DOCTORS
MEDICAL CENTER

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

Tuesday, September 25, 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
SEPTEMBER 25, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

Board of Directors
Eric Zell, Chair
Supervisor John Gioia, Vice Chair
Irma Anderson
Wendel Brunner, M.D.
Deborah Campbell
Nancy Casazza
Sharon Drager, M.D.
Pat Godley
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace

REVISED AGENDA

1. **CALL TO ORDER** — E. Zell
2. **ROLL CALL**
3. **APPROVAL OF AUGUST 22, 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 REPORT** — K. Taylor
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the Quality Report*

6. **PATIENT SATISFACTION REPORT** B. Redlo/V. Moeller
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: 1. Acceptance of Patient Satisfaction Report*
      2. Approval of Press Ganey Contract

7. **PEU LOCAL ONE BARGAINING AGREEMENT** B. Redlo/J. Hardy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of PEU Local One Agreement*

8. **UTILIZATION MANAGEMENT (UM) PLAN** M. Gerardi
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of UM Plan*

9. **FINANCIALS – AUGUST 2012** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the August 2012 Financials*

10. **INFORMATION SYSTEMS DISASTER RECOVERY PLAN** P. Moore/W. Tenney
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of Information Systems Disaster Recovery Plan*

11. **PHYSICIAN TRANSACTIONS AND ARRANGEMENTS** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: 1. Approval of Intensivist Service Agreement*
       2. Approval of Medical Director Agreement (Serramonte Pulmonary Asthma Sleep Clinic, Inc.)

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. MEC review of patient care contracts for quality of care (information only)*
** Robert Panush, Speech Therapy*
** John Wacker, EEG Technician Services*
** Alliance Healthcare, dba Alliance Imaging*
** Baromodedical Associates, Inc., Hyperbaric Medicine*
** John Muir Medical Center, Patient Transfer*
** LabCorp, Specimen Collection/Lab Services*
2. Approval of the Infection Control Plan Policy
3. 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. Conference with Legal Counsel: Pending Litigation pursuant to Government Code Section 54956.9(a): I.K. Sung vs DMC & West Contra Costa Healthcare District.

D. 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
MEDICAL CENTER

MINUTES

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DMC GOVERNING BODY
BOARD OF DIRECTORS

August 22, 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 4:30 P.M.

2. **ROLL CALL**

Quorum was established and roll was called:

Present: *Eric Zell, Chair*
Supervisor John Gioia, Vice Chair
Irma Anderson (via telephone)
Deborah Campbell
Sharon Drager, M.D.
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace
Nancy Casazza
Pat Godley

Excused: *Wendell Brunner, M.D*

3. **APPROVAL OF JULY 25, 2012 MINUTES**

The motion made by Dr. Drager and seconded by Dr. Stern to approve the July 25, 2012 minutes passed unanimously.

4. **PUBLIC COMMENTS**

Dr. Laurel Hodgson thanked Pam Moreno and The DMC Service League department for their dedication in the Code Green incident.

Pam Moreno presented DMC with a $15k check that will be used for the Telemetry Dept. 3rd-Floor. Eric Zell, Chair accepted the check on behalf of DMC.

5. QUALITY REPORT

Ms. Karen Taylor, Director of Quality and Risk Management presented and sought acceptance of the Quality Report.

Ms. Taylor reported the Quality Management Report was in the packet. First item is the Quality metrics for the core measures 1st quarter of 2012. The Acute MI measures did reflect good performance on meeting the goal on all indicators except for ACEI/ARB for LVSD involving one patient and one physician.

Mrs. Taylor reported that there are Meaningful Use Specialist (RN's) that came in late June and have begun to identify the medications and begin the core measures process which will help with compliance. Quality Staff will begin collecting concurrent core measures data in late September. Compliance is expected to improve by the 4th quarter. The one area that DMC is doing well in is Pneumonia care. NO Fall Outs in the 1st quarter. Surgical care is almost completely concurrent; they work directly with the OR Manager and the staff. Lastly, is congestive heart failure care that includes written discharge instructions if the patient doesn't get medication instructions then that are fallout. There have been some fallouts related to the changes when Paragon was implemented. Compliance with Core measures on the. The Joint Commission extranet site shows that we are compliant 96.7%; We are expecting a good survey related to core measures. The 2nd item is we've prioritized projects based on volume such as Medi-Cal and CMS programs to improve the health of the patients. The project includes the seismic structure plans and the quality priorities that DMC Leadership has chosen over the next 3 years.

6. FINANCIALS – JULY 2012

Mr. James Boatman, Chief Financial Officer presented and sought approval for the July 2012 Financials. Mr. Boatman reported the net loss was $2,600,000 in July. Expenses were $289,000 over budget and operating revenue was under budget by $1,300,000. Mr. Boatman explained the operating revenues and what the variances were for the month of July. There was a decline in implant services such as pace makers, prosthetics, etc. Part of the prosthetic volume decrease is for the reduced spine service because of the loss per case. The Collaboration changes have not occurred which contributes $444,000 to the negative variance in the month of July.

The motion made by Director Wallace and seconded by Director Godley to accept the July Financials passed unanimously.

7. CAPITAL EQUIPMENT: *Ultrasound Transducer Sterilization System*

Mr. Boatman sought approval and authorization to purchase new ultra transducer sterilization system at a cost of $22,704.

The motion made by Director Wallace and seconded by Director Anderson to approve the CFO to execute and purchase of the Ultrasound Transducer Sterilization System passed unanimously.

8. CEO REPORT

Ms. Dawn Gideon, Interim President and CEO provided an update on the following update (informational only)

- Ms. Gideon reminded the Board of Directors that in the month of May, the Directors approved a set of policies which are available on the West Contra Costa District website. One of those policies outlines the need for a Board self-assessment. Accordingly, Ms. Gideon will be email each of the Governing Body members later today with the link to an assessment tool prepared by the Association of District Hospitals. All members are encouraged to complete the assessment.

- Ms. Gideon reported at approximately 6:45 pm on Monday August 6, 2012 DMC was notified via Reddinet Service and verified by supplemental services such as social media regarding the fire and the subsequent release at the Chevron Richmond Refinery; at the time it was called a disaster. Two main things that were focused on was securing the physical plant and the environment and also to make sure the hospital was prepared to see patients seeking care. As of this morning there were approximately 5900 patients seen since that Monday evening - a 400% increase over normal volume. Only one patient related to the incident was admitted due to upper respiratory issues. To be able to manage the volume we had to increase the clinical staff, provide emergency credentialing to physicians, and add to admitting staff. It was called Code Green and we are still operating under Code Green. Absolutely everyone stepped up (Medical staff, Clinical staff, Admitting, Medical Records, EVS, Maintenance) and despite everyone's efforts we still needed to reach out to the community. There are 3 organizations that Ms. Gideon especially thanked – the Service League, CEP America, and Marin General. Director Zell will be sending thank you letters on behalf of the Governing Body to each of these organizations. There will be a celebration of the DMC team in the future.

9. MEDICAL EXECUTIVE REPORT

Dr. Hodgson reported on the actions of the August Medical Executive Committee, and sought approval for following 3 polices: 1) 5150 72 Hour Detention/Order to Transport Policy 2) Procedural Sedation Policy 3) Food and Nutrition Services Policy (each policy was explained and approved separately). Dr. Hodgson further reported on the MEC review and approval of the following contracts and sought approval from the Governing Body: Alliance Healthcare Services – MRI, Total Renal Care – DaVita, IV Assist and Sodexo.

The motion made by Dr .Walker and seconded by Director Wallace to approve the 5150 72 Hour Detention Policy passed unanimously.

The motion made by Dr. Stern and seconded by Dr. Drager to approve the Procedural Sedation Policy passed unanimously.

The motion made by Director Godley and seconded by Director Campbell to approve the Food and Nutrition Services Policy and Procedure Manual passed unanimously.

The motion made by Director Anderson and seconded by Dr. Stern to approve the contracts passed unanimously.

THE MEETING ADJOURN TO CLOSED SESSION

Meeting Reconvened following closed session at 6:10 p.m.

The motion by Director Campbell and seconded by Mr. Godley to approved the credentials passed with one abstention. Director Casazza abstained from the vote.

THE MEETING WAS ADJOURNED

DOCTORS
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QUALITY

TAB 5

QUALITY MANAGEMENT REPORT

Karen Taylor, RN, MSN, CPHQ, CPHRM
Director, Integrated Quality /Risk Management

STROKE MEASURES 2ND QUARTER 2012

Quality/Patient Safety Metrics

Stroke Core Measures

Indicator	Apr-12	May-12	Jun-12	Q2 12	Benchmark	Comments
STK-1 VTE prophylaxis	100%(8/8)	94%(15/16)	91%(10/11)	94%(33/35)	90%-100%	2 patients did not receive VTE while hospitalized.
STK-2 DC on Antithrombotic	100%(8/8))	100%(13/13)	100(9/9)	100%(30/30)	90%-100%	STK-4 Thrombolytics is currently at 71.4%. This indicates the percentage of patients who are seen and treated within 2 hours of symptom onset. The emergency room treated two patients in Quarter 2 whose symptoms were resolving after their arrival to the ED. Because their symptoms wre resolving, they did not recieve TPA at the time of arrival. Unfortunately, their symptoms worsened during their stay in the emergency room. By this time, they were outside of the 3 hour window for TPA although they were within the 4.5 hour window. These 2 patients received TPA at the 4.5 hour mark-both recovered.
STK-3 AntiCoags for Atrial Fib/Flutter	100%(3/3)	100%(2/2)	100%(1/1)	100%(6/6)	90%-100%	
STK-4 Thrombolytics	67%(2/3)	100%(3/3)	0%(0/1)	71%(5/7)	90%-100%	
STK-5 Antithrombotics by end of Hospital Day 2	100%(4/4)	100%(11/11)	100(8/8)%	100%(23/23)	90%-100%	
STK-6 DC on STATINS	86%(6/7)	100%(8/8)	100%(7/7)	95%(21/22)	90%-100%	Improvement has been noted from the beginning of Q2 to the end of Q2.
STK-8 Stroke Education	100%(7/7)	100%(7/7)	100%(8/8)	100%(20/20)	90%-100%	
STK-10 Assessed for Rehab	100%(9/9)	100(14/14)	100%(8/8)	100%(32/32)	100%	

DEPARTMENTAL UPDATES

- Sleep Center Patient Satisfaction - 100% Return Rate (Goal - 10%)
- Sleep Center Satisfaction April - August 2012 at 96% (183/191)
- Cancer Center-Breast Care in June 2012 stated they would refer Families & Friends at 98%
- Cancer Center - Infusion Care June - August 2012 stated they would return for care -94%

TJC ORYX PERFORMANCE MEASURE REPORT Q2 2010 - Q1 2012

- Composite Score Calculation
- Most recent 4 quarters of data for core measures
- How it affects the TJC tri-annual survey scores
- Public Posting on Hospital Compare website & TJC website

- 96.8%

DOCTORS MEDICAL CENTER

PATIENT SATISFACTION REPORT AND APPROVAL OF PRESS GANEY CONTRACT

TAB 6

Patient Satisfaction (HCAHPS)									
INDICATOR	**Threshold**	**Target**	**Goal**	**3rd Qtr 2011**	**4th Qtr 2011**	**1st Qtr 2012**	**2nd 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			242	231	232	250	N/A	N/A
Mean Score (Related to Press Ganey Supplemental Questions)	Unavailable	Unavailable	80%	79%	75%	77%	76%	↓ 1%	--
Patients who gave DMC a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	67%	63%	63%	50%	44%	49%	45%	↓ 4%	1%
Patients who reported YES, they would definitely recommend the hospital.	69%	67%	67%	52%	46%	46%	45%	↓ 1%	1%
Patients who reported that their nurses "Always" communicated well.	76%	71%	70%	62%	60%	59%	59%	--	1%
Patients who reported that their doctors "Always" communicated well.	80%	76%	76%	73%	70%	68%	73%	↑ 5%	3%
Patients who reported that they "Always" received help as soon as they wanted.	64%	57%	57%	49%	40%	42%	42%	--	1%
Patients who reported that their pain was "Always" well controlled.	69%	66%	65%	53%	55%	55%	55%	--	1%
Patients who reported that staff "Always" explained about medicines before giving it to them.	61%	58%	56%	49%	46%	48%	50%	↑ 2%	--
Patients who reported that the area around their room was "Always" quiet at night.	58%	48%	47%	41%	41%	33%	33%	--	1%
Patients who reported that their room and bathroom were "Always" clean.	71%	68%	67%	60%	55%	53%	51%	↓ 2%	1%
Patients who reported that YES, they were given information about what to do during their recovery at home.	81%	79%	79%	75%	71%	69%	71%	↑ 2%	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

DOCTORS MEDICAL CENTER- San Pablo

Patient Satisfaction Retreat

Wednesday, August 29, 2012
Cafeteria
4:30pm – 7:00pm

Meeting called to order at 4:45pm by Bob Redlo

I. **Welcome and Sign In/ Introductions**

II. **Opening Overview by Bob Redlo/Vanika Moeller**

Bob Redlo reviewed the agenda. Bob introduced himself and discussed his role at DMC. Patient Satisfaction is a major initiative at DMC. Bob discussed the correlation between employee morale and patient satisfaction. DMC will be expanding its workforce development program, employee rewards and recognition program and training programs that involve new approaches to patient satisfaction. Improvement and training will include employee involvement and improved quality and service training. We are looking forward to working with Press Ganey to assist DMC with patient satisfaction strategies over the next year.

III. **The Challenge by Dawn Gideon**

Dawn discussed the importance of culture change and leadership's support to patient satisfaction. "Let's get on with it"

IV. **You Spoke and We Listened by Bobbie Ellerston**

Bobbie reported on the new remodel of our Third Floor. The remodel was a result of discussion at a previous Patient Satisfaction Committee meeting. The new rooms on third floor have increased space and a Bobbie gave a big thank you to everyone who helped make the remodel a success. The feedback from our employees on the third floor is very positive.

Other changes that Bobbie addressed included:

1. Bedside Nurses from every shift will update the white boards with room number, RN name, physician name, plan of the day, comfort level / pain, diet, fall risk score, anticipated DC, family contact and number.
2. Each shift will do bedside reporting
3. Charge Nurses will be doing Patient Care Rounds twice a shift.

V. **Culture Change by Vanika Moeller**

Vanika addressed the issue of Culture Change at DMC and what some of the main points of change will involve. The three key phases in culture change involve Denial, Habit and Sustainment. Vanika explained each phase and discussed the importance of culture change in our program at DNC.

VI. **Benchmarking for Breakthrough by Press Ganey**

Press Ganey presented a proposal for implementation of our Patient Satisfaction Program. A great deal of attention was paid to accountability and sustainability. Key points included identifying DMC's specific culture, executing our plan, key accountability requirements and implementing our plan over the next twelve months.

Press Ganey gave some good examples of strategies that might improve our patient satisfaction levels. There was also some good discussion that patient satisfaction scores through HCAP do not tell the whole story and that measuring the quality of patient satisfaction is also important to our organization.

Press Ganey described the services that they would provide in the proposed contract agreement that will need to be approved by the Board. They also discussed the <u>The 5 Critical Behaviors for Implementing Sustainable Improvements in Your Hospital:</u>

1. Initiate (The Power of First Encounters)
2. Communicate (The Power of Listening)
3. Anticipate (The Power of Listening)
4. Respond (The Power of Follow-Through)
5. Educate (The Power of Effective Communication)

Bob Redlo addressed the recommendation to employ Press Ganey to assist DMC over the next year with Patient Satisfaction. Bob also discussed the strategy to form Patient Satisfaction teams in each department.

VII. **Employee Recognition Program by Vanika Moeller**

Vanika Moeller shared information on the possible development and implementation of a hospital wide employee recognition program. She stated the implementation of a hospital wide employee recognition program would help foster an environment of modeling good behavior when employees go above and beyond their duties to provide good customer service. A format for employee nomination that was previously used at DMC was presented and the committee agreed it would be great to utilize the available information in developing a new program instead of starting over. Other employee recognition

programs currently in place will continue in addition to the hospital wide program, they are: EDOC Award and Daisy Award.

The recommendation for the hospital wide employee recognition program would be to elect one employee and one manager/director with each quarter with nominations submitted by Med Staff, Managers/Directors, or Peers. The elected winners will receive:

- Photo in main hallway
- Recognition in DMC weekly
- Notice on DMC Website
- Certificate
- Designated Green Parking Permit
- DMC Marketing Item

Per committee feedback a small group should get together to review and finalize a process for the program. These members are:

- Remy Goldsmith
- Vanika Moeller
- Kim Johnson
- Regina Beasley
- Barbara Ewing (Daisy Award Winner)
- Lisa Davis (Union Representative)

Things to consider when developing the program include:
Fair submission process
Confidential HR review of employee file; (see eligibility)

Wrap-up and next steps by Bob Redlo

Bob discussed our implementation program as we move forward. Based on the discussion and the presentation today, we will be expanding our patient satisfaction committee. The oversight committee will meet quarterly and a DMC department committee will meet monthly. The monthly committee will include multidisciplinary representatives from each department In October; we will establish a department satisfaction committee. In November we will initiate the process of setting goals in each department. By December action plans in each department should be developed. Overall goals for patient satisfaction will also be developed for 2013. Press Ganey will assist us with the goal setting process and include the assessment process.

There was no public comment and the meeting was adjourned.

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ADDENDUM TO LETTER OF ENGAGEMENT

This AMENDMENT TO LETTER OF ENGAGEMENT is made by and between **Doctors Medical Center-San Pablo** ("Client") and **Press Ganey Associates, Inc.** ("Press Ganey").

Client and Press Ganey hereby agree to amend the Agreement for satisfaction measurement services entered into between said parties dated February 16, 2011. Both parties agree to extend the terms of the Agreement to include Patient Experience Optimizer - Advanced Solution beginning October 1, 2012 as depicted on the attached Statement of Work.

The Client agrees to pay Press Ganey a contract fee of $119,000.00. The Client agrees to pay $10,000.00 after signing, $54,500.00 in January 2013 and $54,500.00 upon completion.

In addition, the Client and Press Ganey hereby agree to extend the terms of this Agreement to include Value Based Purchasing at no charge for a twelve (12) month term as indicated on the attached Statement of Work.

Any contract services added during the twelve (12) month term of October 1, 2012 through September 31, 2013, will receive a ten percent (10%) discount on then current Press Ganey list price.

Client acknowledges that included in the fees paid under this agreement are one (1) registration to Press Ganey's 2012 National Client Conference and one (1) registration to Elective Leadership Conference to be used by Client's employees.

Other terms and conditions of the Letter of Engagement have not been changed and remain in effect.

EXECUTED THIS _____ DAY OF _____, 2012.

DOCTORS MEDICAL CENTER - SAN PABLO
(Client #7828)

PRESS GANEY ASSOCIATES, INC.

By: _____ By: _____

Title: _____ Title: _____

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EXHIBIT A

STATEMENT OF WORK

7828 DOCTORS MEDICAL CENTER SAN PABLO

$ 119,000.00

	Expected Start Date	Expected Completion Date
Project 1:	October 1, 2012	September 30, 2013

Patient Experience Optimizer – Advanced Solution

Assessment Phase: Preparation, Planning, and Measurement

- Consultant will conduct an in-depth organizational assessment to understand strengths, barriers, current initiatives and critical success factors.
- Consultant will conduct interviews with key leadership, administration and/or board members to assess current situation, understand the culture, objectives, current initiatives and perceived barriers.
- Consultant will conduct focus groups with management, staff, and physicians.
- Consultant will conduct mystery shopping in and observe several service lines.
- Consultant will host a project kick-off session at client site for leaders and selected managers. Kick-off session will be approximately 60-90 minutes to ensure that the internal leaders at the client organization are well versed in the Patient Experience Optimizer model to support implementation.

Analysis Phase: Report and Data Review

- Consultant will analyze data gathered during the assessment phase including but not limited to employee engagement, physician engagement, patient satisfaction trends, competitive landscape, strategic plans, performance improvement plans, organizational structure, reward/recognition data, etc.
- Consultant will integrate findings from organizational data, qualitative information from focus groups, leadership interviews and other methods mentioned above.
- Consultant will conduct assessments in the Patient Experience Optimizer kit to determine strengths and weaknesses in current approaches and deployment

Recommendation Phase: Solution Generation

- Consultant will provide one (1) Patient Experience Optimizer Implementation Kit.
- Consultant will prepare and present a report of conclusions and recommendations
- Consultant will provide an executive overview of analysis, conclusions and recommendations (approx 1 hour) in collaboration with the client project leaders.
- Consultant will facilitate an implementation planning session with key leaders to establish action plans for the PEO kit, accountability and evaluation periods.

Client Initial ____
PG Initial ____

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Implementation Phase: Action Planning

- Based upon analysis, conclusions and recommendations from the Recommendation Phase, Consultant will provide nine (9) monthly implementation support visits after kick-off to ensure successful implementation and accountability and to provide coaching for the identified opportunities, challenges and barriers related to maximizing the patient experience.
- Consultant will provide weekly phone support throughout implementation with client to address additional barriers to success and strategize ideas for improvement.

Any additional travel or services agreed upon shall be added via addendum and will be invoiced as incurred.

STATEMENT OF WORK FACILITY BREAKDOWN

Client #	Facility Name
7828	Doctors Medical Center San Pablo

Client Initial ____
PG Initial ____

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STATEMENT OF WORK - Value Based Purchasing Calculator

Press Ganey's Value Based Purchasing (VBP) calculator is designed to help hospitals position their organization for success under the impending shift in Medicare payment policy. The VBP calculator allows Clients to estimate how their hospital's payment is likely to be affected if proposed VBP models were in place today and to model how incremental improvements at the measure level could affect scores and associated Medicare payments.

The VBP Calculator facility license provides the Client with login credentials to access the web-based VBP Calculator. The facility may designate an unlimited number of users, provided those users are employed by the facility.

Included with the license is access to the web-based resource center, which houses a recorded training session and educational materials that address both the calculator and Value-based purchasing. Among these materials is an executive briefing on VBP, a glossary of VBP terms and a list of frequently-asked questions.

Any updates to the calculator and to the web-based resources are included in the license. Press Ganey will notify VBP Calculator Client(s) of any such updates as they occur.

Initial Training - Initial training for all VBP Calculator Clients consists of:

- Web-enabled training sessions approximately one hour in length. Participant shall be responsible for selecting a session from the posted list of scheduled trainings.
- Pre-recorded training modules available on-demand via web portal.

(Press Ganey offers the training described above at no cost to Client.)

Technical Support - Telephonic and e-mail enabled technical support shall be provided at no additional cost to Client.

Licensing Agreement: During the Term, Press Ganey grants Client a limited, non-exclusive, non-transferable, non-assignable, revocable, internal license to use the VBP Calculator solely for non-commercial use by the facilities listed below. All materials displayed or made available by Press Ganey to Client as a part of this license, including, but not limited to, graphics, documents, text, images, sound, video, audio, artwork, software, and HTML code (collectively, the "Material") are the exclusive property of Press Ganey. The Material is protected by international copyright laws and any other applicable intellectual property rules, regulations, and laws. Except as expressly permitted herein, Client agrees not to (a) commercially use, make non-temporarily downloaded copies, save, modify, broadcast, delete, distribute, store, reproduce, transmit, publish, sell, re-sell, adapt, reverse engineer, or create derivative works of the Material, or (b) use the Material on other websites or any media (e.g. networking environment) without Press Ganey's prior written permission. All trademarks, service marks, and logos (the "Marks") displayed in the VBP Calculator are the exclusive property of Press Ganey.

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Product Fees: Licensed Facilities and Licensed Product

The initial term of this engagement will begin October 1, 2012 and will extend for 12 months.

The following entity shall be granted a license for the product specified below.

Facility ID#	Name of Licensed Entity	Licensed Service	Annual Fees
7828	Doctors Medical Center-San Pablo	VBP Calculator	$0.00

Payment: There will be no license fee during the twelve (12) month term of this Engagement. In the event the Client wishes to extend the VBP Calculator Facility License beyond the 12 month term of this Statement of Work, the parties will negotiate a fair and reasonable license fee, to be invoiced and payable on an annual basis.

Reimbursable Expenses: If travel by Press Ganey staff is required to implement the VBP Calculator, provide additional training, or provide consultative services related to the VBP Calculator, Client will reimburse reasonable travel-related expenses at cost.

DOCTORS
MEDICAL CENTER

PEU LOCAL ONE AGREEMENT

TAB 7

DOCTORS MEDICAL CENTER, SAN PABLO

AND

PUBLIC EMPLOYEES UNION LOCAL ONE CLINICAL LABORATORY SCIENTISTS

New Agreement July 1, 2011 – June 30, 2017

WAGE INCREASE

(Effective the 1st payroll after the date of implementation)

Dates of Implementation

January 1, 2012 - 1%	
January 1, 2013 - 1%	July 1, 2013 – 1%
January 1, 2014 - 1%	July 1, 2014 – 1%
January 1, 2015 - 1%	July 1, 2015 – 1%
January 1, 2016 - 1%	July 1, 2016 – 1%
January 1, 2017 - 1%	

SHIFT DIFFERENTIALS
Increase differential .75 to PM (3.75), and .75 to Night Shift (5.25)

MEDICAL HEALTH BENEFITS
Effective January 1, 2013, the medical health plan benefits will be amended as follows: (See attached schedule)

HEALTH BENEFIT EMPLOYEE CONTRIBUTION
Effective January 1, 2013, the employee health benefits contribution will be amended as follows: (See attached schedule)

DMC INCENTIVE PLAN
The parties agree to work on goals as discussed during collective bargaining that may result in a 1% paid bonus each year beginning in January 2014. The details of the plan will be determined. (See attached)

WORKFORCE DEVELOPMENT FUND
DMC agrees to create a $25,000 Workforce Development Fund for the education and training of Public Employees Union Local Clinical Laboratory employees.

ARTICLE 5A – (add language)
The Medical Center and individual employees, or groups of employees, may agree to alternative schedules which provide for shifts that are longer than eight hours in any work day.

ARTICLE 11B– (add language)
Health insurance benefits will continue under the same conditions that coverage would have been provided if the employee had not gone on leave for up to six (6) months of any Pregnancy Disability Leave. Following the expiration of this six (6) month period, health insurance benefits may be continued under the provisions of COBRA.

ARTICLE 26-N

Employee Life Insurance: Change language to reflect coverage from one time employee annual salary to two time's annual salary.

Dependent Life Insurance: The employees will be offered dependent life insurance on a self-paid basis by the employee

Retirement Medical Insurance: The employee will be offered retirement medical insurance on a self-paid basis by the employee.

DOCTORS MEDICAL CENTER, SAN PABLO

AND

PUBLIC EMPLOYEES UNION LOCAL ONE BUSINESS OFFICE CLERICAL UNIT

New Agreement July 1, 2011 – June 30, 2017

WAGE INCREASE

(Effective the 1st payroll after the date of implementation)

Dates of Implementation

	July 1, 2012 - 1%
January 1, 2013 - 1%	July 1, 2013 – 1%
January 1, 2014 - 1%	July 1, 2014 – 1%
January 1, 2015 - 1%	July 1, 2015 – 1%
January 1, 2016 - 1%	July 1, 2016 – 1%
January 1, 2017 - 1%	

MEDICAL HEALTH BENEFITS

Effective January 1, 2013, the medical health plan benefits will be amended as follows: (See attached schedule)

HEALTH BENEFIT EMPLOYEE CONTRIBUTION

Effective January 1, 2013, the employee health benefits contribution will be amended as follows: (See attached schedule)

DMC INCENTIVE PLAN

The parties agree to work on goals as discussed during collective bargaining that may result in a 1% paid bonus each year beginning in January 2014. The details of the plan will be determined. (See attached)

WORKFORCE DEVELOPMENT FUND

DMC agrees to create a $50,000 Workforce Development Fund for the education and training of Public Employees Union Local One Business Office Clerical Unit employees.

ARTICLE 5A – (add language)

The Medical Center and individual employees, or groups of employees, may agree to alternative schedules which provide for shifts that are longer than eight hours in any work day.

ARTICLE 11B– (add language)

Health insurance benefits will continue under the same conditions that coverage would have been provided if the employee had not gone on leave for up to six (6) months of any Pregnancy Disability Leave. Following the expiration of this six (6) month period, health insurance benefits may be continued under the provisions of COBRA.

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DOCTORS
MEDICAL CENTER

UTILIZATION MANAGEMENT PLAN

TAB 11

DOCTORS MEDICAL CENTER

UTILIZATION MANAGEMENT PLAN 2012

INTRODUCTION

Medicare Conditions of Participation regulations and The Joint Commission require hospitals to have "a utilization management plan that provides for review of services furnished by the institution and by members of the Medical Staff to patients entitled to benefits under the Medicare and Medicaid programs" (§482.30). If a Quality Improvement Organization has assumed binding review for the hospital (§482.30(1) *or* CMS has determined that utilization review procedures established by the state under Title XIX are superior to §482.30 and has required hospitals in that state to meet the Utilization Review (UM) Plan requirements under §§ 456.50 through 456.245 of 42 CFR Ch, IV (10-1-04 Edition), it is NOT necessary to have a utilization review plan.

In the years since these Conditions of Participation were first developed, managed care has prompted the evolution of Utilization Management (UM) to a current form that encompasses utilization management, case management and discharge planning for all patients, regardless of payment source. New systems have been created to provide the resources to address the complexities of utilization review and management, including computerized tools such as InterQual™ and real-time information sharing with third party payors.

This document identifies the fundamental requirements of a comprehensive utilization management plan that satisfies Medicare Conditions of Participation and the Joint Commission requirement and addresses case management and managed care in a format that may be modified.

The plan does not address or include UM conducted by members of the Medical Staff under contract with, or via other means of, delegation by a third party payor.

PURPOSE

The UM Plan describes the organization's establishment and implementation of utilization review to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and Medical Staff. Under this plan, the organization:

- Delineates the responsibilities and authority for those involved in the performance of internal and external utilization management;
- Establishes the protocols to review for medical necessity of admissions, extended stays, professional services, and appropriateness of setting;
- Mandates the review of outlier cases based on extended length of stay and/or extraordinarily high costs;
- Mandates the review of over-utilization, under-utilization and inefficient utilization of resources;
- Specifies the procedures for denials, appeals and peer review within the organization; and
- Establishes the reporting, corrective action and documentation requirements for the utilization review process.

OBJECTIVE

The objective of the UM plan is to maintain high-quality, medically necessary and efficient treatment for all patients, regardless of payment source, by ensuring that patients receive the right care at the right time in the right place.

Essential Requirements for Effective Utilization Management

- Commitment, cooperation and communication by the Governing Body, the Medical Executive Committee, Hospital Administration and Leadership, the Utilization Management Committee, Medical and Hospital Staff and contracted services;
- Objectively established and implemented review criteria, including definitions for outlier thresholds for different diagnoses and/or DRG's, including InterQual criteria;
- Appropriate data base for aggregation of utilization data;
- Corrective action mechanisms and authority, including Medical Staff bylaws and department rules and regulations;
- Integration of utilization management variances with quality improvement activities;
- Adherence to applicable state utilization management statutes, including maintenance of confidentiality of patient information and the privileged status of information.

Composition of the Utilization Management Committee

The Committee shall be a standing committee of the Medical Staff and shall be comprised of at least five physician members of the medical staff to afford fair representation to perform the utilization management function. Subcommittees may be appointed by the committee for departments or sections as the committee may deem appropriate. Committee may be supported by representatives from Case Management, Nursing, Administration, Finance, Health Information Management. The committee's or group's reviews may not be conducted by any individual who has a direct financial interest (for example, an ownership interest) in the hospital; or was professionally involved in the care of the patient whose case is being reviewed.

The duties of the utilization review committee shall include:

(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(b) establishing a utilization review plan which shall be approved by the medical executive committee & be in compliance with current government regulations.

(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

(d) determining whether under or over utilization practices impact adversely on the quality of patient care and recommend the appropriate action to be taken.

(e) tracks, trends and analyzes outlier cases to identify patterns and recommend the appropriate action to be taken.

The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall report at least quarterly its activities and recommendations to the Medical Executive Committee.

RESPONSIBILITIES, AUTHORITY AND DUTIES FOR THE UTILIZATION MANAGEMENT PLAN

Governing Board

1. Establishes the Organization's Utilization Management/Case Management Plan.
2. Performs annual review, evaluation and approval of the Utilization Management/Case Management Plan.
3. Provides the resources necessary to enable Utilization Management/Case Management to perform its function, including human, informational and physical resources.
4. Delegates to the Medical Staff, Utilization Management Committee and Chief Executive Officer the responsibility for implementation of the Plan
5. Requires the Hospital and Medical Staff to implement and report on utilization review activities throughout the organization

Chief Of Staff, Chief Executive Officer and/or Designee

1. Delegates oversight of utilization management to the Utilization Management Committee as a subcommittee of the Medical Executive Committee.
2. Assures that admissions and continued stays are medically necessary and that medical and hospital resources are appropriately used.
3. Evaluates the effectiveness of utilization management activities.
4. Reports evaluation results to the Governing Board.

Medical Executive Committee

Criteria Development

1. Develops and/or approves general admission criteria
2. Develops and/or approves specific admission criteria for specialty patient groups.

Resource Management

1. Ensures the provision of health care that meets professionally recognized quality standards
2. Ensures consistently appropriate and medically necessary treatment for patients

3. Ensures the most efficient use of hospital health services and facilities
4. Ensures the maintenance of consistently valid, accurate and complete medical record information to justify diagnoses, admissions, treatment, and continued care
5. Receives, analyzes and acts on utilization review findings

Peer Review
1. Measures and acts upon peer review information related to medical necessity and appropriate treatment
2. Provides for confidentiality of the peer review process, including mechanisms to protect findings
3. Provides focused review or other restrictions for Medical Staff members with frequent utilization management problems, including denials

Reporting
1. Provides an annual review, evaluation and approval of the UM/Case Management Plan.

ORGANIZATIONAL LEADERSHIP

Vision
1. Knows, understands and implements the rules of utilization review
2. Demonstrates and fosters commitment to the goals and objectives of utilization review
3. Creates an environment that promotes effective utilization review.
4. Engages the Medical Staff in UM / Case Management functions

Structure
1. Allocates adequate resources, including personnel, time, data collection tools and systems, to:
   a. Establish, promote and maintain UM / Case Management
   b. Promote coordinated care and services
   c. Pursue effective internal and external utilization review

Accountability
1. Ensures that the facility satisfies the requirements of the Quality Improvement Organization contract by CMS to review services and items provided to Medicare beneficiaries
2. Ensures that important activities and outcomes, including performance improvement, are monitored, measured, assessed and improved systematically throughout the organization
3. Reviews utilization information to prioritize use and management of limited resources and integrate the information into performance improvement activities
4. Participates in interdisciplinary and interdepartmental activities to improve procedures and promote the most efficient use of services and facilities
5. Considers and acts upon recommendations from various subcommittees regarding hospital policy, procedure and staffing relevant to UM / Case Management
6. Provides mechanisms for corrective or disciplinary action as needed to resolve barriers to effective utilization management and review

UTILIZATION REVIEW COMMITTEE

Administrative Procedures
1. Complies with applicable requirements of the utilization review plan approved by the Medical Staff and governing body
2. Requires documentation that utilization review is applied regardless of payment source
3. Requires that focused reviews be emphasized
4. Determines whether underutilization and, when appropriate, over-utilization of practices impact adversely on the quality of patient care and recommend the appropriate action to be taken
5. Establishes the procedure that provides for notification of non-coverage to beneficiaries or their representatives
6. Provides for confidentiality of the peer review process, including mechanisms to protect findings
7. Establishes protocols and restrictions for external utilization review agents who perform on-site reviews in the facility, including sign-in and confidentiality agreements
8. Meets at an appropriate frequency, but not less than quarterly and as often as necessary, at the call of its chair, to effectively manage the UM process
9. Documents meetings with dates, meeting duration, names and titles of present and absent members, and committee activity
10. Reports at least semi-annually to the Medical Executive Committee, the Governing Board and other committees as determined by the facility
11. Reports to the Medical Staff any findings from the QIO

Utilization and Peer Review Process

1. Ensures that only medically necessary care is delivered
2. Provides notification to the hospital administrator, the attending physician, the care recipient or that person's authorized representative, and the third-party payer within 3 days of adverse decisions
3. Makes medical necessity and appropriateness of care determinations independent of external utilization review decision makers, such as managed care entities
4. Provides peer review for cases referred by the non-physician utilization reviewer
5. Recruits physician advisors as needed when specialty expertise is required for medical and professional peer review
6. Reviews all extended stay/outlier cases as defined by the organization within specified timeframes (recommended in 5-7 days)
7. Tracks, trends and analyzes outlier cases to identify patterns
8. Documents in meeting minutes all extended stay reviews, including approvals, disapprovals and reasons, and actions taken to resolve identified problems.
9. Hears appeals presented by providers for denials related to medical necessity of admissions, continued stays and professional services

PHYSICIAN ADVISOR

1. Provides clinical consultation to utilization review / case manager staff members
2. Provides education to Medical Staff regarding utilization review
3. Reviews any cases initially denied by a non-physician utilization reviewer or case manager
4. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays
5. Documents adverse decisions
6. Assists UM / Case Management staff in writing letters of appeal for denials of payment

MEDICAL STAFF, EMPLOYEES AND CONTRACTED SERVICES

1. Assesses patient needs to determine the appropriate care, services and settings
2. Establishes clear, concrete and attainable care goals against which progress may be evaluated
3. Identifies barriers to efficient treatment and timely discharge
4. Provides efficient and appropriate care
5. Maintains accurate and complete medical records
6. Communicates and coordinates effectively with patients, families and health care providers regarding transition and discharge needs
7. Transitions patients through the continuum of care to internal and external resources
8. Cooperates with and participates in the utilization review and peer review process, including appealing adverse determinations by outside review organizations

UTILIZATION MANAGEMENT/CASE MANAGEMENT STAFF

Coordination

1. Delegates UM responsibilities as needed to appropriate designee(s) as required to ensure weekend and night coverage
2. Provides guidance to the medical and hospital staff, including discharge planners and case managers, regarding medical necessity criteria
3. Participates in Performance Improvement activities, as appropriate

Utilization Review/Case Management Process

1. Reviews medical record documentation thoroughly to obtain information necessary to make UM determinations
2. Uses ONLY documentation provided in the medical record to make determinations
3. Applies utilization review criteria objectively for admissions, continued stay, level of care and discharge readiness, using InterQual guidelines or similar guidelines.
4. Provides UM/Case Management services 24 hours a day, 7 days a week to all relevant hospital departments
5. Screens and coordinates admissions and transfers, including emergency and elective admissions, 23-hour observation, conversions from outpatient to inpatient care, conversions from inpatient to outpatient care, and out of area transfers
6. Provides utilization review to all admissions and continued stays, regardless of payer, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payers

7. Reviews all admissions to the facility within 24 hours of admission Monday through Thursday and on Monday for those admissions occurring Friday through Sunday
8. Reviews all continued stays at a scheduled frequency, but not less than every 3 days
9. Reviews for timeliness, safety and appropriateness of hospital services and resources, including drugs and biologicals
10. Meets weekly for complex case review
11. Implements Retrospective or Focused Review as directed by the UM Committee

Denials / Appeals

1. Appeals denials by external review organizations, using only information documented in the medical record
2. Identifies patients who do not meet admission or continued stay criteria
3. Notifies the attending physician that a patient is not meeting criteria
4. Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the facility's Physician Advisor for peer review when unable to reach consensus with the attending physician
5. Expedites and facilitates attending physician-to-physician advisor reviews
6. Refers cases of physician non-responsiveness or dispute between the attending physician and the Case Manager to the facility's Physician Advisor for peer review

External Review

1. Establishes effective working relationships with third party payer reviewers
2. Provides clinical information as required by and to third party payer sources
3. Facilitates medical record access and supervision for external insurance reviewers coming to the hospital for utilization review, adhering to the protocols established by the Utilization m Committee
4. Communicates external UM determinations to patient and/or family

Discharge Planning

1. Maintains current, accurate information regarding community resources to facilitate discharge planning
2. Provides focused discharge planning, initiated as early as possible after admission to facilitate timely appropriate discharges
3. Identifies patients with complex discharge planning needs arising from diagnoses, therapies, psychosocial or other relevant circumstances
4. Documents discharge planning activities in the medical record
5. Facilitates transfers to appropriate higher level of care facilities when services are not available
6. Includes placement in alternative care facilities, DME, family involvement and community resource referral in discharge planning activities

Information Management

1. Maintains utilization management files and results separately from the medical record
2. If available, uses automated information management systems to optimize efficiency
3. Collects and aggregates utilization data for tracking and trending reports
4. Coordinates and maintains data to address issues of over-utilization, under-utilization and admission necessity.

GLOSSARY
Terms and Definitions Used in Utilization Review

ADMISSION AUTHORIZATION: Approval for treatment obtained from Payer or designated utilization review organization for services to be provided as an inpatient or observation patient.

ADMISSION REVIEW: The initial evaluation of planned or provided medical treatment using clinical appropriateness criteria, e.g. InterQual.

ADVERSE DETERMINATION: Decision by Payer or designated utilization review organization to deny or reduce payment for services provided that are covered benefits.

APPEAL: Request for reversal of authorization/payment following a denial or underpayment.

AUTHORIZATION: Approval for treatment obtained from Payer or designated utilization review organization for services provided.

CLINICAL DENIAL: A classification of denial. Refers to lack of authorization or payment based on a lack of medical appropriateness (usually related to intensity of service not matching severity of illness) or necessity (usually related to the care proposed or given not being medically necessary given the clinical presentation of the patient).

CLINICAL PEER REVIEW – INTERNAL: Evaluation for clinical appropriateness by the facility's designated physician advisor or by a second physician so designated by that physician advisor or the Medical Staff of the facility, who practices in the same or similar specialty as the physician managing the medical condition, procedure, or treatment under review.

CLINICAL PEER REVIEW- EXTERNAL: Evaluation for clinical appropriateness by an external body's designated physician advisor (usually the Payer) who practices in the same or similar specialty as the physician managing the medical condition, procedure, or treatment under review.

CO-PAYMENT: The amount of the billed charges that are the responsibility of the patient (also see Deductible).

CONCUMRENT AUTHORIZATION: Approval for treatment obtained from Payer or designated utilization review organization at the time services are being provided.

CONCUMRENT DENIAL: Decision of Payer or designated utilization review organization not to authorize services prior to or during the period of time that care is being provided and identified by the concurrent review process carried out by either Utilization Review or Case Management.

CONCUMRENT REVIEW: Evaluation of ordered/delivered medical treatment, using clinical appropriateness criteria such as InterQual, prior to or during the period of time that care is being provided. This may be a required step in the process by Payers to obtain continued authorization or may be the normal clinical evaluation process of the facility as determined by approved internal criteria based review guidelines.

DEDUCTIBLE: The amount of the billed charges that are the responsibility of the patient (also see Co-payment).

DENIAL CATEGORY: The major classifications or groupings of denials. These include technical denials, clinical denials, contractual disparities, and underpayments.

DENIAL REASON: The explanation for a denial, reduction in level of service, or underpayment as specified by the denial coding system under use by the facility. The denial reason is often provided by the Payor at the time the denial is received and is then entered into the denial system under the appropriate denial code.

DETERMINATION: Decision by a Payer or designated utilization review organization regarding authorization for payment of services provided.

DISCHARGE SCREEN (DS): The third component of the InterQual criteria review process for clinical appropriateness.

DOWNCODE: A payor driven reduction in payment for services at a lower level of reimbursement than that at which the care was provided.

EXPEDITED APPEAL: Verbal request for appeal that usually takes place concurrently with the medical services that are being provided or within 72 hours of the appeal.

EXPECTED REIMBURSEMENT: The dollar amount, given the clinical services provided and contract or agreement with the Payer source, that the facility anticipates receiving for the care provided.

INTENSITY OF SERVICE (IS): The second component of the InterQual criteria review process for medical appropriateness. The intensity of service is the level of clinical care being provided to the patient.

INTERQUAL CRITERIA: Commercial decision support guidelines licensed for use by hospitals and managed care companies, to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

LEVEL 1 APPEAL: Contractually defined, this is the first written request to the Payer for reconsideration and reversal of denied day(s), services, or payment.

LEVEL 2 APPEAL: Contractually defined, this is the second written request to the Payer for reconsideration and reversal of denied day(s), services, or payment. The 2nd level appeal is sent when the response to the 1st appeal declines, or partially declines, reversal of authorization or payment.

LEVEL 3 APPEAL: A higher level of request for reversal of authorization or payment than the 1st and 2nd level appeals. The 3rd level appeal is to an independent external party (such as the Department of Insurance) and is coordinated with the Hospital A Team and may require legal advice.

PARTIAL DENIAL: Denial of a portion of the days, services, or payment for an individual case.

PENDED CONCUMRENT REVIEW: Request for further clinical information or for referral of the case to a physician level of review, which usually delays, or places a "pending" status on the concurrent authorization, until such time as the information is transmitted to the payor and assessed.

PHYSICIAN ADVISOR: Physician working for the hospital under contract or through Medical Staff position, who provides review of cases for clinical appropriateness. The Physician Advisor is most often used to review cases and consult with the admitting/attending physician when the admitting/attending physician refuses to discharge the patient or move them to another appropriate level of care although they do not meet standard review criteria for continued stay at the current level of care.

PRE AUTHORIZATION: Approval for treatment obtained from Payer or designated utilization review organization prior to services being provided. Generally applicable to non-emergent and elective services.

PRE-CERTIFICATION: Certification by the Payor, prior to care being delivered, that the patient is a member of the Payers group plan or is a policyholder. Pre-certification does not authorize care but certifies that the patient is enrolled in the Payor's product.

REDUCTION IN LEVEL OF CARE (RLOC): Action by the payor to reduce payment for days or services to a level of payment below that which at which the care was provided.

RETROACTIVE DENIAL: Decision by Payer or designated utilization review organization to deny or reduce authorization and/or payment after the services have been provided. This may also be a decision by Payor or designated utilization review organization to deny or reduce payment for services that were previously authorized.

SUBSEQUENT REVIEW: Clinical review(s) following initial review for the same case. See Concurrent Review.

SEVERITY OF ILLNESS (SI): The first component of the InterQual criteria review process for medical appropriateness. The severity of illness is the level of clinical need of the patient given review of disease processes, the risk to the patient's continued health and recovery and ongoing care needs.

TECHNICAL DENIAL: A denial received for other than clinical reasons, usually determined by lack of internal process compliance with technical contract language regarding pre-certification, authorization, notification and/or utilization review.

TOTAL DENIAL: Denial of all days, services, or payment for an individual case.

UNDERPAYMENT: Reduced payment below contractually expected amount. An underpayment is usually linked to the belief on the Payor's part that the services provided were unnecessary given the clinical condition of the patient and alternative treatment sources available within the care continuum.

UTILIZATION REVIEW (UR); UTILIZATION MANAGEMENT (UM): Evaluation of the necessity, appropriateness, and efficiency of the use of health care resources, services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. (Adapted from "Pam Pohly's Net Guide: Glossary of Terms in Managed Health Care", http://www.pohly.com/terms_u.html.)

DOCTORS
MEDICAL CENTER

FINANCIALS
AUGUST 2012

TAB 9

DOCTORS MEDICAL CENTER

Board Presentation

August 2012

Financial Report

Financial Report Key Points

- Net Loss was $1.2M in August.
- Operating revenue was over budget by $1.9M.
- Expenses $1.5M over budget.

Statement of Activity – Summary

For the Period Ending

August 31, 2012

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
11,577	9,642	1,935	**Net Operating Revenues $**	82,271	87,787	(5,516)
13,523	12,055	(1,468)	**Total Operating Expenses $**	99,251	99,702	451
(1,946)	(2,413)	467	**Income/(Loss) from Operations $**	(16,980)	(11,916)	(5,064)
715	873	(158)	**Income from Other Sources $**	5,561	4,578	983
(1,231)	(1,540)	309	**Net Income / (Loss) $**	(11,419)	(7,337)	(4,082)
2,397	2,348	49	**Patient Days**	18,571	20,209	(1,638)
515	479	36	**Discharges**	4,051	4,154	(103)
11,020	6,531	4,489	**Outpatient Visits**	54,880	52,894	1,986
655	609	(46)	**Worked FTE's**	625	639	14
1.54	1.59	0.05	**Medicare CMI**	1.54	1.59	0.06

Budget Variances – **Net Revenue**

- Medi-Cal / Medi-Cal HMO – $66K.
- Medicare / Medicare HMO – $768K.
- Government / Workers Comp – ($141K).
- Commercial / PPO /HMO – $100K.

Budget Variances – Expenses

- **Salaries & Benefits** ($785K) – Additional costs for the Chevron incident. Registry and overtime costs continue to be an issue.
- **Purchased Services** ($222K) – Financial reporting software upgrade and Increased security due to the Chevron incident.
- **Supplies** ($27) – Additional supplies for Chevron incident. Offset by continued underutilization of implants and pharmaceuticals.
- **Professional Fees** ($127K) – Four unbudgeted consultants

Cash Position
August 31, 2012

(Thousands)

	August 31, 2012	December 31, 2011
Unrestricted Cash	$3,119	$13,972
Restricted Cash	$14,271	$29,847
Total Cash	$17,390	$43,819
Days Unrestricted Cash	7	33
Days Restricted	34	72
Total Days of Cash	41	106

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

Accounts Receivable

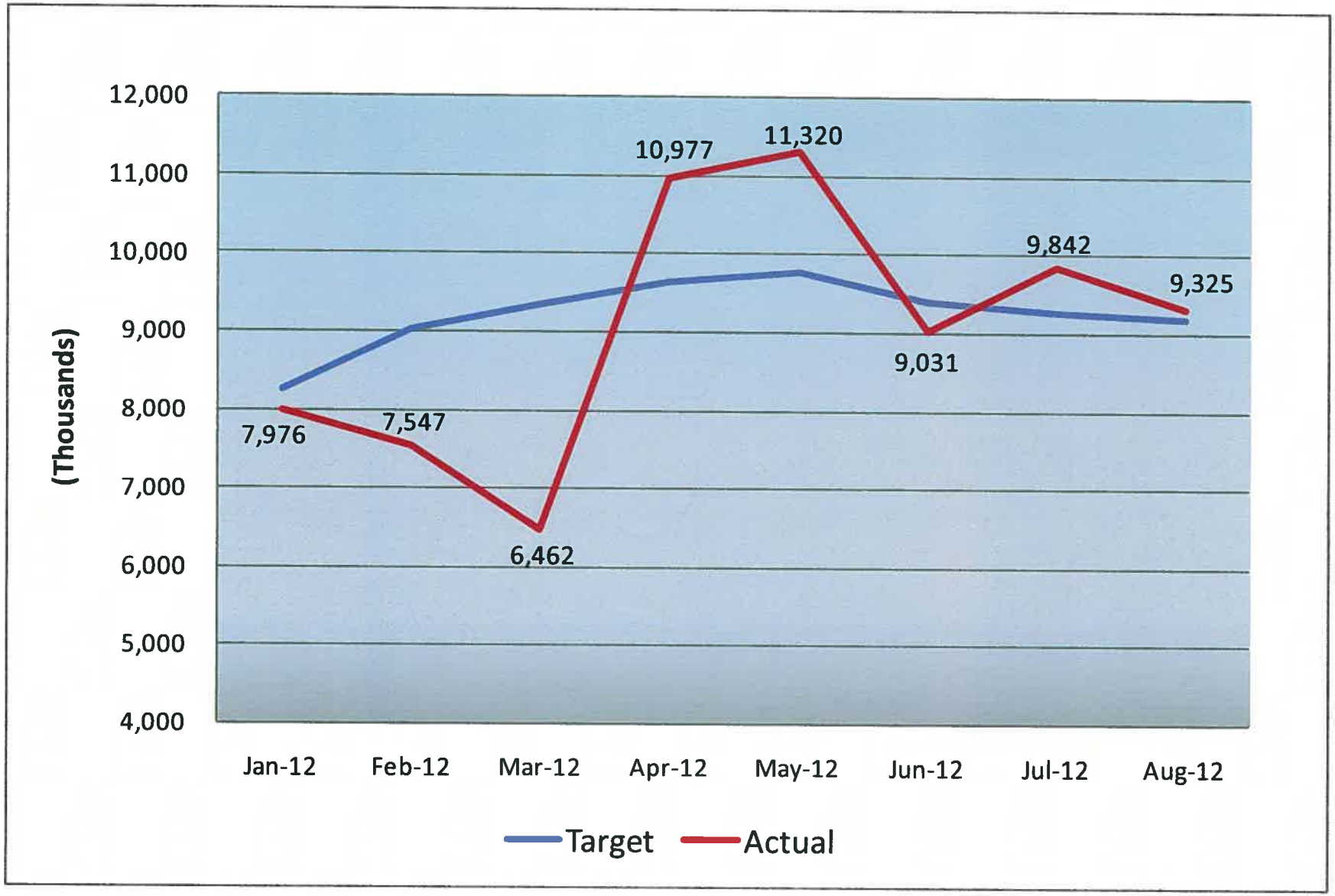
August 31, 2012

(Thousands)

	August 31, 2012	December 31, 2011
Net Patient Accounts Receivable	$28,221	$19,177
Net Days in Accounts Receivable	84.2	60.7

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

2012 YTD Cash Collections



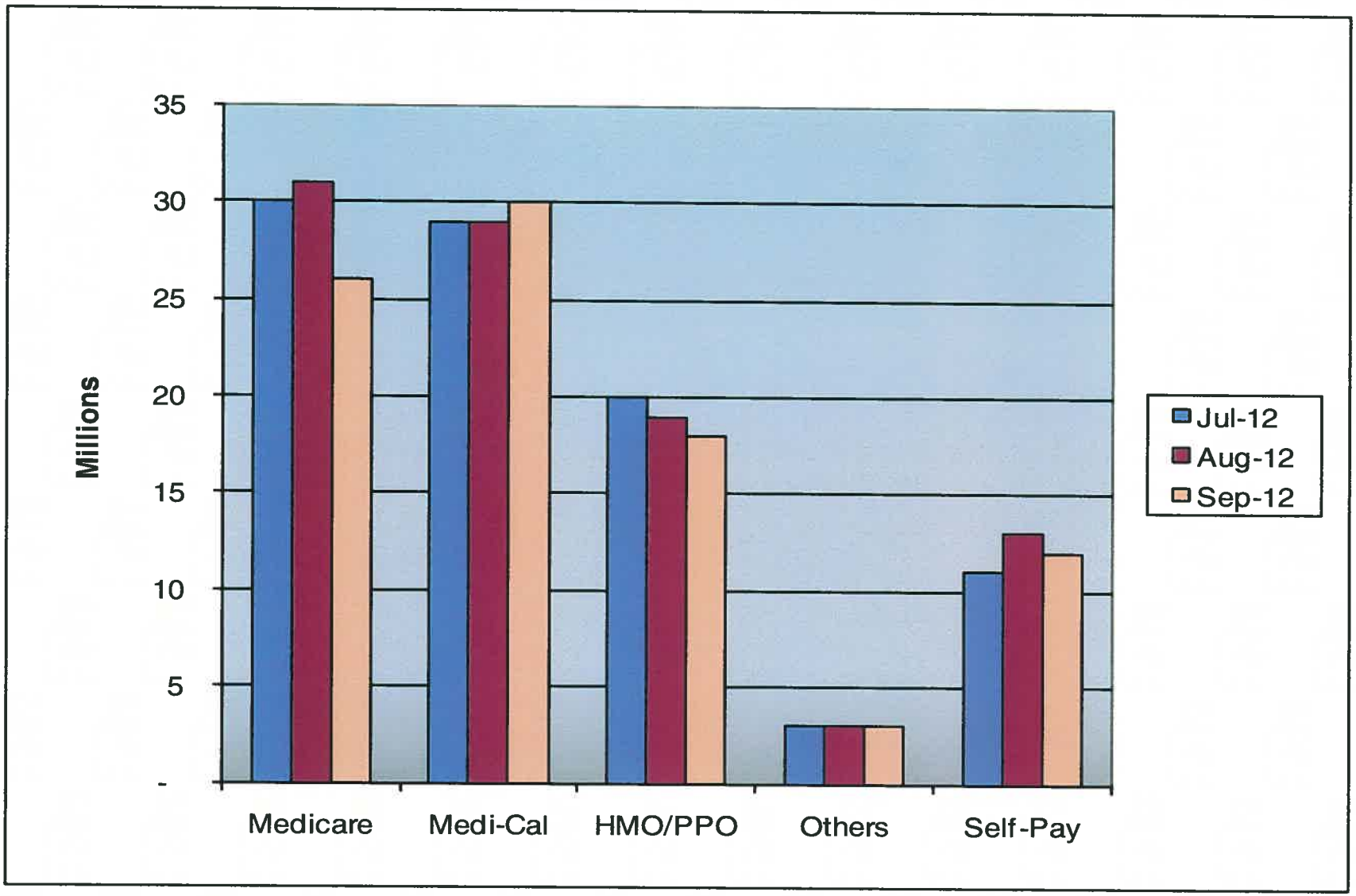
Unrestricted Cash Flow
August 31, 2012
(Amounts in Thousands)

	August-12	Year to Date
Sources (Deposits)		
Net Income (Loss)	($1,231)	($11,419)
Depreciation	425	3,203
Net Cash Inflow	(806)	(8,216)
Uses (Expenses)		
Equipment Expenditures	75	(2,707)
Debt Payments	(72)	(1,365)
Net Current Assets & Liabilities	(207)	(23,565)
Total Uses	(204)	(27,637)
Other Changes		
Transfer from Restricted	-	25,000
Net Change in cash Position	(1,010)	(10,853)
Begining Cash Available	4,129	13,972
Ending Cash Available	$3,119	3,119
Days Cash on Hand	7	7

Capital Budget 2012

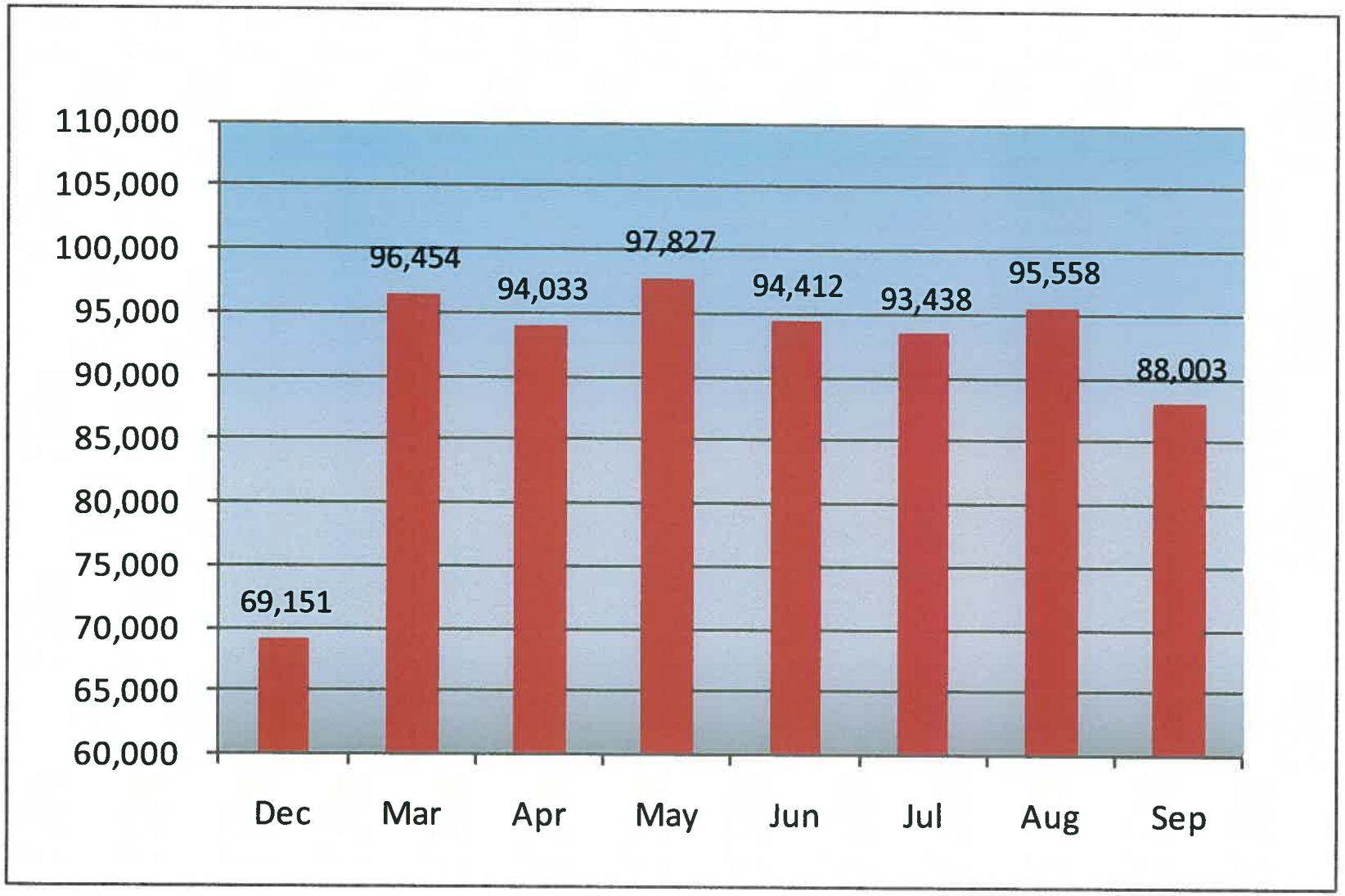
Paragon	$1,757,000
Other	1,000,000
Total Capital Budget:	2,757,000
Committed To Date:	2,684,527
Subtotal Remaining	72,473
Foundation Support	175,000
Remaining Capital	$247,473

AR By Payor


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

Accounts Receivable

(Thousands)



DOCTORS MEDICAL CENTER

August 2012 Executive Report

Doctors Medical Center had a Net Loss of $1,231,000 in the month of August. As a result, net income was over budget by $309,000. The following are the factors leading to the Net Income variance:

Net Patient Revenue Factors	**Positive / (Negative)**
Government/ Workers Compensation	($141,000)
Medi-Cal / Medi-Cal HMO	$ 66,000
Medicare / Medicare HMO	$768,000
Managed Care, Commercial, PPO	$100,000
Expenses	
Salaries & Benefits	($785,000)
Professional Fees	($127,000)
Supplies	($ 27,000)
Purchased Services	($222,000)
Other Operating Expenses	($ 67,000)

Net patient revenue exceeded budget by $618,000. Inpatient gross charges were under budget by 5.8%. Patient days were 2.1% over budget and discharges were 7.5% over budget. Outpatient gross charges exceeded budget in August by 48.3% due to the increased volume, 175% over budget, related to the Chevron incident with 7,427 total visits to the Emergency Department in August. Net revenue includes an estimate for reimbursement of claims related to the Chevron incident. Ancillary outpatient visits were 6.6% under budget and outpatient surgeries were 7.6% over budget. Total Medi-Cal days were over budget by 4% with 75% 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 219 compared to the actual in August of 103. Managed Care, Commercial and PPO combined days were also 20.9% under budget as total budgeted days were 196 compared to 155 actual days in August. The Medicare case mix index for August was 1.54 versus a budget of 1.59.

Salaries and Benefits combined were over budget $785,000 in August. Worked FTE's per adjusted average daily census was favorable to budget by 10.6% with salaries and wages at 16.7% over budget while patient days were 2.1% over budget and outpatient visits were 68.7% over budget. Salaries for August were over budget by $840,000 including additional salary costs of $230,000 related to the Chevron incident. Benefit costs were under budget in August by $55,000. Year to date salaries and benefits combined are $137,000 over budget.

Professional Fees were $127,000 over budget in August. This overage incurred is for four consultants that are not in the current budget. Some of these costs (approximately $40,000) are budgeted in salaries and wages.

Supplies were over budget in August by $27,000 due to the Chevron incident; however, year to date supplies are $1,889,000 under budget as a result of the continued underutilization of implants of and pharmaceuticals.

Purchased Services were $222,000 over budget in August as a result of costs of additional security costs due to the Chevron incident and upgrades to software for financial reporting.

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MEDICAL CENTER

Other Operating Expenses were $67,000 over budget due to additional insurance costs, dues for the District Hospital Association, and amortization of physician assistance costs, which are non-cash expenses.

Budgeted collaboration revenue and expense reductions have not been achieved resulting in a $444,000 negative effect on August and a year to date negative effect of $2,220,000

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
August 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	11,509	9,289	2,220	23.9%	8,838	Net Patient Service Revenue	80,465	85,706	(5,241)	-6.1%	81,682
2		222	(222)	-100.0%	-	Collaboration Savings		1,110	(1,110)	-100.0%	
3	68	131	(63)	-48.1%	209	Other Revenue	1,806	971	835	86.0%	852
4	11,577	9,642	1,935	20.1%	9,047	**Total Operating Revenue**	82,271	87,787	(5,516)	-6.3%	82,534
						OPERATING EXPENSES					
5	5,855	5,015	(840)	-16.7%	4,683	Salaries & Wages	43,120	42,028	(1,092)	-2.6%	42,685
6	2,640	2,695	55	2.1%	2,794	Employee Benefits	21,320	22,275	955	4.3%	23,470
7	1,000	873	(127)	-14.6%	893	Professional Fees	7,744	7,006	(738)	-10.5%	7,195
8	1,731	1,704	(27)	-1.6%	1,431	Supplies	11,862	13,751	1,889	13.7%	13,606
9	1,187	965	(222)	-23.0%	750	Purchased Services	7,199	7,734	535	6.9%	6,983
10	231	267	38	13.6%	273	Rentals & Leases	2,038	2,140	102	4.8%	2,020
11	425	370	(55)	-15.0%	349	Depreciation & Amortization	3,203	2,952	(251)	-8.5%	2,768
12		(222)	(222)			Collaboration Savings	-	(1,110)	(1,110)		
12	454	387	(67)	-17.3%	318	Other Operating Expenses	2,765	2,925	160	5.5%	2,687
13	13,523	12,055	(1,468)	-12.2%	11,491	**Total Operating Expenses**	99,251	99,702	451	0.5%	101,414
14	(1,946)	(2,413)	467	-19.3%	(2,444)	**Operating Profit / Loss**	(16,980)	(11,916)	(5,064)	42.5%	(18,880)
						NON-OPERATING REVENUES (EXPENSES)					
15	-	-	-	0.0%	-	Other Non-Operating Revenue	1,200	-	1,200	0.0%	3,885
16	1,123	1,131	(8)	0.7%	1,400	District Tax Revenue	6,957	6,499	458	-7.0%	5,707
17	20	4	16	371.7%	708	Investment Income	205	34	171	504.4%	34
18	(428)	(263)	(165)	0.0%	5	Less: Interest Expense	(2,801)	(1,955)	(846)	43.3%	(1,023)
19	715	873	(158)	-18.1%	2,113	**Total Net Non-Operating**	5,561	4,578	983	21.5%	8,603
20	(1,231)	(1,540)	309	-20.1%	(331)	**Income Profit (Loss)**	(11,419)	(7,337)	(4,082)	56%	(10,277)
						Profitability Ratios:					
21	-16.8%	-25.0%	24.1%		-27.0%	Operating Margin %	-20.6%	-13.6%	91.8%		-22.9%
22	-10.6%	-16.0%	5.3%		-3.7%	Profit Margin %	-13.9%	-8.4%	-5.5%		-12.5%

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

23	2,069	2,260	191	8.5%	2,276	SWB / APD	2,214	2,151	(63)	-2.9%	2,247
24	62.8%	64.0%			65.1%	SWB / Total Operating Expenses	64.9%	64.5%			65.2%
25	3,294	3,534	240	6.8%	3,498	Total Operating Expenses / APD	3,410	3,335	(75)	-2.2%	3,444
26	35,215	37,372	(2,157)	-5.8%	32,860	I/P Gross Charges	280,949	335,058	(54,109)	-16.1%	323,958
27	25,105	16,924	8,181	48.3%	20,951	O/P Gross Charges	159,401	160,635	(1,234)	-0.8%	158,540
28	**60,320**	**54,296**	**6,024**	**11.1%**	**53,811**	**Total Gross Charges**	**440,350**	**495,692**	**(55,342)**	**-11.2%**	**482,498**
						Payor Mix (IP and OP)					
29	43%	40%	3%		41%	Medicare %	43%	40%	3%		40%
30	5%	15%	-10%		10%	Medi-Cal %	5%	15%	-10%		14%
31	12%	12%	0%		15%	Managed Care HMO / PPO %	13%	12%	1%		11%
32	8%	9%	-1%		8%	Medicare HMO %	10%	9%	1%		9%
33	16%	9%	7%		11%	Medi-Cal HMO %	15%	9%	6%		11%
34	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
35	1%	1%	0%		1%	Worker's Comp %	1%	1%	0%		1%
36	3%	3%	0%		4%	Other Government %	3%	3%	-1%		3%
37	12%	10%	2%		10%	Self Pay /Charity %	11%	10%	1%		10%
						STATISTICS					
38	518	487	31	6.4%	463	Admissions	4,079	4,156	(77)	-1.9%	4,134
39	515	479	36	7.5%	478	Discharges	4,051	4,154	(103)	-2.5%	4,155
40	2,397	2,348	49	2.1%	2,006	Patient Days	18,571	20,209	(1,638)	-8.1%	19,770
41	77.3	75.7	1.6	2.1%	64.7	Average Daily Census (ADC)	76.1	82.8	(6.7)	-8.1%	81.4
42	4.65	4.90	0.25	5.0%	4.20	Average Length of Stay (LOS)- Accrual Based	4.58	4.86	0.28	5.8%	4.76
43	31	31			31	Days in Month	244	244			243
44	882	696	186	26.8%	783	Adjusted Discharges (AD)	6,349	6,146	204	3.3%	6,188
45	4,106	3,411	695	20.4%	3,285	Adjusted Patient Days (APD)	29,108	29,898	(790)	-2.6%	29,445
46	132	110	22	20.4%	106	Adjusted ADC (AADC)	119	123	(3)	-2.6%	121
47	76	84	(8)	-9.5%	87	Inpatient Surgeries	592	746	(154)	-20.6%	750
48	113	105	8	7.6%	125	Outpatient Surgeries	766	752	14	1.9%	789
49	**189**	**189**	-	0.0%	**212**	**Total Surgeries**	**1,358**	**1,498**	(140)	-9.3%	**1,539**

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

50	7,427	2,701	4,726	175.0%	2,780	ED Outpatient Visits	28,619	22,553	6,066	26.9%	23,676
51	3,480	3,725	(245)	-6.6%	3,854	Ancillary Outpatient Visits	25,495	29,589	(4,094)	-13.8%	29,627
52	113	105	8	7.6%	125	Outpatient Surgeries	766	752	14	1.9%	789
53	**11,020**	**6,531**	4,489	68.7%	**6,759**	**Total Outpatient Visits**	**54,880**	**52,894**	1,986	3.8%	**54,092**
54	495	420	75	17.9%	400	Emergency Room Admits	3,740	3,632	108	3.0%	3,606
55	6.7%	15.5%			14.4%	% of Total E/R Visits	13.1%	16.1%			15.2%
56	95.6%	86.2%			86.4%	% of Acute Admissions	91.7%	87.4%			87.2%
57	655	609	(46)	-7.6%	611	Worked FTE	625	639	14	2.1%	673
58	747	695	(52)	-7.5%	735	Paid FTE	727	729	2	0.3%	784
59	4.94	5.53	0.59	10.6%	5.77	Worked FTE / AADC	5.24	5.24	0.00	0.0%	5.56
60	5.64	6.32	0.68	10.7%	6.94	Paid FTE / AADC	6.09	5.99	(0.10)	-1.7%	6.47
61	2,803	2,723	80	2.9%	2,690	Net Patient Revenue / APD	2,764	2,867	(102)	-3.6%	2,774
62	14,691	15,916	(1,225)	-7.7%	16,381	I/P Charges / Patient Days	15,128	16,580	(1,451)	-8.8%	16,386
63	2,278	2,591	(313)	-12.1%	3,100	O/P Charges / Visit	2,905	3,037	(132)	-4.4%	2,931
64	1,426	1,470	44	3.0%	1,426	Salary Expense / APD	1,481	1,406	(76)	-5.4%	1,450
64	5.3	5.8	0.47	8.1%	5.4	Medicare LOS - Discharged Based	4.9	5.8	0.90	15.5%	5.3
65	1.54	1.59	0.05	3.2%	1.63	Medicare CMI	1.54	1.59	0.06	3.5%	1.6
66	3.47	3.65	0.19	5.1%	3.30	Medicare CMI Adjusted LOS	3.18	3.63	0.45	12.4%	3.34
67	4.7	4.2	(0.46)	-10.9%	4.20	Total LOS - Discharged Based	4.6	4.7	0.15	3.1%	4.72
68	1.493	1.393	(0.10)	-7.2%	1.55	Total CMI	1.480	1.469	(0.01)	-0.8%	1.50
69	3.12	3.01	(0.10)	-3.4%	2.71	Total CMI Adjusted LOS	3.11	3.23	0.12	3.8%	3.14

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

		Current Month	Dec. 31, 2011
	ASSETS		
70	Cash	3,119	13,972
71	Net Patient Accounts Receivable	28,221	19,177
72	Other Receivables	1,371	1,160
73	Inventory	2,073	2,109
73	Current Assets With Limited Use	14,271	29,847
74	Prepaid Expenses and Deposits	1,247	999
75	**TOTAL CURRENT ASSETS**	**50,302**	**67,264**
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	1,107	3,129
82	Total Property, Plant & Equipment	96,689	93,982
83	Accumulated Depreciation	-52,230	-49,200
84	**Net Property, Plant & Equipment**	**44,459**	**44,782**
85	**Intangible Assets**	**1,475**	**1,517**
86	**Total Assets**	**96,878**	**114,205**
87	Current Ratio (CA/CL)	***1.50***	***1.89***
88	Net Working Capital (CA-CL)	***16,876***	***31,750***
89	Long Term Debt Ratio (LTD/TA)	***0.63***	***0.55***
90	Long Term Debt to Capital (LTD/(LTD+TE)	***1.03***	***0.87***
91	Financial Leverage (TA/TE)	***-55.5***	***11.8***
92	Quick Ratio	**0.94**	**0.93**
93	Unrestricted Cash Days	**7**	**33**
94	Restricted Cash Days	**34**	**72**
95	Net A/R Days	**84.2**	**60.7**

		Current Month	Dec. 31, 2011
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,706	1,634
97	Accounts Payable and Accrued Expenses	11,688	16,021
98	Accrued Payroll and Related Liabilities	15,880	13,639
99	Deferred District Tax Revenue	2,880	2,880
100	Estimated Third Party Payor Settlements	1,272	1,340
101	**Total Current Liabilities**	**33,426**	**35,514**
	Other Liabilities		
102	Other Deferred Liabilities	3,722	6,105
103	Chapter 9 Bankruptcy	0	0
	Long Term Debt		
104	Notes Payable - Secured	61,251	62,067
105	Capital Leases	1,932	2,481
106	Less Current Portion LTD	-1,706	-1,634
107	**Total Long Term Debt**	**61,477**	**62,914**
108	**Total Liabilities**	**98,625**	**104,533**
	EQUITY		
109	Retained Earnings	9,672	28,400
110	Year to Date Profit / (Loss)	-11,419	-18,728
111	**Total Equity**	**-1,747**	**9,672**
112	**Total Liabilities & Equity**	**96,878**	**114,205**

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INFORMATION SYSTEMS DISASTER RECOVERY PLAN

TAB 10

GAPS and Risks -Critical

- The following are foundational HIPAA requirements that should already be in place, present immediate risk in the event of an OCR audit, and gaps need to be immediately resolved :
  1. Policy and Procedures
  2. Disaster Recovery Plans
  3. Auditing Program

GAPS and Risks -High

The following are areas of High Risk (probability, impact) and are considered Addressable (not optional) by HIPAA:

1. Password Management
2. Workstation Management
3. Termination of Access – process improvement
    a) Employee
    b) Contractors (noting default 90 day expiration in place)
    c) Physician Office Employees
4. DR Program (in addition to the Plan)
    a) Downtime procedures / documentation
    b) Business Impact Analysis (BIA)
    c) Testing
5. Encryption
    a) Laptops
    b) Outbound Email

GAPS and Risks -Medium

The following present at least a medium levels of risk. These are GAPS against established NIST guidelines and best practices, and should be closely reviewed and risk assessed by Executive Leadership and the Security Team. Some items present sufficient risk (probability, impact) that these warrant planned action items to remediate in the next year:

1. Active Directory User Audit and Clean-up
2. Vulnerability / Penetration Test
3. Technology / Infrastructure
    a) A.No data center UPS redundancy
    b) B.No DHCP server redundancy
    c) C.End of life Clarion CX50 SAN – life cycle replacement required
    d) D.Core network redesign – split up Cisco 6509's core switches
    e) E.Evaluate implementing an alternative data carrier to improve redundancy
    f) F.Acquire and implement an Intrusion Prevention System (IPS)
    g) G.Design and implement a DMZ
    h) H.Acquire and implement additional management / monitoring tools

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Security Assessment

Summary Review of Findings and Recommendations

Xerox Consulting Company
Healthcare Provider Solutions
September 17, 2012

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AGENDA

1. HIPAA Security and Meaningful Use Requirement Review
2. Key Findings
3. Additional Findings
4. GAPS and Risks – Prioritization
5. Initial Plan Discussion and Development
6. Next Steps

HIPAA Security and Meaningful Use Background

HIPAA was originally enacted in Spring, 2003.

- Contains a range of security related provisions, based on recommendations from the National Institute of Standards and Technology (NIST) that are required for government and considered industry standard for good business practices
- Providers have been obligated to meet HIPAA requirements, including the Security Rule, since the law was adopted. Compliance has been inconsistent.
- More emphasis historically on Privacy
- Meaningful Use a new enforcement / mandate point

Meaningful Use Requirement

- "Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process"
- "Protect electronic health information created or maintained by a certified EHR through the implementation of appropriate technical capabilities"

HIPAA Security and Meaningful Use
Background

Meaningful Use and HIPAA define the Risk Analysis (Assessment) as the first step in the process

Key elements of the Security Rule:

- Certain aspects are **Required** – primarily established policy and procedure, and continuity (Disaster Recover and Emergency Operations Plans)
- Other aspects are **Addressable** – not optional but providers must declare and document them to be not reasonable or appropriate, and adopt an equivalent measure if reasonable and appropriate

Key terminology:

- Vulnerability – a flaw or weakness that could result in a breach or violation of security policy
- Threat – the potential to exploit a specific vulnerability; typically these are natural, human, or environmental
- Risk – probability and impact

HIPAA Security and Meaningful Use Background

Security Risk Analysis Scope

- All potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI that is created, received, maintained, or transmitted
- Identify all organizational ePHI
- Identify and document potential threats and vulnerabilities
- Assess current security measures
  - Administrative Safeguards
  - Physical Safeguards
  - Technical Safeguards
- Determine likelihood, impact, risk level and list corrective actions to mitigate all identified risks – prioritization and the plan

HIPAA Security and Meaningful Use
Security Measures

Administrative Safeguards

- Security Management Process
  - Risk Assessment, security program, policy and procedures, reviews and audits, and sanctions
- Security Responsibilities
  - The Security Officer
- Workforce Security
  - Authorization, role based security, terminations
- Information Access Management
- Awareness and Training
- Incident Procedures
- Contingency Plans
  - Business Impact Analysis, Disaster Recovery and Emergency Mode Operations Plans
- Evaluation – ongoing reviews

HIPAA Security and Meaningful Use Security Measures

Physical Safeguards

- Facility Access Controls
  - Policies and procedures, controls and monitoring
- Workstation Use
  - Types, physical deployment and surroundings
- Workstation Security
  - Methods of access, safeguards
- Device and Media Controls
  - Receipt and removal of HW with ePHI
  - Data back-up and storage

HIPAA Security and Meaningful Use
Security Measures

Technical Safeguards

- Access Controls
  - Unique IDs, Auto Log-Offs, Access Termination, Encryption, policy and procedures
- Audit Controls
  - Capabilities and tools, ongoing regular reviews, policy and procedure
- Integrity
  - Improper alteration and destruction
- Person or Entity Authentication
  - Passwords, authentication
- Transmission Security
  - Encryption

Summary Findings

Three primary areas of findings

- Policies
- Auditing
- Disaster Recovery

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Key Findings

Policy and Procedure Deficiencies

- 56 Unique HIPAA Citations that call for policy and procedural documentation
  - Either Required or Addressable
- Policies not provided / missing (9)
  - Security Reminders
  - Business Associates (2)
  - Device and Media Controls
  - Electronic Media Re-use
  - Tracking the movement of ePHI
  - Data Back-up and Storage
  - Policy and Procedure updates
  - Documentation
- Policies needing enhancement
  - Risk Analysis and Risk Management
  - Contingency Plan / Disaster Recovery Plan (5)
  - Encryption and Decryption
  - Mechanism to Authenticate ePHI

NOTE: Existing Policies have not been reviewed since 2008 and must be reviewed and updated on a periodic basis by executive leadership.

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Key Findings

Inadequate Auditing Capabilities and Process

- HIPAA Security Provisions have multiple components that require regular auditing of systems with ePHI
- Current State
  - Policy, internal memo, and awareness of need to audit and document
  - Limited to no regular auditing going on including documentation
  - Evidence of reactive auditing that appears to be HPF specific
  - Limited use of tools, audit data archival, etc.
  - Paragon Audit Server being implemented
- Need for more formalized oversight and documentation by a DMC Security Team comprised of the primacy organizational officers – security, privacy, compliance that meets on a monthly basis

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Key Findings

Disaster Recovery Plan and Capabilities

- Core HIPAA and Meaningful Use requirement
- Current State
  - Out of date contact and system recovery documentation
  - Disaster Recovery Plan lacking several key components
    - Organization and Contact Information (more than vendors)
    - Response – triggers, activation, escalation
    - Additional content – media
    - Templates / Detailed system documentation
    - Emergency Mode Operations Plan
      - Procedures to maintain and sustain Operations during the Recovery Phase
  - Lacking other key elements of a DR program
    - Business Impact Analysis (BIA)
      - Recovery Time and Recovery Point Objectives
    - Testing Program

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Additional Findings

The following areas demonstrated **good compliance** with HIPAA Security Standards:

- Security Awareness and Education
  - New Employee Orientation (NEO) and Healthstream
- Initial provisioning process – approvals, documentation, process
  - NOTE: excluded role based security
- The overall physical environment and controls (safeguards)
- Several good security practices in place
  - Current VPN and remote access technology and security (ASA5520s)
  - Anti-virus
  - Web filtering
  - Equipment and media disposal

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Additional Findings

The following areas were found to have **gaps in compliance** with HIPAA Security Standards and require remediation activities to ensure full compliance:

- Termination Process Inadequate and Incomplete
  - Employees (12 of 63 not terminated)
  - Contractors (default set to expire after 90 days)
  - Physician Office Employees (no notification or de-activation process or practice)
- Inconsistencies and bad practices
  - Password Management
    - Strength, characters, expiration, re-use, etc..
  - Device controls
    - Screen savers, auto-logoff, workstation locks, access to USB drives, etc..
    - Nursing units taping paper on monitor and flipping over screen as a "paper screensaver"
    - Screen protectors not on all devices (best practice, not required)
- Need for new and improved downtime (procedures) documentation
- Change control process informal
- Need for improved clarity and understanding of roles and responsibilities between Security, Privacy, and Compliance Officers

Additional Findings

The following areas were found to have **gaps in compliance** with HIPAA Security Standards and require remediation activities to ensure full compliance (continued):

- Technology / Infrastructure
  - Active Directory
    - Significant number of active accounts including training and S_xxxx accounts
    - Significant number of active accounts with no activity in last 30 days (507)
    - Opportunity to better leverage group policies
  - Lack of redundancy presents risk to ongoing system availability and performance
    - Single data center UPS
    - DHCP server
    - Data carrier
  - Server operating system life cycle management (patching, upgrades) lacking
    - Some Windows 2000 Servers – retired
    - Many Windows 2003 Servers – close to final retirement / end of life
  - End of life SAN – Clarion CX500
  - No Laptop Encryption
  - No outbound email encryption capabilities
  - No Intrusion Detection / Protection capabilities
  - No DMZ in place – should consider designing one to meet future demand
  - Limited local monitoring tools – availability, trouble-shooting

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Additional Findings

The following areas were found to have **gaps in compliance** with HIPAA Security Standards and require remediation activities to ensure full compliance (continued):

- Applications risk findings of note
  - Paragon
    - Complex password requirement (6 characters)
    - Follow-up needed to clarify and improve other access configurations (incomplete risk assessment results)
      - New user change password, forced password expiration, locking session after period of inactivity, etc.
  - HPF
    - 4 character password that does not expire
  - Other Applications (Lab, Oncology, Quality)
    - Follow-up also needed to clarify and improve other access configurations (incomplete risk assessment results)
      - Use of complex passwords, password expiration, forced password expiration, locking session after period of inactivity, new user change password, etc.

Threat Assessment

17 DMC responses to the Threat Assessment Survey. Summary of results:

High
- Earthquake
- Long-term Power Failure
- Major Internal Network Failure
- Core Systems Hardware Failure
- Water Leak – Data Center
- Loss of Telecommunications
- HVAC Failure
- Major Database Corruption

Medium
- Loss of Internet / Data Line Services
- Large External Chemical Spill
- Data Center Outage
- Bomb Threat
- Fire UPS / Generator Loss
- Flood / Flash Flood
- Human – Intentional
- Human Error – Unintentional
- Civil Disturbance

Low
- Work Stoppage / Strike
- Winter Storm
- Hurricane / Tropical Storm
- Severe Thunderstorms
- Tornado

Observations:
- Limited surprises in results
  - Human errors – intentional and unintentional are one of the most common security threats / source of breaches
  - DMC has redundant HVAC (High) but no redundancy with UPS (Medium)

Recommendation:
- Executive leadership and the Security Team should review results and determine if any additional measures can and should be taken to reduce the security risk.

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GAPS and Risks
Critical

The following are foundational HIPAA requirements that should already be in place, present immediate risk in the event of an OCR audit, and gaps need to be immediately resolved :

1. Policy and Procedures
2. Disaster Recovery Plans
3. Auditing Program

GAPS and Risks
High

The following are areas of High Risk (probability, impact) and are considered Addressable (not optional) by HIPAA:

1. Password Management
2. Workstation Management
3. Termination of Access – process improvement
   a) Employee
   b) Contractors (noting default 90 day expiration in place)
   c) Physician Office Employees
4. DR Program (in addition to the Plan)
   a) Downtime procedures / documentation
   b) Business Impact Analysis (BIA)
   c) Testing
5. Encryption
   a) Laptops
   b) Outbound Email

GAPS and Risks

Medium

The following present at least a medium levels of risk. These are GAPS against established NIST guidelines and best practices, and should be closely reviewed and risk assessed by Executive Leadership and the Security Team. Some items present sufficient risk (probability, impact) that these warrant planned action items to remediate in the next year:

1. Active Directory User Audit and Clean-up
2. Vulnerability / Penetration Test
3. Technology / Infrastructure
   - A. No data center UPS redundancy
   - B. No DHCP server redundancy
   - C. End of life Clarion CX50 SAN – life cycle replacement required
   - D. Core network redesign – split up Cisco 6509's core switches
   - E. Evaluate implementing an alternative data carrier to improve redundancy
   - F. Acquire and implement an Intrusion Prevention System (IPS)
   - G. Design and implement a DMZ
   - H. Acquire and implement additional management / monitoring tools

Action Plan Development

"Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and **implement security updates as necessary and correct identified security deficiencies as part of its risk management process"**

What – Critical, High, and Medium GAPS

Who – Responsible Party

When – Timeline

How – Requirements

DMC Executive Leadership and the Security Team should review the draft Remediation (Action) Plan, modify and accept it as deemed risk appropriate, and monitor progress including documented plan and executive review updates.


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DOCTORS MEDICAL CENTER

Manual: Information Systems	**Sub Folder:**
Personnel Covered: All HIS users	**Reviewed: September, 2012** **Revised: 10/05, 09/12**
Subject: Disaster Recovery Plan	**Authorization:**
Effective Date: September, 2012 **Expiration Date:**	**Page 0 of 32**

Purpose: This policy reflects Doctors Medical Center commitment to implement a disaster recovery plan to recover its information systems if they are impacted by a disaster

Policy: *"Establish (and implement as needed) procedures to restore any loss of data." In accordance with 45 CFR 164.308(a)(7)(ii)(B).*

Definition/Overview: Doctors Medical Center must create and document a disaster recovery plan to recover its information systems if they are impacted by a disaster.

Procedure: As outlined below

References: Wayne Tenney
Phyllis Moore

Responsible for review/updating (Title/Dept)	Title: Security Officer/ System Admin Dept: Information Systems

Table of Contents

Information Technology Statement of Intent

Information systems are vital to Doctors Medical Center mission/business processes; therefore, it is critical that services provided by Doctors Medical Center are able to operate effectively without excessive interruption. This Disaster Recovery Plan (DRP) establishes comprehensive procedures to recover Doctors Medical Center quickly and effectively following a service disruption.

This document delineates our policies and procedures for technology disaster recovery and summarizes our recommended procedures. In the event of an actual emergency situation, modifications to this document may be made to ensure physical safety of our people, our systems, and our data.

Our mission is to ensure information system uptime, data integrity and availability, and business continuity.

Policy Statement

Corporate management has approved the following policy statement:

- The company shall develop a comprehensive IT disaster recovery plan.
- A formal risk assessment shall be undertaken to determine the requirements for the disaster recovery plan.
- The disaster recovery plan should cover all essential and critical infrastructure elements, systems and networks, in accordance with key business activities.
- The disaster recovery plan should be periodically tested in a simulated environment to ensure that it can be implemented in emergency situations and that the management and staff understand how it is to be executed.
- All staff must be made aware of the disaster recovery plan and their own respective roles.
- The disaster recovery plan is to be kept up to date to take into account changing circumstances.

Objectives

The principal objective of the disaster recovery program is to develop, test and document a well-structured and easily understood plan which will help the company recover as quickly and effectively as possible from an unforeseen disaster or emergency which interrupts information systems and business operations in accordance with 45 CFR 164.308(a)(7)(ii)(B). Objectives include the following:

- The need to ensure that all employees fully understand their duties in implementing such a plan
- The need to ensure that operational policies are adhered to within all planned activities
- The need to ensure that proposed contingency arrangements are cost-effective
- The need to consider implications on other company sites
- Disaster recovery capabilities as applicable to key customers, vendors and others

IT Department Notification Calling Tree

- Person reporting
- IT Director
- Application manager
- Technical Manager
- Network Engineer
- System Administrator
- System Technician

1 Plan Overview

1.1 Plan Updating

It is necessary for the DRP updating process to be properly structured and controlled. Whenever changes are made to the plan they are to be fully tested and appropriate amendments should be made to the training materials. This will involve the use of formalized change control procedures under the control of the IT Director.

1.2 Plan Documentation Storage

Copies of this Plan, CD, and hard copies will be stored in the fire vault located in the purchasing cage. The IT director, network engineer, and system technicians will be issued a CD and hard copy of this plan. A master protected copy will be stored in the Datacenter share established for this purpose.

1.3 Backup Strategy

Key business processes and the agreed backup strategy for each are listed below. The strategy chosen for each application system is listed below.

KEY BUSINESS PROCESS	BACKUP STRATEGY
Domain Controller	Backup Exec
DHCP Server	Backup Exec
DNS Server	Backup Exec
Antivirus Server	Backup Exec
TSM Server	TSM
Backup Exec Server	
Exchange Server	Backup Exec
Horizon Patient Folder (six physical servers)	TSM
Paragon (nine physical servers)	TSM
QDX Cloverleaf	TSM
Horizon Lab	TSM
Horizon Blood Bank	TSM
Horizon Medical Imaging	TSM
Radware	TSM
Citrix Farm	Backup Exec
Midas	TSM
Mosaiq	TSM
Electronic Commerce	TSM
Pathways Compliance Advisor	TSM
Pathways Contract Management	TSM
Shared Drives – Personal Network	Backup Exec

1.4 Risk Management

There are many potential disruptive threats which can occur at any time and affect the normal business process. We have considered a wide range of potential threats and the results of our deliberations are included in this section. Each potential environmental disaster or emergency situation has been examined. The focus here is on the level of disruption which could arise from each type of disaster.

Potential disasters have been assessed as follows:

Boston Medical Center
Threat Assessment Survey Results
As of 05/27/12

Threat	Likelihood	Impact	Total	Ranking	Primary Impact	Secondary Impact	Control Options	Cost Benefit	Action Taken
Earthquake	6.94	7.31	50.78	High	Loss of Availability		Follow directions of Incident Command		
Long Term Power Failure	3.71	7.08	26.19	High	Loss of Availability		Follow directions of Incident Command		
Major Internal Network Failure	3.65	6.61	24.66	High	Loss of Availability	Loss of Integrity	Invest in additional management tools to monitor performance; increase rigor of change control		
Core System Hardware Failure	3.47	6.88	23.87	High	Loss of Availability		Invest in additional management tools to monitor performance; increase rigor of change control		
Water Leak - Data Center	3.65	6.25	22.81	High	Loss of Availability				
Loss of Telecommunications	3.76	5.00	18.80	High	Loss of Availability				
HVAC Failure - Data Center	3.35	5.69	19.06	High	Loss of Availability		Ensure proper preventive maintenance and monitoring of HVAC performance		
Major Database Corruption	2.75	6.88	18.92	High	Loss of Integrity	Loss of Availability	Database monitoring and management tools and practices; restore from incremental backup if database corrupted		
Loss of Internet/Data Line Services	3.12	5.31	16.57	Med	Loss of Availability		Invest in a redundant data network connection with a second carrier		
Large External Chemical Spill	5.62	2.75	16.01	Med	Loss of Availability		Follow directions of Incident Command	Low cost option feasible	
Data Center Outage	2.50	6.27	15.68	Med	Loss of Availability		Acquire a back-up data center UPS unit		
Bomb Threat- Data Center	3.53	4.25	15.00	Med	Loss of Availability				
Fire UPS / Generator Loss	2.50	5.79	14.48	Med	Loss of Availability		Acquire a back-up data center UPS unit		
Flood / Flash Flood	2.25	5.75	12.89	Med	Loss of Availability				
Human - Intentional	3.18	3.88	12.34	Med	Loss of Confidentiality	Loss of Integrity	Acquire and implement Intrusion Detection and Prevention tools (IDS/IPS)		
Human Error - Unintentional	3.76	3.26	12.03	Med	Loss of Availability	Loss of Integrity	Diligent change control process		
Civil Disturbance	4.29	2.75	11.80	Med	Loss of Availability	Loss of Confidentiality	Contract with security company or local police for additional staff.	Low cost option feasible	
Work Stoppage / Strikes	4.00	2.07	8.28	Low	Loss of Availability	Loss of Confidentiality	Contract with security company or local police for additional staff.	Low cost option feasible	
Winter Storm	2.88	2.31	6.65	Low	Loss of Availability				
Hurricanes / Tropical Storms	1.47	4.31	6.34	Low	Loss of Availability				
Severe Thunderstorms	1.76	3.44	6.02	Low	Loss of Availability				
Tornado	1.47	3.75	5.51	Low	Loss of Availability	Loss of Integrity			

Loss of Availability
Loss of Integrity
Loss of Confidentiality

2 Emergency Response

2.1 Alert, escalation and plan invocation

2.1.1 Plan Triggering Events

Key trigger issues at headquarters that would lead to activation of the DRP are:

- Loss of network connectivity
- Loss of patient critical application whereby a restore becomes necessary
- Total loss of power
- Flooding of the premises
- Loss of the building

The following persons or roles may activate the DRP if one or more of these criteria are met:

- Chief Executive Officer
- Chief Operations Officer
- Chief Financial Officer
- Information Systems Director
- Information Systems Manager

2.1.2 Activation of Disaster Response Team

The Activation and Notification Phase defines initial actions taken once a disruption has been detected or appears to be imminent. This phase includes activities to notify recovery personnel, conduct an outage assessment, and activate the DRP. At the completion of the Activation and Notification Phase, DRT staff will be prepared to perform recovery measures. Responsibilities of the DRT are to:

- Respond immediately to a potential disaster and call emergency services;
- Assess the extent of the disaster and its impact on the business, data center, etc.;
- Decide which elements of the DR Plan should be activated;
- Establish and manage disaster recovery team to maintain vital services and return to normal operation;
- Ensure employees are notified and allocate responsibilities and activities as required.

2.2 Disaster Recovery Team

The team will be contacted and assembled by the emergency response team. The team's responsibilities include:

- Outage Assessment
- Decision to relocate/ co-locate based on threat level
- Establish facilities for an emergency level of service within 72 hours
- Restore patient critical services within 96 hours of an incident;
- Coordinate activities with disaster recovery team, first responders, etc.

2.2.1 Outage Assessment

Following notification, a thorough outage assessment is necessary to determine the extent of the disruption, any damage, and expected recovery time. This outage assessment is conducted by a member(s) of the DRT. Assessment results are provided to the DRT Coordinator to assist in the coordination of the recovery.

The assessment should include the cause of the outage; identification of potential for additional disruption or damage; assessment of affected physical area(s); and determination of the physical infrastructure status, IS equipment functionality, and inventory. Procedures should include notation of items that will need to be replaced and estimated time to restore service to normal operations.

2.3 Emergency Alert, Escalation and DRP Activation

This policy and procedure has been established to ensure that in the event of a disaster or crisis, personnel will have a clear understanding of who should be contacted. Procedures have been addressed to ensure that communications can be quickly established while activating disaster recovery.

The DR plan will rely principally on key members of management and staff who will provide the technical and management skills necessary to achieve a smooth recovery. Suppliers of critical goods and services will continue to support recovery of business operations as DMC returns to normal operating mode.

2.3.1 Emergency Alert

The person discovering the incident calls a member of the Emergency Response Team in the order listed:

1. IT Director
2. Chief Financial Officer
3. Chief Operations Officer
4. Chief Executive Officer

The Disaster Response Team (DRT) is responsible for activating the DRP for disasters identified in this plan, as well as in the event of any other occurrence that affects the company's capability to perform normally. The DRT is made up of the IT director, Network Engineer, System Administrator, and a System Technician.

One of the tasks during the early stages of the emergency is to notify the Disaster Recovery Team (DRT) that an emergency has occurred. The notification will request DRT members to assemble at the site of the problem and will involve sufficient information to have this request effectively communicated.

2.3.2 DR Procedures for Management

Members of the management team will be responsible for providing a conduit for anyone in their department to the DRT.

2.3.3 Contact with Employees

Managers will serve as the focal points for their departments, while designated employees will call other employees to discuss the crisis/disaster and the company's immediate plans. Employees who cannot reach staff on their call list are advised to call the staff member's emergency contact to relay information on the disaster.

2.3.4 Backup Staff

If a manager or staff member designated to contact other staff members is unavailable or incapacitated, the designated backup staff member will perform notification duties.

2.3.5 Updates

Updates will be provided by the IT Director as appropriate or every 24hrs, whichever is sooner.

2.3.7 Alternate Recovery Facilities / Cold Site

If necessary, a cold site will be located on the first floor directly above the MPOE or at the Town Center. Any cold site will require an appropriate HVAC system in addition to a connection to IDF closets.

3 Emergency Mode Operations Plan

3.1. Cold Site

In the event the primary site is compromised an alternate site will be instituted. This location resides directly above the current MPOE. HVAC will need to be augmented by portable air conditioning units. LAN lines will need to be extended to each IDF location. Should the facility not present a suitable location, a trailer shall be leased with appropriate means to host the appropriate equipment needed to regain critical operations.

3.2 Helpdesk Operations

The helpdesk will initially be relocated to ACR (code green default) until such time as patient critical systems are restored. The helpdesk will then be relocated to a conference room where the command center for the code green exists.

3.3 Technical Operations

Technical Operations will be based in the PT GYM. Available equipment will be assessed and repaired in this location. Assets will also be staged for use throughout the facility during time of need.

3.4 Analyst Operations

Analysts will be based in the PT GYM.

3.5 Priority of System Restore

The following activities occur during recovery:

- Identify recovery location (if not at original location);
- Identify required resources to perform recovery procedures (including system vendor);
- Retrieve backup and system installation media;
- Recover hardware and operating system (if required); and
- Recover system from backup and system installation media.

Once an assessment has taken place and the necessary resources are accounted for, the recovery procedure should progress on the order outlined below to establish a fundamental framework and connectivity in order of importance. It is mandatory the critical priority systems are restored in the order outlined below.

Critical Priority

- Cisco 2800 series router x3 (Towne Center, Summit, primary)
- Cisco 6500 series core switch
- Cisco 3600 series switch (IDF)
- Cisco ASA firewall
- Websense Appliance
- Domain Controller

- DNS server
- DHCP server
- Antivirus Server
- CX-500 SAN (or equivalent for TSM restore)
- TSM server
- Backup Exec server (SDLT)
- Exchange Server
- Centerra – HPF/HMI storage
- Horizon Patient Folder (six physical servers)
    - Diskextender
    - Database
    - Fax and Web
    - VMware
    - ILE
    - ANSI
- CX4
- Citrix Farm (two physical servers)
    - License server/ Application server
    - Web server/ Application server
- GE/Muse for Cathlab
- Paragon (six physical servers + three processing pc's)
    - Physical Servers
        - Database
        - Ntier
        - Reporting
        - Web
        - Knowledgelake
        - Zetafax
    - Processing PC's
        - Pharmacy
        - Closing
        - Rad
- ASCOM

High priority

- Exitwriter workstation
- QDX Cloverleaf
- Horizon Lab
- Horizon Blood Bank
- Horizon Medical Imaging
- Radware

Standard Priority

- Citrix Farm
- Wireless infrastructure - appliances
- Mailgate
- Websense
- Midas
- Mosaiq
- Electronic Commerce
- Pathways Compliance Advisor
- Pathways Contract Management

4 Recovery Procedures

4.1 Network and Server

The following procedures are provided for recovery at the original or established alternate location. Recovery procedures are outlined per team and should be executed in the sequence presented to maintain an efficient recovery effort.

All network equipment configurations can be found in Appendix C. Network and Server topology diagrams can be found in Appendix D.

4.2 Applications

A record of all physical and logical disks along with all installed applications and service packs can be found in Appendix E. Alternately, these may be restored from the group share or on the backup disk stored in the fire safe.

4.3 Validation Data Testing

Validation data testing is the process of testing and validating recovered data to ensure that data files or databases have been recovered completely. While the list for validation is too broad for this document, a number of basic steps will help ensure nothing is missed from a restoration perspective. The following procedures will be used to determine that the recovered data is complete and current to the last available backup:

- Verify database transaction logs show last written transaction
- Verify application displays correct information from point of last backup
- Reconcile the census
- Balance the charges, payments and adjustments to the host system
- Verify interface connectivity

4.4 Validation Functionality Testing

Validation functionality testing is the process of verifying that the functionality of patient critical systems have been tested, and the system is ready to return to normal operations. IT analysts, super users and department managers should be actively involved in this step.

4.5 Recovery Declaration

Upon successfully completing testing and validation, the DRT will formally declare recovery efforts complete, and that the patient critical system is in normal operations.

5 Offsite Data Storage

It is important that all backup and installation media used during recovery be returned to the offsite data storage location. The following procedures should be followed to return backup and installation media to its offsite data storage location.

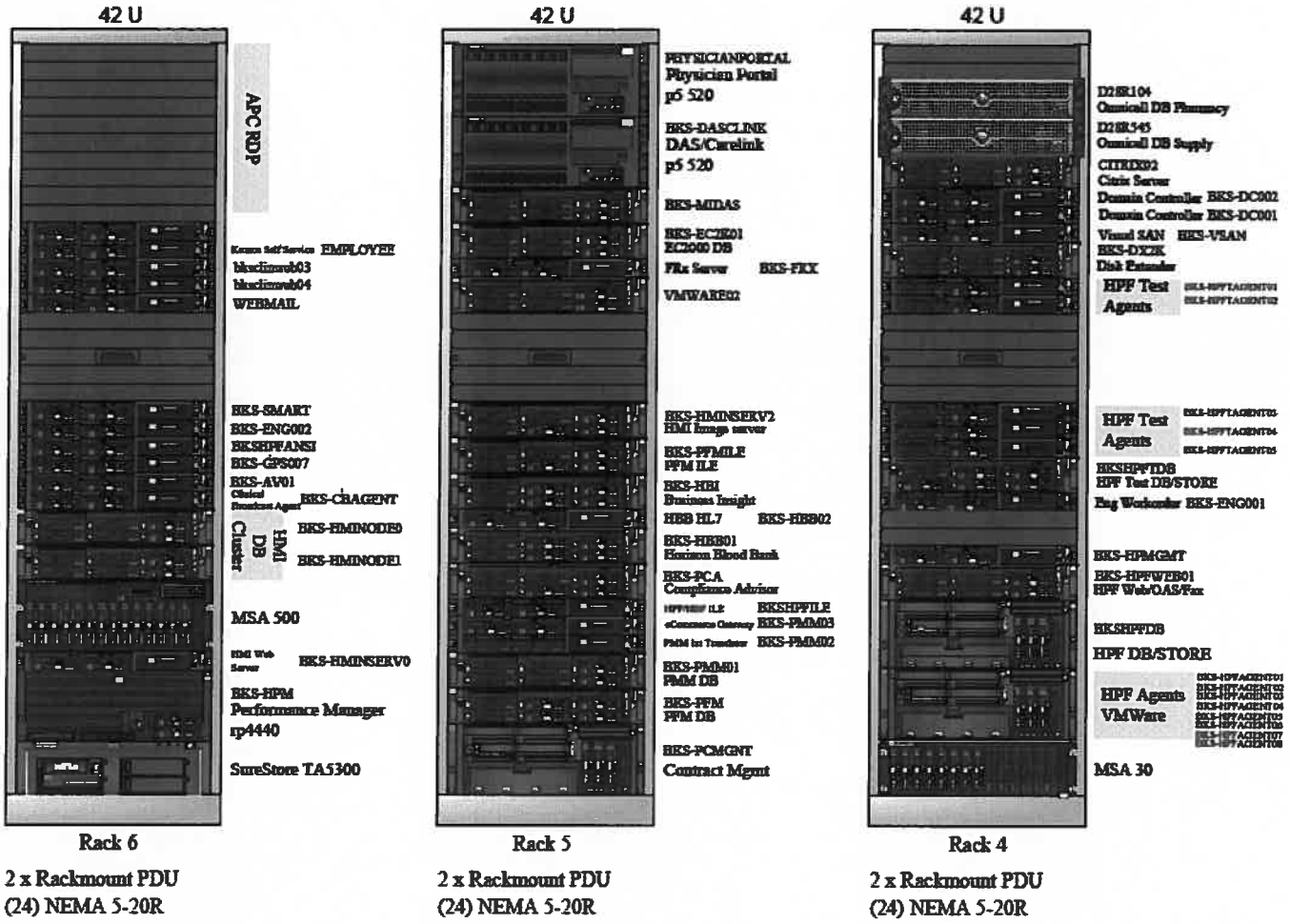
6 DRP Exercising

Disaster recovery plan exercises are an essential part of the plan development process. In a DRP exercise no one passes or fails; everyone who participates learns from exercises – what needs to be improved, and how the improvements can be implemented. Plan exercising ensures that emergency teams are familiar with their assignments and, more importantly, are confident in their capabilities.

Successful DR plans launch into action smoothly and effectively when they are needed. This will only happen if everyone with a role to play in the plan has rehearsed the role one or more times. The plan should also be validated by simulating the circumstances within which it has to work and seeing what happens.

DRP exercises shall take place at least once a year. This will include a meeting of the DRT and SME's from their respective departments to validate backup and recovery efforts. The restore will be preformed and benchmarked to ensure RTO/RTA numbers are valid.

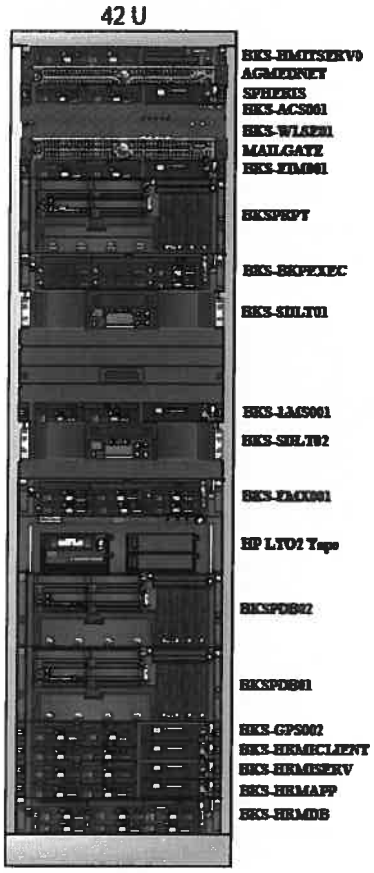
Appendix A – Server Rack Configuration



Centera

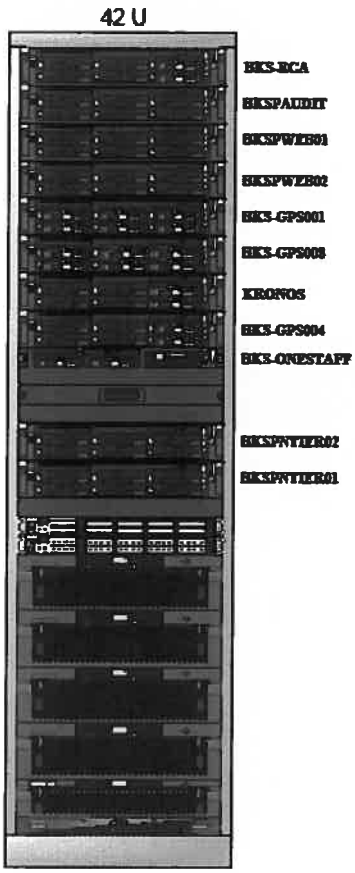
Rack 9

2 x 30 Amp Outlets



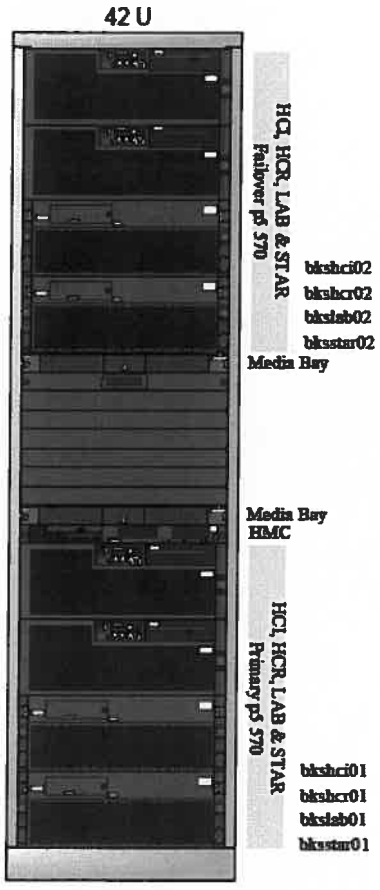
Rack 8

2 x Rackmount PDU
(24) NEMA 5-20R



Rack 7

2 x Rackmount PDU
(24) NEMA 5-20R

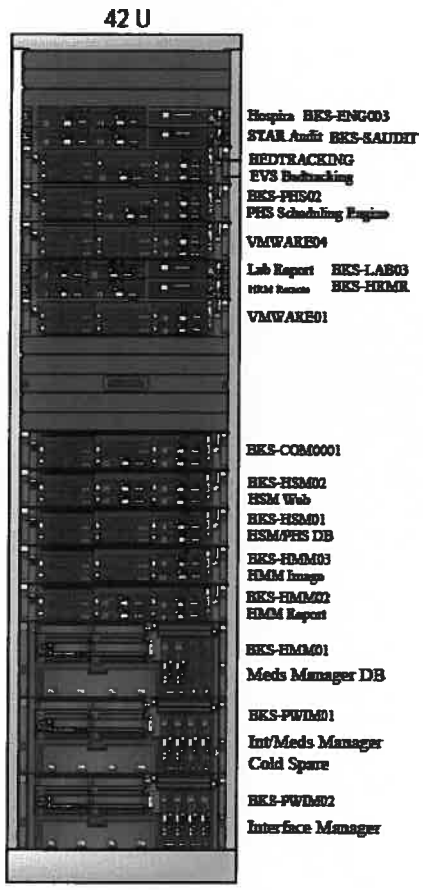


Rack 3

2 x Rackmount PDU
(21) IEC 320 C13
(6) IEC 320 C19

Rack 2

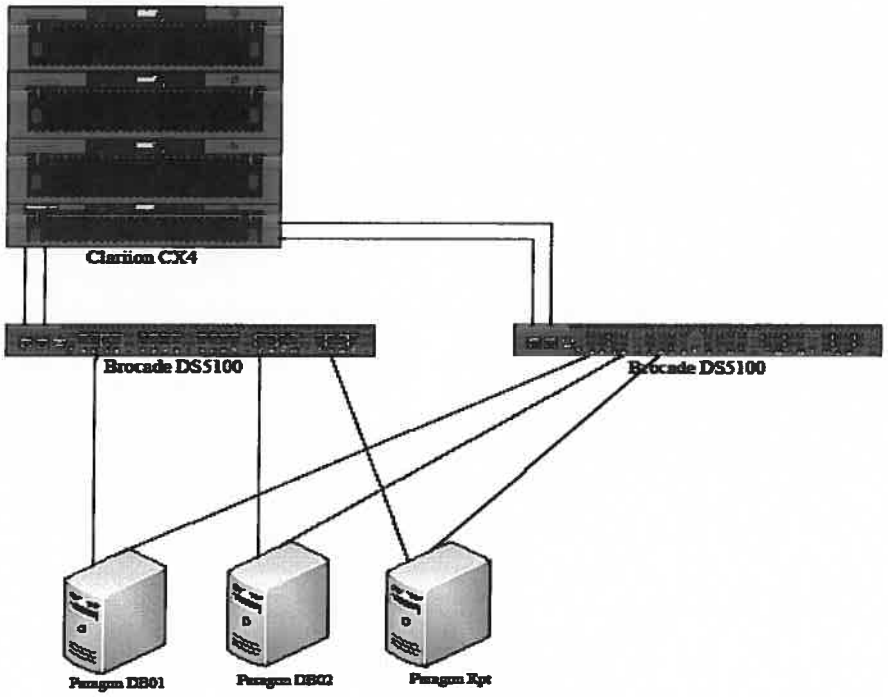
2 x Rackmount PDU
(21) IEC 320 C13
(6) IEC 320 C19

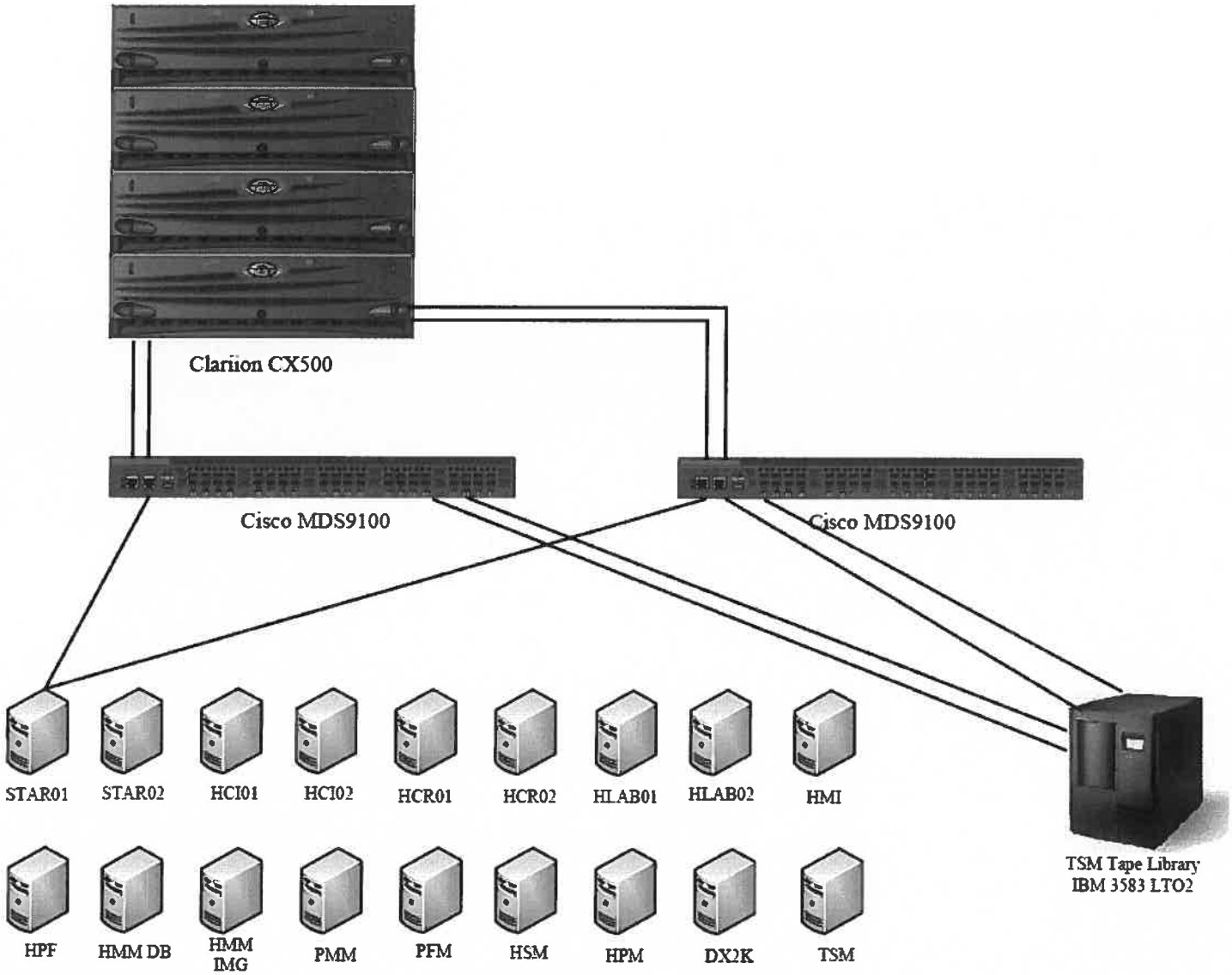


Rack 1

2 x Rackmount PDU
(24) NEMA 5-20R

Appendix B – SAN Topology




Clariion CX500
Cisco MDS9100
Cisco MDS9100
STAR01
STAR02
HCI01
HCI02
HCR01
HCR02
HLAB01
HLAB02
HMI
TSM Tape Library
IBM 3583 LTO2
HPF
HMM DB
HMM IMG
PMM
PFM
HSM
HPM
DX2K
TSM

Appendix C – Network Configuration Profiles

Information removed

Appendix D – Server Restore Procedures

Paragon

Paragon systems are covered under Mckesson Premium SystemCare. The Paragon database server is running Microsoft Cluster services between node BKSPDB01 and BKSPDB02. The DB instance name is "BKSPDBSQL". The paragon database is backed up nightly to TSM.

Name		Role
BKSPDB01		Paragon DB Node 1
BKSPDB02		Paragon DB Node 2
BKSPNTIER01		NTIER Server
WEBSTATION		Webstation Server
BKSPPROCCL		Closing PC
BKSPPROCPH		Pharmacy Proc PC
BKSPROCRAD		RAD Proc PC

Paragon DB Server

Paragon Version:	11.0.314
Hostname:	BKSPDBSQL
Operating System:	Windows Server 2008 R2 Enterprise (64-bit)
Patch Level:	SP1
Machine:	HP Proliant DL580 G5
Processors:	(4) 2.40 GHz
Memory:	32.0GB
Filesystem:	C: 136GB (OS); D:132GB (Log Files); E: 132GB (Temp Log); F:398GB (Data): G:130GB (TempDB)

Paragon NTier Server

Hostname:	BKSPNTER01
Operating System:	Windows Server 2008 R2 Standard (64-bit)
Patch Level:	SP1
Machine:	HP Proliant DL380 G6
Processors:	(2) 2.53 GHz
Memory:	24.0GB
Filesystem:	C: 136GB

Paragon WebStation Server

Hostname:	Webstation
Operating System:	Windows Server 2008 R2 Standard (64-bit)
Patch Level:	SP1
Machine:	HP Proliant DL380 G6
Processors:	(2) 2.53 GHz
Memory:	24.0GB
Filesystem:	C: 136GB (OS)

Paragon Processor Workstations

Hostname:	BKSPPROCCL; BKSPROCPH, BKSPPROCRAD
Operating System:	Windows XP Professional
Patch Level:	SP3
Machine:	Dell Optiplex 960
Processors:	(1)Dual core 3.0 GHz
Memory:	2.0GB
Filesystem:	C: 232GB

Recovery Procedure:
In the event of a total disaster, DMC would have to acquire comparable HP/Dell Servers and workstations as noted above and stage the Paragon systems according to the noted specifications outlined here. A copy of the install media for Windows OS and Paragon Applications will be stored in the fire safe located in DMC warehouse. Once the Paragon DB server staging is complete, then restore the paragon DB from TSM backups. Then follow the Paragon install documentation for loading NTier, Webstation and Processor workstations.

Horizon Patient Folder

Node Name		Role
bkshpfdb		Database Server
bks-hpfagent01		Agent Server
bks-hpfagent02		Agent Server
bks-hpfagent03		Agent Server
bks-hpfagent04		Agent Server
bks-hpfagent05		Agent Server
bks-hpfagent06		Agent Server
bks-hpfagent07		Agent Server
bks-hpfagent08		Agent Server
bks-hpfweb01		Web/Fax Server
bks-dx2k		Legato DiskXtender Server
bkshpfile		ILE Server

HPF Database Server:

Database:	MS SQL Server 2005 Enterprise Edition
Patch Level:	SP2
App Version:	13.0
Patch Level:	N/A
Hostname:	bkshpfdb
Operating System:	Windows Server 2003 Enterprise Edition
Patch Level:	SP2
Machine:	HP ProLiant DL580 G2
CPU:	(4) 3.0 GHz
Memory:	16GB
Filesystem:	C: 72GB, D: 80GB, E: 100GB, F: 10GB, G: 100 GB, H: 280GB, I: 30GB

Recovery Procedure:
The databases backed up to the E:\ drive and transaction logs to I:\ drive. The server is backed up daily using TSM. If there is a total disaster obtain a comparable HP ProLiant server with enough storage space. A copy of Windows Server 2003 Enterprise and MS SQL Server 2005 Enterprise install media is stored in the fire safe located in DMC Warehouse. Install Windows Server 2003 Enterprise SP2 and setup the file system according to the layout above. Contact McKesson for SQL Server 2005 installation instructions.

HPF Agent Servers:

Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1

Machine:	VMware Virtual Server
CPU:	N/A
Memory:	2GB, 3.6GB
Filesystem:	C: 8GB, D: 24GB

Recovery Procedure:
HPF Agent Servers are setup in VMware environment with all eight Agent Servers with the above configuration. The Agent Servers' Windows Registry configuration files are stored in "D:\ global\Software\Hpf10.1 RegIni Files" directory on the Database server.

HPF Web/Fax Server:

Hostname:	bks-hpfweb01
Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1
Machine:	HP ProLiant DL380 G4
CPU:	(2) 3.4 GHz
Memory:	3GB
Filesystem:	C: 10GB, D: 26GB

Recovery Procedure:
The server is backed up daily using TSM. If there is a total disaster obtain a comparable HP ProLiant server with enough storage space. A copy of Windows Server 2003 Standard install media is stored in the fire safe located in DMC Warehouse. Install Windows Server 2003 Standard SP1 and setup the file system according to the layout above. Contact McKesson for HPF Web and Fax server installation media and setup.

HPF DiskXtender Server:

Hostname:	bks-dx2k
Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1
Machine:	HP ProLiant DL380 G4
CPU:	(2) 3.4 GHz
Memory:	4GB
Filesystem:	C: 10GB, D: 60GB, E: 75GB, F: 200GB

Recovery Procedure:
The server is backed up daily using TSM. If there is a total disaster obtain a comparable HP ProLiant server with enough storage space. A copy of Windows Server 2003 Standard and Legato DiskXtender Server install media is stored in the fire safe located in DMC Warehouse. Install Windows Server 2003 Standard SP1 and setup the file system according to the layout above. Contact McKesson for DiskXtender server installation and setup.

HPF ILE Server:

Hostname:	bkshpfile
Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1
Machine:	HP ProLiant DL360 G4
CPU:	(2) 3.4 GHz
Memory:	2GB
Filesystem:	C: 12GB, D: 56GB

Recovery Procedure:
The server is backed up daily using TSM. If there is a total disaster obtain a comparable HP ProLiant server. A copy of Windows Server 2003 Standard install media is stored in the fire safe located in DMC Warehouse. Install Windows Server 2003 Standard SP1 and setup the file system according to the layout above. Contact McKesson for ILE server installation and setup.

Horizon Medical Imaging:

Node Name	IP Address	Role
bks-hminode0	Information removed for privacy	Database Active Node
bks-hminode1	Information removed for privacy	Database Passive Node
bks-hminserv2		Image Server
bks-hmiwserv0		Web Server

HMI Database Server:

Database:	Oracle 9i
Patch Level:	N/A
Hostname:	bks-dbcluster
Operating System:	Windows Server 2003 Enterprise Edition
Patch Level:	SP1
Machine:	HP ProLiant DL380 G4
CPU:	(2) 3.6 GHz
Memory:	4GB
Filesystem:	C: 20GB, E: 50GB, I: 136GB, K: 70GB, L: 70GB, M: 70GB, Q: 1GB

HMI Image Server:

App Version:	11.0.08
Patch Level:	N/A
Hostname:	bks-hminserv2
Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1
Machine:	HP ProLiant DL360 G4
CPU:	(2) 3.2 GHz
Memory:	2GB
Filesystem:	C: 20GB, E: 975GB, F: 275GB, G: 100GB, I: 50GB

HMI Web Server:

Hostname:	bks-hmiwserv0
Operating System:	Windows Server 2003 Standard Edition
Patch Level:	SP1
Machine:	HP ProLiant DL360 G4
CPU:	(2) 3.2 GHz
Memory:	2GB
Filesystem:	C: 20GB, I: 50GB

Recovery Procedure:
In the event of a total disaster obtain comparable HP ProLiant server hardware with appropriate storage. Stage the servers with appropriate version of Operating System and setup the file system of the servers according to the layout above. Contact McKesson Medical Imaging support for Database and Application installation and configuration.

Appendix E – IP Allocation

Information removed for privacy

Appendix F – Vendor Website Credentials

Information removed for privacy

Appendix G – Current Server State

Information removed for privacy

Appendix H – Glossary of Terms

DRP – Disaster Recovery Plan
DRT – Disaster Recovery Team
ERT – Emergency Response Team
TSM – Tivoli Storage Manager
HPF – Horizon Patient Folder
HMI – Horizon Medical Imaging
HLAB – Horizon Lab
HBB – Horizon Blood Bank
ILE – Image Link Engine
SAN – Storage Area Network
WAN – Wide Area Network
LAN – Local Area Network
RTO – Recovery Time Objective
RTA – Recovery Time Achievable
SME – Subject Matter Expert
MPOE – Minimum Point of Entry

Appendix I – Decision Tracking Forms

Damage Assessment Form

Key Business Process Affected	Description Of Problem	Extent Of Damage

Management of DR Activities Form

- During the disaster recovery process all activities will be determined using a standard structure;
- Where practical, this plan will need to be updated on a regular basis throughout the disaster recovery period;
- All actions that occur during this phase will need to be recorded.

Activity Name:
Reference Number:
Brief Description:

Commencement Date/Time	Completion Date/Time	Resources Involved	In Charge

Disaster Recovery Event Recording Form

- All key events that occur during the disaster recovery phase must be recorded.
- An event log shall be maintained by the disaster recovery team leader.
- This event log should be started at the commencement of the emergency and a copy of the log passed on to the business recovery team once the initial dangers have been controlled.
- The following event log should be completed by the disaster recovery team leader to record all key events during disaster recovery, until such time as responsibility is handed over to the business recovery team.

Description of Disaster:
Commencement Date:
Date/Time DR Team Mobilized:

Activities Undertaken by DR Team	Date and Time	Outcome	Follow-On Action Required

Disaster Recovery Team's Work Completed: <Date>
Event Log Passed to Business Recovery Team: <Date>

Disaster Recovery Activity Report Form

- On completion of the initial disaster recovery response the DRT leader should prepare a report on the activities undertaken.
- The report should contain information on the emergency, who was notified and when, action taken by members of the DRT together with outcomes arising from those actions.
- The report will also contain an assessment of the impact to normal business operations.
- The report should be given to business recovery team leader, with a copy to senior management, as appropriate.
- A disaster recovery report will be prepared by the DRT leader on completion of the initial disaster recovery response.
- In addition to the business recovery team leader, the report will be distributed to senior management

The report will include:

- A description of the emergency or incident
- Those people notified of the emergency (including dates)
- Action taken by members of the DRT
- Outcomes arising from actions taken
- An assessment of the impact to normal business operations
- Assessment of the effectiveness of the BCP and lessons learned

- Lessons learned

References

Wayne Tenney – IT Analyst
Ed Macias – Network Engineer
Glen Prieto – Technical Manager
Rithi Phanthalangsy – System Administrator
William Fischer - System Administrator

DOCTORS
MEDICAL CENTER

PHYSICIAN TRANSACTIONS AND ARRANGEMENTS

TAB 11

DOCTORS MEDICAL CENTER

TRANSACTION SUMMARY
PHYSICIAN TRANSACTIONS AND ARRANGEMENTS

Intensivist Services Agreement Effective October 1, 2012

A. Parties

- Identify the physician/group and indicate the specialty/practice area and administrative expertise.

  Serramonte Pulmonary Asthma Sleep Clinic, Inc., (including Dr. Majid, Dr. Raees and a third physician to be recruited), critical care trained physicians.

- Will the arrangement be with the physician as an individual, or with his/her group?

  The arrangement is with a group.

B. Purpose/Reasons to Pursue the Arrangement

- Describe how the arrangement meets a community need.

  The arrangement provides critical care trained physicians to cover the patients in the ICU. Onsite coverage for this high acuity population is the community standard and necessary to support quality patient care.

- Indicate whether the arrangement is new or is a renewal of an existing arrangement.

  This contract consolidates existing/previous contracts, and expands coverage to 3 physicians. This new agreement will replace:

  1. **The existing Intensivist Services contract in place with Dr. Majid, which provides for a net collection guarantee of $500,000 annually; and**
  2. **An expired contract with Dr. Raees that provided $100,000 in sign-on bonus/recruitment support in exchange for a commitment to provide services for a period of time through 2011.**

In addition, this contract expands coverage to a third physician, and provides for added leadership and committee responsibilities and assignments.

C. Services to be Provided

- Describe the services to be provided by the physician/group.

  Group will provide 2 physicians on site from 8:00 a – 6:00 p daily, including weekends and holidays, and from 6:00 p – 8:00 a on an on-call basis. A minimum of 3 physicians will be available to provide these services. Group will manage all unassigned patients on the unit, manage appropriate communication and patient hand-off for patients transferred to the care of an attending physician outside of the unit, and assist in the development of clinical pathways and case management programs for ICU patients.

- Describe the time commitment of physician/group (e.g., FTE, part-time, # of hours)

  Group will provide a minimum of 3 physicians to provide a minimum of 70 hours of onsite coverage and 84 hours of call coverage per week.

- Describe how the services actually provided will be tracked and documented by hospital management.

  Standard Hospital approved monthly time sheets.

D. Financial Terms

- Describe the compensation methodology (hourly fee, monthly or annual salary, etc.). Indicate the aggregate compensation to be paid.

  For patient care services, including call coverage, Group will be compensated $1,400 per day - $474,500 annually.

- Describe any other benefits payable to, or provided to (space, services, equipment, etc.), the physician.

  None

- Describe the methodology for determining that the financial terms meet Fair Market Value requirements.

  The MDRanger Compensation Survey was utilized, and findings are attached.

E. Other Terms

- Indicate whether the arrangement will be structured as an employment or independent contractor relationship.

  Independent Contract relationship

- Indicate the term of the arrangement (dates) and describe the termination provisions.

  The arrangement is effective October 1, 2012 with a three year term. Our standard termination language (90 days without cause) is included.

- Indicate insurance coverage arrangements.

  Group shall ensure that it obtains and continuously maintains professional, malpractice liability insurance coverage in the amount of at least One Million Dollars ($1,000,000) per occurrence or claim and Three Million Dollars ($3,000,000) in the annual aggregate for the acts and omissions of Group, each Program Physician, and any other person employed or retained by Group to provide Intensivist Services pursuant to this Agreement.

F. Business and Financial Risk

- Identify any specific business and financial risks of the arrangement.

  None identified

- Identify any conflicts of interest that have been identified through application of the Conflict of Interest Policy.

  None identified

G. Special Terms

- List any special requests or conditions proposed by the physician.

  None

Recommended for Approval:

_____ Dated: _____

Chief Executive Officer
Doctors' Medical Center – San Pablo

Attachments:

Fair Market Value analysis

Fair Market Value Analysis

Serramonte Pulmonary Asthma Sleep Clinic, Inc.

Services and Medical Director Contract

Date completed: September 19, 2012

Contact Compensation: $474,500 for provision of patient care services and on-call coverage.

Comparison Information Source: MDRanger Emergency Services Compensation Survey 2011/2012

Findings:

Mean Compensation for clinical services only, all hospitals: $811,000

Hospital Type (all Excluding Medical Direction)	25%	50%	75%
General Acute < 125 ADC	$ 346,000	$ 441,000	$ 611,000
ICU Average census under 20 patients	$ 376,000	$ 513,000	$ 1,210,000
Non-Trauma	$ 338,000	$ 617,000	$ 1,080,000
DSH Share Percentage <30%**	$ 469,000	$ 664,000	$ 1,050,000
Average across all 4 parameters	$ 382,250	$ 558,750	$ 987,750

** DMC DSH percentage as defined in the MD Ranger report is 27.6%

DOCTORS MEDICAL CENTER

TRANSACTION SUMMARY
PHYSICIAN TRANSACTIONS AND ARRANGEMENTS

Medical Director Agreement Effective October 1, 2012

A. Parties

- Identify the physician/group and indicate the specialty/practice area and administrative expertise.

  Serramonte Pulmonary Asthma Sleep Clinic, Inc., (including Dr. Majid, Dr. Raees and a third physician to be recruited) critical care trained physicians.

- Will the arrangement be with the physician as an individual, or with his/her group?

  The arrangement is with a group.

B. Purpose/Reasons to Pursue the Arrangement

- Describe how the arrangement meets a community need.

  This agreement provides for clinical leadership for the improvement of patient care outcomes.

- Indicate whether the arrangement is new or is a renewal of an existing arrangement.

  Renewal of existing arrangement. Existing arrangement provides for compensation of $1,500 monthly.

C. Services to be Provided

- Describe the services to be provided by the physician/group.

  The contract provides for leadership activities, including but not limited to:

- **Provide a minimum of one education and in-service instruction programs for DMC's nursing and ancillary personnel in the operation of the Unit.**
- **Make recommendations to DMC's administration regarding the use of facility personnel, the necessary equipment, and general quality standards of patient care in connection with the Unit.**
- **Develop a minimum of one medical education program for DMC's medical staff in the appropriate role of the Unit**
- **Be a liaison to appropriate medical staff committees relevant to the Unit.**
- **Co-Chair the Critical Care Committee of the Medical Staff**
- **Maintain communication with attending physicians admitting patient to the Unit.**
- **At least annually, review and make recommendations as necessary to revise the Unit's policies and procedures.**
- **Ensure proper and timely implementation of established policies and procedures.**
- **Assist the appropriate Medical Staff Committee in reviewing and revising Medical Staff Rules and Regulations which pertain to the Unit.**
- **Review records and reports of patient services in the Unit to promote quality patient care.**

- Describe the time commitment of physician/group (e.g., FTE, part-time, # of hours)

Group will provide a minimum of 12 hours per month of administrative leadership and committee participation.

- Describe how the services actually provided will be tracked and documented by hospital management.

Standard Hospital approved monthly time sheets.

D. <u>Financial Terms</u>

- Describe the compensation methodology (hourly fee, monthly or annual salary, etc.). Indicate the aggregate compensation to be paid.

Group will be paid an hourly rate of $150, not to exceed $1,833 monthly.

- Describe any other benefits payable to, or provided to (space, services, equipment, etc.), the physician.

None

- Describe the methodology for determining that the financial terms meet Fair Market Value requirements.

The MDRanger 2011/2012 Compensation Survey was utilized. That survey places hourly rate for ICU Medical Director at $150 per hour at the 50% of the range.

E. Other Terms

- Indicate whether the arrangement will be structured as an employment or independent contractor relationship.

Independent Contract relationship

- Indicate the term of the arrangement (dates) and describe the termination provisions.

The arrangement is effective October 1, 2012 with a three year term. Our standard termination language (90 days without cause) is included.

- Indicate insurance coverage arrangements.

Group shall ensure that it obtains and continuously maintains professional, malpractice liability insurance coverage in the amount of at least One Million Dollars ($1,000,000) per occurrence or claim and Three Million Dollars ($3,000,000) in the annual aggregate for the acts and omissions of Group, each Program Physician, and any other person employed or retained by Group to provide Intensivist Services pursuant to this Agreement.

F. Business and Financial Risk

- Identify any specific business and financial risks of the arrangement.

None identified

- Identify any conflicts of interest that have been identified through application of the Conflict of Interest Policy.

None identified

G. Special Terms

- List any special requests or conditions proposed by the physician.

None

Recommended for Approval:

_____ Dated: _____

Chief Executive Officer
Doctors' Medical Center – San Pablo

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 13

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD OF DIRECTORS
SEPTEMBER 2012

ITEM	ACTION
A. CHIEF OF STAFF REPORT	Informational
B. COMMITTEE REPORT: **Infection Control Committee: Infection Control Plan 2012 & Risk Assessment 2011**	Review
C. CREDENTIALS REPORT – March 2012	Approval

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD
EXECUTIVE SUMMARY

SEPTEMBER 2012

TOPIC

NON-ACTION ITEMS

A. Joint Commission Survey Preparation

The Medical Staff is in the process of working on several areas of focus relevant to Joint Commission standards which have either recently been implemented, or deficiencies have been identified and require resolution prior to survey.

1. Quality of H&P Elements: The Health Information Department (Medical Records) conducts random review of the medical record for compliance with required elements of the H&P and contents. The overall totals and scores have been reported to the MEC, but the details regarding the quality of the details and content must also be reported to ensure compliance with this Joint Commission Standard. Quarterly reports to be developed with appropriate details, by HIM.
2. Medical Record Delinquencies: To ensure compliance with policies regarding incomplete medical records, the policy for suspension due to record delinquencies has been revised to include a broader notification list of personnel who can assist to ensure medical staff does not elective schedule procedures or admit patients while on medical record suspension.
3. Privilege Delineations Revision Project: Privilege forms are in final stages of revision to convert the laundry list-type privilege forms to an improved "core privilege" format with defined criteria for initial and reappointment as well as proctoring.
4. Medical Staff Bylaws Revision: Initial draft revision currently under legal counsel review.
5. Medical Staff Education: Infection Prevention & Surveillance; Pain Assessment and Management: California acute care hospitals now have responsibility to provide education on these topics to patients/families, employees, contractors and Medical Staff. To ensure compliance with these newly enacted statutes, Medical Staff and the involved departments have collaborated to provide education to physicians and allied health in a variety of ways, including annual distribution of educational packets containing updates on topics such as infection prevention and pain management. All appointment and reappointment application packets will also contain this educational information and grand rounds with CME are currently being planned to provide venues for these topics as they present with new updates and standards.

B. Medical Staff Departmental Reports

The Departments of Medicine and Surgery have reviewed and approved annual list of clinical indicators which are utilized for peer review and performance improvement projects. Each Department has also chosen several focus studies for 2012 in which retrospective chart review will be conducted to determine the appropriateness and clinical outcomes for each procedure.

C. Committee Reports

1. The Medical Executive Committee reviewed information provided by Hospital Administration for the patient care contracts listed below, to determine quality of care being provided. All services, based on administrative information, were deemed as appropriate quality of care.
   a. Robert Panush, Speech Therapy
   b. John Wacker, EEG technician services
   c. Alliance Healthcare, PET Scan
   d. Baromedical Associates, Hyperbaric Medicine
   e. John Muir Medical Center, Patient Transfer
   f. Labcorp, specimen collection/lab services
2. Infection Control Plan 2012 and MDRO Risk Assessment 2011

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: Robert Panush	Accountable Person: COO
Scope of Service: The contractor will provide speech and swallow evaluation (including modified barium swallow studies) and therapeutic procedures for patients requiring these services who have current medical referrals.	
Date of last approval: 9/6/2012	Expiration Date: This agreement becomes effective September 6, 2012 and shall remain in effect until September 5, 2014. Renewal of this contract shall be done every two years automatically unless one or both parties agree on the contrary with 30 days notice.
Information Provided: When requested, in inservice training programs, administrative/professional conferences in which it is felt he can make a professional contribution with the scope of speech-language swallow therapy.	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: John Wacker	Accountable Person: COO
Scope of Service: Provider will provide DMC and the requesting physician, within a reasonable period of time, not to exceed five (5) working days, EEG reports performed for inclusion in the patient medical records, such reports to comply with all of the Hospital's rules and regulation and other reasonable requirements as to form and content	
Date of last approval: 8/1/2012	Expiration Date: The initial term of the Agreement shall be one (1) year commencing on August 1, 2012. At the end of the initial term and any term extension, the term of this agreement shall automatically be extended for additional one (1) year terms unless otherwise terminated by the parties in accordance with the terms of this agreements.
Information Provided: Provider will participate in Hospital's performance improvement, utilization review, and peer review programs with respect to the EEG services. Provider will make available for Hospital's inspection, all quality control or testing data on file regarding specific procedures to assist the Hospital in its quality assurance, utilization review and peer review programs relating to EEG procedures.	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: Alliance Healthcare Services, Inc. d/b/a/ Alliance Imaging	Accountable Person: COO
Scope of Service: Alliance shall provide the services of certified technical personnel who are trained and competent to operate the PET. Alliance and its personnel shall comply with all reasonable and applicable bylaws, policies, rules and regulations of DMC and DMC medical staff as it pertains to the services provided.	
Date of last approval: 5/12/09	Expiration Date: Agreement shall automatically renew for successive twelve (12) month terms, unless either party notifies the other to the contrary in writing at least 180 days prior to scheduled expiration.
Information Provided: Alliance will provide to DMC in writing upon request: (a) a description of the competencies related to Alliance's technical personnel who provide services; (b) copies of any licenses and certifications for such personnel; (c) all vaccinations required; (d) job descriptions; (e) evidence that criminal investigation background checks have been performed for each of Alliance technical personnel who provide services	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: Baromedical Associates INC.	Accountable Person: CFO
Scope of Service: Provide services in wound care therapies, including hyperbaric oxygen therapy to patients who qualify for such Medicare approved treatments.	
Date of last approval: 8/9/2012	Expiration Date: The Agreement shall be renewed for an additional term of one (1) year from September 1, 2012 until August 31,2013
Information Provided: Baromedical Associates agrees, at DMC's request, to participate in the Hospital's Quality Assurance Program, in order to comply with applicable Joint Commission and Medicare standards.	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: John Muir Medical Center	Accountable Person: COO
Scope of Service: Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility in a timely manner after receipt of the request to transfer a patient with an emergency medical condition or in active labor.	
Date of last approval: 11/1/1999	Expiration Date: Renewal every three years unless terminated by either parties.
Information Provided: John Muir Medical Center agrees, at DMC's request, to participate in the Hospital's Quality Assurance Program, in order to comply with applicable Joint Commission and Medicare standards.	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

DOCTORS MEDICAL CENTER

DOCTORS MEDICAL CENTER CONTRACT EVALUATION FORM

Contract: LabCorp	Accountable Person: COO
Scope of Service: DMC to provide LabCorp with specimen collection services and LabCorp will provide the testing services.	
Date of last approval: 7/12/2010	Expiration Date: This Agreement shall become effective on the date set and may be terminated by either party without cause upon a sixty (60) day prior written notice to the other party.
Information Provided: The t4erms of the Agreement are intended to be in compliance with all federal, state and local statutes, regulations and ordinances applicable on the date this Agreement is signed. Both parties agree to execute such amendments as may be necessary for HIPAA compliance as additional regulations are promulgated or become final and effective.	
Medical Executive Committee Approval: YES [X] NO [ ] Date: September 10, 2012	

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE: Infection Control Plan**	†**CHECK ONE:** ☒ **New** ☐ **Reviewed** ☒ **Revised :** ☐ **Major** ☐ **Minor**
† X☐ **Administrative** ☐ **Clinical** ☐ **Department Infection Control** **Committee**_____	
†**SUBMITTED BY**: Cathy King	
†**NEW POLICY - REASON FOR SUBMISSION**: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Annual Update and Review Required.	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES**: 2012 Infection Control based on Risk Assessment and goals for 2012	

	MEETING DATE	APPROVAL
X☐ **Manager or Department Director**†		
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
X☐ Infection Control Committee ☐ IDP Committee	1/12/12	Yes Dr Afsari
☐ 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)**†		
☐ **Executive Leadership**		
x☐ **Medical Executive Committee (MEC)** (as applicable) (By email)	9/21/12	Yes Dr. Hodgson
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual:	Sub Folder:
Title: INFECTION CONTROL PLAN 2012	Reviewed: Revised:
Effective Date: 01/12	Page 1 of 10

PURPOSE: The purpose of the infection control program is to identify risks of infections and opportunities for infection control measures to prevent and reduce the risk of disease transmission for patients, visitors, and staff. Surveillance is focused, prioritized, and based on a risk assessment. Risk reduction strategies are implemented.

POLICY:

The infection control program is designed to provide information and support to all clinical staff in the principles and practices of Infection Control, in order to support the delivery of safe and effective care to our patients. The program supports the development of a safe environment for all who enter the facility: healthcare workers, patients, employees, and physicians, contract workers, volunteers, students, and visitors.

The goals of the Infection Control Program include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice.

DEMOGRAPHICS (Licensed Beds, Setting, Employees)

- Doctors Medical Center is an acute care hospital consisting of 189 licensed beds located in an urban setting with approximately 600 employees.
- Services include general acute care, acute and outpatient rehabilitation
- The patient population served is multi-cultural and includes immigrant populations from Mexico, China, and the Philippines. We serve a large population who are in the lower socio-economic classes, homeless, and with history of substance abuse. Care is provided to pediatric emergency patients as well as elderly patients admitted from local long-term care facilities.

STRUCTURE AND ORGANIZATION OF THE PROGRAM

A. Infection Control Committee

The Infection Control Program is administered by the Infection Control Committee (ICC), a multidisciplinary medical staff committee which reports directly to the Medical Executive Board. The following is an administrative summary of the composition, duties, meeting details and authority as reviewed, revised and approved by the Medical Executive Board.

1. Composition
   The ICC includes medical staff representing internal medicine and surgical specialties. Representation from Nursing, Employee Health , Pharmacy and the Laboratory. Ad hoc committee members include Environmental Services, Central Services/SPD, Laundry, Food & Nutrition Services and Facilities Engineering.

2. Meetings.

The Infection Control Committee shall meet as often as necessary at the call of its chairman but at least every three months. The Committee shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Board.

3. Clinical Authority

The Senior Director of Quality has authority over the Infection Control Program to insure the development and implementation of policies governing control of infections including development of a system for identifying, reporting, investigating and controlling healthcare-acquired infections.

B. Responsibilities of Key Staff

Infection Control Manager

a. Responsibility for daily management of the infection control program.

b. Responsible for drafting and revising hospital infection control policies that will be provided to Infection Control Committee for approval.

c. Reducing infection risks to patients and personnel by verifying compliance with the IC program, through ongoing infection control rounds and as part of regular safety inspections.

d. Assuring appropriate education regarding pertinent infection control and isolation policies for all staff;

e. Performing improvement projects to address aspects of infection prevention and control using sound epidemiologic principles.

f. Reviewing hospital construction/renovation projects (major and minor) and performs an infection control risk assessment (ICRA) to assure adherence to basic infection prevention in the design and construction phases of renovation and building

g. Assuring informative and timely reporting of infection data to the California Dept of Public Health in accordance with SB739, SB158, SB1058.

Infectious Disease Consultant

a. Chairs the Infection Control Committee.

b. Reviews infection cases and applies standard definitions, as needed, in order to properly classify healthcare associated infections.

c. Reviews policies and procedures for appropriateness in the clinical setting.

d. Acts as liaison with medical staff committees to promote use of evidenced-based guidelines and optimal infection control practices by members of the medical staff

Physicians

a. Responsible to recognize the obligation, not only to his/her own patient, but to others in the Hospital as well, in regard to the infection control program;

b. Adheres to the rules and regulations as outlined in the Medical Staff bylaws.

Managers

a. Works with the Infection Control Manager to develop department specific infection control policies and procedures;

b. Assures the adherence to Standard (Universal) Precautions, hospital and department specific infection control policies and procedures in their departments;

c. Provides for infection control education within the department as necessary but at least annually.

Staff Nurse / Ancillary Staff

a. Reports the development of indications of any new communicable disease or infection to the attending physician and Infection Control Manager;

b. Assures proper implementation of isolation precautions for all patients, according to the Infection Control Manual;

c. Complies with Employee Health policies in the event of exposures or injuries;

d. Adheres to Standard (Universal) Precautions, as well as the Bloodborne Pathogen Standard and the Tuberculosis Exposure Control Program.

Pharmacy

a. Gather information so that the antibiotic formulary can be updated regularly, recommend improvements in the arena of cost effective antibiotic use.

b. Strives to improve antibiotic prescribing in the facilities with an active role on the Antibiotic Stewardship Committee.

Microbiology Laboratory

a. The clinical microbiologists identify pathogens and provide information on susceptibility testing as well as assisting in the updating of patient records, and reporting results to nursing and infection control so that patients with epidemiologically significant organisms may be cared for utilizing hospital-approved infection precautions.

b. Clinical microbiologists alert the infection control manager when an organism with a novel resistance pattern is identified from a patient specimen.

c. Submission of Confidential Morbidity Reports to Contra Costa County Public Health.

d. The clinical microbiologist monitors resistance patterns, and participates in the production of the antibiogram.

e. Clinical microbiologists assist in outbreak investigation by saving clinical isolates and preparing specimens for DNA testing of strains.

Employee Health Services

a. Informs the Infection Control Committee of any significant trends in employee illness;

b. Assures that all employees have undergone the appropriate pre-employment physical tests, re-examinations and have received the appropriate inoculations as established by the Infection Control Committee.

c. Assure that all employees receive the appropriate post-exposure follow-up.

d. Works with Infection Control Manager to develop, implement, review and update the employee health policies including the OSHA Bloodborne Pathogens Exposure Control Plan and Tuberculosis Control Plan.

e. Supervises enforcement of the Employee Health policies

f. Reports blood and body fluid exposures and PPD conversions in employees to the Infection Control Manager and the Infection Control Committee.

Infection Control RISK ASSESSMENT

A formal risk assessment/prioritization grid is performed annually to in order to effectively direct the utilization infection control resources. The specific program activities may vary from year to year based upon analysis of:

- Patient demographics.
- Clinical services offered.
- Number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas.
- Type of contract services utilized.
- High risk hospital processes.
- Community demographics.

ELEMENTS OF THE INFECTION CONTROL PROGRAM

A. Surveillance

Active surveillance allows for the early detection and prompt investigation of potential problems. Doctors Medical Center has adopted the Definitions for Nosocomial Infections that was published by the Centers for Disease Control in 1988.

Positive cultures will be reviewed daily by the Infection Control Manager and classified as either:

- Hospital-Acquired Infection: All hospital-acquired infections (both device-associated and non-device-associated) are defined, in general, as organisms not present or incubating at the time of admission and acquired due to, because of, or during hospitalization.

  Community-Acquired: Organisms present or incubating at the time of admission. Includes Community-acquired (non-healthcare-related) and Community-acquired (healthcare-related) infections

  Surveillance projects, approved by the Infection Control Committee are based upon the annual risk assessment is performed annually and whenever a new service or population is introduced. The 2012 IC Surveillance Plan includes:

MICU/FICU: Central Line associated bloodstream infections (CLABSI),
Insertion Practices for Central Lines (CLIP)
Daily assessment of need for the central line
Ventilator associated pneumonia (VAP),

Clusters of epidemiologically significant organisms

HOUSEWIDE CENTRAL LINE-ASSOCIATED BSI (CLABSI)

-

BSI CAUSED BY MRSA OR VRE

-

HOUSEWIDE CA-UTI

MDRO

C. DIFFICILE
VRE
MRSA
ESBL
Carbapenemase-resistant Klebsiella pneumoniae

Clusters of transmission of any epidemiologically significant organism
(*Aspergilllis, Stenotrophomonas, Acinetobacter*)

Cases are identified by:

-Review of positive bacteriologic and serologic results
-Participation in daily ventilator rounds in ICU/CCU
-Review of radiographic results as needed to confirm criteria for VAP
-Concurrent and retrospective chart review utilizing patient charts, lab reports and Health Information reports
-CLIP monitoring will be provided by nurses assisting with CVAD insertions.

SURGICAL SITE INFECTIONS (SSI) following these procedures:

Twenty one operative procedures performed at DMC identified by CDPH as consistent with meeting the requirements of Health and Safety Code Section 1288.55 for reporting of Surgical Site Infections.

Cases will be identified by:

- Daily review of OR schedule for cases of wound debridement
- Daily review of laboratory report
- Review of coded data for post-operative complications
- Concurrent and retrospective chart review
- Notification by physician, surgical department, Quality Management staff, and nursing.

Unusual clusters of SSI will be reported to Infection Control Committee and Surgical Evaluation Committee.
SSI rates will be reported annually.

TUBERCULOSIS for trends in antibiotic resistance, burden to the hospital capacity to accommodate appropriate isolation, staff and patient exposure risks and follow-up and public health reporting responsibility in accordance with laws and regulation

Cases will be identified by:

-Notification by Lab of AFB smear and culture results
-Daily review of laboratory report

-Review of radiographic results
-Concurrent and retrospective chart review utilizing patient charts

REPORTABLE DISEASES as required by Contra Costa County Public Health Department

- Submission of Confidential Morbidity Reports to Contra Costa County Public Health
- Review of positive bacteriologic results
- Daily review of laboratory report

COMMUNITY OUTBREAKS

- Outbreak identified by DHS via phone and electronic mail
- Review of daily laboratory report

BIOTERRORIST EVENTS

- As identified by DHS via phone and electronic mail
- Notification by Microbiology Department

STAFF BLOOD/BODY FLUID EXPOSURE:

-Exposures are documented on the Occupational Injury/Illness form which includes specifics related to the exposure.
- Data is collated and analyzed by Employee Health..
-Action plans are created to reduce the risk of preventable exposures from occurring in the future.
-The data is reported to the Safety Committee.

EMPLOYEE ILLNESS

When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.

B. Outbreak Investigation

In addition to routine data collection of surveillance data, the Infection Control Manager will investigate utilizing *IC Contact/Exposure Investigation Policy* when there are:

1. Clusters of infection above the expected levels.
2. Single cases of unusual nosocomial or infections/syndromes that may be as a result of a bioterrorist source.

Situations such as outbreak investigation and management of patient and healthcare worker exposure to contagious diseases will become a resource priority and may supersede the surveillance plan.

C. **Control and Prevention**

To provide an effective, ongoing program that prevents or reduces the risk of infection for patients, staff and visitors through continuous improvement of the functions and processes involved in the prevention of infection that includes:

- Identifying and preventing the occurrences of healthcare-associated infections by pursuing sound infection control practices such as aseptic technique, environmental sanitation, standard precautions, and other isolation of patients as needed and monitoring the appropriate use of antibiotics and other antimicrobials.
- Providing education on infection control principles to patients, staff, and visitors.
- Maintaining a systematic program of surveillance and reporting of State-mandated infections internally and to public health agencies.
- Assisting in the evaluation of infection-related products and equipment.
- Complying with current standards, guidelines, and applicable local, State and Federal regulations, and accrediting agency standards.
- Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.
- Performing Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment
- Participation in disaster drills where infectious agents are involved.
- Providing written plans, education and leadership during large community events/outbreaks due to Pandemic Influenza or Bioterrorist Agents.

Based upon the formal risk assessment it was determined that the infection control and prevention program for 2012 will focus on these priorities:

GOAL 1. Minimize potential for transmission of infectious agents by improving compliance with hand hygiene through education, availability of hand hygiene agents, and monitoring of compliance with the CDC Guideline for Hand Hygiene in Health-Care settings (2002), and the WHO guidelines on hand hygiene in health care (2009)

Hand Hygiene Program Work Plan :

- Ongoing staff awareness campaigns to increase compliance in all inpatient and outpatient.
- Education to empower patients to request that their caregiver practice hand hygiene.
- Rounding by IC manager to interview patients/visitors on observed hand hygiene practices of their caregivers.
- Monitoring of unit-specific adherence to hand hygiene practices by a variety of observers on all units and shifts to gain most accurate assessments

Measures of Success:

Hand Hygiene Compliance:

Quarterly inpatient units observational audits(secret shopper) show 70% compliance
Provide new hire and annual hand washing education for all staff.

Goal 2. Minimize the risk for transmission of infectious agents.

Work Plan:

- Ensure optimal and standardized cleaning of all patient rooms daily and upon discharge by implementing new cleaning policies and products and providing training and auditing of room cleanliness by EVS leadership.

- Monitor compliance with Isolation Precautions Policy and provide ongoing education and feedback to staff and provide written feedback to managers of individual staff member non-compliance.
- Feedback to physicians who are non-compliant with hospital infection control policies.
- Monitor compliance with MDRO Prevention guidelines.
- Insure compliance with the process that educates patients, and as needed, families who are infected or colonized with multi-drug resistant organisms about healthcare associated infection strategies.
- Antibiotic surveillance and education to physicians
- Food & Nutrition Services EOC inspection monthly by staff and quarterly by IP.
- Reduce sharps injuries to employees using safety devices through continued education by EH Nurse.

Measures of Success:

MRSA HAI rate for MICU/FICU is: 0.13/100 pt-days
Increase compliance with contact precautions to 95% house-wide
No incidents of patient belongings incorrectly labeled or unsafely opened.
Room cleaning audits by EVS leadership will show 100% compliance with proper procedure.
Cleaning audits of patient care equipment will show >90% compliance.
Sharps injuries from improper use of safety devices is decreased by 70% from 2011

Goal 3. Increase numbers of employees who receive annual flu vaccination

- Require a declination statement for those choosing not to be vaccinated against influenza
- Develop strategies to maximize healthcare worker influenza vaccination rates by reviewing reasons for declination the previous year.
- Include contracted and targeted physicians in the flu vaccination program.

Measures of Success:

85% staff influenza vaccination rate

Goal 4._Reduce the risk of device related infection

Work Plan:

CLABSI

- Improve compliance with physician documentation daily need for central line
- Educate all staff with responsibility for care Maintenance Bundle for central lines that includes a standardized protocol for "hub scrub", dressing care, and tubing changes.
- Implement use of alcohol cap for central lines to improve compliance with hub disinfection

VAP ICU/CCU : ensure daily compliance with VAP Bundle

CA-UTI: Feedback of every CA-UTI to Nursing Unit Manager for administrative review of case for rationale for catheter use in each patient.

Measures of Success:

Zero BSI during 2012 in the ICU
0.25 BSI/1000 pt-days house-wide (non-ICU)
Zero VAP in MICU/FICU
Zero CA-UTIs are identified in patients with non-essential catheters.
Audits of alcohol cap use show 100% usage

Goal 5. Prevention of Surgical Site Infection

- Provide SSI Prevention education to surgeons at orientation and through continuing education
- Focus on campaign to discontinue urinary catheters within 48 hours post-op.
- Monitor compliance with Surgical Infection Prevention Guidelines
- Implement pre-op showering of patients with chlorhexidine in all clean surgeries both inpatients and outpatients.

Measures of Success:

Zero SSI following spine surgery

Zero SSI in Joint Replacements (Hips and Knees)

All SCIP measures are at or above benchmark goal.

E. Internal Reporting

Results of all surveillance data, including catheter-associated bloodstream infection rates, surgical site infection rates and multidrug-resistant organism rates, as outlined in this Infection Control Plan 2012, will be reported at least annually to the Infection Control Committee. Infection rates, as appropriate, will be reported to Critical Care Committee, Surgery Committee, Safety Committee, Quality Assurance and Improvement, and the Quality Subcommittee of the Board.
Feedback will guide development of specific action plans.

F. Program Evaluation

Root cause analysis is performed on all CLABSI, VAP , and SSI (included in the surveillance program).

The effectiveness of the program is evaluated quarterly and annually by the Infection Control Committee for its ability to identify problems, to assist in the formulation and implementation of action plans, and ultimately, to demonstrate a reduction of the incidence of healthcare associated infection. Processes known to reduce risk of infection outcomes are monitored continuously in order to achieve 100% compliance.

The report will be forwarded to the Medical Executive Committee and to the Board of Directors

Annual goals are created in response to identified risks.

F. Evaluation of the Infection Prevention and Control Plan

The Infection Control Plan is reviewed annually by the Manager of the Infection Prevention and Control Department, with updates and revisions approved by the Infection Control Committee. Evaluation of the Infection Prevention and Control Plan shall take into consideration the following:

- Results of the Infection Control Annual Risk Assessment
- Evaluation of Infection Control Goals
- Changes in demographics of patients served
- Changes in services provided
- New regulatory standards
- New guidelines/best practices
- Surveillance data
- Outbreaks and exposures
- Any other pertinent findings or recommendations from the Infection Control Committee

G. Communicable Disease Reporting

1. The occurrence and follow-up of infections/communicable diseases among patients, staff, and visitors will be documented and reported to the Public Health Department.
2. Incidents that pose a potential risk of increasing risk of transmission of infectious diseases to patients, staff, and visitors will be reported promptly to the Department of Health Services.

H. Sentinel Event Reporting

In cooperation with the Quality Department, the Infection Control Manager will perform a root cause analysis of all nosocomial infections that result in serious injury or harm. Intense analysis may be conducted on unusual infections or events.

I. Public Reporting

In accordance with SB739 central line insertions that are performed in the ICUs will be audited for adherence to optimal insertion practices and the data will be reported to the California Department of Public Health.

In accordance with SB 1058 all healthcare-acquired MRSA bloodstream infections, all healthcare-acquired VRE bloodstream infections, all healthcare-acquired *C.difficile* infections, all central line-associated bloodstream infections, and all surgical site infections resulting from required surgeries will be reported to the California Department of Public Health.

Responsible for review/updating (Title/Dept)	Title Dept

DOCTORS MEDICAL CENTER

Annual MDRO Risk assessment

Year: 2011

Organism	# of Isolates in 2011	# HA	MDRO Rate (per 100 pt-days)	Compliance with Contact Precautions (score 1-5)	Compliance with Hand Hygiene (score 1-5)	Evidence for cross-transmission
MRSA						
MICU	78	0	6.61	5	4	0
SICU	8	0	2.06	-	-	0
3rd	8	0	0.56	3	4	0
4th	61	0	0.67	4	3	0
5th	87	0	1.02	4	4	0
6th	7	0	0.19	-	4	0
7th	8	0	1.50	-	5	0
Surgery	-	2	-	-	-	0
VRE						
MICU	5	0	0.42	5	4	0
SICU	1	0	0.26	-	-	0
3rd	2	0	0.14	3	4	0
4th	4	0	0.04	4	3	0
5th	7	0	0.08	4	4	0
6th	0	0	0.00	-	4	0
7th	0	0	0.00	-	5	0
Surgery	-	1	-	-	-	0
ESBL						
MICU	11	3	0.93	5	4	0
SICU	1	0	0.26	-	-	0
3rd	0	0	0.00	3	4	0
4th	4	1	0.04	4	3	0
5th	11	0	0.13	4	4	0
6th	1	0	0.03	-	4	0
7th	0	0	0.00	-	5	0
Surgery	-	0	-	-	-	0
C.diff						
MICU	6	0	0.51	5	4	0
SICU	0	0	0.00	-	-	0
3rd	0	0	0.00	3	4	0
4th	8	0	0.09	4	3	0
5th	10	0	0.12	4	4	0
6th	1	0	0.03	-	4	0
7th	0	0	0.00	-	5	0
Surgery	-	0	-	-	-	0
Other Gram Neg						
MICU	0	0	0.00	5	4	0
SICU	0	0	0.00	-	-	0
3rd	0	0	0.00	3	4	0
4th	0	0	0.00	4	3	0
5th	0	0	0.00	4	4	0
6th	0	0	0.00	-	4	0
7th	0	0	0.00	-	5	0
Surgery	-	0	-	-	-	0
KpC Housewide	0	0				

DOCTORS MEDICAL CENTER

Doctors Medical Center Infection Prevention and Control Program Risk Assessment-Prioritzation Grid 2012

Program Components	Probability of Performance Failure				Impact (Regulatory/Financial/Resources)			Infection Prevention Systems				Score
See definition and instruction tabs for further clarification of elements of assessment	High	Medium	Low	Never	High	Moderate	Minimal	Poor	Fair	Good	Excellent	
	3	2	1	0	3	2	1	3	2	1	0	
Transmission Precautions												
Hand Hygiene	3				3					1		7
Isolation Precautions		2			3					1		6
Service Line/Procedures: Health Care acquired Infections												
Knee Arthroplasty		2			3					1		6
Hip Arthroplasty			1		3					1		5
Spinal Surgery (Laminectomy, Fusion, Refusion)		2			3					1		6
Abdominal Surgery			1			2				1		4
Device Related HAI												
VAP in ICU			1		3					1		5
CLABSI Housewide			1		3				2			6
CAUTI Housewide		2			3				2			7
Community External/Internal												
Community TB			1			2			2			5
Flu			1			2				1		4
Employee Health												
Annual TB				0	3						0	3
Flu Vaccine Compliance		2			3					1		6
Annual Fit Testing				0	3						0	3
Needle/Sharps Injury												
Non-Teaching facility	3				3					1		7
Construction Risk												
Remodel or Remediation			1		3					1		5
Environment												
Pet/Service Animals		2				2			2			6
Patient belongings			1				1			1		3
Room Cleaning compliance		2			3				2			7
Flash sterilization 0=0, 0-5=low,5-10=med, >10= high (per day)			1		3					1		5
Dialysis equipment testing QI (water testing)			1			2					0	3
Infectious waste handling non-compliance			1		3					1		4
Patient equipment cleaning outside central sterile		2			3					1		6
Refrigerator temp logs			1			2				1		4
Dietary Services-Foodborne Illness			1		3						0	4
Negative pressure room monitoring	3				3					1		7
Transmission of Multiple Drug Resistant Organisms												
See separate MDRO Risk Assessment 2011												

DOCTORS MEDICAL CENTER

(OPEN SESSION)

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

August 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 (08/30/12) and the Medical Executive Committee (09/05/12).

CREDENTIALS REPORT TO THE BOARD AUGUST 2012	
INITIAL APPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Gondi, Neelima, MD	Medicine/Family Practice/Internal Medicine
Win, Khaing Soe, MD	Surgery/Pathology
REAPPOINTMENTS	
Golden, Donald, MD	Medicine/Family Practice/Internal Medicine
Khakmahd, Oliver, MD	Medicine/Family Practice/Nephrology
Majid, Abid, MD	Medicine/Family Practice/Critical Care
DeLos Reyes, Cipriano, MD	Medicine/Family Practice/Internal Medicine
Gomez, Robert, MD	Surgery/Orthopedics
Brown, Michael, MD	Surgery/Urology