DOCTORS MEDICAL CENTER

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

Wednesday, November 16, 2011
3:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
NOVEMBER 16, 2011, 3:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

Board of Directors
Supervisor John Gioia, Chair
Eric Zell, 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** — J. Gioia

2. **ROLL CALL**

3. **APPROVAL OF OCTOBER 26, 2011 MINUTES** — J. Gioia

4. **PUBLIC COMMENTS** — J. Gioia
   [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. **FIRE MARSHAL UPDATE** — William Appling/ K. White
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For information only.*

6. **2012 BUDGET** — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Approval of 2012 Budget

7. **CERTIFICATE OF PARTICPATON (COP) FINANCING** D. Gideon
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: For information and discussion only.

8. **FINANCIALS – OCTOBER 2011** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the October 2011 Financials.*

9. **PALLIATIVE CARE PROGRAM & CATH LAB POLICIES** J. Maxworthy
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: *Approval of the following policies:*
      i. Spiritual Needs Assessment
      ii. The Palliative Care Referral
      iii. Plan of Care and Providing Continuity of Care
      iv. Defining Scope of Care
      v. Fire Safety and Fires Risk Assessment (Cath Lab)

10. **QUALITY REPORT** J. Maxworthy
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: For information only.*

11. **CEO UPDATE** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: For information only.*

12. **MEDICAL EXECUTIVE REPORT** S. Drager, M.D.
    a. Presentation
    b. Discussion
    c. Public Comment
    e. *ACTION:*
       - *Acceptance of Medical Staff Report*

- *Approval of Appointments, Reappointments and Changes of Staff Status, and Policies and Procedures*

ADJOURN TO CLOSED SESSION

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

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: John Hardy, Vice President of Human Resources: California Nurse Association.

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

DOCTORS
MEDICAL CENTER

MINUTES

October 26, 2011

TAB 3

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
OCTOBER 26, 2011, 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, Vice Chair*
	Irma Anderson
	Wendel Brunner, M.D.
	Deborah Campbell
	Nancy Casazza
	Sharon Drager, M.D.
	William Walker, M.D.
	Beverly Wallace
Excused:	*Supervisor John Gioia*
	Pat Godley
	Richard Stern, M.D.

3. APPROVAL OF SEPTEMBER 28, 2011 MINUTES

The motion made by Director Anderson and seconded by Director Wallace to approve the September 28, 2011 minutes passed unanimously.

4. PUBLIC COMMENTS

There were no public comments.

5. FINANCIALS – SEPTEMBER 2011

Mr. Jim Boatman, CFO reported September 2011 was a net loss of 960K. The net loss to date is $11M. Payroll and supply expenses were under budget for the 2nd straight month. Operating cash in September was 2.4M or 6 days.

The motion made by Director Wallace and seconded by Director Anderson to accept the September Financials passed unanimously.

6. QUALITY REPORT

Ms. Juli Maxworthy, VP of Quality and Risk Management presented an update on surveys. The Stroke Certification was approved by Joint Commission and certified as of September 30th. The action plans for the Lab Recertification will be submitted to Joint Commission beginning of November. We received no citations for the MERP Survey, but while that surveyor was on site, she did identify Title 22 citations. We will complete the necessary follow-up and will submit by October 26, 2011.

Ms. Maxworthy also reported on the following items:

Core Measures:

- Congestive Heart Failure (CHF). Issue of patient receiving both of the last pages of their educational documents instead of it being included in their medical records. Compliance shows improvement.
- Acute Myocardial Infarction (AMI). All AMI elements for 2nd quarter are in the green, above 90%.
- Surgical Care Improvement Project (SCIP). Ongoing education continues with staff.
- Pneumonia (PN). Antibiotic MONOtherapy for patients admitted to the ICU is a fallout. The recommended PNA antibiotic selection is listed on the back of the core measure alert form. Currently, due to a low ratio (5/6), antibiotic selection for ICU patients is 83.3%.

Appropriate Care Measure (ACM):

- The Joint Commission is expecting hospitals to achieve a composite score for the ACM of at least 85%, starting January 2012.

Patient Satisfaction:

- Improve communication between caregivers and patients.
- Training new managers to closely monitor and track unit scores and patient comments.
- Dawn Gideon speaking about scores at town halls and department meetings.

Pressure Ulcer:

- Rates have been relatively low. Reported only 1 incident to CDPH.

7. CEO REPORT

Ms. Dawn Gideon, Interim President and CEO reported the following updates:

- Continue quarterly town hall meetings throughout October and provided a formal presentation on general hospital updates to employees, medical staff and volunteers.
- Collaborate with Kathy White, Interim COO and Teri Grassau, CNO to conduct interdepartmental rounds and discuss three major issues: 1) clinical quality 2) patient satisfaction and 3) financial status.
- Physicians meetings: focusing on internal medicine and family medicine doctors, to keep them informed of activities and provide a forum to discuss improved loyalty to DMC for those not referring patients at 100%.
- Senate Bill 644 was signed by the governor with zero opposition and received unanimous support.
- Measure J: the administrative team and many employees have volunteered their time to the campaign effort for the parcel tax.
- Expense reduction and 2012 budget preparation. Set a goal of $5M expense reduction.
- Accounts receivables financing: the District Board met on October 16th and approved and authorized management to execute the financing documents with Gemino.
- Vendor Negotiations: negotiated approximately $1.2 million in reductions, more than 18% savings. Vendors are also agreeing to stretch out payments on their remaining outstanding balance.
- Community Outreach: Breast Cancer and Prostrate screenings were oversubscribed. Administered 600 flu shots to the community.

8. MEDICAL EXECUTIVE REPORT

Dr. Drager sought approval of the revised Patient Controlled Analgesia (PCA) Policy. The revision reflects current practice, including the guidelines for the set up and use of patient controlled analgesia, and ensure compliance with Joint Commission standards.

Dr. Drager also sought approval of the September 2011 Credentials Report.

The motion made by Director Zell and seconded by Director Anderson to approve the Medical Staff Report/Policy and Credentials Report for August 2011 passed unanimously.

The meeting went into closed session at 5:30 P.M. Director Zell announced that there would be no reportable actions taken in closed session.

DOCTORS MEDICAL CENTER

2012 Budget

TAB 6

DOCTORS MEDICAL CENTER

2012 Budget

November 16, 2011

Goals of 2012 Budget

- Improve "same store" performance by $5.0 million
- Increase ownership and accountability of DMC Department Leadership in the 2012 Budget.
- Increase commitment to quality & patient safety
- Improve operational support for clinical services

2012 Budget Process

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

Met with each Department Director to review revenue assumptions and expenses.

Created detailed work plans for changes needed to each department.

Looked to each Department Director for efficientcies in delivering services.

Outcome: Budget changes that reflect a $5,000,000 savings over the prior year costs.

2012 Budgeted Improvements

Revenue Changes

- Medicare payor Increases $2,200
- Payer Contract Revisions $2,000
  HMO Contracts

Expense Changes

- Salary Expense Reductions $3,310
- Other Expense Reductions $2,280

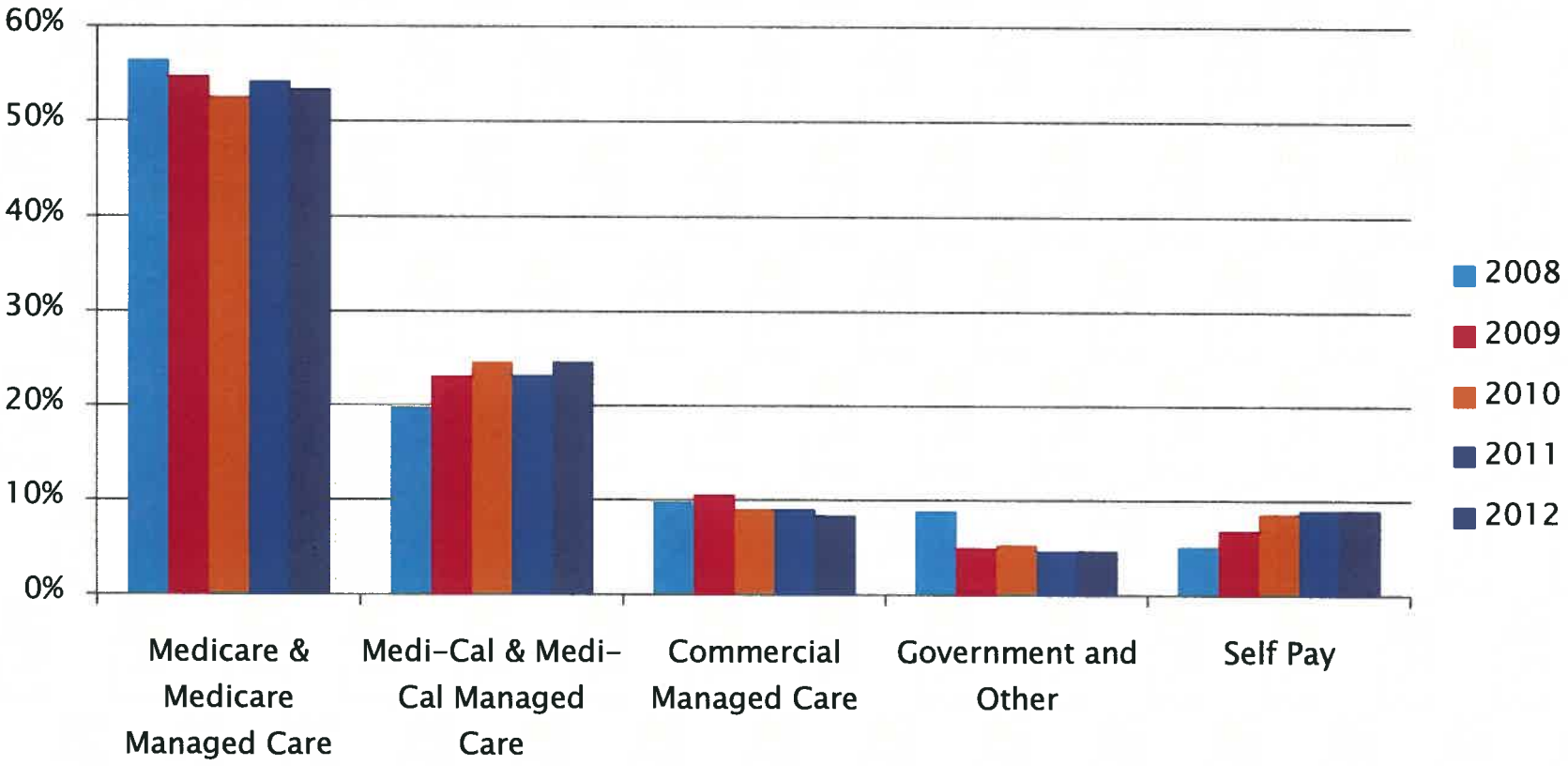
2012 Budgeted Statement of Revenues and Expenses
Amounts in Thousands

OPERATING REVENUE	Actual 2010	Projected 2011	Budget 2012	Change	% Change
Net Patient Service Revenue	135,651	117,896	128,114	10,218	8.7%
Other Revenue	1,164	1,182	1,461	279	23.6%
Total Operating Revenue	136,815	119,078	129,575	10,497	8.8%
OPERATING EXPENSES					
Salaries & Wages	64,686	62,249	62,823	(574)	-0.9%
Employee Benefits	30,839	34,275	33,588	687	2.0%
Professional Fees	10,022	10,400	10,398	2	0.0%
Supplies	20,928	19,868	21,460	(1,591)	-8.0%
Purchased Services	10,166	10,044	11,595	(1,551)	-15.4%
Rentals & Leases	2,193	3,067	3,245	(179)	-5.8%
Depreciation & Amortization	3,593	4,167	4,432	(265)	-6.4%
Other Operating Expenses	4,344	4,165	4,422	(256)	-6.2%
Restructuring Cost (Savings)		1,833	(5,000)	7,833	427.3%
Total Operating Expenses	146,772	150,068	146,963	4,105	2.7%
Operation Profit/Loss	(9,957)	(30,990)	(17,388)	6,392	-20.6%
NON-OPERATING REVENUES (EXPENSES)					
Other Non-Operating Revenue	5,313	5,443	1,200	(4,243)	-78.0%
District Tax Revenue	8,492	8,706	11,024	2,318	26.6%
Investment Income	92	48	51	3	7.0%
Less: Interest Expense	(1,396)	(1,557)	(2,992)	(1,435)	92.1%
Total Net Non-Operating	12,502	12,640	9,283	(3,357)	-26.6%
Income Profit (Loss)	2,545	(18,351)	(8,105)	3,035	-16.5%

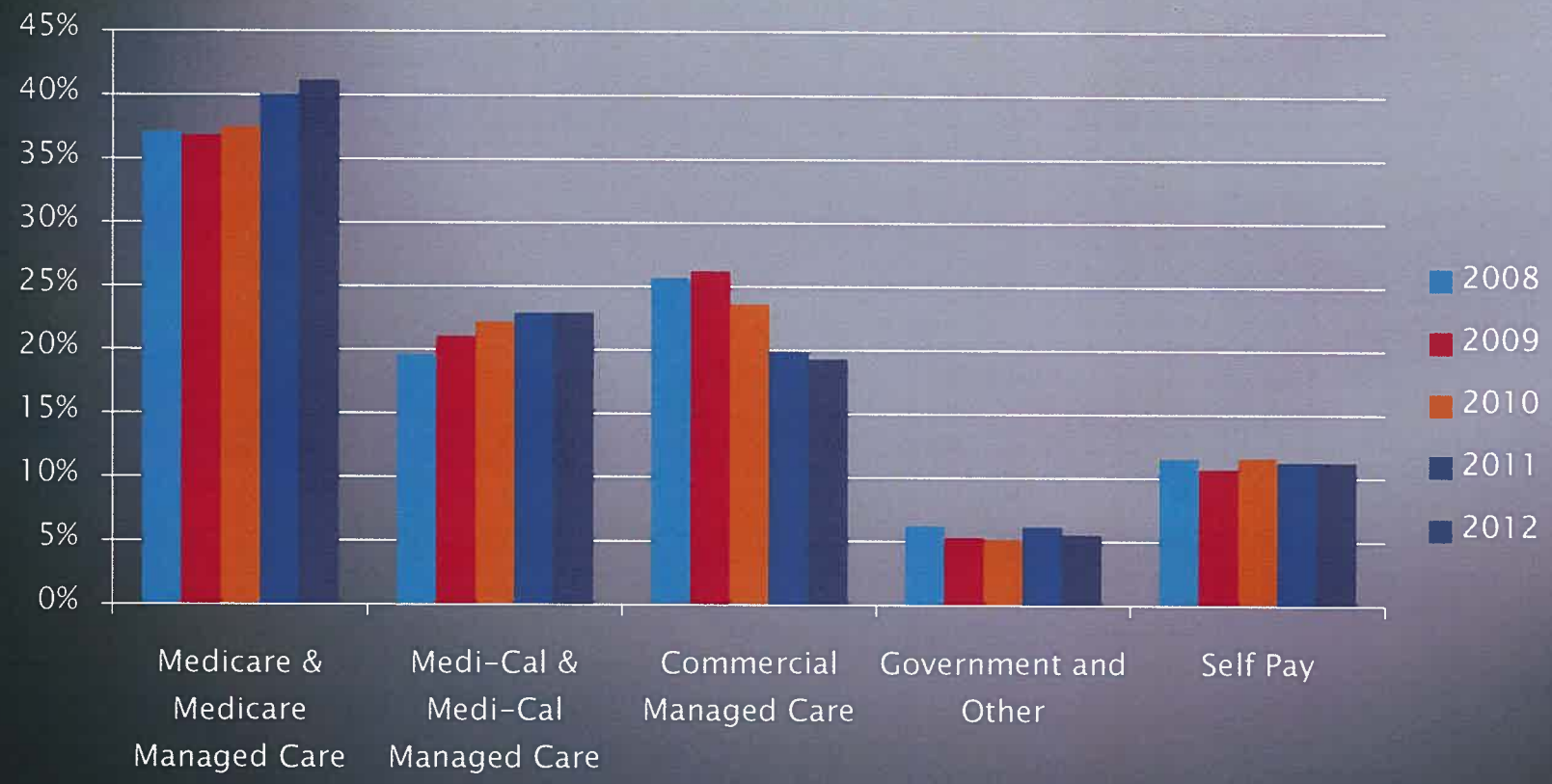
2012 Budget
Volume Assumptions

	Estimated Budget			
Volume Assumptions	**2010**	**2011**	**2012**	**% Change**
Discharges	6,158	6,144	6,158	0.02%
Average Daily Census	86.4	77.1	81.8	6.10%
Average Length of Stay	5.12	4.58	4.85	5.90%
ED Visits	40,210	41,059	39,000	-5.01%
Total Other Outpatient Visits	40,944	45,441	45,118	-0.71%

Inpatient Payer Mix



Outpatient Payer Mix



2012 Budget
Net Revenue Changes

Contracted Payor Increases	$ 1,998
Annual Medicate Increase	$ 2,169
Maintain 2011 Gross Revenue volume as of June 30	$ 6,000

2012 Budget
Other Operating Revenue

Medical Office Building	$	547
340B Pharmacy Income	$	500
Cafeteria Revenue	$	221

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

	Paid Full Time Equivalents		Per Adjusted Occupied Bed	
Fiscal Year	**(FTE's)**	**Percent Change**	**(AOB)**	**Percent Change**
2010	771	10.36%	5.99	7.31%
2011	763	-1.13%	6.53	9.07%
2012	729	-2.71%	5.99	-0.42%

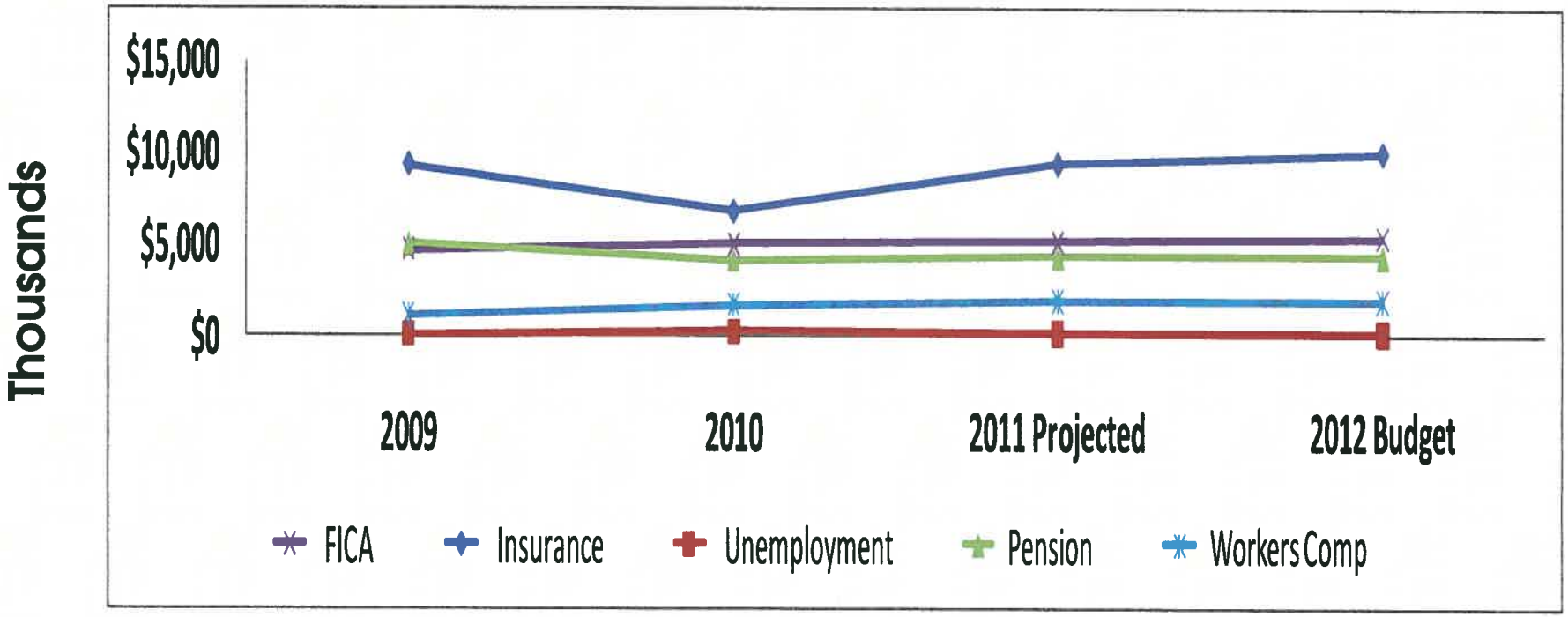
2011 October Year to Date., Paid FTE's

2012 Budget
Changes in Salaries
Additions(Reductions)

Wage increase, consistent with RN Union Contract	**$**	**882**
Reductions in Force	**$**	**(2,725)**

Employee Benefits

Amounts in Thousands



2012 Benefits – Employee Contributions

Medical/RX/Dental/Vision	Employee Only	Employee +1	Family
Current Employee Cost	$10	$10	$20
Under $50,000	$30	$60	$90
$50,000 to $100,000	$45	$90	$135
$100,000 to $150,000	$70	$120	$210
Over $150,000	$120	$240	$360

Benefit Changes for Non-Union

- Emergency Room coverage will be $35
- Preventative care will be covered at 100%
- Employees Can enroll in medical, dental and vision plans separately
- DMC will be the only Tier 1 facility
- DMC Physicians & Allied Providers will be Tier 1
- Employee pre tax contributions will increase
- Part time employees contribution cost will increase

2012 Budget
Changes in Benefits

Increase in Benefit Costs	$ 700
Increase in Workers Compensation	$ 350
Decrease in paid time off for reduced force	($450)

2012 Budget
Professional Fees

Physician Related	$6,646
Other	$3,752
Total	$10,398

2012 Budget
Professional Fees Physician Related

Hospitalist	$1,686
Emergency Room Call Coverage	$1,410
Cancer Center	$764
Anesthesia	$750
Stockton Pathology	$612
Affiliates in Imaging (Radiology)	$510
Baromedical Assoc (HBO)	$403
Endoscopy Coverage	$210
Physician Directorships	$194
EEG Coverage	$106

2012 Budget
Professional Fees – Other

Legal Fees	$1,095
Sodexo Fees	$879
Admin Consulting Fees	$822
Nursing Consulting Fees	$276
Audit Fees	$235
Other Professional Fees	$445

2012 Budget
Supply Costs Changes

2011 One Time Savings Reduction	$1,000
Inflation Pharmaceuticals (7%)	$ 367
Inflation Supply Costs (2%)	$ 333
Pharmacy Supply Savings	($ 250)

2012 Budget
Purchased Services – Major Items

McKesson and other IT Maintenance	$1,328
Inpatient Renal Dialysis	$1,300
Security Services	$909
Equipment Repair and Maintenance	$876
Plant Maintenance Contracts	$645
Transcription Services	$586
Laundry Service (Angelica)	$544
Administrative Service Contracts	$417
Central Supply Service Contract	$403
Lab Test Send Outs – John Muir	$377
PET-CT	$366
Digital Mammography	$343
Collection Agency Fees	$326
MRI	$292

2012 Budget
Leases – Major Items

UHS Contract	$358
Outpatient Center Equipment Leases	$376
Outpatient Center	$328
Pharmacy Equipment	$268
CT Scanner	$246
IT Equipment	$237
Radiology Equipment	$180
Anesthesia Equipment	$170
Lift Equipment for Nursing	$167
Storage	$155
Ventilator Equipment	$110
Other Equipment Leases	$651

Other Operating Expenses
Major Items

Utilities	$2,091
Recruitment/Travel	$ 841
Insurance	$ 701
License, Dues, Memberships	$ 620

Non-operating Revenue and Expenses Changes

New District Tax Revenue	$2,550
Loss of Non-Operating Funding	($4,243)
Interest New Bond	$1,186
Interest on Line of Credit	$239

2012 Budget – Cash Flow

	In Millions
Beginning Total Cash	**$2.0**
Net Loss	**($8.1)**
Other Cash Flow Items:	
Add-Back Depreciation (Non-Cash Expense)	4.4
Equipment Purchases	(1.0)
Payment on Long Term Debt	(2.8)
County Loan Payment	(1.6)
Cash flow from Operations	(9.1)
New Bond Funds	23.0
Net Cash Flow	**$13.9**
Ending Total Cash Balance	**$15.9**

Assumes no change in the outstanding accounts payable balances

2012 Capital Budget

Project Description/Category	2010 Budget
Paragon (to be financed)	$1,757,000
Emergency Equipment Replacement	$1,000,000
TOTAL CAPITAL REQUESTED	**$2,757,000**

Questions?

DOCTORS
MEDICAL CENTER

OCTOBER 2011
FINANCIAL REPORT

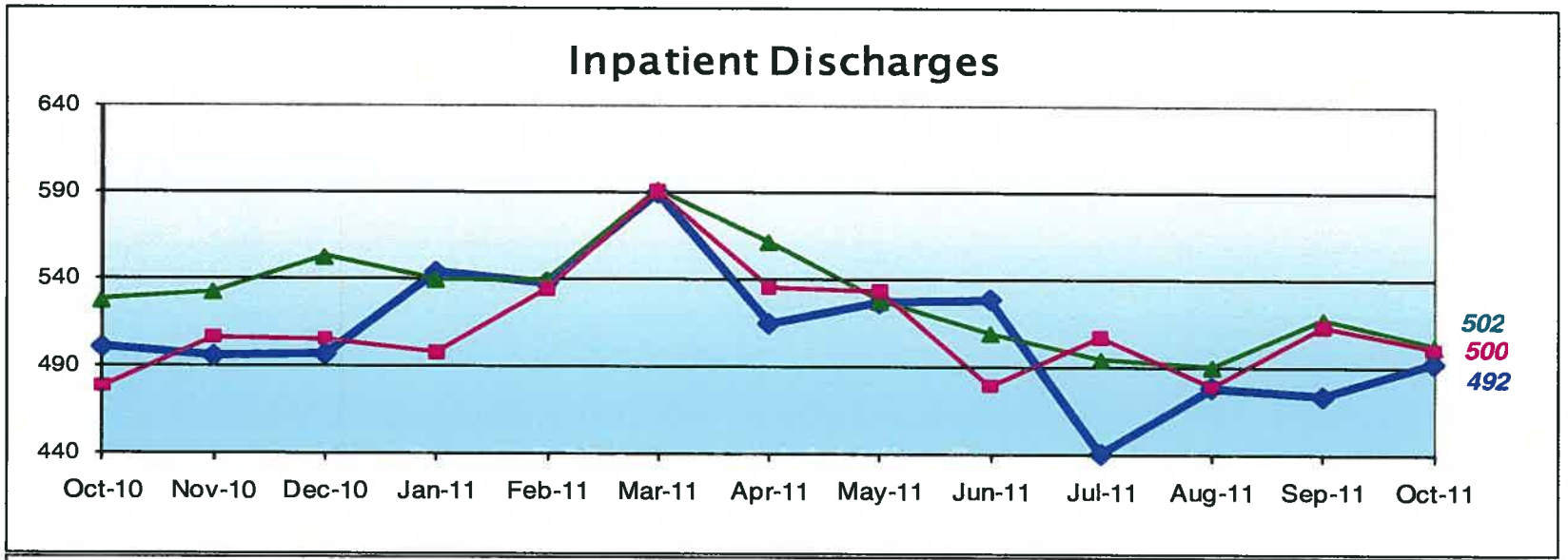
TAB 8

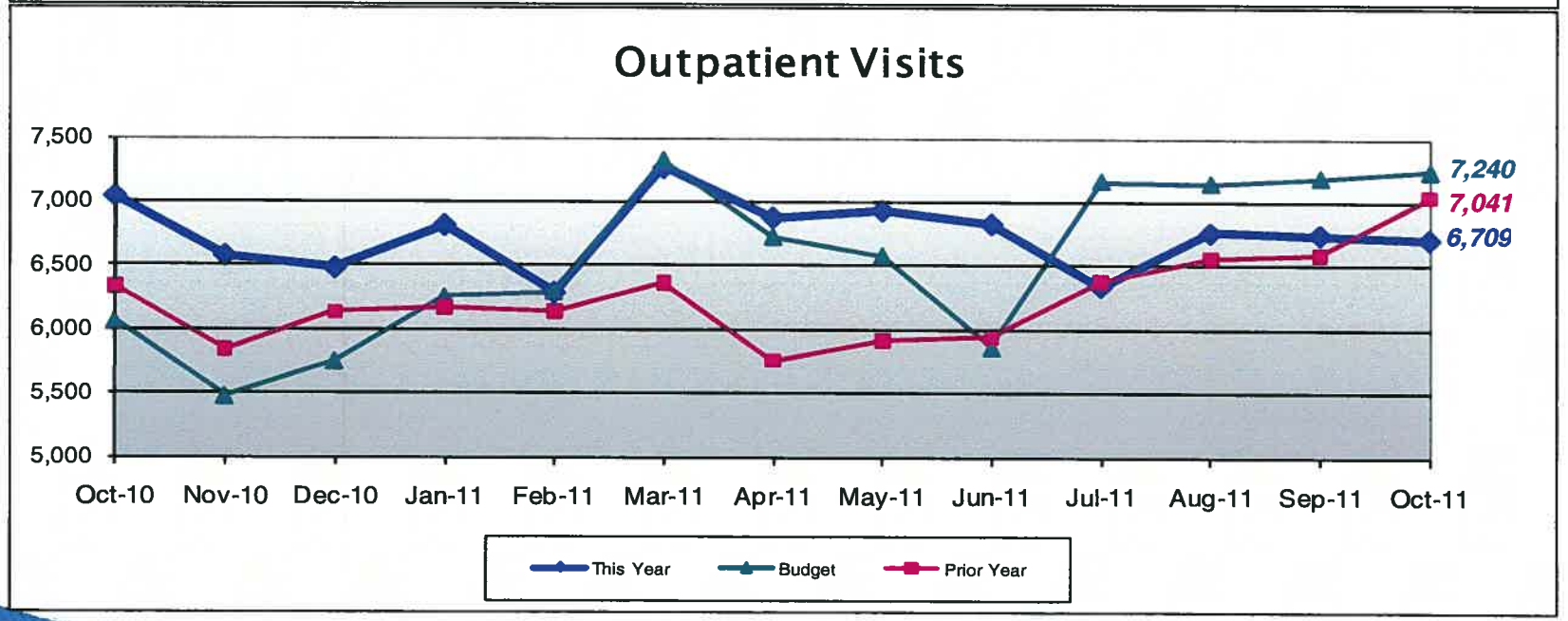
DOCTORS MEDICAL CENTER

Board Presentation

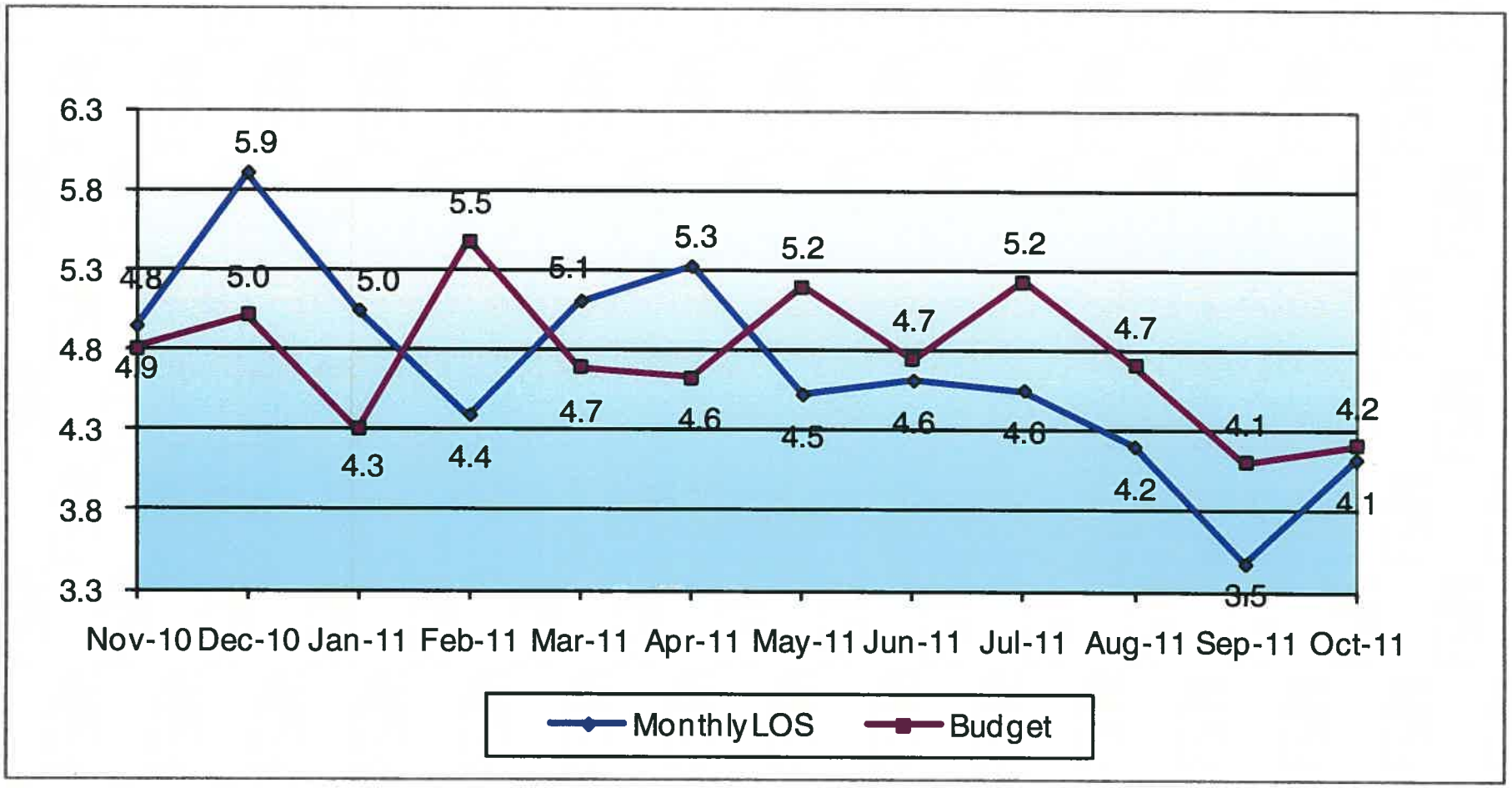
October 2011 Financial Report

Patient Volumes





Monthly Length of Stay
Discharged Patients



Statement of Activity - Summary

For the Period Ending

October 31, 2011

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
8,401	11,154	(2,753)	**Net Operating Revenues $**	99,318	113,192	(13,874)
11,339	11,636	297	**Total Operating Expenses $**	123,958	120,990	(2,968)
(2,938)	(483)	(2,455)	**Income/(Loss) from Operations $**	(24,640)	(7,798)	(16,842)
879	669	210	**Income from Other Sources $**	11,344	6,619	4,725
(2,059)	186	(2,245)	**Net Income / (Loss) $**	(13,296)	(1,179)	(12,117)
(24.5%)	1.7%	(26.2%)	**Net Income Percentage**	(13.4%)	(1.0%)	(12.3%)

California Benchmark Avg	2.1%
Top 25%	7.1%
Top 10%	11.5%

Budget Variances – **Net Revenue**

- Medi-Cal/Medi-Cal HMO - ($200K).
- HMO/PPO/Commercial - ($1,682K).
- Medicare / Medicare HMO- ($653K).

Budget Variances – Expenses

- Salaries & Benefits $246K – Salaries under budget due to low contract labor, flexing and hospital reorganization.
- Supplies $417K – Flexed supply costs, reduction in implants, pacemakers, and pharmaceuticals.
- Rentals & Leases ($52K) – New unbudgeted equipment leases.
- Other Operating Expenses ($56K) – Utilities and membership dues.
- Restructuring Costs ($208K)

Cash Position
October 31, 2011

(Thousands)

	October 31, 2011	December 31, 2010
Unrestricted Cash	$2,337	$5,229
Restricted Cash	$2,658	$4,006
Total Cash	$4,995	$9,235
Days Unrestricted Cash	6	12
Days Restricted	9	11
Total Days of Cash	15	23

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

Accounts Receivable

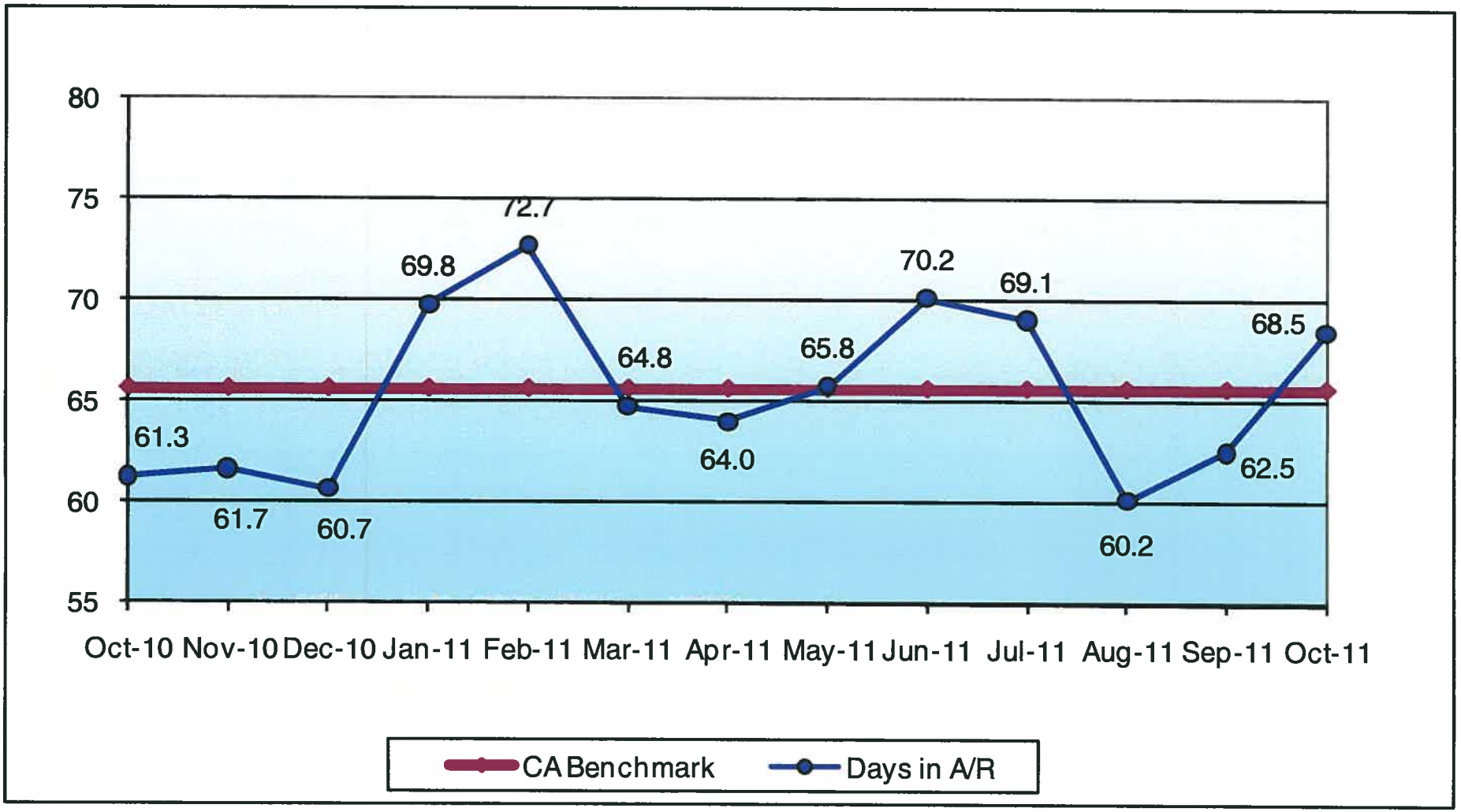
October 31, 2011

(Thousands)

	October 31, 2011	December 31, 2010
Net Patient Accounts Receivable	$18,952	$20,433
Net Days in Accounts Receivable	68.5	60.7

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

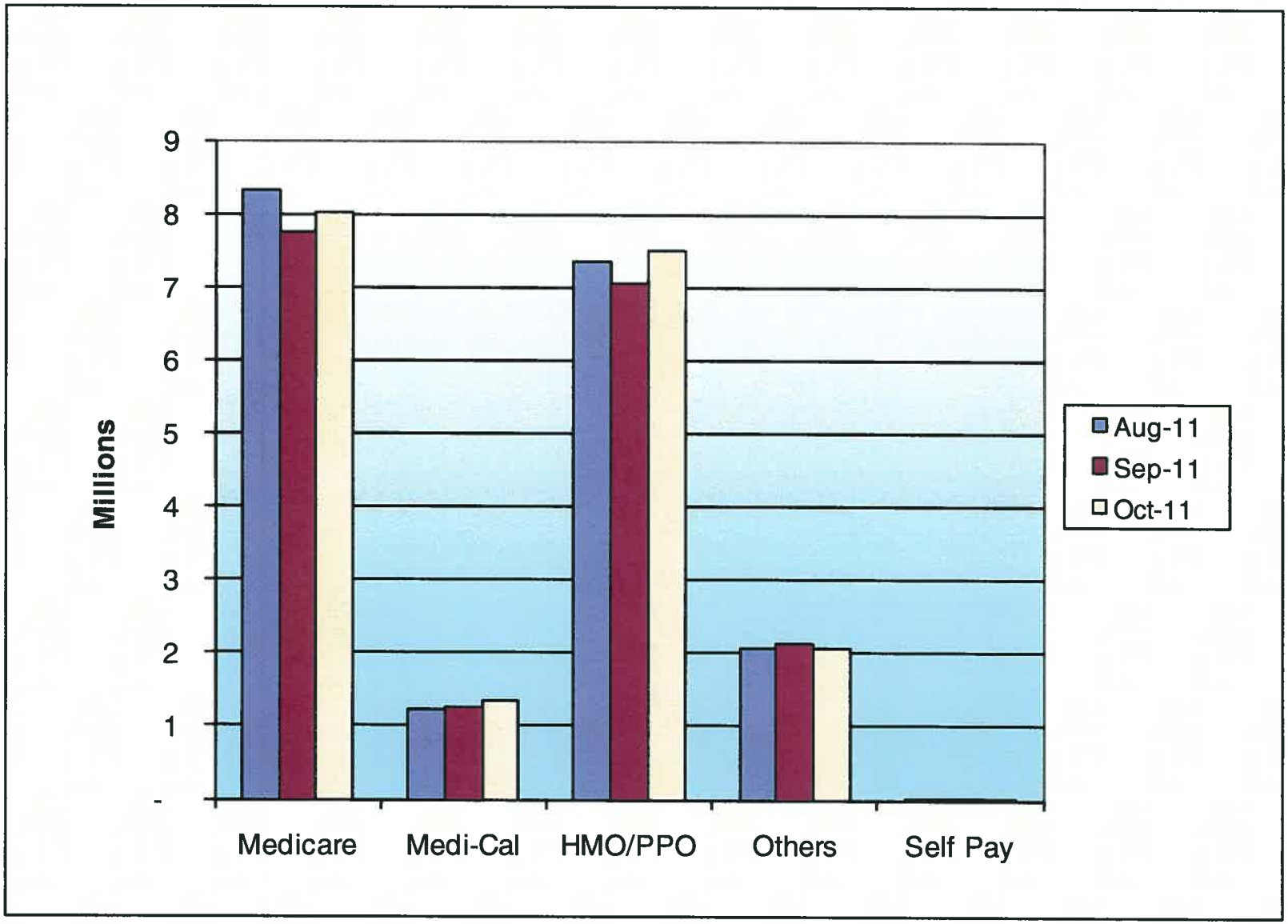
Accounts Receivable
Net Days in A/R



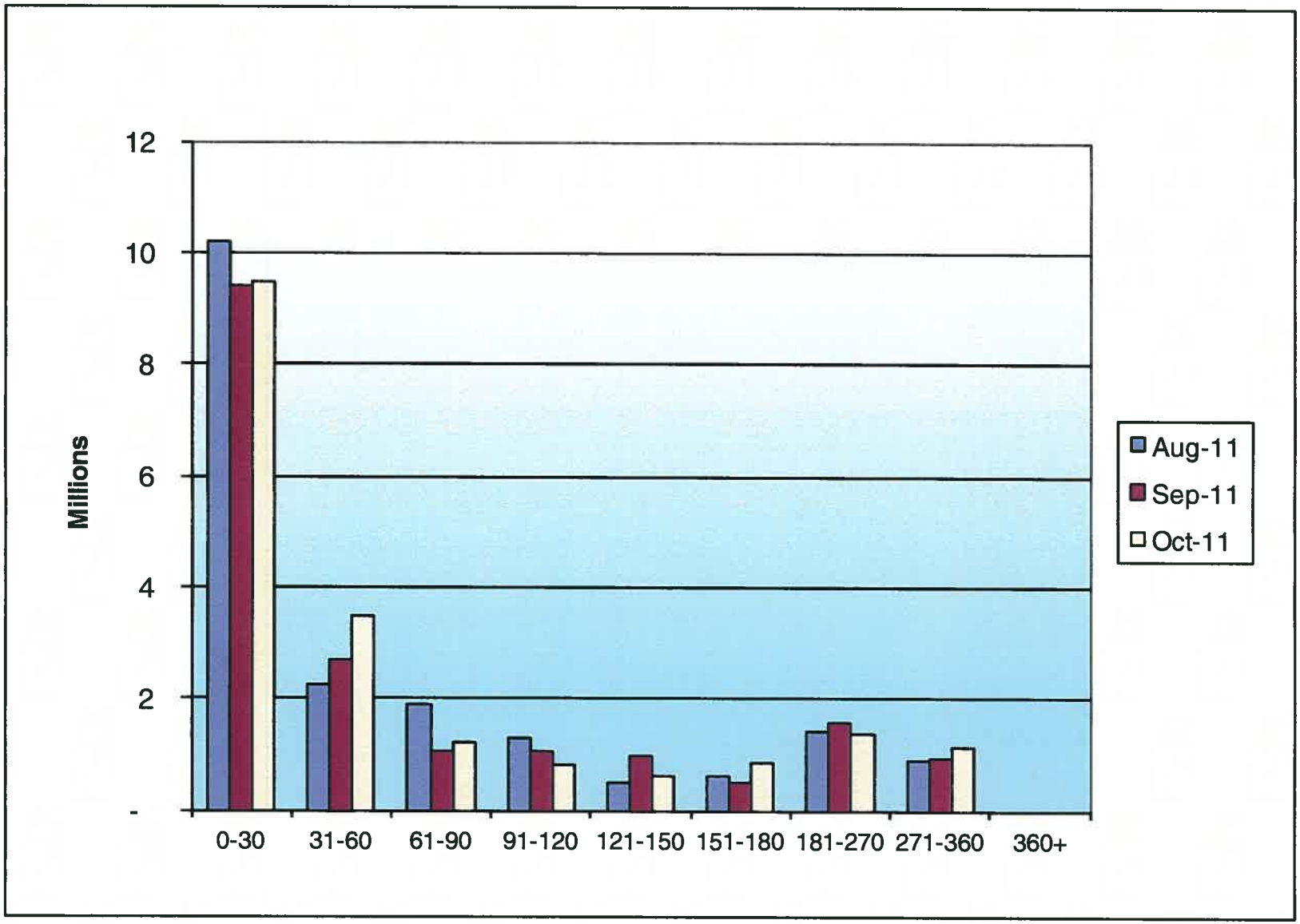
Financial Report Key Points

- Net Loss was $2.0M in October. Net Loss to date is $13M.
- Payroll and Supply expenses under budget for the third straight month.
- Worked FTE's were 11.7% below budget.
- Operating Cash in October was $2.3M or 6 Days.

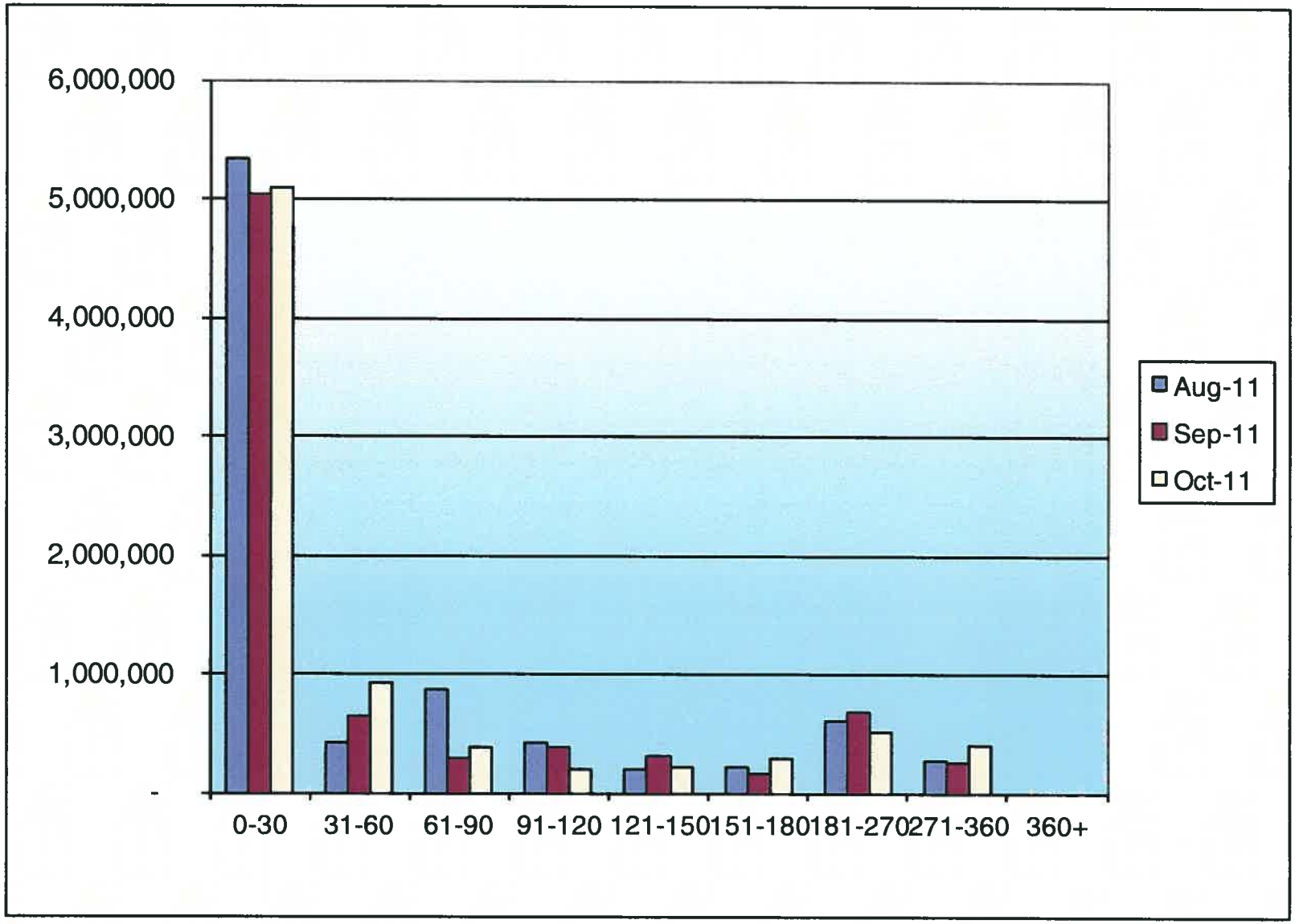
Net A/R by Payor



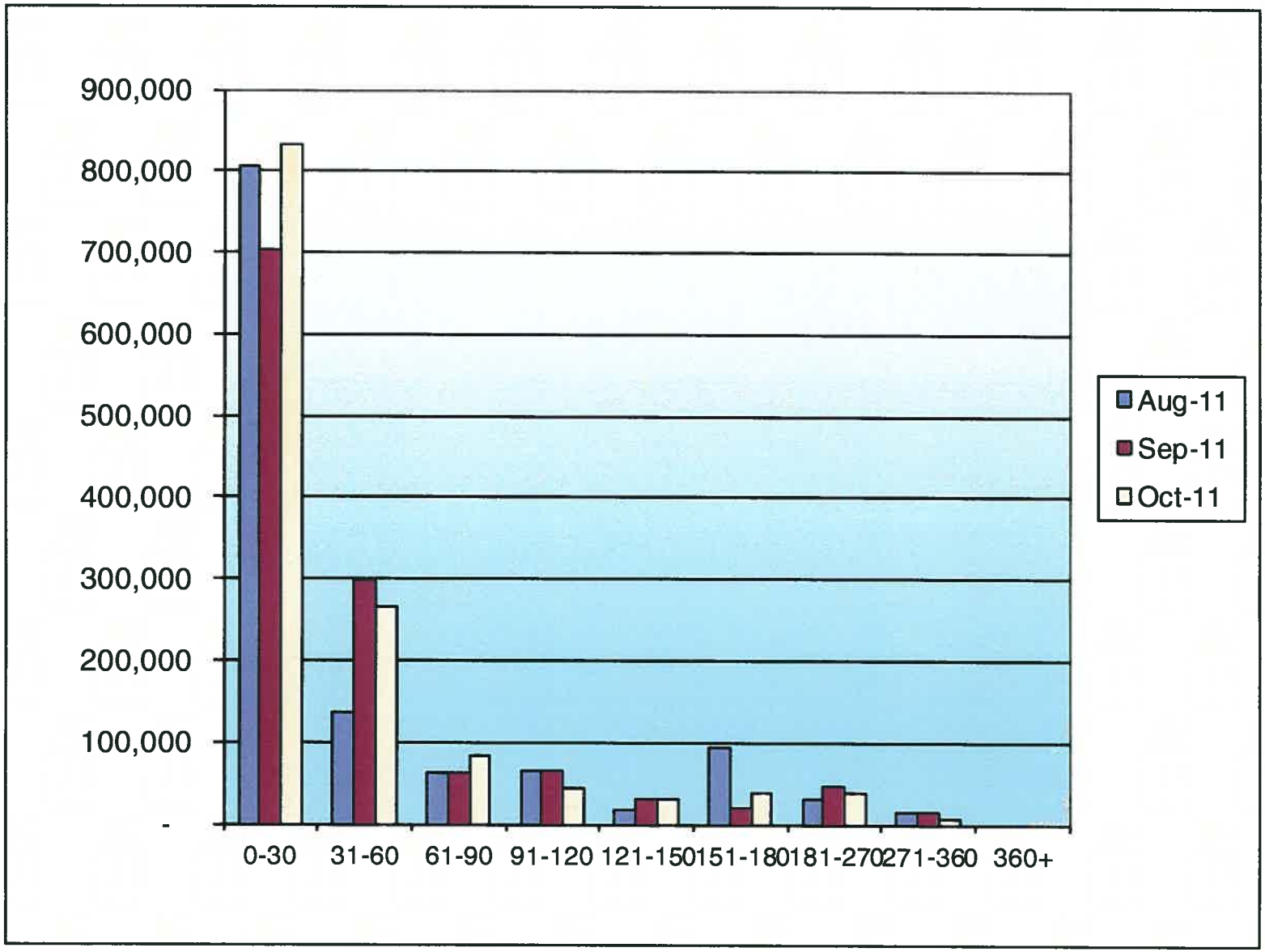
Aged Total Net Accounts Receivable



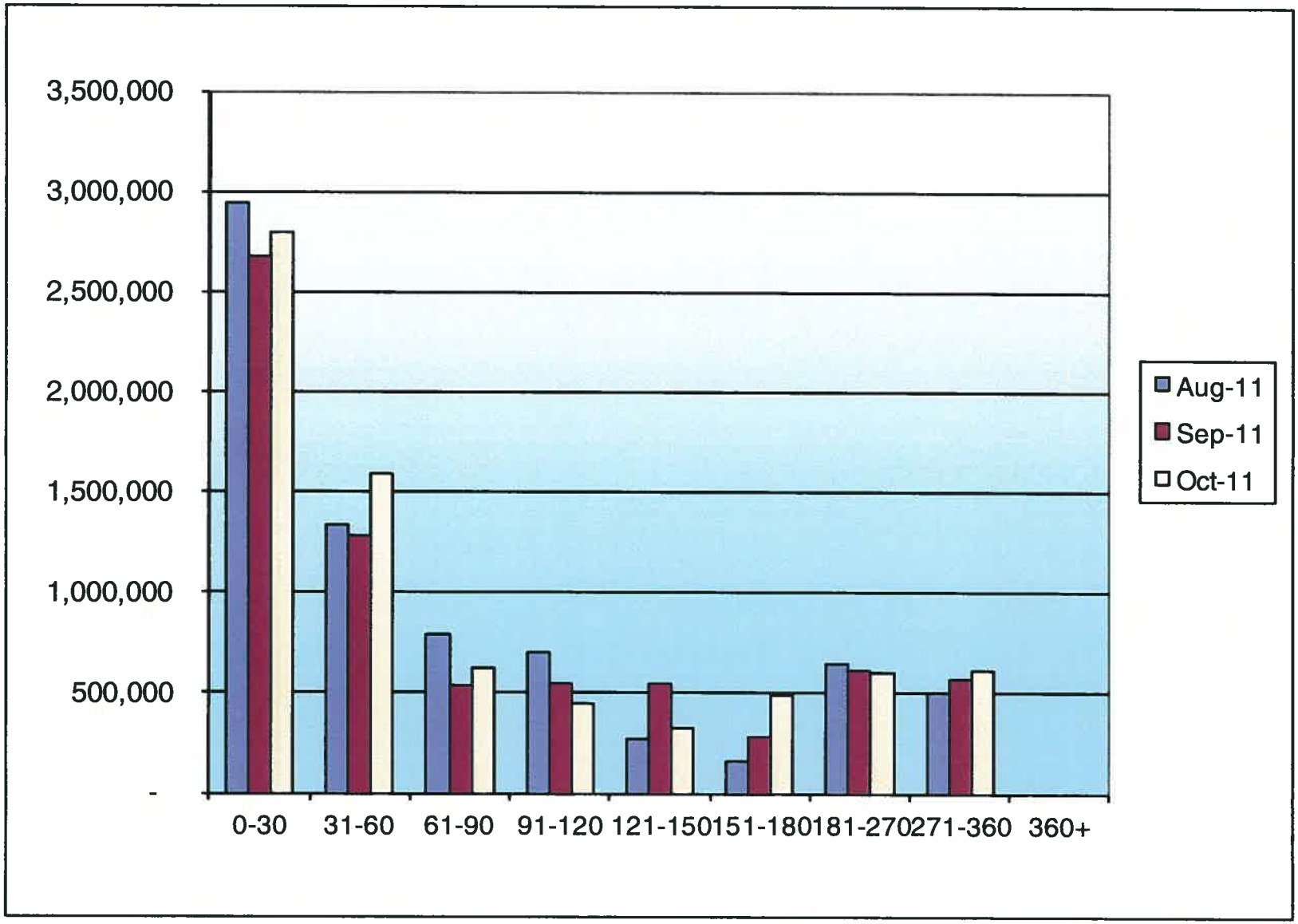
Net Medicare Receivables



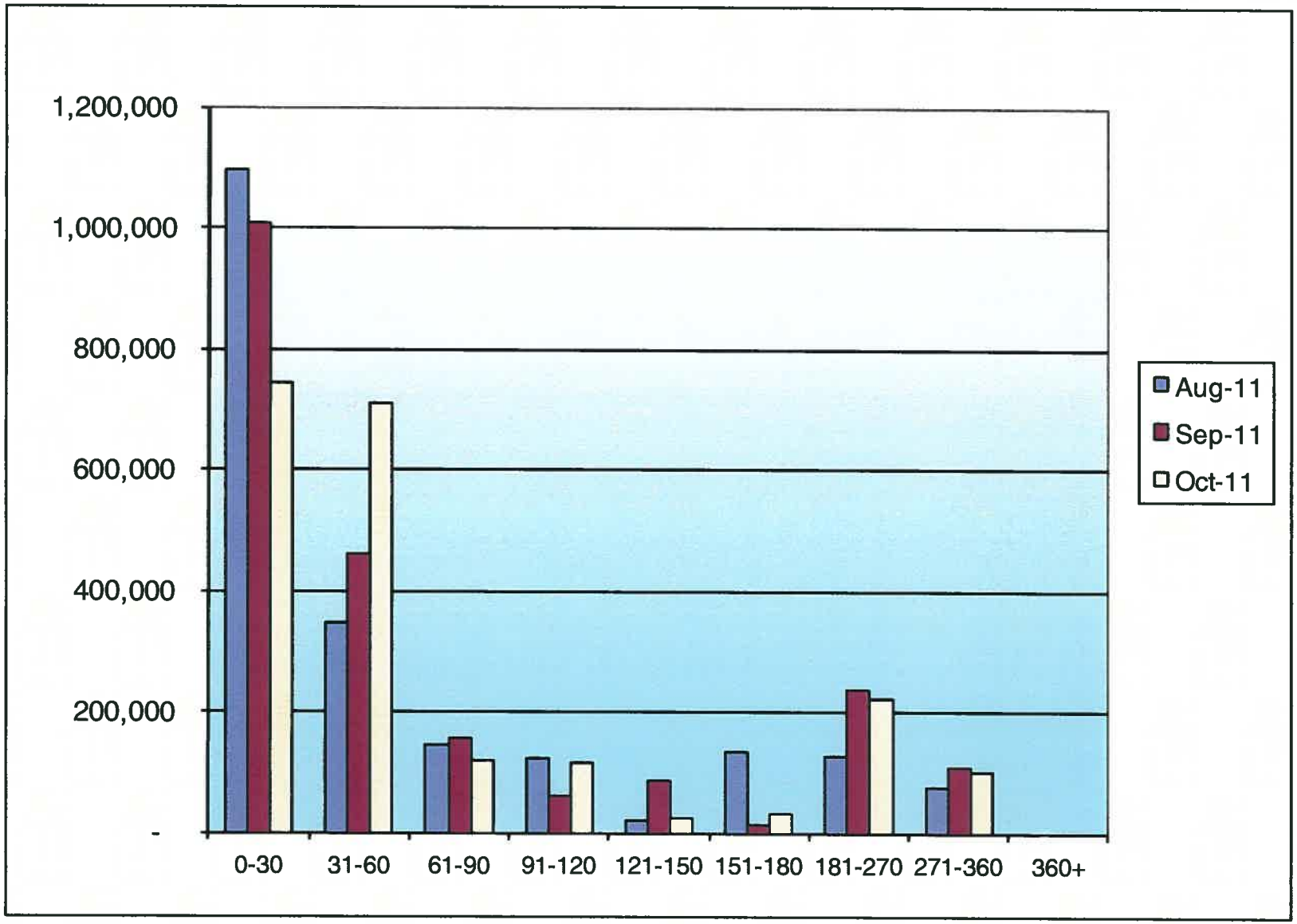
Net Medi-Cal Receivables



Net HMO / PPO Receivables



Net Other Payors Receivables



DOCTORS MEDICAL CENTER

October 2011 Executive Report

Doctors Medical Center had a Net Loss of $2,059,000 in the month of October. As a result, net income was under budget by $2,245,000. The following are the other factors leading to the Net Income variance:

Net Patient Revenue Factors	**Over / (Under)**
HMO/PPO/ Commercial Volume	($1,682,000)
Medi-Cal/ Medi-Cal HMO	($200,000)
Medicare / Medicare HMO	($653,000)

Expenses	
Salaries & Benefits	$246,000
Supplies	$417,000
Rentals & Leases	($52,000)
Other Expenses	($56,000)
Restructuring Costs	($208,000)

Net patient revenue was under budget by $2,745,000. Gross charges were under budget in October 12.4%. Patient days were 4.0% under budget and discharges were 2.0% under budget. The large revenue variance is created by the decrease in HMO/PPO business including rate increases put into the budget that have not occurred. That business group by itself accounted for a $1,682,000 variance from budget. Our volumes in Medicare and Medi-Cal were also under budget resulting in missing the net revenue target.

Salaries and Benefits combined were under budget $246,000 while patient days were 4.0% under budget. Worked FTE's were under budget 11.7% as a reflection of the staffing reduction. The normal flexing of staff for the volume decrease would have been $89,000 but we exceeded that amount by $493,000. Benefits increased this month as employee health benefits cost $170,000 more than was budgeted. Workers Compensation for our employees also ran $ 42,000 over budget. Other Non-Productive pay was over budget $200,000 and is the remainder of the benefit variance.

Supplies were under budget $417,000. Our supplies should have been reduced by $191,000 based on our volume. We were able to flex supplies another $226,000 with most of this reduction in implant and pacemaker costs.

Rentals and Leases were over budget by $52,000 in October. The unbudgeted lease for paragon ($14,000), and the new CT scanner ($27,000), show up this month and will until next fiscal year.

Other expenses were over $56,000 in October. Utility costs exceeded budget by $36,000 and unbudgeted VHA and membership dues for $18,000 were paid in October.

Restructuring Costs in the month were $208,000. These costs are one time unbudgeted costs we are incurring due to the financial restructuring of the hospital.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2011
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
1	8,321	11,066	(2,745)	-24.8%	12,975	Net Patient Service Revenue	98,296	112,251	(13,955)	-12.4%	108,180
2	80	88	(8)	-9.0%	98	Other Revenue	1,022	941	81	8.6%	957
3	8,401	11,154	(2,753)	-24.7%	13,073	**Total Operating Revenue**	99,318	113,192	(13,874)	-12.3%	109,137
						OPERATING EXPENSES					
4	4,645	5,227	582	11.1%	5,581	Salaries & Wages	51,749	53,247	1,498	2.8%	53,079
5	2,687	2,351	(336)	-14.3%	2,503	Employee Benefits	28,425	25,820	(2,605)	-10.1%	25,409
6	850	821	(29)	-3.5%	899	Professional Fees	8,509	8,212	(297)	-3.6%	8,451
7	1,257	1,674	417	24.9%	1,710	Supplies	16,256	17,495	1,239	7.1%	17,540
8	693	672	(21)	-3.2%	821	Purchased Services	8,218	7,358	(860)	-11.7%	7,788
9	271	219	(52)	-23.8%	378	Rentals & Leases	2,509	2,138	(371)	-17.4%	1,742
10	349	350	1	0.3%	316	Depreciation & Amortization	3,467	3,487	20	0.6%	2,975
11	208	-	(208)		326	Restructuring Costs	1,417	-	(1,417)		-
11	379	323	(56)	-17.3%	326	Other Operating Expenses	3,408	3,232	(176)	-5.4%	3,354
12	11,339	11,638	297	2.6%	12,860	**Total Operating Expenses**	123,958	120,990	(2,968)	-2.5%	120,338
13	(2,938)	(483)	(2,455)	508.5%	213	**Operating Profit / Loss**	(24,640)	(7,798)	(16,842)	216.0%	(11,201)
						NON-OPERATING REVENUES (EXPENSES)					
14	258	-	258	0.0%	417	Other Non-Operating Revenue	5,443	-	5,443	0.0%	9,476
15	708	754	(46)	6.1%	755	District Tax Revenue	7,123	7,541	(418)	5.5%	7,713
16	2	9	(7)	-77.8%	6	Investment Income	39	85	(46)	-54.2%	83
17	(89)	(94)	5	0.0%	(118)	Less: Interest Expense	(1,261)	(1,007)	(254)	25.2%	(1,164)
18	879	669	210	31.3%	1,060	**Total Net Non-Operating**	11,344	6,619	4,725	71.4%	16,108
19	(2,059)	186	(2,245)	-1204.7%	1,273	**Income Profit (Loss)**	(13,296)	(1,179)	(12,117)	1027.7%	4,907
						Profitability Ratios:					
20	-35.0%	-4.3%	89.2%		1.6%	Operating Margin %	-24.8%	-6.9%	121.4%		-10.3%
21	-24.5%	1.7%	-26.2%		9.7%	Profit Margin %	-13.4%	-1.0%	-12.3%		4.5%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2011
(Amounts in Thousands)

22	2,272	2,222	(50)	-2.2%	2,183	SWB / APD	2,258	2,080	(179)	-8.6%	1,968
23	64.7%	65.1%			62.9%	SWB / Total Operating Expenses	64.7%	65.3%			65.2%
24	3,513	3,413	(101)	-3.0%	3,472	Total Operating Expenses / APD	3,492	3,183	(309)	-9.7%	3,018
25	33,861	38,110	(4,249)	-11.1%	39,124	I/P Gross Charges	386,109	415,825	(29,716)	-7.1%	393,847
26	20,024	23,391	(3,367)	-14.4%	21,324	O/P Gross Charges	198,752	218,552	(19,800)	-9.1%	191,727
27	**53,885**	**61,501**	**(7,616)**	**-12.4%**	**60,448**	**Total Gross Charges**	**584,861**	**634,377**	**(49,516)**	**-7.8%**	**585,574**
						Payor Mix (IP and OP)					
28	39%	37%	2%		39%	Medicare %	40%	37%	3%		38%
29	10%	17%	-7%		14%	Medi-Cal %	13%	17%	-4%		17%
30	15%	15%	0%		14%	Managed Care HMO / PPO %	11%	14%	-3%		14%
31	10%	10%	0%		11%	Medicare HMO %	9%	10%	-1%		9%
32	11%	7%	4%		8%	Medi-Cal HMO %	11%	7%	4%		7%
33	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
34	2%	1%	1%		1%	Worker's Comp %	1%	1%	0%		2%
35	3%	3%	0%		3%	Other Government %	3%	3%	0%		3%
36	10%	10%	0%		10%	Self Pay /Charity %	10%	10%	0%		10%
						STATISTICS					
37	503	502	1	0.2%	488	Admissions	5,116	5,269	(153)	-2.9%	5,162
38	492	502	(10)	-2.0%	500	Discharges	5,120	5,269	(149)	-2.8%	5,167
39	2,028	2,113	(85)	-4.0%	2,397	Patient Days	23,436	24,919	(1,483)	-6.0%	26,820
40	65.4	68.2	(2.7)	-4.0%	77.3	Average Daily Census (ADC)	77.1	82.0	(4.9)	-6.0%	88.2
41	4.12	4.21	0.09	2.1%	4.79	Average Length of Stay (LOS)	4.58	4.73	0.15	3.2%	5.19
42	31	31			31	Days in Month	304	304			304
43	783	810	(27)	-3.4%	773	Adjusted Discharges (AD)	7,756	8,038	(283)	-3.5%	7,682
44	3,227	3,410	(183)	-5.4%	3,703	Adjusted Patient Days (APD)	35,500	38,016	(2,516)	-6.6%	39,876
45	104	110	(6)	-5.4%	119	Adjusted ADC (AADC)	117	125	(8)	-6.6%	131
46	85	93	(8)	-8.6%	89	Inpatient Surgeries	902	881	21	2.4%	873
47	94	110	(16)	-14.5%	115	Outpatient Surgeries	996	980	16	1.6%	964
48	**179**	**203**	(24)	-11.8%	**204**	**Total Surgeries**	**1,898**	**1,861**	37	2.0%	**1,837**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
October 31, 2011
(Amounts in Thousands)

49	3,068	3,457	(389)	-11.3%	3,253	ED Outpatient Visits	29,677	33,205	(3,528)	-10.6%	29,158
50	3,547	3,673	(126)	-3.4%	3,673	Ancillary Outpatient Visits	36,872	33,578	3,294	9.8%	32,716
51	94	110	(16)	-14.5%	115	Outpatient Surgeries	996	980	16	1.6%	964
52	**6,709**	**7,240**	(531)	-7.3%	**7,041**	**Total Outpatient Visits**	**67,545**	**67,763**	(218)	-0.3%	**62,838**
53	480	393	87	22.1%	416	Emergency Room Admits	4,539	4,176	363	8.7%	4,417
54	15.6%	11.4%			12.8%	% of Total E/R Visits	15.3%	12.6%			15.1%
55	95.4%	78.3%			85.2%	% of Acute Admissions	88.7%	79.3%			85.6%
56	583	661	77	11.7%	657	Worked FTE	652	661	9	1.4%	626
57	676	781	105	13.4%	743	Paid FTE	763	769	6	0.8%	724
58	5.60	6.01	0.40	6.7%	5.50	Worked FTE / AADC	5.58	4.83	(0.75)	-15.5%	4.77
59	6.49	7.10	0.61	8.5%	6.22	Paid FTE / AADC	6.53	5.62	(0.91)	-16.1%	5.52
60	2,578	3,245	(667)	-20.5%	3,503	Net Patient Revenue / APD	2,769	2,953	(184)	-6.2%	2,713
61	16,697	18,036	(1,339)	-7.4%	16,322	I/P Charges / Patient Days	16,475	16,687	(212)	-1.3%	14,685
62	2,985	3,231	(246)	-7.6%	3,029	O/P Charges / Visit	2,943	3,225	(283)	-8.8%	3,051
63	1,439	1,533	94	6.1%	1,507	Salary Expense / APD	1,458	1,401	(57)	-4.1%	1,331
64	4.4	4.3	(0.09)	-2.0%	4.9	Medicare LOS	5.1	4.9	(0.18)	-3.6%	5.3
65	1.41	1.51	0.11	7.0%	1.52	Medicare CMI	1.55	1.56	0.00	0.2%	1.54
66	3.12	2.85	(0.28)	-9.7%	3.24	Medicare CMI Adjusted LOS	3.26	3.14	(0.12)	-3.8%	3.42
67	4.1	4.2	0.09	2.1%	4.8	Total LOS	4.5	4.7	0.20	4.2%	5.22
68	1.360	1.520	0.16	10.5%	1.509	Total CMI	1.482	1.517	0.04	2.3%	1.482
69	3.03	2.77	(0.26)	-9.4%	3.17	Total CMI Adjusted LOS	3.06	3.12	0.06	1.9%	3.52

DOCTORS MEDICAL CENTER

PALLIATIVE CARE PROGRAM AND CATH LAB POLICIES

TAB 9

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

†TITLE: 4 policies and mission statement/goals Palliative care Program: 1. Palliative care referral 2. Palliative Plan of care and continuity of care 3. Scope of care 4. Spiritual needs assessment	†CHECK ONE: XNew ☐Reviewed ☐ Revised : ☐ Major ☐Minor

† X Administrative X Clinical ☐Department _____

†SUBMITTED BY: Eileen Scott RN,OCN, Clinical Director Cancer Center

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

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

Policies reflect program objectives, goals and mission, scope of care, patient clinical care, process for referrals and process for program quality improvement initiatives for assurance of quality of care and meeting regulatory requirements of commission on cancer and TJC.

	MEETING DATE	APPROVAL
☐ **Manager or Department Director**†		
☐ **Medical Staff Department(s):**		
X Cancer Committee ☐ CV Surgery Committee	Sept 14, 2011	
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☐ P&T Committee		
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☐ EM Committee		
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
X **Administrative Policy Review Committee (APRC)**†	pending	
☐ **Executive Leadership**		
☐ **Medical Executive Committee (MEC)** (as applicable)		
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual: Cancer Center	Sub Folder: Palliative Care Program
Title: The Palliative Care Referral	Originated: 9/11 Reviewed: Revised:
Board Approval/Effective Date:	Page 1 of 4

PURPOSE: To assist physicians, staff, patients and families in making appropriate palliative care referrals and to help coordinate the care, treatment and services to patients needing palliative care in a timely manner.

POLICY: The referral process is be handled according to the procedure below.

RESPONSIBILITY: Referring staff/physicians, palliative care team.

PROCEDURE:

Making a referral:

- A referral to the palliative care service can come from many sources: physicians, nurses, family members, patients, social workers and clergy are some of the more common sources.
- With each referral, the palliative care nurse and social worker assess the patient for eligibility to the palliative care program. If found eligible, the palliative care team notifies the attending or primary care physician of the referral and requests permission to provide a palliative care physician consultation (see Palliative Care Screening Tool in Appendix A).
- The patient referral to the palliative care program will be sent by phone or fax along with pertinent medical records, labs and other data.

Responding to a consult request:

- The palliative care team responds to all requests for referrals/consultations even if the initial request seems inappropriate for continued follow-up (e.g., address uncontrolled post -operative pain). These consultations are opportunities to build relationships with referring physicians and educate staff on the scope and benefits of palliative care.
- If the palliative care team member determines that a palliative care referral is not appropriate for continued follow-up, the palliative care team helps resolve the current situation and facilitates patient access to the appropriate resource(s).
- If the palliative care team determines the patient will benefit from the program the primary care physician is called, the patient condition and needs discussed and the patient referral to the program is requested.

Role of the palliative care team after initial consultation:

- Based on the specific needs of the patient, discussion ensues between the palliative care team member and the primary care physician to determine the role of the palliative care team.
- Once a decision is made about the role of the palliative care team, the patient and family members (as appropriate) are involved in subsequent assessment, planning and treatment of the patient.
- The role of the palliative care team can be:
    - Providing advice to patient/family or staff (e.g., no orders are written by the palliative care physician/nurse practitioner)
    - Consulting with orders (e.g., provide pain management and symptom control)

REFERENCES: Center to Advance Palliative Care : www.capc.org 2011

Responsible for review/updating (Title/Dept)	Title Director, Cancer Center Dept Cancer Center

Appendix A

DOCTORS MEDICAL CENTER Regional Cancer Center, Palliative Care Program Nov. 2011	Patient Name: DOB MR#

Screening Worksheet for Cancer Patient
Palliative Care Consult

Please check ONLY the criteria that apply to your patient.

	1. Patient is not believed to benefit from cancer directed therapy or whose quality of life has been significantly negatively affected by their cancer treatment or disease process. Comment:
	2. Patient needs assistance with symptom management, especially uncontrolled acute pain, nausea and vomiting, dyspnea, malignant bowel obstruction and constipation. Comment:
	3. Patient is critically ill with no advanced directive or plan of care established. Comment:
	4. Patient is a full code with overall poor prognosis and has disparate advanced directive (AD) goals. Comment:
	5. Patient has a family in disagreement with pt AD. Example: • Artificial hydration / nutrition requested by family or patient with a short anticipated survival from their underlying medical condition. • Patient or family of patient has unrealistic goals of care or expectations for recovery. **Please explain:**_____ _____ _____ Comment:
	6. Patient needs assistance with goals of care planning and/or consideration for hospice referral. Comment:
	7. Patient or family requests a palliative care consult. The care managers, nurses or physician believes that the patient or family could benefit from a palliative care consultation Comment:
	Additional Comments:_____ _____ _____ _____ _____

Palliative Care Referral not submitted: ❑ Family refused ❑ Patient refused
❑ Referral delayed_____
❑ Other: _____

Discussed with Primary care physician (Must be attending physician only.)

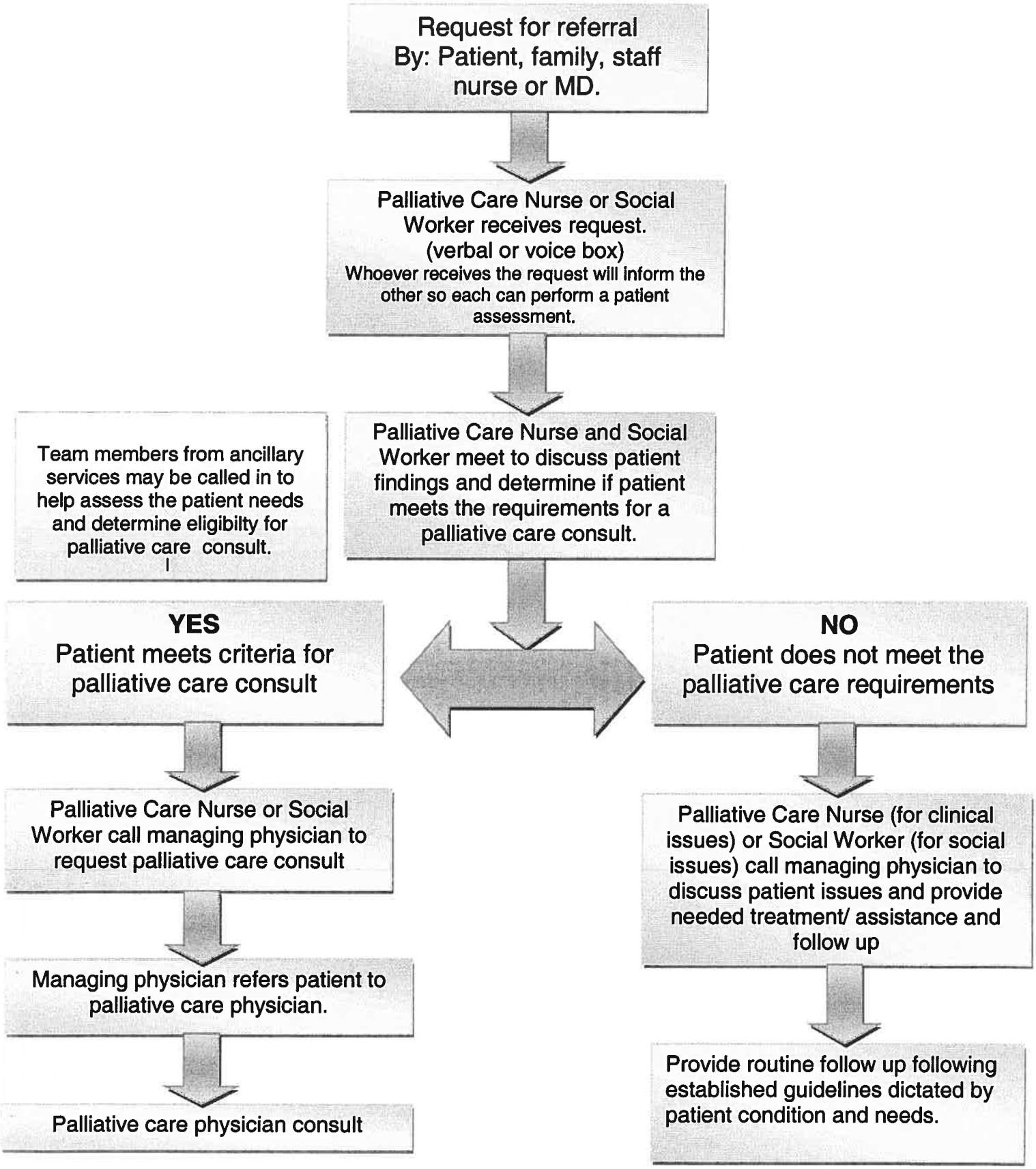
Physician name (print): _____

If one or more criteria are checked, please consider Palliative Care consult.
Consult Ordered? ☐ **YES** ☐ **NO**

Completed by:
Name: _____/_____Title_____Date/time: ____
Print Signature

11/2011

Palliative Care Referral Process Flow



11/2011

DOCTORS MEDICAL CENTER

Manual: Cancer Center	Sub Folder: Palliative Care Program
Title: Plan of Care and Providing Continuity of Care	Originated: 9/11 Reviewed: Revised:
Board Approval/Effective Date:	Page 1 of 2

Purpose:
To ensure care planning is individualized, multidisciplinary and based on the assessed needs of the patient and to assure care throughout the continuum of patient treatment.

Definition:
Continuity of care: The multidisciplinary coordination of care that includes or considers all clinical diagnoses, treatments, psychosocial needs, patient preferences and personal resources throughout the continuum patient treatment.

Policy:
All patients will have a multidisciplinary, individualized, documented care plan that is based on the assessed needs of the patient. All patients will receive a comprehensive assessment by the palliative care team. The care plan is developed based on the assessment, the patient's current status, the resources available in the home and in the community, and the care needs of the patient. The team refers patients to clinical and community resources based on their documented needs and regardless of their ability to pay for services. When an agency/program denies care, treatment or services, or when a payer denies reimbursement, the team works with the patient and family to identify alternative sources of care and support.

Responsibility: Palliative care team

Procedure:
- Based on presenting problems, appropriate team members assess the patient and develop a plan of care. Care plan changes are based on the evolving needs and preferences of the patient and family over time, and will recognize the complex, competing and shifting priorities in goals of care.
- The care plan is considered a factor from the time the patient is admitted to the palliative care program. It is based on ongoing patient and family assessments and determined by goals set with the patient and family. Consideration is taken of the patient's changing benefit/burden assessment at critical decision points during the course of illness.
- The palliative care team is responsible for the multidisciplinary coordination that drives the care plan. The care plan is developed through the input of patient, family, caregivers, involved health care providers and the palliative care team with the additional input, when indicated, of other specialists and caregivers, spiritual advisors, friends, etc.

- The multidisciplinary team coordinates and shares the information, provides support for decision-making, develops and carries out the care plan, and communicates the palliative care plan to patient and family, to all involved health professionals, and to the responsible providers when patients transfer to different care settings.

- The team arranges access to services that can assist the patient with various social needs. This includes, but is not limited to:
    - Home care
    - Transportation
    - Rehabilitation
    - Medications
    - Counseling

- The sharing of information is documented on the Multidisciplinary Team Progress form.

REFERENCES:

Center to Advance Palliative Care : www.capc.org 2011

Responsible for review/updating (Title/Dept)	Title Director, Cancer Center Dept Cancer Center

DOCTORS MEDICAL CENTER

Manual: Cancer Center	Sub Folder: Palliative Care Program
Title: Defining Scope of Care	Originated: 9/11 Reviewed: Revised:
Board Approval/Effective Date:	Page 1 of 2

PURPOSE:
To define the practice of palliative care and ensure appropriate cancer patient referrals into the Cancer Center palliative care program.

Definition:
Palliative Care:

- Is the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients and their families with chronic, debilitating, or life threatening cancer.
- May be complementary to other therapies that are available and appropriate to the identified goals of care.

POLICY:
The Palliative Care Program:

- Admission to the Cancer Center Palliative Care Program requires a cancer diagnosis.
- Consists of an MD, RN and/or NP, MSW, and spiritual advisor.
- Defines immediate and long term goals of care and promotes advance care planning.
- Optimizes symptom control.
- Optimizes functional status when appropriate.
- Promotes the highest quality of life for the patient and family.
- Educates patients and family to promote understanding of the underlying disease process.
- Establishes an environment that is comforting and healing.
- Assists actively dying patients and their families in preparing for and managing self-determined life closure by referring to hospice services when appropriate.

The Palliative Care Team:

- Promotes timely access to palliative care services.
- Provides physical, psychological, social and spiritual support to the patient and family.
- Facilitates patient understanding of diagnosis and prognosis to promote informed choices.
- Assists patients in establishing goals of care and establishing priorities.
- Encourages advanced care planning.
- Facilitates care planning with family to meet multidimensional care needs caused by life-limiting illness.
- Collaborates with primary care professionals in developing a plan of care.
- Serves as educators and mentors for staff.

Quality of Care:

- Palliative care team meetings will occur at regular intervals with multidisciplinary attendance depending on the patient needs. Discussion will occur regarding patient progress and ongoing assessments and changes needed in the care plan. Meeting discussion and action plans will be documented and subjected to quarterly review for Quality Assurance (QA) by the Quality Improvement (QI) committee of the Cancer Committee.
- Palliative Care patients will be surveyed for satisfaction and results reported to the QI committee of the Cancer Committee.
- Routine statistical data on the Palliative Care Program will be submitted to the Cancer Committee biannually.
- The palliative care team will meet quarterly to review quality improvement initiatives identified in the Quality Improvement Plan. The Quality Improvement Plan will be defined annually at the first quarter Cancer Committee meeting. The plan is reviewed annually and recommendations are submitted via hospital wide QI reporting mechanisms.

Core Competencies:

- Core competencies of the palliative care team require that the palliative care needs of patients can be matched and coordinated expeditiously and to demonstrate that these competencies are consistent with the hospital's scope of care.

REFERENCES: Center to Advance Palliative Care : www.capc.org 2011

Responsible for review/updating (Title/Dept)	Title Director, Cancer Center Dept Cancer Center

DOCTORS MEDICAL CENTER

Manual: Cancer Center	Sub Folder: Palliative Care Program
Title: Spiritual Needs Assessment	Originated: 9/11 Reviewed: Revised:
Board Approval/Effective Date:	Page 1 of 3

Purpose: To provide an outline for the comprehensive assessment of spiritual needs and desires of the palliative care patient for implementing spiritual comfort and guidance.

Policy: A spiritual assessment will be completed for all patients upon entering the Palliative Care Program. The spiritual assessment will be incorporated into the patient care plan. Care plan changes are based on the evolving needs and preferences of the patient and family over time and the spiritual needs will be reassessed to accommodate the shifting priorities in the patient's goals of care.

The SPIRIT model (abridged: Maugans, 1997; Ambuel & Weissman, 1999) will be used for patient assessments. The following is the SPIRIT assessment:

SPIRIT

S - Spiritual belief system

P - Personal spirituality

I - Integration with a spiritual community

R - Ritualized practices and Restrictions

I - Implications for medical practice

T - Terminal events planning

- In addition, it is important to determine if the family is involved with the patient's spirituality or possibly opposed to some aspects.
- Following the assessment, a plan of spiritual care and implementation of the plan is to be developed and shared with the palliative care team.
- The attached worksheet will be used to assist in the completion of the Spiritual Assessment.
- Patient progress, assessments and action plans will be documented in the patient medical record and tracked in the patient assessment and care plan form.

REFERENCES:

1. Ambuel & Weissman, 1999; originally edited by David E Weissman MD. 2nd Edition published August 2005. Current version re-copy-edited March 2009.
2. Maugans, 1997; most current source 2009; http://cancerresearch.umaryland.edu/spirituality.htm

Responsible for review/updating (Title/Dept)	Title Director, Cancer Center	Dept Cancer Center

Cancer Center Palliative Care Program

Questions to assist in the completion of an individualized Spiritual Care Plan.
(adapted from Maugans, 1997)

Spiritual belief system:
Do you have a formal religious affiliation? Can you describe this? Do you have a spiritual life that is important to you?

Personal spirituality:
Describe the beliefs and practices of your religion that you personally accept Describe those beliefs and practices of your religion that you do not accept or follow. In what ways is your spirituality/religion meaningful for you?

Integration with a spiritual community:
Do you belong to any religious groups or communities? How do you participate in the group/community? What importance does this group have for you? What types of support and help does or could this group provide for you in dealing with health issues?

Ritualized practices and restrictions:
What specific practices do you carry out as part of your religious and spiritual life? What lifestyle activities or practices does your religion encourage, discourage or forbid? To what extent have you followed these guidelines? What aspects of you religion/spirituality would you like to keep in mind as we care for you?

Implications for medical practice:
Are there specific elements of medical care your religion discourages of forbids? To what extent have you followed these guidelines? What aspects of you religion/spirituality would you like to keep in mind as we care for you?

Terminal events planning:
Are there particular aspects of medical care that you wish to forego or have withheld because of your religion/spirituality? Are there religions or spiritual practices or ritual that you would like to have available in the hospital or at home? Are there religious or spiritual practices that you wish to plan for at the time of death, or following death? As we plan for your medical care near the end of life, in what ways will your religion and spirituality influence your decisions?

REFERENCES:

1. Ambuel & Weissman, 1999; originally edited by David E Weissman MD. 2nd Edition published August 2005. Current version re-copy-edited March 2009.
2. Maugans, 1997; most current source 2009; http://cancerresearch.umaryland.edu/spirituality.htm

DOCTORS MEDICAL CENTER Regional Cancer Center, Palliative Care Program 11/2011	Patient Name: DOB MR#

Date/Time_____ Interviewed by: Print:_____/ Signature: _____

SPIRITUAL ASSESSMENT

Formal religion affiliation :
Name and address of place of worship:
Spiritual belief system:
Personal spirituality:
Integration with a spiritual community:
Ritualized practices and Restrictions:
Implications for medical practice:
Terminal events planning:
Family involvement with patient's spiritual beliefs and practices
Do you wish us to notify your place of worship/spiritual leader if you are hospitalized?
Plan:
□Translator utilized. □ Follow-up needed
Implementation:

DOCTORS MEDICAL CENTER

Manual: CATH LAB	**Sub Folder: Safety**
Title: Fire Safety & Fire Risk Assessment in Cath Lab	**Reviewed:** **Revised:**
Effective Date: 9/2011	**Page 1 of 3**

PURPOSE:

To define department specific Fire Safety Procedure within Cardiac Catheterization Laboratory.

SUPPORTIVE DATA and DEFINITIONS

The Cardiac Catheterization Laboratory (Cardiac Cath Lab) fire safety procedure is intended to minimize the risk of injury to patients and employees by adherence to policies/procedures as outlined in the Fire Prevention Management Plan and the OR Fire Disaster and Evacuation Plan.

Fire Triangle:

PROCEDURE

A. Fire Risk Assessment

1. A Fire Risk Assessment is performed by the surgical team as part of the Time Out immediately prior to the start of each procedure in the Cardiac Cath Laboratory. The circulating or bedside RN assesses the potential fire risks
   - Open Oxygen Source
   - Available Ignition Source
   - Surgical Site Above The Xiphoid (< 30 cm /12 inches from Oxygen source)
2. If an item is present a score of 1 is applied, if the item is not present a score of 0 is applied. The numbers are added to achieve the Fire Risk Assessment Score. Fire Risk Scores may range from the lowest risk score of 0 to the highest risk score of 3.
3. Based on the resulting Fire Risk Assessment score, the Cardiac Cath team will take the required precautions associated with each score as listed below:

Fire Risk Score of 0 - 1

A fire risk assessment score of 0-1 indicates a low level risk of fire and the routine fire safety protocol is followed.

Routine protocol:

- If using alcohol based solutions for a surgical prep, use the minimal amount of solution needed.
- Allow sufficient drying time (a minimum of 2 minutes) to effectively allow the dissipation of fumes.
- Do not drape until the prep area is fully dry.
- Do not allow pooling of any prep solution (including under the patient).

- Close open bottles of flammable agents and remove all bowls of volatile solutions from the sterile field as soon as possible after use.
- Utilize standard draping procedure.
- Check all electrical equipment before use.
- Protect all heat sources when not in use

Fire Risk Score of 2

A fire risk assessment score of 2 indicates a low risk of fire and the routine fire safety protocol is followed. However, a fire risk score of 2 has the potential to convert to a high fire risk of 3.

- If the fire risk converts to a high risk of 3, a fire safety moment of verification must take place.
- The RN verbalizes the high fire risk score to the team, the fire triangle (heat source, fuel, and oxidizers) is assessed and the appropriate safety measures applied as indicated below.

Fire Risk Score of 3

A fire risk assessment score of 3 indicates the highest risk of fire and the high fire safety protocol is followed.

High Risk Protocol:

- Include all routine protocol measures
- Utilize appropriate draping techniques used to minimize oxygen concentration (tenting, incise drape etc)
- Minimize the Electrical Surgical Unit (ESU) setting.
- Use wet sponges as appropriate.
- Have a basin of sterile saline and bulb syringe readily available for suppression purposes only

B. Fire Safety Strategies

1. Electrical Equipment and Cords:
   a. Check all electrical equipment, cords, and plugs for damage and verify inspection sticker is current before each use.

C.EDUCATION

1. The Departmental Fire Safety Procedure are reviewed at the time of hire and at least annually through in-service programs and / or use of a self-learning tool.
2. Records for annual Fire Safety education are maintained in Healthstream.

REFERENCE:

ECRI, Health Devices 35 (2), February 2006, Surgical Fire Safety, pp 45-66.

AORN Standards, Recommended Practices, and Guidelines (2007), Statement on Fire Prevention, pp. 385-386.

AORN Standards, Recommended Practices, and Guidelines (2007), Guidance Statement on Fire Prevention, pp. 259-268.

Responsible for review/updating (Title/Dept)	**Cath Lab Director** **Title**	**Cath Lab** **Dept**

DOCTORS MEDICAL CENTER

QUALITY REPORT

TAB 10

West Contra Costa County Health District Board Meeting

November 16, 2011

JULI MAXWORTHY, VP, QUALITY/RISK MANAGEMENT

INFECTION CONTROL UPDATE

INFECTION CONTROL UPDATE

Legend: N = Numerator D = Denominator Rate=N/D x 1000

			July	Aug	Sept	Q3 2010	Oct	Nov	Dec	Q4 2010	Jan	Feb	Mar	Q1 2011	Apr	May	Jun	Q2 2011	COMPARISON BENCH MARK
PERFORMANCE INDICATORS																			
Ventilator Associated Pneumonia (VAP)	# VAP	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	# Vent days	D	218	134	311	663	250	188	182	620	256	252	259	767	275	144	157	576	2.7
	Rate		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Blood Stream Infections (Central Venous Catheters= CVC) ICU	#CVC	N	0	1	0	1	1	0	0	1	0	0	0	0	1	0	0	1	
	# Device Days	D	248	108	266	622	214	197	194	605	239	232	205	676	234	115	149	498	2.2
	Rate		0.0	9.3	0.0	1.6	4.7	0.0	0.0	1.7	0.0	0.0	0.0	0.0	4.3	0.0	0.0	2.0	
Blood Stream Infections (Central Venous Catheters= CVC) NON-ICU	#CVC	N	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	
	# Device Days	D	396	359	323	1078	202	288	291	781	239	169	239	647	286	223	125	634	2.6
	Rate		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	0.0	0.0	1.5	0.0	0.0	0.0	0.0	
Catheter Associated UTI (UTI=Urinary Tract Infection) ICU	#UTI	N	0	0	1	1	1	0	1	2	2	1	0	3	3	0	1	4	
	# Device Days	D	262	237	360	859	308	242	282	832	348	376	353	1077	382	248	250	880	3.1
	Rate		0.0	0.0	2.8	1.2	3.2	0.0	3.5	2.4	5.7	2.7	0.0	2.8	7.9	0.0	4.0	4.5	
Catheter Associated UTI (UTI=Urinary Tract Infection) NON-ICU	#UTI	N	0	0	3	3	3	1	1	5	4	1	0	5	0	0	0	0	
	# Device Days	D	459	490	390	1339	364	402	560	1326	467	487	488	1442	400	403	405	1208	2.6
	Rate		0.0	0.0	7.7	2.2	8.2	2.5	1.8	3.8	8.6	2.1	0.0	3.5	0.0	0.0	0.0	0.0	
Total Infections Hospital-wide	#Infections	N	**0**	**1**	**4**	**5**	**5**	**1**	**2**	**8**	**7**	**2**	**0**	**9**	**4**	**0**	**1**	**5**	
	# Device Days	D	**1583**	**1328**	**1650**	**4561**	**1338**	**1317**	**1509**	**4164**	**1549**	**1516**	**1544**	**4609**	**1577**	**1133**	**1086**	**3796**	
	Rate		**0.0**	**0.8**	**2.4**	**1.1**	**3.7**	**0.8**	**1.3**	**1.9**	**4.5**	**1.3**	**0.0**	**2.0**	**2.5**	**0.0**	**0.9**	**1.3**	

Variance Analysis:

Non-ICU areas: Quarter 2, 2011: No Hospital Acquired Infections noted

ICU areas: Quarter 2, 2011: 4 CAUTIs observed. One CLABSI in April 2011. No VAPs observed in Q2, 2011.

Action Plan:

Non-ICU areas: Infection Control Preventionist is working with nursing staff to maintain sterility during urinary catheter insertion, daily catheter care and removal if possible.

ICU areas: Infection Control Preventionist attended ICU staff meetings enforcing "scrub the hub". New needleless connectors have been implemented. Education has hosted Infection Prevention in Central Line Management classes.

ORGAN DONATION

SCORECARD FOR QUARTER 2 2011

California Transplant Donor Network

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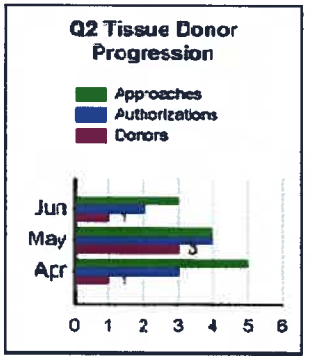
Tissue Donation & Referral Scorecard Q2 2011

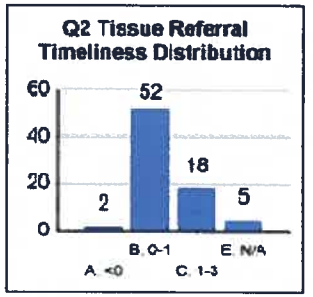
Doctors Medical Center San Pablo

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL
All Referrals	Deaths	26	32	31	27	26	24	-	-	-	-	-	-	166
	Referrals	25	31	30	27	26	24	-	-	-	-	-	-	163
Tissue Donors	Potentials	2	6	5	5	4	3	-	-	-	-	-	-	25
	Approaches	2	6	5	5	4	3	-	-	-	-	-	-	25
	Authorizations	0	3	2	3	4	2	-	-	-	-	-	-	14
	Donors	0	2	2	1	3	1	-	-	-	-	-	-	9

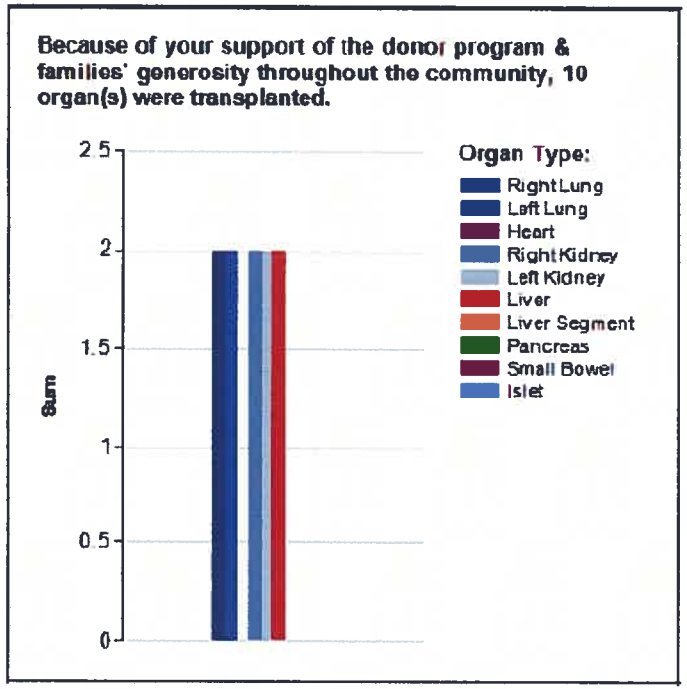


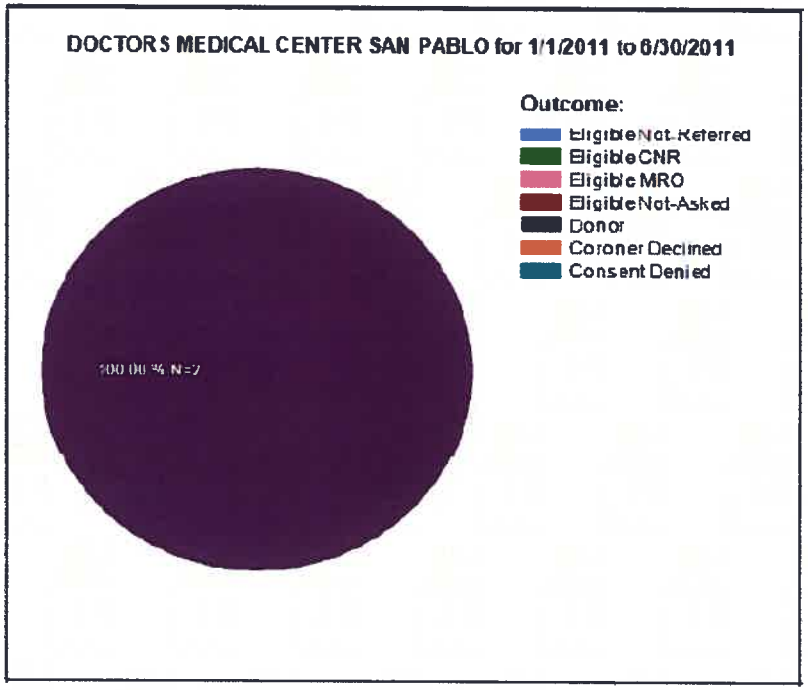
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Rate
Process Measures	Referral Rate	96%	97%	97%	100%	100%	100%	-	-	-	-	-	-	98.19%
	Timely Referral	86%	70%	69%	65%	68%	9[illegible]%	-	-	-	-	-	-	74.32%
	Average Death to Referral	43m	47m	17h 19m	53m	52m	33m	-	-	-	-	-	-	3h 40m
Outcome Measures	Authorization Rate	0%	50%	40%	60%	100%	67%	-	-	-	-	-	-	56.00%
	Conversion Rate	0%	33%	40%	20%	75%	33%	-	-	-	-	-	-	36.00%

Impressive numbers for June



10 ORGANS DONATED TO SAVE LIVES





This report has been prepared by The California Transplant Donor Network (CTDN). CTDN has made a reasonable effort to ensure that the accompanying information is up-to-date, accurate, complete, and comprehensive at the time of disclosure. CTDN is not responsible for data that is misinterpreted or altered in any way. The information disclosed here in is confidential and intended for the sole use of the original requestor. No other use of this information is allowed without prior written consent of CTDN and maybe subject to restriction in accordance with applicable laws governing healthcare information.

QUALITY UPDATES

PATIENT SATISFACTION SUMMIT

- What: Patient Satisfaction Summit to develop our plan for 2012
- When: During early part of the first quarter of 2012
- Why: To discuss our opportunities for improving the patient experience
- Who:
  - Board members
  - Medical staff
  - Management
  - Patients
- Save the Date invitations to be distributed soon

SENTINEL EVENT ALERT

- The Joint Commission recently issued an alert regarding the over utilization of ionizing radiation. This document cited the risks versus benefits of diagnostic radiology procedures, especially computerized tomography exams. They noted how the use of diagnostic radiographic exams had double in the last 20 years, especially the over usage of CT exams. While they noted the amount of side effects that may arise from this huge increase, they did not lose sight of the great number of beneficial diagnoses that were made due to these exams.
- As a result of these concerns multiple safety regulations/controls have been put into place by Centers for Medicaid/Medicare Services, the Joint Commission and the State of California's department of radiologic health. Doctors Medical Center is compliant in all areas per Wiley Watterlond, Director of Imaging Services.

- Patient Safety Plan
  - Reviewed and approved by appropriate committees
- Utilization Management
  - Recent utilization data identifies that the overall length of stay for September was 3.72 (lowest rate since 6/2009)
  - Most common discharge diagnosis during period between 1/1/2011 and 8/31/2011 was chest pain with heart failure second
- Immunization Screening Form Update
  - Due to changes in screening requirements by the Joint Commission and CMS the form has been updated to reflect the new requirements