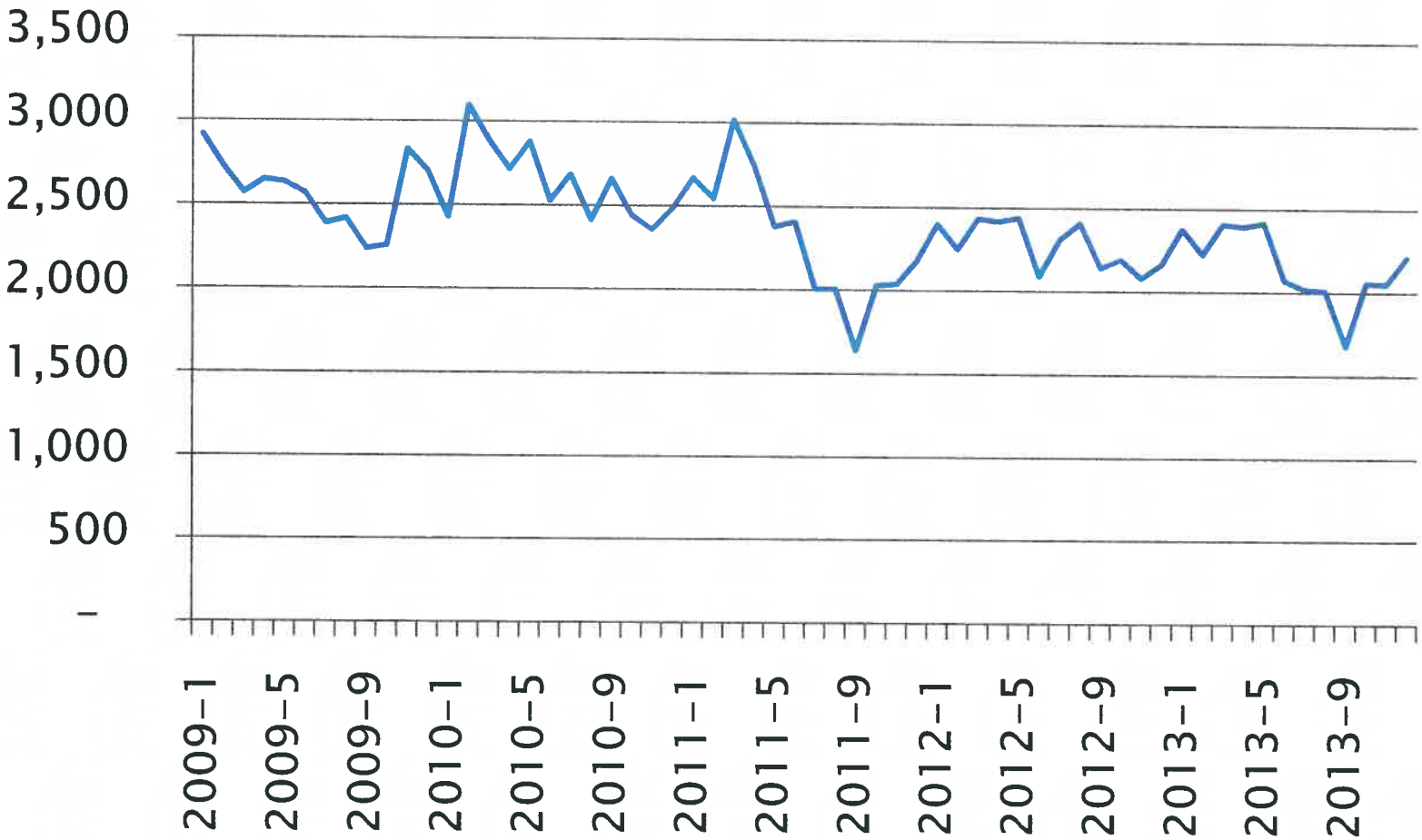
OPERATING REVENUE	Actual 2011	Projected 2012	Budget 2013	Change	% Change
Net Patient Service Revenue	$115,839	$121,607	$119,453	($2,154)	-1.8%
Other Revenue	1,190	3,610	3,106	(505)	-14.0%
Total Operating Revenue	117,029	125,217	122,559	(2,659)	-2.1%
OPERATING EXPENSES					
Salaries & Wages	61,563	64,440	62,580	(1,861)	-2.9%
Employee Benefits	34,684	33,024	32,642	(382)	-1.2%
Professional Fees	10,907	11,418	11,022	(396)	-3.5%
Supplies	18,775	17,962	16,792	(1.170)	-6.5%
Purchased Services	11,194	11,157	10,509	(648)	-5.8%
Rentals & Leases	3,106	3,043	3,424	381	12.5%
Depreciation & Amortization	4,163	4,882	5,433	551	11.3%
Other Operating Expenses	3,845	4,133	4,887	754	18.2%
Total Operating Expenses	148,237	150,060	147,289	(2,771)	-1.8%
Operation Profit/Loss	(31,208)	(24,842)	(24,730)	113	-0.5%
NON-OPERATING REVENUES (EXPENSES)					
Other Non-Operating Revenue	5,990	1,200	0	(1,200)	-100.0%
District Tax Revenue	8,498	11,466	13,613	2,147	18.7%
Investment Income	56	234	51	(183)	-78.2%
Less: Interest Expense	(1,657)	(4,593)	(4,733)	(140)	3.0%
Total Net Non-Operating	12,889	8,308	8,931	623	7.5%
Income Profit (Loss)	**($18,319)**	**($16,535)**	**($15,799)**	**$736**	**4.4%**

2013 Budget
Volume Assumptions

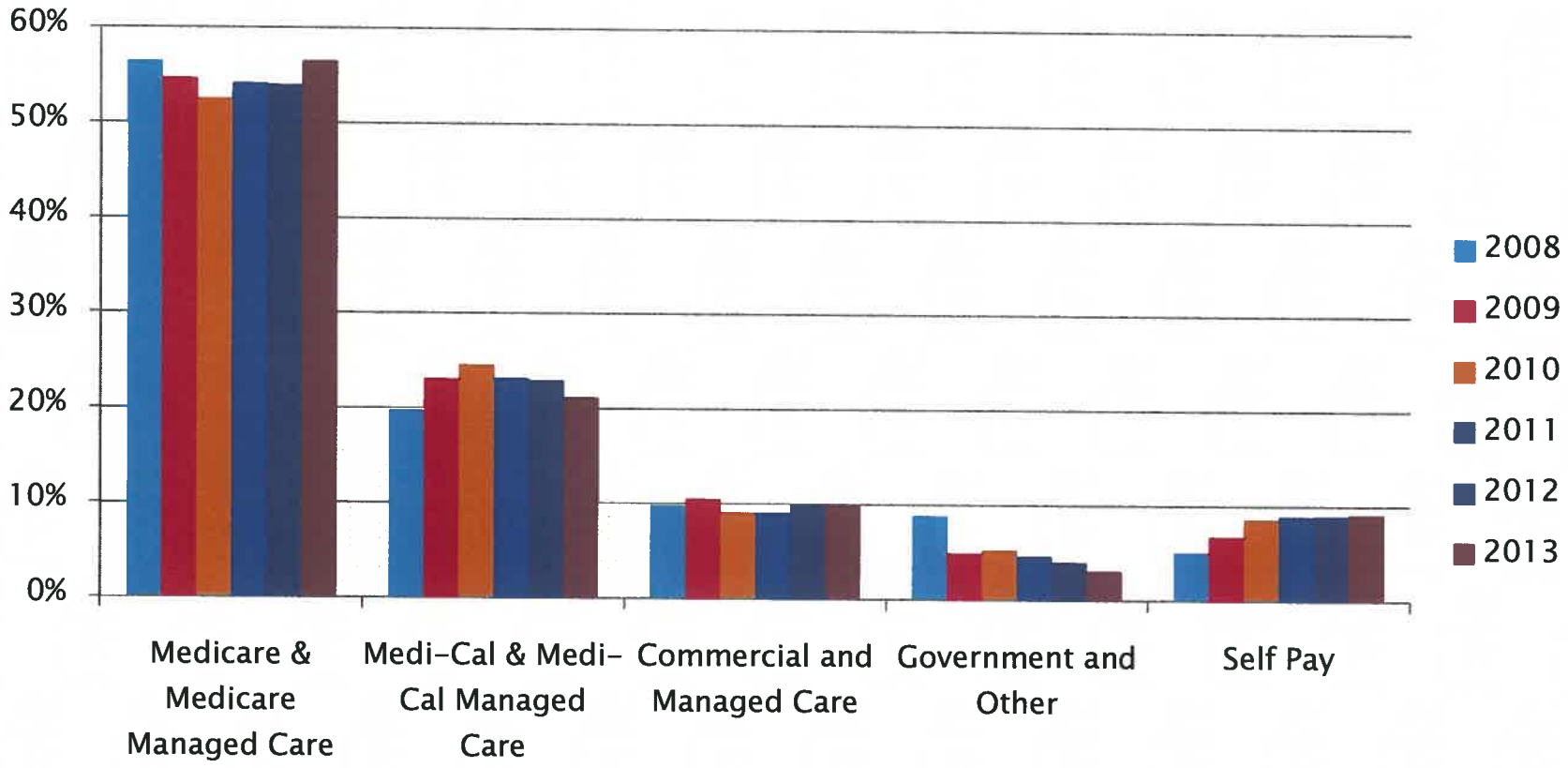
Volume Assumptions	2011	2012	2013	% Change
Discharges	6,075	6,052	5,681	-6.13%
Average Daily Census	76	76	71	-6.01%
Average Length of Stay	4.55	4.55	4.42	-2.95%
ED Visits*	40,825	42,460	40,535	-4.53%
Total Other Outpatient Visits	44,993	40,604	40,104	-1.23%

* 2012 ER Visits Exclude Chevron Patients

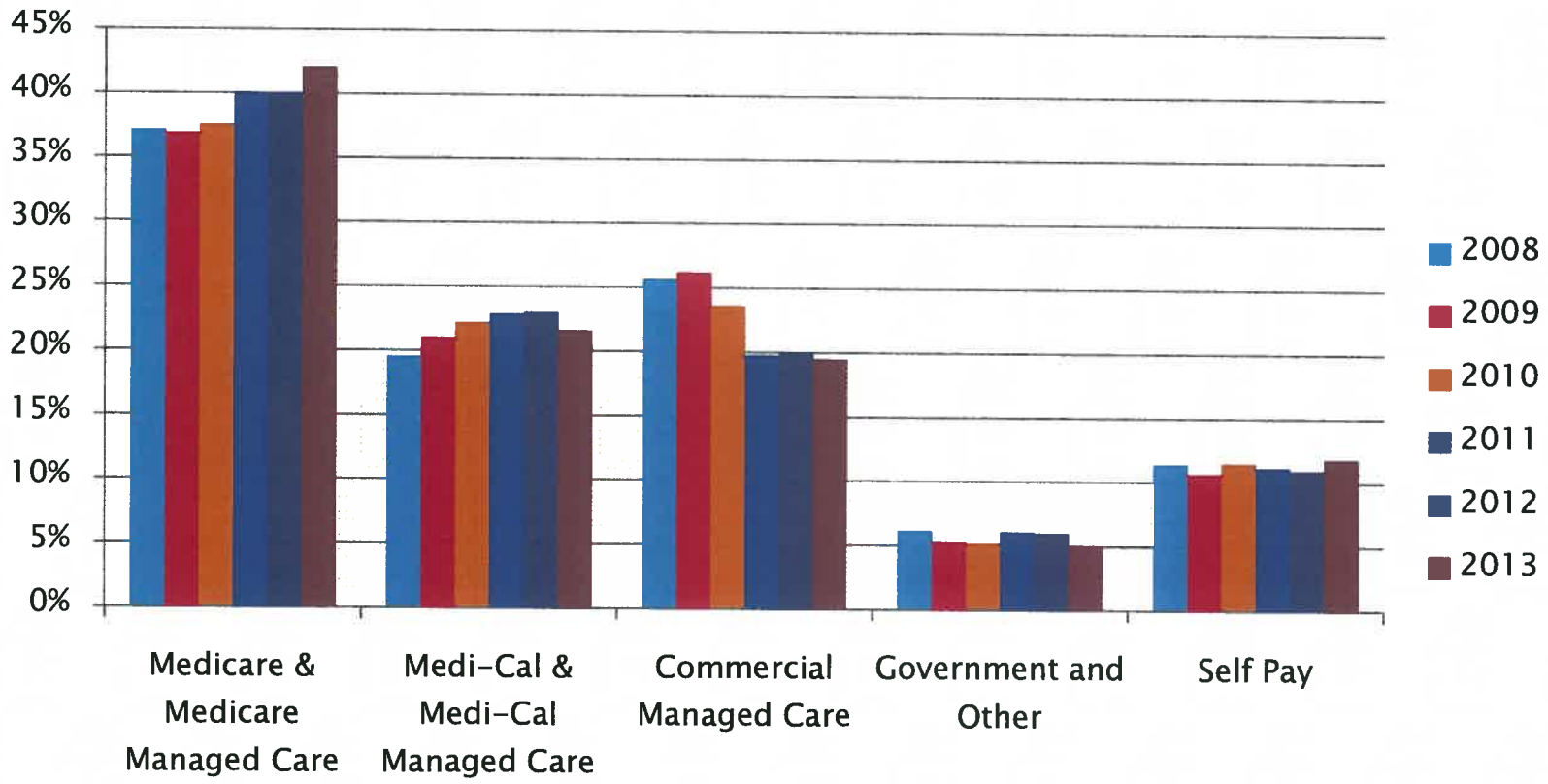
Patient Days



Inpatient Payer Mix



Outpatient Payer Mix



Net Patient Service Revenue

Patient Revenue	$116,662
AB915	2,000
Medi-Cal Matching Funds	791
Total Net Patient Service Revenue	$119,453

Other Operating Revenue

Meaningful Use	$1,563
340B Pharmacy Program	500
MOB Rental	459
Cafeteria Revenue	235
Town Center Rent	99
Other Department Revenue	95
Rebates	74
Other Revenue	81
Total	$3,106

Number of Employees and FTE's Adjusted FTE per Occupied Bed

	Paid Full Time Equivalents		Per Adjusted Occupied Bed	
Fiscal Year	**(FTE's)**	**Percent Change**	**(AOB)**	**Percent Change**
2010	771	10.36%	5.99	7.31%
2011	750	-2.77%	6.23	4.01%
2012	738	-1.66%	6.57	5.47%
2013	716	-2.95%	6.37	-2.96%

Benefits

Health, Dental, Vision & Life Insurance	$ 8,403
Vacation, Holiday, Sick & Non-Productive	12,086
Pension Plans	4,858
Worker's Compensation	1,656
Employer Taxes, Unemployment & Other	5,639
Total	$32,642

Professional Fees

Physician Related	$ 7,170
Other	3,852
Total	$11,022

Supplies – Major Items

Pharmaceuticals & IV	$4,511
Other Medical	2,962
Implants and Prostheses	2,410
Lab Supplies	1,661
Pacemakers and ICD's	1,589
Surgical Supplies	1,168

Purchased Services – Major Items

McKesson and Other IT Maintenance	$1,645
Plant Maintenance Contracts	1,522
Imaging Services	889
Security Services	860
Inpatient Renal Dialysis	824
Service Contracts	597
Laundry Service (Angelica)	570

Rents and Leases – Major Items

Farnam Clinical (Patient Lift & Outpatient Center)	$735
UHS	596
Outpatient Center Lease	377
CT Scanner	306
OMNICELL Equipment	268

Other Operating Expenses – Major Items

PG&E	$1,487
Recruitment/Travel/Training	968
Insurance	863
Hospital License and Association Dues	522

Non-operating Revenue and Expenses

District Tax Revenue	$13,613
Interest on Bonds and Line of Credit	(4,733)
Investment Income	51
Total Net Non-Operating	$ 8,931

2013 Budget – Cash Flow

	In Millions
Net Loss from Operations	**($24.7)**
Other Cash Flow Items:	
Add-Back Depreciation (Non-Cash Expense)	5.4
Total Cash Flow from Operations	(19.3)
District Tax Revenue	13.6
Equipment Purchases	(2.0)
Payment on Long Term Debt	(6.5)
Payment to the County	(2.9)
Net Cash Flow for 2013	($17.1)

Assumes no change in the outstanding accounts payable balances (60 days in A/P

Capital Plan

Information Systems	$ 641
MICU	300
PACU	120
Lab	94
Anesthesia	75
Radiation Oncology	66
Emergency Room	59
ECHO	52
Respiratory	39
Interventional Radiology	30
Radiology	10
Surgery	7
Total Departments	1,493
Emergency Funds	507
Total Budgeted Equipment	$2,000

Budget Risks

- Will we hit budgeted volume targets?
- Will the patient mix remain constant and not deteriorate in 2013?
- Can the departments operate at the budgeted levels without a deterioration in quality?

Questions?

DOCTORS
MEDICAL CENTER

APPOINTMENT OF AUDIT FIRM

TAB 10

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
GOVERNING BODY
BOARD OF DIRECTORS
CONTRACT RECOMMENDATION FORM

TO: **GOVERNING BODY**
BOARD OF DIRECTORS

FROM: **Jim Boatman**

DATE: **November 26, 2012**

SUBJECT: **Annual Audit**

REQUEST / RECOMMENDATION(S): Recommend to the District Governing Board to approve and authorize the Chief Financial Officer to execute on behalf of DMC, approval of the audit proposal from TCA Partners, LLP. The proposal will save the District $57,000 for the 2012 audit as the previous audit firm's contract in 2011 was for $113,000.

FISCAL IMPACT: **2012 - $56,000**
2013 - $58,000
2014 - $60,000

STRATEGIC IMPACT: Each year West Contra Costa Healthcare District is required, per our bond indentures, to have an annual independent audit of the districts activities. This contract will meet the requirements of the bond indenture.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: A Request for Proposal (RFP) was sent out to 12 local CPA firms with a request to bid on the annual audit services for the District for a three year term. We received only one bid to audit the District for the next three years. We are requesting approval of TCA Partners, LLP as our audit firm for the next three years.

Presentation Attachments: Yes X No____

Requesting Signature: James Boatman Date: 11 / 16 / 12

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____

Vote of Board Members:

____ Unanimous (Absent____)
Ayes: ____ Noes: ____
Absent: ____ Abstain: ____

I HEREBY ATTEST THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: Jerrel Tucker CPA

Attested by: _____
John Gioia, Chair, Governing Body
Board of Directors

Cc: Accounts Payable, Contractor, CFO/Controller, Requestor

TCA PARTNERS, LLP
Certified Public Accountants

Proposal to Serve

West Contra Costa Healthcare District

TCA Partners, LLP

Certified Public Accountants

1111 East Herndon Avenue, Suite 211, Fresno, CA 93720

Voice: (559)431-7708 Fax: (559)431-7685

September 15, 2012

West Contra Costa Healthcare District
James Boatman, Chief Financial Officer
2000 Vale Road
San Pablo, CA 94806

We appreciate the opportunity to submit our proposal to serve West Contra Costa Healthcare District (the District) as your independent auditors. We look forward to serving you, and you can be certain of a full time commitment to serve your needs. We feel we would be a uniquely qualified choice as your independent auditors due to the following reasons:

- **Healthcare auditing is our expertise.** 100% of the audits performed by our firm are for hospitals, clinics and healthcare related entities. We currently serve approximately 150 healthcare entities of various sizes. As such, we are very familiar with the operational, accounting, regulatory and reimbursement issues facing hospitals today;

- **We are unique in that the professionals who are on-site performing the audit engagement are all partner level or have significant healthcare experience.** Our firm is comprised solely of healthcare professionals who have on average 25 years of experience. It is our policy to only employ those who have experience in the healthcare industry. As a result, we know what the issues are, what questions to ask, where weaknesses and issues may be, and exactly what information we need and how to go about getting it. Our firm commits to consistency with regard to our assigned auditors for clients. There will be no change in assigned professionals for the term of the engagement. All professionals in TCA Partners, LLP have never had any complaints or actions taken by any regulatory agencies. In addition, we have built a vast network of healthcare professionals throughout the western United States whom we can call upon to assist us in resolving any audit issues. **We feel our healthcare clients enjoy a more efficient and knowledgeable audit due to the quality and experience of the professionals who perform the engagement. This also translates into a significant reduction in fees;**

- **Our firm has over 25 years experience in the healthcare industry**, we have background in all areas of healthcare finances such as financial audits, Medicare and MediCal cost report settlements and appeals, joint venture issues, managed care operations, regulatory and compliance issues, revenue bonds, tax-exempt issues, physician relations, patient billing issues, etc.

We understand the environment that hospitals operate in and the services which can be offered. We understand and are experienced in service areas such as acute care, long-term care, sub acute care, psychiatric care, community health centers, rural health care clinics, home health agencies, etc. **We understand which services are successful in a given environment and market area and the reasons why**.

TCA Partners, LLP is a partnership located in Fresno, California offering a full compliment of audit, cost report and tax services for healthcare entities. We have been based in Fresno for the past 25 years and service healthcare entities all over the western region of the United States.

We would invite you to discuss our professionalism in the course of performing healthcare audits and consulting engagements. Please feel free to contact any of the references listed in the following pages to inquire as to the quality of our services. Also, feel free to call Jerrel Tucker, CPA at (559) 431-7708, ext.3 if you have any further questions.

Sincerely,

TCA Partners, LLP

OVERVIEW OF TCA PARTNERS

Background - TCA Partners, LLP is a certified public accounting firm based in Fresno, California. We serve healthcare facilities such as hospitals, rural health clinics, Federally Qualified Heath Clinic's, home health agencies, skilled nursing facilities, psychiatric facilities, rehabilitation units, and healthcare-related foundations. We provide audit, pension audit, cost report, tax and consulting services as they relate to healthcare. TCA Partners, LLP currently audits over 50 hospitals, including non-profit community, for-profit, districts and critical access designated. We are also involved in audits with several clients that are multi-entity. Please feel free to contact individuals from the following list for references.

David Benjamin, CFO
Avanti Health System, LLC
424-241-1550

Mark Foote, CFO
Madera Community Hospital
559-675-5505

Dan Heckathorn, CFO
Memorial Hospital of Gardena
310-532-4200

John McCormick, CEO
Oak Valley Hospital District
209-848-4104

Partial listing of clients served:

Bear Valley Community Health Care District
Bloss Memorial Healthcare District
Catalina Island Medical Center
Children's Hospital Central California
Chowchilla District Hospital
City of Alameda Hospital
Coalinga Medical Center
Coast Plaza Doctors Hospital
Cobre Valley Community Hospital
Colorado River Medical Center
Colusa Regional Medical Center
Community Hospital of Huntington Park
Corcoran District Hospital
Del Puerto Healthcare District
East Los Angeles Doctors Hospital
Easter Plumas Healthcare District
El Centro Regional Medical Center
Fresno Community Medical Centers
Fresno Heart Hospital
Glenn Medical Center
Hanford Community Hospital
Hazel Hawkins Memorial Hospital
Hi-Desert Medical Center
Healdsburg District Hospital
Kern Valley Healthcare District
Kingsburg Healthcare District
La Paz Regional Hospital
Lompoc Healthcare District
Madera Community Hospital
Mark Twain Healthcare District
Mee Memorial Hospital
Memorial Hospital of Gardena
Mountain Communities Healthcare District
North Hawaii Community Hospital
Palm Drive Healthcare District
Pioneers Memorial Healthcare District
Rancho Specialty Hospital
Ridgecrest Regional Medical Center
Salinas Valley Memorial Healthcare District
San Bernardino Mts Community Hospital

Partial listing of clients served (continued):

San Gorgonio Healthcare District
Seneca Healthcare District
Sheridan Memorial Hospital
Sierra Kings Healthcare District
Sierra View District Hospital
South Bay Community Hospital
Soledad Community Healthcare District
Southern Inyo Healthcare District
Summit Healthcare Regional Medical Center
Surprise Valley Healthcare District
Tehachapi Valley Healthcare District
Thousand Oaks Surgical Hospital
Trinity Hospital
Tulare District Hospital
Tuolumne General Hospital
West Contra Costa District Hospital
White Mountain Regional Medical Center
Victor Valley Community Hospital
Vista HealthCare
Alta Family Health Center
Borrego Community Health Center
Castle Family Health Centers
Central California Blood Center
Central Valley Health Network
Central Valley Indian Health Clinic
Clinicas de Salud Del Pueblo
Coastal Health Alliance
Darin M. Camarena Health Centers
Del Norte Clinics
Family Health Care Network
Foothills Family Medical Center
Golden Valley Health Center
Haight Ashbury Free Clinics
Imperial Valley Health Authority
Kings View Corp.
Mad River Community Health Center
Marin Community Clinic
Mendocino Coast Health Centers
Migrants Clinician Network
Mission City Community Health Network
Mountain Health & Community Services
Mountain Valley Health Centers
Neighborhood Healthcare
Nevada Health Center
North County Health Services
Open Door Community Health Centers
Petaluma Health Center
Redwoods Rural Health Center
SANTE Health Systems, Inc.
San Ysidro Health Center
Sierra Sunrise Senior Village
Southern Trinity Health Services
Sunrise Community Health Centers
Tule River Indian Health Center
United Health Centers
Valley-Wide Health Services, Inc.
Valley Health Team Clinic
Vista Community Clinc
Walden House, Inc.
Western Sierra Medical Clinic

OUR AUDIT APPROACH

Professional Standards - Our audit for the District will be conducted in accordance with generally accepted auditing standards approved by the American Institute of Certified Public Accountants (AICPA).

OUR AUDIT APPROACH (continued)

We conform to the latest industry and governmental pronouncements issued by both the Financial Accounting Standards Board (FASB) and the Governmental Accounting Standards Board (GASB). We also adhere to the latest AICPA's audit and accounting guide for healthcare organizations.

Audit Timeline - The audit would begin upon notice of selection in an effort to plan the audit and resolve any accounting or reimbursement issues. Field work would include three or four on-site experienced professional CPA's (partners and associates) for approximately two weeks, during which time the majority of the audit would be completed. TCA Partners, LLP is committed to provide the staff, time and resources to meet your reporting requirements.

In understanding the time table and reporting requirements for healthcare entities, we are aware of the deadlines you face such as Medicare and MediCal cost reports, trust agreements, OSHPD Reports, other regulatory reports, and other such requirements.

Healthcare Qualifications - We have been involved in the audits of healthcare entities since the late 1970's. Beginning with that period and moving forward through the years, we have had to deal with Medicare changes (Cost-Based, TEFRA, PPS, APC's, etc.) in healthcare reimbursement and the auditing issues which have arose as a result of those changes. We have experienced similar changes in the Medical program from cost-based programs to contracted rate programs and MediCal managed care programs.

Two main focuses of our audit are in the areas of patient accounts receivable and their related allowances and third-party settlements. These areas can be difficult to understand and have the potential for significant audit adjustments.

We spend a great deal of time auditing patient accounts receivable. In order to validate the allowances (both contractual and private pay doubtful accounts) for patient accounts receivable, we take several approaches. One of the approaches is a very detailed remittance advice review of subsequent payments for payor types. Other approaches deal with reasonableness tests to support our conclusion in the detailed test, review and analysis of collection agency reports, testing of the aging categories, testing of credit balances, detailed testing of individual accounts, etc. Although allowances are estimates, they need to be as accurate, yet conservative, as possible.

OUR AUDIT APPROACH (continued)

Through the past 25 years, we have been involved in the preparation of hundreds of Medicare and MediCal cost reports and in defending them before UGS and the State. We understand the impact of proposed adjustments to the cost reports and the issues which arise from the audit process. We are well versed in the appeal process and currently are assisting several of our clients through that process at all levels. We have had to deal with DRG's, PIP payments, Capital Pass-Through costs, Exception Payments, Disproportionate Share Payments, Geographic Reclassifications, Wage Index issues, Medicare Crossover Bad Debt issues and a variety of other issues. We are familiar with issues involving acute care, long-term care, home health agencies, rural health clinics, FQHC's, and many others.

In summary, we are very familiar with the audit issues arising from the cost report preparation and the financial impact to healthcare entities' financial statements. Our process is to work closely with your cost report preparer in analyzing, and confirming amounts related to third-party settlements. Given our cost report expertise, we will also do an independent confirmation, verification and analysis of third-party settlements.

Recently, a lot of emphasis has been placed on compliance issues. We understand the focus of this emphasis from both the viewpoint of the hospitals and the regulators. Compliance issues have become a central focus of our audits due to the exposure many entities possibly are facing today.

Initial Audit Planning - We believe that a smooth engagement is based upon the early identification and resolution of reporting and accounting issues. Upon our selection, we would begin the planning phase of our audit almost immediately by identifying accounting issues in a timely manner in order to resolve any issues as quickly as possible.

We consider the methods in which the the District gathers information in planning the audit. Such methods influence the design of the accounting system and the nature of the internal accounting control procedures. The extent to which the information processing is used in significant accounting applications will influence the nature, timing and extent of our audit procedures.

Audit Program Development - Our evaluation of the issues which arise during our planning phase will determine the nature, timing and extent of our audit procedures for specific transactions and accounts. In developing the audit program, our aim will be to:

- Provide a complete audit program for all financial statement amounts,
- Eliminate redundant procedures,
- Use procedures for more than one purpose,
- Provide for review and analysis of balances and their relationships to the accounts within the entity's chart of accounts.

OUR AUDIT APPROACH (continued)

Audit Program Execution and Reporting - During this stage of our audit, we will perform the test of year end balances. We will work with management so that there will be minimal disruption of the day-to-day operations. In our engagements we try to utilize schedules and information that clients have already prepared somewhere within their system to close their year end. This work is then supplemented with schedules which we, ourselves, prepare. All of our schedules are electronic in form and are available for client use by e-mail, fax or other form of correspondence.

We will comment on the adequacy of the District's system of internal controls. Should a material weakness or significant deficiency be noted during our fieldwork, we will immediately notify appropriate management. We will then work with management in estimating the financial impact of the noted weakness, establishing the necessary controls, and ensuring that they are functioning.

We recognize that the Board of Directors and management have a critical responsibility to the District. Therefore, we will remain in contact with the Board and management members, as considered necessary, throughout the engagement and will be available to comment on the District's operations, procedures, policies, etc. A Board Report (or Management Letter) will be provided upon the conclusion of the audit which typically covers three areas: (1) Accounting controls, efficiencies and ideas for improvements in the operations of the District; (2) Reimbursement issues; (3) Statistical trends and operational ratios of the District for the past several years and comparisons to peer healthcare entities whose operations are similar to those of the District.

ENGAGEMENT FEES

Rates and Hours - Our fees are based upon an estimate of total hours to perform the audit extended by the hourly rates for individuals assigned to the engagement. Hourly rates range from $175 to $275 for specific personnel.

Audit fees - Based upon the scope of the audit, the entities included and our knowledge and understanding of the healthcare industry, we would propose that all inclusive fees for audits and required board reports and meetings would be as follows:

For year ended December 31:	
2012	$ 56,000
2013	$ 58,000
2014	$ 60,000

Expenses - All travel and out-of-pocket expenses will be billed separately and includes supplies, travel and lodging and other such out-of-pocket expenses. Such expenses will be capped at $7,500 per year. We always strive to minimize our audit related expenses.

ENGAGEMENT FEES (continued)

Other Services - Any additional services if requested and performed outside the scope of the services listed above would be based upon our customary hourly rate or a flat fee and would be discussed with you prior to performing any work. Such services could include cost report preparation and appeals, internal controls and processes reviews, tax returns, contract reviews, etc.

RESUMES OF KEY STAFF MEMBERS

Jerrel Tucker: Jerrel is a CPA and audit partner with the firm and will be responsible for the audit planning, field-work, report preparation and presentation and any other meetings as required. He will be the audit partner in charge for future years if retained and is reachable at any time by phone or cell phone to assist the District. A brief outline of his experience follows:

> Over 25 years of experience in healthcare audits, reimbursement and consulting work, in over 100 different healthcare facilities;
>
> Is a researcher for healthcare audit issues conducted by the firm and is involved in on-going consulting for several of the facilities in areas such as reimbursement, appeals, retirement plans, cash flow issues, and operational issues;
>
> Has prepared numerous special projects, feasibility studies, budgets and other healthcare related engagements for the firm's clients;
>
> Had over 6 years of experience as an Ernst & Young audit manager before being one of the original forming partners of TCA Partners, LLP. Is the firm specialist for healthcare and retirement plan audits.

Jerrel received his degree in accounting from Fresno State University. He is a member of the California Society of Certified Public Accountants, the American Institute of Certified Public Accountants and the Healthcare Financial Management Foundation.

Rick Jackson - Rick is a CPA and an audit partner with the firm in charge of several healthcare engagements and is considered a healthcare reimbursement specialist. Rick oversees the firms cost report preparation and related services. He will assist with field work, concentrating on accounts receivable and reimbursement related issues, and will be responsible for much of the review of reporting for the audit. A brief outline of his experience follows:

> Over 30 years of experience in healthcare audits, reimbursement and consulting work, in over 150 different healthcare facilities;
>
> Is the lead researcher for healthcare audits issues conducted by the firm and is involved in on-going consulting for several of the facilities in areas such as reimbursement, appeals, retirement plans, tax issues, and operational issues;
>
> Has prepared numerous cost reports, appeals, special projects, feasibility studies, budgets and other healthcare related engagements for the firm's healthcare clients;
>
> Over 8 years of experience as an Ernst & Young audit senior manager and consultant in the healthcare industry before being one of the original forming partners of TCA Partners, LLP.

Rick received his degree in accounting from Brigham Young University. He is a member of the Healthcare Financial Management Association, the American Institute of Certified Public Accountants, and the California Society of Certified Public Accountants.

John Church - John is an associate with the firm and is in charge of all healthcare consulting engagements. John will assist on third-party settlement issues, internal control review and preparation of the board report. A brief outline of his experience follows:

> Over 30 years of healthcare experience in audit, reimbursement, and various consulting areas of healthcare in over 200 healthcare facilities. He has consulted with several healthcare facilities in the areas of managed care, contracting, physician relations, reimbursement and strategic planning;
>
> Spent several years as a Medi-Cal auditor with the State of California, auditing the cost reports in order to finalize reimbursement for healthcare entities; and is currently contracted with the federal government in the capacity of financial reviews for FQHC's all across the nation;
>
> Served as a healthcare reimbursement consultant with Ernst & Young for several years and was employed as the CFO of two large healthcare entities, an HMO and two IPA's during his career and has vast reimbursement and managed care experience;

John attended Brigham Young University where he received his degree in accounting. He also earned his Master of Public Administration from the University of San Francisco. He is a member of several healthcare organizations both in California and nationally.

Kelly Holbrink - Kelly is a CPA and a partner with the firm. He will assist with audit field work as necessary. A brief outline of his professional experience follows:

Over 15 years experience in the health care industry with various size hospitals serving in the capacity as Controller, Associate CFO and CFO. Responsibilities included financial reporting, advanced revenue cycle management, treasury management, cost control and benchmarking, reimbursement planning, physician ventures and healthcare clinics. Kelly is experienced in multiple types of health care financing arrangements.

Five years experience with KPMG Peat Marwick as an audit manager and 8 years experience as an auditor and consultant at TCA Partners, LLP.

Kelly received his Bachelor of Science degree in Business Administration emphasis in Accounting from California State University Fresno. Kelly is a member of Healthcare Financial Management Association.

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 13

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD
EXECUTIVE SUMMARY

NOVEMBER 2012

TOPIC

The Medical Executive committee met in regular monthly session on Monday, November 12, 2012. In addition to standing general updates provided by the administrative leadership team, the following is a summary of discussion and action:

- Semi-annual meeting of the medical staff will be held on December 11, 2012 at Maple Hall.
- Dr. Hodgson announced the resignation of LaDonna Creech as Director of the Medical Staff Office and of Dr. Seth Thomas as Medical Director of the Emergency Department. Dr. Thomas has been a great physician and leader within his department, the hospital and the community and his presence and support will be greatly missed. CEP is in the process of working with the administrative team to recruit/appoint a new Director.
- Dr. Evans presented the job descriptions for technical staff employed in Imaging Services. The Joint Commission requires medical staff approval of those job descriptions, and approval was provided consistent with that requirement.
- Intravenous Drug Administration Guidelines were presented for annual review without changes.

ITEMS REQUIRING ACTION

Policies, Procedures, Forms: The attached Policy, Procedure and Forms Report for November 2012 includes the following document approved by the Medical Executive Committee and presented for Board approval:

- Lexiscan Administration During Radionuclide Myocardial Perfusion Imaging Policy
- Metered Dose Inhaler Therapy Policy
- Medical Record Suspension Policy

October 2012 Credentials Report (attached report)

DOCTORS
MEDICAL CENTER

MEC APPROVAL DATE: 11/12/12

BOARD OF DIRECTORS APPROVAL DATE: 11/26/12

POLICY, PROCEDURE AND FORMS REPORT

NOVEMBER 2012

IN ACCORDANCE WITH MEDICAL STAFF BYLAWS, REGULATORY AND ACCREDITATION STANDARDS, THE POLICIES, PROCEDURES AND FORMS LISTED BELOW HAVE BEEN DEVELOPED AND/OR REVISED BY APPROPRIATE HOSPITAL AND/OR MEDICAL STAFF COMMITTEES AND HAVE BEEN APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE.

**NOTE: COPIES OF ALL POLICIES LISTED IN SECTION A AND SECTION B BELOW ARE ATTACHED TO THIS REPORT. THESE POLICIES ARE AVAILABLE FOR REVIEW IN THE MEDICAL STAFF OFFICE AND ADMINISTRATION.*

POLICY/PROCEDURE/FORMS	TYPE	REASON FOR REVIEW
A. New		
1. Lexiscan (Regadenoson) Administration During Radionuclide Myocardial Perfusion Imaging	Housewide Policy	New policy developed to identify the critical components involved in performing pharmacologic myocardial perfusion imaging (MPI) stress test with Lexiscan (Regadenoson). Lexiscan is replacing IV Persantine.
B. Revised with Major/Substantive Changes		
1. Medical Staff Suspension For Delinquent Medical Records	Health Information Management P&P	Combined two policies (suspension and operative reports) and broadened the notification process to include more staff for awareness of suspensions and reduce potential for non-compliance (i.e. admitting when suspended)
2. Metered Dose Inhaler Therapy	Housewide Policy	Revised to reflect oversight by Respiratory Therapy which was formerly shared with Nursing.

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

All items marked with † must be completed, and or required routing

†TITLE: Lexiscan (Regadenoson) Administration during Radionuclide Myocardial Perfusion Imaging Tests	†CHECK ONE: ☒ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor

† ☐ Administrative ☒ Clinical ☐ Department _____

†SUBMITTED BY: Therese Helser, Pharmacy Director

†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other

†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:

New policy developed to identify the critical components involved in performing pharmacologic myocardial perfusion imaging (MPI) stress test with Lexiscan (Regadenoson). Lexiscan is replacing IV Persantine.

	MEETING DATE	APPROVAL
☐ **Manager or Department Director**†		
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee (electronic)	10/26/12	10/26/12
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	11/12/12	11/12/12
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	11/26/12	

DOCTORS MEDICAL CENTER

Manual: CARDIOLOGY	Sub Folder:
Subject: Lexiscan(Regadenoson) administration during radionuclide myocardial perfusion imaging tests	Reviewed: Revised:
Effective Date: 9/2012	Page 1 of 4

PURPOSE: To identify the critical components involved in performing a pharmacologic myocardial perfusion imaging (MPI) stress test with Lexiscan (Regadenoson).

DEFINITIONS: Lexiscan is a pharmacologic agent indicated for use in radionuclide myocardial perfusion imaging in patients unable to undergo exercise on a treadmill. It is an adenosine receptor agonist that produces coronary artery vasodilation and increases coronary blood flow. The maximal plasma concentration is achieved within 1-4 minutes. The intermediate phase follows with a half-life of about 30 minutes and coincides with a loss of pharmacodynamic effect. The last phase consists of a decline in plasma concentration with a half life of about 2 hours. Myocardial perfusion imaging with Lexiscan is used for the detection of coronary artery disease, risk assessment, detection of viable myocardium, and evaluation of the effects of various therapeutic interventions.

The Isotope used for myocardial perfusion is Myoview (Technetium Tc99m Tetrofosmin.)

POLICIES:

1. Nuclear medicine:
   a. Nuclear medicine technologist or R.N. starts IV.
   b. Initial Myoview isotope is given and resting myocardial images are obtained.
   c. Approximately 15-20 minutes.
2. Patient is escorted between locations by nuclear technologist or R.N.
3. Cardiology Department:
   a. Supervision and monitoring the patient is performed by an ACLS certified R.N. in conjunction with the cardiac stress technician and nuclear medicine technologist.
   b. An in-house Cardiologist is available for any questions or concerns that may arise.
   c. Lexiscan and final Myoview injections are given.
   d. When vital signs are stable and any adverse reactions resolved, the patient returns to Nuclear Medicine for post-stress images.
4. The patient is NPO for 2 hours prior to the test and should avoid the following for 24-hours:
   - Persantine containing medications (Aggrenox), caffeine-containing beverages, medications and products and theophylline.
   - Dipyridamole is withheld for at least 48-hours.
5. Diabetics will ask their physicians for special instructions prior to the test.
6. Lexiscan is not administered if any of the following are present:

a. Second or third degree AV block or SA node dysfunction unless the patients have a functioning pacemaker.
b. Active wheezing.
c. Systolic blood pressure less than 90 mmHg.

7. Use of dipyridamole-containing medications in past 48-hours, aminophylline or ingestion of caffeinated foods in the last 24 hours.
8. R.N. and stress technician monitor the patient for adverse reactions.
   a. The most common adverse reactions include:
      - Dyspnea
      - Headache
      - Flushing
      - Tachycardia
   b. Less common reactions include:
      - Chest discomfort
      - Angina or ST depression
      - Dizziness
      - Chest pain
      - Nausea
      - Abdominal discomfort
      - Feeling hot
   c. Lexiscan can cause the following:
      - Myocardial ischemia
      - 1st 2nd or 3rd degree AV block, asystole
      - Sinus bradycardia
      - Hypotension
      - Bronchoconstriction
      - Transient ischemic attack
   d. A caffeinated beverage is offered for mild to moderate adverse reactions
9. Unresolved adverse reactions during recovery are treated according to standing orders:
   a. To reverse Lexiscan: aminophylline 50mg to 250 mg IV slowly (50 mg over 30 seconds).
   b. If aminophylline does not resolve chest pain: nitroglycerine 0.4 mg sublingual every 3-5 minutes.
   c. For symptomatic hypotension: IV normal saline 250-500 mls.
   d. For chest pain or dyspnea: oxygen 1-4 liters via nasal cannula.
10. For significant symptoms or concerns, unstable vital signs or persistent EKG changes during recovery, the R.N. notifies the in-house Cardiologist.

11. Stress technician responsibilities include:
    a. Obtaining the physicians orders, with a written diagnosis.
    b. For inpatients, the R.N. assigned to the patient is notified of the scheduled testing time.

PROCEDURE:

Note: Patient comes to cardiology department after having Myoview injection and resting scan completed.

1. Stress technologist:
   a. Verifies that the patient has been NPO for a minimum of two hours (except for medications with some water).
   b. Enter information into the stress testing computer including the patient's name, date of birth, medical record number, test type, diagnosis from the physician's written order, current medications and patient's weight.
   c. Prep skin for electrode placement, place the electrodes and attach the monitor.
   d. Obtain resting EKG and initial blood pressure.
   e. Communicate any pertinent patient information obtained from patient during initial interaction to R.N.
   f. Monitor and record the heart rate, blood pressure, and 12-lead EKGs once every minute during the procedure. Alert the R.N. to any problems.
   g. Record medications, doses and times given as well as symptoms of pain and pain intensity (on pain rating scale), shortness of breath, and any other discomfort.
2. The R.N.
   a. Conducts a Time Out to verify the patient's name, date of birth, and the procedure to be performed; and reviews the physician's order and patient diagnosis.
   b. Discusses procedure and possible side effects of Lexiscan with patient and answers any questions.
   c. Verify signed consent and witness.
   d. Performs initial assessment: reviews EKG, blood pressure, and cardiac history with any current symptoms; auscultates breath and heart sounds.
   e. Determines if any contraindications are present and discusses any concerns with the ordering physician and/or a cardiologist.
   f. Assess patient throughout procedure.
   g. Before administering Lexiscan, the R.N., stress technician, and nuclear medicine technician are present in the Stress Lab.
3. Lexiscan Administration
   a. The R.N. administers Lexiscan as a standard 0.4 mg/5ml dose over 10 seconds and immediately flushes with 5 ml saline flush.
   b. The Nuclear Medicine technician administers Myoview 10-20 seconds after the saline flush.
   c. The stress tech monitors the continuous 12 lead EKG and blood pressure at baseline during the procedure and every minute for a minimum of 5 minutes through recovery.
   d. Give a caffeinated beverage for mild to moderate adverse reaction. Most adverse reactions begin soon after dosing and generally resolve within 15 minutes, except for headache which resolves in most patients within 30 minutes.
4. When the patient's vital signs and EKG return to baseline and patient asymptomatic, the R.N. takes the patient back to Nuclear Medicine for the post stress images.

R.N. PROTOCOL FOR THE MANAGEMENT OF LEXISCAN ADVERSE EFFECTS

Most adverse effects of IV Lexiscan (Regadenoson) appear to be related to the attenuation of Lexiscan reactions.

For Dizziness, headache, flushing, nausea, generalized malaise or other minor symptoms:

1. Aminophylline 50 mg IV over 30 seconds – 1-2 minutes post-isotope injection and every 2 minutes until symptoms relieved to a maximum of 250 mg.
2. Diarrhea – could be due to too fast of an injection.

For chest pain:

1. Place patient on oxygen at 2 L/min via nasal prongs.
2. Administer IV aminophylline 50-100 mg over 30 seconds and every 2 minutes after to a maximum of 250 mg. If the patient's condition allows, the administration of aminophylline should be delayed until 1-2 minutes after the nuclear isotope has been injected.
3. Administer sublingual Nitroglycerin 0.4 mg every 5 minutes (x3) for chest pain and/or symptomatic ST segment depression that is not relieved by aminophylline.
4. Notify the in-house cardiologist.

For symptomatic hypotension:

1. Administer aminophylline as above.
2. Infuse Normal Saline bolus of 250 ml over 10 minutes.
3. Call physician if hypotension persists.

For shortness of breath or wheezing:

1. If respiratory symptoms exacerbate, follow aminophylline protocol.
2. Administer Albuterol inhaler, 2 puffs every 2 minutes to maximum of 6 puffs or until symptoms improve.
3. Call physician if the symptoms persist.

For arrhythmia management:

1. Monitor the patient for aminophylline induced arrhythmias.
2. Follow ACLS protocol for the treatment of ventricular tachycardia, ventricular fibrillation, supraventricular tachyarrhythmias.
3. Call Code Blue for life threatening arrhythmias, and call physician on call.

Responsible for review/updating (Title/Dept)	Title: Director	Dept: Cardiology

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

All items marked with † must be completed, and or required routing

†TITLE: Metered Dose Inhaler Therapy	†CHECK ONE: ☐ New ☐ Reviewed ☑ Revised : ☐ Major ☐ Minor
† ☐ Administrative ☑ Clinical ☐ Department _____	
†SUBMITTED BY: Therese Helser, Pharmacy Director	
†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES: Revised to reflect oversight by Respiratory Therapy which was formerly shared with Nursing.	

	MEETING DATE	APPROVAL
☐ **Manager or Department Director†**		
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee (electronic)	10/26/12	10/26/12
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)†**		
☐ **Executive Leadership**		
☑ **Medical Executive Committee (MEC)** (as applicable)	11/12/12	11/12/12
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	11/26/12	

DOCTORS MEDICAL CENTER

Manual: RESPIRATORY CARE	Sub Folder:
Title: Metered Dose Inhaler Therapy	Reviewed: 11/2000, 2/2003, 2/2006 3/28/2009 Revised: 9/2012
Effective Date: 11/2000 Expiration Date: 10/2015	Page 1 of 2

Purpose: To establish a guideline for administration of medications ordered by metered dose inhaler.

Policy: All Metered Dose Inhalers will be administered with a spacer, excluding discus inhalers (triamcinolone acetonide).

Responsibility	Action
Unit assistant/RN/	1.Notifies Respiratory Therapy (RT) Department via Order Communication System 2. Copy of order to Pharmacy (faxed).
Pharmacy.	1. Notifies RT via O/C system (to San Pablo Respiratory Therapy printer) to pick up medication and spacer then indicates RT to administer on the eMAR and document on RT charting sheet.
Respiratory Therapist	1. Assess patient for order appropriateness. a. INDICATIONS: 1. Bronchospasm 2. Wheezes 3. Stridor 4. Drug Delivery b. A Vital Capacity and peak flow are obtained. c. Charge/document assessment. 2. Obtains medication from Pharmacy with spacer. May be obtained from automated dispensing system if Pharmacy is closed or medication is STAT. 3. Instructs patient with initial treatment a. Assessment includes cognitive understanding, measurement of Vital Capacity, pulse, respiratory rate; hand/eye coordination. b. Explains procedure, indication and possible side effects. Documents education. c. Assembles equipment. d. Positions patient in high fowlers. e. Instructs correct breathing (inspiratory hold) f. Delivers ordered number of puffs g. Reassess breath sounds, pulse, and respiratory rate. h. Identifies problem in Multi-disciplinary Care Plan, documents plan of care, and initializes.

i. Charts on the respiratory charting sheet, including date, time, medication and dosage, and assessment/re-assessment.

Pharmacy:

1. Assures medication is in the patient cassette drawer in Pharmacy and maintains stock in Automated dispensing machine, (i.e. Omnicell). STAT meds may be obtained from Omnicell and after Pharmacy is closed.

Hazards and Complications	**Action**
1. Tachycardia>130 beats/min.	Stopped/held Charge RN and MD notified.
2. Acute bronchospasm	Stopped/held Charge RN and MD notified.
3. Chest pain.	Stopped/held Charge RN and MD notified.
4. Nausea/vomiting	Stopped/held Charge RN and MD notified

Infection Control

Category I. Gloves required. If there are instances where body fluids, especially blood, are likely to be spattered during the procedure, the therapist or practitioner should wear a gown, mask, gloves and goggles.

1. Discard all disposable equipment in the room. Empty MDI canisters are disposed in its appropriate disposal bin.

All MDI are labeled with patient name and date. A new MDI is obtained if any contaminant present.

REFERENCES:

1. **Doovich M. Clinical aspects of aerosol physics. Respiratory Care 1991;36:931-938**
2. **Lindgren S, Bake B, Larsson S. Clinical consequences of inadequate inhalation technique in asthma therapy. Eur J Respiratory Dis 1987;70:93- 98**
3. **Newman SP, Clarke SW. The proper use of metered dose inhalers. Chest 1984; 86: 342-344.**

Responsible for review/updating	Respiratory Therapy Director	Respiratory Therapy

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

†TITLE: Medical Staff Suspension For Delinquent Medical Records	†CHECK ONE: ☐ New ☐ Reviewed X☐ Revised : ☐ Major ☐ Minor

† X☐ Administrative ☐ Clinical ☐ Department _____

†SUBMITTED BY: Jody Popke, HIM Director

†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other

†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:

Addition of the following to the policy:

. **REPORTING SUSPENSIONS**

Medical Executive Committee to review monthly reports of physicians on medical record suspension greater than 30 days to determine if the deficiencies in medical records are related to physician competence or conduct and adversely affect or could adversely affect a patient's health or welfare.

	MEETING DATE	APPROVAL
x☐ **Manager or Department Director†**	8/29/12	Jody Popke, HIM Director
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☐ P&T Committee		
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)†**	09/26/2012	
X☐ **Executive Leadership**	8/29/2012	Kathy White, COO Bobbie Ellerston, VP Patient Care Svcs Dawn Gideon, CEO
X☐ **Medical Executive Committee (MEC)** (as applicable)	9/10/12	Laurel Hodgson, MD
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual: **HEALTH INFORMATION MANAGEMENT**	Sub Folder:
Title: **Medical Staff Suspension For Delinquent Medical Records**	Reviewed: **2/05, 2/06, 2/07, 1/08, 1/09** Revised: **5/00, 5/03, 8/04, 9/12**
Effective Date: **8/04** Expiration Date:	

PURPOSE:
To ensure completion of all medical records within 14 days post-discharge.

POLICY:
Current State Law and the Medical Staff Bylaws require completion of the medical records within 14 days of discharge of the patient. Each medical record stands alone. Failure to comply with State Law, the Medical Staff Bylaws and this policy for completion of medical records will result in suspension of the Admitting, Consulting, and Surgical Privileges.

PROCEDURE:
The physician suspension status is updated daily Monday through Friday, however upon completion of delinquent records, removal from suspension will occur immediately.

Seven days after discharge, physicians shall be given written and verbal notification of their incomplete records. If the records are not completed within the next seven days, the physician shall be suspended for those now delinquent records. On the 14th day, a phone call will be made and a second letter will be sent indicating they will be suspended on the following day at 2:00 p.m. The suspension shall remain in effect until all records are completed. Additionally, cases shall not be permitted to be scheduled while a physician is on suspension.

THIS POLICY DOES NOT APPLY TO ADMISSIONS OR SURGERIES THAT ARE DEEMED AN EMERGENCY, OR TO OTHER EXTENUATING CIRCUMSTANCES WHICH MAY EXIST, TO BE DETERMINED BY THE CHIEF OF STAFF.

The HIM Department will notify the following departments and/or individuals when physicians are suspended and again once the suspension is lifted.

- Chief of Staff
- Chair, Department of Medicine
- Chair, Department of Surgery
- Medical Director, Hospitalist Program
- Medical Director, Emergency Medicine
- Executive Leadership
- Director, Medical Staff Services
- Director, Integrated Quality Services
- Director, Perioperative & Out-Patient Services
- Director, Emergency Medicine
- Director, Imaging Services
- Director, Patient Financial Services/Admitting
- House Supervisor
- Medical Executive Committee on a monthly basis

OPERATIVE REPORTS

All operations and procedures performed shall be fully described in reports by the Licensed Independent Practitioner (LIP) immediately post-operatively. These operative reports shall be handwritten in the medical record as well as dictated.
Physician responsibilities are as follows:

- Hand writes legibly operative/procedure note immediately after surgery/procedure
- Dictates operative/procedure report immediately after surgery/procedure
- All reports shall include the following seven elements:
  - Name of primary surgeon and assistants
  - Findings
  - Procedures performed
  - Description of the procedure
  - Estimated blood loss
  - Specimens removed (as indicated)
  - Postoperative diagnosis

Health Information Technician responsibilities are as follows:

- On a daily basis, obtains the completed surgery schedule – include the GI lab and cardiac cath lab (which includes notations of add-ons and cancellations)
- Document on schedule completed operative dictations
- By 11:00am daily, researches system for missing operative reports
- Notifies physician office of any remaining missing dictations, and documents notification on schedule
- If operative report is not dictated within 24 hours, HIM department will call physician and notify them that the physician will be suspended if dictation is not completed by the next working day
- If operative report is not dictated within the next working day, HIM department will notify physician that he/she will be suspended by 2:00pm of that day. Physician will remain on suspension until operative report has been dictated

REPORTING SUSPENSIONS

Medical Executive Committee to review monthly reports of physicians on medical record suspension to determine if the deficiencies in medical records are related to physician competence or conduct, and adversely affect or could adversely affect a patient's health or welfare.

REFERENCES:

- The Joint Commission, Comprehensive Accreditation Manual for Hospitals
- California Code of Regulations, Title 22
- Medical Staff Bylaws, Rules & Regulations

Responsible for review/updating (Title/Dept)	Title: Director	Dept: Health Information Mgmt

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

NOVEMBER 2012

The following practitioners' applications for appointment and/or reappointment have been reviewed by the appropriate committees of the Medical Staff and have been deemed as complete and are recommended for approval by the Credentials Committee (10/25/12) and the Medical Executive Committee (11/12/12).

CREDENTIALS REPORT TO THE BOARD NOVEMBER 2012	
INITIAL APPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Talavera, Mark, MD	Medicine/Family Practice/Internal Medicine
REAPPOINTMENTS	
Ajayi, Michael. MD	Surgery /Oral Maxillofacial
Ellis, William, MD	Surgery/Ophthalmology
Grimes, Michael DPM	Surgery/Podiatry
Silvert, Mark, MD	Surgery/Urology
Tedeschi, Adrian G., MD	Surgery/Anesthesia
Welborn, John, H., MD	Surgery/Orthopedics

- MEDICAL STAFF COMMITTEE RECOMMENDATIONS	DATE
CREDENTIALS COMMITTEE	October 25, 2012
MEDICAL EXECUTIVE COMMITTEE	November 12, 2012
BOARD OF DIRECTORS APPROVAL	November 26, 2012

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
OCTOBER 2012

INITIAL APPOINTMENTS

The following practitioners have applied for membership and/or clinical privileges at DOCTORS MEDICAL CENTER. This summary includes factors that determine status of membership, licensure, professional liability insurance, required certifications (if applicable), etc. Factors that determine current competence include medical/professional education, training (internship/residencies/fellowship) and experience, board certification (if applicable), current and previous hospital and other institutional affiliations, physical and mental health status, peer references, and past or pending professional disciplinary action.

NAME	DEPARTMENT/SPECIALTY	CATEGORY	PROCTORING	APPOINTMENT TERM	RECOMMENDATION
Talavera, Mark G, MD	Med./Family Practice/Internal Medicine	Provisional	Per Department Plan	10/24/2012 – 10/23/2014	Approval

ADVANCEMENT FROM PROVISIONAL STAFF STATUS

In accordance with Medical Staff Bylaws, the members listed below have satisfactorily demonstrated their ability to exercise the clinical privileges initially granted and otherwise appear qualified for continued medical staff membership. The Medical Executive Committee recommends advancement to the appropriate staff category as indicated below.

NAME	DEPARTMENT/SPECIALTY	STAFF CATEGORY
Akbar, Jamila, MD	Medicine/Family Practice/Internal Medicine	Active

COMPLETION OF PROCTORING REQUIREMENTS

In accordance with Medical Staff Bylaws and Medical Staff Proctoring Policies, the members listed below have satisfactorily completed proctoring requirements as reported below:

NAME	DEPARTMENT/SPECIALTY	STATUS OF PROCTORING REQUIREMENTS
Akbar, Jamila, MD	Medicine/Family Practice/Internal Medicine	Complete

REAPPOINTMENTS

The following practitioners have applied for reappointment to the Medical Staff. This summary includes factors that determine membership; licensure, DEA, professional liability insurance, required certifications (if applicable), etc. Qualitative/quantitative factor, developed through on-going professional performance evaluation, include peer review, quality performance, clinical activity, privileges, competence, technical skills, behavior, health, medical records, blood review, medication usage, litigation history, utilization and continuity of care. ***Membership requirements are met, unless specified below.***

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Ajayi, Michael MD	Surgery/Oral/Maxillofacial	Affiliate Associate	11/25/12 - 11/24/14	Approval

DOCTORS MEDICAL CENTER CREDENTIALS REPORT OCTOBER 2012				
Ellis, William MD	Surgery/Ophthalmology	Active	11/25/12 - 11/24/14	Approval
Grimes, Michael DPM	Surgery/Podiatry	Active	12/23/12 - 12/22/14	Approval
Silvert, Mark MD	Surgery/Urology	Active	11/25/12 - 11/24/14	Approval
Tedeschi, Adrian G MD	Surgery/Anesthesia	Active	11/25/12 - 11/24/14	Approval
Welborn, John H MD	Surgery/Orthopedics	Active	11/25/12 - 11/24/14	Approval