DOCTORS
MEDICAL CENTER

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

Wednesday, July 25, 2012
4:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
JULY 25, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

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

AGENDA

1. **CALL TO ORDER** — E. Zell

2. **ROLL CALL**

3. **APPROVAL OF JUNE 27, 2012 MINUTES** — E. Zell

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

5. **QUALITY REPORT** — K. Taylor
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the Quality Report and Approval of the Following Policies:*
      i. Performance Improvement Plan 2012 Policy
      ii. Patient Safety Plan Policy

6. **FINANCIALS – JUNE 2012** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the June 2012 Financials*

7 **CAPITAL EQUIPMENT**: Stryker Overhead Surgical Lights J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Approval and authorize CFO to execute on behalf of DMC to purchase new surgical lights for 3 rooms (2 per room).

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

9. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: 1. Approval of the Following Policies:*
      i. Swallow Screen
      ii. Admission, Discharge and Transfer of Patients
      2. Acceptance of the Medical Staff Report and Approval of Appointments, Reappointments and Changes of Staff Status and Procedures

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: John Hardy, Vice President of Human Resources: California Nurses Association, NUHW, Local 1.

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

DOCTORS
MEDICAL CENTER

MINUTES

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DMC GOVERNING BODY
BOARD OF DIRECTORS

JUNE 27, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

MINUTES

1. **CALL TO ORDER**

   The meeting was called to order at 4:30 P.M.

2. **ROLL CALL**

   Quorum was established and roll was called:

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

   Excused:
   Nancy Casazza
   Patrick Godley

3. **APPROVAL OF MAY 23, 2012 MINUTES**

   The motion made by Director Anderson and seconded by Director Campbell to approve the May 23, 2012 minutes passed unanimously.

4. **PUBLIC COMMENTS**

   There were no public comments.

5. STROKE PROGRAM UPDATE

Dr. Desmond Carson, ER/Medical Director for the Stroke Program, gave an update presentation on the Stroke Program, which entailed the history, data summary for Q1 2012, and community outreach efforts. He thanked and acknowledged Susila Patel, Program Coordinator, Dr. Seth Thomas, ER Medical Director, Jason Shorter, ER Director for their tremendous team work and support for the program.

6. QUALITY REPORT

Ms. Karen Taylor, Director of Quality and Risk Management presented and sought acceptance of the Quality report. Ms. Taylor gave a report on The Joint Commission (TJC) Accreditation Assessment for May 2012. The Joint Commission visits DMC every three years and allows us to bill Medicare and Medicaid "Deemed Status" for payment billing, which was one of the important opportunities for improvements. The TJC education fair is scheduled for July 26, 2012, and The Joint Commission Visit is anticipated to occur before October 3, 2012.

The motion made by Director Anderson and Seconded by Director Campbell to accept the Quality Report passed unanimously.

7. FINANCIALS – MAY 2012

Mr. James Boatman, CFO began by introducing Ms. Vickie Scharr, DMC's new Controller. She is a CPA and has an MBA from St. Mary's College.

Mr. Boatman presented and sought approval for the May 2012 Financials. Mr. Boatman reported variances in operating revenue and expenses in May, resulting in a net loss of $1.7M. Patient days were 2.0% better than budget and discharges were better than budgeted by 0.6%. Outpatient visits, however, continue to fall behind.

Medi-Cal volume in total was down, specifically traditional Medi-Cal was 366 days under budget, but managed Medi-Cal was 200 days over budget. On a net basis, there was a $625K negative variance in Medi-Cal revenue.

Salaries and Benefits were over budget by $202K in May and Professional fees over budget by $232K. Supplies continue to be under budget by $262K.

The motion made by Director Anderson and seconded by Director Wallace to approve the May 2012 Financial passed unanimously.

8. AUTHORIZIATION OF SIGNATORIES

Mr. James Boatman sought approval for Resolution# 2012-03, Authorization of Signatories, which required changes to reflect Eric Zell as Chair of the Governing Body, and added Vickie Scharr as the new Controller for Doctors Medical Center.

The motion made by Director Anderson and seconded by Supervisor Gioia to approve Resolution# 2012-03 for Authorization of Signatories passed unanimously.

9. HUMAN RESOURCES ANNUAL REPORT

Mr. John Hardy, Vice President of Human Resources presented and sought acceptance of the Human Resources 2012 Annual Report. Under labor relations, Mr. Hardy reported approximately 60% of DMC's total work force is represented by collective bargaining units. DMC will continue to focus on managing the contract with these unions: NUHW, Local One Clerical, Local One Laboratory, Local 29 Stationary Engineers, and California Nurses Association Case Managers. The California Nurse Association Nurses will expire June 30, 2013.

Workforce Development: A new management education program has been developed and offered to managers and directors for middle management staff:

1. Building effective teams
2. Leadership and leading
3. Managing challenging workplace behaviors
4. Ethics and integrity in the workplace
5. Creating a positive work environment
6. Sexual harassment training (federal and state requirement)

Mr. Bob Redlo was recruited to the position of Vice President of Patient Relation, Labor Relations and Work Force Development to support the development of an improved culture for both employee and patient relations. One of Bob's primary goals will be to develop labor management partnership incentives and long term education programs to manifest improved patient family satisfaction, improved job performance and improved employee satisfaction.

Mr. Hardy provided a summary of statistics, which references mandatory compliance in order for employees to work in our acute care setting.

The motion made by Director Campbell and seconded by Director Anderson to accept the Human Resources 2012 Annual Report passed unanimously.

10. CORPORATE COMPLIANCE PROGRAM

Ms. Dawn Gideon, Interim President and CEO presented and sought approval of Resolution# 2012-04, Doctors Medical Center Corporate Compliance Program and Compliance Officer.

The purpose of this program is to ensure compliance with all applicable statues, regulations and policies governing daily business activities. The program will service as a guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies.

Questions about this Compliance Program can be directed to the Compliance Officer, Karen Taylor, Director of Quality and Risk Management.

The motion made by Director Campbell and seconded by Director Wallace for Approval of Resolution# 2012-04, Corporate Compliance Program and Corporate Compliance Officer passed unanimously.

11. CEO REPORT

Ms. Gideon provided an update on priorities that had been outlined in the beginning of the year:

- Development of the Strategic Plan: The management, medical staff and Governing Body continue to work through the development of the Plan. As part of that Plan, we are presently exploring partnership/affiliation options.
- Patient Satisfaction: Held second Patient Satisfaction Summit with patients, physicians, employees, management, union leadership and community members to develop a plan to improve patient satisfaction. One of the things we're doing is the expansion of the 3rd floor telemetry. We received $150k from the Foundation Board to help finish the project
- Quality: We continue to be focused on core measures, Joint Commission, measurable and reportable items.
- Operating Priorities: We are two months live since the completion of Paragon implementation and feel that we will meet the meaningful use criteria

12. MEDICAL EXECUTIVE REPORT

Dr. Laurel Hodgson, Chief of Staff began her report by acknowledging Dr. Stern and Dr. Tufail for their efforts and input at the Patient Satisfaction Summit.

Dr. Hodgson was proud to announce and introduce two of DMC's ER Scribes: Paul Pugsley, who will be attending medicine school in Albany and Maxwell Jen, leaving for residency at U.C. Irvine. She also acknowledged Dr. Joe Maung, Galen Physician and EDOC award recipient. Once a month, we nominate someone outside the ER, who's made a significant difference to do their job, going above and beyond to be of assistant.

Dr. Hodgson stressed the importance of community outreach. She and Remy Goldsmith, Director of Public Relations recently attended SIRS (Sons In retirement) monthly luncheon, a non-profit public corporation for retired men. They gave a general update of the hospital and provided vital information to 88 attendees on the urgency of responding to stroke and heart attack symptoms.

Dr. Hodgson sought approval for the June Credentials Report and approval of the changed amendment to Rules and Regulations Article 5.16.

The motion was made by Supervisor Gioia and seconded by Dr. Campbell to approve the June Credentials and approve the changed amendment to Rules and Regulations Article 5.16 passed unanimously.

The meeting adjourned to closed session.

DOCTORS
MEDICAL CENTER

QUALITY

TAB 5

DOCTORS MEDICAL CENTER

Manual:	Sub Folder:
Title: PERFORMANCE IMPROVEMENT PLAN 2012	Reviewed: Revised:
Effective Date: Expiration Date:	Page 1 of 9

PURPOSE AND OBJECTIVES OF THE PERFORMANCE IMPROVEMENT PLAN (PI)

The purpose of the Performance Improvement Plan is to continuously improve the key functions and processes relative to patient care. The goal of this plan is to ensure all staff consistently endeavors to deliver safe patient care and deliver it in a cost effective manner. This plan is coordinated and focused on continually improving processes including patient care and sustaining excellent patient outcomes. The performance improvement plan is based on the concept of patient centered care and the integration of:

- Quality – reducing process variation
- Clinical Effectiveness – using evidence based practice when available
- Safety – reduction of potential for harm, risk, and errors
- Value – provision of efficient, cost effective care with patient satisfaction

Objectives of the Performance Improvement Plan

1. Maintain a comprehensive, effective system for the ongoing measurement and assessment of the quality of patient care and services provided throughout the Medical Center.
2. Assure that the patient care provided and maintained is at an optimal level, consistent with the professional standards held in the medical community and as outlined in The Joint Commission National Patient Safety Goals and utilizating evidence based practice.
3. To continuously improve existing processes through the FOCUS/PDSA Rapid Cycle Improvement method. This includes identifying a potential improvement, testing a strategy for change, assessing data from the implemented change to determine if it improved performance, and initiating the improvement strategy system wide.
4. Provide for a collaborative multidisciplinary approach to health care practices at the Medical Center, which includes the evaluation of quality, cost effectiveness, and positive patient outcomes.
5. Focus the collection of quality improvement data at a central point for examination, analysis and documentation.
6. Provide an assessment process that includes comparative data and benchmarks whenever possible about the Medical Center processes and outcomes over time, and the Medical Center's performance in relationship to that of other health care organizations.
7. Provide for a system that sets priorities for improvement activities. These priorities will be determined by an assessment of the opportunities for improvement or the need to reduce or eliminate undesirable performance outcomes. Leadership will identify opportunities for improvement. Consideration will be given to staff opinions and needs, staff perceptions of risks and patient perceptions of care.

8. Reduce liability through objective patient care evaluation and intensive review of specific occurrences resulting in adverse outcomes.
9. Establish an effective communication system for reporting Performance Improvement activities to all Medical Center staff.
10. Assure compliance with the requirements of federal, state, and accrediting agencies in regard to Performance Improvement activities.
11. Provide support and facilitate organization wide Periodic Performance Review annually to evaluate systems and programs and identify opportunities for improvement.

THE MISSION, VISION AND GUIDING PRINCIPLES OF DOCTORS MEDICAL CENTER

MISSION:

Doctors Medical Center is dedicated to providing high quality health care to meet the diverse needs of our community. Through the allocation of appropriate services, we are committed to improving the community's health status by providing a full spectrum of services. This will be achieved by:

- Providing a caring team of professionals committed to patient/customer satisfaction and continual performance improvement to reduce/eliminate medical errors;
- Assuring technologically sophisticated medical care;
- Promoting community health education and disease prevention;
- Working cooperatively with other health care providers; and
- Operating in an economically prudent manner while assuring full access to all members of our community.

VISION:

Doctors Medical Center will distinguish itself through our:

Community Leadership in delivering outstanding quality healthcare, which surpasses the expectations of the diverse population, we serve.

Passion for Excellence manifested through our people who are dedicated to provide a supportive, empowering environment, which emphasizes innovation and caring.

Continual Search for New Opportunities to improve our care and enhance our partnerships with our community and other health care providers.

Commitment to promoting a healthy community by assuring access to healthcare resources and promoting patient, family and community health education.

Respect of the Individual by promoting high standard of professional ethics and conduct while striving to create a caring and compassionate environment for delivering quality patient care.

VALUES

Customer Focus: Our success is built upon understanding and satisfying the needs of our customers. We exist to serve our external customers - patients, families, and members of our community. To do this we must also meet each other's needs as internal customers of the Medical Center. We seek out customers, listen to them, take their expectations to heart and orient processes and people to satisfy their expectations.

Professional Integrity: We are committed to honesty and integrity. We recognize that the community requires our continuing commitment to the highest standards of moral, professional and ethical conduct.

Organization-wide thinking: Senior Leadership of our organization believes that our systems are interdependent and therefore needs to be thought of in holistic terms. We encourage active participation across disciplines.

Action-oriented decision-making: Organizations that utilize philosophy of rapid identification intervention and execution are proven most successful. We strive to impact outcomes and accountability through timely identification, action plan design and execution.

DOCTORS MEDICAL CENTER SCOPE OF SERVICE

Doctors Medical Center-San Pablo is licensed by the State of California for 189 beds and is accredited by The Joint Commission. The Medical Center provides an array of inpatient and ambulatory care services. The services include Acute Medical/Surgical Services, Emergency Department, Critical Care , Telemetry Unit, Surgical Services , Regional Cancer Center, and Hyperbaric Medicine. Ancillary Services include: Rehabilitation (Physical Therapy, Speech Therapy, and Occupational Therapy), Pharmacy, Respiratory Therapy, Diagnostic Imaging, Ultrasound, Radiology, Nuclear Medicine, Pathology Clinical Laboratory, G.I. Lab, Social Services, and Discharge Planning.

Doctors Medical Center provides Ambulatory Care Services including Same Day Surgery, Cardiac Rehabilitation, Diabetes and Nutrition Education, Lung Clinic, and a Sleep Disorders Program.

AUTHORITY AND ACCOUNTABILITY

West Contra Costa Healthcare District Governing Board : The West Contra Costa Healthcare District Board carries the ultimate accountability for assuring the quality of care and performance improvement of patient care services provided by its professional and support staff. The organization's leaders set expectations, develop overall plans, provide resources, and support the implementation of procedures that assess and improve the quality of the organization's administrative, clinical and support processes. The Board delegates the responsibility to Medical Staff Leaders and Administration for implementing and monitoring Performance Improvement activities. The Board of Directors Quality Committee

Medical Staff Leadership at DMC

The Medical Staff provides leadership in Performance Improvement through active participation in multidisciplinary committees, peer review (Appendix A), and Department-specific Performance Improvement activities. Functions unique to the Medical Staff, such as credentialing and privileging, are coordinated between the Medical Staff Credentialing and Privileging Committees and the Medical Executive Committee (Appendix B).

Senior Leadership at DMC

The Administrative staff is responsible for fostering an environment for performance improvement and staff empowerment to improve patient care. They provide the resources needed to foster the Medical Center's Performance Improvement activities, including the ongoing education and training of the staff. Ongoing survey readiness strategy is a function of the Senior Leaders in organization. Senior Leaders along with the Director of Quality serve as the Steering Committee for all quality functions in the organization.

Directors and Managers at DMC

The Directors and Managers are responsible for the day-to-day, ongoing operation and, therefore, the continuous measurement, assessment and improvement of the care and services provided. This includes:

1. Assuring adequate resources are allocated for staff to receive training, including the scheduling of time to participate in performance improvement activities.
2. Developing with their staff performance measurements for the department that continuously measures, assess, and improve their clinical or administrative processes. This includes the identification of department-specific practice guidelines where appropriate.
3. Encouraging participation in multidisciplinary Performance Improvement teams and supporting participation in improvement of patient care by staff.
4. Ensuring sentinel events and adverse events are immediately reported using the electronic EQRR reporting system. Managers and Directors review events for opportunities of improvement and document in the Midas system in a timely manner.
5. Participation in an annual report and quarterly reports to Hospital Performance Improvement Committee (HPIC) as appropriate.
6. Communicating to the staff the importance of understanding and utilizing the performance improvement process in their daily work assignments as well as in their interactions with all internal and external customers.

EDUCATION

The education of the staff in Performance Improvement is ongoing:

1. All leaders are educated in the principles and methods of Performance Improvement so that they can identify opportunities, understand, implement and participate effectively in the process. All Medical Center staff and medical staff are introduced to the basic

components of performance improvement and their role as active participants in continuous improvement.

2. Ongoing education is provided whenever needed to enable staff to fully participate in the Performance Improvement process.

PERFORMANCE IMPROVEMENT PLAN, SCOPE AND FUNCTIONS

The scope of this plan is system-wide, focusing on both patient care and organizational functions. It includes Medical Center-wide and department-specific Performance Improvement measurements. Measurements of both key processes and outcomes of care are designed, measured, and assessed in an effort to improve overall organizational performance. All indicators are objective, measurable, based on current knowledge and are structured to produce valid performance measures of care. Data are collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Performance Improvement data is monitored and reported on a house wide standardized indicator report card. The report card summarizes the plan of action, monthly progress, and monthly follow up if the department is not meeting its target score.

When an opportunity for improvement is identified and prioritized, the FOCUS-PDSA model is implemented which includes:

F = *Find* an opportunity for improvement.
O = *Organize* a team that knows the process.
C = *Clarify* current knowledge of the process.
U = *Uncover* the causes of the process variation.
S = *Start* the Plan-Do-Study-Act Cycle.

P = *Plan* the improvement.
D = *Do* the improvement.
S= *Study* the results.
A = *Act* to hold the gain.

During this process, statistical tools such as flowcharts, fishbone diagrams, Pareto charts, histograms, run charts and control charts will be used.

Immediate attention is given to "sentinel events". These are serious and undesirable occurrences involving the loss of patient life, limb or function or meeting other specific criteria. All sentinel events require thorough examination, a root cause analysis, and the development of an action plan to prevent recurrence.

Prevention of adverse outcomes is high priority. High-risk areas are identified and risk reduction strategies implemented whenever possible.

Both the Medical Center-wide and department-specific Performance Improvement measurements are used to identify opportunities for improvement in the following functional areas:

a. Patient-Focused Functions:
   1. Ethics, Rights and Responsibilities (RI)
   2. Provision of Care, Treatment and Services (PC)
   3. Medication Management (MM)
   4. Surveillance, Prevention and Control of Infection (IC)
   5. Nursing (NR)
   6. National Patient Safety Goals

b. Organizational Functions:
   1. Improving Organizational Performance (PI)
   2. Leadership (LD)
   3. Management of Environment of Care (EC)
   4. Management of Human Resources (HR)
   5. Management of Information (IM)
   6. Medical Staff (MS)

Performance is monitored through the collection of data, which includes:

1. Use of blood and blood components, including transfusion reactions.
2. Restraint use.
3. Medications use, including significant medication errors and adverse drug reactions.
4. Risk Management.
5. Utilization Management.
6. Quality Control.
7. Infection control surveillance.
8. Customer perception of care and service, including opportunities for improvement in care, service or patient safety.
9. Anesthesia, Operative and other procedures.(Procedural Sedation)
10. Health Information Management (accurate, timely and legible completion of medical records).
11. Organ Procurement
12. Use of Autopsy.
13. Core Measures for Stroke, Pneumonia, AMI, CHF, and SCIP.
14. Participation in external databases, e.g., studies done for NCDR, NIOSH CMS, and other regulatory agencies.
15. Contract Services.
16. Complaints/Grievances.
17. Operative and other high risk invasive procedures
18. Resuscitation and its outcomes
19. Identification of high-risk populations.
20. Pain Management.
21. CMS "preventable" hospital complications(HAC)
    a. Object left in during surgery
    b. Air Embolism
    c. Major Transfusion Reaction
    d. Foley catheter associated UTI
    e. Vascular catheter associated infection

f. Mediastinitis after CABG (Does not apply at DMC)
g. Falls and trauma: fractures, head injuries and burns
h. Hospital Acquired Infections

PERFORMANCE IMPROVEMENT STRUCTURE AND ROLES

A. Organization and Responsibilities of the *Medical Staff/ Performance Improvement I Committee*

The committee reports directly to the *Medical Executive Committee and the West Contra Costa* Healthcare District Governing Board. It is responsible for providing the direction for and general oversight of the Medical Center's Performance Improvement activities. It is composed of the Chief Executive Officer (CEO), Chief Nursing Officer /VP Patient Care Services, Chief of Staff, physicians representing departments of Medicine, Surgery and Emergency Services , Director Quality/Risk , and other departments as required to address performance improvement opportunities. This committee meets monthly and performs the following functions:

1. Reviews and analyzes data described in Section VI.

2. Identifies Medical Center-wide multidisciplinary projects on which to focus based upon the functions noted in Section VI. These are consistent with the goals for the Performance Improvement Program established on an annual basis

3. Reviews all Opportunities for Improvement submitted by any individual, department, or committee at the Medical Center after initial screening by the Director of Quality. The following dimensions of performance are considered: efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, respect and caring.

   Prioritize these Opportunities for Improvement are based on criteria Support of Doctors Medical Center's Mission, Vision and Guiding Principles
   - Effect on High Volume/High Risk Population Outcomes
   - Effect on Patient/Staff Satisfaction
   - Implementation Feasibility (resource analysis)
   - Patient Safety

4. Recommends one of the following actions after examining each Opportunity for Improvement:
   a. Creation of a work group to focus on a process improvement using rapid cycle improvement techniques.
   b. Referral to department chair as appropriate to resolve issue.

5. Assures adequate resources are available for staff to receive training in performance improvement.

6. Oversees participation in the data collection for national core measures (Stroke, Pneumonia, AMI, CHF, and SCIP), analysis of data and identification of performance improvement opportunities.

7. Develops annual goals for the Performance Improvement Program and evaluates the effectiveness of the program from the previous year.

B. Organization and Responsibilities of the work groups appointed by Medical Staff PI Committee or the Hospital Performance Improvement Committee (HPIC):

Members are appointed by the Medical Staff Performance Improvement Committee or the Hospital Performance Improvement Committee (HPIC). Each team has an identified Team Leader and meets as needed to perform the following functions:

1. Team members design, implement and assess a plan of action based on the identified Opportunity for Improvement. To do this they utilize the FOCUS-PDSA process using rapid cycle improvements with a small test of change.
2. Present progress reports based on established time lines.
3. Summarize their process, findings, and plan for reassessment on at the completion of their work.
4. Identify the person or group who will continue to monitor this process.

C. Hospital Quality Improvement Committee (HPIC) consists of Integrated Quality Services, Utilization Management, Health Information Management, Education, Patient Relations, Patient Safety Officer and Environment of Care Director, Radiology , Lab , Human Resources, Pharmacy, other departments as required, and 4 member of the West Contra Costa Healthcare District Board and performs the following functions:

1 Reviews and tracks ongoing Medical Center performance improvement data. Processes or outcomes are retrieved for review from the following sources:
   a. Medical Records
   b. Employee Surveys
   c. Patient Satisfaction Surveys
   d. Committee and Department Minutes
   e. Risk Management data including RCA outcomes
   f. Environment of Care
   g. Medical Center-wide Indicators
   h. Regulatory Agencies (Surveys, Sentinel alerts, regulatory change)
   i. Ongoing Survey Readiness activities
   j. FMEA activities
   k. Nutrition Services related to Patient Activities
   l. Human Resources
   m. Core Measures
   n. Patient Satisfaction
   o. National Patient Safety Goals (NPSG)

2. Recommends Opportunities for Improvement to the departments and functions based on performance activities. A summary of patient care reports is submitted to the Medical Staff Performance Improvement Committee.

PROGRAM CONFIDENTIALITY

Due to the highly confidential nature of clinical information reviewed in the Performance Improvement Plan, all necessary precautions will be taken to protect individuals and the organization activities and documents related to quality activities. Medical Staff Committee activities are confidential and protected under California Evidence Code 1157 and the Code of Professional Ethics.

ANNUAL REAPPRAISAL

HPIC Committee will review the Performance Improvement Program and the Program's effectiveness annually and will be documented in a report reviewed by the Medical Staff PI Committee ,reported to the Medical Executive Committee and the Governing Board.

APPROVAL

Review and recommendation of this Performance Improvement Plan is conducted by the Medical Staff Performance Improvement Committee and Medical Executive Committee, and submitted to the Governing Board for final approval.

Responsible for review/updating (Title/Dept)	DIRECTOR **Title**	INTEGRATED QUALITY SERVICES **Dept**

DOCTORS MEDICAL CENTER

Manual: Patient Safety Plan	Subfolder:
Title: Patient Safety Plan	Reviewed: 3/03, 4/04, 5/05, 3/06, 4/07 Revised: 9/10, 11/11
Effective Date: 11/02	Page 1 of 13

PURPOSE:
To provide direction and guidance for the delivery of safe, reliable and quality care at Doctors Medical Center by ensuring patient centered care in an environment and culture of safety.

To ensure that Doctors Medical Center implements and maintains a patient safety program in accordance with the Joint Commission Standards, Standard of Practices by different licensing authority and guidelines from state and federal regulatory agencies.

This approach centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient safety priorities.

GOALS:
To provide a systematic, coordinated and continuous approach to the assurance and improvement of patient safety, by linking the Quality, Performance Improvement, Patient Safety Plan to the organization's mission, values and quality vision. This will be accomplished through:

1. Championing the adoption of a culture of quality performance improvement and patient safety
2. Advocating for the system alignment of federal, state and local quality, performance improvement and patient safety initiatives
3. Advancing organization-wide adoption and dissemination of leading evidence-based practices in quality, performance improvement and patient safety

OBJECTIVES:
CHAMPIONING THE ADOPTION OF A CULTURE OF QUALITY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Assist Board with fulfilling their role in quality, performance improvement and patient safety:
- Develop resources, strategies, tools, and templates to assist trustees in understanding their role in quality and patient safety.
- Assess the effectiveness of the board as its correlates to patient safety.
- Develop educational sessions for trustees to support their role in advancing the hospital quality, performance improvement and patient safety agenda.

Assist organizational leadership with driving cultural change in quality, performance improvement and patient safety:
- Establish educational programs and standardized curriculum for quality, performance improvement and patient safety as a priority for leaders.
- Develop programs, tools, and resources to enhance leadership capacity and understanding in quality performance improvement and patient safety with organizational transformation, leadership, organizational infrastructure, rigorous measurement, transparency and accountability as foundational concepts.

Support healthcare team in creating a safety culture that empowers and engages staff in quality performance improvement and patient safety:
- Disseminate an employee and physician experience tool to identify links between employee/physician engagement and patient satisfaction.

- Develop/sponsor educational and certification programs to promote leading practices aimed at enhancing quality, performance improvement and safety competencies.

Support the DMC healthcare team in engaging and empowering patients to be partners in their health care:

- Continue to enable public reporting
- Provide resources and consistent organization-wide messaging to support the DMC healthcare team to implement initiatives aimed at improving patient health care knowledge, engagement and active care participation.
- Utilize and interpret patient satisfaction data for quality improvement.

Support systems that build organizational and people capability, competency and capacity for enhancements in quality, performance improvement and patient safety:

- Develop a comprehensive educational resource, including targeted educational sessions to assist DMC's healthcare staff and medical staff in meeting their educational needs in quality, performance improvement, efficiency and patient safety.
- Research span of control tools, guidelines and impacts for front-line managers.
- Advocate for the optimization of scopes of practice and professionalism to enhance efficiency, effectiveness, and access to quality patient care.
- Collaborate with Organizational Education Department to develop, establish, and maintain standards and guidelines to promote the ability of healthcare staff and providers to respond to changes in practice.
- Develop an organizational awards program to facilitate an organizational culture of performance improvement and teamwork.

ADVOCATING FOR THE SYSTEM ALIGNMENT OF FEDERAL, STATE AND LOCAL QUALITY, PERFORMANCE IMPROVEMENT AND PATIENT SAFETY INITIATIVES

Work with organizational partners to identify and champion priorities for quality, performance improvement and patient safety:

- Facilitate the Patient Safety/Performance Improvement Committee (PICO) and Medical Staff (MSPI).
- The Executive leadership team will ensure that key quality, performance improvement and patient safety issues are addressed and completed
- Work with the Patient Safety/Performance Improvement Committees to identify priorities, and make recommendations to advance quality and patient safety in Doctors Medical Center
- Continue to participate on national, state, and local committees/councils, supporting the interests of members in the areas of quality, performance improvement and patient safety.
- Hold educational forums to support dialogue and enhance networking related to quality, performance improvement and patient safety.
- Work in partnership with community groups to identify issues in points of access and hand-over in the co-management of patients.
- Identify issues and develop tools, resources, and education programs to assist in the transitions patients make across the health system (i.e..transfer summary)

Work with organizational partners to implement plans to protect and improve patient care outcomes as well as meet regulatory requirements:

- Facilitate organization-wide adoption and implementation of the Infection Prevention and Control Strategic Plan and Goals.

Advocate for the development of appropriate indicators and measurement systems:

- Advocate to the stakeholder groups for a common set of quality, performance improvement and patient safety indicators with consistent definitions, collection, analysis, and reporting systems, which directly link to improvements in quality of care and patient safety.
- Through the organizational Quality Performance Improvement and Patient Safety Committee (PICO), establish a reliable and valid minimum data set for quality, performance improvement and patient safety reporting.
- Provide educational programs in collaboration with Organizational Education Department to assist in improving reporting consistency and quality improvement strategies.

Influence stakeholders to act on organization-wide quality performance improvement and patient safety priorities:

- Influence and leverage the development of the PDCA (Plan, Do, Check, & Act) as a catalyst for the development of organizational wide quality, performance improvement and patient safety strategy and promote the alignment of initiatives across the continuum of care.
- Advocate for appropriate resources in quality and patient safety that support priorities and are grounded in evidence-based practice.

ADVANCING ORGANIZATION-WIDE ADOPTION AND DISSEMINATION OF LEADING EVIDENCE-BASED PRACTICES IN QUALITY, PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Support health system providers and stakeholders in delivering quality patient care through the dissemination, promotion, integration, and implementation and of leading evidence-based practices:

- Utilize technology to support the sharing and dissemination of leading evidence-based practices in quality, performance improvement and patient safety to varying target audiences.
- Promote the adoption of standardized order sets to facilitate the use of evidence-based practices, enhance the quality of care and improve patient outcomes.
- Create an inventory repository of international, national, and provincial improvement tools, implementation guides, and leading practices to support hospitals in meeting accountabilities and priorities.
- Develop a toolkit to support the implementation and development of a patient safety program.
- Identify issues and develop tools, resources, and education programs.
- Provide knowledge translation and dissemination of research grounded in evidence-based practice.

Advocate for policies and procedures that drive evidence-based practices in quality and patient safety, and lead to a highly reliable healthcare organization

- Advocate for care that is grounded in quality, performance improvement and patient safety.
- Promote the adoption of technology as an enabler of quality, performance improvement and patient safety improvement to support priorities identified at the organizational level

SCOPE OF ACTIVITIES:

Patient Safety Officer

1. Provides oversight and ensures alignment of patient safety activities and opportunities for all individuals who work in the organization to be educated and to participate in safety initiatives.
2. Authority to intervene any clinical or non-clinical activities, which poses negative outcome to the patient's well being, and involves the hospital leadership in the initiation of corrective action measures
3. Authority to intervene any clinical or non-clinical activities, which poses negative outcome to the patient's well being, and involves the hospital leadership in the initiation of corrective action measures.

Proactive Risk Identification and Process for Mitigating the Risk Factors

1. Quality, Performance Improvement &Patient Safety department is informed about the risk event via the electronic Quality & Risk Report (e-QRR) and/or a phone call to the Risk Hotline.
   a. The report includes actual or potential occurrences involving inpatients, outpatients, employees and visitors.
   b. Incident reporting system it is available to all departments, employees and medical staff via computer terminal completion of electronic incident reports or verbal communication by contacting the Performance Improvement and Patient Safety Office.
2. After implementing any necessary immediate action to ensure patient, Staff, Medical Staff and bystander safety, Staff will report all Adverse Occurrences, Sentinel Events and Near Misses on a Quality Review Report (QRR). Staff will limit their reports to the pertinent clinical facts and will avoid assigning blame or responsibility.
3. Staff will also report any Hazardous Conditions even though the conditions have not yet resulted in an Adverse Occurrence, Sentinel Event or Near Miss. Occurrence Reports/ Risk Events will be submitted to and reviewed by the Patient Safety Officer.
4. Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the requirement and method of reporting Adverse Occurrences, Sentinel Events, Near Misses and Hazardous Conditions.
5. Proactive assessment of high risk activities and hazardous conditions are identified through FMEA (failure mode and effect analysis), aggregate data collection and utilization.
6. Available information about sentinel events known to occur in health care organizations that provide similar care and services and knowledge based information for risk reduction are built in the system progressively. (I.e.The Joint Commission Alerts and CIHQ, etc.)
7. Staff involved in serious /sentinel events have access to support through post-incident debriefing and the invocation of the Employee Assistance Program.
8. Organizational measures are implemented to ensure adverse events associated with misconnecting of Intravenous lines, enteral feeding tubes and epidural lines. Enteral feeding tubes and intravenous lines are incompatible and cannot be connected together. All epidurals infusions are placed in locked boxes to protect against line confusion and tampering.
9. Emphasis also is placed upon patient safety in areas such as patient's rights, patient family education, continuity of care and managerial plans for managing performance deficit.
10. Full disclosure of serious medical errors, reportable events and any unanticipated outcome are made to patients/families through the provider as appropriate.
11. Doctors Medical Center has a process to inform the accrediting and licensing bodies as appropriate.
12. Developing a culture of safety by communicating information about patient safety which is an important responsibility of all employees of Doctors Medical Center.
13. Employ strategies that consistently inform and engage staff in patient safety activities.

a. Certain situations increase the risk of adverse events and should prompt staff to be even more safety conscious than usual. Examples include patients with same last name, trials of new equipment, and research protocols.
b. Identifying these higher risk situations and bringing them to the attention of all staff members at the start of each shift decreases the likelihood of errors and adverse events.

14. Opportunities for improvement regarding patient safety issues are prioritized according to;
    a. Level of severity,
    b. Frequency of the occurrence,
    c. Potential for harm to the patient, employee or visitor
    d. Potential for liability.
15. Ongoing review of information is performed to direct the administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical/health care errors included in data analysis are:

1. Near Misses: Any process variation which did not affect the outcome due to a screening by chance but for a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.

2. Risk Events: An event that is not consistent with routine patient care or hospital procedure which either did not or could have resulted in injury, loss to a patient or visitor or which may give rise to a claim against the Hospital, an employee of the hospital, or a member of the hospital medical staff.
3. Error: An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions
4. Hazardous Condition: Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
5. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.
   a. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.*
   b. The event is one of the following (even if the outcome was not death, or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
   c. Suicide of any patient receiving care, treatment and services in a staffed around-the clock in an acute care setting or within 72 hours of discharge
   d. Unanticipated death of a full-term infant
   e. Abduction of any patient receiving care, treatment, and services
   f. *A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed under the Sentinel Event policy) and a death or major permanent loss of function that is associated with the treatment (including "recognized complications") or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition.
   g. Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.
   h. Discharge of an infant to the wrong family
   i. Rape
   j. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
   k. Surgery on the wrong patient or wrong body part
   l. Unintended retention of a foreign object in a patient after surgery or other procedure
   m. Prolonged fluoroscopy with cumulative dose> 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose, etc.
   n. A Hospital wide interdisciplinary response mechanism to all the sentinel event alerts occurs. It is done through a correction plan to intercept any such occurrence in our health care facility and to its consumers.
   o. To address any patient safety issue related to sentinel event alerts, we construct immediately an interdisciplinary sub-committee to formulate the risk reduction strategy and follow up through an action plan.
6. In the patient safety plan it includes our performance and measure of success through an analysis of Patient Safety Indicators based on multiple patient safety programs, such as; National Patient Safety Goals by the Joint Commission, AHRQ Patient Safety Indicators, IHI's 5 Million Live campaign.
7. Any care giving process with a misuse, under use or over use of care will also be a subject for review and further analysis.

Investigation, Analysis, Coordination and Regulatory Reporting

1. A broad range of data analysis will be reported to and reviewed by the Patient Safety Committee (PICO) monthly.
   a. The results of investigations and analytical reviews will, in turn, be forwarded by the committee to the appropriate entities for further, in-depth evaluation, review and responses.

   b. Responses will include any corrective action taken or plan for corrective action.
2. The Patient Safety Committee serves as a clearing house for these data and information that affect patient Safety.
3. Any incident, process, event and condition may be subject to investigation through the Root Cause Analysis (RCA) method as determined by Risk Management Investigation or other venues.
4. Intensive assessment may be initiated when undesirable patterns or trends are identified or a serious or sentinel event occurs.
5. An RCA will be conducted if a staffing issue was identified during the investigation phase.
6. Proactively this plan suggests to conduct at least one system based Failure Mode Effect Analysis (FMEA) in a year.
7. In accordance with the Joint Commission's Accreditation Participation Requirements- APR.09.02.01 this plan implies to:
   a. Educates staff and medical staff that any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to The Joint Commission.
   b. Informs the staff that no disciplinary or punitive action will be taken when an employee reports safety or quality of care concerns to The Joint Commission.
   c. Takes no disciplinary or punitive action against employees when they report safety or quality of care concerns to The Joint Commission

Committees

The Governing Body, Medical Executive Committee and Performance Improvement Committee are committed to patient safety, assuring an environment that encourages error identification, remediation, non-punitive reporting and prevention through education, system redesign or process improvement for any adverse events.

Administrative Patient Safety/ Performance Improvement Committee (PICO):

1. Reviews and analyzes data gathered as well as reports generated by the Quality & Performance Improvement Department.
2. Reviews and approves Quality and Patient Safety Plan.
3. Receives and reviews reports of ;
   - Adverse Events
   - Potential Adverse events or patterns of events
   - Health-care-associated events
4. Monitors implementation of corrective actions for patient safety events
5. The set up of indicators is done through internal and external metrics.
6. Makes recommendation to eliminate future patient safety events
7. Reviews and revises the Patient Safety Plan annually if not more in effort to update and incorporate patient safety advancement as well as reviews effectiveness of plan.
8. The Patient Safety Plan will be proactive and ongoing and will utilize internal, external knowledge and best practice to reduce patient risk.
9. Takes a collaborative and interdisciplinary approach to improving patient safety.
10. The Committee seeks input from and distributes information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety.
11. Annually, the Patient Safety Committee will ensure that Staff and Medical Staff are also queried regarding their willingness to report medical/health care errors. The surveys will allow those surveyed to comment on improving patient safety.
12. Ensures that patients/family members and Staff are periodically surveyed regarding their opinions, needs and perceptions of risks to patients.
13. A summary of patient safety activities are submitted to the Medical Staff Leadership on an ongoing basis to ensure communication of activities.
14. Results of patient safety activities are communicated to the Governing Board and Executive Leadership team in reports given by the Patient Safety Officer in regularly scheduled reports.

Patient Safety Event Review:

1. Patient safety events will be reviewed by the Patient Safety Officer and the Risk Manager to determine if the event needs further review. If a need to further review the event is identified, the Patient Safety Officer or designee will set up a root cause investigation with the identified parties to resolve the issue. The identified parties may include CNO, physicians, nursing staff, other clinical staff, and non clinical staff as needed to thoroughly identify opportunities for improvement.

2. The Patient Safety Officer or designee will evaluate all Adverse, Sentinel Events, Near Misses and other patient safety matters reported on a QRR. After evaluation, the Performance Improvement Patient Safety Department will determine what action is required or may, given the nature of the Occurrence, determine to take no action.

3. The Hospital will provide emotional support to Staff involved in Adverse Events and Sentinel Events including the utilization of the Employee Assistance Program when warranted.

4. Patients and, when appropriate, their families will be promptly informed about the outcomes of care, including unanticipated outcomes, and will be assured that appropriate clinical measures have been taken to respond to the unanticipated outcome.
   a. Communications with the patient and family will follow the Patient/Family Notification Procedure.
   b. Involvement, staff will encourage patients' active involvement in their own care as a patient safety strategy.

Internal Monitoring

1. Providing periodic (monthly, quarterly etc) Report on specific sets of indicators is a routine essential of the Hospital Patient Safety Plan.
2. The set up of indicators is done through internal and external metrics and approved by the Performance Improvement Committee (PICO).
3. Patient Safety Officer and Risk Management will review events for required reporting to the California Department of Public Health (CDPH). Reported events will be discussed with Executive Leadership and Medical Staff Leadership by the Patient Safety Officer or designee.

PATIENT SAFETY INDICATORS for Monthly Analysis

NPSG.01.01.01 Hospital wide monthly Two patient's identifier is met across the continuum of care report. It includes comparing the ID Band for patient's date of birth and name.

NPSG.01.03.01 Eliminate transfusion errors related to patient misidentification by observing two person bedside or chair side verification process

NPSG.02.03.01 Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical results or values for the tests.

NPSG.03.04.01 Label all medications, medication containers, and other solutions on and off the sterile field in Perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.05.01 Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

NPSG.07.01.01 Hospital wide monthly report of unit based and health care provider based compliance on Hand Hygiene to reduce hospital acquired infections.

NPSG.07.03.01 Hospital wide program on health care-associated infection due to Multidrug-resistant organism (MDRO) & its reporting. This requirement applies to, but is not limited to MRSA, CDI, VRE & Multiple drug resistant gram negative bacteria

NPSG.07.04.01 Hospital wide program for preventing central line associated bloodstream infections (CLABS) & its reporting

Note: This requirement covers short- and long- term central venous catheters and peripherally inserted central catheter (PICC) lines.

NPSG.07.05.01 Hospital wide program for preventing surgical site infections (SSI) & its reporting

NPSG.08.01.01
NPSG.08.02.01
NPSG.08.03.01
NPSG.08.04.01

Monthly compliance of Home Medication List and its application at admission, and Discharge stages. A copy of the list is provided to the next provider and to the patient/family at discharge. .

NPSG.15.01.01 The hospital identifies safety risks inherent in its patient population. Assessment for suicide risks.

UP.01.01.01
UP.01.02.01
UP.01.03.01

Monthly report of Universal Protocol (preoperative verification process, marking the operative site and conduct a "time out" immediately before starting the procedure as per hospital policy and DOH protocol)

Medication Safety and Error Reporting

Monthly Medication Error Rate Report through intervention, investigation of self-reporting and incident report mechanism with distribution of attributable variables

DEFINITIONS:

Patient Safety - risk-reduction activities which include the emphasis on the reporting, analysis, and prevention of medical errors in effort to reduce the risk of adverse outcomes

Quality- Defined as "doing the right thing, at the right time, in the right way, for the right person and having the best possible results (AHRQ)

Adverse Occurrence – an untoward Occurrence, therapeutic misadventure, iatrogenic injury or other unanticipated Occurrence that does not achieve its intended Outcome but does not meet the definition of a Sentinel Event and is directly associated with the care or services provided within the Organization.

Failure Mode and Effect Analysis – a process for identifying and improving those critical points in a process that are necessary to reasonably ensure a safe and clinically desirable Outcome.

Hazardous Condition – any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse Outcome.

Medical Staff – all physicians credentialed as members of the Organization's medical staff, whether such physicians are active members, courtesy members or other members.

Near Miss – an Occurrence or situation directly associated with care or services provided within the Organization that could have resulted in an accident, injury or illness, but did not, either by chance or

through timely intervention. Near misses do not impact the patient's plan of care but a recurrence would carry a significant chance of impacting another patient's plan of care.

Occurrence, Event or Incident – the performance or nonperformance of a function or process (es).

Occurrence Report – an Incident report or other report designated by the Organization to report Adverse Occurrences, Sentinel Events and Near Misses.

Organization – Doctors Medical Center

Outcome – the result of the performance or nonperformance of a function or process (es).

Root Cause Analysis – a process for identifying the base or contributing causal factors that underlie variations in performance associated with Adverse Occurrences, Sentinel Events or Near Misses.

Sentinel Event – an unanticipated Occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse Outcome.

Staff – employees, contractors, agency staff and volunteers of the Organization.

Unanticipated Outcome – an Outcome that is not anticipated in the normal course of the patient's care.

Responsible for review/updating (Title/Dept)	Quality/Risk Manager Title	Quality/Risk Management Services Dept

DOCTORS MEDICAL CENTER

FINANCIALS
June 2012

TAB 6

DOCTORS MEDICAL CENTER

Board Presentation

June 2012 Financial Report

Statement of Activity - Summary

For the Period Ending

June 30, 2012

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
10,217	11,810	(1,593)	**Net Operating Revenues $**	61,329	67,269	(5,940)
12,528	12,212	(316)	**Total Operating Expenses $**	72,693	74,902	2,209
(2,311)	(401)	(1,910)	**Income/(Loss) from Operations $**	(11,364)	(7,633)	(3,731)
361	444	(83)	**Income from Other Sources $**	3,748	2,834	914
(1,950)	42	(1,992)	**Net Income / (Loss) $**	(7,616)	(4,799)	(2,817)
2,086	2,421	(335)	**Patient Days**	13,879	15,276	(1,397)
490	479	11	**Discharges**	3,058	3,168	(110)
6,118	6,719	(601)	**Outpatient Visits**	37,918	39,840	(1,922)
613	623	11	**Worked FTE's**	623	646	23
1.48	1.56	0.08	**Medicare CMI**	1.52	1.56	0.04

Budget Variances – **Net Revenue**

- Medi-Cal / Medi-Cal HMO – ($301K).
- Medicare / Medicare HMO – $85K.
- Government / Workers Comp – ($723K).
- Commercial / PPO /HMO – ($648K).

Budget Variances – Expenses

- **Salaries & Benefits** ($168K) – High utilization of agency labor.
- **Purchased Services** ($128K) – McKesson eligibility flat fee ($204K).
- **Supplies** $282K – Underutilization of implants ($226K) and pharmaceuticals ($115K).

Cash Position
June 30, 2012

(Thousands)

	June 30, 2012	December 31, 2011
Unrestricted Cash	$2,069	$13,972
Restricted Cash	$26,736	$29,847
Total Cash	$28,805	$43,819
Days Unrestricted Cash	5	33
Days Restricted	66	72
Total Days of Cash	71	106

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

Accounts Receivable

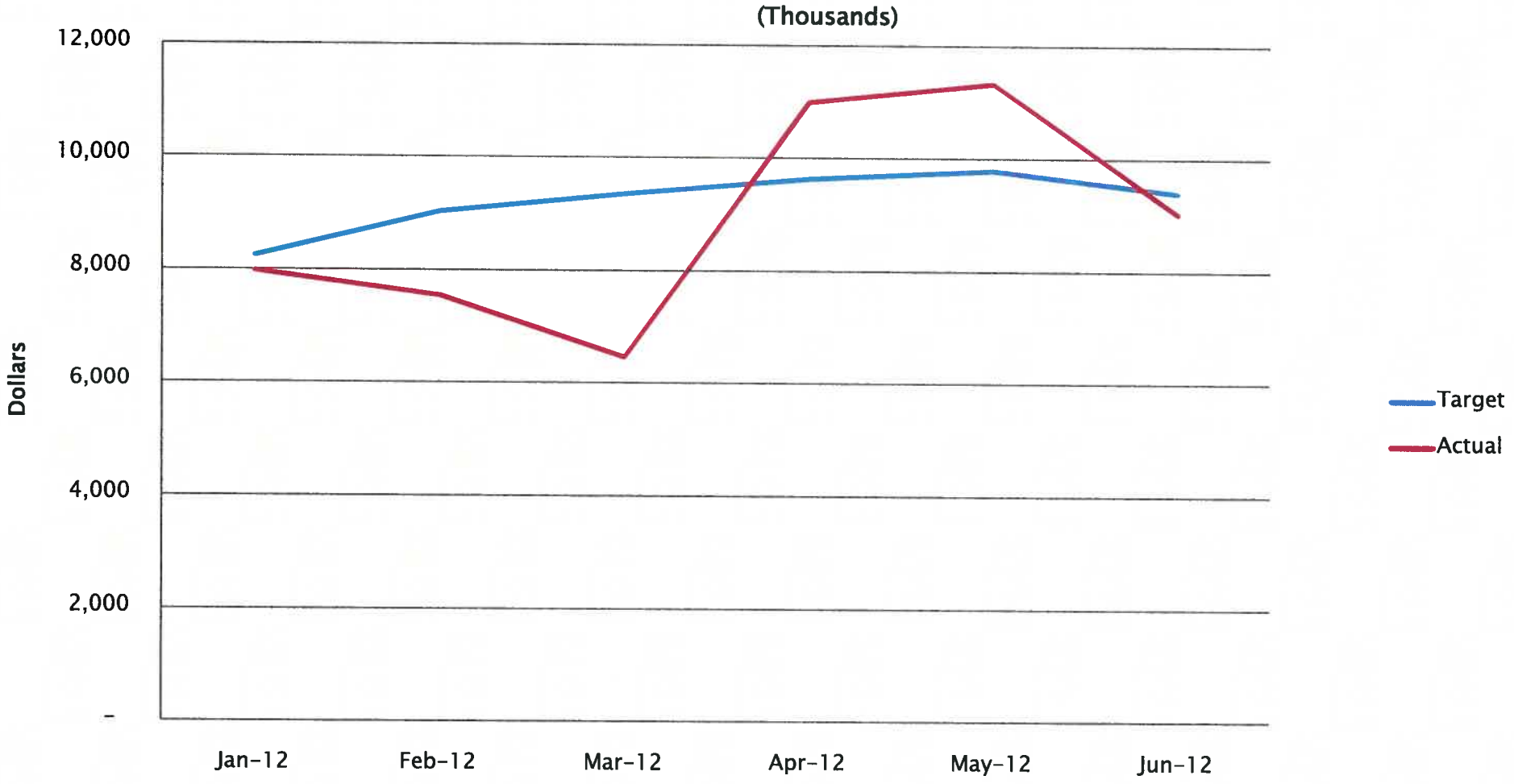
June 30, 2012

(Thousands)

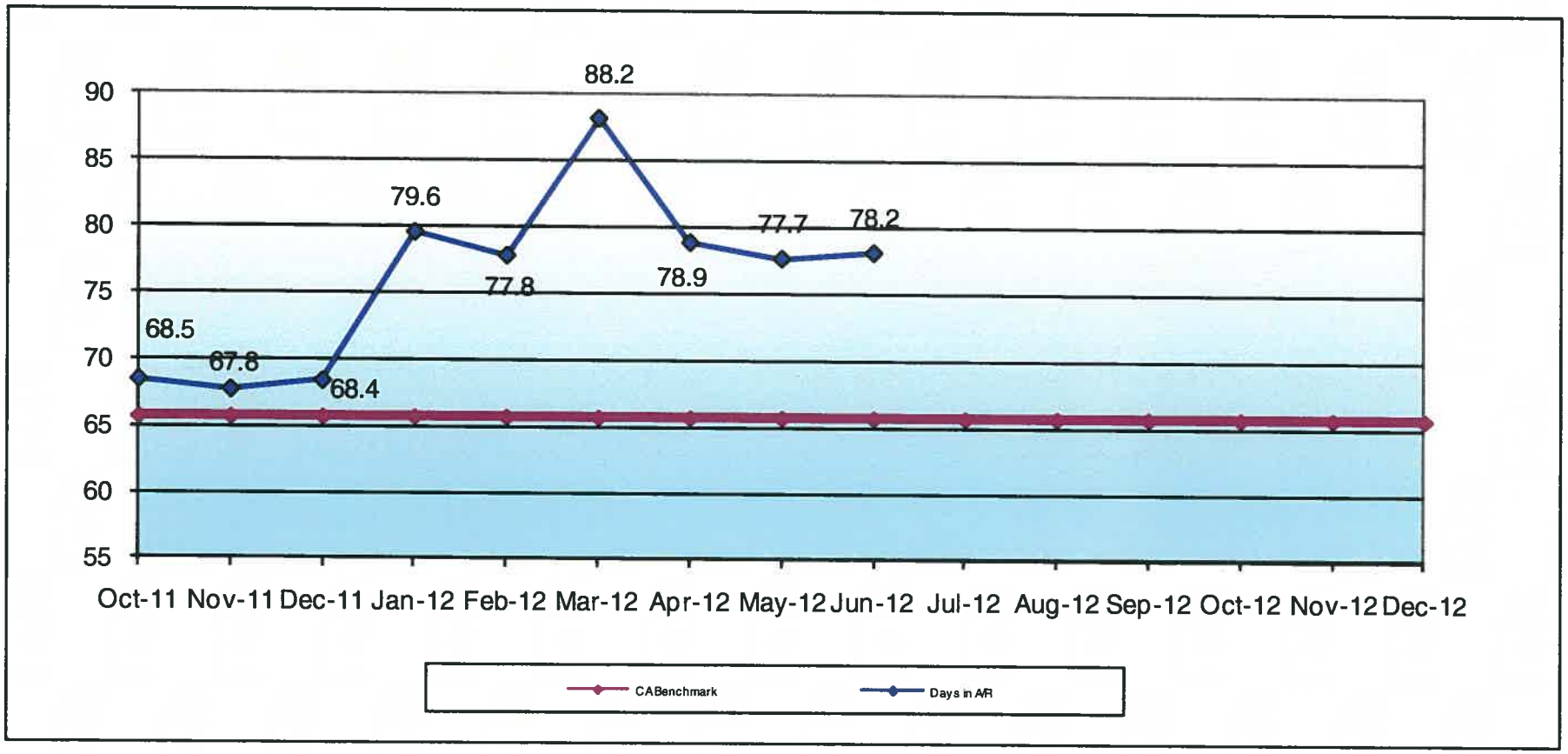
	June 30, 2012	December 31, 2011
Net Patient Accounts Receivable	$26,030	$19,177
Net Days in Accounts Receivable	78.2	60.7

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

2012 Year to Date Cash Collections / Projected vs. Target



Accounts Receivable
Net Days in A/R



Financial Report Key Points

- Net Loss was $1.9M in June.
- Operating revenue was under budget by $1.6M.
- Expenses $316K over budget.

DOCTORS MEDICAL CENTER

June 2012 Executive Report

Doctors Medical Center had a Net Loss of $1,950,000 in the month of June. As a result, net income was under budget by $1,992,000. The following are the other factors leading to the Net Income variance:

Net Patient Revenue Factors	**Positive / (Negative)**
Government/ Workers Compensation	($723,000)
Medi-Cal / Medi-Cal HMO	($301,000)
Medicare / Medicare HMO	$ 85,000
Managed Care, Commercial, PPO	($648,000)
Expenses	
Salaries & Benefits	($168,000)
Professional Fees	($ 83,000)
Supplies	$282,000
Purchased Services	($128,000)

Net patient revenue was under budget by $1,338,000. Gross charges were under budget in June by 15.5%. Patient days were 13.8% under budget while discharges were 2.3% over budget. Ancillary outpatient visits were 22.9% under budget while outpatient surgeries were 7.7% over budget. Total Medi-Cal days continue to be under budget by 15% with 73% of Medi-Cal days coming to us as managed Medi-Cal days. Our days from both the Government programs and Workers Compensation also remain under budget as total budgeted days were 226 compared to the actual in June of 24. Managed Care, Commercial and PPO combined days were 14.4% under budget as total budgeted days were 202 compared to 173 actual days in June.

Salaries and Benefits combined were over budget $168,000 in June. Worked FTE's per adjusted average daily census was over budget by 9.2% with salaries at 8.1% over budget while patient days were 13.8% under budget. Salaries continue to be over budget by $410,000 due to an overlap of nursing staff utilizing contract labor to train new employees. Our benefit costs continue to be under budget in June and we are under our year to date goal by $998,000.

Professional Fees were $83,000 over budget in June. This overage incurred is for four consultants that are not in the current budget. Some of these costs (approximately $40,000) are budgeted in salaries and wages.

Supplies were under budget in June by $282,000 due to the underutilization of implants ($226,000) and pharmaceuticals ($115,000). This was partially offset by an adjustment for a physical inventory count.

Purchased Services were $128,000 over budget in June due to a McKesson payment of an eligibility flat fee of $204,000 which is offset by cost reductions in security ($41,000) and McKesson service contracts ($35,000).

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
June 30, 2012
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
1	10,128	11,466	(1,338)	-11.7%	10,593	Net Patient Service Revenue	59,740	65,887	(6,147)	-9.3%	63,243
2	89	344	(255)	-74.2%	118	Other Revenue	1,589	1,382	207	15.0%	568
3	10,217	11,810	(1,593)	-13.5%	10,711	**Total Operating Revenue**	61,329	67,269	(5,940)	-8.8%	63,811
						OPERATING EXPENSES					
4	5,482	5,072	(410)	-8.1%	5,249	Salaries & Wages	31,935	31,529	(406)	-1.3%	32,972
5	2,596	2,838	242	8.5%	3,702	Employee Benefits	15,650	16,648	998	6.0%	17,465
6	958	875	(83)	-9.5%	964	Professional Fees	5,810	5,266	(544)	-10.3%	5,327
7	1,389	1,651	282	17.1%	1,643	Supplies	8,610	10,343	1,733	16.8%	10,563
8	1,093	965	(128)	-13.2%	1,033	Purchased Services	4,955	5,804	849	14.6%	5,340
9	293	267	(26)	-9.8%	243	Rentals & Leases	1,501	1,605	104	6.5%	1,384
10	403	368	(35)	-9.4%	348	Depreciation & Amortization	2,361	2,213	(148)	-6.7%	2,074
11		(222)	(222)			Collaboration Savings	-	(666)	(666)		
11	334	398	64	16.1%	283	Other Operating Expenses	1,871	2,160	289	13.4%	1,996
12	12,528	12,212	(316)	-2.6%	13,465	**Total Operating Expenses**	72,693	74,902	2,209	2.9%	77,121
13	(2,311)	(401)	(1,910)	475.6%	(2,754)	**Operating Profit / Loss**	(11,364)	(7,633)	(3,731)	48.9%	(13,310)
						NON-OPERATING REVENUES (EXPENSES)					
14	-	-	-	0.0%	-	Other Non-Operating Revenue	1,200	-	1,200	0.0%	1,085
15	708	706	2	-0.3%	708	District Tax Revenue	4,248	4,237	11	-0.3%	4,291
16	160	4	156	3673.6%	4	Investment Income	182	25	157	615.4%	25
17	(507)	(267)	(240)	0.0%	(120)	Less: Interest Expense	(1,882)	(1,429)	(453)	31.7%	(698)
18	361	444	(83)	-18.6%	592	**Total Net Non-Operating**	3,748	2,834	914	32.3%	4,703
19	(1,950)	42	(1,992)	-4726.4%	(2,162)	**Income Profit (Loss)**	(7,616)	(4,799)	(2,817)	59%	(8,607)
						Profitability Ratios:					
20	-22.6%	-3.4%	119.9%		-25.7%	Operating Margin %	-18.5%	-11.3%	62.8%		-20.9%
21	-19.1%	0.4%	-19.4%		-20.2%	Profit Margin %	-12.4%	-7.1%	-5.3%		-13.5%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
June 30, 2012
(Amounts in Thousands)

22	2,416	2,129	(287)	-13.5%	2,445	SWB / APD	2,208	2,122	(86)	-4.0%	2,193
23	64.5%	64.8%			66.5%	SWB / Total Operating Expenses	65.5%	64.3%			65.4%
24	3,747	3,288	(460)	-14.0%	3,678	Total Operating Expenses / APD	3,373	3,299	(74)	-2.2%	3,353
25	32,484	40,165	(7,681)	-19.1%	39,420	I/P Gross Charges	208,917	256,587	(47,670)	-18.6%	257,895
26	19,576	21,460	(1,884)	-8.8%	20,511	O/P Gross Charges	115,536	124,782	(9,246)	-7.4%	118,472
27	**52,060**	**61,624**	**(9,564)**	**-15.5%**	**59,931**	**Total Gross Charges**	**324,453**	**381,369**	**(56,916)**	**-14.9%**	**376,367**
						Payor Mix (IP and OP)					
28	44%	39%	5%		39%	Medicare %	43%	40%	3%		40%
29	5%	14%	-9%		14%	Medi-Cal %	6%	15%	-9%		15%
30	12%	13%	-1%		8%	Managed Care HMO / PPO %	13%	12%	1%		9%
31	10%	9%	1%		10%	Medicare HMO %	11%	9%	1%		10%
32	16%	9%	7%		14%	Medi-Cal HMO %	15%	9%	6%		12%
33	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
34	1%	2%	-1%		1%	Worker's Comp %	1%	1%	0%		1%
35	2%	4%	-2%		3%	Other Government %	3%	3%	-1%		4%
36	10%	10%	0%		11%	Self Pay /Charity %	10%	10%	1%		10%
						STATISTICS					
37	477	470	7	1.5%	520	Admissions	3,060	3,168	(108)	-3.4%	3,226
38	490	479	11	2.3%	528	Discharges	3,058	3,168	(110)	-3.5%	3,237
39	2,086	2,421	(335)	-13.8%	2,408	Patient Days	13,879	15,276	(1,397)	-9.1%	15,760
40	69.5	80.7	(11.2)	-13.8%	80.3	Average Daily Census (ADC)	76.3	83.9	(7.7)	-9.1%	87.1
41	4.26	5.05	0.80	15.8%	4.56	Average Length of Stay (LOS)- Accrual Based	4.54	4.82	0.28	5.9%	4.87
42	30	30			30	Days in Month	182	182			181
43	785	735	50	6.9%	803	Adjusted Discharges (AD)	4,749	4,709	41	0.9%	4,724
44	3,343	3,715	(371)	-10.0%	3,661	Adjusted Patient Days (APD)	21,554	22,705	(1,151)	-5.1%	23,000
45	111	124	(12)	-10.0%	122	Adjusted ADC (AADC)	118	125	(6)	-5.1%	127
46	73	97	(24)	-24.7%	97	Inpatient Surgeries	434	578	(144)	-24.9%	578
47	112	104	8	7.7%	104	Outpatient Surgeries	574	564	10	1.8%	564
48	**185**	**201**	(16)	-8.0%	**201**	**Total Surgeries**	**1,008**	**1,142**	(134)	-11.7%	**1,142**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
June 30, 2012
(Amounts in Thousands)

49	3,019	2,740	279	10.2%	2,848	ED Outpatient Visits	18,200	16,926	1,274	7.5%	18,085
50	2,987	3,875	(888)	-22.9%	3,875	Ancillary Outpatient Visits	19,144	22,350	(3,206)	-14.3%	22,350
51	112	104	8	7.7%	104	Outpatient Surgeries	574	564	10	1.8%	564
52	**6,118**	**6,719**	(601)	-8.9%	**6,827**	**Total Outpatient Visits**	**37,918**	**39,840**	(1,922)	-4.8%	**40,999**
53	439	431	8	1.9%	444	Emergency Room Admits	2,784	2,752	32	1.2%	2,805
54	14.5%	15.7%			15.6%	% of Total E/R Visits	15.3%	16.3%			15.5%
55	92.0%	91.7%			85.4%	% of Acute Admissions	91.0%	86.9%			86.9%
56	613	623	11	1.7%	649	Worked FTE	623	646	23	3.6%	694
57	734	735	1	0.2%	770	Paid FTE	723	733	10	1.3%	798
58	5.50	5.03	(0.46)	-9.2%	5.32	Worked FTE / AADC	5.26	5.24	(0.01)	-0.3%	5.46
59	6.58	5.94	(0.65)	-10.9%	6.31	Paid FTE / AADC	6.10	5.99	(0.11)	-1.9%	6.28
60	3,030	3,087	(57)	-1.9%	2,894	Net Patient Revenue / APD	2,772	2,902	(130)	-4.5%	2,750
61	15,572	16,590	(1,018)	-6.1%	16,370	I/P Charges / Patient Days	15,053	16,797	(1,744)	-10.4%	16,364
62	3,200	3,194	6	0.2%	3,004	O/P Charges / Visit	3,047	3,132	(85)	-2.7%	2,890
63	1,640	1,365	(274)	-20.1%	1,434	Salary Expense / APD	1,482	1,389	(93)	-6.7%	1,434
64	4.6	6.0	1.40	23.3%	5.6	Medicare LOS - Discharged Based	4.8	5.7	0.96	16.8%	5.3
65	1.48	1.56	0.08	5.0%	1.57	Medicare CMI	1.52	1.56	0.04	2.6%	1.6
66	3.11	3.85	0.74	19.3%	3.54	Medicare CMI Adjusted LOS	3.13	3.66	0.53	14.6%	3.33
67	4.3	4.6	0.36	7.7%	4.61	Total LOS - Discharged Based	4.6	4.9	0.31	6.4%	4.83
68	1.481	1.450	(0.03)	-2.1%	1.45	Total CMI	1.466	1.492	0.03	1.7%	1.49
69	2.88	3.18	0.31	9.6%	3.18	Total CMI Adjusted LOS	3.11	3.26	0.16	4.8%	3.24

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
June 30, 2012
(Amounts in Thousands)

		Current Month	Dec. 31, 2011
	ASSETS		
70	Cash	2,069	13,972
71	Net Patient Accounts Receivable	26,030	19,177
72	Other Receivables	540	1,160
73	Inventory	2,147	2,109
73	Current Assets With Limited Use	26,736	29,847
74	Prepaid Expenses and Deposits	1,023	999
75	**TOTAL CURRENT ASSETS**	**58,545**	**67,264**
76	**Assets With Limited Use**	**642**	**642**
	Property Plant & Equipment		
77	Land	12,120	12,120
78	Bldg/Leasehold Improvements	29,432	33,733
79	Capital Leases	10,926	10,926
80	Equipment	41,673	34,074
81	CIP	2,465	3,129
82	Total Property, Plant & Equipment	96,616	93,982
83	Accumulated Depreciation	-51,529	-49,200
84	**Net Property, Plant & Equipment**	**45,087**	**44,782**
85	**Intangible Assets**	**1,486**	**1,517**
86	**Total Assets**	**105,760**	**114,205**

87	Current Ratio (CA/CL)	***1.60***	***1.89***
88	Net Working Capital (CA-CL)	***21,967***	***31,750***
89	Long Term Debt Ratio (LTD/TA)	***0.59***	***0.55***
90	Long Term Debt to Capital (LTD/(LTD+TE)	***0.97***	***0.87***
91	Financial Leverage (TA/TE)	***51.4***	***11.8***
92	Quick Ratio	**0.77**	**0.93**
93	Unrestricted Cash Days	**5**	**33**
94	Restricted Cash Days	**66**	**72**
95	Net A/R Days	**78.2**	**60.7**

		Current Month	Dec. 31, 2011
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,665	1,634
97	Accounts Payable and Accrued Expenses	16,446	16,021
98	Accrued Payroll and Related Liabilities	14,305	13,639
99	Deferred District Tax Revenue	2,880	2,880
100	Estimated Third Party Payor Settlements	1,282	1,340
101	**Total Current Liabilities**	**36,578**	**35,514**
	Other Liabilities		
102	Other Deferred Liabilities	4,665	6,105
103	Chapter 9 Bankruptcy	0	0
	Long Term Debt		
104	Notes Payable - Secured	62,055	62,067
105	Capital Leases	2,072	2,481
106	Less Current Portion LTD	-1,666	-1,634
107	**Total Long Term Debt**	**62,461**	**62,914**
108	**Total Liabilities**	**103,704**	**104,533**
	EQUITY		
109	Retained Earnings	9,672	28,400
110	Year to Date Profit / (Loss)	-7,616	-18,728
111	**Total Equity**	**2,056**	**9,672**
112	**Total Liabilities & Equity**	**105,760**	**114,205**

DOCTORS
MEDICAL CENTER

CAPITAL EQUIPMENT

TAB 7

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

TO: **GOVERNING BODY**
BOARD OF F DIRECTORS

FROM: **Carla Knight RN, BSN/Director of Perioperative, Procedural & Critical Care Services**

DATE: **July 25, 2012**

SUBJECT: **Surgical Lights**

REQUEST / RECOMMENDATION(S): Recommend to the District Board to approve and authorize the Chief Financial Officer to execute on behalf of DMC, approval of the Surgical Lights, at an estimated total cost, including installation, of $99,847.64. This was the lowest bid submitted, and was the most favored of the surgeons.

FISCAL IMPACT: Cost of $99,847.64

STRATEGIC IMPACT: These lights will replace the lights in ORs 1, 2, & 3, which are the primary rooms used. The existing lights can no longer be refurbished, the reflectors are now dull and cannot be replaced, making them a potential for a patient safety event. The proposed lights are LED lights, and can be removed and placed in another location should that be the need.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Replacement of Surgical lights in ORs 1, 2, & 3, thereby allowing optimal visualization of surgical site during procedures. The existing lights are over 20 years old and have reached end of life and can no longer be refurbished. The existing lights are extremely dim, and the new lights are LED, giving extremely good visualization.

Presentation Attachments: Yes X No____

Requesting Signature: Carla Knight Date: 7 / 25 / 12

SIGNATURE(S):

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

Vote of Board Members:

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

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

Contact Person:

Attested by: _____
Eric Zell, Chair, Governing Body
Board of Directors

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

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Communications

PROPOSAL

1410 Lakeside Pkwy, #100 / Flower Mound, TX 75028 / (877) 789-8106
David Florczyk
Technology Consultant
Stryker Communications
david.florczyk@stryker.com
Phone: (408) 205-8784

Proposal Submitted To:
Doctor's Medical Center

Date: 7/12/2012

We are pleased to submit our quotation for the following Stryker Communications products.

Dual Surgical LEDs for Three ORs

Part No.	Description	Qty	List Price	Extended List Price	Discounted Price	Extended Discounted Price
Stryker Triple Mount Surgical Lights/FP Monitor						
682-001-307	Mounting Plate Single, Heavy Duty	3	$687.00	$2,061.00	$320.14	$960.43
682-001-551	Hardware Kit	3	$119.34	$358.02	$55.61	$166.84
882-000-202LED	Visum LED/LED Dual Surgical Lights (OR 1)	3	$47,471.00	$142,413.00	$22,121.49	$66,364.46
Universal Disposable Adapter Handles						
682-400-032	Universal Light Handle Adapter ULH(Flimsy)	6	$492	$2,952	$229	$1,376
Engineering Services						
888-8888-900	Engineering Services	1	10,063.00	10,063.00	0.00	0.00
Installation Services						
888-8888-322	Installation BNL - Light suspension	3	800.00	2,400.00	372.80	1,118.40
888-8888-401	Base Installation Charge	1	2,250.00	2,250.00	1,912.50	1,912.50
Stryker will provide a 2 year warranty					**List Price**	162,497.02
This Quote is not to be provided to MD Buyline or ECRI					**Discount**	-90,598.77
					Subtotal	71,898.25

Pricing valid for 60 days
Estimated Shipping and Handling: $2,095.00
Estimated Sales Tax (based on 8.25%) $5,854.39

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Communications

Stryker Representative Signature

Authorized Customer Signature

stryker

Finance

7/12/2012

Doctor's Medical Center
San Pablo, CA

Thank you for considering Stryker Corporation and Stryker Finance for your equipment acquisition. We are pleased to present the following financing terms for your review:

Equipment: Stryker Communications Products and Accessories

Proposal Prices: See proposal for itemized pricing

$1 Out End of Term Option:
- Purchase the equipment for $1.00

Payment Terms:

Proposal Total: **$71,898.25**

$1 OUT	36 Months	48 Months	60 Months
TOTAL MONTHLY PMT	$2,169.09	$1,675.38	$1,382.32

* Payments are exclusive of all applicable taxes and freight unless otherwise noted.

Deal Consummation: This is a proposal and not a commitment. This proposal is subject to final credit, pricing, and documentation approval. Legal documents must be signed before your equipment can be delivered. Documentation will be provided upon completion of our review process and your selection of a payment schedule.

Financial Information: The following information is required to complete our review process:
- Two years of financial statements, audited if available
- Current interim financial statements if audited statements are more than 6 months old

Again, thank you for your consideration. Please note that this proposal is subject to change if documents are not signed prior to July 31, 2012 and is exclusive of certain taxes and shipping costs.

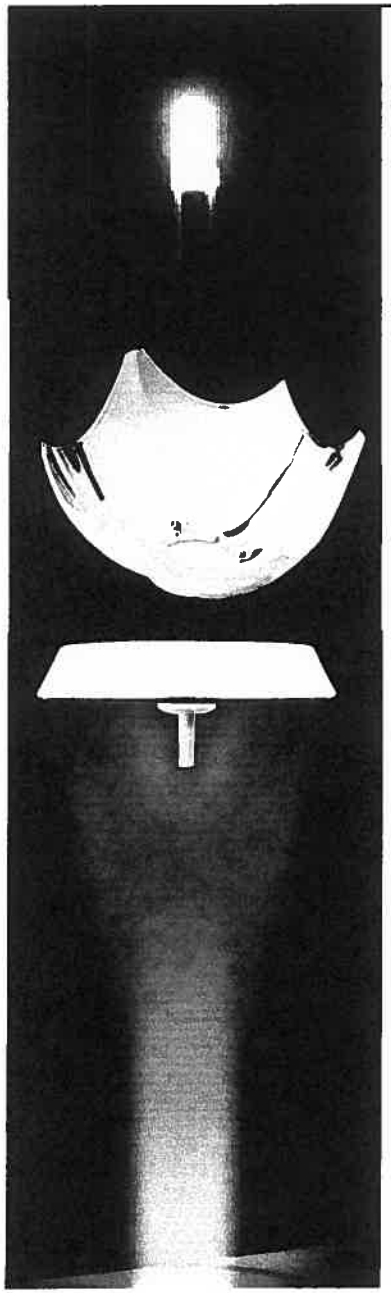
Regards,

Stryker Finance

Customer Signature and Date

Stryker Visum II LED Surgical Lights

WHAT YOU SHOULD KNOW



BRIGHTEST PURE WHITE LIGHT

•Brightest Light available: 160,000 LUX
•Patented LED for Pure White Light and Correct Color Reproduction
• Light face is made of medical grade safety glass (vs. plastic) ensuring the color does not change over time

LEAST HEAT/MORE ECONOMICAL

•Low energy coupled with our aluminum alloy light head design (instead of plastic) allows less heat to travel to the surgical field
•The Stryker LEDs last for over 50,000 hours

BEST SHADOW RESOLUTION

•Unique Patented Reflector Design virtually eliminates shadows cast from head and shoulders
•30 Reflective Pods with 90 LEDs

INTEGRATION

•Remote Diagnostics
•Lights proactively send status to monitoring server
•Multiple Control options

SUPERIOR SPOT

•Larger Spot size 8.5" - 12.9" (less need to move)
•Adjustable spot
•Consistent color from edge to edge
•41" Depth of Field eliminates the need to focus the light

SUPERIOR MANEUVERABILITY

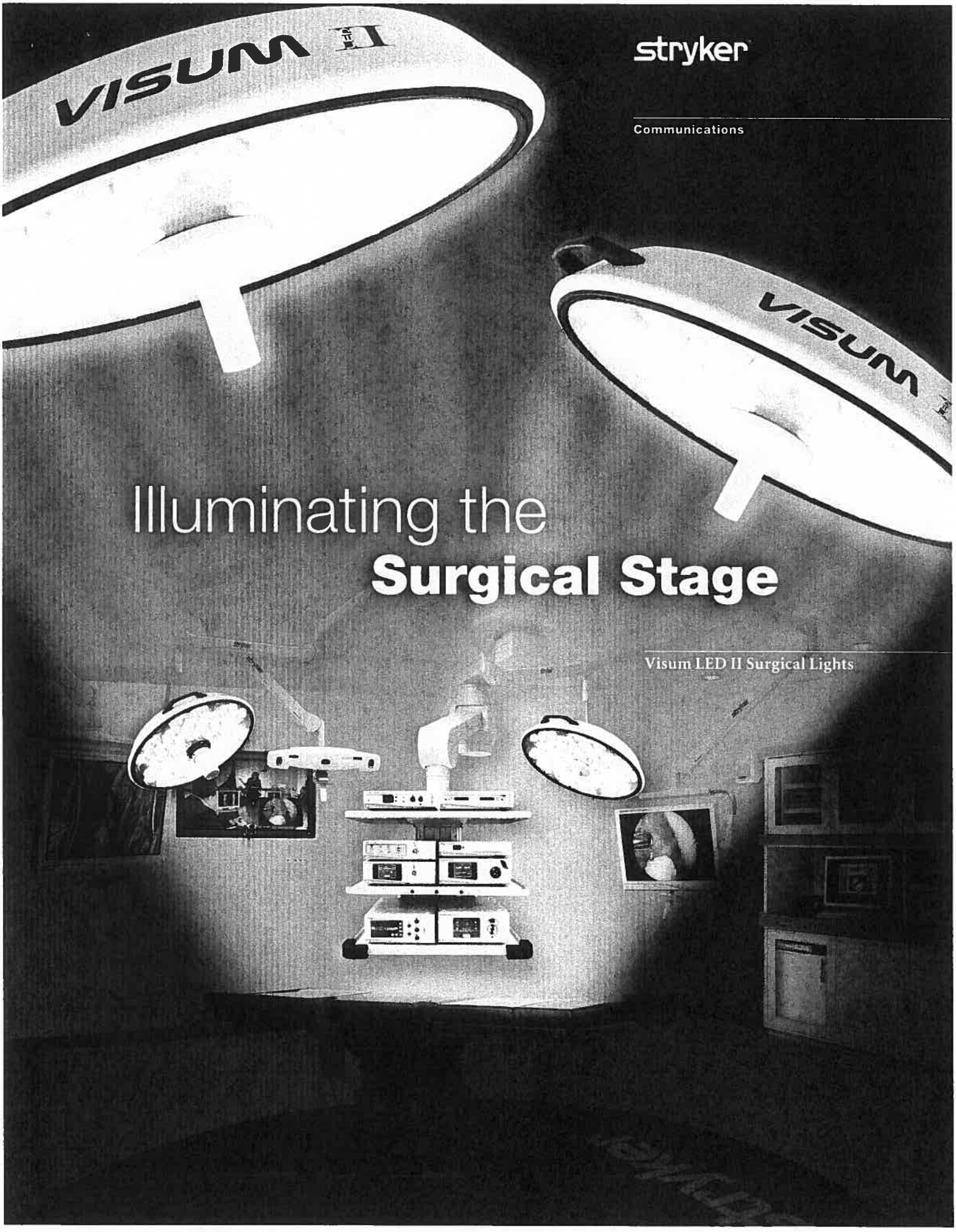
•Single Point Cardanic Attachment
•Needle Bearings
•Light Weight Suspension

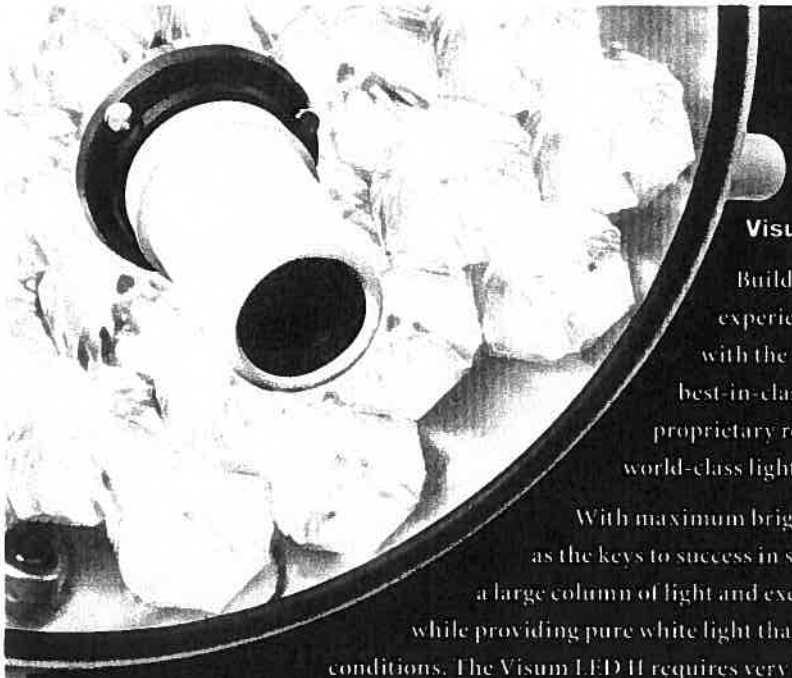
stryker

Communications

Illuminating the **Surgical Stage**

Visum LED II Surgical Lights





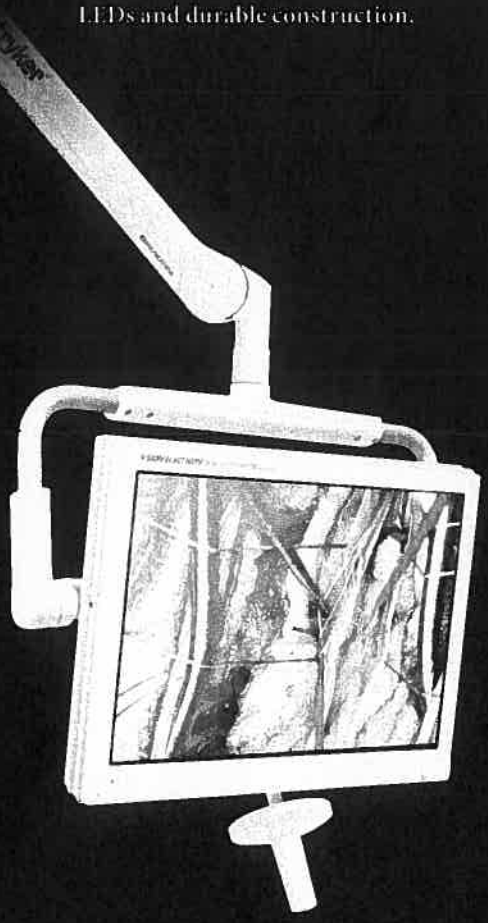
Visum LED Surgical Lights

Building upon years of surgical lighting experience, Stryker has raised the bar again with the Visum LED II Surgical Light. Using best-in-class LEDs (Light Emitting Diodes) and a proprietary reflector design, the Visum LED II provides world-class lighting for your OR.

With maximum brightness and exceptional shadow resolution as the keys to success in surgical lighting, the Visum LED II provides a large column of light and exceptional shadow resolution. This is achieved while providing pure white light that will remain cool under the most demanding conditions. The Visum LED II requires very little maintenance and no bulb changes during ownership due to long lasting LEDs.

Saving Time and Money While Improving Service

A major advantage of Stryker's LED based surgical lighting is long life and durability. Stryker chose aluminum and glass construction that is designed for years of use in the OR. The LEDs are designed for 50,000* hours of use while using up to 38% less energy than traditional halogen lighting. The Visum LED II is designed for the demanding environment it is placed in, allowing for great savings in time and money by combining long lasting LEDs and durable construction.



In-Light Camera Image

Consistent Light Field

Stryker's proprietary reflector design produces a light field that is more consistent from edge to edge than previous lighting systems. This field consistency and large spot size are the foundation of the Visum LED II which—when positioned properly—will not need to be readjusted during surgery, allowing the staff to focus on the patient and not periphery equipment.

SORN Remote Device Management

Each Visum LED light system can remotely connect to the Stryker Support Center through SORN, where technicians can provide remote customer support when you need it most.

Through SORN, technicians can monitor light head operation and set notifications and alerts. By utilizing SORN, Stryker can provide you with exceptional, proactive service.

Optional In-Light Camera

The Visum LED system is available with an optional in-light camera with 32x zoom capability. The in-light camera engages all staff in the O.R. and is also beneficial in remote teaching and teleconferencing applications.

*LED Light Output - To remain at or above 70% initial output. Estimate based on LED manufacturer data.

LED Surgical Lighting

Just Got Brighter

41" Column of Light
Large spot size and depth of field provides a large column of light, decreasing the need to adjust the light during a procedure

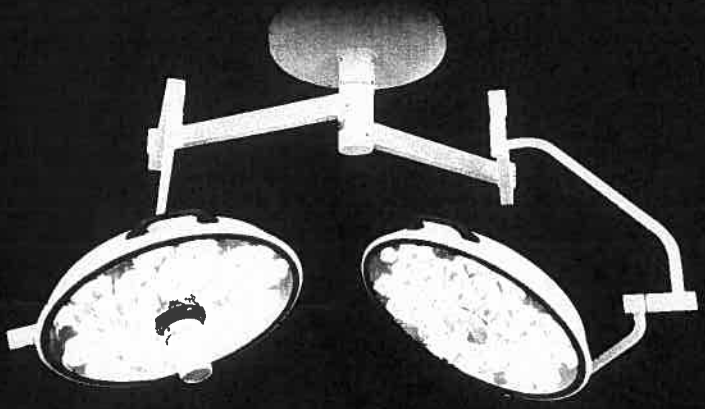
Superior Shadow Resolution
Stryker's proprietary reflector technology effectively resolves shadows to keep the surgical site clearly illuminated while maintaining a large depth of field

Single Color LEDs
Provides 160,000 lux of pure white light

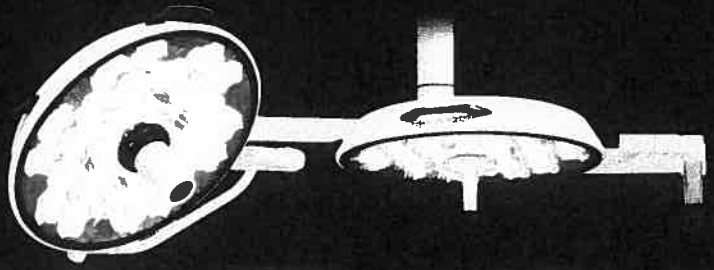
Low Heat
LEDs do not emit UV or Infrared light waves, helping to keep the OR staff cool even during long cases, and creating a more comfortable work environment

No Bulb Changes
LEDs eliminate the risk of bulb burn out during a procedure, decreasing operating costs and downtime while increasing your return on investment

Compact, Light-Weight Suspension
Allows for easy repositioning during surgical procedures



Dual Cardanic Standard Suspension



Single Cardanic Low Ceiling Suspension

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Joint Replacements

Trauma, Extremities & Deformities

Craniomaxillofacial

Spine

Biologics

Surgical Products

Neuro & ENT

Interventional Spine

Navigation

Endoscopy

Communications

Imaging

Patient Care & Handling Equipment

EMS Equipment

Stryker Communications
1410 Lakeside Parkway
Flower Mound, TX 75028
t: 1 877 789 8106

www.stryker.com

Literature Number: 1004700139 (Rev. D)
BC/EP 11/B1

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 9

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD
EXECUTIVE SUMMARY

JULY 2012

TOPIC

Joint Commission Survey Preparation: The Medical Staff is in the process of working on several areas of focus relevant to Joint Commission standards which have either recently been implemented, or deficiencies have been identified and require resolution prior to survey. The following projects are underway, and have target completion dates in mid-July to mid-August:

1) Medical Staff Bylaws-require extensive rework to ensure compliance with new, recently implemented Joint Commission standards, as well as recent California State Laws enacted regarding Infection Prevention and Surveillance. Reorganization of some committees is also necessary to reflect current practice and provide more comprehensive monitoring for improved quality care and patient satisfaction. Approval by Medical Staff to be conducted through mail ballot. Medical Staff Bylaws currently require that the General Medical Staff have 30 days to review the proposed amendments and respond with their write-in vote. The proposed Bylaws and a ballot shall be mailed to those members eligible to vote July 20th. The affirmative vote of a majority of the returned ballots received by August 18th is required for approval, and forwarding to August Governing Board for final approval.
2) Privilege Delineations: Current privilege delineations are not reflective of current practice, and have not been revised in more than three to five years. The Departments are working to establish specific criteria for the privileges and proctoring to ensure applicants meet current competency requirements for the privileges requested, and new forms will be more streamlined and less cumbersome than the current forms. Target completion date is third week in August, with presentation for approval at August Governing Board.
3) On-Going Professional Practice Evaluation (OPPE): These Joint Commission standards require organizations to establish routine measures or indicators of practitioner performance for current medical staff members. While DMC has maintained an approved policy for this process since 2009, a lack of computerized reporting functions and personnel turn-over has made the completion of this function difficult in the past. Medical Staff and Quality are currently collaborating to identify and manually gather criteria-based, peer review data in an on-going way, at six month intervals, rather than just at the two-year reappointment all medical staff members must undergo. Appropriate forms for reporting and communication have already been developed and will be included in this process, with 100% of those medical staff members maintaining clinical privileges having a review every six months. Process underway, with expectation that all medical staff will have aggregate data, meeting the OPPE requirements, prior to survey. This does not require Board approval, as the policy/process was Board-approved in March 2009.

ITEMS REQUIRING ACTION

Policies, Procedures, Forms: The attached Policy, Procedure and Forms Report for July 2012 includes four documents approved by the Medical Executive Committee and are presented for Board approval.

DOCTORS MEDICAL CENTER

MEC APPROVAL DATE: 07/09/12

BOARD OF DIRECTORS APPROVAL DATE: 07/25/12

POLICY, PROCEDURE AND FORMS REPORT

JULY 2012

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

**NOTE: COPIES OF ALL POLICIES LISTED IN SECTION A AND SECTION B BELOW ARE ATTACHED TO THIS REPORT; THOSE POLICIES/DOCUMENTS LISTED IN SECTION C: REVISED WITH MINOR/NON-SUBSTANTIVE CHANGES, WILL BE AVAILABLE FOR REVIEW IN THE MEDICAL STAFF OFFICE AND ADMINISTRATION.*

POLICY/PROCEDURE/FORMS	TYPE	REASON FOR REVIEW
A. New 1. Swallow Screen	Patient Care P&P	Establishes process to screen for swallow impairments when speech therapist is unavailable
B. Revised with Major/Substantive Changes 1. Admission, Discharge & Transfer of Patients	Patient Care P&P	Major rewrite of ADT policy to reflect current practice and ensure compliance with regulatory and accreditation standards

DOCTORS MEDICAL CENTER

Manual: PATIENT CARE SERVICES	Sub Folder:
Title: Swallow Screen	Reviewed: Revised:
Effective Date: 07/12 Expiration Date:	Page 1 of 2

PURPOSE:
Many patients demonstrate swallow impairment. These patients may be at risk for choking, aspiration, pneumonia, malnutrition/dehydration and death. This policy outlines how to appropriately assess and treat swallow impairment.

POLICY:
When an physician has a concern about a patient's swallow function, the physician will order a swallow evaluation by the hospital speech therapist. If the speech therapist is not expected to be available (e.g., during weekends, evenings), the physician will still order a swallow evaluation, but can, in addition, order a "nursing swallow screen." Regardless of the outcome of the nursing swallow screen, the speech therapist will still subsequently perform a swallow evaluation.

The "Nursing Swallow Screen" permits the physician to formally address the swallow concern when the speech therapist is not available and the patient may become hungry and may need oral meds. The "nursing swallow screen," then, is to serve as a stopgap, very short-term measure until the speech therapist is available.

Any records regarding the nursing swallow screen (e.g., training and participants) will be maintained by the stroke coordinator.

PROCEDURE:
1. When an physician is concerned about a patient's swallow function, the physician will order a swallow evaluation by speech therapy.
2. If the speech therapist is not available (e.g., on weekends), the physician will order a swallow evaluation by speech therapy, and can order a nursing swallow screen.
3. Nurses who have been trained formally by the speech therapist to perform the nursing swallow screen, will perform the swallow screen and notify the referring physician of the results.
4. If the patient fails the swallow screen, the patient will remain NPO until the speech therapist performs a swallow evaluation.
5. If the patient passes the nursing swallow screen, the patient can begin a "pureed food, thin liquid diet, as tolerated."
6. Nursing will put the nursing swallow screen in the patient's chart in the nursing notes section.
7. Regardless of the outcome of the nursing swallow screen, the speech therapist will perform a swallow evaluation subsequently.

REFERENCES:
Perspectives on Swallowing and Swallowing Disorders (Dysphagia), December 2009 vol. 18 no. 4 111-116 Yale University School of Medicine

Responsible for review/updating (Title/Dept)	Stroke Coordinator Title	Stroke Program/ Emergency Medicine Dept

NURSING SWALLOW SCREEN

Step 1

Answer the following questions:

a. Is the patient alert *and* attentive?	yes	no
b. Is the patient's speech normal?	yes	no
c. Can the patient sit up at 90 degrees with good head control?	yes	no

If the answer to any of the questions was "**NO**," **STOP**. Patient has failed the screen. Keep patient NPO including meds and inform physician. If the answer to **ALL** of the questions above was "**YES**," continue to Step 2.

Step 2

Answer the following questions:

a. Does the patient have pneumonia or breathing problems?	yes	no
b. Does the patient (or family) report a (baseline or current) problem eating or drinking?	yes	no

If the answer to any of the questions was "**YES**," **STOP**. Patient has failed the screen. Keep patient NPO including meds and inform physician. If the answer to **ALL** of the above is "**NO**," continue to Step 3.

Step 3

Do the following.

a. put head of bed to 90 degrees (fully upright).
b. give the patient **a tsp (use actual spoon)** of water.

c. Did the patient cough or choke?	yes	no

If the answer is "**YES**," **STOP**. Patient has failed the screen. Keep patient NPO including meds and inform physician. If the answer is "**NO**," continue to Step 4.

Step 4

Do the following.

a. Give the patient **90 ml** of water in a **cup** and ask the patient to "**drink it all at once**."

b. Did the patient cough or choke?	yes	no

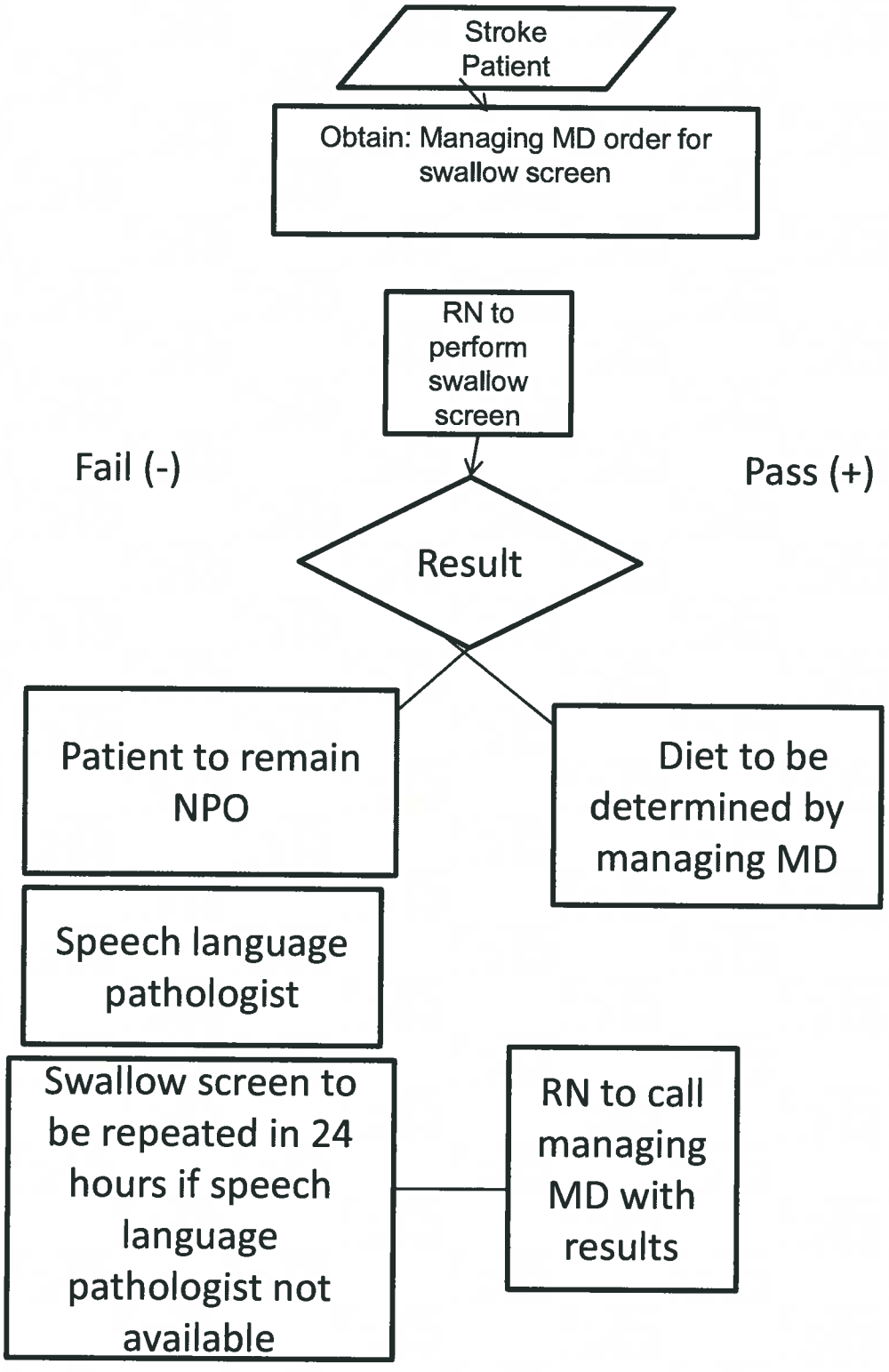
If the answer is "**YES**," **STOP**. The patient has failed the screen. Keep patient NPO including meds and inform physician. If the answer is "**NO**," the patient has now passed the swallow screen. Notify the patient's doctor that the patient passed the screen, and request an order for a pureed food, thin liquids diet, as tolerated.

Nursing comments (if any):_____

_____ _____ _____

RN completing this form Date Time

NURSING SWALLOW SCREEN FOR STROKE PATIENTS



DOCTORS MEDICAL CENTER

Manual: ADMINISTRATIVE	**Sub Folder: PATIENT SERVICES**
Title: Admission, Discharge and Transfer of Patients.	**Reviewed:** **Revised:**
Effective Date: 07/12 **Expiration Date:**	**Page 1 of 4**

PURPOSE:
To provide guidelines for employees and staff regarding the Admission, Discharge and Transfer procedures of Doctors Medical Center.

POLICY:
Patients shall be admitted, transferred and discharged, in a timely and safe manner without regard to sex, age, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity, or marital status, or the source of payment of care. Patients shall be admitted in accordance with clinical diagnosis for which the hospital provides services and within the limitations imposed by law or licensure, staffing, and rules governing emergency admissions.

Patients shall be accepted and admitted only upon the order, and under the care of a member of the Medical Staff of Doctors Medical Center who is a licensed health care practitioner acting within the scope of his or her professional licensure.

The patient's condition and provisional diagnosis shall be established at the time of admission by the member of the Medical Staff who admits the patient, subject to the Medical Staff General Rules and Regulations of Doctors Medical Center, and the provisions of California Code of Regulations, Title 22, Section 70705 (a).

No mentally competent adults shall be detained in the hospital against their will.

Emancipated minors shall not be detained in a hospital against their will.

Unemancipated minors shall not be detained against the will of their parents or legal guardians.

In those cases where law permits, unemancipated minors to contract for medical care without the consent of their parents or legal guardians, the minors shall not be detained in a hospital against their will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in the patient's own interest nor the detention of mentally disordered patients for the protection of themselves or others under the provision of the Lanterman-Petris-Short Act (Welfare and Institutional Code, Section 5000, et seq.,) if the hospital has been designated by the County as a treatment facility pursuant to said act nor to prohibit minors legally capable of contracting for medical care from assuming responsibility for their discharge.

In no event shall a patient be detained solely for nonpayment of a hospital bill.

No patient shall be transferred or discharged solely for the purpose of affecting a transfer from a hospital to another health facility unless:

- Arrangements have been made in advance for admission to such health facility.
- A determination has been made by the patient's physician or clinical psychologist, acting within the scope of his or her professional licensure, that such a transfer or discharge would not create a hazard to the patient's physical or mental health.
- The patient or the person legally responsible for the patient has been notified or attempts have been made over the 24-hour period prior to the patient's transfer and the legally responsible person cannot be reached.

Minors shall be released only to the custody of their parents or legal guardians or custodian, unless such parents or guardians shall otherwise direct in writing. This provision shall not be construed to preclude minors legally capable of contracting for medical care from assuming responsibility for themselves upon discharge.

Each patient, upon admission, shall be provided with a wrist band identification tag or other means of identification unless the patient's condition will not permit such identification. Minimum identification shall include the name of the patient, the admission number, and the name of the hospital.

PROCEDURE:

Admission

1. A patient may only be admitted to Doctors Medical Center-owned and operated by West Contra Costa County Health Care District by a member of the Medical Staff with admitting privileges.
2. Hospital Outpatient Surgery, Outpatient and OutPatient Procedure patients may be cancelled/rescheduled in the absence of a responsible adult to pick up the patient at discharge.
3. A provisional diagnosis will be stated for all patients except in cases of emergency.
4. Clinical services/conditions for which patients may be admitted to the Doctors Medical Center include but are not limited to:
    - Medical
    - Surgical
    - Oncology
5. Due to limitations imposed by law and licensure, the hospital does not admit for the following services:
    - Patients age 17 years and under
    - Cardiac Surgery
    - Obstetrics
    - Organ Transplants
    - In-Patient Psychiatric Care
    - GYN

Documentation
The complete history and physical examination, as required for the patient's medical record, shall be completed within 24 hours after admission of the patient and, in the case of patients admitted for surgery, shall be completed prior to the time at which the surgery is scheduled.

Discharge:

1. Patients shall be discharged upon the written order of the attending practitioner or other approved/privileged member of the professional staff, acting as his/her representative (Allied Health Staff cannot write discharge orders).

2. Whenever appropriate, physicians should give priority to their dischargeable patients when they round, to allow the greatest amount of lead time for nursing and other ancillary staff to make discharge arrangements.

3. If the patient's medical status allows as determined by the discharging physician (to ensure patient will not be discharged using a taxi after surgery, conscious sedation, or administration of narcotics or sedation to the extend the patient's cognitive status is decreased) and the patient agrees, a patient may be transported home by taxi if family/friends are not available at discharge time and no other means are available.

4. Social Workers will assist with transportation arrangements if family members/friends are not available to transport patient at discharge.

5. Interested patients, family members or interested persons may be counseled to prepare for post-hospital care as needs are identified.

6. The patient will be informed, orally or in writing, of the continuing health care requirements following discharge from the hospital.

7. If the patient is unable to make decisions for him or herself, the right to information regarding continuing health care requirements following discharge shall apply to the person who has legal responsibility to make decision regarding medical care on behalf of the patient.

8. Further, the patient may request that friends or family members also be given this information, even if the patient is able to make his or her own decisions regarding medical care.

Transfer to Outside Acute Care Facilities

1. If the attending physician concludes that the patient is suffering from a problem for which Doctors Medical Center physicians and staff are not able to care for, he/she shall make arrangements for transfer of the patient to a facility that can provide the services the patient needs.

2. A patient shall be transferred to another facility only when such transfer is authorized by the attending physician as being in the best interest of the patient and after the

transfer has been agreed upon by the accepting physician, the accepting facility, and patient and/or family is present except in cases of emergency.

REFERENCES:

www.cdph.ca.gov/programs/Inc/pages/PSLS.aspx
www.jointcommission.org/accreditationprograms/hospitals
CHA's California Hospital Compliance Manual
California Code of Regulations, Title 22
State Standard HCS 1262.5
CMS Conditions of Participation Appendix V: EMTALA
SB 633

Responsible for review/updating (Title/Dept)	Vice-President of Patient Care Services Title	Nursing Administration Dept

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

JUNE 2012

The following practitioners' applications for appointment and/or reappointment have been reviewed by the appropriate committees of the Medical Staff and have been deemed as complete and are recommended for approval by the Credentials Committee (06/28/12) and the Medical Executive Committee (07/09/12).

CREDENTIALS REPORT TO THE BOARD JUNE 2012	
INITIAL APPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Yu, Thomas, MD	Surgery/Pathology
REAPPOINTMENTS	
Afsari, Khosrow, MD	Medicine/Family Practice/Internal Medicine
Quang, Angela, MD	Medicine/Family Practice/Internal Medicine
Sankary, Richard, MD	Medicine/Family Practice/Pulmonary Medicine
Yoon, Edward, MD	Medicine/Family Practice/Cardiology
Barry, Peter, MD	Surgery/Orthopedics
Pappas, Peter, MD	Surgery/Orthopedics
Ryan, Paul, MD	Surgery/Ophthalmology