DOCTORS
MEDICAL CENTER

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

Wednesday, August 28, 2013

4:30 PM

Doctors Medical Center
Auditorium

2000 Vale Road

San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
August 28, 2013 – 4:30 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 JULY 24, 2013** — E. Zell

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

5. **QUALITY MANAGEMENT REPORT** — B. Ellerston
   a. Presentation
   b. Discussion
   c. Public Comment
   d. ACTION: Acceptance of the August 2013 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 – JULY 2013** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the July 2013 Financials*

8. **BANKING RESOLUTION AND SIGNATURE AUTHORIZATION UPDATE FOR: BofA MERRILL LYNCH & MECHANIC BANK** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the Signature Authorization*

9. **CAPITAL APPROVAL REQUEST: PARAGON VERSION 12.0** J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the Capital Request Paragon Upgrade Version 12.0*

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

11. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the MEC report 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
JULY 24, 2013

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS

July 24, 2013, 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

MINUTES

1. CALL TO ORDER

The meeting was called to order at 4:35 P.M.

2. ROLL CALL

Quorum was established and roll was called:

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

Excused: *Irma Anderson*

3. APPROVAL OF JUNE 26, 2013 MINUTES

The motion made by Director Deborah Campbell and seconded by Director Beverly Wallace to approve the June 26, 2013 minutes passed unanimously.

4. PUBLIC COMMENTS

Mr. Joseph Reid spoke regarding concerns of departments not fulfilling their posted regular hours of operation. He sited an example where the Radiology Department was closed at 4:30, although the posted hours listed 5:00 closure. This inconsistency is confusing and inconvenient to patients.

5. FINANCIALS- JUNE 2013

Mr. James Boatman, Chief Financial Officer, presented and sought acceptance of the June 2013 Financials. Doctors Medical Center had a Net Loss of $1,970,000 for the month of June, worse than budget by $951,000.

He reported that net patient revenue was under budget by $1,205,000 for June. Inpatient gross charges were under budget by 8.1% with patient days and discharges at 9.3% and 10.9% under budget respectively. While total outpatient volume was on target for June, outpatient surgeries were under budget by 22.3%.

Mr. Boatman pointed out that total Managed Care inpatient volume was 22.0% under budget with outpatient volume down 6.6% representing $724,000 in patient revenue. Medicare patient days were under budget by 11.4% while discharges were over budget by 15.6%. Additionally, Medicare reimbursement was reduced by 2% or $79,000 due to mandatory sequestration.

Regarding expenses, Salaries and Benefits combined were under budget by $403,000 in June. Salaries were favorable by $595,000 mainly due to continued flexing in all departments. Benefits were $192,000 over budget as a result of a significant unfavorable variance in medical benefits. Professional Fees were $53,000 over budget in June. The contract rate used in the budget along with higher than anticipated volume for the hospitalists' created the variance. Purchased Services were over budget $198,000 due to continued analytical support services and the timing of expenses related to the revenue cycle project and software invoicing.

Mr. Godley questioned the reasons for the continued increase in medical benefit costs. Ms. Gideon and Mr. Boatman reported that we have recently changed brokers, and will soon be changing the Third Party Administrator (TPA) on our benefits. These changes are a result of poor performance of the current vendors in helping to management costs. Over the next several months management will be working with the new vendors to identify the drivers of the cost increases and strategies for better management.

A motion made by Pat Godley and seconded by Sharon Drager, M.D. to accept the June 2013 Financial report passed unanimously.

6. QUALITY MANAGEMENT REPORT JULY 2013

Ms. Bobbie Ellerston, Chief Nursing Officer, presented and sought acceptance of the July 2013 Quality Management Report. She focused her presentation on the status of the Joint Commission 45-Day Evidence of Standards Compliance, and the 60-Day Evidence of Standards Compliance. We are on schedule for all compliance items.

A motion made by Sharon Drager, M.D. and seconded by Director Nancy Casazza to approve the July 2013 Quality Management Report passed unanimously.

7. PATIENT SATISFACTION REPORT AND WORK UNIT PRESENTATIONS

Mr. Bob Redlo, Vice President of Patient Relations, Labor Relations and Workforce Development, presented the patient satisfaction program update.

- The Patient Satisfaction Board Committee meetings have been occurring every other month and participation has been expanded to include co-leads of the unit based Performance Improvement teams.
- Training for all staff continues, with the third of the three modules currently offered. The training was offered across all shifts and on weekends.
- We have established nine multidisciplinary unit based performance improvement teams. The teams have selected initiatives to impact overall facility goals to improve communication and team work.
- The feedback from frontline staff and leadership regarding communication was used to develop standardized communication boards; they have been installed in all staff lounges/break rooms for easy access.
- The employee recognition program was initiated and formed a permanent recognition committee, which includes frontline, management and physician representation. Twenty-nine employees were nominated, Leizel Lago was selected as the employee of the quarter.

Mr. Redlo concluded by presenting graphs that showed a positive one quarter change in Press Ganey Patient Satisfaction scores.

Ms. Gideon and Mr. Redlo introduced three of the unit Performance Improvement Teams.

Ms. Therese Helser, Director of Pharmacy and Ms. Leizel Lago presented the goals and action plans for the pharmacy department. Ms Lago spoke on the Delivery Time of medications to the bedside to assist the clinical staff in providing medications to patients in a timely manner. The second goal focused on medication reconciliation for surgical patients.

Ms. Christine Mariner, Director of Peri-Operative Services, Ms. Beth Amaral and Ms. Darril Duthie presented the goals of the Peri-Operative PI team. They focused on improving team work through the "Blameless Apology" and "Managing-Up". They also spoke about improving communication between the patient and caregiver to increase patient awareness of what to expect by use of 5W's and Purpose Statements.

Ms. Becky McFarlain, Director of Telemetry, Ms. Nancy Kairia, Ms. Lena Yaqubi and Ms. Hermelinda Gonzales, Telemetry staff, presented the two main goals for the Telemetry Department PI team. They addressed team work, including efforts to increase patients satisfaction through an improved sense of caring, as patients transition from one department to the next, by way of Arrival and Departure Check. The "arrival" checklist guidelines require staff to introduce themselves to patients and complete standard initial

clinical activities. "Departure" check guidelines include explaining transfer and discharge processes, encourage advanced transportation planning, review medication and belongings, educate patient about any medication changes and thank patient for choosing us as their provider.

Mr. Eric Zell thanked all the PI teams for their dedication and excellent work. It is seen in the improvement in patient care satisfaction scores.

Information Only No Action Required

8. CAPITAL APPROVAL REQUEST: PROVATION MEDICAL, INC.

Mr. James Boatman, CFO sought approval of a capital item: ProVation Medical Inc. Software. The strategic impact of ProVation software will automate the documentation of cases for Cath Lab, GI, Opthalmology and Echo patients. As the physician documents the procedure it also creates the 1CD- 9 or ICD- I 0 codes needed for billing. The software will improve coding, and enhance compliance thereby improving workflow. The system also comes with data reporting tools for compliance reporting and eliminates time spent by staff creating the required reports.

Mr. Boatman stated that the ProVation software is projected to pay for itself in just over one year. It improves documentation and the efficiency of the staff for reporting and coding as well as giving physician's tools for education of their patients. Our current method of documenting cases and reporting the results is manual and can lead to under billing for procedures performed.

Dr Sharon Drager questioned if the ophthalmologists are aware of this new technology, and also questioned several process items. Dr Richard Stern indicted that he did take a look at this program and believes it will save time in documentation and you can also print off the report to put in HPF.

Ms. Bobbie Ellerston agreed with Dr. Drager that physician education will need to occur, and tightly controlled processes will need to be established to ensure access to the dictations by all consulting providers.

In response to a question from Mr. Zell, Mr. Jim Boatman stated that all updates are included in the agreement at no addition cost. This is a $204,000 of annual savings and includes the updates to the software.

A motion made by Director Nancy Casazza and seconded by Director Beverly Wallace to approve the capital purchase request for ProVation Medical Inc. software passed unanimously.

9. PROFESSIONAL SERVICES CONTRACT: G.I. SERVICES

Ms. Dawn Gideon, Interim president and Chief Executive Officer presented the contract summary for the Northern California Gastroenterology Associates (NCGA) for the provision of emergency and inpatient gastroenterology coverage, and medical direction.

She also presented the Fair Market Valuation. This arrangement is with a group/corporation, providing emergency and inpatient consult and procedure coverage on a 24 hour/7 day basis to meet the GI medical needs of the community. This arrangement is for the renewal of an existing contract but the terms have changed from the existing arrangement. Ms. Gideon answered questions regarding current and future processes and cost.

A motion made by Director John Gioia and seconded by Director Deborah Campbell to approve the Contract Terms for Northern California Gastroenterology passed unanimously.

10. CEO REPORT

Ms. Dawn Gideon reported that on Monday July 15, 2013 the Board of Directors approved the third Property Tax Transfer with Contra Costa County. This Agreement was subsequently approved by the Contra Costa County Board of Supervisors on July 16, 2013. The Tax Transfer will provide DMC an additional $9.0 million in working capital in order to close the budget gap. She also announced that on July 2, 2013 the county hosted a county wide tour for UCSF and DMC was part of that process. The group toured the Emergency Department and the Cancer Center.

Ms. Gideon highlighted that DMC has twenty high school students that have interned with the hospital this summer. The group will be "graduating" from the internship on July 26, 2013 and Mr. Eric Zell will be the honoree presenting the graduate certificates to the students. This is an excellent program for the students and for DMC to be recognized within the West Contra Costa community.

Ms. Gideon concluded with the update of the up-coming Town Hall Meetings at DMC on August 12 and 13, 2013. The presentation will have all the latest updates and changes within the hospital organization.

Information Only No Action Required

11. MEDICAL EXECUTIVE REPORT

Dr. Laurel Hodgson presented and sought approval of the Medical Executive Committee report. She pointed out that the Medical Executive Committee of the Medical Staff met on July 8, 2013 and Kathy White provided an administrative update. The MEC approved the following policies and is seeking Governing Body approval at this time:

- Nutrition Screening Policy
- IV Administration Guidelines (Updated 2013)
- Therapeutic Substitution/Restrictions (Updated 2013 Revised Antibiotic List)
- ER SEPSIS Order Set (New Form)
- DKA Order Set (Revisions)

- Lasix/Albumin
- Critical Care Insulin Infusion Protocol

Dr. Laurel Hodgson pointed out that at the recommendation of The Joint Commission, the medical staff is revising privilege forms within each of the departments to outline a set of "core" privileges that are granted to all members of the department, and expanded privileges that are granted only upon request and based on evidence of proficiency. The MEC approved the new privilege forms for Internal Medicine/Family Practice and for Emergency Medicine, and is seeking Governing Body approval at this time of the attached privileges forms.

Finally, Dr. Hodgson presented the report of the Credentials Committee.

A motion made by Richard Stern M.D. and seconded by Sharon Drager M.D. to approve the MEC presented Policies and Procedures, the new Privileges Forms, and the Credentials Report passed unanimously.

THE MEETING ADJOURNED TO CLOSED SESSION AT 6:20 PM

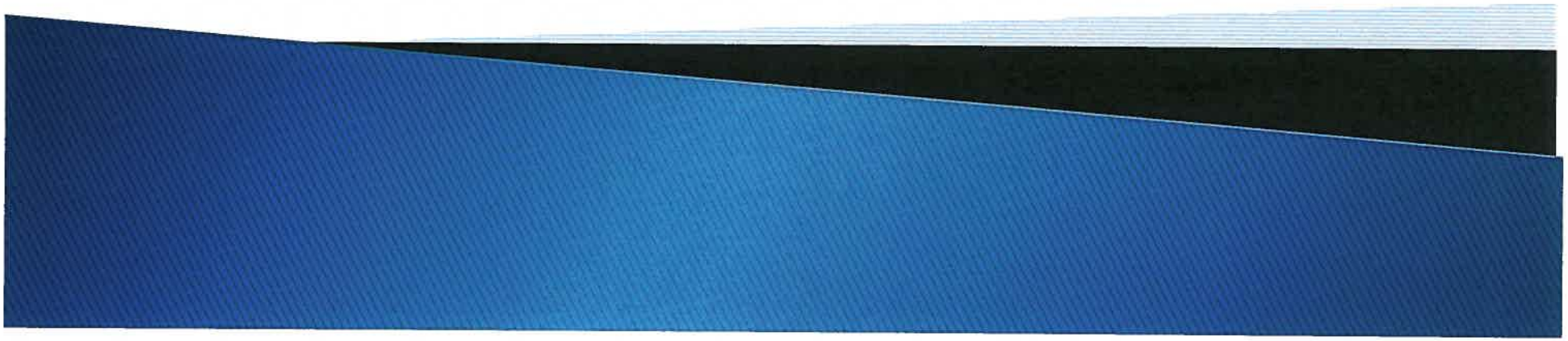
DOCTORS MEDICAL CENTER

QUALITY REPORT

TAB 5

Quality Management Report

AUGUST 2013

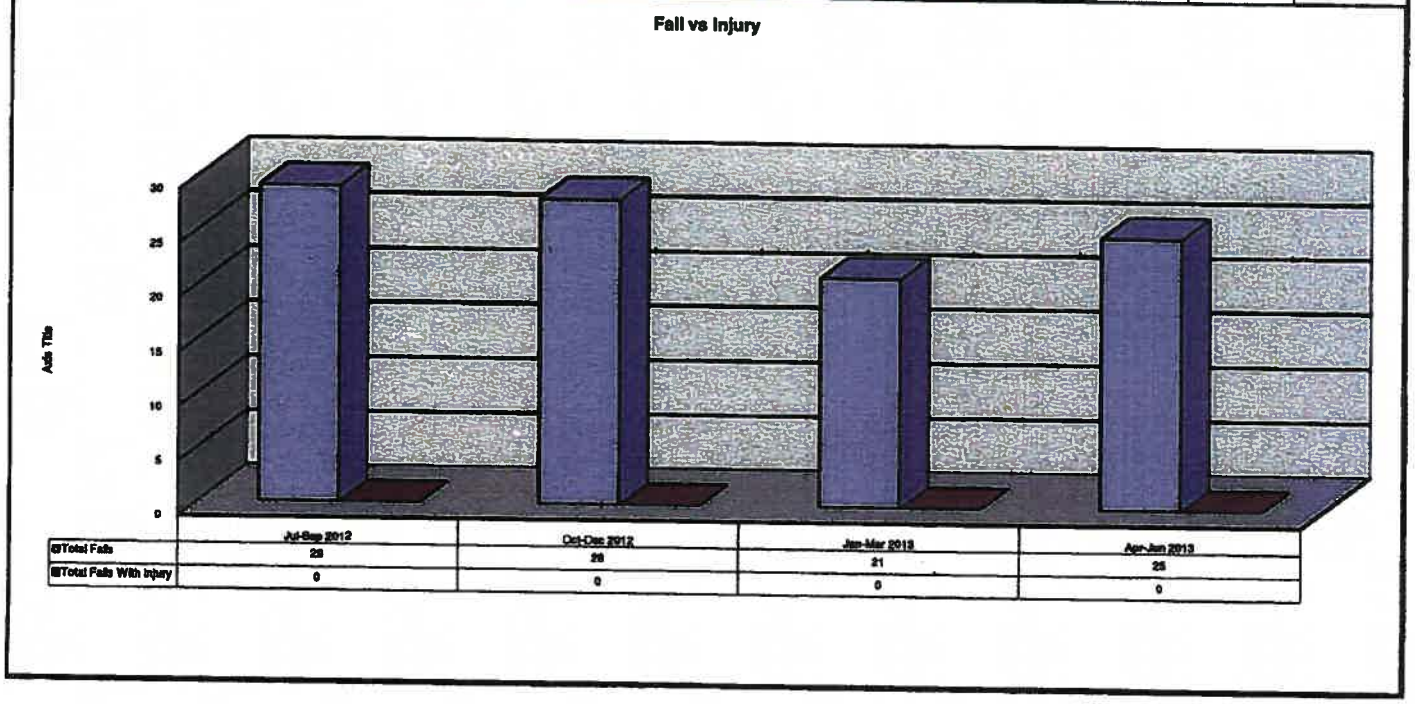


DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Patient Safety: Falls

Indicator	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	Total
Total Falls	29	28	21	25	103
Total Falls With Injury	0	0	0	0	0
% Falls with Injury	0	0	0	0	0
Total Falls per 1,000 Patient Days (APD)	2.657	2.217	2.016	2.612	2.376
Total Falls w/Injury per 1,000 Patient Days (APD)	0	0	0	0	0.000
CALNOC Benchmark	2.94	2.94	2.94	2.94	
CALNOC Benchmark (Falls with Injury)	0.1	0.1	0.1	0.1	

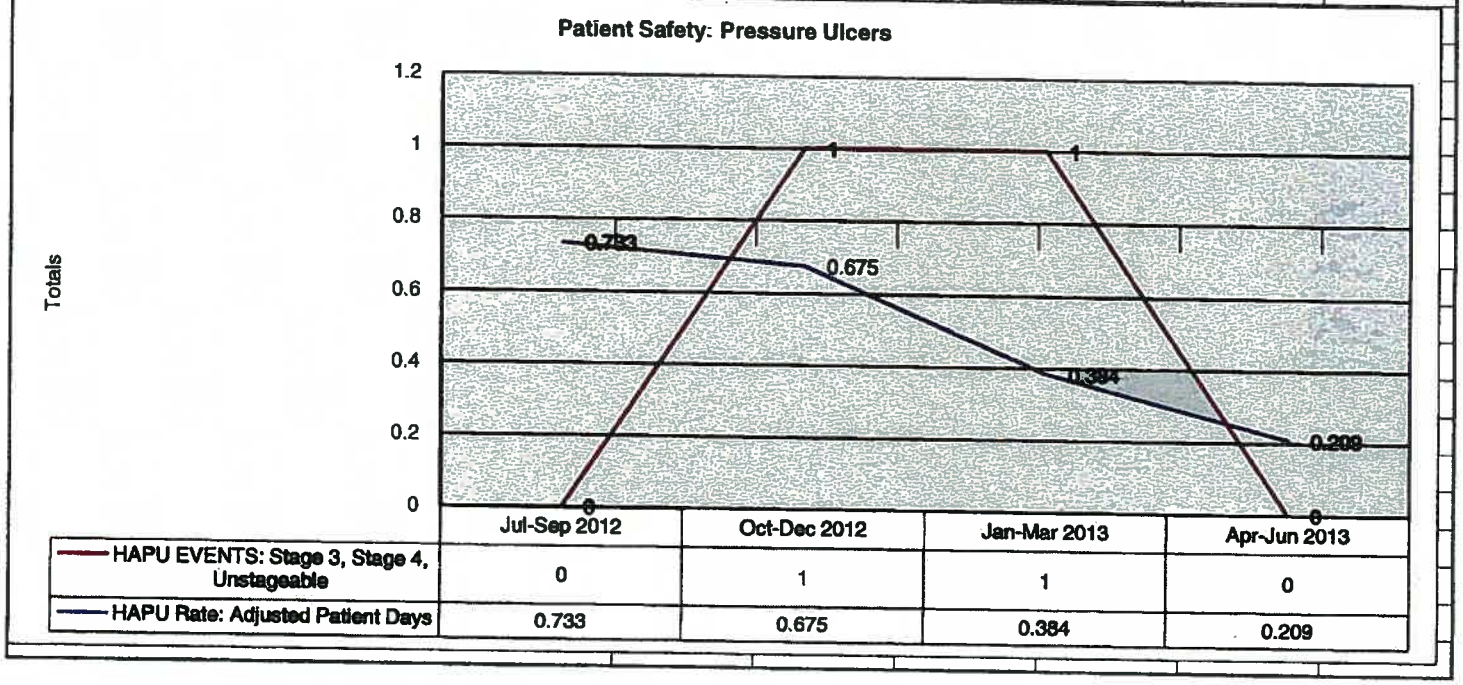


DOCTORS MEDICAL CENTER

Quality/Patient Safety Metrics

Patient Safety: Pressure Ulcers

Indicator	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	Total
Total HAPU Events	8	7	4	2	21
HAPU EVENTS: Stage 3, Stage 4, Unstageable	0	1	1	0	2
Skin Integrity Events by Location	28	30	14	16	88
HAPU Rate: Adjusted Patient Days	0.733	0.675	0.384	0.209	0.500



HOSPITAL PERFORMANCE IMPROVEMENT COMMITTEE (HPIC) REPORTING FORM

Information Technology

Mobile Device Management

Report is for August 2013

SITUATION (Reason indicator was selected & What the indicator is):

An increase in the number of mobile devices accessing DMC email and sharing PHI and/or confidential information.

BACKGROUND (Information about the indicator & past data)

HIPAA requires electronic communication that travels outside the hospital network be encrypted while in motion. We also need a way to protect this data while at rest and if the device is lost or stolen.

ACTION TAKEN & RESULTS:

DMC has purchased mobile device encryption solution to ensure compliance. This solution ensures that data at rest on the device (including BYOD), is encrypted and allows the end user to wipe PHI from the device if it should become compromised or lost.

RECOMMENDATIONS/FOLLOWUP:

The solution is currently undergoing testing by a pilot group and will be available to the population by September 1st.

Submitted by: Wayne Tenney **Date: 08/05/2013**

HOSPITAL PERFORMANCE IMPROVEMENT COMMITTEE (HPIC) REPORTING FORM

Information Technology

Laptop Encryption

Report is for August 2013

SITUATION (Reason indicator was selected & What the indicator is):

HIPAA requires that we take reasonable action to secure patient data on portable computers.

BACKGROUND (Information about the indicator & past data)

DMC has 49 laptop computers that could contain PHI or confidential information and are at risk of theft either inside or outside the facility.

ACTION TAKEN & RESULTS:

DMC is currently testing and evaluating possible solutions to ensure compliance. Any solution chosen will ensure data is encrypted if the laptop should become compromised or lost.

RECOMMENDATIONS/FOLLOWUP:

Many solutions are currently being evaluated. Approval is expected by September 1st.

Submitted by: Wayne Tenney **Date: 08/05/2013**

HOSPITAL PERFORMANCE IMPROVEMENT COMMITTEE (HPIC) REPORTING FORM

Information Technology

Secure Mail

Report is for August 2013

SITUATION (Reason indicator was selected & What the indicator is):

DMC is not able to share PHI via email and meet HIPAA requirements.

BACKGROUND (Information about the indicator & past data)

HIPAA requires electronic communication that has a destination outside the hospital network be encrypted while in motion. DMC does not have a uniform way to accomplish this. Often times relying on the vendor to supply the technology so that we can remain compliant. If there is no way to encrypt PHI, this information is sent unprotected.

ACTION TAKEN & RESULTS:

DMC has purchased an email encryption solution to ensure compliance. This solution is active and passive in order to help mail users that may forget.

RECOMMENDATIONS/FOLLOWUP:

The solution is currently undergoing testing by a pilot group and will be available to the population by September 1st.

Submitted by: Wayne Tenney **Date: 08/05/2013**

DOCTORS
MEDICAL CENTER

STROKE CENTER PRESENTATION

TAB 6

West Contra Costa Healthcare District Board

DMC Stroke Program

August 28, 2013

DOCTORS MEDICAL CENTER

West Contra Costa Healthcare District

Doctors Medical Center is owned and operated by the West Contra Costa Healthcare District, a public agency formed under the State of California Local Healthcare District Law. The District encompasses West Contra Costa County. Doctors Medical Center is dedicated to providing high-quality healthcare to meet the diverse needs of our community.

DOCTORS MEDICAL CENTER

2012 Service Population

reported in percentages

Women: 52

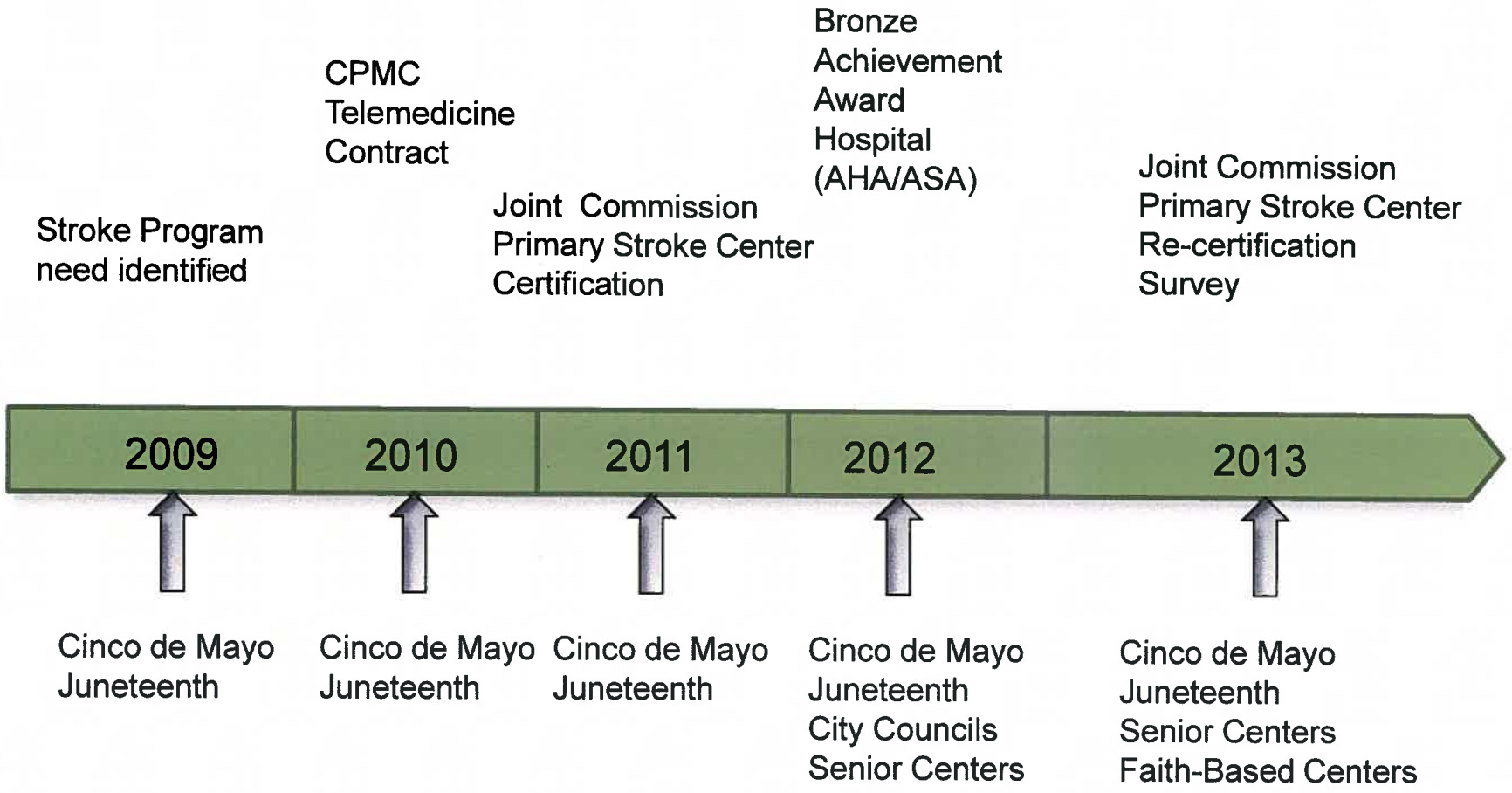
Men: 48

White: 39
Hispanic: 10
Black: 24
Other: 22
Asian: 15

Ages 18-45: 6
Ages 46-65: 30
Ages 66-85: 37
Ages >85: 27

DOCTORS MEDICAL CENTER

Key Milestones and Events



DOCTORS MEDICAL CENTER

The Teams

- **Senior Leadership Team**
  - Dawn Gideon, Interim CEO
  - Kathy White, Interim COO
  - Jim Boatman, CFO
  - Bobbie Ellerston, Interim CNO
  - John Hardy, VP Human Resources
- **Stroke Program Team**
  - Robert Fox MD, Staff Neurologist
  - Desmond Carson MD, Stroke Program Director
  - Susila Patel RN, Stroke Program Coordinator

DOCTORS MEDICAL CENTER

Stroke Committee Members

- Robert Fox MD, Neurology
- Desmond Carson MD, Stroke Program Director
- Humayun Tufail MD, Galen Physicians Medical Director
- Malcolm Johnson MD, CEP Director Emergency Physicians
- Susila Patel RN, Stroke Program Coordinator
- Kathy White, Interim COO
- Bobbie Ellerston, Interim CNO/SVP Patient Care Services
- Denise Jow, Clinical Dietician
- Wiley Watterlond, Director Imaging Services
- Maureen Fitzgibbons, Director Laboratory Services
- Ron Moore, Director Rehabilitation Services
- Andra Kaminsky RN, Director MICU and ED
- Therese Helser, Pharmacy Director
- Remy Goldsmith, Community Relations
- Leslie McGee, Education Coordinator
- Huong Nguyen, CEP Administrative Assistant

DOCTORS MEDICAL CENTER

Community Partners

Sutter Health CPMC

Genentech
A Member of the Roche Group

American Heart Association | American Stroke Association

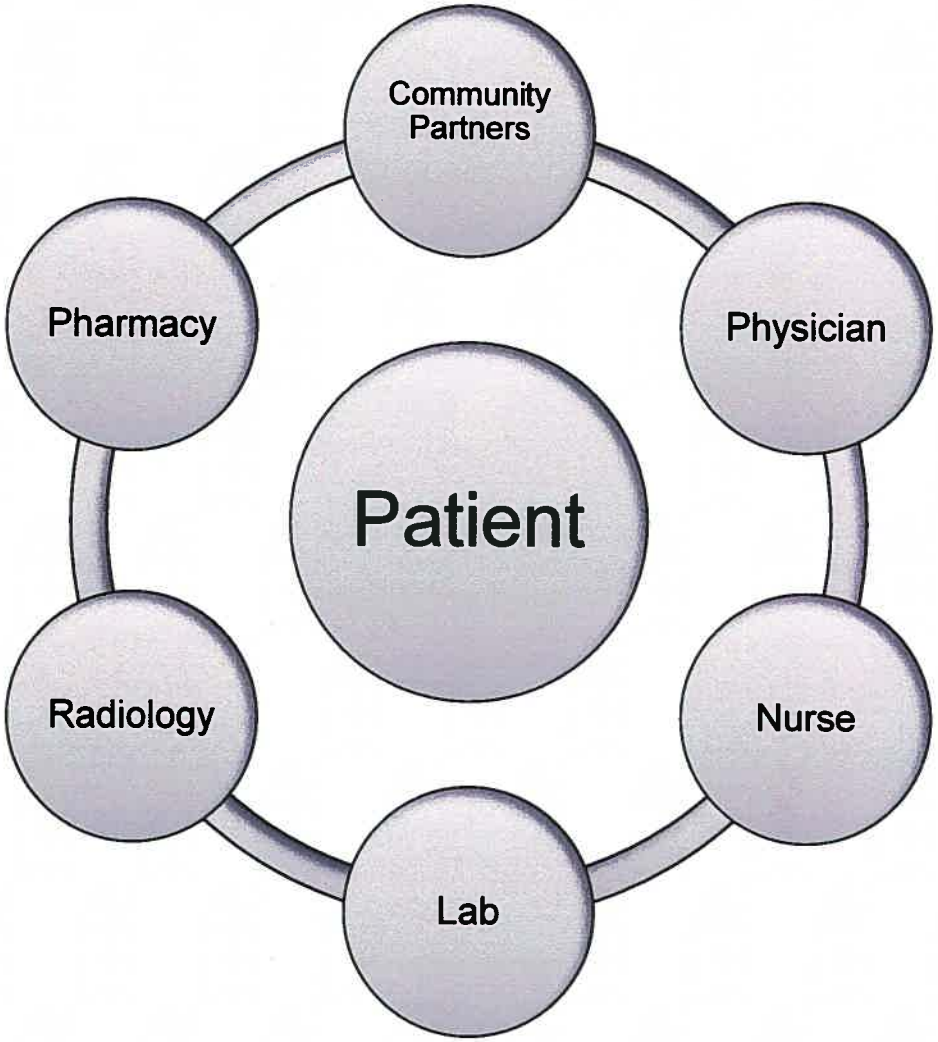
AMR

CONTRA COSTA HEALTH SERVICES

KAISER PERMANENTE

DOCTORS MEDICAL CENTER

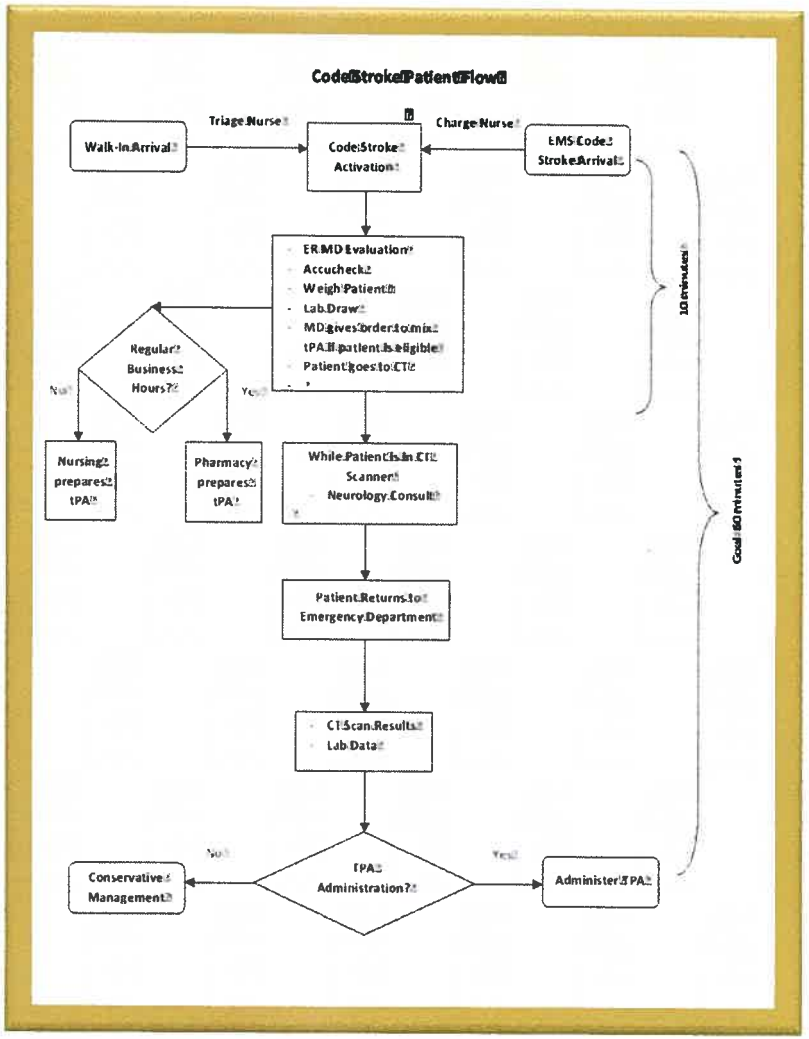
Stroke Alert Team



DOCTORS MEDICAL CENTER

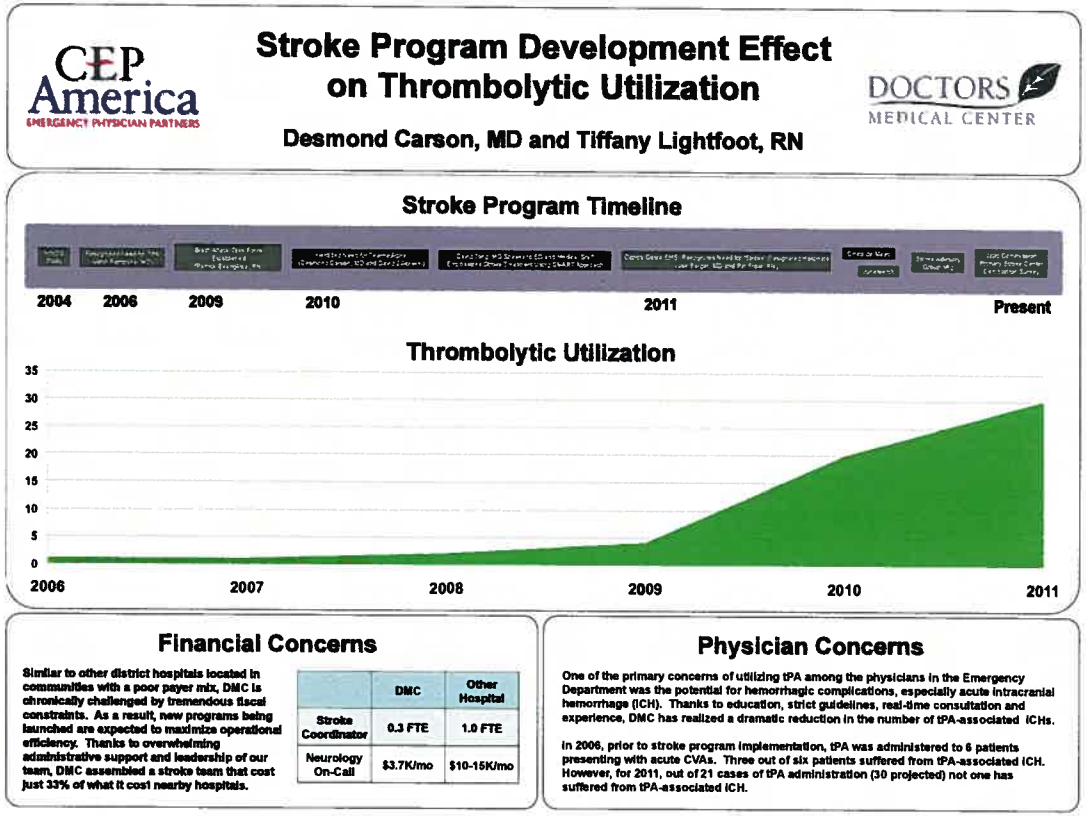
Stroke Alert

- Patient pathways for Emergency Department and inpatient stroke alerts
- Maps team coordination for timely care



DOCTORS MEDICAL CENTER

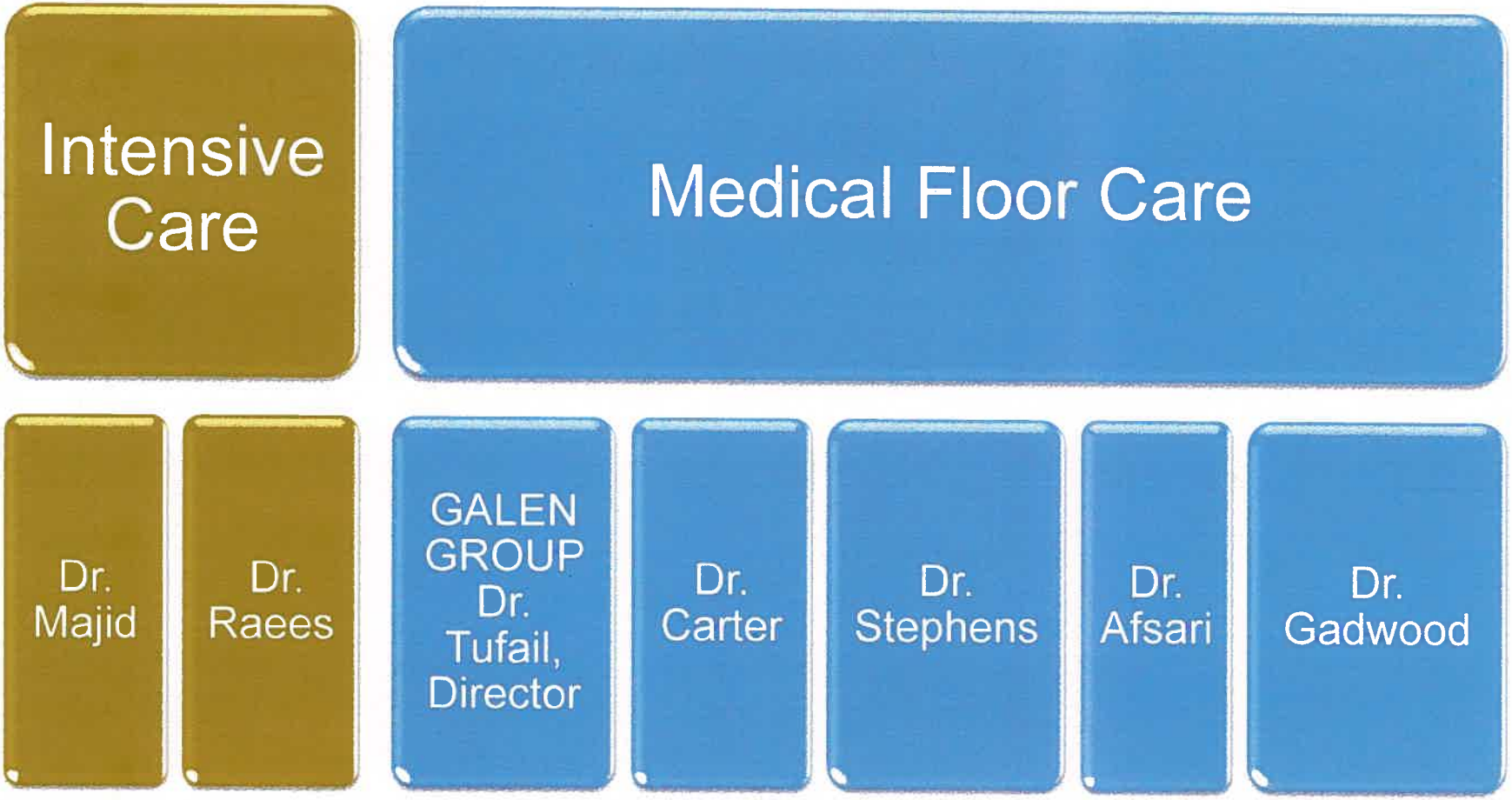
Thrombolytic Utilization



- 2000: 6 patients treated with IV thrombolytics
- 2012: 56 patients treated with IV thrombolytics

DOCTORS MEDICAL CENTER

Inpatient Physician Partners



DOCTORS MEDICAL CENTER

OUTPATIENT REHABILITATION

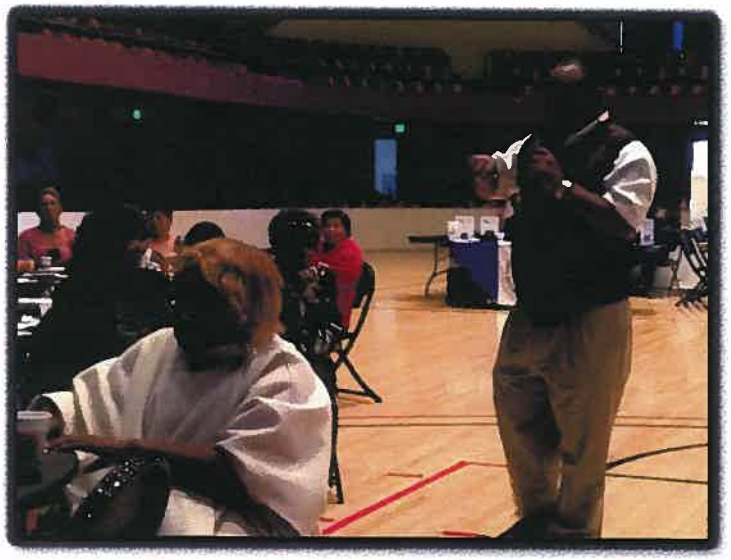
DOCTORS MEDICAL CENTER

COMMUNITY EDUCATION

DOCTORS MEDICAL CENTER

Education

- **Patient/Family**
  - Take-Home Information, Pre-Discharge Education, Follow up Phone Calls
- **Community Outreach**
  - Cinco de Mayo
  - Juneteenth
  - City Council Meetings
  - Senior Centers
  - Faith-Based Centers
  - Housing Communities



DOCTORS MEDICAL CENTER

Hospital Staff Education

- Board of Directors: Presentation
- Executive Team: Computer Modules
- Physicians: Grand Rounds, Telemedicine In-Service, and CME Guided Information
- Nursing: Classroom and Computer Modules
- Ancillary Staff: In-Service and Computer Modules

DOCTORS MEDICAL CENTER

Performance Improvement Initiatives

from 1Q12 to 1Q13

VTE Prophylaxis
88% → 96%

Patient Education
81% → 90%

D/C on Statin Medication
89% → 100%

DOCTORS MEDICAL CENTER

Thank you

From the Doctors Medical Center Stroke Program

Questions & Answers

DOCTORS MEDICAL CENTER

DOCTORS
MEDICAL CENTER

FINANCIALS
JULY 2013

TAB 7

DOCTORS MEDICAL CENTER

Board Presentation

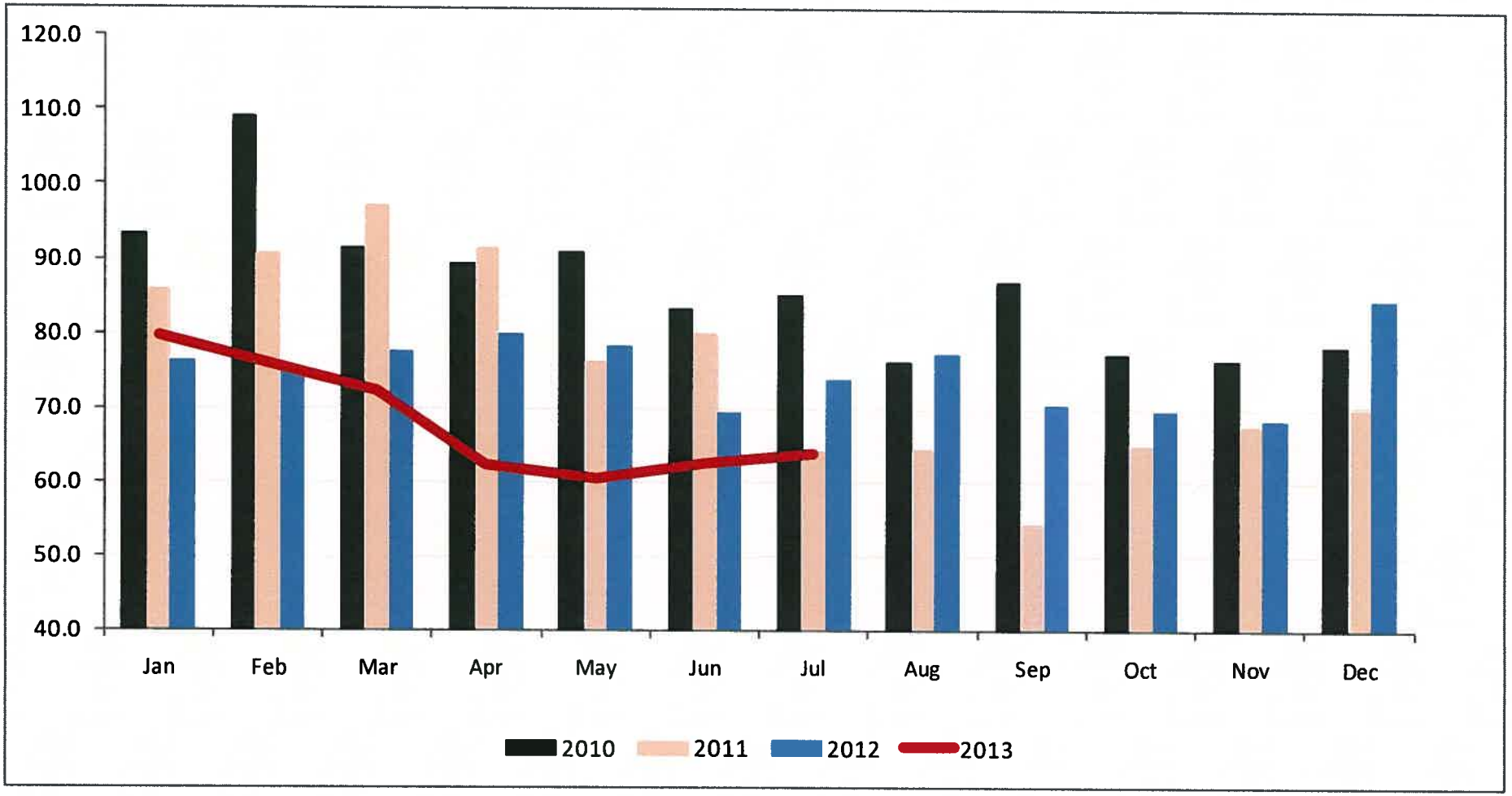
July 2013

Financial Report

Financial Report Key Points

- Net loss was $1.9 M in July, under budget by $235K.
- Net patient revenue was $792K under budget.
- Operating expenses were $617K under budget.

Average Daily Census
Jan-10 thru Jul-13



Statement of Activity - Summary

For the Period Ending

July 31, 2013

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
8,679	9,502	(823)	**Net Operating Revenues $**	67,155	72,952	(5,797)
11,333	11,950	617	**Total Operating Expenses $**	82,557	85,204	2,647
(2,654)	(2,449)	(205)	**Income/(Loss) from Operations $**	(15,402)	(12,252)	(3,150)
725	755	(30)	**Income from Other Sources $**	5,205	5,220	(15)
(1,929)	(1,694)	(235)	**Net Income / (Loss) $**	(10,197)	(7,032)	(3,165)
1,976	2,017	(41)	**Patient Days**	14,441	15,901	(1,460)
450	438	12	**Discharges**	3,288	3,471	(183)
5,788	6,069	(281)	**Outpatient Visits**	42,664	43,510	(846)
515	564	49	**Worked FTE's**	574	617	43
1.46	1.55	(0.09)	**Medicare CMI**	1.55	1.55	0.00

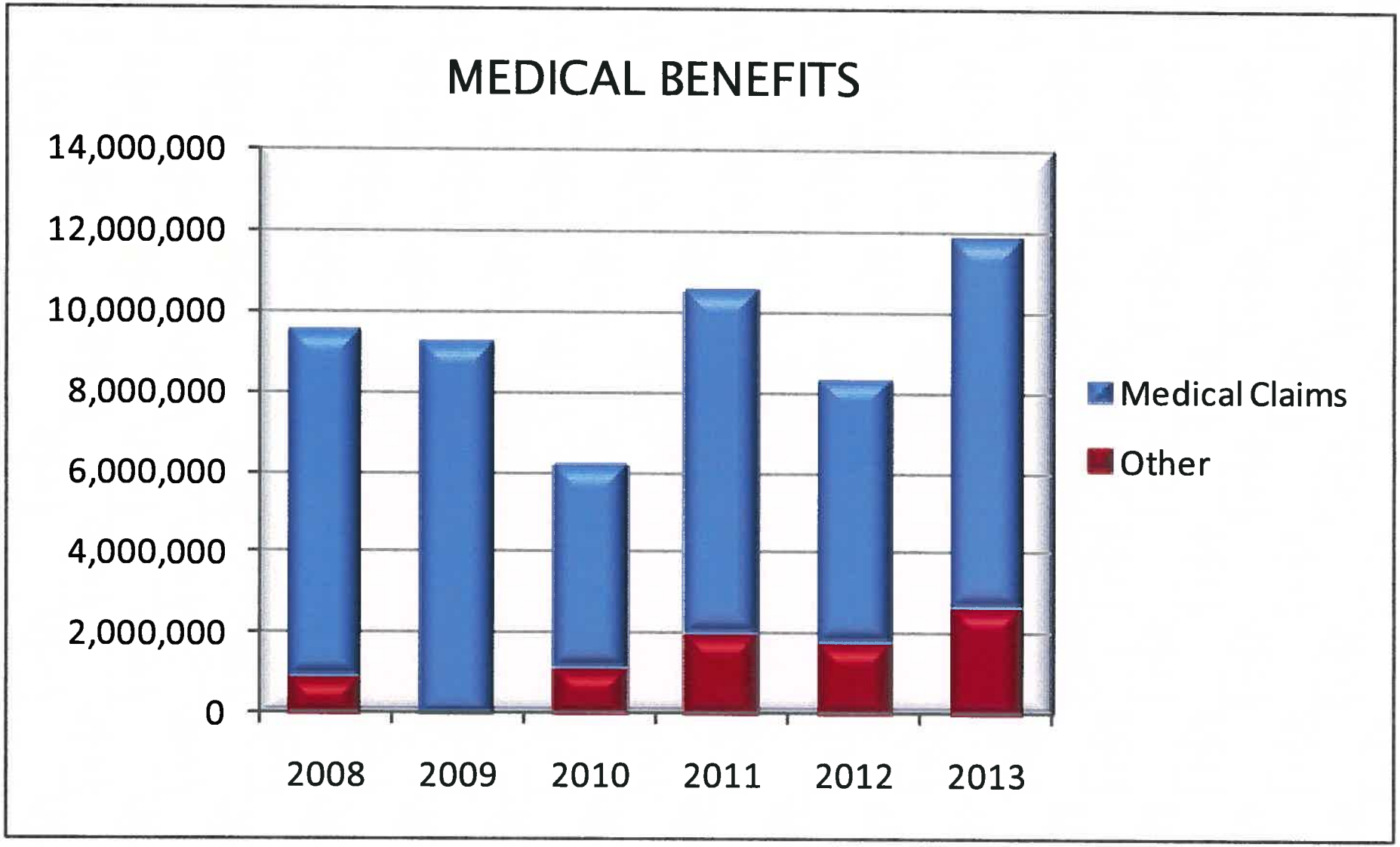
Budget Variances – Net Revenue

- Commercial / PPO / HMO – ($ 902K)
- Government / Workers Comp– $ 153K
- Medi-Cal / Medi-Cal HMO – ($ 48K)
- Medicare / Medicare HMO – ($ 40K)
  - 2% Sequestration – ($77K)

Budget Variances - Expenses

- **Salaries & Benefits** $464K - Effective flexing primarily in clerical staff offset by higher health insurance costs.

- **Supplies** $123K - Hospital wide cost savings are offset by increased cost for implants.

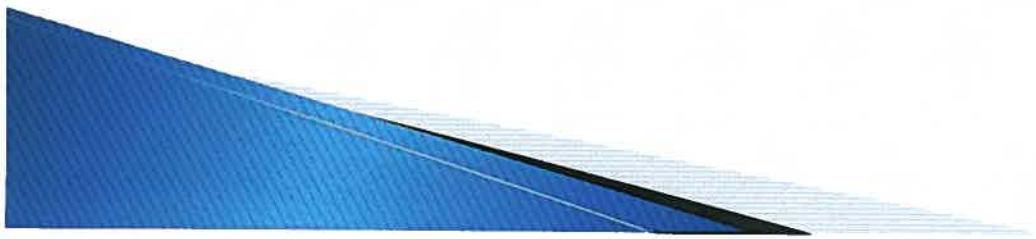

MEDICAL BENEFITS
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
0
2008
2009
2010
2011
2012
2013
Medical Claims
Other

WEST CONTRA COSTA HEALTHCARE DISTRICT
INCOME STATEMENT
Seven Months Ended July 31, 2013
(Amounts in Thousands)

	CURRENT YTD				PRIOR YEAR		
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL	VAR	VAR %
OPERATING REVENUE	67,155	72,952	(5,797)	-7.9%	70,694	(3,539)	-5.0%
OPERATING EXPENSES							
Salaries & Wages	33,128	36,096	2,968	8.2%	37,265	4,137	11.1%
Employee Benefits	20,098	19,306	(792)	-4.1%	18,680	(1,418)	-7.6%
Professional Fees	6,887	6,562	(325)	-5.0%	6,744	(143)	-2.1%
Supplies	9,168	9,424	256	2.7%	10,131	963	9.5%
Purchased Services	6,025	5,996	(29)	-0.5%	6,012	(13)	-0.2%
Rentals & Leases	1,916	2,017	101	5.0%	1,807	(109)	-6.0%
Depreciation & Amortization	2,880	3,141	261	8.3%	2,778	(102)	-3.7%
Other Operating Expenses	2,455	2,662	207	7.8%	2,311	(144)	-6.2%
Total Operating Expenses	82,557	85,204	2,647	3.1%	85,728	3,171	3.7%
Operating Profit / Loss	(15,402)	(12,252)	(3,150)	25.7%	(15,034)	368	-2.4%

Medicare Inpatient Payment Changes

	Dollar Impact (thousands)	Percent Change
Estimated Inpatient Payments	$35,053	
Marketbasket Update (includes budget neutrality)	$758	2.20%
ACA-Mandated Marketbasket Reductions	($268)	0.70%
ATRA-Mandated Coding Adjustment Reduction	($266)	-7.00%
Inpatient Admission Guidance Offset	($71)	-2.00%
Wage Index/GAF	$711	2.00%
MS-DRG Updates	($141)	-0.40%
ACA- Mandated Quality-Based Payment programs	$27	0.10%
ACA-Mandated DSH Payment Changes	($2,896)	8.10%
Budget Control Act – Sequestration	($658)	1.90%
Estimated 2014 IPPS Payments	$32,249	
Total Estimated Change FFY 2013 to FFY 2014	($2,804)	-8.00%



Quality Program Changes for 2014

	2013	2014	Change
Base Operating Dollars Subject to Quality Programs**	$26,666,500	$27,217,200	
Value Based Purchasing Adjustment Factor	0.9997	0.9996	
Dollar Impact	($8,000)	($10,300)	($2,300)
Readmission Adjustment Factor	0.9989	1.0000	
Dollar Impact	($29,300)	$0	$29,300
Net Impact of Quality Programs	($37,300)	($10,300)	**$27,000**

Cash Position
July 31, 2013

(Thousands)

	July 31, 2013	December 31, 2012
Unrestricted Cash	$8,856	$5,059
Restricted Cash	$9,929	$11,612
Total Cash	$18,785	$16,671
Days Unrestricted Cash	24	11
Days Restricted	29	27
Total Days of Cash	53	39

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

Accounts Receivable

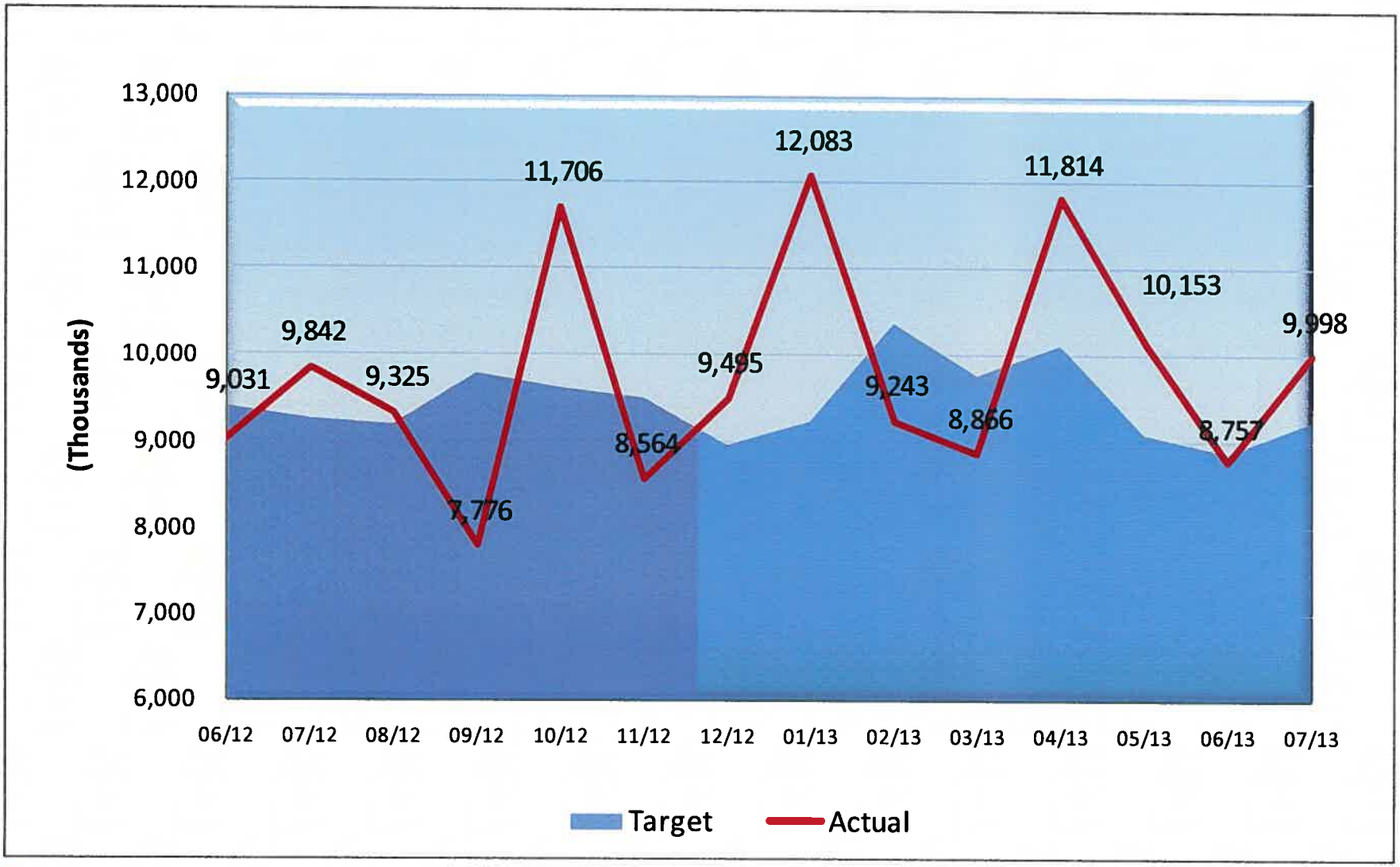
July 31, 2013

(Thousands)

	July 31, 2013	December 31, 2012
Net Patient Accounts Receivable	$20,404	$31,007
Net Days in Accounts Receivable	69.7	92.6

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

Cash Collections



Capital Budget 2013

Listed Equipment	$1,493,000
Emergency Funds	507,000
Total Capital Budget:	$2,000,000
Commited To Date:	$1,319,000
Remaining Capital	$681,000

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

CURRENT PERIOD ACTUAL	CURRENT PERIOD BUDGET	CURRENT PERIOD VAR	CURRENT PERIOD VAR %	PRIOR YEAR ACTUAL		CURRENT YTD ACTUAL	CURRENT YTD BUDGET	CURRENT YTD VAR	CURRENT YTD VAR %	PRIOR YEAR ACTUAL
					OPERATING REVENUE					
8,579	9,371	(792)	-8.5%	9,216	Net Patient Service Revenue	66,494	72,043	(5,549)	-7.7%	68,956
100	130	(30)	-23.2%	151	Other Revenue	661	909	(248)	-27.3%	1,738
8,679	9,502	(823)	-8.7%	9,367	**Total Operating Revenue**	67,155	72,952	(5,797)	-7.9%	70,694
					OPERATING EXPENSES					
4,305	4,936	631	12.8%	5,330	Salaries & Wages	33,128	36,096	2,968	8.2%	37,265
3,009	2,842	(167)	-5.9%	3,030	Employee Benefits	20,098	19,306	(792)	-4.1%	18,680
873	860	(13)	-1.5%	934	Professional Fees	6,887	6,562	(325)	-5.0%	6,744
1,268	1,391	123	8.8%	1,521	Supplies	9,168	9,424	256	2.7%	10,131
789	802	13	1.7%	1,058	Purchased Services	6,025	5,996	(29)	-0.5%	6,012
287	281	(6)	-2.0%	306	Rentals & Leases	1,916	2,017	101	5.0%	1,807
407	469	62	13.3%	416	Depreciation & Amortization	2,880	3,141	261	8.3%	2,778
395	368	(27)	-7.5%	440	Other Operating Expenses	2,455	2,662	207	7.8%	2,311
11,333	11,950	617	5.2%	13,035	**Total Operating Expenses**	82,557	85,204	2,647	3.1%	85,728
(2,654)	(2,449)	(205)	8.4%	(3,668)	**Operating Profit / Loss**	(15,402)	(12,252)	(3,150)	25.7%	(15,034)
					NON-OPERATING REVENUES (EXPENSES)					
-	-	-	0.0%	-	Other Non-Operating Revenue	-	-	-	0.0%	1,200
1,123	1,133	(10)	0.9%	1,586	District Tax Revenue	7,861	7,950	(89)	1.1%	5,834
7	4	3	76.0%	4	Investment Income	125	35	90	254.3%	185
(405)	(383)	(22)	0.0%	(491)	Less: Interest Expense	(2,781)	(2,765)	(16)	0.6%	(2,373)
725	755	(30)	-3.9%	1,099	**Total Net Non-Operating**	5,205	5,220	(15)	-0.3%	4,846
(1,929)	(1,694)	(235)	13.9%	(2,569)	**Income Profit (Loss)**	(10,197)	(7,032)	(3,165)	45%	(10,188)
					Profitability Ratios:					
-30.6%	-25.8%	25.0%		-39.2%	Operating Margin %	-22.9%	-16.8%	54.3%		-21.3%
-22.2%	-17.8%	-4.4%		-27.4%	Profit Margin %	-15.2%	-9.6%	-5.5%		-14.4%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
July 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
2,296	2,396	99	4.2%	2,413	SWB / APD	2,297	2,192	(105)	-4.8%	2,237
64.5%	65.1%	75.3%		64.1%	SWB / Total Operating Expenses	64.5%	65.0%			65.3%
3,558	3,680	122	3.3%	3,763	Total Operating Expenses / APD	3,563	3,371	(192)	-5.7%	3,427
32,945	34,115	(1,170)	-3.4%	36,817	I/P Gross Charges	235,405	250,951	(15,546)	-6.2%	245,734
20,165	20,807	(642)	-3.1%	18,760	O/P Gross Charges	142,313	147,945	(5,632)	-3.8%	134,296
53,110	**54,922**	**(1,812)**	**-3.3%**	**55,577**	**Total Gross Charges**	**377,718**	**398,896**	**(21,178)**	**-5.3%**	**380,030**
					Payor Mix (IP and OP)					
52%	50%	2%		51%	Medicare %	55%	50%	4%		51%
21%	22%	-1%		20%	Medi-Cal %	20%	22%	-2%		20%
11%	14%	-3%		12%	Managed Care	12%	14%	-2%		12%
4%	4%	0%		4%	Other Government %	3%	4%	-1%		4%
12%	10%	2%		13%	Self Pay %	10%	10%	0%		13%
					STATISTICS					
461	445	16	3.6%	501	Admissions	3,330	3,495	(165)	-4.7%	3,561
450	438	12	2.7%	478	Discharges	3,288	3,471	(183)	-5.3%	3,536
1,976	2,017	(41)	-2.0%	2295	Patient Days	14,441	15,901	(1,460)	-9.2%	16,174
63.7	65.1	(1.3)	-2.0%	74.0	Average Daily Census (ADC)	68.1	75.0	(6.9)	-9.2%	75.9
4.39	4.61	0.21	4.6%	4.80	Average Length of Stay (LOS)- Accrual Based	4.39	4.58	0.19	4.1%	4.57
31	31			31	Days in Month	212	212			213
725	705	20	2.9%	722	Adjusted Discharges (AD)	5,276	5,517	(242)	-4.4%	5,468
3,185	3,247	(62)	-1.9%	3,464	Adjusted Patient Days (APD)	23,171	25,275	(2,104)	-8.3%	25,013
103	105	(2)	-1.9%	112	Adjusted ADC (AADC)	109	119	(10)	-8.3%	117
66	69	(3)	-4.3%	82	Inpatient Surgeries	512	542	(30)	-5.5%	516
83	82	1	1.2%	79	Outpatient Surgeries	567	642	(75)	-11.7%	653
149	**151**	(2)	-1.3%	**161**	**Total Surgeries**	**1,079**	**1,184**	(105)	-8.9%	**1,169**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
July 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
2,856	2,828	28	1.0%	2992	ED Outpatient Visits	21,929	20,699	1,230	5.9%	21,192
2,849	3,159	(310)	-9.8%	2871	Ancillary Outpatient Visits	20,168	22,169	(2,001)	-9.0%	22,015
83	82	1	1.2%	79	Outpatient Surgeries	567	642	(75)	-11.7%	653
5,788	**6,069**	(281)	-4.6%	**5,942**	**Total Outpatient Visits**	**42,664**	**43,510**	(846)	-1.9%	**43,860**
402	398	4	0.9%	461	Emergency Room Admits	3,028	3,128	(100)	-3.2%	3,245
14.1%	14.1%			15.4%	% of Total E/R Visits	13.8%	15.1%			15.3%
87.2%	89.5%			92.0%	% of Acute Admissions	90.9%	89.5%			91.1%
515	564	49	8.6%	612	Worked FTE	574	617	43	7.0%	621
641	668	27	4.0%	729	Paid FTE	682	718	35	4.9%	724
5.01	5.38	0.37	6.9%	5.48	Worked FTE / AADC	5.25	5.18	(0.07)	-1.4%	5.29
6.24	6.38	0.14	2.1%	6.52	Paid FTE / AADC	6.24	6.02	(0.22)	-3.7%	6.16
2,693	2,886	(193)	-6.7%	2,660	Net Patient Revenue / APD	2,870	2,850	19	0.7%	2,757
16,673	16,914	(241)	-1.4%	16,042	I/P Charges / Patient Days	16,301	15,782	519	3.3%	15,193
3,484	3,428	56	1.6%	3,157	O/P Charges / Visit	3,336	3,400	(65)	-1.9%	3,062
1,351	1,520	169	11.1%	1,539	Salary Expense / APD	1,430	1,428	(2)	-0.1%	1,490
4.77	5.54	0.77	13.9%	5.12	Medicare LOS - Discharged Based	4.70	5.14	0.44	8.5%	4.81
1.46	1.55	(0.09)	-5.9%	1.60	Medicare CMI	1.55	1.55	0.00	0.2%	1.53
3.27	3.57	(0.31)	-8.6%	3.20	Medicare CMI Adjusted LOS	3.02	3.31	(0.29)	-8.7%	3.14
4.39	4.61	0.21	4.6%	4.80	Total LOS - Discharged Based	4.39	4.59	0.20	4.3%	4.59
1.46	1.52	(0.06)	-3.7%	1.55	Total CMI	1.50	1.47	0.03	2.1%	1.48
3.00	3.03	(0.03)	-1.0%	3.10	Total CMI Adjusted LOS	2.92	3.11	(0.19)	-6.2%	3.11

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
July 31, 2013
(Amounts in Thousands)

	Current Month	Dec. 31, 2012
ASSETS		
Cash	8,856	5,059
Net Patient Accounts Receivable	20,404	31,007
Other Receivables	1,908	464
Inventory	1,670	1,731
Current Assets With Limited Use	9,929	11,612
Prepaid Expenses and Deposits	1,298	1,621
TOTAL CURRENT ASSETS	**44,065**	**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	44,435	43,579
CIP	587	860
Total Property, Plant & Equipment	97,501	96,917
Accumulated Depreciation	-56,731	-53,887
Net Property, Plant & Equipment	**40,770**	**43,030**
Intangible Assets	**1,418**	**1,454**
Total Assets	**86,895**	**96,620**

		Current Month	Dec. 31, 2012
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,357	1,613
97	Accounts Payable and Accrued Expenses	11,787	16,509
98	Accrued Payroll and Related Liabilities	16,945	17,512
99	Deferred District Tax Revenue	3,090	3,091
100	Estimated Third Party Payor Settlements	1,740	1,868
101	**Total Current Liabilities**	**34,919**	**40,593**
	Other Liabilities		
102	Other Deferred Liabilities	10,123	2,804
	Long Term Debt		
103	Notes Payable - Secured	60,328	61,242
104	Capital Leases	1,132	1,647
105	Less Current Portion LTD	-1,357	-1,613
106	**Total Long Term Debt**	**60,103**	**61,276**
107	**Total Liabilities**	**105,145**	**104,673**
	EQUITY		
108	Retained Earnings	-8,053	9,667
109	Year to Date Profit / (Loss)	-10,197	-17,720
110	**Total Equity**	**-18,250**	**-8,053**
111	**Total Liabilities & Equity**	**86,895**	**96,620**

Current Ratio (CA/CL)	***1.26***	***1.27***
Net Working Capital (CA-CL)	***9,146***	***10,901***
Long Term Debt Ratio (LTD/TA)	***0.69***	***0.63***
Long Term Debt to Capital (LTD/(LTD+TE)	***1.44***	***1.15***
Financial Leverage (TA/TE)	***-4.8***	***-12.0***
Quick Ratio	**0.84**	**0.89**
Unrestricted Cash Days	**24**	**11**
Restricted Cash Days	**29**	**27**
Net A/R Days	**69.7**	**92.6**

DOCTORS MEDICAL CENTER

July 2013 Executive Report

Doctors Medical Center had a Net Loss of $ 1,929,000 for the month of July. As a result, net income was worse than budget by $235,000. The following are the factors leading to the Net Income variance for the month:

Net Patient Revenue Factors	**Positive / (Negative)**
Managed Care, Commercial, PPO	($902,000)
Expenses	
Salaries & Benefits	$465,000
Supplies	$123,000

Net patient revenue was under budget by $792,000 for July. Inpatient gross charges were under budget by 3.4% with patient days under budget by 2.0% while discharges over budget 2.7%. Total outpatient volume was 4.6% under budget for July with total surgeries 1.3% under budget.

In July Managed Care inpatient volume was 22.5% under budget and outpatient managed care net revenue was 27% lower than budget which represents a combined negative variance of $902,000 in patient revenue. Approximately 39% of this negative variance was due to lower volume and 61% was due to a lower rate of reimbursement per patient.

Salaries and Benefits combined were under budget by $464,000 in July. Salaries were favorable by $631,000 as a result of the continued flexing in all departments. Benefits were $167,000 over budget primarily due to employee healthcare costs which were $184,000 over budget for the month.

Supplies expense was favorable to budget by $123,000 for the month of July. Supplies have been under budget in all categories except implants which have increased in cost per patient by 37% in 2013 compared to 2012.

Year to date net patient revenue is under budget by $5,549,000, 7.7%. Patient days are under budget by 9.2% for the seven months. Ancillary outpatient visits were 9% under budget which is partially offset by ED visits at 5.9% higher than budget. Year to date operating expenses—mostly salaries and wage expenses—were under budget by $2,397,000 for the seven months. The net loss for the first seven months of 2013 is $10,297,000 which is $3,415,000 worse than budget for the period.

DOCTORS MEDICAL CENTER

BANKING RESOLUTION AND SIGNATURE AUTHORIZATION UPDATE FOR:
Bank of America Merrill Lynch & Mechanic Bank

TAB 8

GOVERNMENTAL ENTITY CERTIFICATE

2/5/2013

To: Mechanics Bank
Michael Jones

RE: West Contra Costa Healthcare District ("District")

As of the date of this Certificate, the following persons constitute the officers of the non-profit governmental entity who are authorized to execute documents on behalf of West Contra Costa Healthcare District and the signatures opposite their names are their genuine signatures.

CEO: DAWN M GIDEON _____ Signature

CFO: James Boatman _____ Signature

Secretary: _____ _____ Signature

OTHER: Vickie Scharr Controller _____ Signature
(clearly type name and title) if applicable

OTHER: _____ _____ Signature
(clearly type name and title) if applicable

According to the Corporate Bylaws, a minimum of _____ (enter number of persons here) of the above signers are required to sign loan documents on behalf of the Corporation.

Attested by:

_____
[name]
Secretary of Corporation

Mechanics Bank
Commitment That Lasts Generations

Application for Amendment to Standby Letter of Credit

TO: THE MECHANICS BANK

Please amend your Irrevocable Letter of Credit No: 90039 , dated 09/02/2004

issued for our account in favor of: Zurich American Insurance Co.

as follows:

☐Increase Amount by USD to a new Amount of USD

☑Decrease Amount by USD 175,000.00 to a new Amount of USD 175,000.00

Other amendment to terms and conditions:

All other terms and conditions remain unchanged.

It is understood that this amendment is subject to acceptance by the Beneficiary and yourselves. All other terms and conditions of the Letter of Credit shall remain unchanged and all of our obligations and liabilities to you with respect to the Application and Agreement for the Letter of Credit shall apply to the Letter of Credit as so amended.

In Witness Whereof, Applicant has caused this Application to be duly executed as of the date below.

Date: (MM/DD/YYYY)

West Contra Costa Healthcare District

Name of Applicant

By (Name & Title): Signature _____

By (Name & Title): Signature _____

Bank of America
Merrill Lynch

Deposit Account Documentation
Signature Card

CLIENT INFORMATION

Select One: ☐ New Account ☒ Update (Add/Delete) Signers ☐ Supersede Existing Signature Card

Account # (If new account, Bank will complete): 0011 9660 8780

ORGANIZATION LEGAL NAME (Must match legal name indicated in company formation documents)
West Contra Costa Healthcare District

DBA NAME or OWNER BUSINESS NAME OF DISREGARDED ENTITY or THIRD PARTY / FUNDS OWNER NAME, if applicable
Doctors Medical Center - San Pablo

DESCRIPTIVE ACCOUNT TITLE (if applicable, e.g. Operating Account, Rent Account, etc. **Cannot** be another legal entity name.)
Operating Account

Address For Statement: 2000 Vale Road

City: San Pablo State: CA Postal Code: 94806

STATE OF FORMATION (You may be required to provide copies of your company charter or formation documents.):

TYPE OF BUSINESS (Select One):

☒ Corporation	☐ Sole Proprietorship
Limited Liability Company: ☐ Manager Managed ☐ Member Managed ☐ Sole Member	☐ Unincorporated Organization or Association
☐ General Partnership	☐ Joint Venture
☐ Limited Liability Partnership	☐ Government Authority/ Agency (Type:)
☐ Limited Partnership	☐ Other (Type:)

Note: Property management accounts must be accompanied by appropriate owner and agent indemnities and property management account supplement.

TAX CLASSIFICATION

Employer Identification Number: 94-6003145 ☐ Exempt Payee

Legal name of the owner of the E.I.N listed above: West Contra Costa Healthcare District

Federal Tax Classification: ☐ Indiv SP ☒ C Corp ☐ S Corp ☐ Partnership ☐ Trust/Estate ☐ Other:

LLC Tax Classification (ONLY for Limited Liability Company): ☐ C Corp ☐ S Corp ☐ Partnership

AGREEMENT, TAX INFORMATION CERTIFICATION and AUTHORIZATION

You begin or continue a deposit account relationship with us by giving us information about your business and by signing this Agreement. The deposit agreement we give you is part of your agreement with us regarding use of your account and tells you the current terms governing your account. We may change the deposit agreement at any time and will inform you of changes that affect your rights and obligations. By signing below, you acknowledge receipt of the deposit agreement. The deposit agreement includes a provision for **alternative dispute resolution**.

By signing below, you authorize each person who has signed in *the Designated Account Signer* section below to operate any account opened under this signature card now or in the future. The authority to operate an account includes: authority to sign checks and other items and to give us other instructions, including by electronic signature, electronic record or other electronic form, to withdraw funds; to endorse and deposit checks and other items payable to or belonging to you to the account; and, to transact other administrative business. including by electronic signature, electronic record or other electronic form, relating to the account, including closing the account. If you wish to restrict a designated signer's authority to check signing you must indicate that by checking the box to the left of their name. We may rely on this authorization for any account opened under this signature card until we receive written notice revoking the authorization at the office where we maintain the account, and we have a reasonable time to act upon such notice.

By signing below, you certify under penalty of perjury that 1) the employer identification number listed above for this organization is correct; 2) that the organization listed above is a United States person (defined below); and 3) the organization listed above is not subject to backup withholding because: (a) the organization is exempt from back-up withholding, or (b) has not been notified by the Internal Revenue Service (the IRS) that it is subject to back up withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the organization that it is no longer subject to backup withholding. **[Cross out item 2 above if the organization listed above is not a United States person and follow the instructions in the paragraph immediately below.*] [Cross out item 3 above if you have been notified by the IRS that you are currently subject to backup withholding for failure to report interest or dividends.]**

* If the organization listed above is a foreign entity use the applicable Form W-8 (for additional information please see IRS Pub 515 Withholding of Tax on Non-Resident Aliens or Foreign Entities). The term "United States person" means: a citizen or resident of the United States, a partnership created or organized in the United States or under the law of the United States or of any State, a corporation created or organized in the United States or under the law of the United States or of any State, or any estate or trust other than a foreign estate or foreign trust.

By signing below, this organization hereby agrees to be bound to the above Agreement, Tax Information Certification and Authorization.
For CA Public Funds only: Any person signing this Agreement for the Organization certifies that they are duly authorized to do so as evidenced by attached banking resolution/contract for deposit of moneys or existing banking resolutions/contract for deposit of moneys on file with us.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Authorized Signer Signature:
(**Must** match Banking Resolution & Certificate of Incumbency) :

Print Name: Print Title: Date:

Authorized Signer Signature:
(**Must** match Banking Resolution & Certificate of Incumbency) :

Print Name: Print Title: Date:

DESIGNATED ACCOUNT SIGNERS (use Supplemental Signature page form # 00-35-4504NSBW as needed for additional signers)

Select if signer can ONLY sign checks	Add/Delete Signer (A/D)	Name	Title	Signature
☐				
☐				
☐				
☐				

Bank of America
Merrill Lynch

Deposit Account &Treasury Management Services
Banking Resolution and Certificate of Incumbency

CLIENT INFORMATION

Please select one of the following options:

☐	New Resolution/Incumbency
☒	Update Incumbency *(Used to Add or Delete individual authorized signers)*
☐	Supersede Resolution/Incumbency *(Replaces any and all prior banking resolutions)*

ORGANIZATION LEGAL NAME (Must match legal name indicated in company formation documents)
West Contra Costa Healthcare District

- **This Banking Resolution and Certificate of Incumbency will apply to all accounts the Organization maintains with us.**
- **The Organization adopts the following Banking Resolution and Certificate of Incumbency (with specimen signatures)***

The undersigned certifies that:

1) Any individual (each an "Authorized Signer") with any of the following Titles

Title:	
Title:	
Title:	

is authorized, acting alone, including by electronic signature, electronic record or other electronic form, (a) to establish accounts from time to time for the Organization at Bank of America, N.A. (the "Bank"), as well as to operate and close such accounts, (b) to enter into any and all agreements and transactions contemplated by the provision of treasury management services by the Bank, including but not limited to Electronic Funds Transfer Services, and (c) designate persons to operate each such accounts including closing the account, and to designate persons to act in the name and on behalf of the Organization/Client with respect to the establishment and operation of treasury management services.

2) the person whose signature, name, and title appear in the "AGREEMENT, TAX INFORMATION CERTIFICATION and AUTHORIZATION" section of the Deposit Account Documentation Signature Card ("Signature Card") and those persons listed below on the Incumbency Certificate, are Authorized Signers who are authorized, including by electronic signature, electronic record or other electronic form, to establish accounts and to designate persons to operate each such account and to execute contracts and agreements (including treasury management service agreements, including but not limited to Electronic Funds Transfer Agreements) with the Bank and that the signatures of such Authorized Signers are genuine.

3) the persons who signed in the Designated Account Signers section of the Signature Card are authorized to operate any accounts opened with the deposit account documentation unless otherwise noted on the Signature Card, and that the signatures of such Designated Account Signers are genuine.

4) the foregoing is a complete, true and correct copy of the banking resolutions adopted by the Board of Directors, the Members or the General Partners, Commission, Council or Governing Board as applicable, of the Organization, government entity or authority and that the resolutions are still in full force and effect and have not been amended or revoked and do not exceed the objects or powers of the Organization, government entity, authority or the powers of its management or Governing Board, Commission or Council.

Incumbency Certificate:

Add/Delete	Name	Title	Signature
Select One	Rick Reid	CFO	
Select One			
Select One			

*** If you choose to provide your own Banking Resolution and Certificate of Incumbency (with specimen signatures), it must be attached to the signature card.**

This Banking Resolution and Certificate of Incumbency must be signed as follows:

- **Corporations**: Secretary or assistant secretary of the company **must** sign.
- **Any Partnership type**: One of the general partners must sign. If the general partner is an organization, show the name of the general partner and include capacity of signer.
- **Limited Liability Company**:
  - **Member Managed LLC**: One of the members or an officer of the company must sign. If the member or manager is an organization, show the name of the member or manager and include capacity of signer.
  - **Manager Managed LLC**: The manager or managers or an officer authorized of the company must sign. If the member or manager is an organization, show the name of the member or manager and include capacity of signer.
- **Other unincorporated organizations**: An officer of the organization who is authorized by the by-laws or operating agreement of the company must sign.
- **Government entities, authorities or agencies**: An authorized signer of the government entity/authority who is authorized by the statutes must sign.

In Witness Whereof, I have hereunto set my hand as (title) of the Organization listed above
Title:

Type or Print Name of Certifying Individual

Name of Company who is General Partner or Member, leave blank if not applicable. (Type or print Name of company including the legal name of any member, managing member, manager, or general partner who is signing and who is not an individual)

Signature:		**Date:**	

Bank of America
Merrill Lynch

Deposit Account &Treasury Management Services
Banking Resolution and Certificate of Incumbency

CLIENT INFORMATION

Please select one of the following options:

☐	New Resolution/Incumbency
☒	Update Incumbency *(Used to Add or Delete individual authorized signers)*
☐	Supersede Resolution/Incumbency *(Replaces any and all prior banking resolutions)*

ORGANIZATION LEGAL NAME (Must match legal name indicated in company formation documents)
West Contra Costa Healthcare District

- **This Banking Resolution and Certificate of Incumbency will apply to all accounts the Organization maintains with us.**
- **The Organization adopts the following Banking Resolution and Certificate of Incumbency (with specimen signatures)***

The undersigned certifies that:

1) Any individual (each an "Authorized Signer") with any of the following Titles

Title:	
Title:	
Title:	

is authorized, acting alone, including by electronic signature, electronic record or other electronic form, (a) to establish accounts from time to time for the Organization at Bank of America, N.A. (the "Bank"), as well as to operate and close such accounts, (b) to enter into any and all agreements and transactions contemplated by the provision of treasury management services by the Bank, including but not limited to Electronic Funds Transfer Services, and (c) designate persons to operate each such accounts including closing the account, and to designate persons to act in the name and on behalf of the Organization/Client with respect to the establishment and operation of treasury management services.

2) the person whose signature, name, and title appear in the "AGREEMENT, TAX INFORMATION CERTIFICATION and AUTHORIZATION" section of the Deposit Account Documentation Signature Card ("Signature Card") and those persons listed below on the Incumbency Certificate, are Authorized Signers who are authorized, including by electronic signature, electronic record or other electronic form, to establish accounts and to designate persons to operate each such account and to execute contracts and agreements (including treasury management service agreements, including but not limited to Electronic Funds Transfer Agreements) with the Bank and that the signatures of such Authorized Signers are genuine.

3) the persons who signed in the Designated Account Signers section of the Signature Card are authorized to operate any accounts opened with the deposit account documentation unless otherwise noted on the Signature Card, and that the signatures of such Designated Account Signers are genuine.

4) the foregoing is a complete, true and correct copy of the banking resolutions adopted by the Board of Directors, the Members or the General Partners, Commission, Council or Governing Board as applicable, of the Organization, government entity or authority and that the resolutions are still in full force and effect and have not been amended or revoked and do not exceed the objects or powers of the Organization, government entity, authority or the powers of its management or Governing Board, Commission or Council.

Incumbency Certificate:

Add/Delete	Name	Title	Signature
Select One			
Select One			
Select One			

*** If you choose to provide your own Banking Resolution and Certificate of Incumbency (with specimen signatures), it must be attached to the signature card.**

This Banking Resolution and Certificate of Incumbency must be signed as follows:

- **Corporations**: Secretary or assistant secretary of the company **must** sign.
- **Any Partnership type**: One of the general partners must sign. If the general partner is an organization, show the name of the general partner and include capacity of signer.
- **Limited Liability Company**:
  - **Member Managed LLC**: One of the members or an officer of the company must sign. If the member or manager is an organization, show the name of the member or manager and include capacity of signer.
  - **Manager Managed LLC**: The manager or managers or an officer authorized of the company must sign. If the member or manager is an organization, show the name of the member or manager and include capacity of signer.
- **Other unincorporated organizations**: An officer of the organization who is authorized by the by-laws or operating agreement of the company must sign.
- **Government entities, authorities or agencies**: An authorized signer of the government entity/authority who is authorized by the statutes must sign.

In Witness Whereof, I have hereunto set my hand as (title) of the Organization listed above
Title:

Type or Print Name of Certifying Individual

Name of Company who is General Partner or Member, leave blank if not applicable. (Type or print Name of company including the legal name of any member, managing member, manager, or general partner who is signing and who is not an individual)

Signature:		**Date:**	

DOCTORS MEDICAL CENTER

CAPITAL APPROVAL REQUEST FOR PARAGON UPDATE VERSION 12.0

TAB 9

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

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

FROM: **James Boatman**

DATE: **August 28, 2013**

SUBJECT: **Paragon Upgrade to Version 12.0**

REQUEST / RECOMMENDATION(S): Recommend to the District Board to approve and authorize the Chief Financial Officer to execute on behalf of DMC, approval of the Paragon upgrade to version 12.0 at a cost of $79,760.

FISCAL IMPACT: The onetime cost of the upgrade is $79,760. Annually we will incur an annual software support cost of $62,330.

STRATEGIC IMPACT: The new upgrade will greatly improve the functionality of the Paragon System. Many of the areas of weakness in the current version are rewritten to reduce duplication of work along with process improvements. Medicine reconciliation and webstation for physicians have changes that will improve productivity in the daily care of our patients. The enhancements also improve the physician documentation process which will complete the electronic medical record.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: This upgrade will add additional functionality to our electronic Medical Record. The key functional changes are:

1. Patients allergies identified are next to same class medication (less pop-ups)
2. Webstation will default to current visit for the physicians
3. Improved Medicine reconciliation
4. Improved Nursing documentation eliminating duplicate work by the nurses
5. Physician Offices will have access to more complete information.
6. Improved Physician documentation.

Presentation Attachments: Yes X No____

Requesting Signature: James Boatman Date: 8/28/2013

SIGNATURE(S):

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

Vote of Board Members:

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

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

Contact Person:

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

Cc: Accounts Payable, Contractor, CFO, Controller, Requestor

McKESSON

CONTRACT SUPPLEMENT

Contract Supplement to Information System Agreement No. C0508364, dated September 08, 2005.

THIS CONTRACT SUPPLEMENT, including all Exhibits, Schedules, and Attachments hereto and incorporated herein (this **"Contract Supplement"**) amends the agreement identified above including all Exhibits, Schedules, and Attachments thereto, and as amended (the **"Agreement"**), and is made effective as of this _____ day of _____, 2013 (the **"CS Effective Date"**). Unless otherwise expressly set forth in this Contract Supplement, the terms and conditions set forth in this Contract Supplement apply only to the Facilities, Software, and/or Services listed herein. To the extent that this Contract Supplement conflicts with the Agreement, the terms and conditions of this Contract Supplement shall control. Where not in conflict, all applicable terms and conditions set forth in the Agreement are incorporated herein.

	EXHIBITS
A	**Facilities, Fees Summary, Payment Schedule and Administration**
A-1	**Products and Pricing**
A-2	**Additional Terms**
A-3	**Additional Terms – Paragon Direct Services**
A-4	**Additional Terms – QeM Subscription Services**
B-1	**Paragon Program Services Service Path**

The pricing in this Contract Supplement and McKesson's corresponding offer to Customer expires unless McKesson receives this Contract Supplement signed by Customer on or before September 30, 2013.

McKesson will include Customer's purchase order (**"PO"**) number on Customer invoices if provided by Customer on or before the CS Effective Date. If this Contract Supplement includes an amount equal to or greater than $10,000, a copy of Customer's PO must be attached. Failure to provide McKesson with a PO number or copy does not suspend or negate any Customer duty, including payment, under this Contract Supplement. Pre-printed terms and conditions on or attached to Customer's PO shall be of no force or effect.

By signing this Contract Supplement, Customer acknowledges and agrees that (a) McKesson has made no warranty or commitment with regard to any functionality not Generally Available as of the CS Effective Date, whether or not included as part of Software Maintenance Services, for any of the Software licensed in this Contract Supplement and (b) Customer has not relied on the availability of any future version of the purchased Product or any other future Product in executing this Contract Supplement and (c) the decision by Customer to execute this Contract Supplement was not influenced by any discussions regarding future functionality of any Software or Services not Generally Available.

Each signatory hereto represents and warrants that it is duly authorized to sign, execute, and deliver this Contract Supplement on behalf of the party it represents.

Doctors Medical Center San Pablo

Signature: _____
Printed Name: _____
Title/Position: _____
Customer PO#: _____
Date: _____

McKesson Sales Center
Thank you for your business

MCKESSON TECHNOLOGIES INC.

Signature: _____
Printed Name: Nate Dean
Title/Position: Inside Sales Representative
Date: _____

Phone: (404) 338-2124
Fax: (404) 338-5116

EXHIBIT A

FACILITIES, FEES SUMMARY, PAYMENT SCHEDULE AND ADMINISTRATION

FACILITIES:

Customer No.	Facility	Full Address
1010453	Doctors Medical Center San Pablo	2000 Vale Rd, San Pablo, CA 94806

FEES SUMMARY:

Products and Services	Initial Term (Years)	One-Time Fees	Annual Recurring Fees
Software (Perpetual):		$5,960	$1,490
Software (Term):	2		$17,840
Implementation / Professional Services:		$60,800	
Subscription Services (Paragon Direct):	2		$28,000
Subscription Services (QeM):	2		$15,000
GRAND TOTALS:		$66,760	$62,330

PAYMENT SCHEDULE:

Software (Perpetual): 25% is due on January 15, 2014 (versus CS Effective Date), and 75% is due in three equal, consecutive monthly payments commencing February 15, 2014..

Software (Term): The first annual fee is due on the earlier of (i) Live Date or (ii) 12 months after CS Effective Date. For subsequent years, the annual fees are due in advance on the anniversary of the date such first annual fee was due.

Software Maintenance Services: The first annual Software Maintenance Services fee is due on the earlier of the Live Date or 12 months after the CS Effective Date. Subsequent annual Software Maintenance Services fees will be due annually in advance.

Implementation / Professional Services: 25% is due on January 15, 2014 (versus CS Effective Date), and 75% is due in three equal, consecutive monthly payments commencing February 15, 2014..

Subscription Services (QeM and Paragon Direct): Annual Recurring Fees: The first annual fee is due in advance on the earlier of (i) Live Date or (ii) 12 months after CS Effective Date. For subsequent years, the annual fee is due in advance on the anniversary of the date such first annual fee was due.

The transaction covered by this Contract Supplement may involve a discount, rebate or other price reduction on the items covered by this Contract Supplement. Customer may have an obligation to report such price reduction or the net cost in its cost reports or in another appropriate manner in order to meet the requirements of applicable federal and state anti-kickback laws, including 42 U.S.C. Sec. 1320a-7b(b)(3)(A) and the regulations found at 42 C.F.R. Sec. 1001.952(g) and (h). Customer will be responsible for reporting, disclosing, and maintaining appropriate records with respect to such price reduction or net cost and making those records available under Medicare, Medicaid, or other applicable government health care programs.

Unless Customer provides McKesson prior to the CS Effective Date satisfactory evidence of exemption (including evidence of renewal if applicable) from applicable sales, use, value-added, or other similar taxes or duties, McKesson will invoice Customer for all such taxes applicable to the transactions under this Contract Supplement.

ADMINISTRATION:

Sold To:	**Ship To:**
Doctors Medical Center San Pablo	Doctors Medical Center San Pablo
2000 Vale Rd	2000 Vale Rd
San Pablo CA 94806	San Pablo CA 94806
	Attention: Phyllis Moore
	Telephone: (510) 970-5042
	Facsimile:
	E-mail: pmoore@dmc-sp.org
Bill To:	**Paid By:**
Doctors Medical Center San Pablo	Doctors Medical Center San Pablo
2000 Vale Rd	2000 Vale Rd
San Pablo CA 94806	San Pablo CA 94806
Attention: Phyllis Moore	Attention: Jim Boatman
Telephone: (510) 970-5042	Telephone: (510) 970-5002
Facsimile:	Facsimile:
E-mail: pmoore@dmc-sp.org	E-mail: jboatman@dmc-sp.org

EXHIBIT A-1

PRODUCTS AND PRICING

Perpetual Software:

Perpetual Software Product No.	Software Maint. Product No.	Module / Description	Third Party SW	List Software License Fee	Quantity	Net Software License Fee	Annual Software Maintenance Fee
72026501	73023151	Paragon Rules Engine (MS BizTalk - 2 processors)	X	$5,960	1	$5,960	$1,490
Paragon Rules Engine - Embedded Lic; 2 Servers							
					Software (Perpetual) Total:	$5,960	$1,490

Term Software:

Term Software Product No.	Module / Description	Third Party SW	List License Fee	Net License Fee
72025386	Truven Integrated Care Notes Hospital License	X	$13,447	$13,447
72025387	Truven IMicromedex Hosp License	X	$4,393	$4,393
			Software (Term) Total:	$17,840

Implementation/Professional Services:

Implementation /Professional Services Product No.	Module / Description	Product Family	List Services Fee	Net Services Fee
74039947	Paragon Stage 2 Program Services	Paragon	$42,000	$33,600
74039948	Paragon Direct Services	Paragon	$6,000	$4,800
74038368	Quality eMeasures™ 2014 Edition Operation	Paragon	$28,000	$22,400
		Implementation / Professional Services Total:	$76,000	$60,800

Subscription Services:

Subscription Services annual recurring fee Product No.	Module / Description	Annual Recurring Fee
74039956	Paragon Direct Subscription Services	$28,000
74038377	ARRA Stage 2 QEM Subscription	$15,000
	Subscription Services Total:	$43,000

EXHIBIT A-2

ADDITIONAL TERMS

SECTION 1: PARAGON RELEASE 12.0

1.1 Customer acknowledges that (i) the use of the Software and services set forth in Exhibit A-1 may require customer to implement Paragon Release 12.0, (ii) Paragon Release 12.0 will be available to customers receiving Paragon Software Maintenance Services when McKesson deems Paragon Release 12.0 Generally Available, and (iii) as of the CS Effective Date, Paragon 12.0 is not Generally Available.

SECTION 2: LIMITATIONS OF LIABILITY

2.1 Total Damages. MCKESSON'S TOTAL CUMULATIVE LIABILITY UNDER, IN CONNECTION WITH, OR RELATED TO THIS CONTRACT SUPPLEMENT WILL BE LIMITED TO (A) WITH RESPECT TO ANY PRODUCT, THE TOTAL FEES PAID (LESS ANY REFUNDS OR CREDITS) BY CUSTOMER TO MCKESSON HEREUNDER FOR THE PRODUCT GIVING RISE TO THE CLAIM, OR (B) WITH RESPECT TO ANY SERVICE, THE TOTAL FEES PAID (LESS ANY REFUNDS OR CREDITS) BY CUSTOMER TO MCKESSON HEREUNDER FOR THE SERVICE GIVING RISE TO THE CLAIM DURING THE 12-MONTH PERIOD PRECEDING THE DATE OF THE CLAIM, AS APPLICABLE, WHETHER BASED ON BREACH OF CONTRACT, WARRANTY, TORT, PRODUCT LIABILITY, OR OTHERWISE.

2.2 Exclusion of Damages. IN NO EVENT WILL MCKESSON BE LIABLE TO CUSTOMER UNDER, IN CONNECTION WITH, OR RELATED TO THIS CONTRACT SUPPLEMENT FOR ANY SPECIAL, INCIDENTAL, INDIRECT, OR CONSEQUENTIAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS OR LOSS OF GOODWILL, WHETHER BASED ON BREACH OF CONTRACT, WARRANTY, TORT, PRODUCT LIABILITY, OR OTHERWISE, AND WHETHER OR NOT MCKESSON HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGE.

2.3 Material Consideration. THE PARTIES ACKNOWLEDGE THAT THE FOREGOING LIMITATIONS ARE A MATERIAL CONDITION FOR THEIR ENTRY INTO THIS CONTRACT SUPPLEMENT.

SECTION 3: INTELLECTUAL PROPERTY INFRINGEMENT

3.1 Duty to Defend. McKesson will defend, indemnify, and hold Customer harmless from any action or other proceeding brought against Customer to the extent that it is based on a claim that (a) the use of any McKesson Software (other than Third Party Software) delivered under this Contract Supplement infringes any U.S. copyright or U.S. patent or (b) the McKesson Software (other than Third Party Software) incorporates any misappropriated trade secrets. McKesson will pay costs and damages finally awarded against Customer as a result thereof; provided, that Customer (i) notifies McKesson of the claim within ten business days, (ii) provides McKesson with all reasonably requested cooperation, information and assistance, and (iii) gives McKesson sole authority to defend and settle the claim.

3.2 Exclusions. McKesson will have no obligations under this Section with respect to claims arising from: (a) McKesson Software modifications that were not performed by McKesson or authorized by McKesson in writing, (b) custom interfaces, file conversions, or other programming for which McKesson does not exclusively develop the specifications or instructions, (c) use of any McKesson Software in combination with products or services not provided by McKesson, if use of the McKesson Software alone would not result in liability under this Section, or (d) any use of the McKesson Software not authorized by this Contract Supplement or the Documentation.

3.3 Infringement Remedies. If a claim of infringement or misappropriation for which Customer is entitled to be indemnified under this Section arises, then McKesson may, at its sole option and expense: (a) obtain for Customer the right to continue using such McKesson Software (b) replace or modify such McKesson Software to avoid such a claim, provided that the replaced or modified McKesson Software is substantially equivalent in function to the affected McKesson Software, or (c) take possession of the affected McKesson Software and terminate Customer's rights and McKesson's obligations under this Contract Supplement with respect to such McKesson Software.

Upon any such termination, McKesson will refund to Customer a prorated portion of the fees paid for that McKesson Software based upon a period of depreciation equal to the Initial SWM Term period, as applicable, with depreciation deemed to have commenced on the corresponding Software Live Date, if any, or the corresponding date of delivery.

3.4 Exclusive Remedy. THE FOREGOING ARE MCKESSON'S SOLE AND EXCLUSIVE OBLIGATIONS, AND CUSTOMER'S SOLE AND EXCLUSIVE REMEDIES, WITH RESPECT TO INTELLECTUAL PROPERTY INFRINGEMENT OR TRADE SECRET MISAPPROPRIATION.

SECTION 4: TIMELY PAYMENTS

4.1 Any early payment discount described in the Agreement will not apply to this Contract Supplement.

SECTION 5: PRICE INCREASES

5.1 McKesson may increase its recurring fees, including but not limited to, for Software Maintenance Services, Technology Services, and any Term license fees, once every 12 months upon 60 days written notice to Customer. The amount of such increase will not exceed five percent. Price increases are effective as of the next annual, quarterly or monthly payment due date.

SECTION 6: SOFTWARE MAINTENANCE TERM

6.1 The initial term for Software Maintenance Services (the "**Initial SWM Term**") begins upon the CS Effective Date and continues (i) for perpetual Software licenses, for five years, and (ii) for term Software Licenses, for the initial term as set forth in the Contract Supplement. Unless otherwise set forth in the Contract Supplement, the Initial SWM Term for perpetual and term licenses will automatically renew for successive one year periods, unless either party provides the other with written notice of termination of Software Maintenance Services no less than three months prior to the end of the then-current term. McKesson will invoice Customer for Software Maintenance Services annually in advance for each 12-month period. Termination is effective as of the next annual payment due date, and no refund or credit will apply in the event of early termination of Software Maintenance Services. Annual Software Maintenance Services fees will be prorated on a 365-day calendar year.

SECTION 7: PROFESSIONAL RESPONSIBILITY AND CLINICAL CONTENT DISCLAIMER

7.1 CUSTOMER ACKNOWLEDGES AND AGREES THAT ANY CLINICAL CONTENT FURNISHED BY MCKESSON HEREUNDER (WHETHER SEPARATELY OR INCLUDED WITHIN A PRODUCT) IS AN INFORMATION MANAGEMENT AND DIAGNOSTIC TOOL ONLY AND THAT ITS USE CONTEMPLATES AND REQUIRES THE INVOLVEMENT OF TRAINED INDIVIDUALS. CUSTOMER FURTHER ACKNOWLEDGES AND AGREES THAT MCKESSON HAS NOT REPRESENTED ITS PRODUCTS AS HAVING THE ABILITY TO DIAGNOSE DISEASE, PRESCRIBE TREATMENT, OR PERFORM ANY OTHER TASKS THAT CONSTITUTE THE PRACTICE OF MEDICINE. THE PARTIES AGREE THAT, AS BETWEEN CUSTOMER AND MCKESSON, CUSTOMER IS RESPONSIBLE FOR THE ACCURACY AND QUALITY OF CUSTOMER DATA AS INPUT INTO THE PRODUCTS. CUSTOMER ACKNOWLEDGES THAT MCKESSON: (A) HAS NO CONTROL OF OR RESPONSIBILITY FOR CUSTOMER'S USE OF THE CLINICAL CONTENT, AND (B) HAS NO KNOWLEDGE OF THE SPECIFIC OR UNIQUE CIRCUMSTANCES UNDER WHICH THE CLINICAL CONTENT PROVIDED MAY BE USED BY CUSTOMER. THE PARTIES AGREE THAT MCKESSON DOES NOT PROVIDE MEDICAL SERVICES TO PATIENTS AND IS NOT ENGAGED IN THE PRACTICE OF MEDICINE, AND THAT CUSTOMER'S USE OF THE PRODUCTS DOES NOT ABSOLVE CUSTOMER OF ITS OBLIGATION TO EXERCISE INDEPENDENT MEDICAL JUDGMENT IN RENDERING HEALTH CARE SERVICES TO PATIENTS. CUSTOMER ACKNOWLEDGES THAT THE PROFESSIONAL DUTY TO THE PATIENT IN PROVIDING HEALTHCARE SERVICES LIES SOLELY WITH THE HEALTHCARE PROFESSIONAL PROVIDING THE SERVICES. MCKESSON MAKES NO WARRANTY AS TO THE NATURE OR QUALITY OF THE CONTENT OF RESULTS, MESSAGES OR INFORMATION SENT BY CUSTOMER, OR ANY THIRD PARTY USERS OF THE SUBSCRIPTION SERVICES.

SECTION 8: TERM SOFTWARE

8.1 License Grant - Term License. Subject to the terms of the Agreement, McKesson grants to Customer, and Customer accepts, a limited, nonexclusive, nontransferable, non-sublicensable, license to use the Software or Clinical Content identified herein as "term" or as a "term license" for Customer's internal purposes at the Facilities identified on Exhibit A for the license term specified therein (**"Term License"**).

8.2 Term. Unless otherwise specified herein, Customer's right to use the term Software begins on the earlier of (i) Live Date or (ii) 12 months after CS Effective Date and ends at the expiration of the term identified in Exhibit A-1. Following the expiration of the Term License, and subject to Customer's payment of the applicable fees, Customer's right to use the term Software shall continue for successive, automatically renewable one year periods, unless either party provides the other party with written notice of termination no less than three months prior to the end of the applicable term.

8.3 Fees payable during any renewal period will be at the prevailing rate.

SECTION 9: THIRD PARTY TERMS AND CONDITIONS

9.1 Customer agrees to the applicable Third Party terms and conditions, if any, as set forth at http://customerportal.mckesson.com, which Customer may access using the following confidential login information:

User ID: contractprovisions@mckesson.com
Password (case sensitive): Portal!Access

SECTION 10: INTERNET DISCLAIMER

10.1 CERTAIN PRODUCTS AND SERVICES PROVIDED BY MCKESSON UTILIZE THE INTERNET. MCKESSON DOES NOT WARRANT THAT SUCH SERVICES WILL BE UNINTERRUPTED, ERROR-FREE, OR COMPLETELY SECURE. MCKESSON DOES NOT AND CANNOT CONTROL THE FLOW OF DATA TO OR FROM MCKESSON'S OR CUSTOMER'S NETWORK AND OTHER PORTIONS OF THE INTERNET. SUCH FLOW DEPENDS IN LARGE PART ON THE INTERNET SERVICES PROVIDED OR CONTROLLED BY THIRD PARTIES. ACTIONS OR INACTIONS OF SUCH THIRD PARTIES CAN IMPAIR OR DISRUPT CUSTOMER'S CONNECTIONS TO THE INTERNET (OR PORTIONS THEREOF). ACCORDINGLY, MCKESSON DISCLAIMS ANY AND ALL LIABILITY RESULTING FROM OR RELATED TO THE ABOVE EVENTS.

SECTION 11: DATA RIGHTS

11.1 Notwithstanding anything to the contrary in any Business Associate Agreement between the parties or elsewhere in this Contract Supplement, Customer authorizes McKesson to (a) de-identify PHI in accordance with 45 C.F.R. 164.514(b) or (b) perform Data Aggregation (as defined in those regulations relating to the privacy of protected health information at 45 C.F.R. parts 160 and 164, as may be amended from time to time), both for statistical compilations, reports, research and all other purposes allowed under applicable laws. McKesson acknowledges and agrees that between Customer and McKesson, McKesson makes no claim of ownership of the PHI and McKesson retains use rights as set forth in this Section.

SECTION 12: DEFINITIONS

For purposes of this Contract Supplement, the following terms, as such terms are used herein or in the Agreement shall have the following meanings:

"Clinical Content" means medical, clinical, or billing and coding information such as terminology, vocabularies, decision support rules, alerts, drug interaction knowledge, care pathway knowledge, standard ranges of normal or expected result values, and any other clinical content or rules provided to Customer under an Contract Supplement, together with any related Documentation and Upgrades.

Depending on the intended usage, Clinical Content may be provided in either paper or electronic formats. Examples of Clinical Content include the InterQual® Clinical Decision Support Criteria, Clinical Evidence Summaries, InterQual® SmartSheets, KnowledgePacks, HIC – ED FC, HIC – ED PC and Medical Necessity Content. Clinical Content may be either (a) owned by McKesson or (b) Third Party Clinical Content.

"Enhancements" means enhancements or new releases of the Software, Documentation, Clinical Content, or Services providing new or different functionality that are separately priced and marketed by McKesson.

"Generally Available" means available as a non-development product, licensed by McKesson in the general commercial marketplace.

"Maintenance Services" means Software Maintenance Services and Equipment Maintenance Services. Maintenance Services do not include services required as a result of (a) improper use, abuse, accident or neglect, including Customer's failure to maintain appropriate environmental conditions for the Products, or (b) modifications or additions to the Products.

"Medical Necessity Content" means rules, including diagnosis and procedure code pairs developed by the Centers for Medicare and Medicaid Services and Medicare Administrative Contractors, related to Medicare payment eligibility for medical services, treatment procedures, and medical technologies, including medical necessity determination.

"Products" means Software, Equipment, Clinical Content and any other products that McKesson provides to Customer pursuant to this Contract Supplement.

"Professional Services" means any consulting, programming or other professional services that McKesson provides to Customer pursuant to this Contract Supplement.

"Services" means Implementation Services, Maintenance Services, Processing Services, Professional Services, Subscription Services, Technology Services, Remote Hosting Services, and any other services that McKesson provides to Customer under this Contract Supplement.

"Software" means and shall include software in object code form only (and related Documentation) identified in a Contract Supplement or otherwise provided by McKesson to Customer, including any upgrades that McKesson provides to Customer.

"Subscription Services" means the internet-based or subscription-based Services provided to Customer by McKesson that are identified in this Contract Supplement.

"Technology Services" means the SystemCare Services, the CareBridge™ Secure Extranet Services and any other services provided by McKesson's Technology Services group.

"Time and Materials Fee" means McKesson's hourly Prevailing Rate(s) set forth herein for providing Services multiplied by the actual (not estimated) hours or days spent by McKesson in providing Services, including all hours incurred by McKesson (both at Customer's site and at various McKesson sites, whether or not previously estimated) to perform the required Services, including tasks, administrative duties, status reports, problem analysis, attendance of meetings or telephone calls, and research of Customer questions and issues.

"Upgrades" means corrections, modifications, improvements, updates or releases of the Software, Documentation, Clinical Content, or Services designated by McKesson as **"Upgrades,"** which are Generally Available and generally provided to customers as part of Software Maintenance Services. Upgrades do not include Enhancements.

EXHIBIT A-3

PARAGON DIRECT SERVICES

Statement of Purpose

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") provides certain incentive payments ("Incentive Payments") for healthcare providers such as eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) making "meaningful use" of qualified electronic health records technology that is certified pursuant to the HITECH Act ("Certified EHR Technology"). The 2011 Edition certification standards are set forth in the effective final rules of the HITECH Act published on July 28, 2010 (the "2011 Edition Standards"). The 2014 Edition certification standards are set forth in the effective final rules of the HITECH Act published on August 23, 2012 ("2014 Edition Standards").

Paragon Direct Services, which is powered by RelayHealth, supports:

- Transitions of Care (Direct Exchange)
  - Where an EP, EH, or CAH transitions their patient to another setting of care or provider of care or refers their patient to another provider of care, the EP, EH or CAH provides an accompanying summary of care record.
- View/Download/Transmit using the Patient Portal (Patient Portal)
  - EPs provide patients the ability to view online, download, and transmit their health information within four (4) business days of the information being available to the EP.
  - EHs and CAHs provide patients the ability to view online, download, and transmit information about a hospital admission.

SECTION 1: DEFINITIONS

"Affiliated Physician Customer User" means a Physician affiliated with a Customer who is a Customer User.

"Activation URL" means the URL designated by McKesson for Customer User activation

"Claim" means all liabilities, losses, damages, claims and expenses (including legal expenses of any kind and nature).

"Clinical Content" means medical or clinical information such as terminology, vocabularies, decision support rules, alerts, drug interaction knowledge, care pathway knowledge, standard ranges of normal or expected result values, and any other clinical content or rules provided to Customer under an Contract Supplement, together with any related Documentation. Depending on the intended usage, Clinical Content may be provided in either paper or electronic formats.

"Customer Marks" means the trademarks, service marks, logos, trade names and other indicia of origin of Customer.

"Customer User" means, with respect to the Paragon Direct Services, each Physician Customer User, and each non-physician staff member or other individual authorized to use the Paragon Direct Services by Customer or a Physician Customer User (including by the health care provider group with whom such Physician Customer User is associated, whether affiliated with or owned by Customer). Customer Users are either ("Employed Customer Users") if such individual is employed by Customer, or ("Affiliated Customer Users") if such individual is affiliated with Customer.

"Employed Physician Customer User" means a Physician employed by Customer.

"Enterprise Pricing" means, pricing covering unlimited access to the Paragon Direct Services by Customer for use by an unlimited number of employed Providers or affiliated Providers.

"Login Credentials" means a Customer User's unique user identification and password combination, as well as any other applicable security measures that are required to allow such Customer User to gain access to Clinical Content, Software, Subscription Services, or any other secured McKesson solution.

"McKesson Affiliates" means any U.S. entities that, now or in the future, are controlled by or under common control with McKesson.

"McKesson Provider Terms of Use" means the terms of use posted on the McKesson Site which governs, among other things, use of the Paragon Direct Services by Customer Users.

"McKesson Site" means the website operated by McKesson.

"Non-Physician Professional" means an individual, who is licensed, certified or otherwise designated to assist physicians in providing healthcare services to patients and includes a nurse practitioner, physician assistant, therapist, technician and social worker.

"Physician" means an individual legally licensed to provide healthcare services to patients as a "physician," "doctor," or other similar designation, and includes a medical or dental doctor, optometrist, certified consulting psychologist, osteopath, and chiropractor.

"Paragon Direct Services" means McKesson's provision of the clinical Services and products described in this Exhibit.

"Physician Customer User" means each Employed Physician Customer User, Affiliated Physician Customer User, or Non-Physician Professional that Customer identifies in writing to McKesson as a Customer User of a McKesson solution.

"Processing Services" means the Transaction processing Services, and related Subscription Services, described herein, that McKesson will provide to Customer hereunder.

"Provider" means a Physician or Non-Physician Professional who is employed by, or under contract to provide health care services on behalf of, Customer or its affiliates, whether full or part-time.

"Services" means all services that McKesson will provide to Customer hereunder including, but not limited to, Implementation Services, Processing Services, Professional Services, Subscription Services, and other Services performed on a Time and Materials basis.

"Subscription Service" means a remotely hosted computing Service, provided to Customer by McKesson or a McKesson Affiliate as part of the Paragon Direct Services.

"Temporary Identity" means a temporary Login Credential for a Customer User that McKesson provides to Customer.

"Transaction" means information received from Customer or its agent that is processed by McKesson, including, but not limited to, a distinct claim, remit, information request, statement, collection letter, print image, patient estimation letter or other item.

SECTION 2: PARAGON DIRECT

2.1 License Grant. Subject to the terms of this Contract Supplement, McKesson grants to Customer, and Customer accepts, a limited, nonexclusive, non-transferable, non-sublicensable license to access the Subscription Services portion of the Paragon Direct Services, solely for Customer's internal purposes at the Facilities identified on Exhibit A, during the term specified herein. The Paragon Direct Services may be used by Customer Users in conjunction with McKesson software in the inpatient, hospital-based outpatient, and emergency department care settings. Use of the Paragon Direct Services with non-McKesson software or in the ambulatory clinic care setting is subject to additional fees. The license granted in this Section 2.1 is expressly subject to the following conditions: (i) the Subscription Services may only be accessed by users referenced in Section 4.2, below who are physically located within the U.S.; (ii) access to the Subscription

Services may be limited to users who connect to the Subscription Services via computer networks located within certain Facilities, or by any other usage-based variables specified in a Contract Supplement; (iii) the Subscription Services may not be used to provide service bureau or other similar services to third parties unless expressly permitted herein; and

(v) use of the Subscription Services is subject to the terms of this Exhibit, the Documentation, and any Third-Party Software terms referenced herein in the Documentation. Customer and Customer Users may not attempt to access the Subscription Services in a manner not permitted under this Exhibit, or the Documentation. McKesson may immediately suspend Customer's and all Customer Users' access to the Subscription Services if Customer or a Customer User takes any action that would violate, or be reasonably likely to violate, the license granted under this Section 2.1.

2.2 Customer acknowledges and agrees that the patients who have subscribed to the McKesson services will have access to medical information stored in their personal health records.

2.3 Customer acknowledges and agrees that Paragon Connect services are required for Paragon Direct Services. If Customer has not purchased the required Paragon Connect Services, then additional license and service fees may apply.

SECTION 3: TERM AND TERMINATION

3.1 The term of the Paragon Direct Services that are Subscription Services will commence on the on the earlier of (i) Live Date or (ii) 12 months after CS Effective Date and continue for a period of two years ("**Term**"). McKesson reserves the right to terminate the Paragon Direct Subscription Services immediately and without further notice if Customer fails to make timely payments as they come due or otherwise breaches this Contract Supplement.

3.2 Fees will be subject to one, one-year renewal at then current rates.

SECTION 4: IMPLEMENTATION, HOSTING AND USE OF THE PARAGON DIRECT SERVICES

4.1 Implementation. McKesson will use commercially reasonable efforts to implement the Paragon Direct Solution within the timeframe set forth in the applicable Implementation Services Project Plan.

4.2 Terms of Use.

4.2.1 By Providers. Access to and use of the Paragon Direct Services by Customer Users and Customer Users' patients will be subject to McKesson's then-current Provider Terms of Use that are posted on the McKesson Site. The Provider Terms of Use will be applicable to Customer, its employees and contractors and all Employed Customer Users upon Customer's execution of this Contract Supplement. The Provider Terms of Use must be accepted by all Customer Users at the time they seek access to the Paragon Direct Services at the McKesson Site. The Provider Terms of Use are incorporated herein by this reference, and may be amended by McKesson in its sole discretion from time to time. The provisions set forth in this Exhibit and each Contract Supplement will control in the event of a conflict with the Provider Terms of Use.

4.2.2 By Patients. Access to and use of the Paragon Direct Services by Customer Users' patients will be subject to McKesson's then-current McKesson Patient Terms of Use also set forth on the McKesson Site.

SECTION 5: REGISTRATION AND DEACTIVATION PROCESSES

5.1 Registration Process. Customer, at its own cost and expense, agrees to follow the Registration Process set forth in the Implementation Services Project Plan or Implementation Services Guide for Customer and all Customer Users, as well as any other information which McKesson reasonably requests. If Customer chooses to provide individual access for their Employed Physician Customer Users, Customer represents and warrants that each Employed Physician Customer User is, and will remain during the term of the Paragon Direct Services: (a) properly licensed under applicable state law; (b) credentialed in accordance with Customer's standard credentialing process; and (c) required to report changes to his or her professional license status to Customer within an appropriate time interval following any such change.

McKesson will pre-register Customer Users for the Paragon Direct Services based on Customer's licensure certification. McKesson will provide to Customer a Temporary Identity and an Activation URL. Customer will authenticate the identity of each Customer User by distributing the Activation URL and Temporary Identity that correlates to each prospective Customer User. McKesson will accept such authentication by activating the Customer Users who log-on to the Paragon Direct Services at the Activation URL using the assigned Temporary Identity.

5.2 Deactivation Process. Customer will notify McKesson (i) within two business days after Customer receives notice of any change to the professional licensure status of any Employed Physician Customer User, and (ii) within a commercially reasonable number of business days after Customer elects to terminate any Customer User's access to the Paragon Direct Services for any reason. Upon receipt of such notice, McKesson will, as soon as practicable after the date of receipt, and in any event within two business days, use commercially reasonable efforts to deactivate each such Customer User's access to the Clinical Solutions.

SECTION 6: DATA

6.1 Data. McKesson will use reasonable judgment to correct inaccurate inbound data, and will perform such Services on a Time and Materials basis. McKesson will invoice Customer for all such error correction Services, and Customer will pay all applicable fees related to McKesson's correction of errors discovered in the inbound data.

SECTION 7: IMPLEMENTATION SERVICES

7.1 McKesson will provide, and Customer will accept, the Implementation Services for the Paragon Direct Services at the Facility(ies) or data center(s) set forth herein in order to facilitate Customer's installation and use of the Paragon Direct Services. McKesson will provide such Implementation Services in accordance with the implementation services project plan or the implementation services guide, and all other terms included in this exhibit, and Customer will pay for the same at the applicable Implementation Services fee(s) set forth herein. Customer will fully cooperate with McKesson during implementation of the Paragon Direct Services and complete all prerequisite tasks designated as Customer's responsibility under the implementation services project plan. Customer's failure to comply with the terms of this Section 7.1, and any resulting refusal by McKesson to provide implementation services or any related McKesson solutions, will not excuse customer's duty to timely pay fees due hereunder.

SECTION 8: SUSPENSION OF SERVICES

8.1 McKesson reserves the right to suspend provision of any Services contracted for hereunder (a) 15 days after notice to Customer of nonpayment of any fees owed to McKesson hereunder (excluding Time and Materials fees and expenses), which are disputed by Customer in good faith, that are 30 days or more past due, where such breach remains uncured, (b) if McKesson determines in its reasonable discretion that such suspension is necessary to comply with any applicable law, regulation or order of any governmental authority, or (c) immediately if McKesson determines in its reasonable business judgment that the performance, integrity or security of the Paragon Direct Services are being adversely impacted or in danger of being compromised, as a result of Customer's or its users' access.

SECTION 9: INTERNET CONNECTIVITY

9.1 Customer acknowledges and agrees that Customer and Customer Users will provide all hardware, software, and services necessary to access the Internet, and Customer shall maintain Internet connectivity as a prerequisite for access to and use of the Paragon Direct Services, as and when required. Customer will take, and will require all Customer Users to take, all necessary and feasible steps to safeguard the integrity and confidentiality of all data and communications transmitted or stored when using the Paragon Direct Services, and when Customer or Customer Users are providing any services using servers or other hardware owned or maintained by or for Customer or Customer Users that are in any way related to, or based upon, the Paragon Direct Services.

SECTION 10: HOSTING

10.1 The Paragon Direct Services include Subscription Services that McKesson hosts on servers owned or maintained by or for McKesson at a McKesson, or McKesson-approved, site.

SECTION 11: EXPENSES

11.1 Fees for the Paragon Direct Services do not include any postage, third party fees or charges, network surcharges, government imposed access fees, fees resulting from changes in regulation or statute, or fees charged by communications common carriers or timesharing suppliers, which will be separately invoiced to and paid by Customer.

SECTION 12: MONITORING AND AUDITING

12.1 To ensure that Customer is in compliance with this Exhibit and the applicable usage limitations set forth herein, McKesson may continuously monitor and audit Customer's usage of the Paragon Direct Services. If an audit reveals that Customer's use of the Paragon Direct Services exceeds the applicable usage limitations, then McKesson may immediately invoice Customer for all such past excess use, based on McKesson's Prevailing Rates in effect at the time the audit is completed, and Customer will pay any such invoice within 30 days.

SECTION 13: INDEMNIFICATION.

13.1 Notwithstanding anything to the contrary contained in this Exhibit, Customer assumes the risk of liability for, and agrees, at its sole expense, to indemnify, defend, and hold McKesson, the McKesson Affiliates, and all other third-party McKesson suppliers, safe and harmless from and against any and all Claims sought by a third-party or a Customer User, that directly or indirectly arise out of or relate to: (a) any unauthorized access to the Paragon Direct Services granted by Customer or a Customer User, or gained through Customer's or a Customer User's network, login credentials, or computing hardware; and (b) Customer's or a Customer User's identity management errors, data mapping errors, connectivity errors, or inaccurate or corrupted data sent by Customer or a Customer User into the Paragon Direct Services. This indemnity will survive the termination of this Contract Supplement.

SECTION 14: DISCLAIMER

14.1 For avoidance of doubt, the services set forth in this CS do not address all services and products that are needed to meet the 2014 Edition Standards of the HITECH Act. In order to qualify as Certified EHR Technology under the 2014 Edition Standards, Customer acknowledges that it may need to purchase additional products and services, including without limitation, fees for McKesson Software, Implementation Services, Software Maintenance Services, Third Party Software and Equipment, on a separate, written agreement to complete the necessary suite of products and services to satisfy the 2014 Edition Standards for meaningful use demonstration. These products and services may be subject to additional fees, which will be priced and scoped separately. McKesson makes no commitment of any kind with respect to Customer's ability to use any McKesson Product to (1) demonstrate "meaningful use" as such term may be defined pursuant to the HITECH Act, or (2) receive Incentive Payments.

EXHIBIT A-4

QEM SUBSCRIPTION SERVICES TERMS

SECTION 1: DEFINITIONS

Except as otherwise stated herein, the capitalized terms used in this Exhibit will have the following meanings:

"Benchmarks Collaborative" ("BC") consists of aggregated data from public or proprietary sources for the purpose of comparisons.

"Benchmarks Collaborative Activation Checklist" means McKesson's written checklist and procedures for activation of the BC Services, incorporated herein by reference, as may be reasonably modified from time to time.

"Benchmarks Collaborative Services" ("BC Services") means the annual subscription service consisting of McKesson's preparation of submitted Data and creation of the Scorecard for Customer. The BC Services includes the designated Data feeds from the "data specification" that will provide Customer with one standard Scorecard and user defined Scorecards.

"Benchmarks Collaborative Website" means the website for the BC product purchased by Customer,.

"Data" means the information submitted by Customer pursuant to this Exhibit, as further defined in the Data Specification.

"Data Specification" means the file layout structure for electronic data submission and other required data elements for Data to be submitted, all as outlined on the BC Website.

"Data Submission Window" means the calendar period during which Data is to be submitted by Customer to McKesson, as defined on the BC Website.

"File Layout" means the Data input specifications as defined in the Data Specifications.

"KPI" means the Key Performance Indicators, as defined by McKesson, in its sole discretion.

"McKesson Performance Analytics" means the combination of a data warehouse, healthcare enterprise data model and business logic and web-based business intelligence solution licensed as Horizon Performance Manager TM and Horizon Business Insight TM.

"QBC Availability" means the date at which McKesson provides Customer with comparative benchmark data for quality measures.

"Scorecard" means the display of Metrics data accessed by Customer via the McKesson Performance Analytics solution at Customer site.

"Setup" means Customer's profile setup and staffing plan, explanation of information needed to complete the setup, assistance with Customer's first data submission, review of Customer's initial Scorecard to ensure accuracy of the Data, and phone support as Customer completes the setup.

"Subscription Start Date" occurs on the earlier of (i) Live Date or (ii) 12 months after CS Effective Date , except for Quality Benchmarks Collaborative whereby the Subscription Start Date occurs the earlier of ten months after the CS Effective Date or the QBC Availability date. If Customer meets the conditions for the submission of data to McKesson on the Subscription Start Date, then Customer' Scorecard will be available for viewing by Customer no later than the last day of the second full month following the First Term Fee Date.

SECTION 2: TERM AND TERMINATION

2.1 The initial term of the BC Services will commence on the Subscription Start Date and will continue for the period indicated in the Fee Summary (**"Initial Term"**), unless earlier terminated as provided herein or in the Agreement. Following the Initial Term and subject to Customer's payment of the applicable BC fees, Customer's continued right to access and use the BC shall continue for successive, automatically renewable periods each the same length as the Initial Term (**"Renewal Terms"**), unless either party provides the other party with written notice of termination of the BC no less than 60 days prior to the end of the Initial Term or the Renewal Term, as applicable. McKesson reserves the right to terminate the BC immediately and without further notice if Customer fails to make timely payments as they come due or otherwise breaches this Contract Supplement.

SECTION 3: LICENSE

3.1 Subject to the terms and conditions of this Contract Supplement and this Exhibit, and payment of the BC Services fees, McKesson hereby grants Customer, during the term described in the Fees Summary, a limited, revocable, non-exclusive, non-transferable, non-sub-licensable right and license to access and use the web-hosted software, content, and documentation constituting the BC Services solely for Customer's internal use only and related to the Facilities identified on Exhibit A. Customer's use of the BC Service constitutes Customer's agreement that McKesson may disclose the fact that customer is a user of the BC Services to other McKesson users of the BC Services.

SECTION 4: USER ACCESS

4.1 McKesson will provide Customer unlimited user logins per BC Services subscription (**"User Login"**). Each User Login will be a separate username and password. Customer will be responsible for the protection and security of each User Login username and password and the access to Customer's Data available via such User Login.

SECTION 5: DATA SUBMISSION

5.1 Within 60 days after the CS Effective Date, Customer shall submit its prior 24 calendar months of Data to McKesson in electronic format via the appropriate User Login and File Layout, and otherwise pursuant to the terms and conditions of this Exhibit. Customer shall submit Data to McKesson monthly within the Data Submission Window in electronic format via the appropriate User Login and File Layout, and otherwise pursuant to the terms and conditions of this Exhibit ("Monthly Data Submission"). If Customer does not properly complete its Monthly Data Submission during the Data Submission Window, Customer will be deemed to have declined to receive BC Services during that month, and Customer must wait until the next Data Submission Window to submit Data and receive the BC Services. Customer shall not be entitled to any credit or refund for any month in which Customer was deemed to have declined to receive BC Services. Any incomplete or otherwise incorrectly submitted Monthly Data Submission will be excluded from the Scorecard.

SECTION 6: DATA PREPARATION AND SCORECARD GENERATION

6.1 McKesson will provide the BC Services to Customer, and the Scorecard will become available to Customer via the User Login, by the last day of the month. The Scorecard data will be an aggregate compilation of the previous 12 months data.

SECTION 7: NO CUSTOMIZATION

7.1 The KPI will not be customized for Customer. Any requests by Customer to prepare customized reports or KPI are not included in the BC Services to be provided pursuant to this Exhibit, and may be contracted for on a separate basis, as mutually agreed by the parties. In addition, McKesson reserves the right at any time, with or without cause to add and delete features from the BC Services and, subject to not less than 120 days advance notice, to cease to offer and provide the BC Services. Changes in laws or regulations requiring changes to the BC Services are not included in the BC Services fees.

SECTION 8: DATA

8.1 Data Accessibility. Customer's identifiable Data will be accessible only via Customer's User Login, and will not be viewable by other BC Services subscribers. Customer's de-identified Data will be aggregated with the data of other BC Services subscribers to enable the KPI comparisons that are viewable in the BC Scorecard.

8.2 Data Ownership. Notwithstanding anything to the contrary in the Agreement or any Business Associate Agreement between the parties, Customer acknowledges and agrees that McKesson shall have the right to collect, use, distribute, disclose, sell or license the Customer Data provided to McKesson pursuant to the terms and conditions of this Exhibit (excluding Customer Data that identifies Customer, a specific individual or a Customer patient) or reports utilizing the Customer Data (excluding Customer Data that identifies Customer, a specific individual or a Customer patient) to third parties in any form, including, but not limited to, raw data, stripped data, cumulated data or statistical information derived from the Customer Data, without a duty to account. McKesson's rights under this subsection survive termination of this Exhibit, Contract Supplement and the Agreement.

SECTION 9: SUPPORT

9.1 Notwithstanding anything contrary in this Contract Supplement, support terms for the BC Services are on the BC Website. Any request for support beyond the terms on the BC Website is outside the scope of this Exhibit. Additional support can be requested by Customer through the BC Website, and will be billed to Customer at McKesson's then-current rates for such support.

SECTION 10: TRAINING

10.1 Training for the BC Services is on the BC Website. Any request for training beyond the training that is found on the BC Website is outside the scope of this Exhibit. Additional training may be provided at McKesson's then-current rates for such training upon the mutual agreement of the parties and execution of a separate contract.

SECTION 11: DISCLAIMER

11.1 For avoidance of doubt, the services set forth in this CS do not address all services and products that are needed to meet the 2014 Edition Standards issued pursuant to the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") which provides certain incentive payments ("Incentive Payments") for healthcare providers making "meaningful use" of qualified electronic health records technology that is certified pursuant to the HITECH Act ("Certified EHR Technology"). In order to qualify as Certified EHR Technology under the 2014 Edition Standards, Customer acknowledges that it may need to purchase additional products and services, including without limitation, fees for McKesson Software, Implementation Services, Software Maintenance Services, Third Party Software and Equipment, on a separate, written agreement to complete the necessary suite of products and services to satisfy the 2014 Edition Standards for meaningful use demonstration. These products and services may be subject to additional fees, which will be priced and scoped separately. McKesson makes no commitment of any kind with respect to Customer's ability to use any McKesson Product to (1) demonstrate "meaningful use" as such term may be defined pursuant to the HITECH Act, or (2) receive Incentive Payments

EXHIBIT B-1

PARAGON PROGRAM SERVICES SERVICE PATH

SCOPE

The Paragon Meaningful Use Stage 2 Program Services ("Program Services") are designed for all Paragon Customers planning to attest for Stage 2 Meaningful Use. The Program Services aim to assist Customers in their preparation for Stage 2 Meaningful Use attestation by providing assistance with the deployment of the Meaningful Use Stage 2 components of Paragon release 12 and by providing Super User training and support of build, testing and go live of products and features required for Stage 2. All services, including training will be delivered remotely through conference calls, webinars and other methods. This training will be conducted during normal business hours.

The Program Services are delivered to Customer during a 9 week period, with a defined start date.

During the 9 week slot, Customer will receive the following:

- Setup and configuration of modules defined in this service path
- Mapping and build guidance for new modules or features
- Education on Stage 2 objectives and measures
- Introduction to and demonstration of new product functionality and proposed workflows
- Build Guides
- Testing assistance and issue triage management
- Group and 1:1 Question & Answer sessions
- 1-on-1 calls from Paragon Project Manager to customer Project Management (or assigned resource)
- Integrated Test week test plan, with targeted and scheduled test periods throughout program for validation of successful build and workflow design
- Go-Live support and Post Go-Live follow-up
- Transition to National Support

Exclusions:

The following are outside the scope of this program:

- Project management within the Customer's organization
- Implementation of QeM, IT Adoption Scorecard or other solutions
- Paragon Prescription Writer e-Prescribing Services
- Barcoding implementation and setup
- Onsite assistance or consulting

Transition to National Support:

- Program Services will end at the end of Customer's 9 week slot, at which time Customer's support will be transitioned to National Support.

Rescheduling/Cancellation:

- If Customer requests to reschedule Program Services less than 4 weeks before the assigned start date or if defined pre-requisites are not completed, Customer will be responsible for payment to McKesson of all labor expenses incurred by McKesson to date related to the Program Services.
- If Customer requests to reschedule Program Services after the start date, a pro-rated rescheduling fee equal to the amount project time used will be charged.
- Labor expenses are non-refundable and cannot be deducted from the cost of the rescheduled Program Services.
- The length of the delay and settlement terms will be based on availability and mutual agreement between McKesson and Customer and the parties shall execute separate agreement for Program Services rendered to date by McKesson.

SLOTTING CHECKLIST

Software, hardware and resource requirements are required in order to meet the objectives of the Program Services. Once contracted, customers will be placed in the requested "slot", if available. A specially trained team will deliver and support the Program Services.

Ideal Preparation/Implementation Schedule for Stage 2 Meaningful Use Solutions :

- Physician Documentation
- Paragon Release 12.0
- Program Services; including Paragon Connect (production) and Paragon Direct
- QeM

Hardware requirements:

- Hardware required for Paragon Release 12.0

Required Software:

- Paragon Release 12.0 must be installed in both the Test and Live environments ***4 weeks prior to the start of the slot.***
- All products required for Meaningful Use Stage1 must be installed (see Paragon Meaningful Use Stage 1 Checklist).
- All products required for Meaningful Use Stage 2 must be contracted ***4 weeks prior to the start of the slot*** (see Paragon Meaningful Use Stage 2 Checklist).
- Required Third Party Software licenses prior to Program Services Start Date
  - Truven Care Notes, Truven Micromedex, and Microsoft BizTalk must be licensed prior to the beginning of Program Services Start Date.

Required Services:

- Implemented Prior to beginning of Program Services:
  - Carebridge – Customer's servers must be configured and accessible via Carebridge *4 weeks prior to the start of assigned slot.*

REQUIRED RESOURCES

Paragon Resources: Paragon resources with domain specific expertise will provide in-depth training and support throughout the term of the Program Services. This will include a Project Manager to manage the overall program in addition to technical resources and implementation consultants.

Customer Resources: Specific Customer Resources participation will be identified prior to Project Kickoff. Customer must provide adequate resources to support the education and build required for this program.

Your quote has been published on shi.com. Please let me know if you need anything else. Thank you and hope to hear from you s

Best,

Osman

Pricing Proposal

Quotation #:	6786768
Description:	HP Blade BL460c Gen8 Server
Created On:	Jun-24-2013
Valid Until:	Jun-30-2013

Doctors Medical Center - San Pablo Campus

William Fischer
Phone: (510) 970-5000
Fax:
Email: WFischer@dmc-sp.org

All Prices are in US Dollar(USD)

	Product	Qty	Your Price	Total
1	HP ProLiant BL460c Gen8 - Server - blade - 2-way - RAM 0 MB - SAS - hot-swap 2.5" - no HDD - Matrox G200 - Monitor : none. - CTO Hewlett Packard - Part#: 641016-B21	1	$2,253.00	$2,253.00
2	Intel Xeon E5-2680 - 2.7 GHz - 8-core - 16 threads - 20 MB cache Hewlett Packard - Part#: 662063-L21	1	$2,171.00	$2,171.00
3	Intel Xeon E5-2680 - 2.7 GHz - 8-core - 16 threads - 20 MB cache - for ProLiant BL460c Gen8 Hewlett Packard - Part#: 662063-B21	1	$2,171.00	$2,171.00
4	HP - Memory - 16 GB - DIMM 240-pin - DDR3 - 1600 MHz / PC3-12800 - CL11 - registered - ECC Hewlett Packard - Part#: 672631-B21	8	$280.00	$2,240.00
5	HP 300GB 6G SAS 15K 2.5IN SC ENT HD Hewlett Packard - Part#: 652611-B21	2	$470.80	$941.60
6	HP FlexFabric 10Gb 2-port 554FLB Adapter - Network adapter - PCI Express 2.0 x8 - Gigabit LAN, 10 Gigabit LAN, FCoE - 10GBase-KR, 10GBase-KX4 - 2 ports - factory integrated - for ProLiant BL420c Gen8, BL460c Gen8, BL465c Gen8 Hewlett Packard - Part#: 684212-B21	1	$10.00	$10.00
7	HP LPe1205A 8Gb Fibre Channel Host Bus Adapter - Host bus adapter - PCI Express 2.0 x4 / PCI Express x8 - 2Gb Fibre Channel, 4Gb Fibre Channel, 8Gb Fibre Channel - 2 ports - for ProLiant BL420c Gen8, BL460c Gen8, BL465c Gen8 Hewlett Packard - Part#: 659818-B21	1	$769.00	$769.00
8	FIO RAID 1 SETTINGS REQ 2 DRIVES CTO ONL Tech Data - Part#: 339778-B21	1	$0.10	$0.10
9	HP Care Pack 4-Hour 24x7 Proactive Care Service - Extended service agreement - parts and labor - 3 years - on-site - 24x7 - 4 h Hewlett Packard - Part#: H1K92A3#7XE	1	$1,062.00	$1,062.00
10	HP Care Pack Installation Service - Installation / configuration - on-site Hewlett Packard - Part#: HA113A1#5CY	1	$169.00	$169.00

Additional Comments

Retrieve your quote:

https://www.shi.com/Quotes/Quoteinfo.aspx

The Products offered under this proposal are subject to the SHI Return Policy, unless there is an existing agreement between SHI and the Customer.

Pricing Proposal

Quotation #:	6996388
Description:	Paragon 12 OS -
Created On:	Aug-22-2013
Valid Until:	Aug-31-2013

Doctors Medical Center – San Pablo

Glen Prieto
Phone: 510-970-5025
Fax:
Email: gprieto@dmc-sp.org

All Prices are in US Dollar(USD)

	Product	Qty	Your Price	Total
1	Microsoft SQL Server 2012 Standard - license Microsoft - Part#: 228-09904 **Note:** Doctors Medical Center – San Pablo	2	$625.97	$1,251.94
			Total	$1,251.94

Additional Comments

budget only.

Retrieve your quote:
https://www.shi.com/Quotes/QuoteInfo.aspx

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 11

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD

MEC DATE: August 12, 2013

BOARD DATE: August 28, 2013

TOPIC	Comment (S)
Dawn Gideon, Interim CEO distributed the presentation that will be provided at Town Hall meetings in August. She highlighted: • Patient Satisfaction continues to be a priority • She presented the financial summary through June, and discussed the recent $9 million County Tax Advance • Status of potential partnership discussions • Health Benefit costs continue to be an issue. DMC has recently retained a new broker and will retain a new third party administrator shortly. • On-going programs on Employees Recognition and Employee Wellness	No action required by the Board
Laurel Hodgson, Chief of Staff: • Bylaws revisions will be sent out to medical staff by the end of the month. • Quicken program installed in two computers in the Medical Staff Office.	No action required by the Board
Presentation on Medical Injury Compensation and Reform Act (MICRA): • Mark Kogan, MD, member of the Medical Staff / Representative of CMA urged physicians to help the 5M campaign to support MICRA ballot initiatives.	No action required by the Board
POLICIES, PROCEDURES, FORMS • Performance Improvement Plan 2013 • Plan for the Provision of Care • Rapid Response Team Policy	Approval.

II. MEDICAL STAFF COMMITTEE	DATE
CREDENTIALS COMMITTEE	July 25, 2013
MEDICAL EXECUTIVE COMMITTEE	August 12, 2013
BOARD OF DIRECTORS APPROVAL	August 28, 2013

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
JULY 2013

INITIAL APPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	APPOINTMENT TERM	RECOMMENDATION
Nguyen, Josephine, MD	Med./Family Practice/Radiology	Provisional	08/28/2013 – 09/30/2015	Approval
Afzali, Edris, MD	Med./Family Practice/Emergency Medicine	Provisional	08/28/2013 – 09/30/2015	Approval
McCartt, Matthew, PA	Med./Family Practice/Physician Assistant	Allied Health	08/28/2013 – 09/30/2015	Approval

REAPPOINTMENTS

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

NAME	DEPARTMENT/SPECIALTY	CATEGORY	REAPPOINTMENT TERM	RECOMMENDATION
Aung, Lai Lai, MD	Med./Family Practice/Internal Medicine	Active	09/21/2013 – 09/30/2015	Approval
Dawkins, Rogelio, MD	Med./Family Practice/Emergency Medicine	Active	09/21/2013 – 09/30/2015	Approval
Nachtwey, Frederick	Med./Family Practice/Pulmonary Medicine	Active	09/21/2013 – 09/30/2015	Approval

DOCTORS MEDICAL CENTER
CREDENTIALS REPORT
JULY 2013

Rounds, Otis, MD	Med./Family Practice/Internal Medicine	Active	09/21/2013 – 09/30/2015	Approval
Chorba, John, MD	Med./Family Practice/Cardiology	Courtesy	09/21/2013 – 09/30/2015	Approval
Rausa, Katherine	Med./Family Practice/Nephrology	Active	09/21/2013 – 09/30/2015	Approval
Wong, Bryan, MD	Med./Family Practice/Nephrology	Courtesy	09/21/2013 – 09/30/2015	Approval
Cabayan, Vatche, MD	Surgery/Orthopedic	Active	09/26/2013 – 09/30/2015	Approval
Jaffin, Henry Michael	Surgery/Orthopedic	Active	09/21/2013 – 09/30/2015	Approval
Sato, Ronald, MD	Surgery/Plastic Surgery	Active	09/21/2013 – 09/30/2015	Approval
Stanten, Russell, MD	Surgery/Cardiothoracic Surgery	Courtesy	09/21/2013 – 09/30/2015	Approval
Wren, David, MD	Surgery/Orthopedic Surgery	Active	09/21/2013 – 09/30/2015	Approval

VOLUNTARY RESIGNATIONS

NAME	*DEPARTMENT/SPECIALTY*	*EFFECTIVE DATE*
Mitchel, Albert, DO	Medicine/Neurology	06/17/2013
Matecki, Amy, MD	Medicine/Internal Medicine	06/17/2013
Siegel, Alan, MD	Medicine/Internal Medicine	06/17/2013
Davenport, Mary MD	Surgery/OB/GYN	06/17/2013

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD OF DIRECTORS
AUGUST 2013

ITEM	ACTION
A. POLICIES, PROCEDURES, FORMS – August 2013	
1. PI Plan 2013	Approval
2. Plan for the Provision of Care	Approval
3. Rapid Response Team	Approval

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†TITLE: PERFORMANCE IMPROVEMENT PLAN	†CHECK ONE: ☐ New ☐ Reviewed ☑ Revised : ☐ Major ☑ Minor
† ☑ Administrative ☐ Clinical ☐ Department _____	
†SUBMITTED BY: PERFORMANCE IMPROVEMENT COMMITTEE	
†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES: MINOR CHANGES TO ARTICLES: I; III; IV; VI	

	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		
☐ EOC/Safety Committee ☑ Other ELECTRONICALLY TO P.I. MEMBERS	07-13-13	ELECTRONICALLY ✓
☐ **Nursing Department:**		
☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☑ **Medical Executive Committee (MEC)** (as applicable)	08-12-13	✓
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

Changes to the Performance Improvement Plan

Year change to 2013

I. In the first paragraph, changes in flow of sentences. Addition of patient outcome oriented and focuses on the integration
   2. added regulatory
   3. Shortened to state "as described in Section VI"
   7. Added selection of Performance Improvement priorities
   8. Changed to an effective Risk Management Program to identify risk exposure and evaluate

II. No changes

III. In first paragraph deleted services, department and unit and changed Regional Cancer Center to oncology. Second paragraph added Urgent Care and Oncology

IV. Added Health Care District after West Contra Costa. In the first paragraph added provided and ongoing and changed organizational leaders to Board. Under Senior Leadership deleted at DMC, changed Administrative staff to Senior Leadership, deleted ongoing survey readiness strategy is a function of the Senior Leaders in organization and added to the last statement - and ensure ongoing survey readiness. Under Directors and Managers, deleted at DMC. In the first paragraph changed and, therefore to of their units including. Under 1. Added Encouraging participation in multidisciplinary Performance Improvement teams and supporting participation in improvement of patient care by staff. Under 2. Deleted continuously measures, and improve their. Added Implementing the Hospital's PI process to improve identified PI indicators. Deleted number 3. Changed number 5 to Hospital Performance Improvement Committee (HPIC). Added a section of All Staff – All staff at Doctors Medical Center are responsible for the Quality of Care provided, Patient Safety, Performance Improvement and the efficient operation of the facilities. This includes: 1. Reporting hazards, 2. Participating in Performance Improvement efforts, 3. Following hospital policies, 4. Financial Stewardship

V. No changes

VI. Stating the same just reworded to flow better. Added statement on page 6: the Hospital selects Quality Indicators and PI projects by evaluating high-risk, problem-prone and high-frequency processes. In addition, the Hospital monitors Quality Indicators as required by regulations.

DOCTORS MEDICAL CENTER-SAN PABLO
PERFORMANCE IMPROVEMENT PLAN – 2013

I. PURPOSE AND OBJECTIVES OF THE PERFORMANCE IMPROVEMENT PLAN (PIP)

The purpose of the Performance Improvement Plan is to guide the systematic improvement and maintenance of the hospital's key functions and processes to ensure safe patient care is delivered in a cost effective manner.
The performance improvement plan is patient outcome oriented and focuses on the integration of:

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

The Objectives of the Performance Improvement Plan include:

1. Maintain a comprehensive, effective system for the ongoing measurement and assessment of the quality of patient care and services provided throughout the Medical Center.
2. Assure that patient care provided is consistent with the professional and regulatory standards including The Joint Commission National Patient Safety Goals.
3. To continuously improve existing processes through the FOCUS/PDSA Rapid Cycle Improvement method as described in Section VI.
4. Provide for a collaborative multidisciplinary approach to health care practices at the Medical Center, which includes the evaluation of quality, cost effectiveness, and positive patient outcomes.
5. Focus the collection of quality improvement data at a central point for examination, analysis and documentation.
6. Provide an assessment process that includes comparative data about the Medical Center processes and outcomes over time, and the Medical Center's performance in relationship to that of other health care organizations.
7. Provide for a system that sets priorities for improvement activities. The selection of Performance Improvement priorities will be determined by an assessment of the opportunities for improvement or the need to reduce or eliminate undesirable performance outcomes. Leadership will identify opportunities for improvement. Consideration will be given to staff opinions and needs, staff perceptions of risks and patient perceptions of care.
8. Reduce liability through a effective Risk Management Program to identify risk exposure and evaluate occurrences resulting in adverse outcomes.
9. Establish an effective communication system for reporting Performance Improvement activities to all Medical Center staff.
10. Assure compliance with the requirements of federal, state, and accrediting agencies in regard to Performance Improvement activities.

Deleted: 2¶

Deleted: continuous

Deleted: ly

Deleted:

Formatted: Font: Not Bold

Deleted: relative to patient care The goal of this plan is

Deleted: all staff consistently endeavors to deliver

Deleted: and

Deleted: to

Deleted: This plan is a systematic, coordinated and focused on continually improving and sustaining

Deleted: excellent patient outcomes

Deleted: based on the concept of patient centered care and

Formatted: Indent: Left: 0.44"

Formatted: Font: Not Bold, Not Italic

Deleted: the

Deleted: and maintained is at an optimal level.

Deleted: held in the medical community and as outlined in

Deleted: This includes identifying a potential improvement, testing a strategy for change, assessing data from the implemented change to determine if it improved performance and initiating the improvement strategy system wide

Deleted: objective patient care evaluation and intensive review of specific

11. Provide support and facilitate organization-wide Periodic Performance Review annually to evaluate systems and programs and identify opportunities for improvement.

Deleted: organization

II. THE MISSION, VISION AND GUIDING PRINCIPLES OF DOCTORS MEDICAL CENTER

MISSION:

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

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

VISION:

Doctors Medical Center will distinguish itself through our:

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

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

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

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

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

VALUES

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

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

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

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

III. DOCTORS MEDICAL CENTER SCOPE OF SERVICE

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

Deleted: Services
Deleted: Department
Deleted:
Deleted: Unit
Deleted:
Deleted: Regional Cancer Center

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

IV. AUTHORITY AND ACCOUNTABILITY

West Contra Costa Health Care District Governing Body

The West Contra Costa Health Care District Governing Body carries the ultimate accountability for assuring the quality of care provided and ongoing performance improvement. The Governing Body sets expectation, develops overall plans, provides resources and supports the implementation of procedures that assess and improve the quality of the organization's administrative, clinical and support processes. The Governing Body delegates the responsibility to Medical Staff Leaders and Administration for implementing and monitoring Performance Improvement activities.

Medical Staff Leadership

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

Senior Leadership

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

Directors and Managers

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

1. Assuring adequate resources are allocated for staff to receive training, including the scheduling of time to participate in performance improvement activities. Encouraging participation in multidisciplinary Performance Improvement teams and supporting participation in improvement of patient care by staff.
2. Developing with their staff performance measurements for the department that assess clinical and administrative processes. Implementing the Hospital's PI process to improve identified PI Indicators. This includes the identification of department-specific practice guidelines where appropriate.

0

Deleted: *Board*

Formatted: Indent: Left: 0.38", Hanging: 0.32", Tabs: 0.38", Right + Not at 0.31"

Formatted: Font: Bold, Italic

Deleted:

Formatted: Font: Bold, Italic

Deleted: West Contra Costa

Deleted:

Deleted: Board

Deleted:

Deleted: and

Deleted: of patient care services provided by its professional and support staff

Deleted: Board

Deleted: organization's leaders

Deleted: s

Deleted: ,

Deleted: Board

Deleted:

Deleted: *at DMC*

Formatted: Indent: Left: 0.31", Hanging: 0.25"

Deleted: *at DMC*

Deleted: Administrative staff

Deleted: to

Deleted: foster

Deleted: Ongoing survey readiness strategy is a function of the Senior Leaders in organization

Deleted: *at DMC*¶

Deleted: and, therefore

Deleted:

Deleted:

Deleted: continuously measures,

Deleted: , and improve their

Deleted: or

3.
4. Ensuring sentinel events and adverse events are immediately reported using the electronic EQRR reporting system. Managers and Directors review events for opportunities of improvement and document in the Midas system in a timely manner.
5. Participation in an annual report and quarterly reports to the Hospital Performance Improvement Committee (HPIC) as appropriate.
6. Communicating to the staff the importance of understanding and utilizing the performance improvement process in their daily work assignments as well as in their interactions with all internal and external customers.

Deleted: Encouraging participation in multidisciplinary Performance Improvement teams and supporting participation in improvement of patient care by staff.

Deleted: O

All Staff

All Staff at Doctors Medical Center are responsible for the Quality of Care provided, Patient Safety, Performance Improvement and the efficient operation of the facilities. This includes:

1. Reporting hazards
2. Participating in Performance Improvement efforts
3. Following hospital policies
4. Financial Stewardship

Formatted: Indent: Left: 0.44", First line: 0", Tabs: 0.38", Left + Not at 0.75"

Formatted: Indent: First line: 0"

Formatted: Indent: Hanging: 0.13", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Tab after: 0" + Indent at: 0.5"

V. EDUCATION

The education of the staff in Performance Improvement is ongoing:

1. All leaders are educated in the principles and methods of Performance Improvement so that they can identify opportunities, understand, implement and participate effectively in the process. All Medical Center staff and medical staff are introduced to the basic components of performance improvement and their role as active participants in continuous improvement.

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

Formatted: Indent: Left: 0.38", Hanging: 0.25", Tabs: 0.63", Left + Not at 0.75"

VI. PERFORMANCE IMPROVEMENT PLAN, SCOPE AND FUNCTIONS

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

Deleted: Measurements of both k

Deleted:

Deleted: All

Deleted: i

Deleted:

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

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

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

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

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

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

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

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

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

The Hospital selects Quality Indicators and PI Projects by evaluating high-risk, problem-prone and high-frequency processes. In addition, the Hospital monitors

Quality Indicators as required by regulations. Performance is monitored through the collection of data, which includes:

1. Use of blood and blood components, including transfusion reactions.
2. Restraint use.
3. Medications use, including significant medication errors and adverse drug reactions.
4. Risk Management.
5. Utilization Management.
6. Quality Control.
7. Infection control surveillance.
8. Customer perception of care and service, including opportunities for improvement in care, service or patient safety.
9. Anesthesia, Operative and other procedures.(Procedural Sedation)
10. Health Information Management (accurate, timely and legible completion of medical records).
11. Organ Procurement
12. Use of Autopsy.
13. Core Measures for Stroke, Pneumonia, AMI, CHF, and SCIP.
14. Participation in external databases, e.g., studies done for NCDR, NIOSH CMS, and other regulatory agencies.
15. Contract Services.
16. Complaints/Grievances.
17. Operative and other high risk invasive procedures
18. Resuscitation and its outcomes
19. Identification of high-risk populations.
20. Pain Management.
21. CMS "preventable" hospital complications(HAC)
    a. Object left in during surgery
    b. Air Embolism
    c. Major Transfusion Reaction
    d. Foley catheter associated UTI
    e. Vascular catheter associated infection
    f. Mediastinitis after CABG (Does not apply at DMC)
    g. Falls and trauma: fractures, head injuries and burns
    h. Hospital Acquired Infections

VII. PERFORMANCE IMPROVEMENT STRUCTURE AND ROLES

A. Organization and Responsibilities of the *Medical Staff Performance Improvement Committee(MSPIC)*

The MSPIC reports directly to the Medical Executive Committee and the West Contra Costa County Health Care District's Governing Body. The MSPIC is composed of the Chief Executive Officer (CEO), Chief Nursing Officer /VP Patient Care Services, Chief of Staff, physicians representing departments of Medicine and Surgery Services and the Emergency

Deleted: /

Deleted: /

Deleted: ¶

Formatted: Indent: Left: 0.5", Hanging: 0.25", Tabs: 0.75", List tab + 0.94", Left + Not at 0.44" + 0.7" + 0.95"

Deleted: committee

Deleted:

Deleted: Board

Deleted: It is responsible for providing the direction for and general oversight of the Medical Center's Performance Improvement activities It

Deleted: ,

Department Director Quality/Risk , and other departments as required to address performance improvement opportunities. It is responsible for providing the direction for and general oversight of the Medical Center's Performance Improvement activities. This committee meets monthly and performs the following functions:

1. Reviews and analyzes data described in Section VI.

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

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

4. Prioritizes Opportunities for Improvement based on criteria which supports Doctors Medical Center's Mission, Vision and Guiding Principles. These include:
   - Effect on High Volume/High Risk Population Outcomes
   - Effect on Patient/Staff Satisfaction
   - Implementation Feasibility (resource analysis)
   - Patient Safety

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

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

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

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

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

Deleted: Services
Deleted: ,
Deleted: Identifies
Deleted: 3
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.44" + Tab after: 0.94" + Indent at: 0.94"
Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 0.31" + 0.45" + 1.7" + 1.95" + 2.2" + 2.45" + 2.7" + 2.95" + 3.2" + 3.45" + 3.7" + 3.95" + 4.2" + 4.45" + 4.7" + 4.95" + 5.2" + 5.45" + 5.95" + 6.2" + 6.45"
Deleted: these
Deleted: are
Deleted: S
Deleted: of
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.44" + Tab after: 0.94" + Indent at: 0.94"
Deleted: 6
Deleted: 7
Deleted: 8
Deleted: O

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

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

C. Hospital Performance Improvement Committee (HPIC) consists of Integrated Quality Services, Infection Control, Utilization Management, Health Information Management, Education, Patient Relations, Patient Safety Officer and Environment of Care Director, Radiology, Lab, Human Resources, and Pharmacy. It performs the following functions:

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

2. Recommends opportunities for improvement to the departments and functions based on performance activities. A summary of patient care reports flow to the Medical Staff PIC

VII. PROGRAM CONFIDENTIALITY

Deleted: O

Deleted: O

Formatted: Indent: Left: 0.44", Hanging: 0.31", Tabs: Not at 0.45"

Deleted:

Deleted:

Deleted:

Deleted: and

Formatted: Indent: First line: 0"

Deleted:

Formatted: Indent: Left: 0.75", First line: 0"

Deleted:

Formatted: Indent: Left: 0.44", Hanging: 0.31", Tabs: 0.69", Left + Not at 0.45"

Deleted: O

Deleted: I

Formatted: Font: Not Bold

Deleted: ¶

Formatted: Indent: Left: 0", First line: 0"

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

Deleted:

Formatted: Indent: Left: 0", First line: 0", Tabs: 0", Left + Not at 0.45"

Deleted:

VIII. ANNUAL REAPPRAISAL

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

Deleted: O

Deleted:

IX. APPROVAL

Approval of this Performance Improvement Plan is recommended by the Governing Board, the Medical Executive Committee and the Chief Executive Officer.

Formatted: Indent: Left: 0", First line: 0", Tabs: 0", Left + Not at 0.45"

Deleted:

ORIGINATOR (Name/Title/Dept)	K. Taylor RN, MSN Director, Integrated Quality Services		
APPROVAL DATES / OTHER AFFECTED DEPARTMENTS	Hospital Performance Improvement Committee (HPIC)		
APPROVAL DATE(S) / MEDICAL STAFF COMMITTEE(S)1	Medical Staff Performance Improvement Committee		
APPROVAL DATE / MEC		**APPROVAL DATE: Governing BOARD**	

Deleted: 0

Deleted:

10

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†TITLE: PLAN FOR THE PROVISION OF CARE	†CHECK ONE: ☐ New ☐ Reviewed ☑ Revised : ☐ Major ☑ Minor
† ☑ Administrative ☐ Clinical ☐ Department _____	
†SUBMITTED BY: PERFORMANCE IMPROVEMENT COMMITTEE	
†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other	
†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES: - YEAR CHANGE TO 2012-2013 - PAGE 4 - UNDER PLANNING PROCESS, CHANGED DESIGNATED TO DESIGNED - PAGE 7 - CHANGED INTEGRATING TO INTEGRATED AND ADDED MEDICAL STAFF OFFICE	

	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		
☐ EOC/Safety Committee ☑ Other: ELECTRONICALLY TO PI MEMBER	07-17-13	ELECTRONICALLY ✓
☐ **Nursing Department:**		
☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☑ **Medical Executive Committee (MEC)** (as applicable)	08-02-13	✓
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

Changes to the Plan for the Provision of Care

Year change to 2012-2013

Page 4 – Under Planning Process, changed designated to designed

Page 7 – Changed Integrating to Integrated and added Medical Staff Office

DOCTORS MEDICAL CENTER

PLAN FOR THE PROVISION OF CARE

2012-2013

Deleted: 3

Deleted: 4

1

DOCTORS MEDICAL CENTER
PLAN FOR THE PROVISION OF CARE

Mission Statement:

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

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

Vision and Values Statement:

Doctors Medical Center will distinguish itself through our:

- **Community Leadership** in delivering amazing care that surpasses the expectations of the diverse population we serve.
- **Passion for Excellence** manifested through our people who are dedicated to providing a supportive, empowering environment which emphasizes innovation and caring.
- **Continual Search for New Opportunities** to improve our care and enhance our partnership with our community and other healthcare providers.
- **Commitment to Promoting a Healthy Community** by assuring access to healthcare resources and promoting patient, family, and community health education.
- **Respect of Individual** by promoting a high standard of professional ethics and conduct while striving to create a caring and compassionate environment for delivering amazing care.

Goals:

- To maintain the role of patient advocate.
- To promote a collaborative relationship with the physicians and all members of the interdisciplinary team.

- To systematically monitor the efficiency and effectiveness of patient care.
- To respect the right of all individuals and recognize the values, opinions, dignity of everyone who works with or utilizes the services of Doctors Medical Center.
- To promote a working environment that is conducive to creativity, satisfaction, and the advancement of Nursing as a profession.
- To provide a comprehensive education and developmental program that maintains and upgrades the quality of care while prompting personal and professional growth and satisfaction.
- To promote the involvement and education of all patients, families, and significant others from the time of admission, through the healing process, and throughout the continuum of care.
- To provide, promote, and maintain the same standard of excellence in care to all patients in all units, areas, and departments throughout the organization.

Outcomes of Success:

- Customer Satisfaction (patient, employee, and physician)
- Retention of skilled employees and physicians
- Superior clinical skill of employees
- Superior economic performance
- Meeting and exceeding quality benchmarks in key areas (Core Measures, National Patient Safety Goals)

Doctors Medical Center has established standards of care and practice and supports those established by the Joint Commission. Doctors Medical Center believes each member of the staff has the responsibility to pursue excellence in the delivery of care.

Doctors Medical Center provides an organizational structure that promotes:

- Provision of the highest quality of patient care
- Effective utilization of resources
- Support of education programs
- Teaching to utilize knowledge to improve health care and its delivery
- Patient and family involvement in the continuum of care from admission through discharge.

All clinical personnel are expected to strive for excellence in practice. The health care provider must develop respectful, understanding relationships and utilize systematic problem solving and decision-making processes based on accurate assessments, appropriate knowledge, evidence based practice, and standards of care.

Doctors Medical Center believes in responsible action and awareness of the public and self-regulation to strive for quality in performance.

Doctors Medical Center believes that professional growth demonstrates a continued pursuit of excellence and support through promotions, continuing education, and recognition of national certification. Doctors Medical Center also believes excellence is demonstrated through the ongoing evaluation of qualifications and competency of personnel related to the performance of their professional duties. Age-specific criteria based job descriptions specific to positions are used to measure these expectations.

Planning Process:

The organization's plan for the provision of care is designed to support the integration of patient services throughout the organization. The goal of the plan is to integrate each department and/or service into the overall functioning of the organization, improve functional relationships by interdisciplinary collaboration on identified patient care issues, and improve communication. The integration of patient care services is accomplished through distribution and management of information such as:

Deleted: nated

- Policies and Procedures
- Interdisciplinary patient care plans
- Departmental newsletters
- Interdisciplinary meetings
- Review of trending data
- Evidence based practice

Doctors Medical Center, as an organization, plans for the services provided in response to the need of the community it serves. This planning is consistent with the Mission, Vision, and Values of the medical center. The planning process seeks input from many sources, including but not limited to, the community, our customers, and the internal organization. Examples of obtaining such input include:

- Internal and external satisfaction surveys
- Community assessment process
- Administrative and Medical Staff networking with area health care providers
- Involvement with local businesses, schools, churches, and civic organizations

Evaluation Process:

The evaluation process is largely based on feedback, monitoring and evaluation, education, and communication. Identifiable sources of information include, but are not limited to:

- Patient, employee, and physician satisfaction surveys

- Direct patient and family interviews
- Observations and/or recommendations by medical staff
- Observations and/or recommendations by administrative staff
- Observations and/or recommendations by nursing
- Observations and/or recommendations by hospital clinical departments and support staff
- Observations and/or recommendations by members of the community
- Observations and/or recommendations by accrediting bodies
- Review of occurrences with trending data
- Recommendations from medical staff and hospital committees
- Recommendations from the Governing Board
- Policy and Procedure review
- Continuing education
- Performance Improvement teams and work groups
- Ongoing monitoring and evaluation
- Participation and review in national data banks

Patient Assessment:

Patient assessment, both initial and ongoing, involves all disciplines required to meet the needs of the patient. The Interdisciplinary Plan of Care (IPOC), completed by a Registered Nurse on admission, establishes the framework for the assessment process. It provides basic information from which other disciplines develop a more comprehensive assessment in their areas of expertise. The IPOC and other discipline-specific assessment data are found together under the IPOC tab in the medical record as a resource for all members of the health care team.

Each patient is assessed:

- At regular specified times
- To determine response to treatment
- To identify any significant change in condition/diagnosis
- To identify and prioritize need for care and treatment

The plan of care, including identification and prioritization of care needs, is developed from this IPOC data.

Patient Care Services Staff Assessment:

The professional practice at Doctors Medical Center is defined in accordance with the following standards:

- California Nurse Practice Act

- American Nurses Association Professional Ethics
- California Code of Regulations (Title XXII)
- The Joint Commission
- California state licensure requirements
- Code of Federal Regulations
- Departmental policies and procedures

Professional staff who provide inpatient care and are not subject to the medical staff privilege delineation process receive a performance review annually. The annual appraisal is based on specific job descriptions and emphasizes specific work requirements, teamwork, guest relations, and overall employee and organizational development.

Organization and Functional Relationships:

Doctors Medical Center is a public acute care hospital, owned and operated by the West Contra Costa Health Care District. The Doctors Medical Center Governing Body, comprised of five (5) District representatives, four (4) County representatives, two (2) representatives of the medical staff, representing West Contra Costa County, has final authority in conducting the affairs of the hospital. The Board has empowered the President and Chief Executive Officer (CEO) to take appropriate steps to ensure clinically effective patient care and to enforce the Bylaws, Rules, and Regulations. The CEO delegates immediate authority to the Administrative Team comprised of (COO/CNO, CFO, VP, Patient Care Services, VP, Human Resources and Director, Community Relations) for daily operational and decision making related to the administrative and financial aspects of the hospital operations and clinical patient care.

The Administrative Team, in collaboration with Board Members, Medical Staff, Department Directors, and Medical Staff Performance Improvement Committee, has established the Mission and strategic direction of the organization.

The Administrative Team, Department Directors and Manager, DMC employees, and Medical Staff actively participate in cross functional performance improvement, service development and/or enhancement, problem solving, and other organizational teams. The results of these teams are communicated through medical staff meetings, employee staff meetings, and related newsletters.

Medical Center Services:

Support Services: Provided to all patient care areas on a regular basis. The core areas providing support services include Internal Support Services and Integrating Services

Internal Support Services – Support the comfort, safety, and efficiency of patient services:

- Environment Services which includes laundry and linen services and housekeeping
- Plant Operations which includes Engineering, Maintenance, Biomedical, and Utilities Management
- Materials Management which includes Purchasing. Central Distribution, and Mail Room
- Admissions
- PBX; Telephone Communications

Integrated Services – Ensures that patient care services are maintained in an uninterrupted and continuous manner.

Deleted: ing

- Management of Information Systems
- Human Resources
- Organization Education
- Health Information Management
- Infection Control
- Occupational Health
- Business Development
- Financial Services which includes Accounting, Payroll, Patient Business Office and Contracting
- Medical Staff Office

Ancillary Services:

- Respiratory Therapy
- Cardiology
- Diagnostic Imaging which includes Ultrasound, Nuclear Medicine, Invasive Radiology, and Cardiac Catheterization Lab
- Case Management
- Social Services
- Food & Nutrition
- Rehabilitation Services which include Physical Therapy, Occupational Therapy, and Speech Therapy
- Cardiac Rehabilitation
- Enterostomal Therapy
- Dialysis
- EEG
- Hyperbaric Medicine
- Cancer Center which includes Chemotherapy, Radiation Therapy, Mammography,

Brachytherapy, and Lung Clinic
- Wound
- Pharmacy
- Laboratory, Pathology
- Wellness Services
- Sleep Lab

Nursing Services:

- Emergency Department
- Intensive Care Unit
- Surgical Services which include PACU, Same Day Surgery, Central Sterile, and GI/Endoscopy Lab
- Telemetry (3rd & 4th Floors), Medical/Surgical Unit (5th Floor), and Forensic Unit (7th Floor)

Nursing Care:

Doctors Medical Center views its responsibility to assure that nursing care includes those functions including basic health care which help people cope with difficulties in daily living which are associated with actual or potential health/illness/problems/treatment which require a substantial amount of scientific knowledge and technical skill. The purpose of Nursing is to promote an optimal level of health and to assist patients, families, and significant others to cope with illness outcomes. Guidelines for practice have been developed with reference to nursing trends, literature, evidence-based best practice, and identified patient needs in concert with regulatory guidelines:

Monitoring:

The provision of Nursing Care is monitored and evaluated on a continuous basis to ascertain the effectiveness of action plans, acuity systems, and patient care requirements throughout the hospital. Assessment and evaluation tools include:

Deleted: c

- Performance improvement data
- Staffing guidelines
- Standards of Nursing Practice
- Financial reports
  Outcome statistics
- Customer Satisfaction Surveys

Integration of Information:

It is recognized that a cooperative and collaborative relationship between the Department of Nursing and other services is necessary to ensure that safe and appropriate care is delivered to each patient. It is

the responsibility of the Vice President of Patient Care Services to oversee and evaluate the ongoing care of the patient population and interdepartmental systems that affect this care. The primary methods of communication, problem identification, and resolution include, but are not limited to:

- Performance improvement activities
- Performance Improvement Committee
- Department head meetings

Interdisciplinary Teams:

- Environment of Care Team
- Department of Nursing Meetings
- Unit Staff Meetings
- Medical Staff Meetings

Staffing Plan:

Staffing plans for patient care services are developed based on the populations served, level and scope of care that needs to be provided, the frequency of the care provided, and a determination of the skill level of staff that can most appropriately provide the type of care needed.

Each department has a formalized staffing plan which is reviewed annually and based on the following:

- Patient care trends and data
- Performance improvement activities
- Changes in customer needs or expectations
- Operating budget
- Customer satisfaction date

Staffing variances are monitored via monthly financial reports and review of patient classifications.

Service Availability:

Medical care is provided to our patients and consultations are provided in accordance with Medical Staff Bylaws, Rules and Regulations, and credentialing requirements.

In circumstances where Doctors Medical Center cannot provide the service necessary to meet a patient's needs, appropriate referrals to outside organizations are made by medical staff members in collaboration with the appropriate hospital staff. The medical staff, in collaboration with hospital staff, the patient, and family, determine the need for referral, transfer, or discharge to another facility or level of care based on the patient's assessed needs and the hospital capacity to provide the necessary care or treatment. Examples of such cases include referral of major trauma, cardiac surgery, obstetrics, complex pediatric

patients to tertiary facilities and psychiatric disorders. Referrals for community-based services are handled by appropriate hospital staff in collaboration with physicians and care givers.

Financial Planning Process:

Financial planning and budgeting will be done on an annual basis and is an essential component of assuring patient care service delivery, as well as the overall long term viability of the organization.

Department directors and manager are responsible and accountable for providing input, implementing, and monitoring their respective departmental budgets.

Capital equipment budgets are developed annually and reviewed throughout the year to prioritize the needs of the medical center. This is done with input from Finance Department Directors/Managers, as well as the Medical Staff.

Deleted: ill

The Department Directors/Managers, appropriate Medical Staff members, Finance Department, Human Resources, and Administrative Team members collaborate to develop budgeting goals.

APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

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

†TITLE: RAPID RESPONSE TEAM	†CHECK ONE: ☑ New ☐ Reviewed ☐ Revised : ☐ Major ☐ Minor
† ☐ Administrative ☑ Clinical ☐ Department _____	
†SUBMITTED BY: BOBBIE ELLERSTON	
†NEW POLICY - REASON FOR SUBMISSION: ☐ Change in Law ☑ New Regulation: CMS CDPH TJC Other HOSPITAL	
†REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES: .	

	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		
☐ EOC/Safety Committee ☑ Other: INVASIVE LAB	08-09-13	✓
☐ **Nursing Department:** ☐ Nursing Practice:		
☐ **Forms Committee** (as applicable)		
☐ **Administrative Policy Review Committee (APRC)**†		
☐ **Executive Leadership**		
☑ **Medical Executive Committee (MEC)** (as applicable)	08-12-13	✓
☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)*		

DOCTORS MEDICAL CENTER

Manual: PATIENT CARE	**Sub Folder:**
Title: Rapid Response Team	**Reviewed:** **Revised:**
Effective Date: 6/2013	**Page 1 of 1**

PURPOSE: To provide guidelines for staff that provide for the emergency medical needs of patients, staff, and visitors.

POLICY: A Rapid Response will be initiated for any patient within the hospital requiring rapid assessment with acute status changes to prevent cardiopulmonary arrest outside the critical care environment and expedite transfer to a higher level of care when appropriate. All Team members having direct patient contact will be certified in Basic Life Support. The leader for all codes will have current Advance Cardiopulmonary Life Support (ACLS) or Pediatric Advanced Life Support (PALS), or Neonatal Resuscitative Program (NRP), as appropriate.

DEFINITION/OVERVIEW:

Rapid Response – An event requiring the rapid assessment and intervention of trained medical personnel which may include, but is not limited to, serious injury, unconsciousness, serious respiratory symptoms, or symptoms of cardiac crisis.

PROCEDURE:

1. Dial ext. 5555 and state the patient's room number
2. The Rapid Response Team (RRT) consists of Critical Care RN/Unit Director or Unit Supervisor/Respiratory Therapist/Patient's Primary Nurse
3. The Primary Nurse will use SBAR communication tool to notify the attending physician that the RRT has been activated
4. The Primary Nurse will take the patient's information and stay in the patient's room at all times, assist the RRT, and perform other duties as defined by protocol or assigned by the RRT within their scope of practice.
5. Information given to the team will be:
    - Patient's code status
    - Diagnosis/Pertinent history
    - Patient's medications stating which were given and when
    - Why the RRT was called
    - What has been done so far
    - The patient's normal condition and when it changed
    - Current vital signs, blood sugar, and oxygen saturation
6. If RRT is cardiac:
    - The RRT RN obtains a 12 Lead EKG (<10 min. from call)
    - If annotation assessment on EKG states "Acute MI" or Clinical Suspicion of ischemic chest pain, the primary nurse takes the EKG/chart/primary MD's phone number to ED
    - If Cardiologist confirms a STEMI, the EKG is stamped with the time
    - ED clerk activates STEMI page per order with room number and follows STEMI protocol

REFERENCES:

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

ALGORITHM FOR THE INPATIENT WITH CHEST PAIN: PATIENT C/O PAIN SUGGESTIVE OF MYOCARDIAL ISCHEMIA