DOCTORS MEDICAL CENTER

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

Wednesday, December 18, 2013
4:45 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
December 18th, 2013 – 4:45 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

Governing Body Members
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

AGENDA

1. **CALL TO ORDER** — E. Zell

2. **ROLL CALL**

3. **APPROVAL OF MINUTES OF NOVEMBER 12th , 2013** — 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 MANAGEMENT REPORT** — B. Ellerston
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Acceptance of the December 2013 Quality Management Report

6. **PRESENTATION ON COVERED CALIFORNIA** — V. Scharr
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only*

7. **FINANCIALS – OCTOBER 2013 AND NOVEMBER 2013** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the October and November 2013 Financials*

8. **2014 BUDGET PRESENTATION** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the First Quarter 2014 Budget*

9. **PROPOSED CHANGES TO HEALTH BENEFITS** B. Redlo
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of Proposed Changes in Health Coverage*

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

11. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the MEC report, Credentials Committee Report*

ADJOURN TO CLOSED SESSION

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

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

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

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

DOCTORS
MEDICAL CENTER

MINUTES
NOVEMBER 12, 2013

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS

November 12, 2013, 5:30 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 5:35 P.M.

2. ROLL CALL

Quorum was established and roll was called: 5:36 PM

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

Excused:
Pat Godley
Deborah Campbell

3. **APPROVAL OF OCTOBER 23, 2013 MINUTES**

The motion made by Director Beverly Wallace and seconded by William Walker, M.D. to approve the October 23, 2013 minutes passed unanimously.

4. **PUBLIC COMMENTS**

NUHW representative Patrick Doyle spoke regarding the notice of this special WCCHD DMC Governing Body meeting, questioning the Governing Body's right to schedule a special meeting.

5. **CEO REPORT**

Ms. Dawn Gideon, Interim President and Chief Executive Officer gave a presentation to WCCHD DMC Governing Body Board on the current DMC financial position. Doctors Medical Center continues to have a liquidity crisis and will run out of cash by May 2014 without outside support. The main drivers of the financial crisis inpatient volume declines, low reimbursement for those patients that do come to DMC and high employee benefit costs.

Ms. Gideon spoke in detail regarding the main drivers of the financial crisis. DMC has experienced a 14 percent decline in operating revenue and a 22 percent decline in inpatient volume through the loss of commercially insured patients to privately owned area medical centers and other competing entities. The low reimbursement is mainly because of the high numbers of MediCal, Medicare and uninsured patients that DMC serves, its average reimbursement per patient per day is nearly 57 percent lower than the average for other hospitals operating in the East Bay. The high benefits costs at DMC's have resulted in employment related costs that represent 83 percent of total hospital operating revenue compared to an average of 60 percent at other district hospitals in the Bay Area.

Ms. Gideon pointed out that employees and management continue to pursue efforts to efficiently manage the organization. This is evident in the fact that Doctors Medical Center's cost per adjusted discharge is the 2nd lowest in the region, and nearly 24% below the regional average. Operating expenses have been reduced by 6% and managerial staffing has been reduced by 19%. Ms. Gideon reported that DMC continues to look for a partner, without which the hospital will not survive in the long term.

The 2014 budget is complete and the current loss is projected at $19 million, we need a minimum of $15 million in order to reach 2015. The seismic/facility issues still exist and the City of San Pablo is still pursuing possible new hospital development on the "Circle S" site.

Ms. Gideon recommended three steps for moving forward: secure funding to continue operations until March 2015, or "no go" decision by potential partner, declare a Fiscal Emergency to alert community and stake holders of financial crisis and continue overall expense reduction.

Information Only No Action Required

6. RECOMMENDATION OF DECLARATION OF FISCAL EMERGENCY RESOLUTION # 2013-09

Ms. Dawn Gideon, Interim President and Chief Executive Officer, presented WCCHD DMC Governing Body with the Recommendation of Declaration of Fiscal Emergency Resolution #2013-09 as follows:

The West Contra Costa Healthcare District has responsibly and proactively managed its limited finances in order to operate Doctors Medical Center (DMC) despite a sustained reduction in patient volume, declining Medicare reimbursement revenue, and substantial loss of supplemental support from the State of California and local providers.

Because of the high numbers of MediCal, Medicare and uninsured patients that DMC serves, its average reimbursement per patient per day is nearly 57 percent lower than the average for hospitals operating in the East Bay.

DMC expects further declines in revenue in an amount to exceed 3.4 million dollars due to the budget sequestration and the impact of changes caused by the implementation of the Affordable Care Act.

Over the past three years, DMC has experienced a 14 percent decline in operating revenue and a 22 percent decline in inpatient volume through the loss of commercially insured patients to privately owned area medical centers and other competing entities.

Since 2010, DMC has lost $17 million in supplemental support from the State of California and area providers.

DMC's employment related costs represent 83 percent of total hospital operating revenue compared to an average of 60 percent at other district hospitals in the Bay Area.

Since 2010, DMC has taken significant steps to reduce its expenses. Operating expenses have been reduced by 6 percent and managerial staffing has been reduced by 19 percent while the costs of drugs and medical supplies has increased 5 to 8 percent and the total revenue, including patient care revenue and tax receipts, has declined by 16 percent.

In 2011 the District obtained support from the community through a new parcel tax to partially replace lost funds and, in addition, borrowed $40 million to be used to cover operational deficits. However those funds have since been depleted.

The District retained the Camden Group as an outside consultant to assist in finding a strategic partner with whom the hospital could either merge or affiliate in an effort to gain economies of scale and to develop a sustainable business model. Supplementing these efforts, the Governing Body and management have similarly pursued other area providers to seek a partner. However, as a result of these actions, only one potentially viable candidate has agreed to discussions, the University of California San Francisco, and any merger or affiliation would take at least a year to negotiate and implement.

The District has now determined that at the current rate of monthly operating losses, DMC will completely exhaust its existing funds by May 2014 and will be unable to keep the hospital or its emergency room open for the period long enough to finalize an agreement with a healthcare partner.

The fiscal emergency is so severe that, if not relieved, DMC will be forced to cease operating the hospital and its emergency room.

An independent study has concluded that the closure of the DMC emergency room would be catastrophic to the West Contra Costa County community that it serves and would result in overcrowding at other area hospitals, increased emergency room wait times, a shortage of emergency treatment facilities and intensive care units, the elimination of critical infrastructure to provide support in case of a disaster, increased costs to maintain EMS services, and the loss of the region's only accredited stroke program and program to treat severe heart attack patients.

Resolution

NOW, THEREFORE, be it known that the Governing Body of the Board of Directors of the West Contra Costa Healthcare District resolves as follows:

Section 1. Closure of Doctors Medical Center and its emergency room will create a substantial threat to the health, safety and welfare of the community it serves, the community of San Pablo and surrounding communities, and will cause serious harm to that community since Doctors Medical Center is its principal provider of emergency, acute care and other essential healthcare services.

Section 2. The Governing Body recommends to the Board of Directors that action be taken to declare the existence of a fiscal emergency of grave character and serious moment relating to the continued operation of Doctors Medical Center and delivery of its essential healthcare services.

Section 3. The Governing Body further recommends that the Board of Directors direct District management to investigate and recommend further actions necessary to mitigate the impacts of the fiscal emergency.

A motion made by Supervisor John Gioia and seconded by Director Beverly Wallace to adopt Recommendation of Declaration of Fiscal Emergency Resolution #2013-09.

THE MEETING ADJOURNED AT 6:11 PM

DOCTORS MEDICAL CENTER

QUALITY REPORT

TAB 5

Doctors Medical Center

PERFORMANCE MEASUREMENT REPORT

PHARMACY DOCTORS MEDICAL CENTER - 3RD Quarter 2013 Quarter: 3rd Year: 2013

Instructions: Submit this form to the Quality Management Department on a quarterly basis. Legend: N = Numerator D = Denominator

% OF OVERRIDES	# Overrides/ #Doses from OMNI	N	91.0	89.0	81.0	87	55.0	46.0	39.0	48.7	68.0	48.0	52.0	56.0				#DIV/0!	#DIV/0!		
		D	2619.0	2232.0	2151.0	2334.0	1834.0	1921.0	1364.0	1706.3	1700	1784.0	1430.0	1638.0				#DIV/0!	#DIV/0!	5%	5%
			4%	5%	5%	6%	6%	3%	4%	4%	5%	4%	4%	4%			#DIV/0!	#DIV/0!	5%		
# OF INAPPROPRIATE OVERRIDES (TJC/MERP)	# eQRM Med Errors Reported	N	23	11	13	15.6667	6	7	5	6	7	11	5	7.67							
		D	79	60	72		59	52	61		46	61	52	53						10.25	18.5
		#												#DIV/0!							
MEDICATION ERRORS REPORTED (TJC/MERP)	# eQRM Doses Dispensed	N	79	60	72	70.3333	58	52	61	57.33333	46	61	52	53							
		D	292000	257482	268350	272611	218249	240121	225,089	227619.3	224673	235750	242212	234212						0.0400%	0.0240%
		%		0.02%	0.03%	0.02%	0.03%	0.02%	0.03%	0.03%	0.02%	0.03%	0.02%	0.02%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
ADVERSE DRUG REACTIONS (TJC/MERP)	# Reports/ Admissions	N				22				25									47		
		D																		1%	6.50%
		%				1.2%				1.3%									1%		
CARTFILL ERRORS (WRONG DRUG)	#Errors/ Days of Month	N	13.0	15.0	7.0	12.0	13.0	11.0	20.0	14.7	22.0	16.0	12.0	17							
		D	31.0	28.0	31.0		30.0	31.0	30.0	30.3	31.0	31.0	30.0	30.7				#DIV/0!		9	20
		%								#DIV/0!		52%	40%	48%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
UNIT INSPECTIONS (TJC/MERP)	#Completed /Total	N	22.0	21.0	22.0		22.0	22.0	22.0	22.0	22.0	22.0	22.0								
		D	22	22	22	22	22	22	22	22	22	22	22	22						100%	98%
		%	100%	95%	100%	95%	100%	100%	100%	100%	100%	100%	100%								

Variance Analysis/Action Plan:

1. **OVERRIDES:**

Meeting benchmark at 4% for 3Q. 24 hour Pharmacy service began 9/15/13. Expect to see a continued decrease in overrides overall, target = 1-2%.

2. **MEDICATION ERRORS:**

Trends: Continue to see Nursing documentation and Controlled substance overrides as the most often reported medication errors.

A/P: Review nursing documentation and controlled substance overrides at annual competencies and one on one with Nursing Managers.

3. **ADVERSE DRUG REACTIONS:**

1-2% of admissions = below the national benchmark of 6.5%. This is due to the patient safety practices in place at DMC including:

Interdisciplinary rounding of the pharmacist in Critical Care. Pharmacists will also be rounding on 3-7th floors during the day effective mid-October.

Doctors Medical Center

PERFORMANCE MEASUREMENT REPORT

PHARMACY DOCTORS MEDICAL CENTER PHARMACY Quarter: 3rd Year: 2013

Instructions: Submit this form to the Quality Management Department on a quarterly basis. Legend: N = Numerator D = Denominator

[illegible]	DEVELOPMENT [illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	COMPARISON LAST YEAR	COMPARISON BENCH MARK
OUTDATES CHECKED IN PHARMACY	# Areas Checked/ Total	N	23.0	24.0	24.0	23.7	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0				#DIV/0!	#DIV/0!	98%	95%
		D	24	24	24	24	24	24	24	24	24	24	24	24				#DIV/0!	#DIV/0!		
		%	96%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%				#DIV/0!			
AIR MONITORING - IV ROOM (Weekly Rd. RQ	#Checks/ Total Areas	N	4	4	4	4	4	4	4	4	4	4	4	4						100%	100%
		D	4	4	4	4	4	4	4	4	4	4	4	4				#DIV/0!			
		%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100%	100%				#DIV/0!			
WEEKLY CLEANING - IV ROOM (Weekly Rd.	#Events/ #Weeks in Month	N	4.0	4.0	5.0	4.3	4.0	4.0	5.0	4.3	4.0	4.0	5.0	4.3				#DIV/0!		97%	100%
		D	4.0	4.0	5.0	4.3	4.0	4.0	5.0	4.3	4.0	4.0	5.0	4.3				#DIV/0!			
		%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				#DIV/0!			
MEDICATION REFRIGERATOR LOG	# 100 % Compliance /83 Ref	N	3	3	3	3	3	3	3	3	3	3	3	5				#DIV/0!	#DIV/0!	100%	95%
		D	3	3	3	3	3	3	3	3	3	3	3	3				#DIV/0!	#DIV/0!		
		%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				#DIV/0!			
MEDICATION SECURITY (MERP)	# Locked Areas/Total Surveyed	N	378.0	395.0	296.0	363.0	420.0	500.0	504.0	474.7	511.0	536.0	476.0	557.7				#DIV/0!	#DIV/0!	94%	100%
		D	504.0	448.0	392.0	448.0	532.0	566.0	560.0	560.0	566.0	616.0	560.0	588.0				#DIV/0!	#DIV/0!		
		%	75%	88%	75%	79%	79%	88%	90%	85%	87%	87%	85%	95%				#DIV/0!			
MONTHLY MEDICATION PASS	#Criteria Passed/Total Criteria	N	18.0	16.0	20.0	17.7	17.0	19.0	21.0	19.0	20.0	16.0	19.0	18.3				#DIV/0!		94%	95%
		D	20.0	21.0	22.0	21.0	18.0	22.0	23.0	21.0	21.0	17.0	21.0	19.7				#DIV/0!			
		%	90%	71%	91%	84%	94%	86%	91%	94%	95%	94%	90%	93%				#DIV/0!	94%		

Variance Analysis/Action Plan:

4. **MEDICATION SECURITY:**

Average @ 86% vs. 95% benchmark due to manual hand locking of medication carts . To be survey ready, Pharmacy recommends to purchase 3-4 new carts with autolock functionality for 2014.

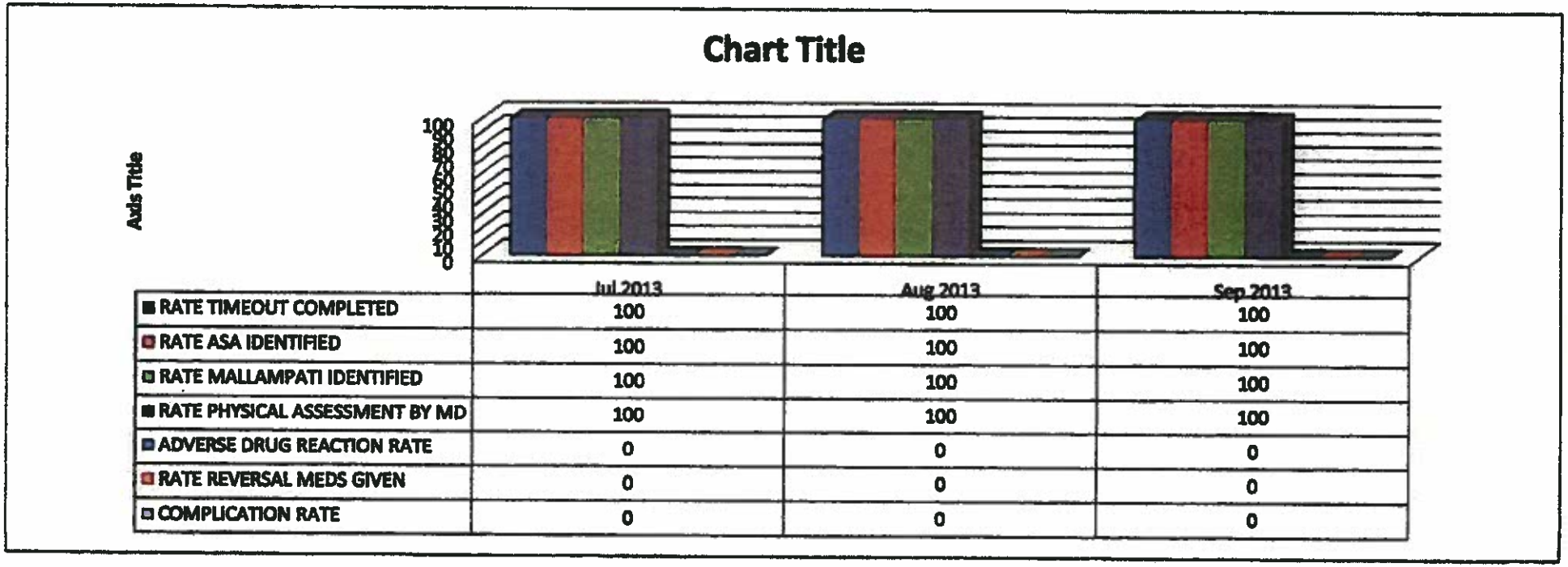
5. **MEDICATION PASS:**

Continue to monitor. Variances include: checking expiration dates before medication is given and knowledge of where to access drug information and protocols electronically. This information is reviewed with each nurse during the medication pass observation. Other areas Other areas of focus include: labeling of medications prior to administration and review of bar code administration process.

DOCTORS MEDICAL CENTER

Profile: Procedural Sedations Audits
Facility: All Facilities

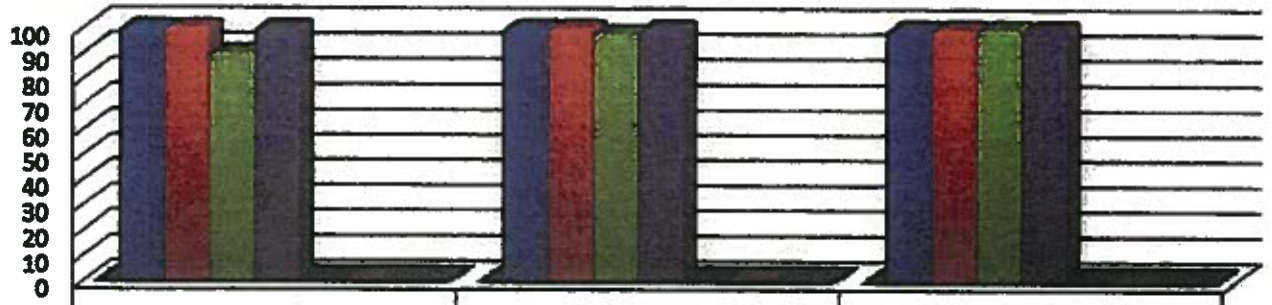
Indicator	Jul 2013	Aug 2013	Sep 2013	Total
RATE TIMEOUT COMPLETED	100	100	100	100
Timeout Not Completed OFI	0	0	0	0
RATE ASA IDENTIFIED	100	100	100	100
ASA Not Identified OFI	0	0	0	0
RATE MALLAMPATI IDENTIFIED	100	100	100	100
Mallampati Not Identified OFI	0	0	0	0
RATE PHYSICAL ASSESSMENT BY MD	100	100	100	100
MD Physical Assessment Not Performed b4 Sedation Start OFI	0	0	0	0
ADVERSE DRUG REACTION RATE	0	0	0	0
Adverse Drug Reaction OFI	0	0	0	0
RATE REVERSAL MEDS GIVEN	0	0	0	0
Reversal Meds Given OFI	0	0	0	0
COMPLICATION RATE	0	0	0	0
Complications OFI	0	0	0	0
TOTAL PROCEDURAL SEDATION AUDITS	17	14	16	47



DOCTORS MEDICAL CENTER

Profile: Procedural Sedations Audits
Facility: All Facilities

Indicator	1Q13	2Q13	3Q13	Total	COMMENTS:
RATE TIMEOUT COMPLETED	100	100	100	100	
Timeout Not Completed OFI	0	0	0	0	
RATE ASA IDENTIFIED	100	100	100	100	
ASA Not Identified OFI	0	0	0	0	
RATE MALLAMPATI IDENTIFIED	90	98	100	96	
Mallampati Not Identified OFI	4	1	0	5	
RATE PHYSICAL ASSESSMENT BY MD	100	100	100	100	
MD Physical Assessment Not Performed b4 Sedation Start OFI	0	0	0	0	
ADVERSE DRUG REACTION RATE	0	0	0	0	
Adverse Drug Reaction OFI	0	0	0	0	
RATE REVERSAL MEDS GIVEN	0	0	0	0	
Reversal Meds Given OFI	0	0	0	0	
COMPLICATION RATE	0	0	0	0	
Complications OFI	0	0	0	0	
TOTAL PROCEDURAL SEDATION AUDITS	**39**	**42**	**47**	**128**	



	1Q13	2Q13	3Q13
RATE TIMEOUT COMPLETED	100	100	100
RATE ASA IDENTIFIED	100	100	100
RATE MALLAMPATI IDENTIFIED	90	98	100
RATE PHYSICAL ASSESSMENT BY MD	100	100	100
ADVERSE DRUG REACTION RATE	0	0	0
RATE REVERSAL MEDS GIVEN	0	0	0
COMPLICATION RATE	0	0	0

NPSG Provision of Care

DOCTORS MEDICAL CENTER

Audits with Data:									
Pain		Goal	Jun-2013	Jul-2013	Aug-2013	Sep-2013	Oct-2013	Nov-2013	Dec-2013
	Pain Assessment/reassessment documented	95.00%	71%	91%	86%				
Critical Labs									
	Critical lab notification sticker is on physician order sheet	100%	90%	90%	90%				
	Is the Time/Date Documented on the Sticker	100%	75%	70%	100%				
	Physician Notified within 120 minutes	100%	90%	90%	100%				
	Documentation of action taken	100%	65%	70%	80%				
Anticoagulation Discharge Education									
	Discharge Instuctions Completed:	100%	58%	49%	36%				
Analysis:									
	In all indicators we have not met our goals. It is across all inpt								
	units and shifts. Could not identify any specific nurses.								
Action:									
	Unit Supervisors will take this over from the charge nurses.								
	Audits will be done concurrently and f/u with individual								
	nurses at the time it's found.								

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Medical Restraints Audit

Indicator	Jul 2013	Aug 2013	Sep 2013
Rate REASONS for Medical Restraints use DOCUMENTED	100%	100%	100%
Rate Alternatives to Restraints Documented	100%	100%	100%
Rate SOFT LIMB RESTRAINTS used	100%	100%	100%
Rate Med Restraint ORDER present/current for each episode	100%	100%	100%
Rate MD authenticates Med Restraint TEL Order within 12 hrs	(1/4) 75%	100%	(2/7) 71%
Rate MD authenticates Med Rest renewal order q 24 hours	(1/4) 75%	(3/3) 50%	100%
Rate of Med Restraint INJURY to Staff	0%	0%	0%
Rate of Med Restraint INJURY to Patient	0%	0%	0%
Rate RN documentations showing q2 monitoring Med Restraints	100%	100%	(2/7) 71%
Rate Med Restraint Release Were Trialed during this shift	(1/4) 75%	(1/6) 83%	(2/7) 71%
Total Medical Restraints (DENOMINATOR)	4	6	7
Comments:			
(auth TEL Order within 12 h) Autistic female having procedures completed			
(auth TEL Order within 12 h) pulling tubes			
(auth renewal orders q 24 h) Autistic female having procedures completed			
(auth renewal orders q 24 h) patient pulling out tubes,confused.Patient still with restraint not dcd.			
(auth renewal orders q 24 h) patient still have bilateral soft wrist restraint			
(auth renewal orders q 24 h) patient still on restraints to prevent pulling dressing ,foley catheter and ivf.			
(q2 Monitoring) pulling tubes			
(q2 Monitoring) PULLING TUBES			
(Release Trials) Autistic female having procedures completed			
(Release Trials)patient still on restraints to prevent pulling dressing ,foley catheter and ivf.			
(Release Trials)restraints removed, sitter order written			

California Transplant Donor Network

CONTACT
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Donation Services Liaison
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kcluff@ctdn.org / http://www.ctdn.org

Hospital Combined Donation & Referral Scorecard

Doctors Medical Center San Pablo Q2 2013

YTD Donation/Referral Counts	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
All Deaths	32	32	28	21	21	10							144
Eligible Deaths	0	0	0	0	0	0							0
Hospital Referrals	32	32	28	20	21	10							143
Missed Referrals	0	0	0	1	0	0							1
Organ/Tissue Referrals	1	0	3	1	1	2							8
Organ Potential	0	0	0	0	0	1							1
Timely Organ Referrals	0	0	2	1	1	2							6
Organ Donors	0	0	0	0	0	0							0
Eligible Donors	0	0	0	0	0	0							0
Non-Eligible Donors	0	0	0	0	0	0							0
Organs Transplanted	0	0	0	0	0	0							0
Tissue Donors	1	3	1	3	3	1							12

YTD Donation/Referral Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Adjusted Conversion Rate	0%	0%	0%	0%	0%	0%							0%
Potential Conversion Rate	0%	0%	0%	0%	0%	0%							0%
Overall Referral Rate	100%	100%	100%	95%	100%	100%							99%
Organ Referral Rate	100%	100%	100%	100%	100%	100%							100%
Timely Organ Referral Rate	0%	0%	67%	100%	100%	100%							75%
Organ Donor FPA Rate	0%	0%	0%	0%	0%	0%							0%
OTPD	0.00	0.00	0.00	0.00	0.00	0.00							0.00
Death to Tissue Donor Rate	3.1%	9.4%	3.6%	14.3%	14.3%	10.0%							8.3%
Tissue Donor FPA Rate	0%	0%	0%	0%	0%	0%							0%
CTOD Timeliness Rate	68%	69%	80%	70%	90%	88%							75%

↑ 78% 3Q

See Definitions and Disclosure Notice on Pages 9-11

Organ Referral Details: Q2 2013 (Doctors Medical Center San Pablo)

Detail Data for Report Period Only (Q2 2013)

Referral #	Referral Date/Time	Age / Gender/ Ethnicity	Timely Ref	Organ Potential	CTDN Onsite	Hosp Supp	Collab Mention	Eval Prior	CTDN Disc	Plan Disc	Authorization Type	Organ Outcome	Total TX'd
13-10444	4/10/2013 1:15:53 PM	73 / M / Caucasian	Yes	No	--	--	--	--	--	--	AP Not Asked	Screening Rule Out	-
13-14107	5/21/2013 9:17:42 AM	76 / M / African American	Yes	No	--	--	--	--	--	--	AP Not Asked	Screening Rule Out	-
13-16067	6/14/2013 8:21:05 PM	63 / M / Hispanic	Yes	No							AP Not Asked	Screening Rule Out	-
13-16973	6/25/2013 1:44:05 PM	60 / F / African American	Yes	Yes	--	--	--	--	--	--	First Person Auth	Screening Rule Out	-

See Definitions and Disclosure Notice on Pages 9-11

Definitions & Measurement Goals

Measure	Definition	In Range	Out of Range	Needs Improvement
All Deaths	The number of Hospital Referrals plus any Missed Referrals identified through death record review.	N/A		
Eligible Deaths	CMS definition: Deaths that meet all of the following criteria: patient was 70 years old or younger, declared legally brain dead, and had no CMS contraindications. (See section 7.1.7 at http://optn.transplant.hrsa.gov/PoliciesandBylaws2/policies/pdfs/policy_23.pdf.)			
Hospital Referrals	All referrals made to the CTDN referral line by the hospital.			
Missed Referrals	Any death identified through death record review that was not referred to CTDN.			
Organ/Tissue Referrals	All referrals made to the CTDN referral line which were evaluated for organ donation.			
Organ Potential	All referrals determined to have potential for organ donation.			
Timely Organ Referrals	All referrals made within one hour of the patient meeting the clinical cues for referral.			
Organ Donors	The total of all patients that became organ donors.			
Eligible Donors	All organ donors that meet the CMS definition of "Eligible Death" (above).			
Non-Eligible Donors	All organ donors that do not meet the CMS definition of "Eligible Death" (above).			
Organs Transplanted	The total number of organs transplanted from all organ donors.			
Tissue Donors	The total of all patients that became tissue donors.			
Adjusted Conversion Rate	The count of Organ Donors divided by the count of Eligible Deaths plus the count of Non-Eligible Donors (aka Collaborative Conversion Rate).	**≥ 75%**	**70% - 74%**	**< 70%**
Potential Conversion Rate	The count of total Organ Donors compared to the number of Referrals with Organ Potential.	**≥ 40%**	**39%-35%**	**< 35%**
Overall Referral Rate	The count of all Hospital Referrals divided by all Deaths.	**100%**	**97%-99%**	**< 97%**
Organ Referral Rate	The count of Organ Referrals divided by Organ Referrals plus Missed Imminent/Eligibles.	**100%**	**97%-99%**	**< 97%**
Timely Organ Referral Rate	Count of Timely Referrals (those marked "Yes" in Referral Detail) divided by the count of Referrals (those marked "Yes" and "No" in Referral Detail). Excludes cases in which the death or referral times are not known.	**≥ 80%**	**75%-79%**	**< 75%**
Organ Donor FPA Rate	The count of all Organ Donors with First Person Authorization (FPA) divided by the count of all Organ Donors.	**≥ 45%**	**40%-39%**	**< 40%**
OTPD	Organs Transplanted Per Donor. The count of Organs Transplanted divided by the number of Organ Donors.	**≥ 3.75**	**3.00 - 3.74**	**< 3.00**
Death to Tissue Donor Rate	Nationally recognized metric where the count of Tissue Donors is divided by the count of all Deaths.	N/A		
Tissue Donor FPA Rate	The count of all Tissue Donors with First Person Authorization (FPA) divided by the count of all Tissue Donors.			
CTOD Timeliness Rate	The count of all non-organ referrals made within 60 minutes before or after cardiac time of death divided by all non-organ referrals. Excludes cases where the referral was made prior to death or in which the death or referral times are not known.	**≥ 85%**	**80%-84%**	**< 80%**

Definitions & Measurement Goals

Section	Definitions

Organ Referral Details
Report Period Only
	Table includes all referrals that qualify as possible Organ Donors (generally those referred prior to circulatory time of death) during the report period (Q2 2013) only.
	• **Referral #:** The referral number for the donor, typically assigned by the referral call center. Used to cross-reference to the referral details table.
	• **Referral Date/Time:** The date and time of the referral in Pacific time, as captured in CTDN's electronic donor management system.
	• **Age/Gender/Ethnicity:** The age, gender, and approximate ethnicity of the referred patient.
	• **Timely Ref (Timely Referral):** Whether or not the referral was made within one hour of meeting clinical cues for patient referral.
	• **Organ Potential:** Organ referral that was determined to be medically suitable for organ transplant during post-case review with all available medical information.
	• **CTDN Onsite (CTDN Onsite Timely):** Did a representative from CTDN arrive onsite at the referreing hospital in a timely manner?
	• **Hosp Supp (Hospital Supporting):** Did the hospital clinically support the medical needs of the patient to optimize the potential for donation?
	• **Collab Mention (Collaborative Mention):** Did the hospital collaborate with CTDN and be sure that donation was not brought up until the most appropriate time for the family?
	• **Eval Prior (Evaluation Prior to BDD/EOL):** Was CTDN onsite at the hospital in order to conduct a proper evaluation prior to brain death declarations or end of life discussions?
	• **CTDN Disc (Donation Discussion by CTDN):** Was CTDN able to have an appropriate donation discussion with the family?
	• **Plan Disc (Planned Discussion):** Was the donation discussion a planned event between CTDN and the hospital?
	• **Authorization Type**: Notes authorization details.
	  ◦ *First Person Auth*: The case was authorized for donation by Donor Designation/First Person Authorization (FPA).
	  ◦ *AP Auth:* The case was authorized by the Authorizing Party (AP), formerly reported as the Legal Next of Kin (LNOK).
	  ◦ *AP Decl Auth:* The Authorizing Party declined donation when approached by CTDN.
	  ◦ *AP Decl Other:* The Authorizing Party declined donation when approached by someone other than CTDN.
	  ◦ *AP Not Asked:* CTDN did not approach the Authorizing Party for donation. This could occur for many reasons. For example, the case was medically ruled out for donation earlier or the Authorizing Party was not available.
	  ◦ *AP Revoked Auth:* The case was authorized for donation at some point, but the Authorizing Party revoked the authorization.
	• **Organ Outcome:** The basic organ outcome for the referral.
	  ◦ *Screening Rule Out:* The case was ruled out for donation. This could be due to a variety of factors, including medical reasons, logistical reasons, or a lack of authorization.
	  ◦ *Authorized Not Recovered:* The case was authorized but was later ruled out for donation, usually for medical reasons.
	  ◦ *Organ Donor:* At least one organ was recovered with the intent to transplant. (Note that a patient could be listed as a donor even if no organs were transplanted as long as at least one organ was recovered with the intent to transplant.)
	• **Total TX'd (Total Organs Transplanted):** The total number of organs that were transplanted for the case. This total does not include organs that were recovered for research or organs that were recovered but not ultimately transplanted for clinical or other reasons.

Section	Definitions
Organ Donor Recovery Details *Report Period Only*	*Table includes all referrals that became Organ Donors during the report period (Q2 2013) only.* • **Organ ID:** The CTDN ID number assigned to an Organ Donor. Note, a donor could have both an Organ ID and a separate Tissue ID. • **Referral Date/Time:** The date and time of the referral in Pacific time, as captured in CTDN's electronic donor management system. • **Organs Recovered:** A single X denotes a single organ recovered and a double XX denotes two organs recovered (ie, two lungs or two kidneys) per donor. • **Total Rec'd (Total Number of Organs Recovered):** The total number of organs recovered per Organ Donor. Because this number *includes* organs recovered for research and organs recovered but not transplanted, the total number of Organs Recovered *could* be higher than the number of Organs Transplanted. • **Referral #:** The referral number for the donor assigned by the CTDN call center. Used to cross-reference to the referral details table.
Tissue Donor Recovery Details *Report Period Only*	*Table includes all referrals that became Tissue Donors during the report period (Q2 2013) only.* • **Tissue ID:** The CTDN ID number assigned to a Tissue Donor. Note, a donor could have both an Organ ID and a separate Tissue ID. • **Referral Date/Time:** The date and time of the referral in Pacific time, as captured in CTDN's electronic donor management system. • **Tissues Recovered:** An X denotes that the particular tissue type was recovered from the donor. • **Referral #:** The referral number for the donor assigned by the referral call center. Used to cross-reference to the referral details table.
Referral Details *Report Period Only*	*Table includes All Deaths (Hospital Referrals plus Missed Referrals) reported during the report period (Q2 2013) only.* • **Referral #:** A unique identification number for the referral, typically assigned by the referral call center. • **MRN:** The hospital's Medical Record Number for the patient, as captured in CTDN's electronic donor management system. • **Death Date/Time:** The date and time of death noted in CTDN's electronic donor management system. Priority order is: 1. Second brain death note (California referral facilities only) 2. Brain death note (Nevada referral facilities only) 3. Cardiac/circulatory death time/asystole (CTOD) *If blank, patient expiration may have occurred after donor/referral documentation was discontinued.* • **Referral Date/Time:** The date and time of the referral in Pacific time, as captured in CTDN's electronic donor management system. • **Unit & Location:** The hospital unit where the referral was made followed by a more specific location, if known. • **Referral Person:** The person who called in the referral to the CTDN donor referral line, if known. • **Organ/Tissue Donor:** Whether or not the patient became an organ and/or tissue donor. Each referral marked with a "Yes" in one of these two columns should be represented by an entry in one or both of the recovery details tables. • **CTOD Timely:** Whether or not the referral was made within one hour of asystole or cardiac/circulatory time of death (CTOD). ◦ **YES:** Referral was made less than one hour after cardiac/circulatory death ◦ **LATE:** Referrals made over 60 minutes from the time of cardiac/circulatory death. ◦ **MISSED:** The referral was not made. Identified through the death record review process. ◦ **--** : Not Applicable, The death time is not known or the patient did not die. ◦ **Before CTOD:** Referral was made before the noted cardiac/circulatory time of death. • **Referral Type:** Category of referral, specifically OTE - Organ Tissue Eye; TE - Tissue Eye; RO - Rule Out. • **Missed Imminent/Eligible:** A missed referral on a patient that was identified as "imminent" or "eligible" under CMS reporting criteria. ◦ MI: Missed Imminent ◦ ME: Missed Eligible

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Acute Myocardial Infarction (AMI)

	4Q 2012	1Q 2013	2Q 2013	3Q 2013	Goal
Medication: Aspirin at arrival (AMI1)	100.0%	100.0%	100.0%	100.0%	90-100%
Aspirin at discharge (AMI2)	100.0%	100.0%	100.0%	100.0%	90-100%
ACEI/ARB for LVSD[1] (AMI3)	100.0%	100.0%	100.0%	100.0%	90-100%
Beta blocker at discharge (AMI5)	100.0%	100.0%	100.0%	100.0%	90-100%
Fibrinolysis Tx within 30 min of arrival (AMI7a)	n/a	n/a	n/a	n/a	90-100%
Percutaneous Cardiac Intervention (PCI) w/in 90 min of arrival (AMI8a)	100.0%	(4/5) 80%	100.0%	(6/7) 85.7%	90-100%
Statin Prescribed at Discharge (AMI10)	100.0%	100.0%	100.0%	100.0%	90-100%

COMMENTS:

- Currently, most elements are 100% for 3rd Quarter (3Q13) 2013 except for PCI within 90 minutes (AMI-8a).
- One fallout due to missed EKG reading in ED. Pt was non-english speaking. Results were reviewed at STEMI Committee meeting.
- Ongoing daily report sent to Nursing leadership. Meets twice a month for Core Measure Quality Improvement.

ACTION PLAN:

NONE required

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Congestive Heart Failure (CHF)

	4Q 2012	1Q 2013	2Q 2013	3Q 2013	Goal
All Discharge Instructions (HF1)	(49/76) 64.5%	**(62/69) 89.9%**	98.4%	100.0%	90%-100%
Activity Instructions at discharge (HF1a)	97.4%	100.0%	100.0%	100.0%	90%-100%
Diet instructions at discharge (HF1b)	97.4%	98.6%	100.0%	100.0%	90%-100%
Follow-up instructions at discharge (HF1c)	97.4%	98.6%	100.0%	100.0%	90%-100%
Medications instructions at discharge (HF1d)	97.4%	100.0%	100.0%	100.0%	90%-100%
Symptom worsening instructions at discharge (HF1e)	**(68/76) 89.5%**	100.0%	100.0%	100.0%	90%-100%
Weight monitoring instructions at discharge (HF1f)	(50/76) 65.8%	**(62/69) 89.9%**	98.4%	100.0%	90%-100%
Evaluation of Left Ventricular Systolic (LVS) Function (HF2)	97.8%	100.0%	97.3%	100.0%	90%-100%
ACEI or ARB for LVSD[1] (HF3)	97.6%	96.0%	100.0%	100.0%	90%-100%

COMMENTS:

- Ongoing monthly meeting with physician leadership to discuss identified issues for CHF
- Quality meets with Hospitalist group & Physician Leadership to review Core Measure fallouts and identify actions to be taken to improve numbers.
- Core Measure Review Nurse met with individuals involved (RNs, MDs) during rounds and discussed core measure topics where DMC could improve on, such as discharge instructions.
- eQRR entered for Discharge instructions and medications

ACTION PLAN:

>NONE required

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Pneumonia (PN)

	4Q 2012	Jan-13	2Q 2013	3Q 2013	Goal
Blood Culture within 24 hrs of arrival-ICU (PN3a)	93.3%	100.0%	100.0%	100.0%	90%-100%
Blood Culture in ED prior to Initial Antibiotic (PN3b)	97.8%	95.2%	100.0%	(24/25) 96.0%	90%-100%
Antibiotic selection for ICU/non-ICU patients (PN6)	96.4%	100.0%	100.0%	100.0%	90%-100%
Antibiotic selection for ICU patients (PN6a)	100.0%	100.0%	100.0%	100.0%	90%-100%
Antibiotic selection for Non-ICU patients (PN6b)	95.2%	100.0%	100.0%	100.0%	90%-100%

COMMENTS:

- Data reviewed with Nursing Leadership with an action plan identified.
- Managers/Directors followed up with individual staff to set up expectations.
- Currently, 1/25 (4%) OFI for Blood Culture prior to Antibiotic administration for PNA elements being discussed with MD involved.

ACTION PLAN:

>Daily report sent to Nursing leadership. Meets twice a month for Core Measure Quality Improvement.

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Surgical Care Improvement Project (SCIP)

	4Q 2012	1Q 2013	2Q 2013	3Q 2013	Goal
Antibiotics within 1 hour (SCIP INF 1a)	95.5%	96.8%	100.0%	(34/36) 94.4%	90%-100%
Antibiotics Selection (SCIP INF 2a)	90.9%	100.0%	100.0%	(35/36) 97.2%	90%-100%
Antibiotics discontinued within 24 hours (SCIP INF 3a)	90.9%	96.8%	92.0%	(34/35) 97.1%	90%-100%
Cardiac patients 6am postop serum glucose (SCIP-Inf-4)	n/a	n/a	n/a	n/a	90%-100%
Hair Removal (SCIP INF 6)	100.0%	100.0%	96.2%	100.0%	90%-100%
Urinary Catheter Removed Post-Op Day 1 & Day 2 (SCIP INF9)	(34/38) 89.5%	95.0%	97.1%	100.0%	90%-100%
Perop Temp Mgt (SCIP INF 10)	100.0%	100.0%	100.0%	100.0%	90%-100%
Beta Blocker perioperative (SCIP CARD 2)	100.0%	100.0%	100.0%	(15/16) 93.8%	90%-100%
VTE Prophylaxis Timely (SCIP VTE 2)	(39/45) 86.6%	95.7%	(42/47) 89.4%	(47/48) 98%	90%-100%

COMMENTS:

- Met ALL benchmarks set for the hospital

ACTION PLAN:

- None at this time

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS

		1Q 2013	2Q 2013	3Q 2013	Goal
VTE Prophylaxis (VTE-1)		(83/122) 68.0%	**(98/112) 87.5%**	**(95/110) 86.4%**	90%-100%
ICU VTE Prophylaxis (VTE-2)		92.5%	96.6%	(25/26) 95.2%	90%-100%
VTE pts w/ Anticoag Overlap Tx (VTE-3)		100.0%	100.0%	100.0%	90%-100%
Prin Dx VTE w/ Anticoag Overlap Tx (VTE-3a)		100.0%	100.0%	100.0%	90%-100%
Sec Dx VTE w/ Anticoag Overlap Tx (VTE-3b)		n/a	100.0%	100.0%	90%-100%
VTE pts receiving UFH w/ dosage/platelet Monitoring (VTE-4)		100.0%	100.0%	100.0%	90%-100%
Prin Dx VTE Rec UFH w/ dosage/platelet monitoring (VTE-4a)		100.0%	100.0%	100.0%	90%-100%
Sec Dx VTE Rec UFH w/ dosage/platelet monitoring (VTE-4b)		n/a	100.0%	100.0%	90%-100%
VTE Warfarin Tx DC Instructions (VTE-5)		(2/5) 40%	**(7/8) 87.5%**	(8/11) 72.7%	90%-100%
Prin Dx VTE Warfarin Tx DC Instructions (VTE-5a)		(2/5) 40%	100.0%	(8/11) 72.7%	90%-100%
Sec Dx VTE Warfarin Tx DC Instructions (VTE-5b)		n/a	(1/2) 50%	n/a	90%-100%
Hospital Acquired Potentially-Preventable VTE (VTE-6)		n/a	n/a	n/a	90%-100%

COMMENTS:

- 15 (VTE-1) & 1 (VTE-2) Cases were found with No VTE Prophylaxis documented nor a reason for not receiving it.
- 3 (VTE-5) Cases were sent home without proper dicharge orders regarding Warfarin.
- Fallouts occured before changes were made to CPOE orders.

ACTION ITEMS:

- CPOE orders have been modified to reflect the VTE prophylaxis as "Low VTE risk, not VTE Prophylaxis needed". This will cover both mechanical and pharmacologic VTE prophylaxis.
- Going forward, if the CPOE order sets are used, they should not fall out. There was a glitch in the last version of Paragon where the MD would uncheck the Meaningful Use requirement and should normally have to give the reason but the glitch allowed the MD to not pick the MU reason for NOT prescribing VTE. This has been fixed with this latest version.
- Concurrent reviewer follows up with RN in charge to re-write DC instructions and send the patient a copy at home and retain a copy in the medical record.
- MDs are advised during concurrent review to write an addendum to state a REASON for no VTE prophylaxis ordered on day of/after admission.

DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

STROKE (STK)

	4Q 2012	1Q 2013	2Q 2013	3Q 2013	Goal
VTE Prophylaxis (STK-1)	(22/25) 88%	96.0%	90.3%	(37/41) 90.2%	90%-100%
VTE Prophylaxis - ISCHEMIC (STK-1a)	(21/24) 87.5%	96.0%	90.3%	(36/40) 90.2%	90%-100%
VTE Prophylaxis - HEMORRHAGIC (STK-1b)	100.0%	n/a	n/a	100.0%	90%-100%
DC on Antithrombotic Tx (STK-2)	100.0%	100.0%	100.0%	100.0%	90%-100%
Anticoag Tx for AF/Flutter (STK-3)	100.0%	100.0%	100.0%	100.0%	90%-100%
Thrombolytic Tx (STK-4)	100.0%	100.0%	100.0%	100.0%	90%-100%
Antithrombotic Tx HDZ (STK-5)	95.0%	100.0%	100.0%	(38/39) 97.4%	90%-100%
DC on STATINS (STK-6)	94.1%	100.0%	95.8%	100.0%	90%-100%
Stroke Education (STK-8)	92.9%	(17/19) 89.5%	100.0%	100.0%	90%-100%
Stroke Education ISCHEMIC (STK-8a)	92.9%	(17/19) 89.5%	100.0%	100.0%	90%-100%
Stroke Education HEMORRHAGIC (STK-8b)	n/a	n/a	n/a	100.0%	90%-100%
Assessed for Rehab (STK-10)	100.0%	100.0%	100.0%	(42/43) 97.7%	90%-100%
Assessed for Rehab ISCHEMIC (STK-10a)	100.0%	100.0%	100.0%	(41/42) 97.6%	90%-100%
Assessed for Rehab HEMORRHAGIC (STK-10b)	100.0%	100.0%	n/a	100.0%	90%-100%

COMMENTS:

Currently, all elements are 90-100% for 2nd Quarter 2013.

ACTION PLAN:

1. Lack of accessibility to SCDs on the units was found to be a problem. SCDs are now stocked on 3rd/4th/5th floors as well as MICU.
2. Stroke core measure report being sent to all the units during the week as a reminder to nursing to apply or document SCDs if ordered.
3. On-going education at unit staff meetings regarding importance of VTE prophylaxis in stroke patients.
4. Live time rounding by stroke coordinator.

DOCTORS MEDICAL CENTER

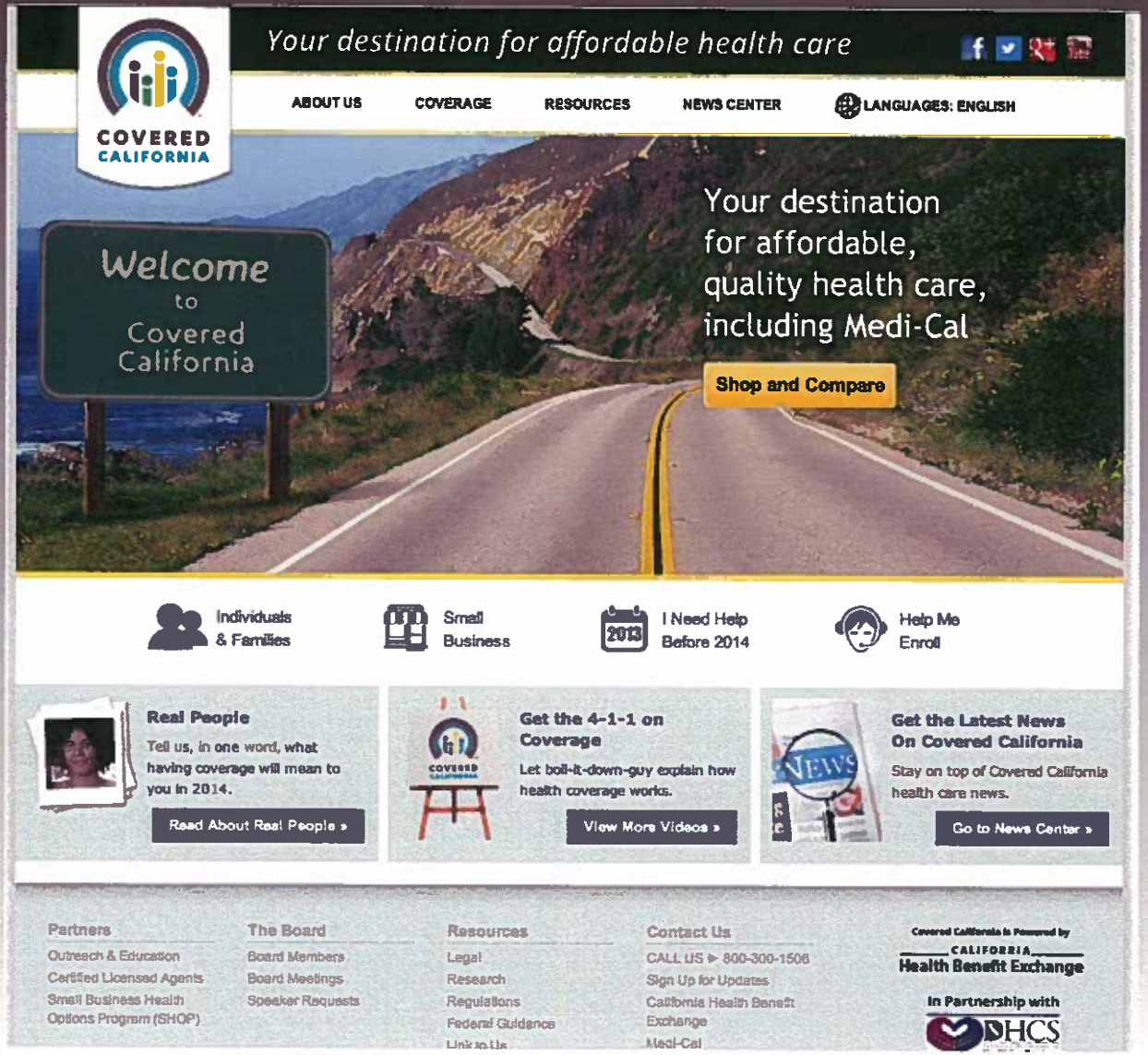
PRESENTATION ON COVERED CALIFORNIA

TAB 6

COVERED CALIFORNIA

Helping Consumers Enroll

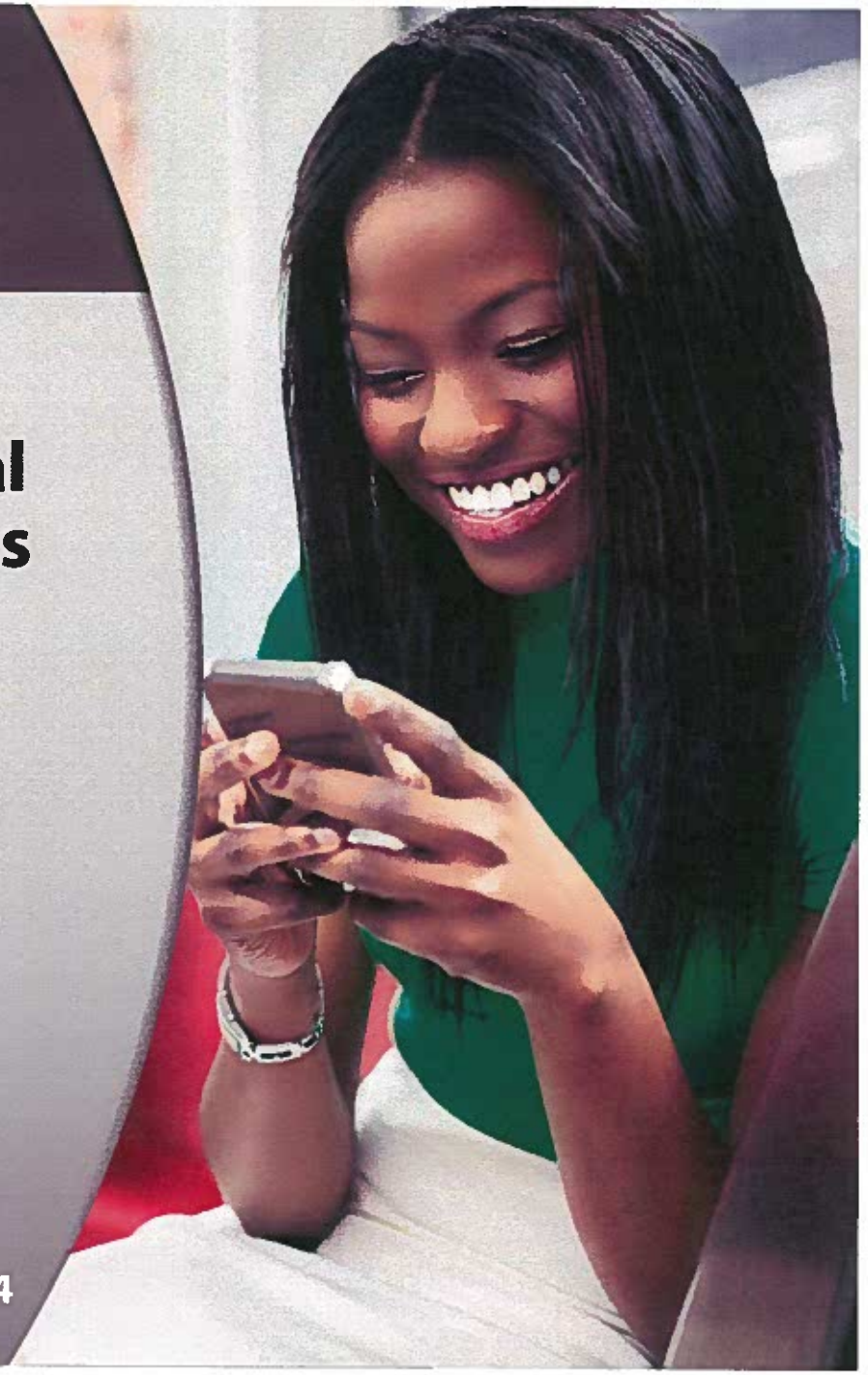
CoveredCA.com



Affordable Care Act
Coverage Improvements

- guaranteed coverage
- no annual limits, no denial for pre-existing conditions
- rates not based on health status
- requires large employers to offer coverage
- affordable coverage — public or private — required for individuals

Coverage improvements begin January 1, 2014



COVERED CALIFORNIA

Who is Eligible?

Who is:

- Legal California residents

Who's not:

- Undocumented immigrants
- Currently incarcerated individuals

Making Care More Affordable

Premium

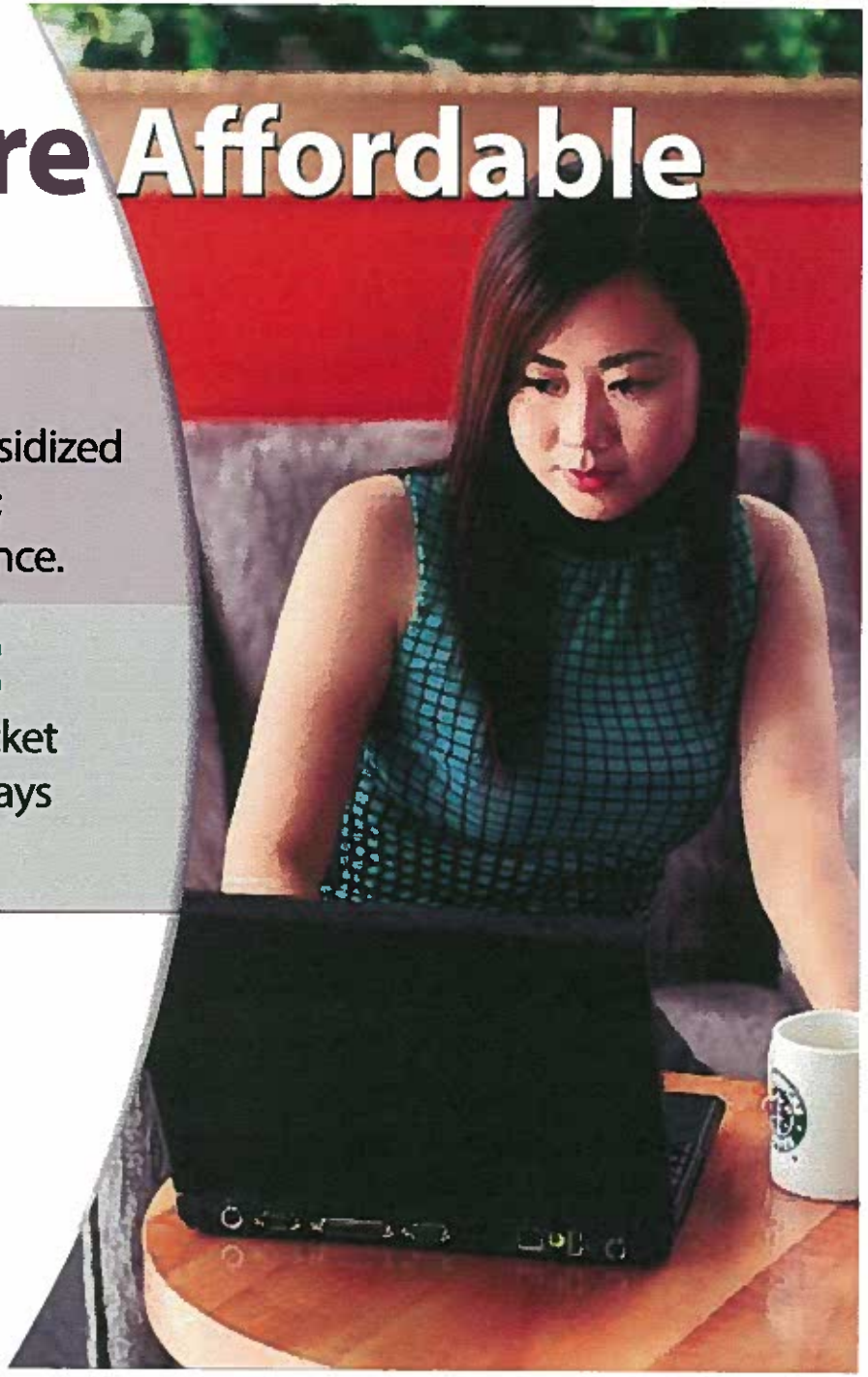
2.6 million Californians eligible for subsidized care pay a percentage of their income; the federal government pays the balance.

+ Out-of-Pocket Cost

Standardized benefits limit out-of-pocket costs based on sliding scale; most copays are not subject to deductibles.

= Affordable Care

True transparency on up-front and out-of-pocket costs.



Making Care More Affordable

Premium Assistance

Eligibility is based on:

Number of People in Your Household	Annual Household Income	
	Medi-Cal	Premium Assistance
1	$0 - $15,856	$15,856 - $45,960
2	$0 - $21,404	$21,404 - $62,040
3	$0 - $26,951	$26,951 - $78,120
4	$0 - $32,499	$32,499 - $94,200
5	$0 - $38,047	$38,047 - $110,280

COVERED CALIFORNIA

Health Insurance Plan Tier Levels

Metal tiers determine how much you pay as a patient, compared with what the plan pays.

Metal Tiers	Paid by Health Plan	Paid by Consumer
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

COVERED CALIFORNIA

2014 Standard Benefits for Individuals

	Bronze	Silver*	Gold	Platinum
Deductible	**$5,000** Medical and drugs	**$2,000** Medical	**None**	**None**
Primary Care Visit Copay	**$60** (Three visits per year)	**$45**	**$30**	**$20**
Generic Medication Copay	**$19**	**$19**	**$19**	**$5**
Emergency Room Copay	**$300**	**$250**	**$250**	**$150**
Maximum Out-of-Pocket for Individual	$6,350	$6,350	$6,350	$4,000
Maximum Out-of-Pocket for Family	$12,700	$12,700	$12,700	$8,000

* Lower cost sharing is available on a sliding scale.

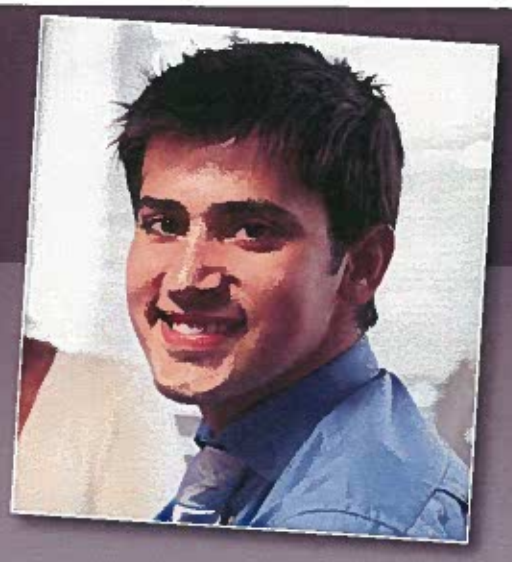
Copays are not subject to any deductible and count toward the annual out-of-pocket maximum.

Blue corners indicate benefits that are subject to deductibles.

COVERED CALIFORNIA

Oscar

Martinez, Calif.



Health insurance plan	Metal level	Premium	Premium assistance	Oscar pays (monthly)
blue of california PPO	Silver	$260	$167	**$93**
KAISER PERMANENTE HMO	Silver	$275	$167	**$108**
CONTRA COSTA HEALTH PLAN HMO	Silver	$279	$167	**$112**
Anthem BlueCross PPO	Silver	$290	$167	**$124**
Health Net PPO	Silver	$315	$167	**$148**

Oscar could also purchase a Bronze plan for as little as $35

Age: 25

Marital status: Single

Annual income*: $22,000

Dependents: None

Pricing region: 5

***Modified adjusted gross income**

COVERED CALIFORNIA

The Taylor family

Martinez, Calif.

Health insurance plan	Metal level	Premium	Premium assistance	Taylors pay (monthly)
blue of california PPO	Silver	$1003	$584	$419
KAISER PERMANENTE HMO	Silver	$1061	$584	$477
CONTRA COSTA HEALTH PLAN HMO	Silver	$1075	$584	$491
Anthem BlueCross PPO	Silver	$1120	$584	$536
Health Net PPO	Silver	$1215	$584	$631

Age: John, 42; Maria, 40

Marital status: Married

Annual income*: $65,000

Dependents: 2 children

Pricing region: 5

*Modified adjusted gross income

DOCTORS MEDICAL CENTER

FINANCIALS
OCTOBER AND NOVEMBER
2013

TAB 7

DOCTORS MEDICAL CENTER

Board Presentation

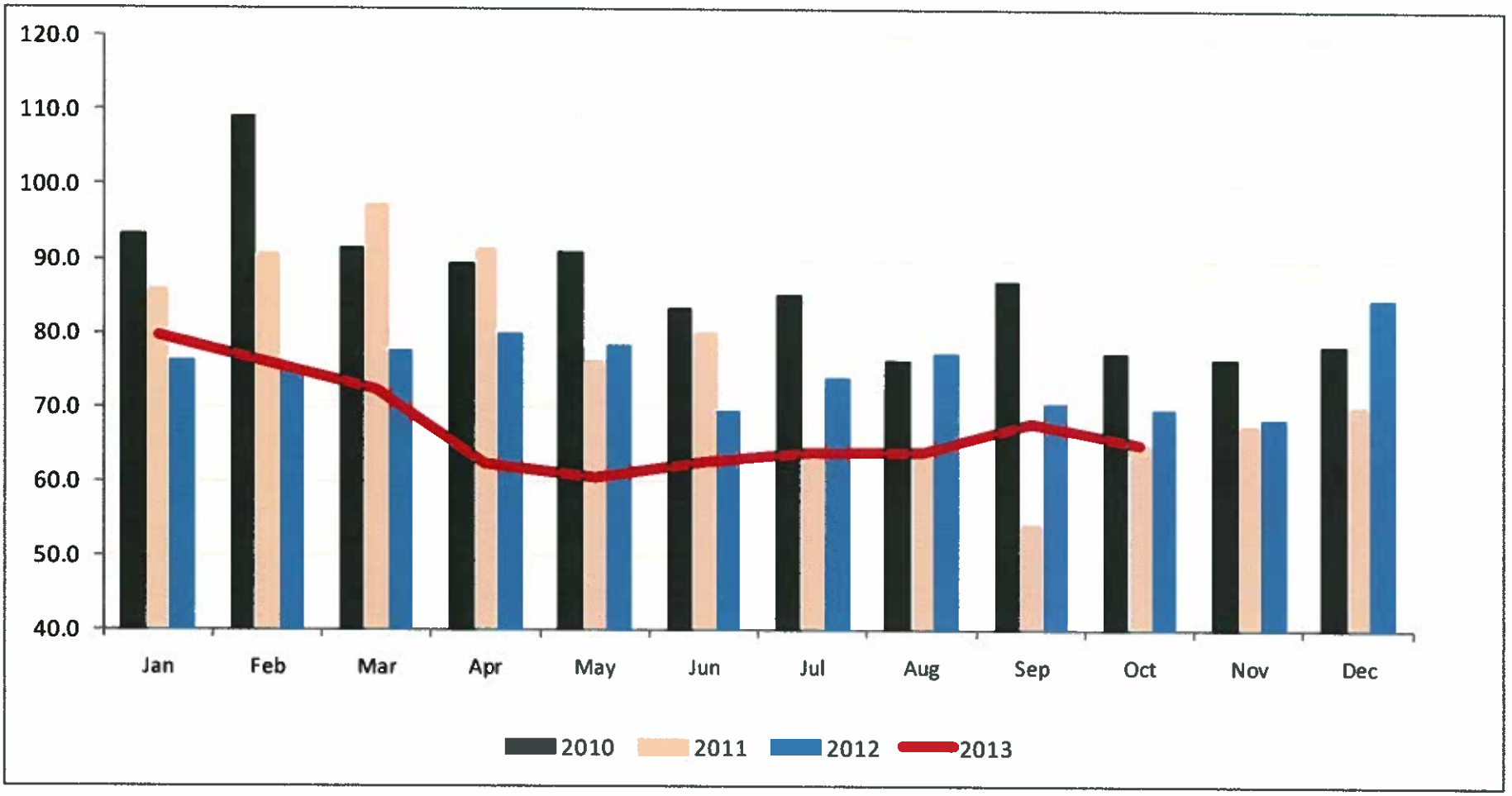
October 2013

Financial Report

Financial Report Key Points

- Net loss was $2.4M in October, $1.8M under budget.
- Net patient revenue was $1.7M under budget.
- Operating expenses were on target.

Average Daily Census
Jan-10 thru Oct-13



Statement of Activity - Summary

For the Period Ending

October 31, 2013

(Thousands)

Month_to_Date				Year_to_Date		
Actual	Budget	Var		Actual	Budget	Var
8,639	10,396	(1,757)	**Net Operating Revenues $**	94,731	103,400	(8,669)
11,757	11,758	1	**Total Operating Expenses $**	117,824	120,387	2,563
(3,118)	(1,361)	(1,757)	**Income/(Loss) from Operations $**	(23,093)	(16,987)	(6,106)
690	755	(65)	**Income from Other Sources $**	7,268	7,486	(218)
(2,428)	(606)	(1,822)	**Net Income / (Loss) $**	(15,825)	(9,501)	(6,324)
2,016	2,055	(39)	**Patient Days**	20,472	21,644	(1,172)
433	490	(57)	**Discharges**	4,569	4,907	(338)
6,098	6,840	(742)	**Outpatient Visits**	60,784	63,811	(3,027)
564	562	(2)	**Worked FTE's**	568	605	37
1.56	1.55	0.01	**Medicare CMI**	1.56	1.55	0.01

Budget Variances – Net Revenue

Medicare 2% Sequestration $(73K)	$ (1,057) K
Managed Care	$ (918) K
Other	$ 204 K

Budget Variances – Expenses

- **Total Operating Expenses** – On target for October.

Cash Position
October 31, 2013

(Thousands)

	October 31, 2013	December 31, 2012
Unrestricted Cash	$3,443	$5,059
Restricted Cash	$7,533	$11,612
Total Cash	$10,976	$16,671
Days Unrestricted Cash	9	11
Days Restricted	22	27
Total Days of Cash	31	39

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

Accounts Receivable

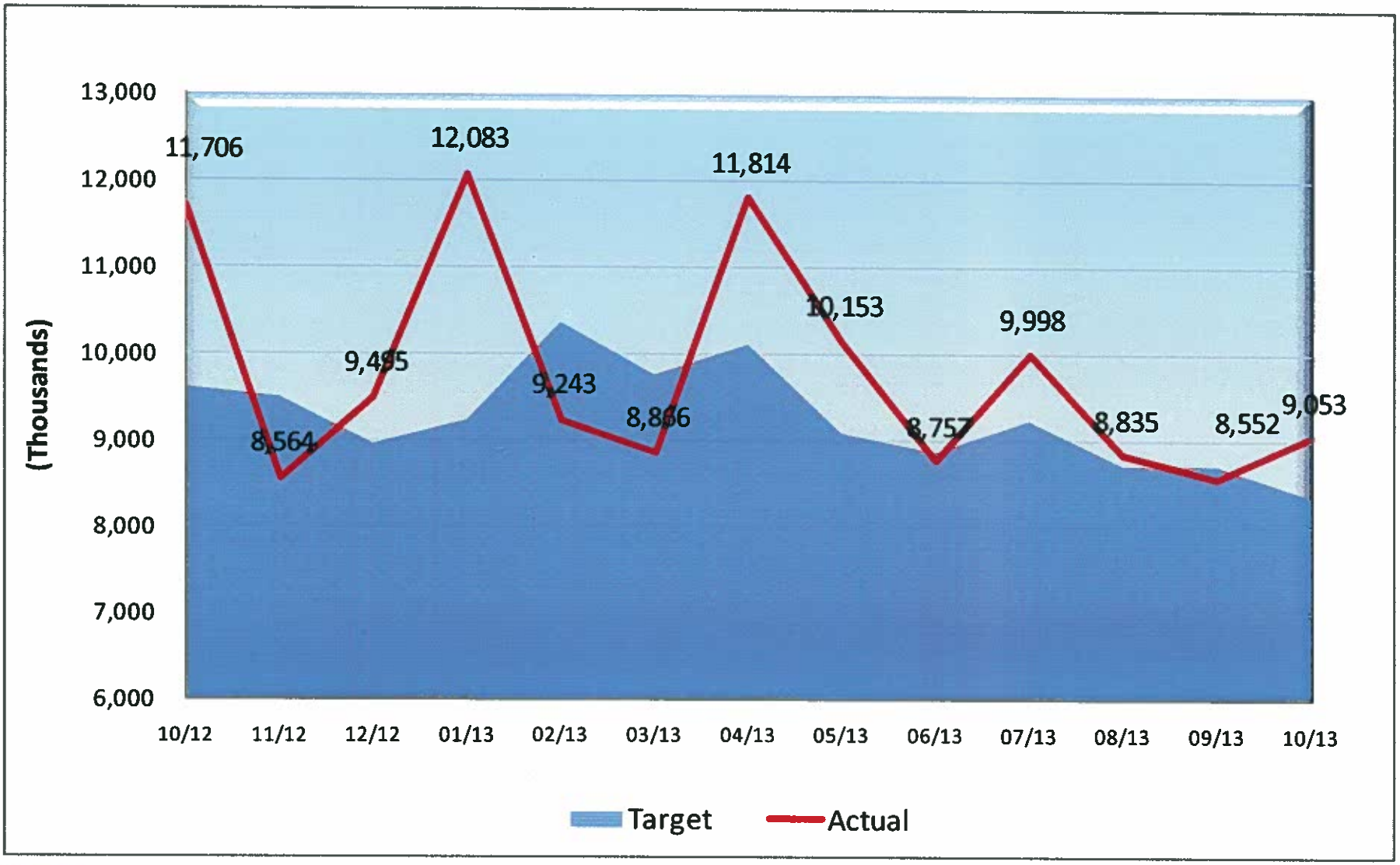
October 31, 2013

(Thousands)

	October 31, 2013	December 31, 2012
Net Patient Accounts Receivable	$21,504	$31,007
Net Days in Accounts Receivable	72.5	92.6

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

Cash Collections



WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2013
(Amounts In Thousands)

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
					OPERATING REVENUE					
8,554	10,266	(1,712)	-18.7%	9,727	Net Patient Service Revenue	93,785	102,094	(8,309)	-8.1%	99,090
85	130	(45)	-34.6%	1,549	Other Revenue	946	1,307	(361)	-27.6%	3,430
8,639	10,396	(1,757)	-16.9%	11,276	**Total Operating Revenue**	94,731	103,400	(8,669)	-8.4%	102,520
					OPERATING EXPENSES					
4,924	4,941	17	0.3%	5,339	Salaries & Wages	47,405	50,529	3,124	8.2%	53,852
2,519	2,603	84	3.2%	2,851	Employee Benefits	28,427	27,355	(1,072)	-3.9%	27,189
1,011	838	(173)	-20.7%	932	Professional Fees	9,736	9,104	(632)	-6.9%	9,542
1,416	1,431	15	1.1%	1,475	Supplies	13,400	13,784	384	2.8%	14,584
877	805	(72)	-8.9%	990	Purchased Services	8,483	8,387	(96)	-1.1%	9,226
249	281	32	11.5%	198	Rentals & Leases	2,859	2,881	202	7.1%	2,473
406	486	80	16.5%	419	Depreciation & Amortization	4,106	4,583	477	10.4%	4,044
355	371	18	4.3%	313	Other Operating Expenses	3,608	3,784	178	4.7%	3,456
11,757	11,758	1	0.0%	12,517	**Total Operating Expenses**	117,824	120,387	2,563	2.1%	124,366
(3,118)	(1,361)	(1,757)	129.1%	(1,241)	**Operating Profit / Loss**	(23,093)	(16,987)	(6,106)	35.9%	(21,846)
					NON-OPERATING REVENUES (EXPENSES)					
-	-	-	0.0%	-	Other Non-Operating Revenue	-	-	-	0.0%	1,200
1,123	1,133	(10)	0.9%	1,124	District Tax Revenue	11,230	11,350	(120)	1.1%	9,204
7	3	4	125.4%	15	Investment Income	144	47	97	208.1%	226
(440)	(362)	(58)	0.0%	(471)	Less: interest Expense	(4,106)	(3,911)	(195)	5.0%	(3,679)
890	755	(65)	-8.8%	668	**Total Net Non-Operating**	7,268	7,488	(218)	-2.9%	8,951
(2,428)	(606)	(1,822)	300.5%	(573)	**Income Profit (Loss)**	(15,825)	(9,501)	(6,324)	67%	(14,895)
					Profitability Ratios:					
-36.1%	-13.1%	100.0%		-11.0%	Operating Margin %	-24.4%	-18.4%	70.4%		-21.3%
-28.1%	-5.8%	-22.3%		-5.1%	Profit Margin %	-16.7%	-9.2%	-7.5%		-14.5%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2013
(Amounts in Thousands)

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
2,200	2,234	34	1.5%	2,388	SWB / APD	2,291	2,221	(70)	-3.2%	2,258
63.3%	64.2%	19492.1%		65.4%	SWB / Total Operating Expenses	64.4%	64.7%			85.2%
3,475	3,481	8	0.2%	3,649	Total Operating Expenses / APD	3,560	3,433	(127)	-3.7%	3,466
29,004	35,268	(6,264)	-17.8%	35,520	I/P Gross Charges	324,342	348,764	(24,422)	-7.0%	349,045
19,670	22,691	(3,021)	-13.3%	20,705	O/P Gross Charges	199,990	216,302	(16,312)	-7.5%	198,936
48,674	**57,960**	**(9,286)**	**-16.0%**	**56,225**	**Total Gross Charges**	**524,332**	**565,067**	**(40,735)**	**-7.2%**	**547,981**
					Payor Mix (IP and OP)					
54%	51%	3%		54%	Medicare %	54%	51%	4%		54%
20%	22%	-2%		19%	Medi-Cal %	20%	22%	-2%		19%
12%	14%	-2%		13%	Managed Care	12%	14%	-2%		13%
4%	4%	0%		4%	Other Government %	3%	4%	0%		4%
10%	10%	0%		10%	Self Pay %	10%	10%	0%		10%
					STATISTICS					
428	497	(69)	-13.9%	511	Admissions	4,637	4,938	(301)	-6.1%	5,092
433	490	(57)	-11.6%	504	Discharges	4,569	4,907	(338)	-6.9%	5,047
2,016	2,055	(39)	-1.9%	2167	Patient Days	20,472	21,644	(1,172)	-5.4%	22,858
65.0	66.3	(1.3)	-1.9%	69.9	Average Daily Census (ADC)	67.3	71.2	(3.9)	-5.4%	74.9
4.66	4.19	(0.46)	-11.0%	4.30	Average Length of Stay (LOS)- Accrual Based	4.48	4.41	(0.07)	-1.6%	4.53
31	31			31	Days in Month	304	304			305
727	805	(79)	-9.8%	798	Adjusted Discharges (AD)	7,388	7,950	(564)	-7.1%	7,924
3,383	3,377	6	0.2%	3,430	Adjusted Patient Days (APD)	33,095	35,068	(1,972)	-5.6%	35,886
109	109	0	0.2%	111	Adjusted ADC (AADC)	109	115	(6)	-5.6%	118
72	73	(1)	-1.4%	85	Inpatient Surgeries	721	748	(27)	-3.6%	769
81	114	(33)	-28.9%	97	Outpatient Surgeries	820	966	(146)	-15.1%	933
153	**187**	**(34)**	**-18.2%**	**182**	**Total Surgeries**	**1,541**	**1,714**	**(173)**	**-10.1%**	**1,702**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2013
(Amounts In Thousands)

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
2,978	3,074	(96)	-3.1%	3229	ED Outpatient Visits	30,898	29,511	1,387	4.7%	35,032
3,039	3,852	(813)	-16.8%	3431	Ancillary Outpatient Visits	29,066	33,334	(4,268)	-12.8%	31,907
81	114	(33)	-28.9%	97	Outpatient Surgeries	820	966	(146)	-15.1%	933
6,098	**8,840**	(742)	-10.8%	6,757	**Total Outpatient Visits**	**60,784**	**63,811**	(3,027)	-4.7%	**67,872**
375	445	(70)	-15.7%	425	Emergency Room Admits	4,191	4,420	(229)	-5.2%	4,625
12.6%	14.5%			13.2%	% of Total E/R Visits	13.6%	15.0%			13.2%
87.6%	89.5%			83.2%	% of Acute Admissions	90.4%	89.5%			90.8%
564	562	(2)	-0.3%	646	Worked FTE	568	605	37	6.1%	629
632	637	4	0.7%	733	Paid FTE	669	701	33	4.8%	730
5.17	5.16	(0.01)	-0.1%	5.84	Worked FTE / AADC	5.21	5.24	0.03	0.8%	5.35
5.79	5.84	0.05	0.9%	6.63	Paid FTE / AADC	6.14	8.08	(0.06)	-1.0%	6.20
2,528	3,040	(512)	-16.8%	2,836	Net Patient Revenue / APD	2,834	2,911	(78)	-2.7%	2,761
14,387	17,162	(2,775)	-16.2%	16,391	I/P Charges / Patient Days	15,843	16,114	(270)	-1.7%	15,270
3,226	3,317	(92)	-2.8%	3,064	O/P Charges / Visit	3,290	3,390	(100)	-2.9%	2,931
1,455	1,463	8	0.5%	1,556	Salary Expense / APD	1,432	1,441	9	0.6%	1,501
4.77	4.94	0.16	3.3%	4.76	Medicare LOS - Discharged Based	4.88	5.06	0.20	3.9%	4.88
1.56	1.55	0.01	0.8%	1.51	Medicare CMI	1.56	1.55	0.01	0.8%	1.54
3.05	3.18	(0.13)	-4.1%	3.16	Medicare CMi Adjusted LOS	3.11	3.28	(0.15)	-4.5%	3.17
4.66	4.19	(0.46)	-11.0%	4.40	Total LOS - Discharged Based	4.49	4.41	(0.08)	-1.8%	4.55
1.49	1.36	0.13	9.8%	1.53	Total CMI	1.51	1.47	0.05	3.2%	1.49
3.12	3.08	0.03	1.1%	2.88	Total CMi Adjusted LOS	2.96	3.01	(0.04)	-1.4%	3.05

Footnote:
a) Reclassed budget of $56K in July from Admin Salaries to Admin Consulting for the CEO,CNO and COO.
b) Reclassed budget of $9K in July from Admin Employee Benefits to Admin Consulting for the CEO,CNO and COO.
c) Moved budget of $79K in July Admin Salaries, Benefits and Recruitment to Admin Consulting for the CEO,CNO and COO.
d) Reclassed budget of $14K in July from Admin Recruitment to Admin Consulting for the CEO,CNO and COO.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
October 31, 2013
(Amounts in Thousands)

	Current Month	Dec. 31, 2012
ASSETS		
Cash	3,443	5,059
Net Patient Accounts Receivable	21,504	31,007
Other Receivables	7,591	464
Inventory	1,656	1,731
Current Assets With Limited Use	7,533	11,612
Prepaid Expenses and Deposits	1,176	1,621
TOTAL CURRENT ASSETS	**42,903**	**51,494**
Assets With Limited Use	**642**	**642**
Property Plant & Equipment		
Land	12,120	12,120
Bldg/Leasehold Improvements	29,433	29,432
Capital Leases	10,926	10,926
Equipment	45,010	43,579
CIP	921	860
Total Property, Plant & Equipment	98,410	96,917
Accumulated Depreciation	-57,821	-53,887
Net Property, Plant & Equipment	**40,589**	**43,030**
Intangible Assets	1,403	1,454
Total Assets	**85,537**	**96,620**
Current Ratio (CA/CL)	***1.07***	***1.27***
Net Working Capital (CA-CL)	***2,921***	***10,901***
Long Term Debt Ratio (LTD/TA)	***0.70***	***0.63***
Long Term Debt to Capital (LTD/(LTD+TE)	***1.66***	***1.15***
Financial Leverage (TA/TE)	***-3.6***	***-12.0***
Quick Ratio	**0.62**	**0.89**
Unrestricted Cash Days	**9**	**11**
Restricted Cash Days	**22**	**27**
Net A/R Days	**72.5**	**92.6**

		Current Month	Dec. 31, 2012
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,314	1,613
97	Accounts Payable and Accrued Expenses	13,755	16,509
98	Accrued Payroll and Related Liabilities	19,008	17,512
99	Deferred District Tax Revenue	3,085	3,091
100	Estimated Third Party Payor Settlements	2,820	1,868
101	**Total Current Liabilities**	**39,982**	**40,593**
	Other Liabilities		
102	Other Deferred Liabilities	9,428	2,804
	Long Term Debt		
103	Notes Payable - Secured	60,323	61,242
104	Capital Leases	996	1,647
105	Less Current Portion LTD	-1,314	-1,613
106	**Total Long Term Debt**	**60,005**	**61,276**
107	**Total Liabilities**	**109,415**	**104,673**
	EQUITY		
108	Retained Earnings	-8,053	9,667
109	Year to Date Profit / (Loss)	-15,825	-17,720
110	**Total Equity**	**-23,878**	**-8,053**
111	**Total Liabilities & Equity**	**85,537**	**96,620**

DOCTORS MEDICAL CENTER

October 2013 Executive Report

Doctors Medical Center had a net loss of $ 2,428,000 for the month of October. As a result, net income was $1,822,000 worse than budget. The following are the factors leading to the net income variance for the month:

Net Patient Revenue Factors	Positive / (Negative)
Medicare	($1,057,000)
Managed Care	($918,000)
Other	$204,000

Net patient revenue was under budget by $1,712,000 for October mainly because inpatient gross charges were under budget by 17.8% and outpatient gross charges were under budget by 13.3%. Patient days were under budget by 1.9% and discharges under budget by 11.6%. Outpatient surgeries were 28.9% worse than budgeted, emergency room visits were 3.1% under budget, and total outpatient volume was 10.8% under budget for October.

In October, regular Medicare inpatient discharges were 11.7% below budget with both inpatient and outpatient reimbursement lower than expected resulting in a $774,000 shortfall. Managed Medicare was also under budget by $283,000, 25.5%, due primarily to a lower reimbursement rate. Managed Care volume was 18.1% under budget resulting in a shortfall of $918,000 in patient revenue.

Salaries were slightly under budget due to continued flexing of staff in response to reduced inpatient and outpatient volume. Health benefit costs continue to exceed budget this month by $90,000, which was offset by favorable variances in payroll taxes and vacation and other non-productive payroll expenses resulting in a positive variance of $84,000 in benefit expenses.

Professional fees were $173,000 worse than budget because of an under budgeted amount for physician costs.

Purchased services exceeded budget by $72,000 primarily due to new contract to manage medical equipment and additional bad debt collection costs, which is offset by increased cash collections.

DOCTORS MEDICAL CENTER

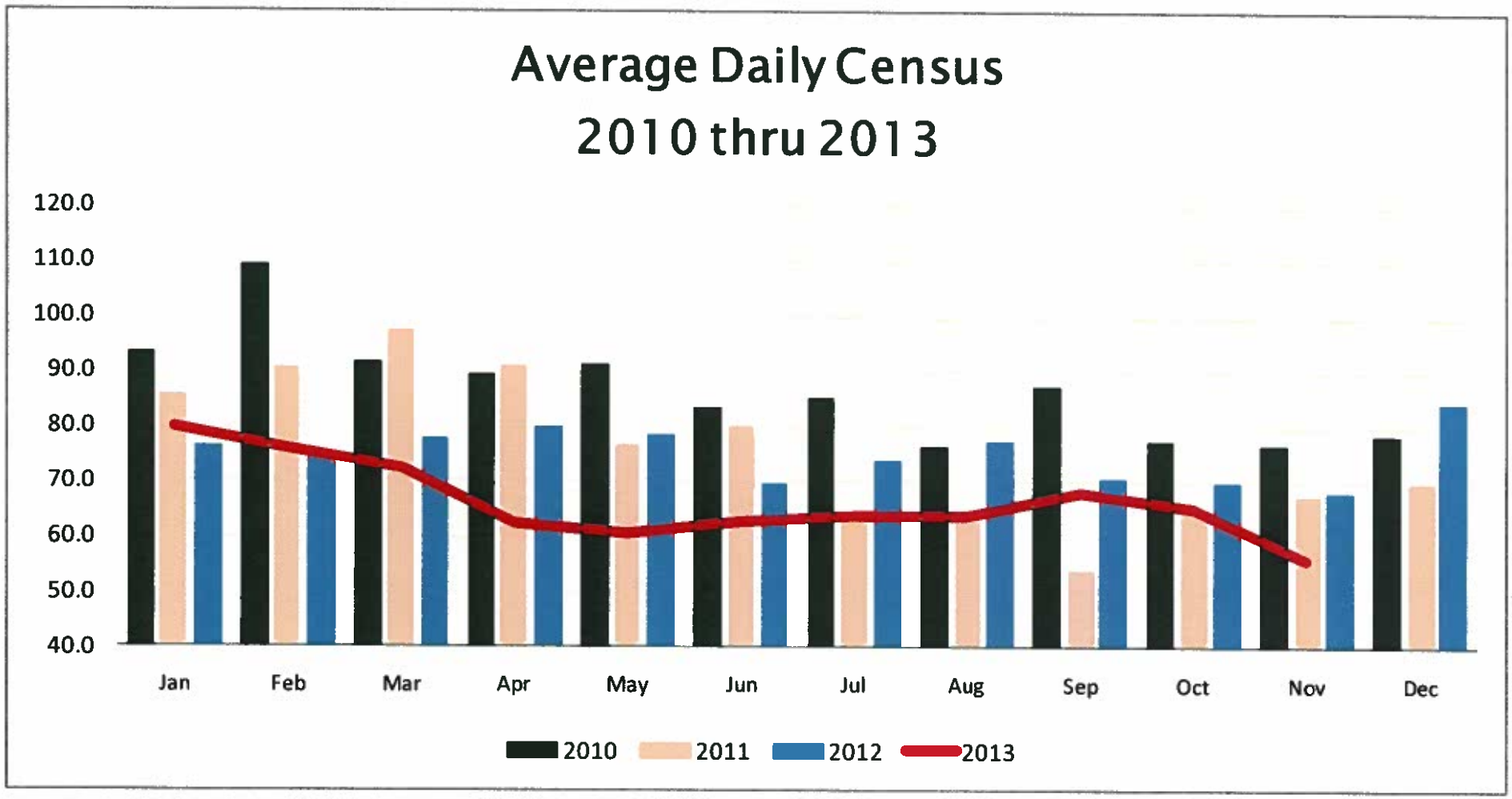
Board Presentation

November 2013

Financial Report

Financial Report Key Points

- Net loss was $2.4M in November, $2.1M under budget.
- Net patient revenue was $1.4M under budget.
- Operating expenses were $553K over budget.


Average Daily Census
2010 thru 2013
120.0
110.0
100.0
90.0
80.0
70.0
60.0
50.0
40.0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2010
2011
2012
2013

Statement of Activity - Summary

For the Period Ending

October 31, 2013

(Thousands)

Month to Date				Year to Date		
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2,016	2,055	(39)	Patient Days	20,472	21,644	(1,172)
433	490	(57)	Discharges	4,569	4,907	(338)
6,098	6,840	(742)	Outpatient Visits	60,784	63,811	(3,027)
564	562	(2)	Worked FTE's	568	605	37
1.56	1.55	0.01	Medicare CMI	1.56	1.55	0.01

Statement of Activity - Summary

For the Period Ending

November 30, 2013

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
9,324	10,787	(1,463)	**Net Operating Revenues $**	104,055	114,187	(10,132)
12,411	11,858	(553)	**Total Operating Expenses $**	130,235	132,246	2,011
(3,087)	(1,072)	(2,015)	**Income/(Loss) from Operations $**	(26,180)	(18,059)	(8,121)
675	754	(79)	**Income from Other Sources $**	7,943	8,240	(297)
(2,412)	(317)	(2,095)	**Net Income / (Loss) $**	(18,237)	(9,818)	(8,419)
1,683	2,051	(368)	**Patient Days**	22,155	23,695	(1,540)
401	448	(47)	**Discharges**	4,970	5,355	(385)
5,536	6,475	(939)	**Outpatient Visits**	66,320	70,286	(3,966)
552	598	45	**Worked FTE's**	566	604	38
1.63	1.55	0.08	**Medicare CMI**	1.57	1.55	0.01

Budget Variances – Net Revenue

Medicare 2% Sequestration $(70K)	$	(573) K
Managed Care	$	(674) K
Other	$	(186) K

Budget Variances – Expenses

- Salaries & Benefits ($57K) – Increasing health insurance costs.
- Professional Fees ($358K) – Under budgeted physician costs, Sodexo management costs catch up.
- Supplies $257K – Underutilization of implants.
- Purchased Services ($439K) – Higher collection costs offset by higher A/R cash collections and new contract to manage medical equipment.
- Other Operating ($63) – Recruitment costs

Cash Position
November 30, 2013

(Thousands)

	November 30, 2013	December 31, 2012
Unrestricted Cash	$2,933	$5,059
Restricted Cash	$7,533	$11,612
Total Cash	$10,466	$16,671
Days Unrestricted Cash	7	11
Days Restricted	20	27
Total Days of Cash	27	39

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

Accounts Receivable

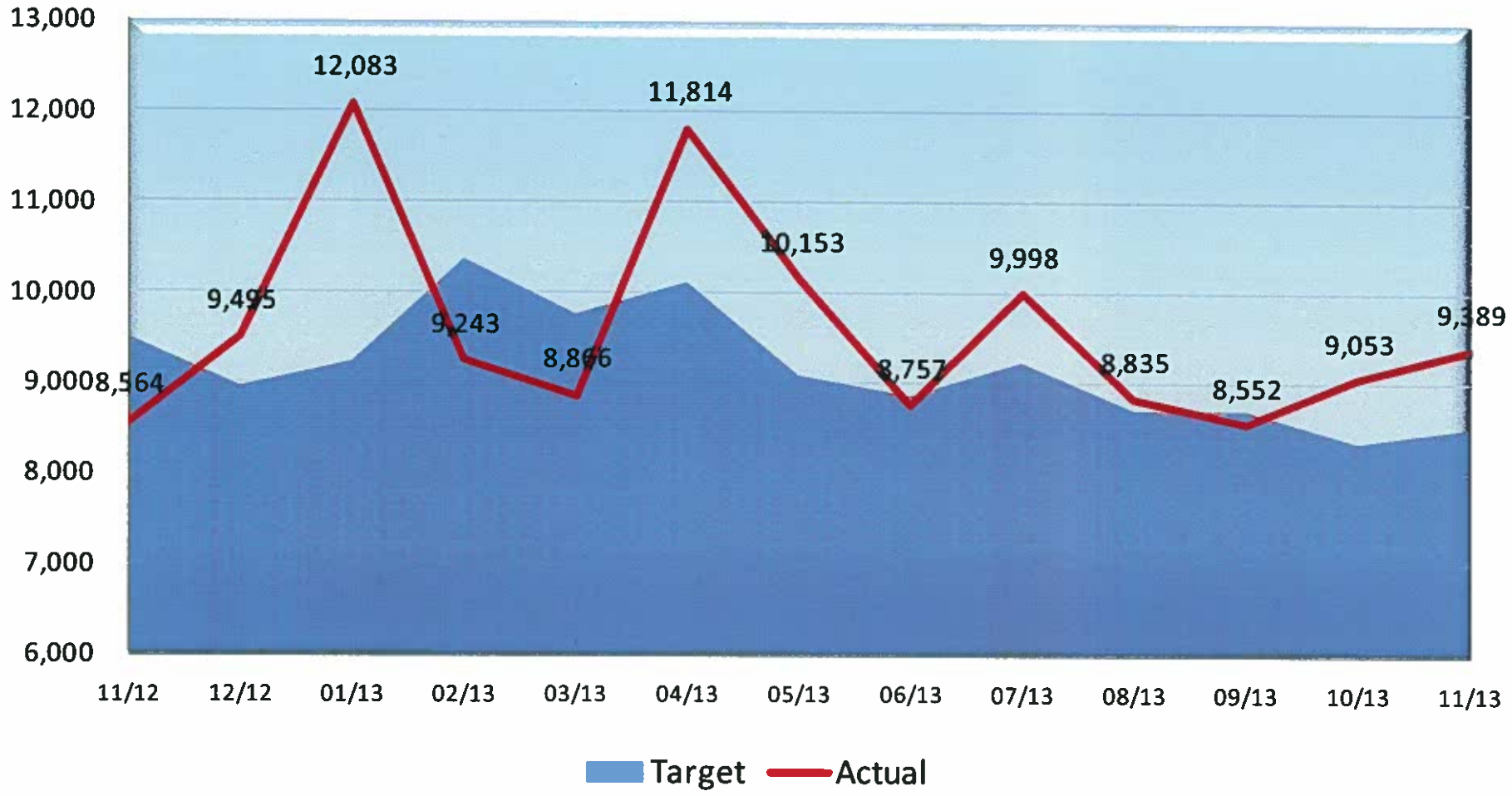
November 30, 2013

(Thousands)

	November 30, 2013	December 31, 2012
Net Patient Accounts Receivable	$20,477	$31,007
Net Days in Accounts Receivable	69.9	92.6

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

Cash Collection



WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
November 30, 2013
(Amounts in Thousands)

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
					OPERATING REVENUE					
8,078	9,511	(1,433)	-15.1%	8,662	Net Patient Service Revenue	101,863	111,605	(9,742)	-8.7%	107,752
1,246	1,275	(29)	-2.3%	65	Other Revenue	2,192	2,582	(390)	-15.1%	3,515
9,324	10,787	(1,463)	-13.6%	8,747	**Total Operating Revenue**	104,055	114,187	(10,132)	-8.9%	111,267
					OPERATING EXPENSES					
4,297	4,821	524	10.9%	4,730	Salaries & Wages	51,702	55,349	3,647	6.6%	58,582
3,423	2,842	(581)	-20.4%	2,957	Employee Benefits	31,850	30,197	(1,853)	-5.5%	30,146
1,232	874	(358)	-41.0%	1,141	Professional Fees	10,968	9,978	(990)	-9.9%	10,683
1,152	1,409	257	18.2%	1,413	Supplies	14,552	15,193	641	4.2%	15,997
1,240	801	(439)	-54.9%	1,043	Purchased Services	9,723	9,188	(535)	-5.8%	10,269
253	281	28	10.1%	297	Rentals & Leases	2,912	3,143	231	7.3%	2,770
410	490	80	16.4%	422	Depreciation & Amortization	4,516	5,073	557	11.0%	4,466
404	341	(63)	-18.6%	167	Other Operating Expenses	4,012	4,125	113	2.7%	3,823
12,411	11,858	(553)	-4.7%	12,170	**Total Operating Expenses**	130,235	132,246	2,011	1.5%	136,536
(3,087)	(1,072)	(2,015)	188.1%	(3,423)	**Operating Profit / Loss**	(26,180)	(18,059)	(8,121)	45.0%	(25,269)
					NON-OPERATING REVENUES (EXPENSES)					
-	-	-	0.0%	-	Other Non-Operating Revenue	-	-	-	0.0%	1,200
1,124	1,133	(9)	0.8%	1,123	District Tax Revenue	12,354	12,483	(129)	1.0%	10,327
9	2	7	315.1%	3	Investment Income	153	49	104	212.9%	229
(458)	(381)	(77)	0.0%	(470)	Less: Interest Expense	(4,564)	(4,292)	(272)	6.3%	(4,149)
675	754	(79)	-10.5%	656	**Total Net Non-Operating**	7,943	8,240	(297)	-3.6%	7,607
(2,412)	(317)	(2,095)	659.9%	(2,767)	**Income Profit (Loss)**	(18,237)	(9,818)	(8,419)	86%	(17,662)
					Profitability Ratios:					
-33.1%	-9.9%	137.8%		-39.1%	Operating Margin %	-25.2%	-15.8%	80.2%		-22.7%
-25.9%	-2.9%	-22.9%		-31.6%	Profit Margin %	-17.5%	-8.6%	-8.9%		-15.9%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
November 30, 2013
(Amounts in Thousands)

CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
2,739	2,283	(456)	-20.0%	2,445	SWB / APD	2,327	2,226	(101)	-4.5%	2,274
62.2%	64.6%	10.4%		63.2%	SWB / Total Operating Expenses	64.2%	64.7%			65.0%
4,403	3,533	(871)	-24.7%	3,870	Total Operating Expenses / APD	3,627	3,442	(185)	-5.4%	3,499
24,645	33,922	(9,277)	-27.3%	34,992	I/P Gross Charges	348,987	382,686	(33,699)	-8.8%	384,037
16,627	21,598	(4,971)	-23.0%	18,681	O/P Gross Charges	216,617	237,900	(21,283)	-8.9%	217,617
41,272	**55,520**	**(14,248)**	**-25.7%**	**53,673**	**Total Gross Charges**	**565,604**	**620,586**	**(54,982)**	**-8.9%**	**601,654**
					Payor Mix (IP and OP)					
51%	51%	0%		53%	Medicare %	54%	51%	3%		53%
19%	22%	-3%		19%	Medi-Cal %	20%	22%	-2%		19%
15%	14%	1%		11%	Managed Care	12%	14%	-1%		11%
4%	4%	0%		4%	Other Government %	3%	4%	0%		4%
11%	10%	1%		13%	Self Pay %	11%	10%	0%		13%
					STATISTICS					
385	468	(83)	-17.7%	464	Admissions	5,022	5,406	(384)	-7.1%	5,556
401	448	(47)	-10.5%	451	Discharges	4,970	5,355	(385)	-7.2%	5,498
1,683	2,051	(368)	-17.9%	2050	Patient Days	22,155	23,695	(1,540)	-6.5%	24,908
56.1	68.4	(12.3)	-17.9%	68.3	Average Daily Census (ADC)	66.3	70.9	(4.6)	-6.5%	74.4
4.20	4.58	0.38	6.3%	4.55	Average Length of Stay (LOS)- Accrual Based	4.46	4.42	(0.03)	-0.7%	4.53
30	30			30	Days in Month	334	334			335
672	733	(62)	-8.4%	692	Adjusted Discharges (AD)	8,055	8,684	(629)	-7.2%	6,613
2,816	3,357	(538)	-16.0%	3,144	Adjusted Patient Days (APD)	35,907	38,425	(2,519)	-6.6%	39,022
94	112	(18)	-16.0%	105	Adjusted ADC (AADC)	108	115	(8)	-6.6%	116
66	80	(14)	-17.5%	79	Inpatient Surgeries	787	828	(41)	-5.0%	848
70	103	(33)	-32.0%	63	Outpatient Surgeries	890	1,069	(179)	-16.7%	996
136	**183**	**(47)**	**-25.7%**	**142**	**Total Surgeries**	**1,677**	**1,897**	**(220)**	**-11.6%**	**1,844**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
November 30, 2013
(Amounts in Thousands)

CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
2,905	2,814	91	3.2%	3124	ED Outpatient Visits	33,803	32,325	1,478	4.8%	38,156
2,581	3,558	(997)	-28.0%	2775	Ancillary Outpatient Visits	31,627	36,892	(5,265)	-14.3%	34,682
70	103	(33)	-32.0%	63	Outpatient Surgeries	890	1,069	(179)	-16.7%	996
5,536	**6,475**	(939)	-14.5%	**5,962**	**Total Outpatient Visits**	**66,320**	**70,286**	(3,966)	-5.8%	**73,834**
347	419	(72)	-17.2%	412	Emergency Room Admits	4,538	4,838	(300)	-6.2%	5,037
11.9%	14.9%			13.2%	% of Total E/R Visits	13.4%	15.0%			13.2%
90.1%	89.5%			88.6%	% of Acute Admissions	90.4%	89.5%			90.7%
552	598	45	7.8%	594	Worked FTE	566	604	38	6.3%	826
822	712	90	12.8%	724	Paid FTE	665	702	38	5.4%	729
5.88	5.34	(0.54)	-10.1%	5.67	Worked FTE / AADC	5.27	5.25	(0.02)	-0.3%	5.38
6.62	6.36	(0.26)	-4.1%	6.90	Paid FTE / AADC	6.18	8.11	(0.08)	-1.3%	8.26
2,866	2,833	33	1.2%	2,755	Net Patient Revenue / APD	2,837	2,904	(66)	-2.3%	2,781
14,643	16,539	(1,896)	-11.5%	17,069	I/P Charges / Patient Days	15,752	16,150	(398)	-2.5%	15,418
3,003	3,336	(332)	-10.0%	3,133	O/P Charges / Visit	3,266	3,385	(119)	-3.5%	2,947
1,525	1,436	(89)	-6.2%	1,504	Salary Expense / APD	1,440	1,440	1	0.0%	1,501
4.77	5.83	1.06	18.2%	4.87	Medicare LOS - Discharged Based	4.61	5.13	0.31	6.1%	4.88
1.63	1.55	0.08	5.1%	1.38	Medicare CMI	1.57	1.55	0.01	1.0%	1.53
2.93	3.76	(0.83)	-22.2%	3.53	Medicare CMI Adjusted LOS	3.07	3.31	(0.23)	-7.0%	3.20
4.20	4.58	0.38	8.3%	4.55	Total LOS - Discharged Based	4.46	4.42	(0.04)	-0.8%	4.55
1.54	1.31	0.23	17.2%	1.41	Total CMI	1.52	1.45	0.06	4.4%	1.48
2.73	3.49	(0.76)	-21.8%	3.23	Total CMI Adjusted LOS	2.94	3.05	(0.10)	-3.4%	3.07

Footnote:
a) Reclassed budget of $58K in July from Admin Salaries to Admin Consulting for the CEO,CNO and COO.
b) Reclassed budget of $9K in July from Admin Employee Benefits to Admin Consulting for the CEO,CNO and COO.
c) Moved budget of $79K in July Admin Salaries, Benefits and Recruitment to Admin Consulting for the CEO,CNO and COO.
d) Reclassed budget of $14K in July from Admin Recruitment to Admin Consulting for the CEO,CNO and COO.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
November 30, 2013
(Amounts in Thousands)

	Current Month	Dec. 31, 2012
ASSETS		
Cash	2,933	5,059
Net Patient Accounts Receivable	20,477	31,007
Other Receivables	5,306	464
Inventory	1,664	1,731
Current Assets With Limited Use	7,533	11,612
Prepaid Expenses and Deposits	1,010	1,621
TOTAL CURRENT ASSETS	**38,923**	**51,494**
Assets With Limited Use	**642**	**642**
Property Plant & Equipment		
Land	12,120	12,120
Bldg/Leasehold Improvements	29,433	29,432
Capital Leases	10,926	10,926
Equipment	45,328	43,579
CIP	624	860
Total Property, Plant & Equipment	98,431	96,917
Accumulated Depreciation	-58,213	-53,887
Net Property, Plant & Equipment	**40,218**	**43,030**
Intangible Assets	**1,397**	**1,454**
Total Assets	**81,180**	**96,620**
Current Ratio (CA/CL)	*1.02*	*1.27*
Net Working Capital (CA-CL)	*596*	*10,901*
Long Term Debt Ratio (LTD/TA)	*0.74*	*0.63*
Long Term Debt to Capital (LTD/(LTD+TE)	*1.78*	*1.15*
Financial Leverage (TA/TE)	*-3.1*	*-12.0*
Quick Ratio	0.61	0.89
Unrestricted Cash Days	7	11
Restricted Cash Days	20	27
Net A/R Days	69.9	92.6

		Current Month	Dec. 31, 2012
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,317	1,613
97	Accounts Payable and Accrued Expenses	13,826	16,509
98	Accrued Payroll and Related Liabilities	17,183	17,512
99	Deferred District Tax Revenue	3,086	3,091
100	Estimated Third Party Payor Settlements	2,915	1,868
101	**Total Current Liabilities**	**38,327**	**40,593**
	Other Liabilities		
102	Other Deferred Liabilities	9,189	2,804
	Long Term Debt		
103	Notes Payable - Secured	60,305	61,242
104	Capital Leases	966	1,647
105	Less Current Portion LTD	-1,317	-1,613
106	**Total Long Term Debt**	**59,954**	**61,276**
107	**Total Liabilities**	**107,470**	**104,673**
	EQUITY		
108	Retained Earnings	-8,053	9,667
109	Year to Date Profit / (Loss)	-18,237	-17,720
110	**Total Equity**	**-26,290**	**-8,053**
111	**Total Liabilities & Equity**	**81,180**	**96,620**

DOCTORS MEDICAL CENTER

November 2013 Executive Report

Doctors Medical Center had a net loss of $ 2,412,000 for the month of November. As a result, net income was $2,095,000 worse than budget. The following are the factors leading to the net income variance for the month:

Net Patient Revenue Factors	Positive / Negative)
Medicare	($573,000)
Managed Care	($674,000)
Other	($186,000)

Net patient revenue was under budget by $1,433,000 for November. Patient days were 17.9% under budget and discharges under budget by 10.5%. Total outpatient volume was under budget by 14.5% with outpatient surgeries at 32.0% worse than budgeted, ancillary outpatient visits at 28.0% under budget for November while emergency room visits were 3.2% higher than budget.

In November, regular Medicare inpatient discharges were 9.8% over budget; however, both inpatient and outpatient reimbursement was lower than expected resulting in a $405,000 shortfall. Managed Medicare was also under budget by $168,000, 15.7%, due primarily to a lower reimbursement rate. Managed Care volume was 12.3% under budget resulting in a shortfall of $674,000 in patient revenue.

Salaries were under budget due to continued flexing of staff in response to reduced inpatient and outpatient volume. Health benefit costs continue to exceed budget this month by $860,000, which was offset by favorable variances in payroll taxes and vacation and other non-productive payroll expenses resulting in a negative variance of $581,000 in benefit expenses.

Professional fees were $358,000 worse than budget because of an under budgeted amount for physician costs and Sodexo management costs catch up.

Purchased services exceeded budget by $439,000 primarily due to a new contract to manage medical equipment, additional renal dialysis expenses, and additional bad debt collection costs which are offset by increased cash collections on claims greater than 150 days old.

Other operating expenses are over budget by $63,000 due to recruitment costs for a new director.

DOCTORS MEDICAL CENTER

2014 BUDGET PRESENTATION

TAB 8

DOCTORS MEDICAL CENTER

2014 Budget

December 18, 2013

Goals of 2014 Budget

- Improve current operational performance
- Reflect rapidly changing healthcare events
- Prepare DMC for future changes to our patient delivery system

2014 Budgeted Statement of Revenues and Expenses
Amounts in Thousands

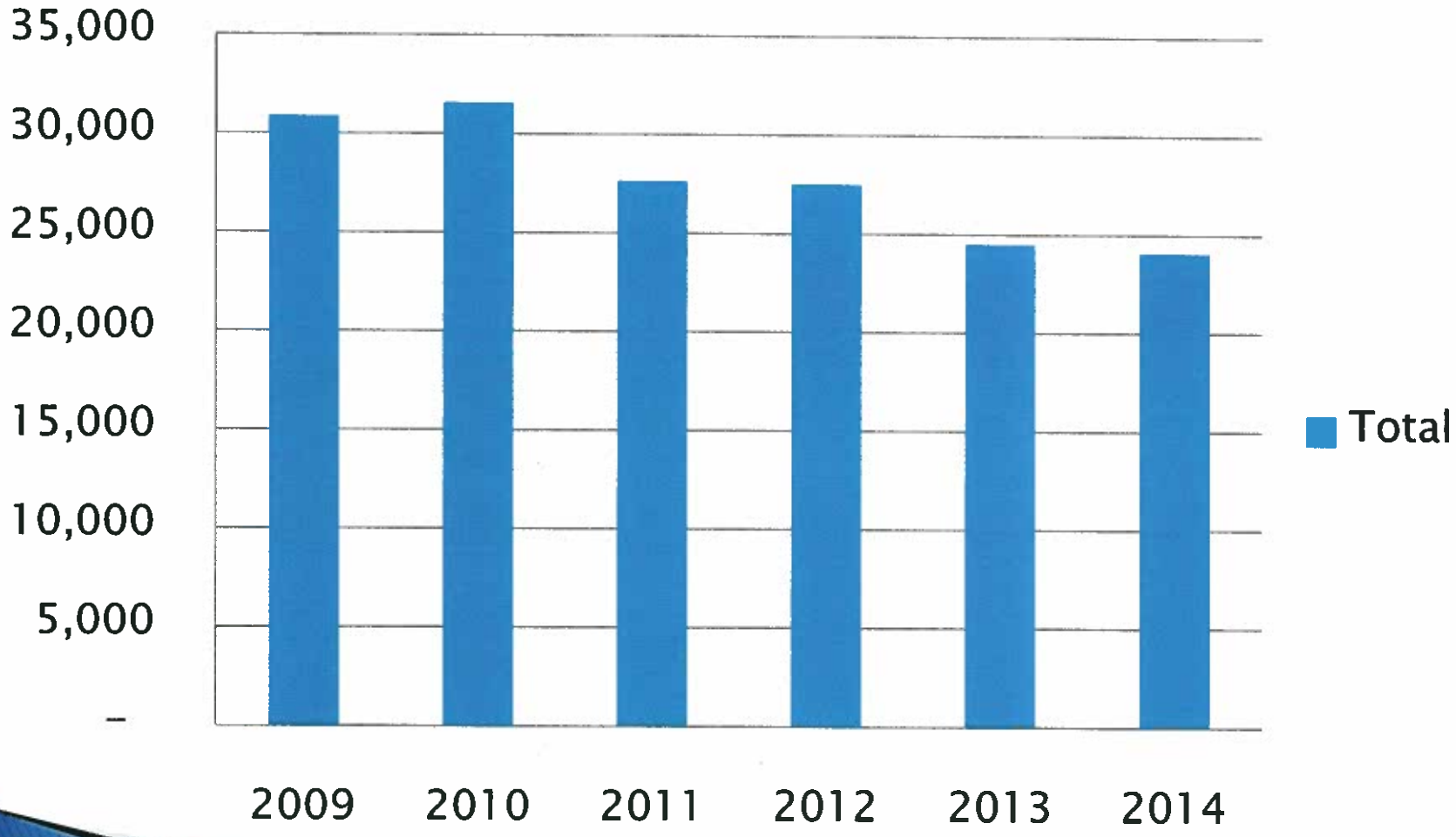
	Actual 2012	Projected 2013	Budget 2014	Change	% Change
OPERATING REVENUE					
Net Patient Service Revenue	121,984	116,589	117,636	1,047	0.9%
Other Revenue	3,549	1,154	1,023	(131)	-11.4%
Total Operating Revenue	125,533	117,744	118,659	915	0.8%
OPERATING EXPENSES					
Salaries & Wages	64,058	57,610	57,580	(29)	-0.1%
Employee Benefits	34,280	35,518	34,151	(1,367)	-3.8%
Professional Fees	11,813	12,008	11,422	(586)	-4.9%
Supplies	17,459	16,275	16,572	297	1.8%
Purchased Services	11,090	10,346	10,775	429	4.1%
Rentals & Leases	3,058	3,241	3,137	(104)	-3.2%
Depreciation & Amortization	4,892	4,957	5,073	117	2.4%
Other Operating Expenses	3,846	3,996	4,254	258	6.5%
Total Operating Expenses	150,496	143,952	142,966	(986)	-0.7%
Operating Profit / Loss	(24,962)	(26,208)	(24,307)	1,901	1.5%
NON-OPERATING REVENUES (EXPENSES)					
Other Non-Operating Revenue	-	-	-	-	
District Tax Revenue	11,608	12,435	13,655	1,221	9.8%
Investment Income	98	181	132	(49)	-27.2%
Less: Interest Expense	(4,629)	(5,058)	(5,383)	(325)	6.4%
Total Net Non-Operating	7,077	7,558	8,404	846	11.2%
Income Profit (Loss)	(17,885)	(18,650)	(15,903)	2,747	-14.7%

2014 Budget
Volume Assumptions

Volume Assumptions	2011	2012*	2013	2014	% Change
Discharges	6,075	6,013	5,457	5,364	-1.71%
Average Daily Census	75.8	75.2	67.1	66.0	-1.73%
Average Length of Stay	4.55	4.58	4.49	4.49	0.02%
ED Visits	40,825	42,827	41,918	41,751	-0.40%
Total Other Outpatient Visits	44,993	38,431	36,383	35,732	-1.79%

* 2012 ER Visits Exclude Chevron Patients

Patient Days



Revenue Changes

ACA Medicare Reduction	($3,400,000)
Medicare Inpatient Net Change	$1,194,000
Medicare Outpatient Net Change	709,000
Decrease in Volume	(932,000)
340B New Participants	110,000
Change in Commercial Rates	1,300,000
Increase in IGT Matching funds	1,500,000
Covered California	563,000

2014 Budget - Expense Changes

Step Increases	$650
Volume Related Reduction	(240)
Health Plan	(1,791)
Other Benefits	423
Consulting Costs	(673)
UHS/McKesson Service Contracts	894
Supply Savings	(144)
Soriant	(502)
Electronic Medical Records	(200)
Operational Efficiencies	(229)
24 Hours Pharmacy	(200)
Deprecation and Other	1,025

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

	Paid Full Time Equivalents		Per Adjusted Occupied Bed	
Fiscal Year	**(FTE's)**	**Percent Change**	**(AOB)**	**Percent Change**
2010	744	6.44%	5.78	3.50%
2011	740	-0.51%	6.38	10.55%
2012	738	-0.28%	6.60	3.36%
2013	681	-7.79%	6.25	-5.26%
2014	677	-0.50%	6.34	1.36%

Benefits

Health, Dental, Vision & Life Insurance	$9,030
Vacation, Holiday, Sick & Non-Productive	11,699
Pension Plans	5,293
Worker's Compensation	2,736
Employer Taxes, Unemployment & Other	5,393

2014 Budget – Cash Flow

	In Millions
Net Loss from Operations	**($24.3)**
Other Cash Flow Items:	
Add-Back Depreciation (Non-Cash Expense)	5.1
Total Cash Flow from Operations	(19.2)
District Tax Revenue	13.7
Equipment Purchases	(2.0)
Payment on Long Term Debt	(4.4)
Payment to the County	(2.9)
Net Cash Flow for 2014	($14.8)

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

Budget Risks

- Will we hit budgeted volume targets?
- Will the patient mix remain constant and not deteriorate in 2014?
- Will Self Pay Patients successfully transfer to ACA?

Proposed Budget Changes

- Changes to healthcare delivery system are quickly evolving.
- Propose to create a quarterly revised budget.
- Future Quarters based on last 12 months and known changes to DMC's costs and revenues.
- Quarterly cash forecast from budget.
- Meeting Dates of reforecast to Board at:
  - February, May, August, and November board meetings

1st Quarter Budget -2014

Amounts in Thousands

	1st Quarter 2014
OPERATING REVENUE	
Net Patient Service Revenue	30,028
Other Revenue	252
Total Operating Revenue	30,280
OPERATING EXPENSES	
Salaries & Wages	14,326
Employee Benefits	9,880
Professional Fees	3,368
Supplies	4,126
Purchased Services	2,868
Rentals & Leases	797
Depreciation & Amortization	1,240
Other Operating Expenses	1,036
Total Operating Expenses	37,641
Operating Profit / Loss	(7,361)
NON-OPERATING REVENUES (EXPENSES)	
District Tax Revenue	3,413
Investment Income	34
Less: Interest Expense	(1,356)
Total Net Non-Operating	2,091
Income Profit (Loss)	(5,270)

Questions?

DOCTORS MEDICAL CENTER

PROPOSED CHANGES TO HEALTH BENEFITS

TAB 9

2014 Benefit Changes

Plan	Benefit Attribute	Current Benefit	Renewing Benefit (as of 1/1/14)
Medical			
Kaiser	Plan Offering	No offering	High and Low plan offerings
ACA Mandatory Changes	Essential Health Benefits	Annual and lifetime limitations such as organ transplants, dollar limitations on skilled nursing facility, etc.	Elimination of all annual and lifetime limitations
	Clinical Trials	No coverage for participants with life-threatening illness participating in clinical trials (Tier 2 & 3)	Tier 2 coverage: 20% Tier 3 coverage: 40% (Tier 1 treatment required first)
	Mammogram	1 visit/calendar year with no limitations	Follow WHCR guidelines: 1 baseline age 35-39 and 1 every 1-2 years thereafter
HDHP	Overall Plan Structure	Maintain current plan, contributions, and Health Savings Account funding	Elimination of the HDHP plan
PPO	Emergency Room	Tier 1, 2, and 3: $35 copay; deductible does not apply	Tier 1: $100 copay; Tier 2: $100 copay; Tier 3: $100 copay (copay waived if admitted) -> Note, per ACA in- and Out-of-Network ER services must be the same
	Office Visit	Tier 1: $10 copay; Tier 2: $10 copay; Tier 3: 40% after deductible	Tier 1: $15 copay; Tier 2: $25 copay; Tier 3: 40% after deductible
	Specialist Office Visit	Tier 1: $10 copay; Tier 2: $10 copay; Tier 3: 40% after deductible	Tier 1: $25 copay; Tier 2: $35 copay; Tier 3: 40% after deductible
	Internet Based Services	Not covered	Covered as any other office visit
	Calendar Year OOP Max	Per Person/Per Family (3+)	Out-of-Pocket Maximum to follow Deductible structure: Per Person/Per Family (2); Per Family (3+)
	Out-of-Network UCR	90th percentile	80th percentile
	Physical Therapy	No visit limitation	40 visit limitation (to match chiro/acupuncture)
	Autism	Speech therapy developmental delay not covered ABA (Applied Behavior Analysis) therapy not covered	Speech therapy developmental delay covered as any other office visit (up to 12 visits) ABA therapy covered as any other specialist visit (up to 12 visits)
	ADD/ADHD	Not covered	Testing covered as any other specialist visit (up to 1 visit)
Prescription Drug			
ACA Mandatory Changes	Generic/Brand Copay	Cost sharing for the following drugs: Asplrin products, iron supplements, and Folic Acid products, OTC contraception (women's only)	100% coverage with prescription (including OTC); Vitamin D, immunizations/vaccines, Bowel preps, Fluoride, Folic Acid, iron, Smoking Cessation, Aspirin, and OTC Contraceptives (all drugs to be covered at 100%, including OTC)
Alternate Benefits	Generic/Brand Copay	Generic: $5 retail/$10 mail; Brand: $10 retail/$20 mail; Non-Preferred Brand: $35 retail/$70 mail	Generic: $10 retail/$20 mail; Brand: $20 retail/$40 mail; Non-Preferred Brand: $40 retail/$80 mail
	Drug Control	N/A	Step therapy - Advantage
Dental			
	Cleanings	1 cleaning/6 months	1 extra cleaning for pregnant women per year (during and after pregnancy)
	Lifetime Deductible	$50 Individual/$150 family	Maintain current plan (no change)
Vision			
Alternate Benefits	Frame & Lense Coverage	Covered at 100%	Reimbursed up to $300 (combined allowance for Frames & Lenses)
	Benefit Frequency	Examination every 12 months Lenses every 12 months Frames every 24 months	Examination every 12 months Lenses every 24 months Frames every 24 months
Monthly Contributions (all salary bands & FTE status)			
Kaiser Low (Deductible Plan) Medical/Kaiser Vision/Delta Dental			$25 EE / $50 EE + 1 / $100 EE + 2+
Kaiser High Medical/Kaiser Vision/Delta Dental			$50 EE / $100 EE + 1 / $150 EE + 2+
Anthem Self-funded Medical/Self-funded Vision/Delta Dental			$100 EE / $200 EE + 1 / $300 EE + 2+
Delta Dental Only (no change)			$10 EE / $20 EE + 1 / $30 EE + 2+
Self-Funded Vision Only (no change)			$10 EE / $20 EE + 1 / $30 EE + 2+
Other			
Benefits Eligibility		20+ hours per week	30+ hours per week

604270 Doctors Medical Center

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/14—12/31/14) High Plan

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply

Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge

(continues)

Proposed Benefit Summary *(continued)*

Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

604270 Doctors Medical Center

Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/14—12/31/14) Low Plan

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your payments toward the Plan Deductible, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$4,000 per calendar year
For any one Member in a Family of two or more Members	$4,000 per calendar year
For an entire Family of two or more Members	$8,000 per calendar year

Plan Deductible for Certain Services	
For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Plan Deductible amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Eye exams for refraction	No charge (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit (Plan Deductible doesn't apply)
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure (Plan Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Plan Deductible doesn't apply)

(continues)

Proposed Benefit Summary *(continued)*

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)

Chemical Dependency Services	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Plan Deductible doesn't apply)
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Print Form

Employer Group Application

LARGE GROUP SALES

KAISER PERMANENTE®

EMPLOYER GROUP INFORMATION

APPLICATION is hereby made for group health coverage based on the following statements and representations:

GROUP LEGAL NAME (as it should appear on contract) West Contra Costa Health Care | GROUP DBA NAME (if applicable) Doctors Medical Center | CUSTOMER OR PURCHASER ID

ADDRESS FOR MAILING CONTRACTS (EMPLOYER HEADQUARTERS ADDRESS)

☒ Send Coordination of Benefits (COB) information here. (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street 2000 Vale Road | City San Pablo | State CA | ZIP 94806

Attention Amy Mendoza | Title Benefits Supervisor

Phone 510-970-5218 | Fax 510-970-5741 | Email amendoza@dmc-sp.org

LOCAL CONTACT *(if different from "contracts" address above)*

☒ Send Coordination of Benefits (COB) information here. (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street 2000 Vale Road | City San Pablo | State CA | ZIP 94806

Attention Amy Mendoza | Title Benefits Supervisor

Phone 510-970-5218 | Fax 510-970-5741 | Email amendoza@dmc-sp.org

BILLING CONTACT *(if different from "contracts" address above)*

☒ Send Coordination of Benefits (COB) information here. (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street Po Box 648 | City Stockton | State CA | ZIP 95201

Attention Andrea Hiykel | Title Account Manager

Phone 209-939-3488 | Fax | Email

(If more than one billing location, please attach information for each location.)

ENROLLMENT INFORMATION

Nature of business Hospital | Years in business 59 years

FEDERAL TAX ID # (TIN/EIN) 94-6003145 | SIC Code

Are all eligible employees in your group associated with the same TIN/EIN? ◉ Yes ○ No

Total # of employees 926 | # of eligible employees 597

Group size—please select the appropriate category:

○ 20–99 full- and/or part-time employees for 20 or more weeks of the current or prior calendar year

◉ 100+ full- and/or part-time employees for 50 percent or more of your regular business days during the prior calendar year

Requested date of contract: Month January | Year 2014

(If requesting an anniversary date other than the usual 12-month period from the effective date, please indicate reason for request.)

Annual open enrollment period: Enroll during the month of November | For coverage effective 2015 1st

New employees are eligible to enroll ○ Date of hire (DOH) ○ First of the month following DOH
○ First of the month following a waiting period of ____ days
◉ Other Mgt 1st of the month following DOH, Non-Mgt 1st of the month following 30 days. Union 1st of the month

Will the group contribute at least 50% of the employee-only rate for the plan (HMO, POS, PPO, OOA) in which the employee is enrolled? (100% if it is a one-step rate.) ◉ Yes ○ No

How much will the employer contribute to the cost of the employees', dependents', and retirees' (if any) health plan?

Employee (and early retiree) | Dependent | Retiree with Medicare

What is the contribution level to the HRA and/or HSA account, if applicable?

Has Kaiser Permanente coverage been offered to your employees within the past 24 months? ○ Yes ◉ No

Type of plan sponsor: ◉ Employer ○ Labor organization ○ Trustees of a fund

Type of company: ○ State government ○ Local government ○ Publicly traded corporation ○ Privately held corporation
◉ Nonprofit ○ Church group ○ Other

Mark any that apply: ○ Taft-Hartley ○ Hours Bank ○ Multi-employer/multiple employer group

BROKER OF RECORD INFORMATION *(as shown on payee's license)*

Broker Name N/A | Broker Firm Name

Street | City | State | ZIP

Phone | Fax | Email

CA A&D License # | Expiration Date

Payee Social Security # | Payee Federal Tax #

BROKER OF RECORD INFORMATION *(continued)*

Authorized Signatory for Broker Firm _____

Kaiser Permanente Individual Broker ID # _____ Kaiser Permanente Broker Firm ID # _____

Payee Address _____

(if different from the address you listed on page 1)

RATE ASSUMPTIONS

1.	Has the group offered health coverage for at least one year?	(•) Yes	( ) No
2.	Do 75% of the eligible employees participate in an employer-sponsored group health plan?	(•) Yes	( ) No
3.	Do 75% of all employees in California who will be offered a Kaiser Permanente product reside in the Kaiser Permanente California service area?	(•) Yes	( ) No
4.	Will the estimated initial enrollment in the PPO and OOA products be less than 25% of the total enrollment in Kaiser Permanente?	(•) Yes	( ) No
5.	Will Kaiser Permanente be offered to all eligible employees? If no, why not? _____	(•) Yes	( ) No
6.	How many carriers has this group had in the past 3 years? 1 ☐ If less than 3, check here If 3 or more, why? _____		
7.	Will Kaiser Permanente be offered on terms less favorable than any other carrier or plan available to the group's employees?	( ) Yes	(•) No

MEDICAL PROFILE

1.	To the best of your knowledge, how many employees or dependents are presently hospitalized or disabled? _____ What is the diagnosis and prognosis of these individuals? (List on a separate sheet.)		
2.	Will the current carrier extend benefits to those disabled upon this transfer of coverage?	( ) Yes	( ) No
3.	How many employees, dependents, or COBRA participants had any individual claims in the last 12 months in excess of $10,000? See Claims Experience (List on a separate sheet and indicate which individuals are COBRA participants.)		
4.	Is anyone likely to have a continuing claim from an existing mental or physical disorder? If yes, what is the diagnosis and prognosis of these individuals? (List on separate sheet.)	( ) Yes	( ) No
5.	Has anyone been advised to have surgery in the last 12 months or anticipate hospitalization for any other reason (i.e., organ transplant, chemotherapy, kidney dialysis, etc.)? If yes, what is the diagnosis and prognosis of these individuals? (List on a separate sheet.)	( ) Yes	( ) No
6.	Are there ongoing HMO or indemnity claims? If yes, please attach explanation on a separate sheet.	( ) Yes	( ) No
7.	How many employees or dependents are pregnant? See Claims Exper		

EMPLOYER DATA

1.	Do you meet CA state law requirement for providing employees worker compensation coverage?	(•) Yes	( ) No
2.	Is Kaiser Permanente the exclusive carrier for this group?	( ) Yes	(•) No
	If yes, will Kaiser Permanente remain the exclusive carrier for the entire contract period?	( ) Yes	( ) No
	If no, who is the other carrier? _____		
3.	Does this census represent all permanent, eligible employees?	(•) Yes	( ) No
4.	Do you have employees currently on family medical leave or leave of absence?	(•) Yes	( ) No
	If yes, were they included on the census?	(•) Yes	( ) No
5.	Are there any special waiting periods for enrollment?	( ) Yes	(•) No
	If yes, were these employees and their effective date(s) included on the census? If not included, please add on separate sheet.	( ) Yes	( ) No
6.	How many are retirees with Medicare? _____ How many are early retirees? _____ Were they identified on the census?	( ) Yes	(•) No
7.	How many are COBRA participants? 4 Were they identified on the census?	(•) Yes	( ) No

CARRIER NAME(S)	KAISER PERMANENTE Plan 1*					ALTERNATIVE CARRIER PLANS Carrier name:				ALTERNATIVE CARRIER PLANS Carrier name:			
PRODUCT TYPE(S)	**HMO 1**	**HMO 2** Deductible	**POS**	**PPO**	**OOA** Indemnity	**HMO**	**POS**	**PPO**	**OOA** Indemnity	**HMO**	**POS**	**PPO**	**OOA** Indemnity
HRA paired with													
HSA-Qualified (x for Yes)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
RATES													
Employee Only	$ 687.69	$ 579.94	$	$	$	$	$	$	$	$	$	$	$
Employee + Child(ren)	$ 1,370.2	$ 1,159.88	$	$	$	$	$	$	$	$	$	$	$
Employee + Spouse	$ 1,370.2	$ 1,159.88	$	$	$	$	$	$	$	$	$	$	$
Family	$ 1,986.79	$ 1,681.83	$	$	$	$	$	$	$	$	$	$	$
BENEFITS													
Deductible													
Calendar-Year Maximum													
Coinsurance													
Physician Office Visits													
Prescriptions													
Optical													
Chiropractic													
ELIGIBILITY													
Domestic Partner Coverage (x for Yes)	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Plan Participation Minimum													
Student Coverage Age Limit	26												

DENTAL

Delta Dental Plans: ☐ FFS Plan _____ ☐ PPO Plan _____

Which health care plan will the dental plan be offered with? ☐ HMO ☐ PPO ☐ Deductible HMO ☐ POS ☐ Stand-alone dental (dental only)

Monthly Dental Rates: ☐ Employee Only $ _____ ☐ Employee + Spouse $ _____ ☐ Employee + Child(ren) $ _____ ☐ Employee + Spouse + Child(ren) $ _____

DeltaCare/PMI: Which health care plan will the dental plan be offered alongside of? ☐ HMO ☐ Deductible HMO ☐ POS

Monthly Dental Rates: ☐ Employee Only $ _____ ☐ Employee + Spouse $ _____ ☐ Employee + Child(ren) $ _____ ☐ Employee + Spouse + Child(ren) $ _____

*** The traditional (HMO) Plan and the In-Network portion of the Point-of-Service (POS) Plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network portion of the POS Plan, the Participating Provider Plan (PPO), the Out-of-Area Indemnity Plan, and the KPIC Group Dental Plan. KPIC is a subsidiary of KFHP. DeltaCare/PMI is underwritten by Delta Dental Plan of California.**

COBRA BILLING

Section 125 Plan: (•) Currently in place ( ) Not applicable

COBRA billing: ( ) Performed by employer (•) Peformed by TPA†

†TPA name Delta Health System TPA address Po Box 648 Stockton, CA 95201 TPA phone 888-212-1231

ERISA STATUS

Is your group's health plan subject to the Employee Retirement Income Security Act (ERISA)? ( ) Yes ( ) No

(If you do not select an answer, we will record the status as Yes.)

CONTRACT DELIVERY

We will deliver your KFHP health plan/KPIC health insurance contracts on our website unless you indicate below that you want your contract(s) delivered by mail:

☒ I want to receive my contracts by mail in paper format

CONDITIONS OF ACCEPTANCE

The rates quoted herein are not final until (1) Kaiser Foundation Health Plan, Inc. (KFHP), and/or Kaiser Permanente Insurance Company (KPIC) receive a signed copy of this Employer Group application, and (2) KFHP and/or KPIC have verified the conditions of offering and accuracy of the underwriting information and completed its review. KFHP and/or KPIC must receive this application before the effective date of coverage. KFHP and/or KPIC reserve the right to withdraw our rate proposal or re-rate any proposed rates if any of the information in this application is incomplete or inaccurate, or if the information provided in the "Rate Assumptions" section of this application is incorrect or materially false.

I, as signatory below for the above employer group, do hereby confirm the accuracy, completeness, and truthfulness of all the information supplied on this Employer Group Application, with the understanding that, should KFHP or KPIC discover any of the material information supplied in this application to be intentionally incorrect or incomplete, or if I have misrepresented or omitted any material fact, KFHP may terminate the KFHP group agreement(s) and KPIC may terminate the KPIC Group Insurance Policy.

I authorize the person named in the "Broker Information" section to act as broker of record for our health plan coverage through KFHP and KPIC effective N/A *. I understand that the broker of record will be paid commissions and may be eligible for monetary and nonmonetary rewards and incentives by KFHP and/or KPIC in connection with this purchase of health plan coverage.*

AGREEMENT TO THE USE OF BINDING ARBITRATION FOR MEMBER DISPUTES

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and for coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) disputes between KFHP members or KPIC enrollees, their heirs, relatives, or associated parties (on the one hand) and KFHP, KPIC, Kaiser Permanente health care providers, or other associated parties (on the other hand), for alleged violation of any duty arising out of or related to KFHP membership or KPIC coverage, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. KFHP members and KPIC enrollees thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* or *Certificate of Insurance*.

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 and 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.*

Name James Boatman **Title** CFO

Signature James Boatman **Date** 12-12-13

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 11

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD

MEC DATE: December 9, 2013

BOARD DATE: December 18, 2013

TOPIC	Comment (S)
Kathy White, Interim COO provided the following report: • New Utilization Management algorithm: Process for admissions from Physician offices	No action required by the Board
Laurel Hodgson, Chief of Staff: • .Introduction of Dr. Stern as new Chief of Staff for the 2014-2015 term. • Gracious thanks to the committee for their work over the last 2 years.	No action required by the Board
Policy, Procedures, Forms: A. Pharmacy & Therapeutics 1. Medication Administration Policy 2. Patient Controlled Analgesia Policy 3. Controlled Substances – Inventory and Disposition Records Policy 4. Prothrombin Complex Concentrate (Treatment of major bleeding associated with Coumadin) CARDIOLOGY ONLY 5. ICU Physician Orders – Therapeutic Hypothermia 6. Acute Ischemic Stroke Alteplase (TPA) Administration/ Admission Orders 7. Acute Ischemic Stroke Alteplase (TPA) Administration - ER B. Formulary Additions: 1. Kcentra (Prothrombin Complex Concentrate 4-factor)	 Approval Approval Approval Approval Approval Approval Approval Approval Approval Approval
Credentials Committee • Credentials Report: October 2013 • Credentials Report: November 2013 • Orthopedic Core Privileges Form (New form)	 Approval Approval Approval

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE: MEDICATION ADMINISTRATION**	†**CHECK ONE:** ☐ **New** ☒ **Reviewed** ☒ **Revised :** ☒ **Major** ☐ **Minor**
† ☐ **Administrative** ☒ **Clinical** ☒ **Department** ____**Nursing, Pharmacy, Respiratory Therapy**	
†**SUBMITTED BY:** Therese Helser, Pharmacy Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law X New Regulation: CMS CDPH TJC Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** See attached cover sheet	

	MEETING DATE	APPROVAL
☒ **Manager or Department Director**†	10/2013	Y
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee	11/14/13	
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☒ Other: Medication Error	10/25/13	Y
☒ **Nursing Department:** ☒ Nursing Practice:	10/31/13	Y
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☐ **Medical Executive Committee (MEC)** (as applicable)		
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

The MEDICATION ADMINISTRATION POLICY (11/2013) was revised to include the following:

- Updated policy to reflect electronic charting for Nursing on the eMAR and Electronic Medical Record (EMR)
    - Spelled out verbiage regarding verification of medications process
    - Spelled out need to reflect a reason if scheduled medications are not given
    - Spelled out process for documenting a STAT medication which has already been given
- Updated labs to be checked for high risk drugs
- Spelled out default autostop is 30 days if not specifically defined for all medications.
- Added to policy: Nurse Supervisor will administer PPD. PPD to be obtained from Pharmacy.

DOCTORS MEDICAL CENTER

Manual: INTRADEPARTMENTAL	Sub Folder: Patient Care
Title: Medication Administration	Reviewed: 10/97,10/09 Revised: 10/95,12/96,7/00,3/03,5/03,7/04,9/05,1/08, 10/09,9/10,11/1,10/13
Effective Date: 12/92	Page 1 of 12

PURPOSE:
To assure safe administration and monitoring of medications in collaboration with the Medical Staff, Department of Nursing, Respiratory Therapy, and Pharmacy. Included is a system to double check the interpretation and transcription of medication orders entered into the Pharmacy computer and transcribed or printed on the electronic Medication Administration Record (eMAR).

DEFINITION/OVERVIEW: (If Needed)
1. eMAR – Electronic Medication Administration Record
2. EMR – Electronic Medical Record
3. CPOE – Computerized Physician Order Entry
4. WOW – Work Station on Wheels (computer)

POLICY:
1. The nurse does not administer medications he/she has not prepared himself/herself.

2. The nurse is expected to know:
   - Reason medication is being administered
   - Patient allergies
   - Corresponding vital signs and lab results effected by medication
   - Desired effects
   - Untoward reactions to watch for
   - Monitoring parameters (per orders or default)

3. If the nurse is unfamiliar with the medication, he/she must:
   - Review the package insert
   - Review drug reference
   - Review the approved protocol for investigational medications
   - Address further questions regarding the appropriateness of the medication order with the Pharmacist

4. The nurse educates the patient regarding any new medication by providing written material from a hospital-approved educational resource ie:) Krames. This education is documented in the patient's EMR (Electronic Medical Record.)

5. The nurse documents the patient's response to the first dose of any new medication in the EMR (i.e. New cardiac drip: heart rate in vitals signs).

6. Medications that differ from the normal color, odor, consistency, or are outdated are not to be administered.

7. The SEVEN (7) Rights of Safe Medication Administration are:
   - RIGHT patient
   - RIGHT medication
   - RIGHT dose
   - RIGHT time
   - RIGHT route
   - RIGHT result
   - RIGHT to refuse

PROCEDURE:

A. ADMINISTRATION GUIDELINES:

1. The nurse reads the medication labels and checks three (3) times against the patient's eMAR before administering the medication:

   - When taking the medication from the cassette drawer or automated dispensing cabinet.
   - When comparing with the medication order/eMAR during preparation of the medication for administration.
   - When reading the label just prior to the administration of the medication.

2. The nurse accurately identifies the patient using two (2) different identifiers:

   - Check the eMAR and Patient Identification Band for Name and Date of Birth
   - Ask Patient to state *Name and Date of Birth*

   The nurse verifies that all medications have:
   - Correct drug name
   - Correct dose
   - Date first ordered
   - Not expired
   - Time to be administered
   - Route of administration
   - Reason for receiving
   - Nurse's initials
   - Physician's name
   - Patient's name and room number

3. The nurse checks for allergies and their reactions before administering any medication. Allergies are listed on the eMAR under the 'Alert History' tab, in Patient Profile, and an allergy history is identified by the patient's allergy armband clip. It is prudent to ask the patient again prior to medication administration in the event they omitted an allergy from their history during admission process.

4. For identification process for confused or unresponsive patients, refer to Administration Policy, Patient Identifcation Process.

5. Check apical pulse before administering Digitalis. If the apical pulse is below 60 beats per minute, hold the dose and notify the patient's physician, and chart on the eMAR the reason the medication was held.

6. Check blood pressure before administering anti-hypertensives, defined as:
   - Beta blockers
   - ACE Inhibitors
   - Angiotension receptor blockers (ARB's)
   - Calcium channel blockers

If the physician writes no hold parameters, a default value of "hold dose and call physician for systolic blood pressure (SBP) below 90mm Hg" will be entered into Paragon Pharmacy by a Pharmacist. These default parameters will print on the eMAR.

7. Before administration of the following medications, the corresponding value must be checked and documented on the eMAR:
   a. Heparin – PTT and Platelets
   b. Coumadin – PT/INR
   c. Lovenox – Platelets and INR
   d. Potassium – K+
   e. Magnesium – Mg+

8. Prior to the administration of Insulin, a fingerstick glucose should be checked no more than 30 minutes prior to the administration of insulin. (i.e.: quick acting vs. long acting.).

9. Open unit dose medications at the patient's bedside. Do not leave medications at the bedside without a physician's order. Before leaving the room, assure the patient has swallowed the medication(s).

10. Medication containers are labeled whenever medications are prepared but not administered immediately. An immediately administered medication is one that is prepared or obtained, taken directly to the patient, and administered to that patient, without any break in the process.

    Medication labels will contain the following:
    - Medication NAME, STRENGTH, and AMOUNT if not apparent from the container.
    - Expiration date when not used within 24 hours.
    - Expiration time if expires within less than 24 hours.
    - Date of preparation and the diluent for all compounded IV admixtures and parenteral nutrition formulas.

11. If a medication is held or the patient refuses the medication, notify the physician and document the reason in the eMAR.

12. Controlled substance narcotics are to be administered and charted timely. They may be administered only by the nurse who signed them out. A nursing student may administer a narcotic under the supervision of the Nurse Preceptor or the Nursing Instructor.

B. The eMAR (Electronic Medication Administration Record):

1. Preoperative medications will be designated as such on the Scheduled tab on the eMAR as an "on call" or 0600 default dose time. The floor nurse is expected to verify with the OR team to either start or send medication with patient to surgery as directed.

2. Schedules for medication necessary to be administered at times other than the standardized medication administration times, and the reasons why, should be communicated to the Pharmacy on a "Nursing to Pharmacy" Communication Form.
   It is best to include special times (e.g., drug specific or patient schedule) with the original order to the Pharmacy whenever possible (See Medication Administration Times policy)

   Every eMAR will contain the following tabs (or folders):
   a. "Unsched" – For unscheduled medications
   b. "Sched" for scheduled medications – All scheduled doses, regardless of route
   c. "IV" – All large volume IV solutions
   d. "PRN" medications – All PRN doses, regardless of route
   e. "Chemo" – For scheduled chemo drugs
   f. "Chemo-PRN" – For PRN chemo drugs
   g. "Resp" – Scheduled respiratory therapy meds
   h. "Resp-PRN" – PRN respiratory therapy meds
   i. "Group" – Tab for nurse to group meds in a given time-frame or by date/time to be given
   j. "Pending" – Tab where all meds should be scanned. ****
   k. "Unverified" – Meds that have been entered by pharmacy, but not verified by a licensed nurse, RN or RT.
   l. "Alert History" – Lists allergy interactions, drug interactions, duplicate therapies.

C. WRITING ORDERS:

1. All medication orders are automatically discontinued at the time of surgery, unless reordered.

2. All postoperative medications are reordered using the '*Transfers Only – Combined Home Medication and Inpatient Medication Reconciliation Order Form*', re-written by the physician, or via CPOE (Computerized Physician Order Entry).

3. All orders are to be re-ordered when a patient is transferred with a change in level of service, (e.g., into or out of a critical care unit, and/or postoperatively).

4. Physicians are to write complete orders or enter complete CPOE orders. Complete orders include:
   - Name of medication
   - Dose
   - Route
   - Frequency
   - Reason for medication
   - Date/time/sign each order

5. All PRN medications must have specific indications/reasons for administering the medication (e.g., incisional pain).

6. Range orders must be written with specific parameters, otherwise they are not acceptable.
   Example: Morphine 2 mg IV q 4 hours/PRN mild pain level (1 – 3)
   Morphine 4 mg IV q 4 hours/PRN moderate pain level (4 – 6)
   Titrated IV medications must have specific parameters including the initial rate and titration dosage (e.g.) Nipride 50mg/250ml D5W 0.5mcg/kg/min initially, then titrate in increments of 0.5 mcg/kg/min every 5 minutes until titration goal met or a maximum dose of 10mcg/kg/min to keep SBP above 140).
   An order written as "same parameters" is not acceptable.

D. CONTROLLED SUBSTANCES:

1. IV drips containing controlled substances will be pre-mixed by the Pharmacy and stored in the automated dispensing cabinet until needed.

2. EPIDURAL ONLY: Once dispensed, the epidural bag will be placed in a clear plastic lock box for administration. Lock box keys are kept in the automated dispensing cabinet under the heading "Epidural Key" and will be retrieved and returned to the machine utilizing the same procedure as for the PCA keys.

3. Narcotics are to be administered and charted in a timely manner. Two (2) licensed personnel must visually inspect any wasted narcotics. The quantity wasted will be recorded in the automated dispensing cabinet with a witness required.

E. ADMINISTRATON OF MEDICATIONS:

1. Medications may be administered by Registered Nurses, Licensed Vocational Nurses, Student Nurses during their clinical rotations (under the direction of a Registered Nurse or Nursing Instructor), or Physicians, the Respiratory Therapists, Nuclear Medicine Technologists, and Registered Physical Therapists within their scopes of practice.

2. Medications may be self-administered by the patient only upon written order of the physician or as part of a patient education program, under the direction of an RN, RT, or the supervision of an LVN ie:) Insulin injection administration.

3. Medications for self-administration may be stored in the locked medication cassette drawer if ordered by the physician. The nurse will record self-administration medications in the eMAR. (Refer to the Self Administration of Medications policy). No medications for self-administration will be stored at the bedside.

4. No medication can be administered unless a licensed nurse has verified the order.

5. Steps by a nurse to give meds to a patient:
   a. Use the 'group' tab on the eMar to know what meds are due to be given to the patient.

   b. Pull medications from the OmniCell or cassette for the patient.

   c. Roll the Workstation on Wheels (WOW) with medications to be given (still in their original packaging) into the patient's room.

   d. Open the eMAR'pending' tab in the eMAR (As meds are scanned, allergy or other contraindications will show on this screen. Nurses are looking for the green checkmark beside each medication).

   e. Place the cursor in the 'visit id' field on the eMAR and then scan the patient's armband. If the correct patient is scanned according to the eMAR, the nurse will get a green checkmark by the patient's name.

   f. If an icon other than a green checkmark is displayed, further action will be needed by the nurse. For instance, if there is no checkmark for the dose scanned, if the dose is above what was ordered, or below what was ordered the nurse will have stop the administration of this med and check the dose. If the icon shows that the nurse needs a witness, or if clinical observation is required then the appropriate measures will be taken.

   g. After the meds are confirmed to be correct for this patient, the 'confirm' button is clicked and the 'chart' button to verify the dose has been documented on the eMAR.

   h. After the patient has taken the medications, click the 'chart' button for confirmation and documentation of the meds to be noted on the eMAR.

6. All orders must be reviewed by Pharmacy before administration unless the order is STAT, an emergency, when the ordering physician is present, or in direct control of the preparation and administration of the medications, or when the

delay caused by the review process places the patient at greater risk of harm than the risk of not doing the review.

7. All new "routine" medication orders must be administered within four (4) hours of the order being written, unless otherwise stated. Pharmacy turnaround time: 2 hours for routine orders, 15 minutes for STAT/NOW orders.

   a.) Initiate antibiotics within one (1) hour from the time the order is written. Patients with community acquired pneumonia must have antibiotics administered within four (4) hours of admission. Stat antibiotics are to be administered within one (1) hour of the time the order is written.

   b.) If specific medications are needed in less than two (2) hours, and are not available in the automated dispensing cabinet, STAT fax the order and call the Pharmacy with the STAT request. This process should be reserved for true STAT or NOW orders. STAT medications are to be processed within 15 minutes of the time the order is written.

   c.) For newly ordered medications not received from Pharmacy within three (3) hours, notify them via STAT FAX by using the preprogrammed button or entering: (510) 970–5960, using a "Nursing to Pharmacy" Communication Form.

   d.) Medications not available in the Pharmacy must be documented on the eMAR as 'unavailable' and include in the notes section that an action plan has been initiated by the Pharmacy or Nursing Supervisor (off hours) for obtaining the medication, and that the physician was notified.

8. Multi-dose vials are for single patient use only and must be labeled with the patient's name, and dated/initialed when opened, and discarded after 24 hours.

9. Insulin is used for 28 days at room temperature and labeled for single patient use. Any Insulin removed from the automated dispensing cabinet must have a patient name label attached.

10. All drugs and supplies are to be checked for expiration dates and returned immediately to the Pharmacy if found expired, or without a date.

11. Drug renewal dates: Refer to Autostop Policy. The default is 30 days renewal for all medications without a specific stop date designated.

12. The hospital uses a unit dose medication system. For patient safety, medications are not to be pre-poured but opened, one at a time, at the patient's bedside – with the eMAR available.

13. Every RN and LVN administering medications will follow Universal Precautions.

F. DO NOT CRUSH PRECAUTIONS:

1. The following types of oral medications are NOT to be crushed prior to administration:
   - Oral medications containing the words "Extended Release (ER)" or "Sustained Release (SR)" as part of their name.
   - Enteric coated oral medications
   - Medications for sublingual administration
   - Medications which cause oral mucosa irritation ie) biophosphonates: Alendronate, Risedronate.
   - Medications which, if handled without adequate protection, are potentially carcinogenic.

Crushing these forms of medications removes their specially protective properties and destroys their purpose.
The ordering physician must be contacted for new orders in the event patients are unable to swallow medications.
For medications that may be crushed, use a disposable, single patient use, pill crusher.

G. MEDICATION DISCREPANCIES OR ERRORS – REPORTING:

1. After notifying the physician and Nursing Supervisor, an eQRR will be completed by any licensed staff that discovers, or makes an error, in administering medications.

2. The Pharmacy will inform the nurse when an order received in Pharmacy requires clarification and that there will be a delay in dispensing the required medication.

3. A "Nursing to Pharmacy" Communication form will be used to report missing doses. Attach a copy of the original order to the form.

4. If the bar code label on the medication does not scan, fill out the green medication form and send to the pharmacy to follow up.

5. If a patient's bar code on their arm band does not scan, contact admitting to print a new arm band for the patient as soon as possible.

H. NEW ORDERS RECEIVED UPON DAY OF ADMISSION:

1. **Written Medication Orders**
   a. Notify Pharmacy of new WRITTEN MD orders.

   b. Enter allergies, height, weight, pregnancy, and lactation status (females 12 – 55 yrs old) and current medications via McKesson "Clinical Profile".

   c. Stamp orders with date and time prior to faxing orders to Pharmacy.

d. Obtain first dose from automated dispensing cabinet for STAT or emergency medications, if available.

e. Send all handwritten physician orders to Pharmacy, including those without specific medication orders.

2.CPOE Medication Orders:

a. If Physician enters medication order in CPOE, the med order flows to Paragon Pharmacy workqueue.

b. The RN, LVN must enter allergies, height, weight, pregnancy,and lactation status (females 12 – 55 yrs old) and current medications via McKession "Patient Profile".

c. Medication will show on eMAR as unverified.

d. Nurse will verify eMAR dose with physician's order on the OCR (Order Confirmation Report).

e. Obtain first dose from automated dispensing cabinet for STAT or emergency medications, if available. Notify Nursing Supervisor for medications not available in the automated dispensing cabinet and are to be administrated when the pharmacy is closed.

f. Nurse Supervisor fills emergency/STAT medications that are not available in the automated dispensing cabinet as soon as possible.

NOTE: Before any medication is given, the patient must have the allergy status identified and verified. Remember the 7 Rights of Safe Medication Administration. All medications ordered during shift must be verified whether the medications are given or not.

I. STAT ORDERS:

A. MD Written STAT Orders:

1. RN obtains medication from automated dispensing cabinet, if available, and indicates "GIVEN" on physician order sheet, prior to faxing to Pharmacy.

2. If medication is unavailable, faxes orders to Pharmacy STAT FAX using pre-programmed stat fax button or (510) 970 5960 and calls Pharmacist to alert them of stat orders.

B. CPOE STAT Orders:

1. RN Administers STAT orders within fifteen (15) minutes of obtaining order.

2. Gives copy of order to the on-coming nurse if medication has not been administered.

3. If STAT medication is given, and the eMAR has not been initiated, the nurse will enter the time given on the OCR. Once the eMAR is generated, the nurse will override the patient barcode and enter the patient account number manually then record medication administration time by backdating and timing the entry with the actual time the patient received the medication.

J. NURSE Entered Orders (Phone Orders):

1. RN calls physician for med order.
2. RN writes the order on a MD Order form.
3. Night shift RN enters STAT medication order in Paragon Medication Administration's Nurse Entered Orders.
4. Med appears on eMAR, allergies are checked, meds verified and dose given.

K. ONE TIME OR LIMITED TIMES ORDERS

1. Hold orders should indicate parameter or length of time, ie.) Hold Digoxin for 24 hours. Resume medication after the 24-hour period.
2. NOTE: if no parameter or time is specified with the hold order, the order will be considered discontinued and processed like any other discontinued order.
3. The Physician writes or enters an order in CPOE to resume the "discontinued" order.

L. DISCONTINUE ORDER:

1. All discontinued medication are sent back to the Pharmacy immediately by placing the medication in the RETURN bin located in the automated dispensing cabinet or Medication Room on the patient care unit.

M. RENEWAL ORDERS:

1. RN identifies medication needing renewal. Inserts Pharmacy SOFT STOP REPORT renewal form in the chart.
2. RN checks written or CPOE renewal order against eMAR to ensure original order has not been changed.

N. RECEIVING/CHECKING MAR Q 8 and Q 24 HOURS:

1. The daily physician's orders and eMAR checks are to be completed by the Night Shift nurses.

a. Verifies each order on eMAR with Physician's order.
b. Communicate all discrepancies to Pharmacy by using the "Nursing to Pharmacy Communication" form and fax to Pharmacy with a copy of original order if written order.

O. ADMINISTRATION AND DOCUMENTATION OF MEDICATIONS:

1. Check eMAR for time of first dose due on shift.

2. Check medication for the dose and route. Verify any "Unverified" medications by comparing the eMAR and the Physician's order.

3. If patient is receiving Insulin, chemotherapy, PCA, TPN, anticoagulants, 3% Saline, IV Potassium Chloride, or IV Potassium Phosphate, double check dose with another licensed nurse before administering to patient. Both nurses must sign eMAR indicating the double check has been completed. PCA, IV Heparin, TPN, and Chemotherapy must be checked against the physician order sheet. SQ Insulin/Heparin are checked from the MAR. (Refer to Double Check Policy).

4. Take medication and WOW to the bedside and identify patient using 2 different patient identifiers.

5. Open Paragon Medication Administration and locate the patient's eMAR.

6. Scan the patient's arm band. Verify that a green checkmark appears showing you have the correct patient.

7. Open the Pending Tab in Med Admin. Scan your first medication dose's bar code. Check to see that you have a green checkmark to identify the witness, clinical observation, above dose, under dose, etc If all checks are green?

8. Scan the next med and repeat step 6.

9. Before administration of a new medication, the patient and/or family is informed about the use of the medication and any potential clinically significant adverse reactions.

10. Administer medication using techniques identified in the Lippincott Manual of Nursing Practice (9th Edition).

11. Remain with patient until the medication is taken. Do not leave the medication at the bedside for the patient to take later.

12. Medications are considered timely if administered within 60 minutes either before or after the scheduled time unless they are time sensitive.

13. Nurse Supervisor will administer PPD and document in the eMAR. The solution will be obtained from the pharmacy.

P. DOCUMENTATION:

1. AM medications held for scheduled dialysis or if patient off unit for procedures will be given as soon as patient returns to the unit unless specifically ordered otherwise by the physician.

2. Notify physician of omission or refusal, if significant.

3. Chart the nature and severity of complaint when PRN medications are requested and effectiveness of medication in Clinical CareStation's Daily Assessment under the Pain tab.

4. If the RN does not give a medication, the RN must document the reason for not giving the medication.

5. The RN must remove the "NG" (Not Given) on the medications before the end of the shift if the patient is expected to return on next shift and resume medications.

REFERENCES:

1. Title 22 (70623) Department of Health Services, State of California.
2. TJC. Medication Management Standards: MM01.01.01, MM.03.01.01, MM.03.01.05, MM.04.01.01, MM.05.01.01, MM.05.01.07, MM.05.01.09, MM.05.01.11, MM.05.01.13, MM.05.01.17, MM.06.01.01, MM.06.01.03, MM.06.01.05, MM.07.01.01
3. CMS 482.25 Condition of Participation: Pharmaceutical Services
4. Lippincott Manual of Nursing Practice (9th Edition) 2008. pp 84 – 110.

Responsible for review/updating	Pharmacy Director V.P. Patient Care Services	Pharmacy Nursing

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE: PATIENT CONTROLLED ANALGESIA**	†**CHECK ONE:** ☐ **New** ☒ **Reviewed** ☒ **Revised :** ☒ **Major** ☐ **Minor**
† ☐ **Administrative** ☒ **Clinical** ☒ **Department** ___**Nursing, Pharmacy** _____	
†**SUBMITTED BY:** Therese Helser, Pharmacy Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law X New Regulation: CMS CDPH TJC Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** See attached cover sheet	

	MEETING DATE	APPROVAL
☒ **Manager or Department Director**†	11/4//2013	Y
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee	11/14/13	
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☒ **Nursing Department:** ☒ Nursing Practice:	11/7/13	Y
☐ **Forms Committee** *(as applicable)*		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☐ **Medical Executive Committee (MEC)** (as applicable)		
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

The PATIENT CONTROLLED ANALGESIA (PCA) POLICY (11/2013) was revised to include the following:

- Definitions were updated
- Documentation of Education is emphasized
- CPOE added to physician order as a choice
- Independent double check is defined and mentioned throughout the policy
- Documentation of assessment of pain and Vital Signs is emphasized, especially the 1st 8 hours – monitoring is q 2hours for the 1st 8hours on PCA
- Clarification of tubing set up
- Co-sign(witness) steps are spelled out
- Appendices added for: Wong-Baker Pain scale, Behavior Pain scale, 0-10 Numeric Pain scale

DOCTORS MEDICAL CENTER

Manual: IV/MEDICATION	Sub Folder:
Title: PATIENT CONTROLLED ANALGESIA	Reviewed: 08/2002 Revised: 07/00, 08/05, 06/10, 11/13
Effective Date: 7/98	Page 1 of 14

PURPOSE:

To outline nursing management of the Patient Controlled Analgesia (PCA). To provide guidelines for the set up and use of the PCA pump and management of patients receiving patient controlled analgesia. The Patient Controlled Analgesia Protocol (PCA) is a multidisciplinary approach toward providing controlled analgesia via an infusion pump in a safe and effective manner. The major objective of PCA is to suppress pain and minimize narcotic dosage requirements and side effects such as respiratory depression, sedation and decreased cough reflex. The PCA pump is designed to administer narcotic analgesics intravenously in a continuous flow mode (basal infusion), patient demand mode, or a combination of the two. In addition, the nurse has the ability to bolus the patient as needed when ordered by the physician.

DEFINITION/OVERVIEW:

1.0 Opiate Tolerant – "Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral HYDROmorphone daily, or an equianalgesic dose of another opioid." *(Food and Drug Administration)*

2.0 Opioid Naïve – Patients who do not meet the definition of opioid tolerant, who have not had narcotic doses at least as much as those listed above for a week or more, are considered to be opioid naïve.

3.0 Clinical Care Area (CCA) – Pump setting for unit that patient is currently on (example: MICU, 5th floor, PCU) Note: For Opiate Tolerant Patients, nurse must select "Opiate Tolerant" instead of which unit the patient is on for CCA.

4.0 Loading dose (initial bolus) - Initial dose given to patient as ordered by physician. All bolus doses must be administered by RNs and BP, R, and LOC monitored closely.

5.0 Lockout interval - period during which the PCA cannot be activated and no analgesic can be delivered by patient. NOTE: A bolus dose can be given during lockout interval if ordered and needed.

6.0 Bolus dose - an additional dose given to a patient on a PRN basis - ordered by physician. All bolus doses must be administered by RN and BP, R, LOC, and pain level monitored as described below.

4.0 All PCA pumps will be initiated by an RN when orders have been entered via Computerized Physician Order Entry (CPOE) or written on the PCA order form.

4.1 Some patients may not be appropriate candidates to receive PCA. The following criteria should be considered as exclusion criteria for PCA:
a. Age – infants and young children
b. Mental State – patients that are confused agitated and restless
c. Level of consciousness, psychological stability or intellectual capacity

4.2 When assessing a patient for Patient Controlled Analgesia, identify risk factors such as:
a. Age
b. Weight
c. Pre-existing conditions including allergies, renal function, and current medication use that may suggest increased monitoring.

5.0 Verify orders for medication in CPOE or pre-printed PCA Order Sheet.

6.0 PCA can be ordered by an anesthesiologist, surgeon or primary physician.

7.0 Every 24 hours, the PCA pump usage should be evaluated by the managing physician/RN to determine if the patient will benefit from continued therapy. Only RNs who have been in-serviced with PCA may initiate and change rates on PCA infusion pumps.

8.0 Two RNs will independently double-check the correct settings and both must co-sign the on the Pain/PCA tab of the daily assessment when:
a. Initially programming and setting up the PCA device,
b. At shift change, noting: credit, demands, injections, total dosage
c. When changing dosing parameters, drug, or giving a bolus
d. When discontinuing PCA and wasting syringe contents.

9.0 The RN may adjust dose as needed within ordered parameters, utilizing patient assessment.

9.1 Carefully monitor patients. Even at therapeutic doses, opiates can suppress respiration, heart rate and blood pressure, so the need for monitoring and observation is critical after PCA has been Initiated. Patients will be monitored every 2 hrs X 4 (8 hours), then every 4 hrs until PCA is discontinued Vital signs will be documented on the flow sheet. Oximetry monitoring may be appropriate in some cases and will be documented on flow sheet. Level of consciousness will be assessed and monitored every 2 hours X 4 (8 hours), then every 4 hours until PCA is discontinued and will be documented in daily assessment.

9.2 After Initiating PCA, adjusting a dose setting, or giving a bolus, the patient must be reassessed in 30 minutes as well as the monitoring described above.

3. Confirm allergies/reactions.	Document any new allergy/reaction information on Patient Profile.

PROCEDURE – Setting Up PCA Pump:

1. Inspect the PCA syringe for cracks. Assemble the syringe to the PCA injector.	If the vial is cracked, discard the vial in the blue stericycle container with a witness and document the waste in the Automated Dispensing Cabinet. Syringes may need to be assembled with the PCA injector.
2. Unlock the PCA pump, open the door, and secure the equipment to the IV pole just below the primary pump (for initial set up).	When the PCA door is locked the pole clamp is also locked to prevent theft. It is not necessary to manually "Power On" the machine. The PCA pumps for patients with existing IV fluids are secured to the IV pole at the bedside when the set up is completed.
3. Squeeze the cradle release mechanism together at the top of the holder and move to the uppermost position.	Always confirm the bar code reader window is clean before inserting the syringe. To clean the window wipe with a dry, soft, clean cloth or alcohol swab.
4. Insert the bottom of the syringe into the middle black bracket of the cradle. Ensure the bar code label faces the bar code reader on the right side.	Positioning the syringe into the upper clip first can crack or chip the syringe.
5. Gently press the upper end of the syringe into the upper black bracket of the cradle.	
6. Squeeze the cradle release mechanism together and move down until the injector snaps into the bottom bracket.	Inserting and loading a vial will automatically "Power On" the PCA equipment. The bar code reader will read the bar code at this time.
7. The infuser will complete a *"Self Test"*. The next screen will indicate the test is complete. The screen will also show *System Settings* and *Continue.*	If the bar code is not read the system will not continue. Slowly rotate the vial and position the bar code on the right until it can be read. *System Settings* will change the volume of the alarm, contrast of the screen, and time/date of the equipment.
8. The next screen confirms the medication and previous settings are cleared.	The system will retain the previous syringe information and history if the machine has

	the running primary IV.
13. Date and Time tubing change on label and affix to tubing	Tubing change is done every 96 hours. Do not interrupt syringe infusion to change tubing. If tubing is due to expire, change it earlier if necessary to avoid interruption of syringe infusion.
14. *Purge?* Select *Yes* or *No.*	Do Not select *No.* **Select *Yes*>** CAUTION: Disconnect the PCA set from the patient before starting purge cycle. Press and hold purge key. Stop purging after flow is seen at the end of the PCA set. Purging through the PCA enables the machine to subtract the amount from the syringe used to prime the tubing.
15. *Set Loading Dose?* Select *No* unless there is a second RN available to verify that the pump has been programmed correctly. If a second RN will be available to confirm the final settings, select *Yes,* program the loading dose and choose *Deliver Later* to finish programming the PCA machine.	**A loading dose cannot be administered until the pump settings are verified by a second RN.** Bypassing this safety measure can be harmful to the patient.
16. *Select Delivery Mode?*	
PCA Only	Administers the dose only at patient request.
PCA + Cont.	Delivers a continuous rate and allows patient to receive doses when requested.
Continuous	Delivers a preset continuous rate.
17. Program the PCA dose.	Enter the amounts using the key pad on the front of the machine and press *Enter* after each selection.
18 Program the lockout interval.	This is the amount of time the pump is "locked out" between patient doses. NOTE: Administering a loading dose or bolus will put the patient in lockout.
19. Program continuous rate if ordered.	
20. Program the four hour dose limit if	This limits the total dose that can be delivered

27. Explain to patient, family and other visitors that the pump is to be **used by the patient ONLY**. Check box on Pain/PCA assessment verifying that the education took place.

Pump use by patient's family or other visitors can be very harmful to the patient. A sedated patient will not push the PCA button. Bypassing this safety measure causes over sedation and is potentially dangerous to the patient.

PROCEDURE – Monitoring And Documentation

28. The patient's RN will verify PCA settings on transfer, at beginning and end of each shift.

Two RNs will independently double check the correct settings and both must co-sign the on the Pain/ PCA tab on the daily assessment when:

a. Initially programming and setting up the PCA device. (PACU will perform this independent double-check in PACU, then receiving in patient nurse will verify settings upon receiving patient to their care.)
b. At shift change, noting: credit, demands, injections, total dosage
c. When changing dosing parameters, drug, or giving a bolus
d. When discontinuing PCA and wasting syringe contents.

Press the *History* button at any time to verify settings. The settings will appear in the display. Press the History button to continue to review the usage including: settings, total delivered, number of demands, number of injections, number of partial doses. Make sure that ml credit in syringe added to total delivered equals 30 ml. Press *Exit* to return to the previous display. (The PCA settings on the PCA are verified with the eMAR by the initiating RN.)

29. The second nurse will co-sign the Independent double check by:

- Nurse #1 will fill out the Pain/PCA tab with the settings ordered and carried out for the PCA.
- S/he will arrow out of the screen to close it.

pump.

Assess for continued complaint of pain. If patient is in pain and is using his maximum hourly dose X 2 hours, confer with physician about decreasing lockout interval, or increasing basal or PCA dose.

36. Document any bolus doses on the Pain/PCA tab and also as an intervention on Daily Assessment.

Additional pain medications or sedatives ordered by the service managing the pump or the Department of Anesthesia – Pain Management Services are charted on the Scheduled (one time only doses) or PRN eMAR.

37. Initiate Pain Nursing Diagnosis and Care Plan on Care plan.

Update the Pain Care Plan at least daily on the Care Plan.

46. *Total Delivered* is **only** cleared when the syringe is changed. However, the 8 hour total and usage is recorded on the record every 8 hours at the end of the shift.

When clearing the Total Delivered, make sure the amount delivered equals amount of credit in mls.

47. Making changes after the initial set up of the PCA equipment:
Anytime the PCA door is unlocked and/or opened, the PCA will pause and the medication cannot be dispensed.

The screen will display several options:

Loading Dose – Select to set up and give a loading dose or bolus.
Change RX - Select to change the PCA mode or dose.
Clear Shift – Select *Yes* > when changing the syringe but not changing the medication. Note: Only select *Yes* when a 2nd nurse is there to witness all settings, credits, and totals.
Change CCA – Select when changing **type** of medication.

Read closely and choose the correct response.

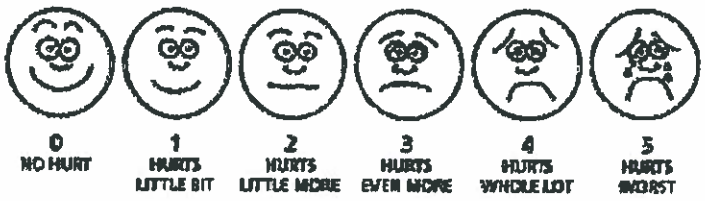
When you select and enter the dose, the next screen will ask you to verify the dose. NOTE: The start button will infuse the dose with the door open.

Changes must be verified by a second RN.

The next screen will warn you that *Changing CCA will clear the RX settings.* Continue or return to previous screen.

Read closely and choose the correct response. The system will confirm clearing the history. Continue to set up the PCA dose from the PCA order on the eMAR for the new medication. A second RN must verify the new medication and settings.

Wong-Baker FACES Pain Rating Scale



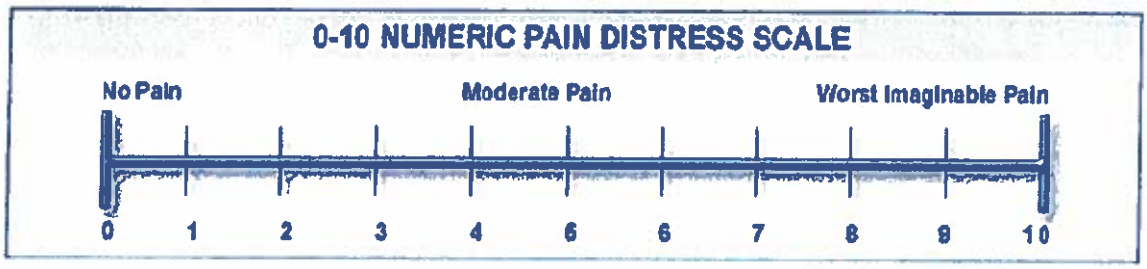
Institute for Safe Medication Practices, (7/2003). *How to prevent errors - Safety issues with patients controlled analgesia.* Medication safety alert.

Joint Commission International Center for Patient Safety, (12/2004). *Patient controlled analgesia by proxy.* Sentinel Event Alert, Issue 33.

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

APPENDIX A:

APPENDIX B:



APPENDIX C:

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE: Controlled Substances- Inventory and Disposition Records**	†**CHECK ONE:** ☐ **New** ☒ **Reviewed** ☒ **Revised :** ☒ **Major** ☐ **Minor**
† ☐ **Administrative** ☒ **Clinical** ☒ **Department _Pharmacy**	
†**SUBMITTED BY:** Therese Helser	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law xx New Regulation: CMS CDPH TJC **Other - DEA**	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** Policy updated to reflect electronic ordering system used for controlled substances = CSOS (Controlled Substance Ordering System) for orders and purchases by the Pharmacy department. Previously done with paper triplicates.	

	MEETING DATE	APPROVAL
☐ **Manager or Department Director**†	10/2013	Y
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☒ P&T Committee	11/14/13	Y
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☐ **Medical Executive Committee (MEC)** (as applicable)		
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual: MEDICATION MANAGEMENT	**Sub Folder:**
Title: Controlled Substances – Inventory and Disposition Records	**Reviewed: 10/97, 7/00, 5/03** **Revised: 4/99,8/05, 7/06, 10/13**
Effective Date: 3/91 **Expiration Date: 10/16**	**Page 1 of 2**

PURPOSE:

The purpose of this policy is to ensure that accurate inventory and disposition records are maintained according to state and federal laws pertaining to controlled substances, schedules II-V. This policy applies hospital-wide. It is the responsibility of the Director of Pharmacy to maintain these records according to Federal and State law and regulation.

POLICY:

Accountable and auditable inventory and disposition records are maintained as required by state and federal laws per the Controlled Substances Act of 1970. The records are maintained separately from other inventory and disposition records. All records pertaining to controlled substances are available for inspection and copying by duly authorized officials of the DEA and State Board.

PROCEDURE:

A. All receipts and issues of controlled substances, to and from the pharmacy, shall be clearly documented. Pharmacy controlled drug inventory records shall routinely be reviewed. Adjustments or corrections to any inventory, or inventory record, shall be reviewed by pharmacy management. Preliminary review of all reports may be assigned to pharmacy department personnel.
   1. Documentation of receipts include:
      a. Copies of DEA 222 order form or a print out of the DEA Controlled Substance Ordering System (CSOS) receipt.
      b. Delivery of invoices of controlled substances received from the wholesaler or other suppliers. All invoices will be double signed by the receiving individual (i.e. buyer) and a pharmacist or pharmacist intern.
      c. Omnicell record or receipt of controlled substances.
      d. Documentation of the creation, and placement into inventory of a Scheduled substance (i..e. Fentanyl/Midazolam drips) through compounding.
      e. Omnicell records or other Pharmacy produced sheets.

B. Documentation of Issues (out of the Pharmacy) Include:
   1. Omnicell records of controlled substance floorstock
   2. DEA 222 forms for drugs sold or transferred to other registrants
   3. Prescriptions for drugs used in compounding
   4. Drug surrender forms for outdated or contaminated drugs sent for destruction to the DEA or other authorized destruction service

provider.
5. Documentation of controlled substances dropped, broken, spilled or damaged and wasted.
6. DEA 106 for to report the loss or theft of Controlled Substances.
7. Documentation of drugs returned to wholesaler.

C. A perpetual inventory of all controlled substances is maintained throughout the hospital.
D. Controlled substances stored in automated dispensing cabinets are blind counted at each removal or access to a drawer.
E. A count of all controlled substances accessed will be performed daily on the nursing units and procedural areas when the unit is open.
F. All nursing units and procedural areas are inventoried monthly and a full count of all controlled substances is performed by Pharmacy personnel.
G. Records for Class II substances will be kept separately from other schedule medication records.
H. A bi-annual inventory of all controlled substances must be done every 2 years, as required by the DEA and the State Board of Pharmacy.
I. All records, receipts and documentation of transactions shall be kept for at least 3 years.

REFERENCES:

Drug Enforcement Agency (DEA), Controlled Substance Act of 1970, 2001 Edition.

Reducing Controlled Substances Diversion in Hospitals, CHA Medication Safety Committee, California Hospital Association May 2013.

Responsible for review/updating	Pharmacy Director	Pharmacy

DOCTORS MEDICAL CENTER
Doctors Medical Center
2000 Vale Road
San Pablo, CA 94806
ICU PHYSICIAN ORDERS
THERAPEUTIC HYPOTHERMIA

11/2013

Patient Sticker Here

Height: _____ **Weight (kg):** _____

Allergies/Reactions: _____

Eligibility Criteria for Therapeutic Hypothermia	
❑ Cardiac arrest with return of spontaneous circulation (ROSC) within 1 hour of collapse	❑ **NO** pre-existing "NO CODE" Status
❑ Persistent coma	❑ **NO** metastatic cancer or other terminal illness
❑ Age 18 or older	❑ **NO** significant chronic neurological impairment
❑ Mechanically ventilated	❑ **NO** uncorrectable hypotension (SBP below or = 90)
	❑ **NO** uncontrolled cardiac arrhythmias
	❑ **NO** QT prolongation greater than 450ms
	❑ **NOT pregnant**
	❑ **NO** active severe bleeding
	❑ Platelet count **NOT** less than 50,000
	❑ **NO** coagulopathy (INR greater than 1.7 or PTT greater than 36)
	❑ **NO** active sepsis

Upon physician signature, all orders will be carried out as stated. To delete an order, cross it out. To activate optional orders, check the box or fill in the blank.

ICU ORDERS – CANCELS ANY PREVIOUS ED ORDER SET

1. **Admit to INTENSIVE CARE UNIT** Dr. _____
2. **Diagnosis:** Resuscitated Cardiac Arrest **Other:** _____
3. **RN to set up for insertion of central venous line and arterial line**
4. **NPO**
5. **ACTIVITY:** Bed rest
6. **NURSING CARE:**
   a. Record I&Os and daily weights
   b. ❑ Place NG tube ❑ To low intermittent suction ❑ For medication
   c. Foley catheter with thermistor
   d. Routine CVP and arterial line care
   e. VAP Bundle order
      - Head of Bed greater than or equal to 30 degree (unless contraindicated)
      - DVT Prophylaxis (sequential compression device, TED Hose)
      - Pantoprazole (Protonix) 40mg IV or NG every 24 hour for Gastric Ulcer Prophylaxis
   f. Oral Care (chlorhexidine 0.12% 15ml every 12 hours)
   g. Skin assessment every two hours and document condition of skin. Braden score every shift

Patient Sticker Here

Height: _____ **Weight (kg):** _____

Allergies/Reactions: _____

7. **DIAGNOSTIC TESTS AND PROCEDURES:**
   a. Admit: ABG, Portable CXR, CMP, Mg, CK, CK-MB, Troponin, CBC, Urine Toxicology Screen.
   b. Other lab: ❑ TSH ❑ Cortisol ❑ Coag Panel (PT/INR, PTT, fibrinogen, D-Dimer) ❑ BNP ❑ Ionized Calcium
   c. ❑ Phosphorous ❑ Lactate ❑ Sputum for C & S
   d. Daily EKG
   e. BMP, CBC x 3 days.
   f. ❑ PT/INR, PTT every 12 hours during cooling.
   g. K+ every 6 hours x 4.
   h. ❑ Portable CXR in a.m.
   i. Echocardiogram within ❑ 1 hr, ❑ 4 hrs, ❑ 24 hrs for LV function and _____
   j. EEG within first 24 hours of admission.
   k. Other diagnostic tests _____

SEDATION/ANALGESIA (have physician complete sustained sedation and analgesia protocol)

Initiate Sedation Protocol – Propofol is preferred sedative; if patient has soy/egg allergy or has elevated triglycerides, contact MD Immediately. Begin prior to applying the cooling pads to the patient. Use sedation protocol while patient is intubated and titrate to appropriate Ramsay Score as indicated by physician. Discontinue at time of extubation.

9. **HYPOTHERMIA INDUCTION:** (If core temp above 35° C) If core temp is below 35° C, initiate cooling with Medi-Therm only
   a. Apply Medi-Therm cooling device and pads to patient. Set to automatic and 33° C.
   b. ❑ Iced (cooled at 4° C.) Normal Saline IV, 30ml/kg and infuse over 30 minutes (ICED) normal saline located in MICU refrigerator.
   c. ❑ Apply ice packs to groin, axilla, and neck, **Discontinue when temp 35° C or less.**

10. **COOLING TREATMENT**
   a. Obtain Medi-Therm cooling device and pads (Central Supply).
   b. Place all 4-5 (weight dependent) cooling pads on the patient and connect water tubes to manifold.
   c. Internal temperature monitoring via insertion of foley catheter with thermistor.
      ❑ rectal temperature probe
   d. Activate Automatic Mode on the cooling unit.
   e. Set Target Temperature at 33° C or _____ C (should require 1-2 hrs to achieve this temperature).
   f. If patient to travel outside of the unit, purge water (about 30 seconds required) and disconnect tubes from manifold. Leave console ON.
   g. ❑ After 24 or _____ hours at less than 34 ° C, begin re-warming.
   h. If the cooling device is being used for another purpose, the Pads must be changed every 3 days.

11. **MONITORING**
   a. Monitor HR, BP, MAP, CVP, temp every 15 minutes during induction of hypothermia, then 30 minutes times 2, then every 1 h after stable.
   b. Monitor neurological status; document Ramsey score every 30 min during induction and then every hour (see reference at end).
   c. Monitor O_2 saturation.
   d. Check peripheral pulses every one hour. **No subcutaneous meds or finger sticks.**

Patient Sticker Here

Height: _____ Weight (kg): _____

Allergies/Reactions: _____

e. Monitor cooling device water temperature every one hour, if water temperature is 10° C or less after the target temperature is achieved; notify MD. (May imply fever or unrecognized shivering; prolonged skin exposure to 10° C temperatures may cause injury to the skin).

f. **If core temp is ≤ 32° C notify physician immediately and:**
   1. Administer warmed (40° C) NS, 250mL every 20 minutes x 3
   2. Replace the Medi-Therm with a new cooling device
   3. **Avoid rapid rewarming (>0.5° C per hour)**

12. SHIVERING SUPPRESSION PROTOCOL

a. If unable to control shivering with Propofol

b. ☐ Meperidine (DEMEROL) 50mg IV every 1 h PRN shivering (avoid in patient with history of seizures or renal failure-contact MD)

c. ☐ Vecuronium (NORCURON) (once the patient is sedated) bolus 0.1mg/kg times one then Vecuronium 0.1mg/kg IV bolus every 30 minutes PRN for uncontrollable shivering

d. Artificial tears to both eyes every 8 hours while receiving paralytic agent.

e. Use peripheral nerve stimulator every 1 hour to adjust paralytic to confirm paralysis. Notify MD for uncontrolled shivering.

13. CARDIOVASCULAR SUPPORT

a. If hypotension develops during Propofol infusion, do not discontinue Propofol but use one of the following to achieve: ☐ SBP above 90mm Hg or ☐ MAP above 60mm Hg: Have MD complete vasoactive medication infusion order form.

   1. ☐ Norepinephrine (LEVOPHED) 4mg in 250mL D5W IV. Start at 2mcg/min.
   2. ☐ Dopamine 400mg in D5W 250 ml. Start at 1 mcg/kg/min.
   3. ☐ Phenylephrine (NEO-SYNEPHRINE) 50mg in NS 250ml IV. Start at 30mcg/min.

b. Anticoagulant: (Complete VTE prophylaxis/treatment order form)

14. METABOLIC SUPPORT

a. ☐ Insulin Infusion (complete critical care IV insulin infusion protocol) – DRAW WHOLE BLOOD FOR GLUCOSE MONITORING, DO NOT USE FINGERSTICKS AS OUTLINED IN PROTOCOL.

b. ☐ Potassium Replacement **(Followed only if checked off by MD)** for next 48 hours.

Check with MD before following if creatinine greater than or equal to 2.0. Give via central line:

- If K+ less than or equal to 3.8 and patient is hypothermic, repeat level when normothermic (DELETE THIS)
- If serum K+ is less than or equal to 3.6, give 10mEq KCl in 100 ml NS IV over 1 hr x2 via central line and check K+ in two hrs.
- If serum K+ is 3.7 – 4.5, give 10mEq KCl in 100ml NS IV over 1 hour via central line.
- If serum K+ is greater than or equal to 4.6, no replacement.
- Notify MD if K+ is greater than or equal to 5.6.

c. ☐ Magnesium protocol (Followed only if checked off by MD) for next -_____

If Mg less than 1.8, give Magnesium Sulfate 1 Gm IV in 50ml D5W over one hour.

d. Other medications: _____

Patient Sticker Here

Height: _____ **Weight (kg):** _____

Allergies/Reactions: _____

15. RESPIRATORY THERAPY

a. Ventilator settings: Mode: Assist Control, RR: _____ V_t: 8 ml/kg IBW, PEEP: _____
b. Titrate FiO_2 to maintain FiO_2 sat. above or = 92%. Do not use heated humidifier. Use Heat Moisture Exchanger (HME).
c. Monitor $EtCO_2$.
d. Establish arterial-exhaled CO_2 gradient and then use capnography to maintain $PaCO_2$ 35-40mm Hg and adjust V_e accordingly.
e. Do ABG 30 minutes after mechanical ventilation initiated.
f. Suction per protocol; manually hyper-inflate and hyper-oxygenate lungs before and after.

16. REWARMING

☐ **Passive Rewarming**

a. Discontinue cooling device.
b. Discontinue Vencuronium or any other paralytic.
c. Titrate sedative to a Ramsay score of 3-4 once patient is rewarmed to 36.5° C.
d. Maintain patient at 35.5° – 37.5° C.

☐ **Active Rewarming**

a. Increase temperature on the cooling device by 0.5°C every hour.
b. Discontinue Vecuronium or any other paralytic agent.
c. Titrate sedatives to Ramsay score of 3-4 once patient is rewarmed to 36.5°C.
d. Maintain patient at 35.5° – 37.5° C.

Discontinue treatment if patient develops:

- Sepsis resulting in hypotension and requires increasing amounts of vasopressors
- New acute myocardial infarction
- Hemodynamically unstable tachydysrhythmias.
- Thrombocytopenia (platelet count less than 50,000)

Notify M.D. for _____

Ramsay Score Reference

1	Anxious, agitated, restless
2	Cooperative, tranquil, oriented
3	Drowsy, response to verbal command
4	Asleep, brisk response to light glabellar tap & loud auditory stimulus
5	Asleep, sluggish response to light glabellar tap & loud auditory stimulus
6	Coma

Date: _____ **Time:** _____ **Physician Signature:** _____

MEDICAL STAFF COMMITTEE RECOMMENDATIONS	DATE
CREDENTIALS COMMITTEE	October 24, 2013
MEDICAL EXECUTIVE COMMITTEE	November 11, 2013
BOARD OF DIRECTORS APPROVAL	December 18, 2013

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
OCTOBER 2013

INITIAL APPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	APPOINTMENT TERM	RECOMMENDATION
Barry, Piers, MD	Department of Surgery/Orthopedic Surgery	Provisional	12/18/2013 – 12/17/15	Approval
Mealey, Forrest, DO	Dept of Med & Family Practice/Internal Medicine	Provisional	12/18/2013 – 12/17/15	Approval

REAPPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Batts, Richard, MD	Dept of Med & Family Practice/Internal Medicine	Affiliate Active	12/17/13 – 10/31/15	Approval
Cooper, Joanna, MD	Dept of Med & Family Practice/Neurology	Courtesy	12/17/13 – 10/31/15	Approval
Chiu, Elaine, MD	Dept of Med & Family Practice/Emergency Med	Courtesy	12/17/13 – 10/31/15	Approval
Raees, Muhammad, MD	Dept of Med & Family Practice/Pulmonary Med	Active	12/17/13 – 10/31/15	Approval
Weiland, David, MD	Dept of Med & Family Practice/Cardiology	Active	12/17/13 – 10/31/15	Approval
Addes, Shirley, DPM	Dept of Surgery/Podiatry	Affiliate Active	01/29/14 – 11/30/15	Approval
Gadwood, Gary, MD	Dept of Surgery/General Surgery	Active	01/29/14 – 11/30/15	Approval
Fahmie, Darlene, DPM	Dept of Surgery/Podiatry	Affiliate Active	01/29/14 – 11/30/15	Approval
Munajed, Amal, MD	Dept of Surgery/Anesthesiology	Active	01/29/14 – 11/30/15	Approval

DOCTORS MEDICAL CENTER CREDENTIALS REPORT OCTOBER 2013		
VOLUNTARY RESIGNATIONS		
NAME	***DEPARTMENT/SPECIALTY***	***EFFECTIVE DATE***
John Bokelman, MD	Dept of Med & Family Practice /Radiology	11/3/2013
Nishant Shah, MD	Dept of Med & Family Practice /Family Medicine	09/21/2013
Anthony Koh, MD	Dept of Med & Family Practice /Internal Medicine	10/10/2013
Amy Matecki, MD	Dept of Med & Family Practice /Internal Medicine	09/21/2013
Alan Siegel, MD	Dept of Med & Family Practice /Internal Medicine	09/21/2013

MEDICAL STAFF COMMITTEE RECOMMENDATIONS	DATE
CREDENTIALS COMMITTEE	November 21, 2013
MEDICAL EXECUTIVE COMMITTEE	December 9, 2013
BOARD OF DIRECTORS APPROVAL	December 18, 2013

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
NOVEMBER 2013

COMPLETION OF PROCTORING REQUIREMENTS

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

NAME	DEPARTMENT/SPECIALTY	STATUS OF PROCTORING REQUIREMENTS
Litmann, Erin, PA-C	Med./Family Practice/ Physician Assistant ER	Complete

REAPPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Arnold, Stephen, MD	Medicine & Family Practice/Cardiology	Active	1/24/14 – 11/30/15	Approval
Carson, Desmond, MD	Medicine & Family Practice/Emergency Med	Active	1/24/14 – 11/30/15	Approval
Chou, Grace, MD	Medicine & Family Practice/Family Practice	Affiliate Active	1/24/14 – 11/30/15	Approval
Escalada, Maria, MD	Medicine & Family Practice/General Med	Affiliate Associate	1/24/14 – 11/30/15	Approval
Goldberg, Michael, MD	Medicine & Family Practice/Internal Medicine	Active	1/24/14 – 11/30/15	Approval
Hill, David, MD	Medicine & Family Practice/Cardiology	Active	1/24/14 – 11/30/15	Approval

DOCTORS MEDICAL CENTER CREDENTIALS REPORT NOVEMBER 2013				
Hodgson, Laurel, MD	Medicine & Family Practice/Emergency Med	Active	1/24/14 – 11/30/15	Approval
Naughton, James MD	Medicine & Family Practice/Internal Medicine	Affiliate Associate	12/17/13 – 10/31/15	Approval
Ruben, Mark, MD	Medicine & Family Practice/Dermatology	Active	12/17/13 – 10/31/15	Approval
Crawford, Thomas, PA-C	Medicine & Family Practice/Physician Assist	Allied Health	1/24/14 – 11/30/15	Approval
Fink, Robert, MD	Surgery/Neurosurgery	From Active to Honorary	12/17/13 – 10/31/15	Approval
Lowe, Darrin, DPM	Surgery/Podiatry	Active	1/24/14 – 11/30/15	Approval

VOLUNTARY RESIGNATIONS		
NAME	***DEPARTMENT/SPECIALTY***	***EFFECTIVE DATE***
Asuncion, Immanuel, MD	Dept of Med & Family Practice /Family Medicine	12/14/2013

Doctors Medical Center
DEPARTMENT OF SURGERY
Request for Clinical Privileges – ORTHOPEDIC SURGERY

SCOPE OF SERVICES

The Department of Surgery provides comprehensive and continued non-surgical care and treatment for diseases and conditions in patients 18 years old through geriatrics. Sections included within the Department of Surgery include, but not limited to: Anesthesiology, Cardiothoracic, Dental, Oral & Maxillofacial Surgery, General Surgery, Otolaryngology, Neurosurgery, Ob/Gyn Oncology, Ophthalmology, Orthopedic, Pain Medicine, Pathology, Plastic Surgery, Podiatry, Vascular Surgery, Genitourinary The Department of Surgery services are available 24 hours a day, 7 days per week.

CORE PRIVILEGES FORMAT

This delineation of privileges represents those most commonly performed within the specialty area and the scope of services provided. The privileges are described in the core privilege (or bundling) format, which, by necessity, is not a detailed list. Each bundle denotes a level of clinical expertise as defined by the department based on evidence of documented education, training and experience. It is assumed that other medical illnesses and problems may require medical management within the Practitioner's scope of care and commensurate with the qualifications of a Practitioner's medical licensure.

Procedures outside the scope of those listed for this department must be obtained on an individual basis through the appropriate department(s) of this facility, upon recommendation of the Chairman of the Department of Surgery.

STANDARDS FOR PRIVILEGES

Applicants need note that initial and reappointments to this department will be based on a system of performance appraisal. This performance appraisal will utilize information regarding clinical activity and from monitoring and evaluation activities.

HEALTH STATUS

Applicants must certify at time of initial appointment and reappointment, that there are no problems of health or mental status, which will interfere with the exercise of the clinical privileges requested.

OBSERVATION REQUIREMENTS

All provisional appointees shall undergo a period of observation to determine clinical/technical competence prior to the granting of privileges to independently perform requested procedures. Members of the staff requesting additional or new privileges are required to be proctored for such privileges. The terms and methods of proctoring are predetermined by each clinical department; however, procedures crossing departmental lines have uniform proctoring requirements.

MINIMUM THRESHOLD CRITERIA

In order to be eligible to request clinical privileges for both initial appointment and reappointment a practitioner must meet the following minimum threshold criteria:

Education: M.D. or D.O.

Minimum Formal Training: All applicants requesting privileges in ***ORTHOPEDICS*** must have successfully completed an orthopedic surgery residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) with documented evidence of active hospital-related practice for at least five years.

Required Clinical Experience: The applicant must be able to demonstrate current clinical competence and adequate volume of at least 100 general orthopedic procedures reflective of the scope of privileges requested with acceptable results, during the past 12 months or demonstrated successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months. Applicants must provide evidence of a level of clinical expertise based on training, experience, judgment and demonstrated competence.

Documented Proficiency: Where indicated, the applicant must substantiate the request for privileges by providing evidence of current competence. This can be accomplished in one or more of the following ways:

1) a letter from the program director verifying training (if training completed within the last three (3) years,
2) copies of proctor reports from another accredited facility where the privileges have been granted,
3) attendance at continuing education programs that include both didactic and laboratory sessions; or

Practitioner Name:_____ From: _____ To: _____

4) procedure logs with outcomes to support privileges for procedures not attested to in postgraduate training.

DOCTORS MEDICAL CENTER

DEPARTMENT OF SURGERY
Delineation of Privileges
ORTHOPEDICS

NAME:	**CATEGORY:** __ACTIVE __COURTESY ___ AFFILIATE ACTIVE ___ AFFILIATE ASSOCIATE

I HEREBY REQUEST ☐ **INITIAL** PRIVILEGES ☐ **RENEWAL** OF PRIVILEGES*

Privileges in Orthopedics are granted for both clinical cognitive areas and specific procedures. All practitioners requesting privileges in Orthopedics must have successfully completed general surgery residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

Recent clinical experience is required of all applicants for appointment and reappointment.

Initial Appointment Requirement:
Recent clinical experience for initial appointment is defined as having performed at least **100** procedures in an accredited hospital, reflective of the scope of privileges requested, with acceptable results, within the last 24 months.

Reappointment Requirement:
To be eligible to renew privileges in general surgery, the reapplicant must meet the following criteria: Current demonstrated competence and an adequate volume of experience (n) general orthopedic procedures with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

EMERGENCIES: It should be recognized that in the case of an emergency, any individual who is a member of the medical staff or who has been granted clinical privileges is permitted to do everything possible within the scope of his/her license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.

CONSULTATIONS: Consultations are expected to be obtained when the diagnosis or management is in doubt for an unduly long period of time, when complications arise or when specialized treatments or procedures are contemplated, that are different from privileges granted.

APPLICANT – PLEASE READ - IMPORTANT

Instructions: *Request only those privileges for which you can provide documentation that you meet requirements and are currently clinically competent to perform. Please see attached "Criteria/Standards for Clinical Privileges" prior to completing this privilege delineation request. Check (√) the appropriate box for each procedure requested. It is recognized that in emergency situations, the best judgment of the practitioner may require the performance of procedures not requested. However, if under normal circumstances, you will not be performing a procedure/privilege, please leave it blank.*

"Write-In" privileges are not accepted
If you wish to request a privilege not listed on this form, please contact the Medical Staff Office

Practitioner Name:_____ From: _____ To: _____

for further instructions.

Practitioner Name:_____ From: _____ To: _____

CORE PRIVILEGES

☐ **CORE ORTHOPEDIC PRIVILEGES: AFFILIATE ASSOCIATE STAFF ONLY**

Affiliate Associate Staff shall consist of members who meet all of the criteria for membership in the Department of Surgery – Orthopedic, but who may not meet the requirements for privileges and/or may not have the level of clinical activity to qualify for another staff category, but who appear likely to provide a distinct service to the Hospital, Medical Staff or hospital patients.

- No Clinical Privileges granted
- Permitted access to the medical record for refer and follow purposes only
- May not write orders or perform any entries into the medical record
- May not admit and/or treat patients

This Staff Category may not request "Non-Core" or any additional privileges.

☐ **CORE ORTHOPEDIC PRIVILEGES: AFFILIATE ACTIVE STAFF ONLY**

Affiliate Active Staff shall consist of members who meet all of the criteria for membership in the Department of Surgery – Orthopedic, but only maintain clinical privileges to perform histories and physicals. Affiliate Active Staff may also have medical record access.

- Perform History & Physical
- Permitted access to the medical record
- May not write orders or perform any entries into the medical record
- May not admit and/or treat patients.

This Staff Category may not request "Non-Core" or any additional privileges.

☐ **CORE ORTHOPEDIC PRIVILEGES: ACTIVE & COURTESY ONLY**

Privileges include admission, evaluation, diagnosis, and provision of consultation to patients 18 years or older, to correct or treat various conditions, illnesses and injuries of the extremities, spine, and associated structures by medical, surgical, and physical means including, but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the spine, hands, feet, knee, hip, shoulder, and elbow including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures listed below and such other procedures that are extensions of the same techniques and skills.

These privileges include, but are not limited to procedures such as those listed below. This list is a sampling of procedures included in the core and is not intended to be all-encompassing but reflective of the categories and/or types of core procedures.

Continue to next page for "Core Orthopedic Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

Core Orthopedic Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

Please CROSS OUT & INITIAL any privileges listed below that you wish to exclude in this core set of Orthopedic Privileges

	PROCEDURE	INITIAL
1.0	Perform history and physical examination	
1.02	Arthrocentesis	
1.04	Arthordesis	
1.06	Arthroplasty-Hand	
1.10	Arthroscopy	
1.12	Bone Graft	
1.14	Bone/Muscle Biopsy	
1.16	Bursectomy	
1.18	Bunionectomy	
1.20	Carpal Tunnel Release	
1.24	Excision, Tumor	
1.26	Excision, Ganglion	
1.28	Excision, Synovium	
1.30	Fasciotomy-Tenotomy	
1.32	Fracture Reduction, Open	
1.34	Fracture Reduction, Closed	
1.36	Insertion, Wire	
1.38	Insertion, Pin	
1.40	Insertion, Plate	
1.42	Menisectomy	
1.44	Metatarsal Ostoetomy	
1.46	Muscle Exploration, Biopsy	
1.48	Myectomy	
1.50	Myoplasty	
1.52	Osteotomy-Corrective	
1.54	Prosthesis Implant	
1.56	Synovectomy	
1.58	Tendon Repair or Transfer	
1.62	Thoroclombar Fusion	
1.64	Total Joint Replacement	
2.02	Injection: Lumbar Puncture (Includes Myelogram)	
2.04	Injection: Discograms	
2.06	Injection: Chemonucleolysis	
2.08	Fracture Dislocation: Closed Reduction, Cervical	
2.10	Fracture Dislocation: Closed Reduction, Dorsal	
2.12	Fracture Dislocation: Closed Reduction, Lumbar	
2.14	Fracture Dislocation: Open Reduction/Post. Approach, Cervical	
2.16	Fracture Dislocation: Open Reduction/Post. Approach, Dorsal	
2.18	Fracture Dislocation: Open Reduction/Post. Approach, Lumbar	
2.20	Fracture Dislocation: Open Reduction/Ant. Approach, Cervical	
2.22	Fracture Dislocation: Open Reduction/Ant. Approach, Dorsal	
2.24	Fracture Dislocation: Open Reduction/Ant. Approach, Lumbar	
2.26	Laminectomy/Foraminotomy (for disc stenosis), Cervical	
2.28	Laminectomy/Foraminotomy (for disc stenosis), Dorsal	
2.30	Laminectomy/Foraminotomy (for disc stenosis), Lumbar	

"Write-In" privileges are not accepted.

If you wish to request a privilege not listed on this form, please contact the Medical Staff Office

Continue to next page for "Core Orthopedic Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

Core Orthopedic Privileges: Active & Courtesy Only - Continued

Practitioner Name:_____ From: _____ To: _____

Please CROSS OUT & INITIAL any privileges listed below that you wish to exclude in this core set of Orthopedic Privileges

	PROCEDURE	INITIAL
2.32	Diskectomy, automated percutaneous lumbar	
2.34	Spinal Fusion, with & without instrumentation, Cervical, Posterior	
2.36	Spinal Fusion, with & without instrumentation, Cervical, Anterior	
2.38	Spinal Fusion, with & without instrumentation, Dorsal, Posterior	
2.40	Spinal Fusion, with & without instrumentation, Dorsal, Anterior	
2.42	Spinal Fusion, with & without instrumentation, Lumbar, Posterior	
2.44	Spinal Fusion, with & without instrumentation, Lumbar, Anterior	
2.46	Scoliosis Surgery, including instrumentation, Anterior Approach	
2.48	Scoliosis Surgery, including instrumentation, Posterior Approach	
2.50	Tumors, Spine-Malignant or Benign Lesions, Post Decomp. with instrumentation	
2.52	Tumors, Spine-Malignant or Benign Lesions, Post. Decomp. without instrumentation	
2.54	Tumors, Spine-Malignant or Benign Lesions, Ant. Decomp. with instrumentation	
2.56	Tumors, Spine-Malignant or Benign Lesions, Ant. Decomp. with instrumentation	
2.58	Tumors, Spine-Malignant or Benign,	
2.60	Tumors, Spine-Malignant or Benign Lesions, Ant. Decomp. without general surgeon	
2.62	Myelomenigocele Repair	
2.64	Dorsal Column Stimulator Implant	
2.68	Rhizotomy	
2,70	Repair of SCF Leak	
3.02	Arthorplasty of Lesser Digits	
3.04	Bunionectomy	
3.06	Correction of Hallux Limitus or Rigidus	
3.08	Excision of Neuroma	
3.10	Metatarsus Primus Varus Reduction	
3.12	Repair of Freiberg's Infraction	
3.14	Hallux Arthroplasty	
3.16	Excision, Cutaneous Lesions	
3.18	Excision, Dorsal Cuneiform Exostosis	
3.20	Excision, Foreign Bodies on the Forefoot	
3.22	Exoision, Plantar Fibroma	
3.24	Resection, Lesser Metatarsal Head Resection	
3.26	Partial Ostectomy-forefoot	
3.28	Plantar Condylectomy	
3.30	Sesamoidectomy	
3.32	Excision Subcutaneous Lesion	
3.34	Toenail Surgery	
3.36	Subungual Exostosis	

"Write-In" privileges are not accepted

If you wish to request a privilege not listed on this form, please contact the Medical Staff Office

Continue to next page for "Core Orthopedic Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

Core Orthopedic Privileges: Active & Courtesy Only - Continued

Practitioner Name:_____ From: _____ To: _____

Please CROSS OUT & INITIAL any privileges listed below that you wish to exclude in this core set of Orthopedic Privileges

	PROCEDURE	INITIAL
4.02	Soft Tissue Repair, Simple Injury (i.e. lacerations, F.B.)	
4.04	Soft Tissue Repair, Complex Injury – Skin Grafts	
4.06	Soft Tissue Repair, Complex Injury – Local/Distant Pedicle Flaps	
4.08	Soft Tissue Repair, Complex Injury – Nail Surgery	
4.10	Soft Tissue Repair, Complex Injury – Burns	
4.12	Skeletal System: Dislocation/Fractures, Open Reduction	
4.14	Skeletal System: Dislocation/Fractures, Closed Reduction	
4.16	Skeletal System: Bone Grafts	
4.18	Skeletal System: Corrective Osteotomy	
4.20	Skeletal System: Amputation	
4.22	Joint Surgery/Arthroplasty Fusion	
4.24	Joint Surgery/Joint Replacement	
4.26	Joint Surgery/Synovectomy	
4.28	Tendon & Ligament Surgery: Repair, Extensor only	
4.30	Tendon & Ligament Surgery: Repair, all other	
4.32	Tendon & Ligament Surgery: Tendon Graft	
4.34	Tendon & Ligament Surgery: Tendon Transfer	
4.36	Tendon & Ligament Surgery: Decompression	
4.38	Tendon & Ligament Surgery: Tenosynovectomy	
4.40	Nerve Surgery: Repair/Standard	
4.42	Nerve Surgery: Repair/Microscopic	
4.44	Nerve Surgery: Transfer	
4.46	Nerve Surgery: Graft	
4.48	Nerve Surgery: Decompression	
4.50	Replantation Surgery	
4.52	Vascular Surgery/Hand	

"Write-In" privileges are not accepted

If you wish to request a privilege not listed on this form, please contact the Medical Staff Office

Continue to next page for "Non-Core Orthopedic Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

NON-CORE PRIVILEGES

ELIGIBILITY CRITERIA: Practitioners requesting any of the follow Non-Core Privileges must have successfully completed an approved residency training program In General Surgery WITH document evidence of active hospital-related practice for at least five (5) years. In addition, for each privilege requested below, documentation of current training and or experience must be submitted for each new applicant, as well as, reappointment and professional staff members requesting a change in privileges.

R	Priv #	PRIVILEGES/PROCEDURES
☐	#1	**MODERATE SEDATION: Provider Competency Evaluation Required:** On initial appointment, a physician must review the material provided and satisfactorily complete the test to obtain this privilege. On reappointment, a physician must have conducted at least eight (8) cases to retain this privilege. If eight (8) cases have not been done, he/she must satisfactorily complete the test. ☐ Proof of 8 cases perform is attached ☐ Request to retake "Provider Competency Evaluation"
☐	#2	**THESE BOXES SHOULD BE DELETED TO PREVENT "WRITE-IN" REQUESTS**
☐	#3	
☐	#4	
☐	#5	

I certify that I have had the necessary education training and have the experience to provide the treatment evaluation and/or procedures requested. I agree to abide by the Medical Staff Bylaws Medical Staff Rules and Regulations and Medical Staff and Hospital policies and procedures and will provide only those services within the scope of my licensure and/or practice.

Applicant Signature _____ Date _____

Practitioner Name:_____ From: _____ To: _____

PRACTITIONER:

RECOMMENDATIONS		
All privileges delineated have been individually considered and have been recommended based upon the Physician's specialty, licensure, specific training, experience, health status, current competence and peer recommendations. ☐ *APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES WITHOUT EXCEPTIONS/LIMITATIONS* ☐ *APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES WITH THE FOLLOWING EXCEPTIONS/LIMITATIONS (Indicate the Privilege # on page 4)* _____ _____ _____		
DIVISION CHIEF *(if applicable)*		*DATE*
DEPARTMENT CHAIRMAN *(Signature required)*		*DATE*
CREDENTIALS COMMITTEE *(No Signature required – See meeting minutes)*		*Meeting Date:*_____
MEDICAL EXECUTIVE COMMITTEE *(No Signature required – See meeting minutes)*		*Meeting Date:*_____
APPROVAL		
BOARD OF DIRECTORS *(No Signature required – See meeting minutes)*		*Meeting Date:*_____