DOCTORS
MEDICAL CENTER

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

Wednesday, January 29, 2014

4:45 PM

Doctors Medical Center
Auditorium

2000 Vale Road

San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
JANUARY 29, 2014 – 4:45 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

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

AGENDA

1. **CALL TO ORDER** — E. Zell

2. **ROLL CALL**

3. **APPROVAL OF MINUTES OF DECEMBER 18, 2013** — E. Zell

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

5. **QUALITY MANAGEMENT REPORT** — B. Nissila
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Acceptance of the January 2014 Quality Management Report

6. **STROKE CENTER PRESENTATION** — D. Carson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: For Information Only

7. **FINANCIALS – DECEMBER 2013** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the December 2013 Financials*

8. **REVISIONS TO LOCAL ONE COLLECTIVE BARGAINING CONTRACT** B. Redlo
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of Revisions to Local One Contract*

9. **RESOLUTION: EMPLOYEE RECOGNITION** B. Redlo
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Adoption of Resolution No. 2014-03*

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

11. **MEDICAL EXECUTIVE REPORT** R. Stern, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the MEC report and the Credentials Committee Report of the Medical Staff*

ADJOURN TO CLOSED SESSION

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

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

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

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

DOCTORS
MEDICAL CENTER

MINUTES
DECEMBER 18, 2013

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS

December 18, 2013 4:45 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 4:52 P.M.

2. ROLL CALL

Quorum was established and roll was called: 4:56 PM

Present:	Eric Zell, Chair
	Supervisor John Gioia, Vice Chair
	Irma Anderson
	Deborah Campbell
	Nancy Casazza
	Sharon Drager, M.D.
	Pat Godley
	Richard Stern, M.D.
	Beverly Wallace
	William Walker, M.D
Excused:	Wendell Brunner, M.D.

3. APPROVAL OF NOVEMBER 12 , 2013 MINUTES

The motion made by Sharon Drager, M.D. and seconded by Director Irma Anderson to approve the November 12, 2013 minutes passed unanimously.

4. **PUBLIC COMMENTS**

No Comment

5. **QUALITY MANAGEMENT REPORT**

Ms. Bobbie Ellerston, Chief Nursing Officer, introduced the new Director of Quality Management and Medical Staff; Rebecca Nissila. The Governing Body welcomed Ms. Nissila to Doctors Medical Center.

Ms. Ellerston provided an update on the 3rd quarter pharmacy report, showing that overrides continue to decrease and adverse drug reactions continue to run below the national benchmark.

She reported that the procedural sedation and nursing quality indicators for the 3rd quarter are at 100% compliance in all indicators. Restraint use is monitored following three indicators, and two of those were below compliance. These indicators have been reviewed with nursing staff and plans for remediation adopted. The Donor Network had one area of noncompliance and is being reviewed with staff on a quarterly basis.

Ms. Ellerston provided an update on core measures for the 3rd quarter, focusing on the one indicator in AMI and three indicators for VTE Prophylaxis that were below the 90% threshold. The AMI indicator has been reviewed at the appropriate medical staff committees and VTE Prophylaxis indicators have resulted in a revision to the Computerized Physician Order Entry (CPOE) orders and a focus on the Warfarin discharge instructions.

A motion was made by Supervisor Gioia and second by Director Campbell to approve the December 2013 Quality Management Report passed unanimously.

6. **PRESENTATION ON COVERED CALIFORNIA**

Ms. Vickie Scharr, Financial Controller, gave a presentation on Covered California. Covered California is the State health insurance exchange created as a result of the Patient Protection and Affordable Care Act. The Affordable Care Act guarantees coverage with no annual limits and no denial for pre-existing conditions. It requires large employers to offer coverage and doesn't allow insurance providers to base rates on current health status. The coverage improvements begin January 1, 2014 and is required for individuals in both the public and private sectors.

Ms. Scharr reviewed the Covered California web-site and available insurance options, outlining the level of premium assistance, health plan options and required services. She reported that DMC currently contracts with outside agencies to assist in enrollment of newly eligible patients.

Information Only

7. FINANCIALS- OCTOBER 2013 AND NOVEMBER 2013

Mr. James Boatman, CFO, presented and sought acceptance of the October and November 2013 Financials but presented the November financials only. Doctors Medical Center had a net loss of $ 2.4 million for the month of November, which was $2.1 million worse than budget. The following are the factors leading to the net income variance for the month.

Mr. Boatman reported that net patient revenue was under budget by $1.3 million for November. Patient days were 17.9% under budget and discharges under budget by 10.5%. Total outpatient volume was under budget by 14.5% with outpatient surgeries at 32.0% worse than budgeted, ancillary outpatient visits at 28.0% under budget for November while emergency room visits were 3.2% higher than budget.

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

Mr. Boatman reported that salaries were under budget due to continued flexing of staff in response to reduced inpatient and outpatient volume. Health benefit costs continue to exceed budget with a November negative variance of $860,000. This was offset by favorable variances in payroll taxes and vacation and other non-productive payroll expenses resulting in a negative variance of $581,000 in benefit expenses. Professional fees were $358,000 worse than budget because of an under budgeted amount for physician costs and Sodexo management costs catch up.

Mr. Boatman updated everyone that purchased services exceeded budget by $439,000 primarily due to a new contract to manage medical equipment, additional renal dialysis expenses, and additional bad debt collection costs which are offset by increased cash collections on claims greater than 150 days old. Other operating expenses are over budget by $63,000 due to recruitment costs for a new director.

A motion was made by Director Irma Anderson and seconded by William Walker, M.D. to accept the October and November 2013 Financial report passed unanimously.

8. BUDGET PRESENTATION

Mr. James Boatman presented and sought acceptance of the first quarter 2014 Budget. The goals of the 2014 budget are to improve current operational performance, reflect rapidly changing healthcare events and prepare DMC for future changes to our patient delivery system. Due to the extreme fiscal crisis that the hospital currently faces, we are only seeking acceptance of a budget for the first quarter of the year. However, Mr. Boatman did present information on the current annual budget.

He began by presenting a graph that explains the actual and projected budget by operating revenue, expenses and non-operating revenues in the last two years and the projected 2014.

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

He provided an overview of the primary drivers of the changes in both revenue and expense. DMC is projected to realize a $3.4M decline in Medicare reimbursement as a result of changes brought about by the Affordable Care Act and a $932,000 Medicare revenue decline associated with continued reduction in volume. Revenue reductions will be off-set by a number of positive factors, including a projected $1.9 million inflation increase for inpatient and outpatient Medicare, a $1.3 million inflation increase in commercial insurance rates, a $1.5 million increase in MediCal funding associated with a new District hospital reimbursement approach, and a projected $563,000 in payments for previously uninsured patients that will be newly insured under Covered California.

The major expense reductions are projected with reductions in benefit costs with the movement of employees to Kaiser and increases in employee contributions to their health coverage ($1.8 million), consulting costs ($673,000), and through the use of Soriant. Increases in expenses include step increases in wage and salary (increase of $650,000), and an increase of $894,000 in purchases services related to the expansion of the UHS and McKesson service contracts.

Although he was not seeking approval of the entire fiscal year budget, Mr. Boatman did present the projected 2014 Cash Flow, showing a negative cash flow for the year of $14.8 million, assuming no changes in the outstanding accounts payable balances.

Mr. Boatman proposed to create a quarterly revised budget and for future yearly quarters to be based on the last 12 months and with known changes to DMC's costs and revenues.

A motion was made by Director Beverly Wallace and seconded by Director Pat Godley to approval of the first Quarter 2014 budget passed unanimously.

9. PROPOSED CHANGES TO HEALTH BENEFITS

Mr. Bob Redlo, VP of Patient and Labor Relations, presented the proposed changes to health benefits. As has been discussed at multiple meeting of the Governing Body, the costs of health benefits under the DMC self-insured program continues to increase significantly. Management has been evaluating options to reduce and control these expenses, including changes in eligibility criteria, increased cost sharing by covered individuals, narrowing the network of preferred providers, and enhanced care management. We have also explored the option to purchase a fully insured plan as an option to our current self-insured program. While we will continue to seek proposals for insurance plans, Kaiser Permanente has presented a plan option that management hopes to introduce with the enrollment of the non-represented employees.

Mr. Redlo presented the proposed Kaiser Permanente plan for approval as outlined in the Governing Body materials, pointing out the potential saving of up to $5,000 per employee that enrolls in Kaiser versus our DMC insured plan.

A motion was made by Director Irma Anderson and seconded by Director Nancy Casazza to approve the proposed changes in health coverage passed unanimously.

10. CEO REPORT

Ms. Dawn Gideon, Interim President and Chief Executive Officer, provided an update on the current DMC fiscal emergency. We need to focus on three major things: stretching our remaining cash by reducing expenses; securing additional funding from Kaiser, the state and other area corporations/stakeholders to provide the support necessary to remain open; and continuing to communicate to all stakeholders regarding the significance of this financial crisis.

Throughout this meeting we have referenced examples of expense reduction, including the change in health benefit plan. She reported that a proposal had been submitted to Kaiser in November, and she and members of the Board are in frequent communication with Kaiser on that request. On the point of communications, Ms. Gideon reported that she is holding Town Hall meeting for employees, volunteers and the medical staff and will be distributing an update letter prior to the holidays. We have been active with the media, both giving interviews and encouraging the writing of letters-to-the-editor, several of which have been published. Meeting have

also been held with elected officials. Management and members of the Governing Body will attend meetings of area City Council meetings and service organizations in January.
Ms. Gideon reported that Dr Laurel Hodgson's term as the Chief of Staff has come to end. Dr Richard Stern will serve as Chief of Staff for 2014 and 2015. Ms. Gideon thanked Dr Laurel Hodgson for all the hard work and excellent job she has done in the last two years. Dr Hodgson helped put together the new medical staff bylaws and made other tremendous changes in the medical staff office.

Ms. Gideon announced that the nursing leadership team will be presenting Andrea Ragland-Vinson (4th floor Charge Nurse) with the Daisy Award for providing outstanding patient care. Ms. Ragland-Vinson was nominated by her peers.

Information Only

11. MEDICAL EXECUTIVE REPORT

Dr. Laurel Hodgson presented and sought approval of the Medical Executive Committee and Credentials Committee report. The Bylaws update is officially available and has been approved by The Joint Commission.

Dr. Hodgson presented several policy revisions for approval, including Medication Administration, Patient Controlled Analgesia, Controlled Substances, Prothrombin Complex Concentrate, ICU physician orders, Acute Ischemic Stroke Alteplase and Kcentra policy. She also presented for approval a new Orthopedic Core Privileges form.

A motion made by William Walker, M.D. and seconded by Sharon Drager, M.D. to approve the MEC report and presented policies passed unanimously.

A motion made by Sharon Drager, M.D. and seconded by Richard Stern, M.D. to approve the Credentials Committee report, including the new Orthopedic Core Privileges form, passed unanimously.

THE MEETING ADJOURNED AT 6:11 PM

DOCTORS MEDICAL CENTER

QUALITY REPORT

TAB 5

Quality Management Report

Doctor's Medical Center

Inpatient Core Measure Trends

Key Quality Indicators for 2013

Inpatient Core Measure Trends 2012-2013

- **AMI** is trending upward and consistently compliant.
  - STEMI Program work is a major contributing factor.
- **Heart Failure** is also trending upward and moving toward being consistently 100%.
  - ACTIONS: Continue the current processes

Inpatient Core Measure Trends 2012-2013

- **Pneumonia** compliance is not consistent.
  - Primary failures come with not drawing blood cultures prior to administering antibiotics on ICU patients.
    - Delays in waiting for Lab
    - Higher contamination rates when ED RN's draw. (false positives)
  - ACTION: Lab and ED teaming up to come to resolution.

Inpatient Core Measure Trends 2012-2013

- **SCIP** compliance is also inconsistent.
  - Failures reside in more than one area
    - Antibiotics within 1 hour of surgery start time
    - Discontinuing of antibiotics within 24 hours of surgery end time.
    - Foley catheter removal on post-op day 1 or 2
    - VTE prophylaxis administration within 24 hours of surgery end time

Inpatient Core Measure Trends 2012-2013

- CPOE is not surgeon friendly (CPOE stats support this theory)
- ACTION: Small group of surgeons to work with IT to overcome barriers to make CPOE more user friendly for post-op orders.

Inpatient Core Measure Trends 2012-2013

- **VTE** compliance is not consistent and still has yet to break 90%.
  - Primary cause is nursing documentation regarding patient refusal of SCD's.
  - ACTION: Unit Supervisors will assist in making all documentation compliant with this measure.

Inpatient Core Measure Trends 2012-2013

- **Stroke** is also inconsistent and has yet to break 90% more than once
  - Primary cause: Discharge instructions does not include all required elements
  - Also a finding with Joint Commission survey
  - ACTION: IT Informaticist created a pick list for instructions specific to the patient's other conditions, as well as stroke.
  - Program manager is tracking compliance for Joint Commission

Key Indicator Report: Quality Snapshot of DMC

- **HIGHLIGHTS of area needing improvement:**
- **HCAHPS**
  - Appears flat, but statistically trending in an upward direction.
  - ACTION: Accountability with Press Ganey – Physicians / Staff / Leadership
- **Resuscitation**
  - Focus is pre-team arrival activities
  - ACTION: Practice / Mock Codes

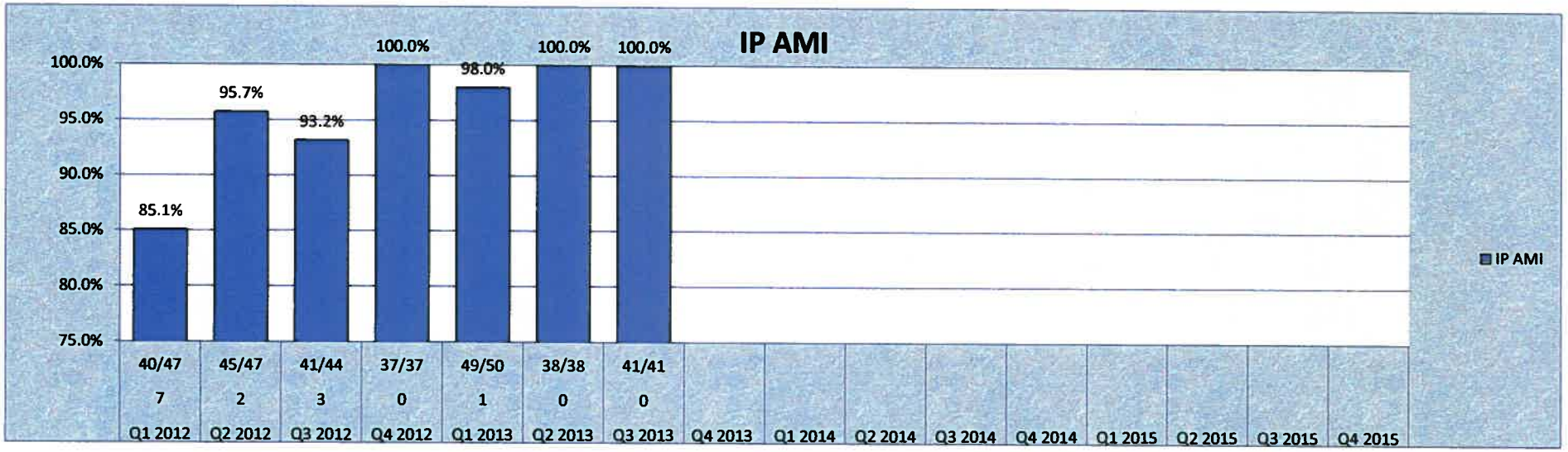
Key Indicator Report: Quality Snapshot of DMC

- **Restraints**
  - Focus on documentation
  - ACTION: Accountability for appropriate documentation
- **Pain**
  - Post-medication assessment not consistently documented
  - ACTION: Accountability for documentation requirements

DMC Core Measure Trends

IP AMI

QTR	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	7	2	3	0	1	0	0									
IP AMI	40/47	45/47	41/44	37/37	49/50	38/38	41/41									
	85.1%	95.7%	93.2%	100.0%	98.0%	100.0%	100.0%									

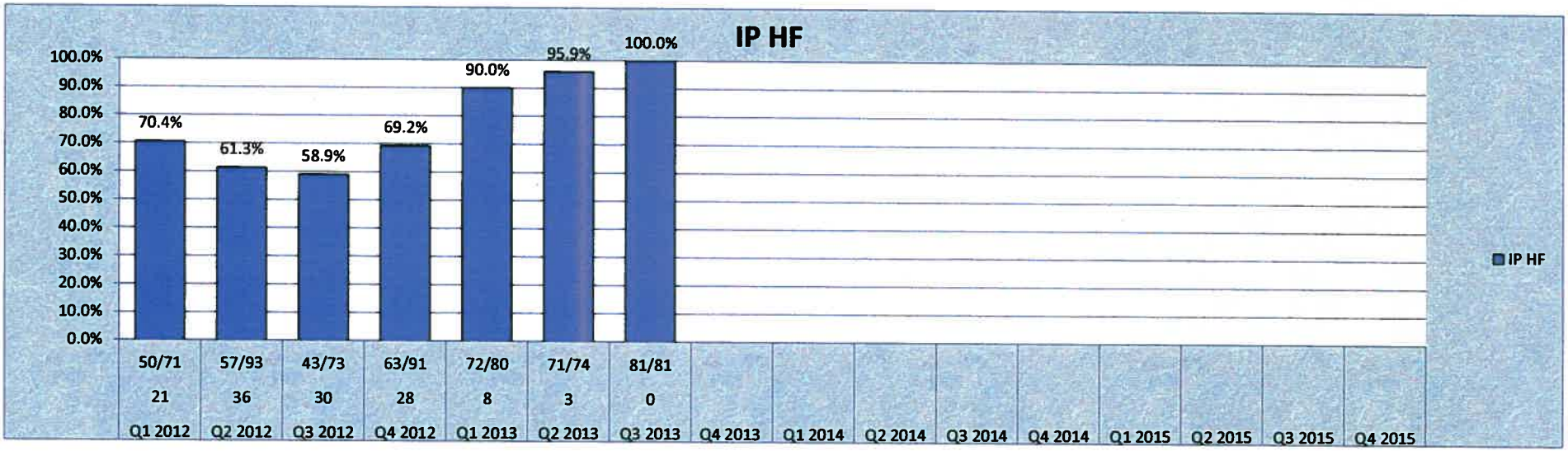


Analysis/Actions:	Trending is upward to 100%. Current processes and evaluation of data and processes in STEMI Committee will continue.

DMC Core Measure Trends

IP HF

QTR	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	21	36	30	28	8	3	0									
IP HF	50/71	57/93	43/73	63/91	72/80	71/74	81/81									
	70.4%	61.3%	58.9%	69.2%	90.0%	95.9%	100.0%									

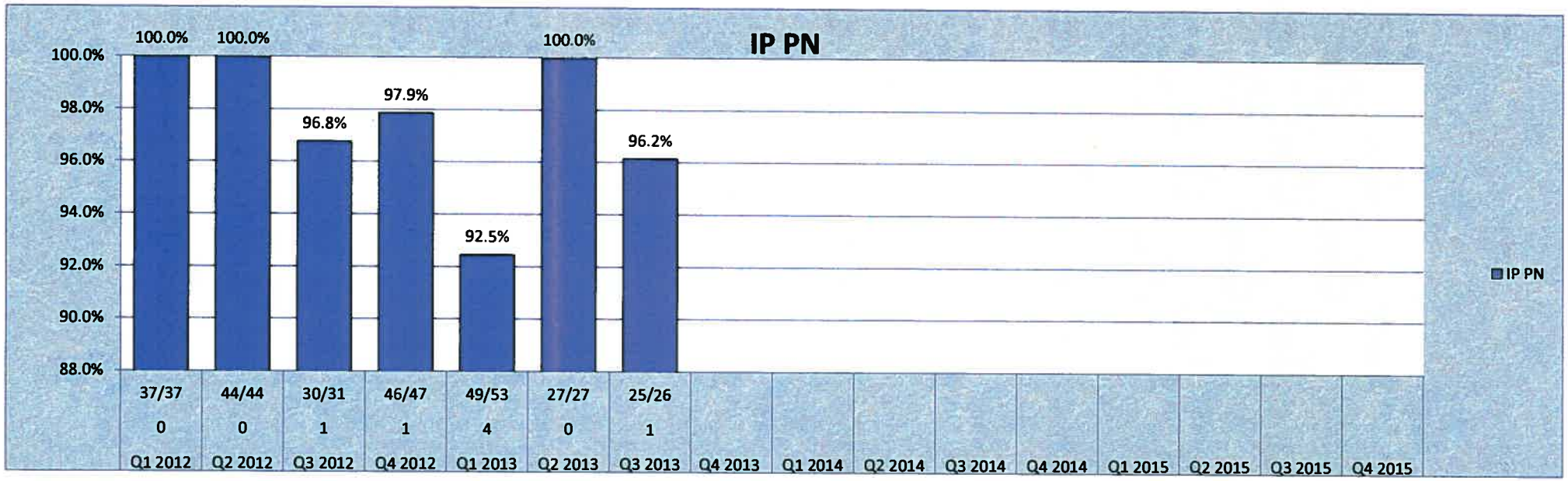


Analysis/Actions:	Trending is increasing to 100% reported in Q3. Opportunities were primarily in DC Instructions. This has been nicely incorporated into Paragon and thus compliance has increased to 100% for Q3. Continued monitoring and assurance DC Instructions are part of the chart prior to patient DC will continue, as well as counseling for staff who are non-compliant.

DMC Core Measure Trends

IP PN

QTR	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	0	0	1	1	4	0	1									
IP PN	37/37	44/44	30/31	46/47	49/53	27/27	25/26									
	100.0%	100.0%	96.8%	97.9%	92.5%	100.0%	96.2%									

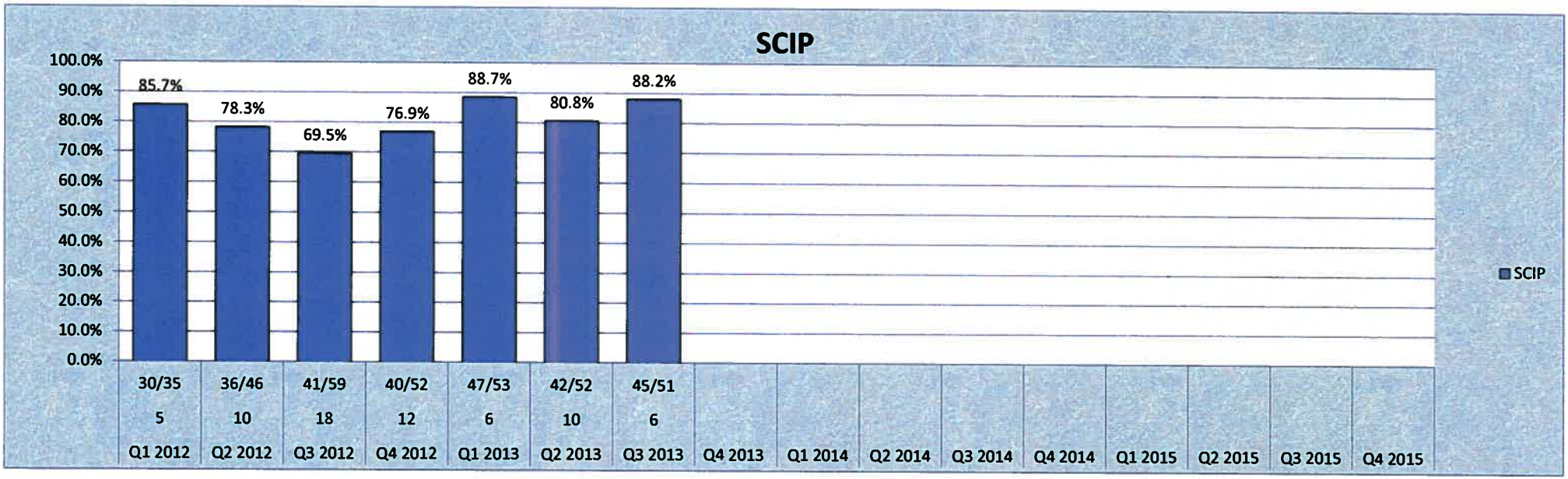


Analysis/Actions:	PN proves to be inconsistent with primary opportunities in obtaining blood cultures prior to administration of the antibiotic. The failures all occurred in the ED. Re-education to nursing and process review will occur to keep scores trending up for 2014.

DMC Core Measure Trends

SCIP

QTR	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	5	10	18	12	6	10	6									
SCIP	30/35	36/46	41/59	40/52	47/53	42/52	45/51									
	85.7%	78.3%	69.5%	76.9%	88.7%	80.8%	88.2%									

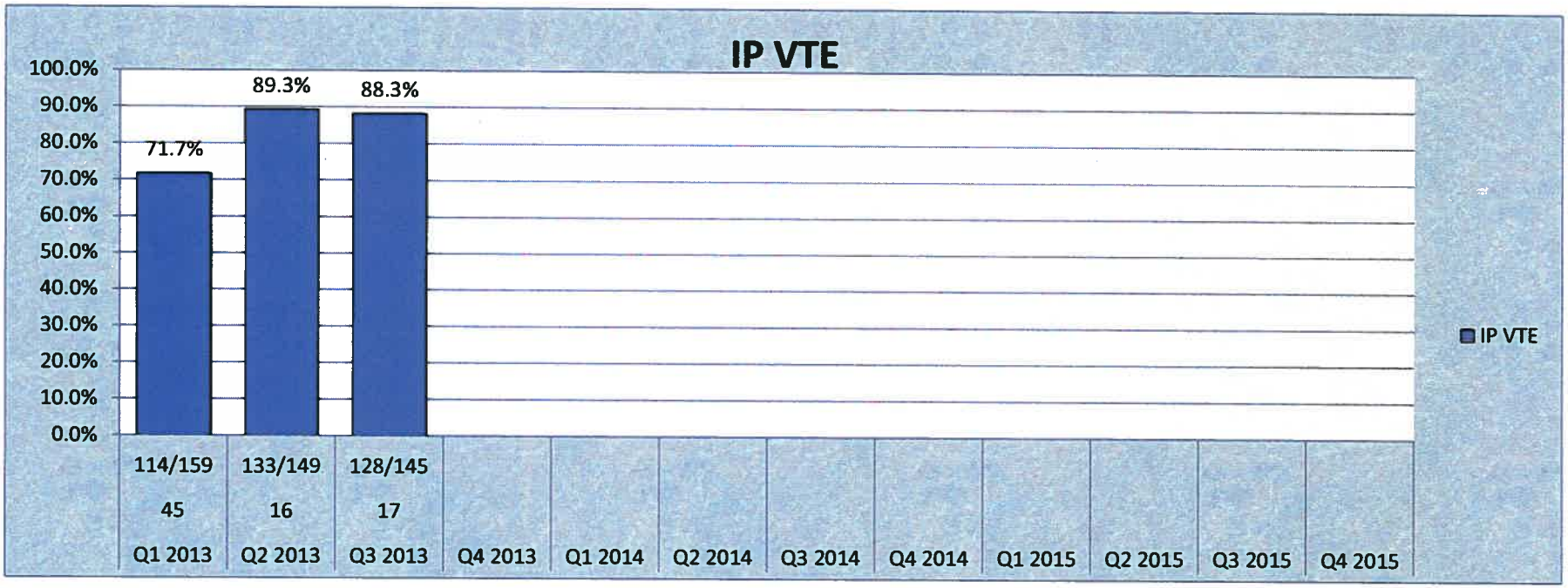


Analysis/Actions :	SCIP remains inconsistent for the last 2 years. Failures are spread between administering antibiotics within 1 hour of surgery, DC antibiotics within 24 hours of surgery end time, Foley catheter removal by day 1 or day 2 of surgery and VTE prophylaxis administration within 24 hours of surgery end time. Compliance to established processes is not consistent, thus making it difficult to determine if these are process or people issues. VTE prophylaxis usually fails if a physician does not utilize the CPOE which has the measure built in. Nursing re-education regarding measures will also assist in compliance as they can discuss with physicians when failures are impending.

DMC Core Measure Trends

IP VTE

QTR	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	45	16	17									
IP VTE	114/159	133/149	128/145									
	71.7%	89.3%	88.3%									

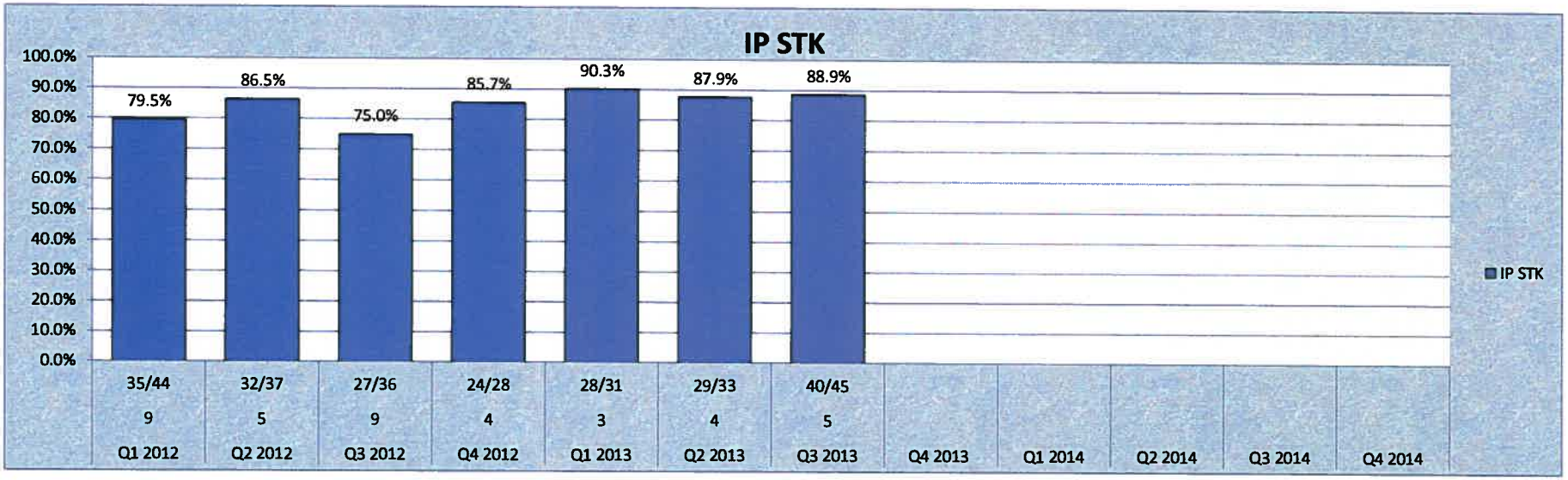


Analysis/Actions	Compliance is improving however still inconsistent. Nursing documentation is lacking for patient refusal to wear SCD's. In addition, TED are not available - discussion with physicians regarding the use of TED's to meet mechanical VTE prophylaxis measures.

DMC Core Measure Trends

IP STK

QTR	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
VAR	9	5	9	4	3	4	5									
IP STK	35/44	32/37	27/36	24/28	28/31	29/33	40/45									
	79.5%	86.5%	75.0%	85.7%	90.3%	87.9%	88.9%									



Analysis/Actions:	Stroke primary failures lie with DC instructions. Following Q3 data, a DC instruction pick list was developed in Paragon to customize the DC instructions and assure they are present and provided for all stroke patients.

DOCTOR'S MEDICAL CENTER 2013	KEY INDICATOR PERFORMANCE IMPROVEMENT 2013	KEY Highlighted cells denote indicators not meeting goal.

MSPI/MEC/BOT Report	Goal	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
VOLUMES																		
Total Hospital Admissions		580	454	512	1546	436	435	452	1323	461	429	450	1340	428	385	na	813	5,022
Total Hospital Discharges		571	461	491	1523	442	438	435	1315	450	440	408	1298	433	401	na	834	4,970
Total Patient Days		2472	2124	2243	6839	1871	1878	1877	5626	1976	1977	2038	5991	2016	1683	na	3699	22,155
Total Adjusted Patient Days		3672	3257	3487	10416	3085	3282	3205	9572	3185	3326	3240	9751	3383	2818	na	6201	35,940
Total ED Visits		3582	3129	3250	9961	2968	3172	2972	9112	2856	2928	3063	8847	2978	2905	na	5883	33,803
Total ED Admissions		556	435	452	1443	369	391	413	1173	402	395	393	1190	375	347	na	722	4,528
ED Admission Rate		15.5%	13.9%	13.9%	14.5%	12.4%	12.3%	13.9%	12.9%	14.1%	13.5%	12.8%	13.5%	12.6%	11.9%	na	12.3%	13.4%
Inpatient Surgeries		77	68	76	221	71	74	80	225	66	51	86	203	72	66	na	138	1436
Outpatient Surgeries		73	83	91	247	74	83	80	237	83	99	73	255	81	70	na	151	1,629
Total Doses Dispensed		292,000	257,482	268,350	817,832	218,249	240,121	225,088	683,458	224,673	235,750	242,212	702,635	na	na	na	694,505	2,898,430
PATIENT SATISFACTION																		
Inpatient Would You Recommend (% Definitely Would)	75%	51.5%				48.9%				51.6%				no data				50.7%
HCAHPS Overall Composite	75%	40.8%				41.4%				45.6%				no data				42.6%
Communication with Doctors	75%	71.6%				69.0%				70.1%				no data				70.2%
BLOOD UTILIZATION																		
RBC Wastage		2.0%				2.1%				3.0%				1.0%				2.0%
C/T Ratio	< 2%	1.5%				1.4%				1.4%				1.4%				1.4%
Infused within 4 hours	100%	100.0%				96.7%				100.0%				95.0%				98.2%
Infusion started within 30 mins	100%	96.7%				100.0%				100.0%				95.0%				98.1%
MEDICATION USAGE																		
Number of Pharmacy interventions																		
Rate of Pharmacy Interventions (per 10,000 doses)																		
MEDICATION ERRORS																		
# of Medication Variances		172				172				171				185				700
Medication Variance Reporting Rate (per 10,000 doses)		2.10				2.52				2.43				2.66				2.42

ANALYSIS AND ACTIONS

Overall scores are trending upward. Improvement is reflective of implemented unit based PI teams, house-wide education on Communication and Teamwork tactics, followed by manager follow-through. Physician communication have fallen slightly. Elected leaders of the Medical Staff will be meeting with Press-Ganey to help indentify tactics for improved patient/family perception in moving forward.

ANALYSIS AND ACTIONS

RBC wastage is normal for facility size and volumes. CT Ratio well below benchmark of 2.0% set by AABB. Blood products infused w/in 4 hours failing in 6 cases of total population due to documentation omission. Staff counseled/re-educated. Infusions started w/in 30 minutes failing in 6 cases also - staff counseled/re-educated as appropriate.

ANALYSIS AND ACTIONS

This will be reported in 2014. The data is presented in full detail at P&T. (See P&T minutes)

ANALYSIS AND ACTIONS

Medication error reporting and trending remain flat. Trend of nursing documentation continues to be root cause of error reports. Plan to include medication documentation in the annual competencies, as well as education at staff meetings and individual education/counseling by unit leaders.

DOCTOR'S MEDICAL CENTER 2013	KEY INDICATOR PERFORMANCE IMPROVEMENT 2013	KEY Highlighted cells denote indicators not meeting goal.

MSPI/MEC/BOT Report	Goal	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD	
# Adverse Drug Reactions		22				24				21				na				67	
RESUSCITATION																			**ANALYSIS AND ACTIONS**
# Rapid Responses										3	3	5	11	4	3	na	7	18	Opportunities lie consistently with initiating compression w/in 1 minute, initiating the ambu bag prior to team arrival and calling an RRT prior to a CB. Re-education will be performed as to the purpose of RRT's (early intervention in attempt to eliminate CB's) Also assessing ambu bag knowledge/technique and when to initiate is in order. In addition, re-education on assessment in recognizing respiratory and/or cardiac arrest and immediate intervention.
# Code Blue (CB)										11	14	20	45	21	11	na	32	77	
Compressions initiated w/in 1 min	90%									18%	57%	55%	43%	71%	64%	na	68%	55.0%	
Ambu Bag imitated prior to CB Team arrival	90%									82%	86%	90%	86%	81%	82%	na	82%	84.0%	
RRT called prior to CB	90%									36%	7%	10%	18%	14%	18%	na	16%	16.0%	
Cardiac rhythm identified w/in 3 min	90%									91%	100%	95%	95%	95%	100%	na	98%	96.0%	
Equipment function properly	90%									100%	100%	95%	98%	100%	100%	na	100%	99.0%	
Necessary supplies available	90%									100%	100%	90%	97%	95%	100%	na	98%	96.0%	
MORTALITY																			**ANALYSIS AND ACTIONS**
Number of IP Mortalities																			This will be reported in 2014. A detailed version of this report will be presented to Department of Medicine and Department of Surgery.
Number of ED Mortalities																			
Total Mortalities																			
House-wide IP Mortality Rate (IP Deaths/IP DC x 100)	< 1.0																		
Death occurred within 48 hrs of procedure	0																		
# Donor Network Notified																			
% Donor Network Notified																			
# Autopsy Criteria Met / # Autopsies Performed																			
% Autopsies Performed																			
RESTRAINTS																			**ANALYSIS AND ACTIONS**
Number of Restraint Episodes Audited						3	2	8	13	4	3	7	14	11	16	5	32	59	Trends for the year involve consistent improvement needed for assuring authentication w/in 12 hours of a TO, 24 hour renewal and documentation for trial release of patients. Directors will work with staff to assure compliance with the nursing documentation and will also assure orders are authenticated and renewed timely. Process and tools will be reviewed for ease of compliance.
IP Restraint Rate (per 1000 patient days)						1.6	1.1	4.3	2.3	2.0	1.5	3.4	2.3	5.5	9.5	na	8.7	2.7	
Death within 24 hrs of patient in restraint (reported to CMS)	0					0	0	0	0	0	0	0	0	0	0	0	0	0	
Injury to Patient	0					0	0	0	0	0	0	0	0	0	0	0	0	0	
Reasons documented	90%					100.0%	100.0%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%	100%	100.0%	
Alternatives documented	90%					100.0%	100.0%	100.0%	100.0%	100.0%	100%	100%	100%	91%	88%	100%	93%	96.5%	
Order Present for each episode	90%					66.7%	71.4%	70.0%	69.4%	100.0%	100%	100%	100%	91%	94%	100%	95%	97.5%	
Authentication w/in 12 hours of TO	90%					70.8%	88.9%	75.0%	78.2%	75.0%	100%	71%	82%	55%	81%	100%	79%	80.3%	
Authentication for renewal every 24 hours	90%					68.2%	45.5%	71.4%	61.7%	75.0%	50%	100%	75%	55%	75%	0%	43%	59.2%	
Documentation for every 2 hour monitoring	90%					100%	100%	92%	97%	100%	100%	71%	90%	45%	88%	100%	78%	84.0%	

DOCTOR'S MEDICAL CENTER 2013	KEY INDICATOR PERFORMANCE IMPROVEMENT 2013																	KEY Highlighted cells denote indicators not meeting goal.
MSPI/MEC/BOT Report	Goal	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD	
Documentation for trial release each shift	90%					na	na	na	na	75%	83%	71%	76%	73%	81%	0%	51%	64%	
PAIN MANAGEMENT																			ANALYSIS AND ACTIONS
# Cases Audited										9	10	0	19	10	10	10	30	49	Audits began in July. Staff was educated on expectations. Cases reviewed are used as education for all staff and individual nurses are counseled as necessary.
Pre-Med assessment documented	90%									78%	100%	na	89%	70%	100%	100%	90%	90%	
eMAR Documented	90%									89%	100%	na	95%	70%	90%	100%	87%	91%	
Post-Med assessment documented	90%									83%	100%	na	92%	70%	95%	10%	58%	75%	
MEDICAL RECORD COMPLETION																			ANALYSIS AND ACTIONS
# Records Audited																			This will be reported in 2014. A detailed report will be presented to the Medical Staff Department meetings.
# Completed in compliance with the Medical Staff Bylaws																		0	
% Completed in compliance with the Medical Staff Bylaws	90%																	#DIV/0!	
RISK MANAGEMENT																			ANALYSIS AND ACTIONS
# Complaints IP																		0	This will be reported in 2014 on a quarterly basis. A detailed version of this report will be reported in HPIC.
IP Complaint Rate																		#DIV/0!	
# Events Reported																		#DIV/0!	
Event Reporting Rate (Per 1000 APD)																		#DIV/0!	
OPERATIVE AND INVASIVE PROCEDURE REVIEW																			ANALYSIS AND ACTIONS
																			This will be reported in 2014. A detailed version of this report will be presented in Department of Surgery.
UTILIZATION REVIEW																			ANALYSIS AND ACTIONS
Readmissions w/in 30 days (Any DRG)																			Readmission data and rates not tracked in 2013, however, will be a part of the regular report in 2014, as this data is closely monitored by CMS. . This information will be reported in detail at the UMC committee.
Readmission Rate																			
Average Length of Stay (Acute)		4.33	4.61	4.57	4.50	4.23	4.29	4.31	4.28	4.39	4.49	5.00	4.63	4.66	4.20		4.43	4.46	
HAC / INFECTION PREVENTION																			ANALYSIS AND ACTIONS
# Surgical Site Infections (SSI) (Actual / Expected)		3 / 2.145				0 / 2.278				1 / 1.983				na				4 / 455	SSI is slightly over 1 in Q1, however the cases were reviewed with the Chair of the Infection Control Committee, none of the cases were found to be of concerning nature at this point in time. Trends are noted and monitoring
SSI Standardized Infection Ratio	≤ 1	1.40				0.00				0.50				na				0.88%	

DOCTOR'S MEDICAL CENTER 2013	KEY INDICATOR PERFORMANCE IMPROVEMENT 2013																
MSPI/MEC/BOT Report	Goal	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
Catheter Associated Urinary Tract Infection (CAUTI) (Actual / Expected)		4 / 3.551				3 / 2.681				2 / 3.147				na				#DIV/0!
CAUTI Standardized Infection Rate	≤ 1	1.13				1.12				0.64				na				0.96
# Ventilator Associated Pneumonia (VAP)	0	0				0				0				na				0.00
Central Line Associated Blood Stream Infection (CLABSI) (Actual / Expected)	0	1 / 1.001				1 / 0.776				0 / 1.047				na				#DIV/0!
CLABSI Standardized Infection Rate	≤ 1	1.00				1.29				0.00				na				0.76

KEY
Highlighted cells denote indicators not meeting goal.

continues. Further values for Q2 and 3 were below the standard value of 1.
CAUTI rates were slightly above 1 for Q1 and 2. The process for order continuation is in place and compliance is an issue. Chart audits and process throughout the units will be reviewed for compliance.
In CLABSI, the rates are slightly up for Q2, however, the p-value indicates the number of observed CLABSI is statistically not significantly different from expected based on national baseline data.

DOCTORS
MEDICAL CENTER

FINANCIALS
DECEMBER 2013

TAB 7

DOCTORS MEDICAL CENTER

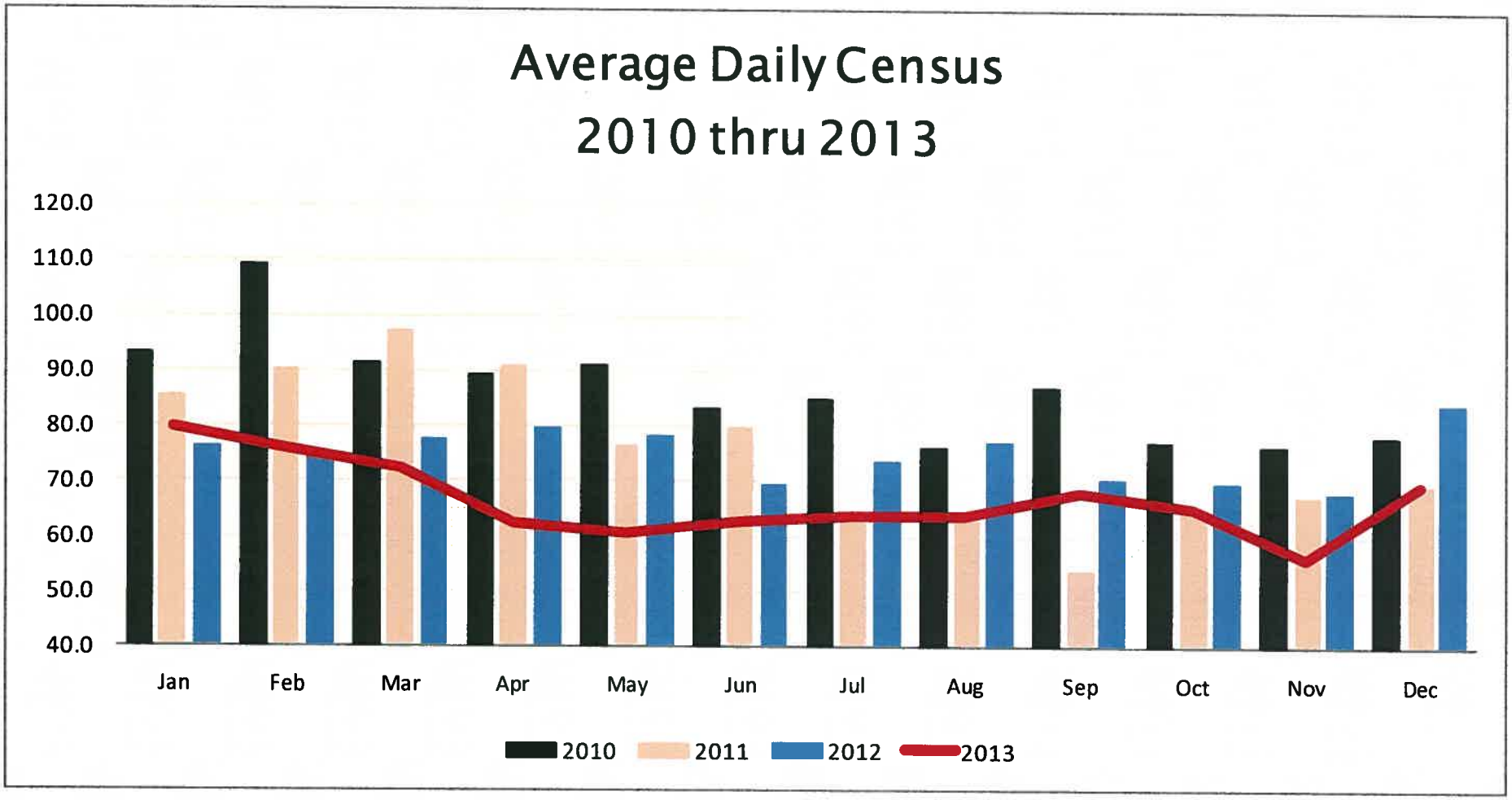
Board Presentation

December 2013

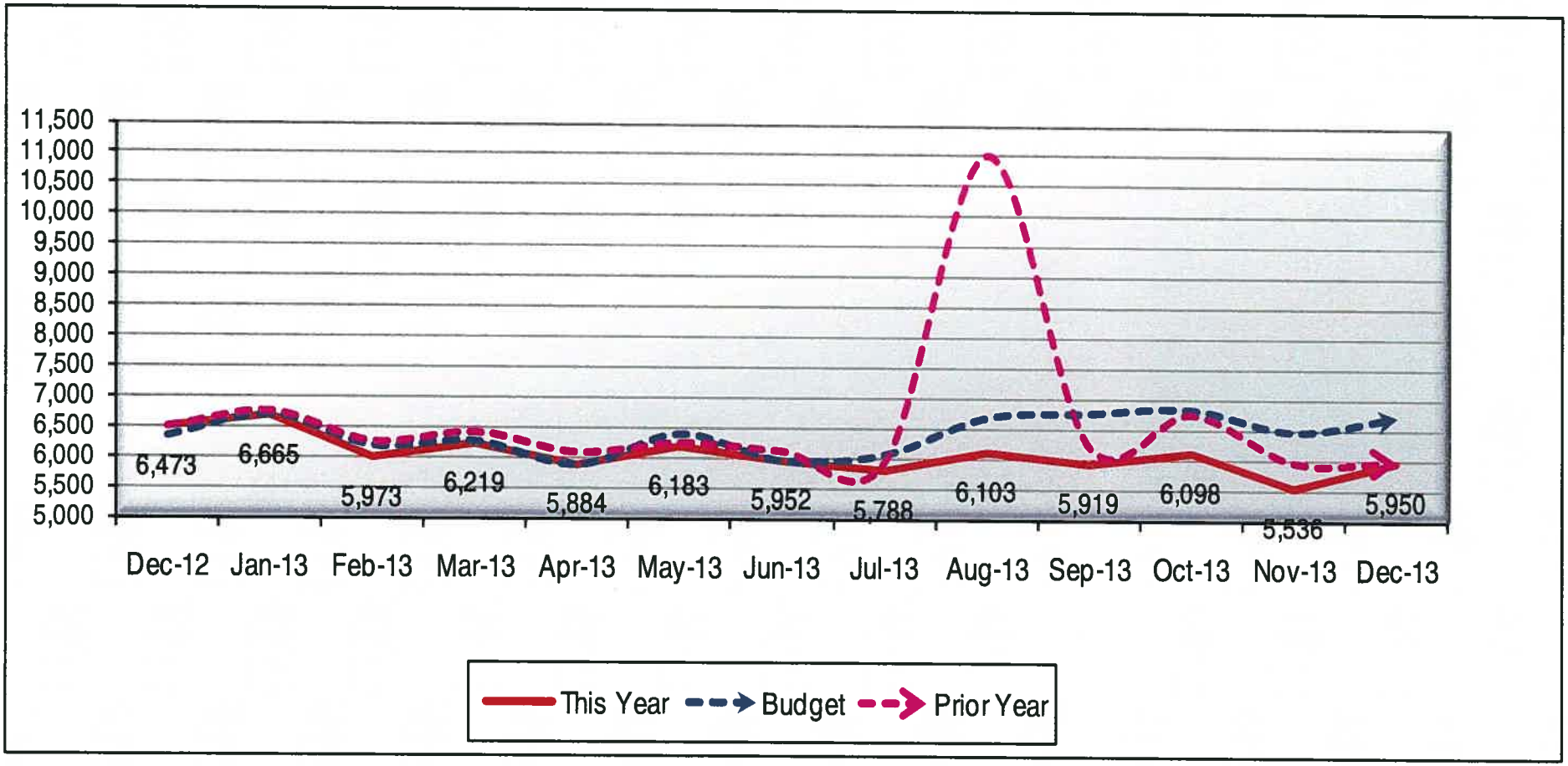
Financial Report

Financial Report Key Points

- Net loss was $1.3M in December, $1.3M over budget
- Net patient revenue was $1.7M under budget
- Operating expenses were $226K under budget


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

Outpatient Visits



Statement of Activity - Summary

For the Period Ending

December 31, 2013

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
9,728	11,428	(1,700)	**Net Operating Revenues $**	113,783	125,614	(11,831)
11,914	12,140	226	**Total Operating Expenses $**	142,149	144,385	2,236
(2,186)	(712)	(1,474)	**Income/(Loss) from Operations $**	(28,366)	(18,771)	(9,595)
927	743	184	**Income from Other Sources $**	8,870	8,983	(113)
(1,259)	31	(1,290)	**Net Income / (Loss) $**	(19,496)	(9,788)	(9,708)
2,157	2,211	(54)	**Patient Days**	24,312	25,906	(1,594)
462	506	(44)	**Discharges**	5,432	5,861	(429)
5,950	6,725	(775)	**Outpatient Visits**	72,270	77,011	(4,741)
543	594	52	**Worked FTE's**	564	603	39
1.62	1.55	0.06	**Medicare CMI**	1.57	1.55	0.02

Budget Variances – Net Revenue

Medicare	$ (1,186) K
2% Sequestration $(73K)	
Managed Care	$ (709) K

Budget Variances - Expenses

- **Salaries & Benefits** $177K - Continued staff flexing offset by increasing healthcare costs.
- **Supplies** $214K - Underutilization of pharmaceuticals and pacemakers offset by higher implant costs.
- **Purchased Services** ($488K) - Higher collection costs offset by higher A/R cash collections and new contract to manage medical equipment.
- **Other Operating** $160K - Reduction of dues and subscriptions and licensing costs.

Cash Position
December 31, 2013

(Thousands)

	December 31, 2013	December 31, 2012
Unrestricted Cash	$9,610	$5,059
Restricted Cash	$4,723	$11,612
Total Cash	$14,333	$16,671
Days Unrestricted Cash	25	11
Days Restricted	14	27
Total Days of Cash	39	38

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

Accounts Receivable

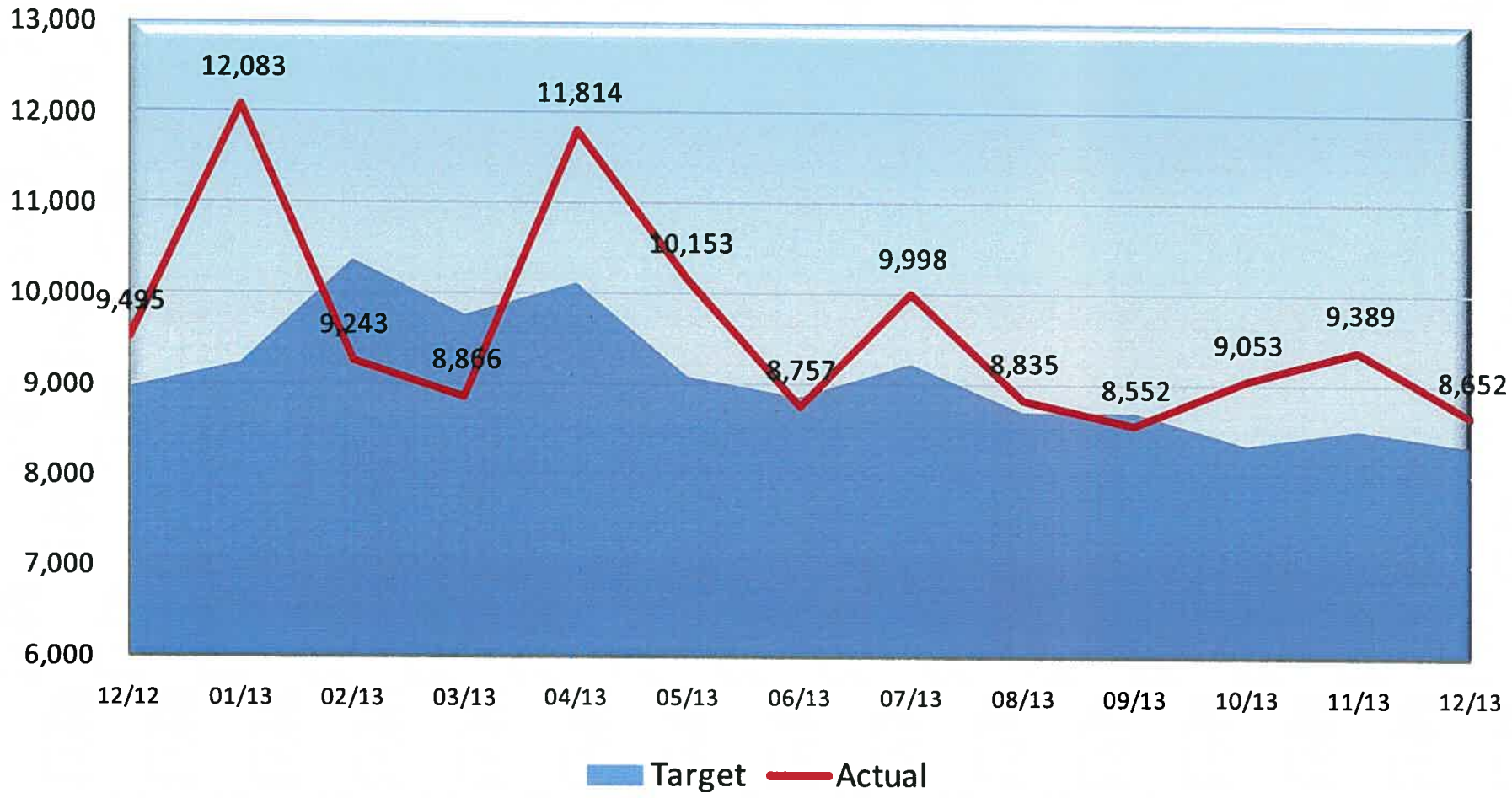
December 31, 2013

(Thousands)

	December 31, 2013	December 31, 2012
Net Patient Accounts Receivable	$20,581	$31,007
Net Days in Accounts Receivable	73.3	92.6

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

Cash Collection



DOCTORS MEDICAL CENTER

December 2013 Executive Report

Doctors Medical Center had a net loss of $1,259,000 for the month of December. As a result, net income was $1,290,000 worse than budget. The following are the factors leading to the net income variance for the month:

Net Patient Revenue Factors	Positive / (Negative)
Medicare	($1,186)
Managed Care	($709)

Net patient revenue was under budget by $1,669,000 for December. Patient days were 2.4% under budget and discharges under budget by 8.7%. Total outpatient volume was under budget by 11.5% with outpatient surgeries at 20.4% worse than budgeted. Ancillary outpatient visits were 27.3% under budget for December while emergency room visits were 8.7% better than budget.

In December, regular Medicare inpatient discharges were 11.1% under budget and both inpatient and outpatient reimbursements were lower than expected resulting in a $1,186,000 shortfall. Managed Care volume was 14.1% under budget resulting in a shortfall of $709,000 in patient revenue.

Salaries were under budget by $285,000 due to continued flexing of staff in response to reduced inpatient and outpatient volume. Health benefit costs continue to exceed budget this month by $129,000, which was offset by favorable variances in payroll taxes and other non-productive payroll expenses resulting in a negative variance of $108,000 in benefit expenses.

Supplies were favorable by $214,000 in December due to lower pharmaceuticals and pacemakers utilization offset by higher than expected implant costs as inpatient surgeries were 21.7% higher than budget.

Purchased services exceeded budget by $488,000 primarily due to a new contract to manage medical equipment and additional bad debt collection costs which are offset by increased cash collections on claims greater than 150 days old.

Other operating expenses are under budget by $160,000 due to reductions made to dues and subscription and licensing fees.

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

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
					OPERATING REVENUE					
9,211	10,880	(1,669)	-15.3%	12,406	Net Patient Service Revenue	111,074	122,485	(11,411)	-9.3%	120,158
517	548	(31)	-5.6%	1,860	Other Revenue	2,709	3,129	(420)	-13.4%	5,375
9,728	11,428	(1,700)	-14.9%	14,266	**Total Operating Revenue**	113,783	125,614	(11,831)	-9.4%	125,533
					OPERATING EXPENSES					
4,755	5,040	285	5.7%	5,476	Salaries & Wages	56,457	60,389	3,932	6.5%	64,058
2,950	2,842	(108)	-3.8%	4,134	Employee Benefits	34,800	33,039	(1,761)	-5.3%	34,280
831	853	22	2.5%	1,130	Professional Fees	11,799	10,830	(969)	-8.9%	11,813
1,217	1,431	214	15.0%	1,461	Supplies	15,769	16,624	855	5.1%	17,458
1,276	788	(488)	-62.0%	821	Purchased Services	10,999	9,975	(1,024)	-10.3%	11,090
228	281	53	19.0%	288	Rentals & Leases	3,140	3,424	284	8.3%	3,058
408	496	88	17.7%	426	Depreciation & Amortization	4,924	5,569	645	11.6%	4,892
249	409	160	39.1%	223	Other Operating Expenses	4,261	4,534	273	6.0%	3,846
11,914	12,140	226	1.9%	13,959	**Total Operating Expenses**	142,149	144,385	2,236	1.5%	150,495
(2,186)	(712)	(1,474)	207.0%	307	**Operating Profit / Loss**	(28,386)	(18,771)	(9,595)	51.1%	(24,962)
					NON-OPERATING REVENUES (EXPENSES)					
-	-	-	0.0%	(1,200)	Other Non-Operating Revenue	-	-	-	0.0%	-
1,350	1,121	229	-20.4%	1,281	District Tax Revenue	13,704	13,604	100	-0.7%	11,608
6	3	3	135.6%	34	Investment Income	159	51	108	209.0%	263
(429)	(381)	(48)	0.0%	(480)	Less: Interest Expense	(4,993)	(4,673)	(320)	6.8%	(4,629)
927	743	184	24.8%	(365)	**Total Net Non-Operating**	8,870	8,983	(113)	-1.3%	7,242
(1,259)	31	(1,290)	-4212.0%	(58)	**Income Profit (Loss)**	(19,496)	(9,788)	(9,708)	99%	(17,720)
					Profitability Ratios:					
-22.5%	-6.2%	-16.2%		2.2%	Operating Margin %	-24.9%	-14.9%	-10.0%		-19.9%
-12.9%	0.3%	-13.2%		-0.4%	Profit Margin %	-17.1%	-7.8%	-9.3%		-14.1%

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

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
2,257	2,213	(44)	-2.0%	2,530	SWB / APD	2,320	2,225	(95)	-4.3%	2,297
64.7%	64.9%	78.5%		68.8%	SWB / Total Operating Expenses	64.2%	64.7%			65.3%
3,490	3,409	(81)	-2.4%	3,675	Total Operating Expenses / APD	3,615	3,439	(176)	-5.1%	3,515
31,197	36,110	(4,913)	-13.6%	41,245	I/P Gross Charges	380,184	418,796	(38,612)	-9.2%	425,282
18,181	22,056	(3,875)	-17.6%	18,467	O/P Gross Charges	234,798	259,956	(25,158)	-9.7%	236,084
49,378	**58,166**	**(8,788)**	**-15.1%**	**59,712**	**Total Gross Charges**	**614,982**	**678,752**	**(63,770)**	**-9.4%**	**661,366**
					Payor Mix (IP and OP)					
53%	51%	2%		54%	Medicare %	54%	51%	3%		53%
20%	22%	-2%		20%	Medi-Cal %	20%	22%	-2%		20%
12%	13%	-1%		11%	Managed Care	12%	13%	-1%		12%
4%	4%	0%		3%	Other Government %	3%	4%	0%		4%
11%	10%	1%		12%	Self Pay %	11%	10%	0%		11%
					STATISTICS					
488	493	(5)	-1.0%	538	Admissions	5,510	5,899	(389)	-6.6%	6,094
462	506	(44)	-8.7%	515	Discharges	5,432	5,861	(429)	-7.3%	6,013
2,157	2,211	(54)	-2.4%	2,624	Patient Days	24,312	25,906	(1,594)	-6.2%	27,532
69.6	71.3	(1.7)	-2.4%	84.6	Average Daily Census (ADC)	66.6	71.0	(4.4)	-6.2%	75.2
4.67	4.37	(0.30)	-6.8%	5.10	Average Length of Stay (LOS)- Accrual Based	4.48	4.42	(0.06)	-1.3%	4.58
31	31			31	Days in Month	365	365			366
731	815	(84)	-10.3%	746	Adjusted Discharges (AD)	8,787	9,499	(712)	-7.5%	9,351
3,414	3,561	(147)	-4.1%	3,799	Adjusted Patient Days (APD)	39,327	41,986	(2,660)	-6.3%	42,816
110	115	(5)	-4.1%	123	Adjusted ADC (AADC)	108	115	(7)	-6.3%	117
73	60	13	21.7%	86	Inpatient Surgeries	860	888	(28)	-3.2%	934
82	103	(21)	-20.4%	76	Outpatient Surgeries	972	1,172	(200)	-17.1%	1,072
155	**163**	(8)	-4.9%	**162**	**Total Surgeries**	**1,832**	**2,060**	(228)	-11.1%	**2,006**

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

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
3,184	2,929	255	8.7%	3,234	ED Outpatient Visits	36,987	35,254	1,733	4.9%	41,390
2,684	3,693	(1,009)	-27.3%	2,677	Ancillary Outpatient Visits	34,311	40,585	(6,274)	-15.5%	37,359
82	103	(21)	-20.4%	76	Outpatient Surgeries	972	1,172	(200)	-17.1%	1,072
5,950	**6,725**	(775)	-11.5%	**5,987**	**Total Outpatient Visits**	**72,270**	**77,011**	(4,741)	-6.2%	**79,821**
432	441	(9)	-2.1%	487	Emergency Room Admits	4,970	5,280	(310)	-5.9%	5,524
13.6%	15.1%			15.1%	% of Total E/R Visits	13.4%	15.0%			13.3%
88.5%	89.5%			90.5%	% of Acute Admissions	90.2%	89.5%			90.6%
543	594	52	8.7%	655	Worked FTE	564	603	39	6.5%	629
663	704	40	5.7%	739	Paid FTE	665	703	38	5.4%	730
4.93	5.17	0.24	4.7%	5.34	Worked FTE / AADC	5.24	5.24	0.01	0.1%	5.37
6.02	6.12	0.10	1.6%	6.03	Paid FTE / AADC	6.17	6.11	(0.06)	-1.0%	6.24
2,698	3,055	(357)	-11.7%	3,266	Net Patient Revenue / APD	2,824	2,917	(93)	-3.2%	2,806
14,463	16,332	(1,869)	-11.4%	15,718	I/P Charges / Patient Days	15,638	16,166	(528)	-3.3%	15,447
3,056	3,280	(224)	-6.8%	3,085	O/P Charges / Visit	3,249	3,376	(127)	-3.8%	2,958
1,393	1,415	22	1.6%	1,441	Salary Expense / APD	1,436	1,438	3	0.2%	1,496
5.36	4.86	(0.49)	-10.1%	5.88	Medicare LOS - Discharged Based	4.86	5.11	0.25	4.8%	4.96
1.62	1.55	0.06	4.1%	1.65	Medicare CMI	1.57	1.55	0.02	1.2%	1.54
3.32	3.13	0.18	5.8%	3.55	Medicare CMI Adjusted LOS	3.10	3.29	(0.20)	-6.0%	3.23
4.67	4.37	(0.30)	-6.8%	5.10	Total LOS - Discharged Based	4.48	4.42	(0.06)	-1.3%	4.60
1.58	1.41	0.17	12.0%	1.58	Total CMI	1.52	1.45	0.07	5.0%	1.49
2.96	3.10	(0.14)	-4.6%	3.22	Total CMI Adjusted LOS	2.94	3.05	(0.11)	-3.5%	3.08

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

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

	Current Month	Dec. 31, 2012
ASSETS		
Cash	9,610	5,059
Net Patient Accounts Receivable	20,581	31,007
Other Receivables	508	464
Inventory	1,646	1,731
Current Assets With Limited Use	4,723	11,612
Prepaid Expenses and Deposits	1,289	1,621
TOTAL CURRENT ASSETS	**38,357**	**51,494**
Assets With Limited Use	**642**	**642**
Property Plant & Equipment		
Land	12,120	12,120
Bldg/Leasehold Improvements	29,433	29,432
Capital Leases	10,926	10,926
Equipment	45,321	43,579
CIP	876	860
Total Property, Plant & Equipment	98,676	96,917
Accumulated Depreciation	-58,618	-53,887
Net Property, Plant & Equipment	**40,058**	**43,030**
Intangible Assets	**1,392**	**1,298**
Total Assets	**80,449**	**96,464**

		Current Month	Dec. 31, 2012
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,320	1,613
97	Accounts Payable and Accrued Expenses	14,081	16,509
98	Accrued Payroll and Related Liabilities	17,731	17,512
99	Deferred District Tax Revenue	3,085	3,091
100	Estimated Third Party Payor Settlements	2,934	1,868
101	**Total Current Liabilities**	**39,151**	**40,593**
	Other Liabilities		
102	Other Deferred Liabilities	8,929	2,803
	Long Term Debt		
103	Notes Payable - Secured	60,703	61,080
104	Capital Leases	920	1,647
105	Less Current Portion LTD	-1,705	-1,613
106	**Total Long Term Debt**	**59,918**	**61,114**
107	**Total Liabilities**	**107,998**	**104,510**
	EQUITY		
108	Retained Earnings	-8,053	9,674
109	Year to Date Profit / (Loss)	-19,496	-17,720
110	**Total Equity**	**-27,549**	**-8,046**
111	**Total Liabilities & Equity**	**80,449**	**96,464**

Current Ratio (CA/CL)	***0.98***	***1.27***
Net Working Capital (CA-CL)	***(794)***	***10,901***
Long Term Debt Ratio (LTD/TA)	***0.74***	***0.63***
Long Term Debt to Capital (LTD/(LTD+TE)	***1.85***	***1.15***
Financial Leverage (TA/TE)	***-2.9***	***-12.0***
Quick Ratio	**0.77**	**0.89**
Unrestricted Cash Days	**25**	**11**
Restricted Cash Days	**14**	**27**
Net A/R Days	**73.3**	**91.1**

DOCTORS MEDICAL CENTER

REVISIONS TO LOCAL ONE COLLECTIVE BARGAINING CONTRACT

TAB 8

Proposed Negotiation Ground Rules

Between Doctors Medical Center and Public Employees Union Local One

The following ground rules are proposed for the negotiations between Doctors Medical Center and Public Employees Union, Local One, regarding the Business Office Clerical Unit and Clinical Laboratory Scientist Unit Memorandums of Understanding (MOU).

The terms of reopening the Memorandums of Understanding between Public Employees Union, Local One and Doctors Medical Center are restricted to the following agreed to conditions:

a. There shall be no public discussion.
b. Bargaining will be limited only to the following Article:
    i. (Article 13 and Article 7 limited to eligibility only)
c. Whatever bargained changes surround the above limited MOU section will be sunsetted based on a mutually agreeable time frame but no longer than 18 months unless another Labor Organization agrees to similar language beyond 18 months, not to exceed 24 months.
d. Both sides will bargain in good faith to reach a mutually agreeable change through bargaining.
e. Any agreement is subject to ratification by the members Public Employees Union, Local One within the Business Office Clerical Unit and Clinical Laboratory Scientist Unit respectively and Doctors Medical Center Governing Board.
f. Each group will keep their own notes.

Public Employees Union, Local One	Doctors Medical Center
1/7/2014	Bal Redlo
1/7/2014	x John Hardy
1/7/2014	
Barbara Hartman	
1-7-2014	
1-7-14	
Linda Mokes 1-7-14	

Current Benefits	Purposed Changes
Emergency Room $35.00 All Tiers / No Deductable	Emergency Room $100.00 All Tiers / No Deductable Waived if admitted
Co-Pays Office Visit $10.00 T1 &T2 / T3 40% Specialist $10.00 T1 & T2 / T3 40%	**Co-Pays** Office Visit T1 $15.00, T2 $25.00 / T3 40% Specialist T1 $25.00, T2 $35.00 / T3 40%
Physical Therapy No co-pay Unlimited Visits	**Physical Therapy** No co-pay - Limited to 40 visits per yr
Employee Contributions All Benefits Employee Only $10.00 per month Employee + Child(ren) $10.00 per month Employee + Spouse or DP $20.00 Per month	**Employee Contributions - All Benefits** Employee Only $100.00 per month Employee + 1 = $200.00 per month Employee + 2 or more $300.00 per month
Prescriptions Generic $5.00 - Mail order $10.00 Brand $10.00 - Mail order $20.00 Non-Brand $35 - Mail Order $70.00	**Prescriptions** Generic $10.00 - Mail order $20.00 Brand $20.00 - Mail order $40.00 Non-Brand $40 - Mail Order $80.00
Dental and Vision only EE only = $15.00 EE + 1 = $20.00 EE + 2 or more $25.00	
Out of Network UCR 90%	80%

Additional Benefit Choices:

Kaiser Plan – (See attached Benefit Schedule)

Employee Contributions

Low – (Deductible Plan)

Employee Only $25.00
Employee + 1 $50.00
Employee + 2 $100.00

Employee Contributions

High

Employee Only $50.00
Employee + 1 $100.00
Employee + 2 $150.00

The employer retains the right to terminate the Doctors Medical Center self-insurance plan during the term of this agreement.

Executive Summary of Final Renewal Considerations

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

11/24/13

Proposed Benefit Summary

KAISER PERMANENTE

Customer Name: Doctors Medical Center San Pablo
Customer ID: Prospect

Benefit Plan 4432
HC2:TYPE HO8; $1500 DED;$20 O P;20% IP;$30/$10RX

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your payments toward the Plan Deductible, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$4,000 per calendar year
For any one Member in a Family of two or more Members	$4,000 per calendar year
For an entire Family of two or more Members	$8,000 per calendar year
Plan Deductible for Certain Services	
For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Plan Deductible amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Lifetime Maximum	None

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

(continues)

Proposed Benefit Summary

(continued)

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply, $60 for a 31- to 60-day supply, or $90 for a 61- to 100-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$30 for up to a 30-day supply or $60 for a 31- to 100-day supply (Plan Deductible doesn't apply)

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

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

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

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

Other	You Pay
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $175 Allowance
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)
Chiropractic care	$10 per visit, to 40 visit limit (Plan Deductible doesn't apply)

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

Proposed monthly dues effective: 1/1/14—12/31/14

Proposed Benefit Summary

Doctors Medical Center

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	None
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge

(continues)

Proposed Benefit Summary *(continued)*

Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge

Other	**You Pay**
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge
Chiropractic care	$10 per visit, to 40 visit limit

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

DOCTORS MEDICAL CENTER

Letter of Understanding on Article 7: Benefit Eligibility

Article 7, Benefit eligibility. Eligibility will be changed from 20 hours/per week to 30 hours/per week. Those who currently work more than 20 hours per week but less than 28 hours, on a one-time basis between Jan 22 and Feb 1st, 2014 will be offered 28 hours, based on the following system:

1. DMC will offer additional hours for Local One employees. The additional hours will only be available if they do not exceed the budgeted hours in the department.
2. A letter and or e-mail will be sent to each eligible employee notifying them of this change and their eligibility.
3. Eligible employees will be given up to one week to reply, to HR, or a management designee, if he/she wants to add extra hours to gain benefit eligibility.
4. If all, or more than there are available extra hours, employees who wish to become eligible for benefits respond, the following bidding process with take place:
    a. Each eligible willing employee, in each classification, will, in seniority order, based on qualified employees will be offered the extra hours.
    b. Each employee that is granted, by this bid, the extra hours, will be red circled. They remain with those extra hours as long as they are employed in their position.
5. Employees may be able by mutual consent of the parties, be able to perform work in more than one classification.
6. No permanent Local 1 represented members will be laid off or suffer hour reductions because of this process to add hours to make eligible employees, as defined above, eligible for benefits.
7. Attached list of current affected employees

1/15/14
Date

Bob Redlo
Bob Redlo, Vice President of Labor Relations, Workforce Development & Patient Relations

John Hardy
John Hardy, Vice President of Human Resources

Peter Tiernan, Local One

Julio Arroyo, Local One

1/15/14
Matt Mason, Local One

Rita Mora 1/15/14

1-16-14

Barbara Hartman 1-16-14

Brenda Hardy 1-16-14

DOCTORS MEDICAL CENTER

Addendum to Side Letter of Understanding
Related to Subcontracting
Within the Business Office Clerical and Clinical Laboratory Scientist Units
Collectively Bargaining Agreements

Doctors Medical Center agrees to the following additions to the Side Letter;

- Any contracting out of services that affect employees, that beyond this Side Letter will only commence after meeting and conferring with PEU Local One.
- DMC agrees to provide 30 day's notice prior to any decision to contract out unit work.
- If Local One can show that the proposed contracted work can be done equally efficiently and is equal or of less cost, performed in-house, DMC will not pursue contracting the work in question.

Date 1/15/14

Bob Redlo, Vice President of Labor Relations, Workforce Development & Patient Relations

John Hardy, Vice President of Human Resources

Peter Tiernan, Local One

Julio Arroyo, Local One

1/15/14
Matt Mason, Local One

1/15/14

1-16-14

Barbara Hartman 1-16-14

1-16-14

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www.doctorsmedicalcenter.org
Owned and operated by the West Contra Costa Healthcare District

DOCTORS
MEDICAL CENTER

EMPLOYEE RECOGNITION RESOLUTION #2014-03

TAB 9

WEST CONTRA COSTA HEALTHCARE DISTRICT

RESOLUTION NO. 2014-03

RESOLUTION EMPLOYEE RECOGNITION

WHEREAS, Ms. Lisa Stallworth has demonstrated commitment to the mission, vision and values of Doctors Medical Center and has provided consistent and outstanding customer service as acknowledged by her peers;

WHEREAS, Ms. Stallworth has voluntarily participated in community outreach and educational programs on behalf of Doctors Medical Center, promoting community health education and disease prevention;

WHEREAS, she has contributed to the financial health of Doctors Medical Center through demonstrated cost savings and has contributed to the learning and growth of her department through leadership and exemplification of professional service behaviors;

WHEREAS she has shown commitment to Doctors Medical Center, our patients, and the surrounding community;

NOW, THEREFORE, BE IT RESOLVED that the West Contra Costa Healthcare District Board of Directors Governing Body recognizes and thanks Ms. Lisa Stallworth for her dedication to the community, this hospital and the many patients we serve.

PASSED AND ADOPTED by the Governing Body of the Board of Directors of the West Contra Costa Healthcare District on this 29th day of January, 2014, by the following vote:

AYES:

NO:

ABSTAIN:

_____

Eric Zell, Chair of the Governing Body

_____

Nancy Casazza, Secretary of the Governing Body

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 11

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD

MEC DATE: January 13, 2014

BOARD DATE: January 29, 2014

TOPIC	Comment (S)
Dawn Gideon, Interim CEO provided the following report: • Dawn Gideon reported current state of DMC's financial situation. Discussions are continued to be made with Kaiser, elected officials, and media to avert hospital closure. • Melissa Hall, Interdisciplinary Informatics Director reported some concerns with Paragon. Paragon system cannot display records past six months after upgrades were made. McKesson is currently working on resolving issues, and Robert Lacey, Gina Stone, and Melissa are available for help.	No action required by the Board
Richard Stern, Chief of Staff: • 1099 forms will be available for pick up in the MSO by the end of the month.	No action required by the Board
Policy, Procedures, Forms: A. Emergency Department 1. Emergency Department Surge Policy	Approval
Credentials Committee • Credentials Report: December 2013 • Podiatric Core Privileges (New form)	Approval Approval

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†**TITLE:** Emergency Department Surge Policy	†**CHECK ONE:** ☒ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor
† ☐ Administrative ☐ Clinical ☒ Department Emergency Department	
†**SUBMITTED BY:** Andra Kaminsky, MICU / Interim ED Director	
†**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☒ New Regulation: CMS CDPH (TJC) Other	
†**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** Plan to manage large influx of patients to the facility i.e. epidemic, Multi Casualty Incident (MCI), etc	

	MEETING DATE	APPROVAL
☐ **Manager or Department Director**†		
☐ **Medical Staff Department(s):**		
☐ Cancer Committee ☐ CV Surgery Committee		
☐ Infection Control Committee ☐ IDP Committee		
☐ Medical Ethics Committee ☐ Patient Safety Committee		
☐ Radiation Safety Committee ☐ P&T Committee		
☐ Respiratory/Critical Care/ED Committee		
☐ Quality Improvement Team: ☒ EM Committee (EPIC)	December 2013	December 2013
☐ EOC/Safety Committee ☐ Other:		
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☒ **Administrative Policy Review Committee (APRC)**†	December 2013	December 2013
☐ **Executive Leadership**		
☒ **Medical Executive Committee (MEC)** (as applicable)	January 13, 2014	January 13, 2014
☒ **Board of Trustees** *(automatic from MEC)* *(as applicable)*	January 29, 2014	

DOCTORS MEDICAL CENTER

Manual:	Sub Folder:
Title: EMERGENCY DEPARTMENT SURGE POLICY	Reviewed: Revised:
Effective Date: Expiration Date:	Page 1 of 7

PURPOSE:
The purpose of this procedure is to provide a rapid response of resources in the medical center in a focused, organized, and efficient manner to decompress the Emergency Department in overcrowded situations. Emergency Department crowding (EDC) is defined as a "situation in which the demand for Emergency Services exceeds the ability of a department to provide quality care within acceptable time frames". [1] Additionally, "Crowding is a systems issue that results from increased input as well as inefficient patient flow throughout the hospital". [2] This procedure will provide "support from all components of the health care system to improve the efficient disposition of emergency patients"[3]. This plan emulates the TJC (The Joint Commission) recommended best practice to Standard LD3.48. [4] "Criteria are written and defined for [saturation] decisions".

POLICY:
Doctors Medical Center recognizes that at certain times, it is necessary to provide additional support to the Emergency Department to maintain patient safety and quality of care. This procedure is designed to:

- expedite patient admissions
- prevent ambulance diversion
- improve patient throughput, satisfaction, safety

PROCEDURE:
Emergency department level of activity is divided into three tiers:

- Level I: Normal operations; ED resources meeting demand
- Level II: Increasing volume and/or acuity; ED resources moderately outweighed by demand
- Level III: ED resources grossly outweighed by demand[5]

The criteria below are indications that of the type of patient capacity that the ED can accommodate. If these criteria are met there may be a need for a new ED level of alert. All of the following criteria do not have to be met to trigger the appropriate level designation:

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[1] Bradley, Victoria M. "Placing Emergency Department Crowding on the Decision Agenda", p. 247.
[2] ENA Board of Directors. "Emergency Nurses Association Position Statement: Crowding in the Emergency Department", p.45.
[3] Ibid.
[4] Doxzon, Gillian; Howard-Ducsay, Janet. "ED Overcrowding: Successful Action Plans of a Southern California Community Hospital", p.329.
[5] Ibid, 327-8.

Level I	Level II	Level III
ED flow is handling patient care	Increase in ambulance traffic	Increase in ambulance traffic and staging in hallway >10 minutes
There are no excessive delays	Patient arrival to triage >15 minutes	Patient arrival to triage >30 minutes
All ancillary departments' work flow is smooth	>5 patients waiting for triage	>8 patients waiting for triage
Inpatient beds are available in all departments	Two ED patients are pending admission	Four ED patients are pending admission
	Only two monitored beds in the Emergency Department are available	Monitored beds, hallway and treatment spaces are all occupied
	Limited critical care bed availability	No inpatient beds are available
		One or more patients in ED requiring 1:1 care
		Legal limits of ED licensed nurse to patient ratios are nearing or exceeding limits

Roles of Personnel:

ED Unit Supervisor /Charge Nurse

The role of the ED Unit Supervisor /Charge RN is to coordinate the response team. He/she assigns staff to begin patient assessments, discharge patients and/or transfer patients to the floor.

Level I

Personnel	Actions
ED MD	Early identification and communication to ED Charge RN of possible admissions and discharges.
ED Unit Supervisor/Charge Nurse	1. Early identification and communication of possible admissions and discharges to the Emergency Department director and Assigned Unit Supervisor/Bed Control. 2. When inpatient bed is clean assign Primary RN to call report.

Patient Care Units	1. Admission from ED will occur within 30 minutes of ready bed 2. If inpatient unit RN is unable to receive verbal report from ED, inpatient charge nurse will receive report.
Assigned Unit Supervisor/Bed Control	Anticipate and identify potential issues that may impede ED admissions

Level II: All actions in Level I, plus:

Personnel	Actions
ED MD	1. Identify possible admit patients 2. Identify, expedite discharge of non-urgent patients 3. Consider call in of additional ED MD and/or PA if treatment space to doc time is > 60 minutes (check next shift ED doc come in early)
ED Unit Supervisor/Charge Nurse	1. Notify the ED director and Assigned Unit Supervisor/Bed Control of Level II status 2. Assess non-urgent patients occupying beds, determine alternative placement, if available 3. Discharge appropriate non-urgent patients 4. Move patients with bed assignments to inpatient unit 5. Communicate with Hospitalists Level II status and request assistance to admit patients rapidly.
Patient Care Units	1. ED will send admissions to floor within 15 minutes of bed ready status 2. Primary RN or Charge Nurse will receive report on first call 3. Call Pre-op re: check for space and admit patients that are to have surgery to the Pre-Op area
Assigned Unit Supervisor/Bed Control	1. Consider overhead page for select resources 2. Notify Vice President of Patient Care Services or AOC 3. Communicate with Patient Care Units/Directors regarding Level II status while on hospital rounds. Include Level II alert with daily Bed Status Report 4. Consider staffing resource RNs/CNA's to support care of overflow patients 5. Facilitate admission of select patients from ED to off-set patient acuity level in

	ED 6. Communicates with ED every hour to reassess Level Status
Hospitalist	1. Responds in person within 60 minutes of notification of patient admission by ED MD 2. If unavailable, or response time > 60 minutes: holding orders will be obtained and patients sent to appropriate unit for completion of admission workup

Level III: All actions in Levels I and II, plus:

Personnel	Actions
ED MD	1. Call in additional ED MD or PA if available 2. Request immediate response to the ED from admitting MD's 3. Assess ability of ED patient delay for MRI/CT/Radiology, treadmill, special procedures 4. Consider ED MD or PA at Triage
ED Unit Supervisor/Charge Nurse	1. Notify and collaborate with ED MD and Nursing Supervisor to determine Level III status 2. Coordinate and delegate patient care and department needs as necessary
Assigned Unit Supervisor/Bed Control	1. Responds to the ED and collaborates with ED Charge RN and ED MD to determine Level III status. If Administrative Coordinator is unavailable, ED Charge RN and ED MD will determine whether to initiate Level III page. 2. Activate overhead page by calling 5555: Tell PBX to page "Emergency Department Level III". Will call PBX to deactivate "Emergency Department Level III clear" after decompression of the ED. 3. Notify the Vice President of Patient Care Services and/or the AOC. 4. Assess "situation reports" from patient care units. 5. Allocate in-house resources as appropriate. 6. Consider call in of additional staff and/or retaining off-going staff to handle patient volume 7. Will assign beds to Male/Female mix if bed is needed (to be changed after Level III is cleared) 8. Consider using FICU or Same Day Surgery areas for admit holds

Personnel	Actions
	9. Assess appropriateness of activating disaster plan 10. Assess departmental staffing matrices, as legal ratios may need to be exceeded to facilitate ED patient placement. Call in additional staff as needed.
Environmental Services	1. Environmental Supervisor/Lead will report to the Emergency Department Charge Nurse. 2. Assess staff availability and prepare to reassign staff to ED or other units as directed. Prepare to keep housekeeping staff to stay overtime until Level III status has been cleared. 3. Prepare to respond to requests for additional linen 4. Clean beds for the patient rooms will be prioritized to facilitate ED patient admissions 5. The rooms will receive a full cleaning at a later time.
Nutrition Services	1. Prepare to respond to requests for staff meals 2. Prepare for requests for patient meals
Laboratory	1. The Laboratory Manager/Lead will report to the Emergency Department Charge Nurse. 2. Assign phlebotomist technician to the ED to obtain lab draws as a priority 3. Prepare to receive and process specimens with "STAT" priority 4. Lab will communicate any foreseeable delays in lab turnaround times
Radiology	1. The Medical Imaging Manager/Lead and CT supervisor will report to the Emergency Department Charge Nurse. 2. Radiology Techs and the CT transporter will retrieve and return ED patients needing radiological procedures 3. ED patients will take priority over scheduled patients.
Security	1. No more than one visitor will be allowed in the Emergency Department at a time.

Personnel	Actions
Physicians/Hospitalists/Medical Directors	1. The Hospitalist on call will immediately report to the Emergency Department to facilitate admissions and specific floor discharges of beds needed by ED patients 2. The Hospitalist will be responsible for making calls to other physicians in the group to coordinate care of ED patients. 3. Consider calling in additional an hospitalist.
Physicians/Hospitalists/Medical Directors (cont'd)	4. The Admitting Physician will perform limited evaluations while in the ED and communicate to the ED Charge RN bed placement requests. 5. The Medical Directors and Hospitalists will facilitate discharges, transfers and admits.
Cardiology	1. The Cardiology Manager/Lead will report to the Emergency Department Charge Nurse. 2. EKG technician will be assigned to the ED. 3. ED patients will take priority over scheduled patients (i.e. Treadmill or Cardiac ECHO).
Transport	1. Lead transporter will report to the Emergency Department Charge Nurse. 2. Designated Transport person will report to the ED to expedite patient transport and necessary retrieval of gurneys.
Pharmacy	1. The Director of Pharmacy/Lead will report to the Emergency Department Charge Nurse. 2. Pharmacy will deliver all non-stocked medications to the Emergency Department in a Stat mode.
Admitting	1. Assign additional personnel to the ED registration as needed. 2. Prepare to process multiple admissions from the ED
Surgery	1. Determine status of available OR suites and advise ED per "Situation report" 2. Have OR techs pick up patients that are going to the OR 3. Consider re-evaluation of surgery

Personnel	Actions
	schedule
Telecommunications	1. Announce "Emergency Department at Level III" or "Emergency Department Level III clear" as directed by the Administrative Coordinator 2. Alert directors and supervisors via text message. 3. Maintain log of date/time of activations and clearance

REFERENCES:

Bradley, Victoria M. "Placing Emergency Department Crowding on the Decision Agenda". *Journal of Emergency Nursing*. 2005 31:6: 247-58.

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"Hospitalist Admission: Speeding Admission Orders". Advisory Board Publication. Available online: http://www.advisory.com/members/default.asp?contentID=40043&collectionID=758&program=5&filename=40043.xml #6 , Feb 17, 2006.

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Pate, Bud; Pete, Derenda S. Solving Emergency Department Overcrowding: Successful Approaches to a Chronic Problem. HCPro, Inc., 2004.

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

MEDICAL STAFF COMMITTEE RECOMMENDATIONS	DATE
CREDENTIALS COMMITTEE	December 21, 2013
MEDICAL EXECUTIVE COMMITTEE	January 13, 2014
BOARD OF DIRECTORS APPROVAL	January 22, 2014

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
DECEMBER 2013

REAPPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Cianci, Paul E., MD	Medicine & Family Practice/HBO	Active	1/24/14 – 11/30/15	Approval
Chen, Charlene, MD	Medicine & Family Practice/Neurology	Telemedicine	1/24/14 – 11/30/15	Approval
Doud, Robert, MD	Medicine & Family Practice/Nephrology	Courtesy	1/24/14 – 11/30/15	Approval
Tufft, Robert, MD	Medicine & Family Practice/HBO	Active	1/24/14 – 11/30/15	Approval
Menut, Gerard, MD	Surgery/General Surgery	Active	1/24/14 – 11/30/15	Approval
Matan, Joseph, MD	Surgery/Orthopedic	Active	1/24/14 – 11/30/15	Approval
Brown, Antonio, PA-C	Surgery/Physician Assistant	Allied Health	1/24/14 – 11/30/15	Approval

VOLUNTARY RESIGNATIONS

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

Cred/Priv Com Reviewed 12/19/2013

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

SCOPE OF SERVICES

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

CORE PRIVILEGES FORMAT

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

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

STANDARDS FOR PRIVILEGES

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

HEALTH STATUS

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

OBSERVATION REQUIREMENTS

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

MINIMUM THRESHOLD CRITERIA

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

Education: DPM.

Minimum Formal Training: All applicants requesting privileges in ***Podiatry*** must have successfully completed a podiatric surgical residency accredited by the Council on Podiatric Medical Education (CPME) with documented evidence of active hospital-related practice for at least five years.

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

1) a letter from the program director verifying training (if training completed within the last three (3) years,
2) copies of proctor reports from another accredited facility where the privileges have been granted,
3) attendance at continuing education programs that include both didactic and laboratory sessions; or
4) procedure logs with outcomes to support privileges for procedures not attested to in postgraduate training.

DOCTORS MEDICAL CENTER

DEPARTMENT OF SURGERY
Delineation of Privileges
PODIATRY

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

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

Privileges in PODIATRY are granted for both clinical cognitive areas and specific procedures. All practitioners requesting privileges in PODIATRY must have successfully completed podiatric surgical residency accredited by the Council on Podiatric Medical Education (CPME)

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

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

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

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

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

APPLICANT – PLEASE READ - IMPORTANT

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

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

Practitioner Name:_____ From: _____ To: _____

CORE PRIVILEGES

❑	**CORE PODIATRIC PRIVILEGES: AFFILIATE ASSOCIATE STAFF ONLY** Affiliate Associate Staff shall consist of members who meet all of the criteria for membership in the Department of Surgery – Podiatry, but who may not meet the requirements for privileges and/or may not have the level of clinical activity to qualify for another staff category, but who appear likely to provide a distinct service to the Hospital, Medical Staff or hospital patients. • No Clinical Privileges granted • Permitted access to the medical record for refer and follow purposes only • May not write orders or perform any entries into the medical record • May not admit and/or treat patients *This Staff Category may not request "Non-Core" or any additional privileges.*

❑	**CORE PODIATRIC PRIVILEGES: AFFILIATE ACTIVE STAFF ONLY** Affiliate Active Staff shall consist of members who meet all of the criteria for membership in the Department of Surgery – Podiatry, but only maintain clinical privileges to perform histories and physicals. Affiliate Active Staff may also have medical record access. • Perform History & Physical (ASA I only) • Permitted access to the medical record • May not write orders or perform any entries into the medical record • May not admit and/or treat patients. *This Staff Category may not request "Non-Core" or any additional privileges.*

❑	**TYPE I CORE PODIATRIC PRIVILEGES: ACTIVE & COURTESY ONLY** Privileges include Co-admit, evaluate, diagnosis, provide consultation, order diagnostic studies, and treat the foot by mechanical, medical, or superficial surgical means on patient 18 years or older. The core privileges in this specialty include privileges and procedures listed below and such other procedures that are extensions of the same techniques and skills. This list is a sampling of procedures included in the core and is not intended to be all-encompassing but reflective of the categories and/or types of core procedures.

"Write-In" privileges are not accepted

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

Continue to next page for Type I Core Podiatric Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

QUALIFICATIONS FOR PODIATRY – TYPE I

Initial Applicants: To be eligible to apply for privileges in podiatry (Type I), the initial applicant must meet the following criteria: The applicant must demonstrate successful completion of podiatric surgery residency accredited by the Council on Podiatric Medical Education (CPME); **AND**

Required Current Experience: At least [n] Type I podiatric procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of an accredited training program within the past 12 months.

Reappointment Requirements: To be eligible to renew privileges in podiatry Type I, the reapplicant must meet the following criteria: Current demonstrated competence and an adequate volume of experience [n] Type I podiatric procedures, with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

Type I Core Podiatry Privileges: Active & Courtesy Only

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

	PROCEDURE	*INITIAL*
1.	Perform history and physical examination **(ASA I & II only** - No organic pathology or patients in whom the pathological process is localized and does not cause any systemic disturbance or abnormality).	
2.	Soft tissue surgery involving a nail or plantar wart excision, avulsion of toenail, excision or destruction of nail matrix or skin lesion, removal of superficial foreign body and treatment of corns and calluses	
3.	Order and interpret diagnostic tests related to podiatric patients, apply or prescribe foot appliances, orthotics, shoe modifications and special footwear	
4.	Write prescriptions for medications commonly used in practice of podiatry.	

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

Continue to next page for
Type II Core Podiatric Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

QUALIFICATION FOR PODIATRY – TYPE II

Initial Applicants: To be eligible to apply for privileges in podiatry (Type II), the initial applicant must meet the following criteria: The applicant must demonstrate successful completion of at least a twenty-four (PSR-24) month podiatric surgical residency accredited by the Council on Podiatric Medical Education (CPME); **AND**

Required Current Experience: At least [n] Type II podiatric procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of a CPME accredited podiatric surgery residency within the past 12 months.

Reappointment Requirements: To be eligible to renew privileges in podiatry Type II, the reapplicant must meet the following criteria: Current demonstrated competence and an adequate volume of experience [n] Type II podiatric procedures, with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

☐	**TYPE II CORE PODIATRIC PRIVILEGES: ACTIVE & COURTESY ONLY** Privileges include Co-admit, evaluate, and treat patients 18 years or older with podiatric problems/ conditions of the forefoot, and midfoot and non-reconstructive hindfoot. The core privileges in Type II privileges include Type I procedures (above) and such other procedures that are extensions of the same techniques. This list is a sampling of procedures included in the core and is not intended to be all-encompassing but reflective of the categories and/or types of core procedures.

Type II Core Podiatry Privileges: Active & Courtesy Only

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

	PROCEDURE	INITIAL
1.	Perform history and physical examination (**ASA I only** - No organic pathology or patients in whom the pathological process is localized and does not cause any systemic disturbance or abnormality).	
2.	Anesthesia (topical, local and regional blocks)	
3.	Debridement of superficial ulcer or wound	
4.	Digital exostectomy	
5.	Digital fusions	
6.	Digital tendon transfers, lengthening, repair	
7.	Digital/Ray amputation	
8.	Excision of benign bone cysts and bone tumors, forefoot	
9.	Excision of sesamoids	
10.	Excision of skin lesion of foot and ankle	
11.	Excision of soft tissue mass (neuroma, ganglion, fibroma)	
12.	Hallux valgus repair with or without metatarsal osteotomy (including 1st metatarsal cuneiform joint)	
13.	Implant arthroplasty forefoot	
14.	Incision and drainage/wide debridement of soft tissue infection	
15.	Incision of onychia	
16.	Metatarsal excision	
17.	Metatarsal exostectomy	
18.	Metatarsal osteotomy	
19.	Midtarsal and tarsal exostectomy (including posterior calc spur)	
20.	External neurolysis/decompression including tarsal tunnel	
21.	Onychoplasty	
22.	Open/closed reduction, digital fracture	
23.	Open/closed reduction, metatarsal fractures	
24.	Plantar fasciotomy with or without excision of calc spur	

Practitioner Name:_____ From: _____ To: _____

25.	Removal of foreign body	
26.	Syndactylization of digits	
27.	Tenotomy/capsulotomy, digit	
28.	Tnotomy/capsulotomy, metatarsal, phalangeal joint	
29.	Treatment of deep wound infections, osteomyelitis	

"Write-In" privileges are not accepted

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

Continue to next page for
Type III Core Podiatric Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

QUALIFICATION FOR PODIATRY – TYPE III

Initial Applicants: To be eligible to apply for privileges in podiatry (Type III), the initial applicant must meet the following criteria: The applicant must demonstrate successful completion of at least a thirty-six (PSR-36) month podiatric surgical residency accredited by the Council on Podiatric Medical Education (CPME); **AND**

Required Current Experience: At least [n] Type III podiatric procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of a CPME accredited podiatric surgery residency within the past 12 months.

Reappointment Requirements: To be eligible to renew privileges in podiatry Type III, the reapplicant must meet the following criteria: Current demonstrated competence and an adequate volume of experience [n] Type III podiatric procedures, with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

☐	**TYPE III CORE PODIATRIC PRIVILEGES: ACTIVE & COURTESY ONLY** Privileges include Co-admit, evaluate, diagnose, provide consultation, order diagnostic studies and treat the forefoot, midfoot, rearfoot and reconstructive and non-reconstructive hind foot and related structures by medical or surgical means. The core privileges in Type III privileges include Types I & II procedures (above) and such other procedures that are extensions of the same techniques.

Type III Core Podiatry Privileges: Active & Courtesy Only

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

	PROCEDURE	INITIAL
1.	Perform history and physical examination (**ASA I only** - No organic pathology or patients in whom the pathological process is localized and does not cause any systemic disturbance or abnormality).	
2.	Excision of accessory ossicles, midfoot and rearfoot	
3.	Excision of benign bone cyst or bvone tumors, rearfoot	
4.	Neurolysis of nerves, rearfoot	
5.	Open/closed reduction of foot fracture other than digital or metatarsal excluding calcaneal	
6.	Osteotomies of the midfoot and rearfoot	
7.	Polydactylism revision	
8.	Rearfoot fusion	
9.	Skin graft	
10.	Syndactylism revision	
11.	Tarsal coalition repair	
12.	Tendon lengthening (non-digital)	
13.	Tendon rupture repair (non-digital)	
14.	Tendon transfers (non-digital)	
15.	Tenodoesis	
16.	Traumatic injury of foot and related structures	

"Write-In" privileges are not accepted

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

Continue to next page for "Type IV Core Podiatric Privileges: Active & Courtesy Only

Practitioner Name:_____ From: _____ To: _____

QUALIFICATION FOR PODIATRY – TYPE IV

Initial Applicants: To be eligible to apply for privileges in podiatry (Type IV), the initial applicant must meet the following criteria: The applicant must demonstrate successful completion of at least a thirty-six (PSR-36) month podiatric surgical residency accredited by the Council on Podiatric Medical Education (CPME); **AND**

Required Current Experience: At least [n] Type IV podiatric procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of a CPME accredited podiatric surgery residency within the past 12 months.

Reappointment Requirements: To be eligible to renew privileges in podiatry Type IV, the reapplicant must meet the following criteria: Current demonstrated competence and an adequate volume of experience [n] Type III podiatric procedures, with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

☐	**TYPE IV CORE PODIATRIC PRIVILEGES: ACTIVE & COURTESY ONLY** Privileges include Co-admit, evaluate, and treat patients 18 years or older with podiatric problems/ conditions of the ankle to include procedures involving osteostomies, arthrodesis, and open repair of fractures of the ankle joint. Assess, stabilize, and determine deposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in Type IV include Type III podiatric privileges and procedures above and such other procedures that are extensions of the same techniques and skills.

Type IV Core Podiatry Privileges: Active & Courtesy Only

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

	PROCEDURE	*INITIAL*
1.	Perform history and physical examination (**ASA I only** - No organic pathology or patients in whom the pathological process is localized and does not cause any systemic disturbance or abnormality).	
2.	Ankle fusion	
3.	Ankle stabilization procedures	
4.	Arthrodesis, tarsal and ankle joints	
5.	Arthroplasty, with or without implants, tarsal and ankle joints, e.g., subtalar joint arthrosdesis	
6.	Major tendon surgery of the foot and ankle such as tendon transpositionings, recessions, suspensions.	
7.	Open and closed reduction fractures of the ankle	
8.	Osteotomy, multiple, tarsal bones, e.g., tarsal wedge osteotomies	
9.	Osteotomy, tibia, fibula	
10.	Surgical treatment of osteomyelitis of ankle	
11.	Plastic surgery techniques involving midfoot, rearfoot, or ankle	

"Write-In" privileges are not accepted

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

Continue to next page for Non-Core Podiatric Privileges

Practitioner Name:_____ From: _____ To: _____

NON-CORE PRIVILEGES

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

R	Priv #	PRIVILEGES/PROCEDURES
☐	#1	**Perform History & Physical – ASA II** (A moderate but definite systemic disturbance, caused either by the condition that is to be treated or surgical intervention or which is caused by other existing pathological processes, forms this group. *Requests documentation of performance of at least 5 ASA II H&Ps and/or first 5 ASA II H&Ps over read.
☐	#2	**MODERATE SEDATION: Provider Competency Evaluation Required:** On initial appointment, a physician must review the material provided and satisfactorily complete the test to obtain this privilege. On reappointment, a physician must have conducted at least eight (8) cases to retain this privilege. If eight (8) cases have not been done, he/she must satisfactorily complete the test. ☐ Proof of 8 cases perform is attached ☐ Request to retake "Provider Competency Evaluation"
☐	#3	
☐	#4	
☐	#5	

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

Applicant Signature _____ Date _____

Practitioner Name:_____ From: _____ To: _____

PRACTITIONER:

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