



**PUBLIC NOTICE
CITY OF ALAMEDA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
AGENDA**

Monday, April 12, 2010 – 6:00 p.m.

Location: Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501

Office of the Clerk: (510) 814-4001

Regular Meeting

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address and present to the District Clerk. This will ensure your opportunity to speak. Please make your comments clear and concise, limiting your remarks to no more than three (3) minutes.

- I. Call to Order (6:00 p.m. – 2 East Board Room)** Jordan Battani
- II. Roll Call** Kristen Thorson
- III. Adjourn into Executive Closed Session**
- IV. Closed Session Agenda**
 - A. Approval of Closed Session Minutes
 - B. Medical Executive Committee Report and Approval of Credentialing Recommendations H & S Code Sec. 32155
 - C. Board Quality Committee Report (BQC) H & S Code Sec. 32155
 - D. Consultation with Legal Counsel Regarding Pending Litigation Gov't Code Sec. 54956.9(a)
 - E. Discussion of Pooled Insurance Claims Gov't Code Sec. 54956.95
 - F. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions Gov't Code Sec. 54957.6
 - G. Discussion of Report Involving Trade Secrets H & S Code Sec. 32106
 - H. Public Employee Performance Evaluation Title: Chief Executive Officer Gov't Code Sec 54957

V. Reconvene to Public Session (Expected to start at 7:30 p.m. – Dal Cielo Conference Room)

A. Announcements from Closed Session Jordan Battani

VI. Consent Agenda

- A. Approval of March 1, 2010 Minutes **ACTION ITEM** [enclosure] (PAGES 3 -7)
- B. Approval of March 16, 2010 Minutes **ACTION ITEM** [enclosure] (PAGES 8-10)
- C. Acceptance of February 2010 Financial Statements **ACTION ITEM** [enclosure] (PAGES 11-31)
- D. Acceptance of the 2009 Environment of Care Annual Report **ACTION ITEM** [enclosure] (PAGES 32-60)
- E. Approval of Administrative Policies and Procedures **ACTION ITEM** [enclosure] (PAGES 61-67)
- F. Approval of Department Specific Policies and Procedures **ACTION ITEM** [enclosure] (PAGES 68-77)
- G. Approval of the Medical Staff 2010 Mission Statement for Continuing Medical Education Program [enclosure] (PAGES 78-79)
- H. Approval of Amendments to Medical Staff Rules and Regulations **ACTION ITEM** [enclosure] (PAGES 80-82)
- I. Approval of Capital Expenditure for Acquisition of Kaiser Surgery Equipment **ACTION ITEM** [enclosure] (PAGE 83)

VI. Regular Agenda

- A. President's Report Jordan Battani
- B. Chief Executive Officer's Report
 - 1. Joint City Council / District Board Committee Discussion Deborah E. Stebbins
 - 2. Monthly Statistics
 - 3. Seismic Planning Status Update Kerry Easthope
- C. Community Relations and Outreach Report
 - 1. Committee Report – March 23, 2010 Rob Bonta
- D. Finance and Management Committee Report
 - 1. Committee Report –March 31, 2010 Jordan Battani
 - 2. PACS Financing Update David Neapolitan
- E. Medical Staff President Report James Yeh, DO

VIII. General Public Comments

IX. Board Comments

X. Adjournment

The next regularly scheduled board meeting is scheduled for May 5, 2010
Closed Session will begin at 6:00 p.m.
Open Session will follow at approximately 7:30 p.m.



Minutes of the Board of Directors
 March 1, 2010

Directors Present:

Jordan Battani
 Robert Bonta
 Robert Deutsch, MD
 J. Michael McCormick
 Leah Williams

Management Present:

Deborah E. Stebbins
 Kerry J. Easthope
 David A. Neapolitan

Medical Staff Present:

Alka Sharma, M.D.

Legal Counsel Present:

Thomas Driscoll, Esq.

Excused:

Submitted by:
 Jaclyn Yuson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:15 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
3. Adjourn into Executive Closed Session	At 6:16 p.m. the meeting adjourned to Executive Closed Session.	

<p>4. Reconvene to Public Session</p>	<p>A. Announcements from Closed Session</p> <p>Director Battani reconvened the meeting into public session at 8:03 p.m. The following closed session announcements were made.</p> <p>[1] Closed Session minutes – February 3, 2010 & February 16, 2010</p> <p>[2] The Board Quality Committee (BQC) Report – December 2009</p>	<p>[1] The Closed Session Minutes for the February 3, 2010 & February 16, 2010 were approved with one abstention (Director Deutsch) on the February 16th minutes.</p> <p>[2] The December 2009 BQC report was accepted as presented.</p>
<p>5. Consent Agenda</p>	<p>[A] Approval of February 3, 2010 & February 16, 2010 Minutes</p> <p>[B] Acceptance of January 2010 Financial Statements</p> <p>[C] Approval of Union Bank Signing Authorization / Resolution</p> <p>[D] Approval of Selected PACS Financing Vendor- US Bankcorp Equipment Financing</p> <p>[E] Approval to Renew Line of Credit with Bank of Alameda</p>	<p>Director Williams moved to approve the Consent Agenda as presented. Director Bonta seconded the motion. The motion approved with one abstention (Director Deutsch) on the February 16th minutes.</p>
<p>6. Regular Agenda</p>	<p>A. President's Report</p> <p>None at this time.</p>	

B. Chief Executive Officer's Report

1. Appropriations Application for Seismic Planning
 Ms. Stebbins discussed the Appropriations Application to Congressman Pete Stark for Seismic Planning with the Board. Management is requesting \$527,065 from the Department / Agency of Labor, HHS, Education Appropriations Subcommittee for Health Resources Services Administration – Health Facilities and Services. If granted, the Hospital would not receive funds until March 2011. The Hospital received many letters from state / local elected officials expressing their support for this project and appropriation.

2. Approval to Advance Seismic Planning with Thornton Tomasetti

Mr. Easthope proposed two recommendations to the Board: 1) to authorize management to enter into a contract with Thornton Tomasetti. The estimated value of the proposed work is \$369, 265 and 2) increase management's spending authority for seismic planning from \$200,00 which was approved at the October 2009 Board meeting to \$315, 265 to help meet the 2013 seismic standards. The funds for this project will come from the FY 2010 Capital Budget.

3. General Statistics

Ms. Stebbins reported the key statistics for February 2010. Average Daily Census was under budget at 87.1 versus a budget of 93.3. ER Visits were under budget by 1.5%, 1,417 compared to a budget of 1,439. Inpatient Surgeries were exactly on budget at 54.

<u>Statistics</u>	February (Prelim)	February Budget	January Actual
Average Daily Census	87.1	93.6	81.68
Acute	31.4	34.9	27.0
Subacute	33.9	33.5	33.68
South Shore	21.7	21.5	21.0
Patient Days	2,438	2,622	2,532
ER Visits	1,417	1,439	1,489
OP Registration	2,653	2,904	2,847
Total Surgeries	461	452	432

Director McCormick moved to advance Seismic Planning with Thornton Tomasetti. Director Bonta seconded the motion. The motion carried unanimously.

C. Strategic Planning and Community Relations Report

1. Committee Report – February 24, 2010

Director Bonta reported that the committee met on February 23, 2010. The committee welcomed Dr. Stuart Chen, former District Board of Directors candidate, as an official member of the committee. Ms. Terrie Kurrasch volunteered to act as Co-Chair to the committee. Meeting will continue to meet on the 4th Tuesday of every month until the Community Relations plan is developed and then possibly change the meeting schedule to every quarter, thereafter. The committee discussed engaging and reaching out to other local organizations to update them about the Hospital.

Mr. Bonta mentioned that 11,000 post cards featuring Vascular Surgeons were mailed out to 94501 and 94502 zip codes.

The Haiti shoe drive is a tremendous success. Boxes of shoes in the lobby have been getting emptied out daily.

2. Recommendation to Accept Community Relations Committee Structure and Purpose

The Board members reviewed and approved the Community Relations structure and purpose as presented.

Director Williams moved to accept the Community Relations Committee Structure and Purpose as presented. Director McCormick seconded the motion. The motion carried unanimously.

D. Finance and Management Committee Report

1. Committee Report – February 24, 2010

Director Battani reported that the Finance and Management Committee met on February 24, 2010. The committee invited James Oddie, former District Board candidate, to be an official committee member. Director Battani mentioned that the net profit for the month of January was \$17,000 better than budget, \$76,000 compared to \$59,000.

The committee discussed renewing the Hospital's revolving Line of Credit with Bank of Alameda and the PACS system financing options.

Director Battani stated that Mr. Easthope updated the committee on nuclear

<p>medicine and outpatient diagnostic imaging volumes.</p> <p>The committee also agreed to continue to explore participating in the CMAC-IGT project.</p> <p>2. <u>Recommendation to Accept Finance and Management Committee Structure and Purpose</u></p> <p>The Board members reviewed and approved the Finance and Management Committee structure and purpose as presented.</p>	<p>E. Medical Staff President's Report</p> <p>Dr. Sharma reported to the Board that Dr. Diane Lee, Neurologist, is actively seeing patients at the Community Clinic of Alameda Towne Center Medical Office Building. Members of the Medical Staff will be meeting with David Loose, Joint commission Consultant, in preparation for the Joint Commission survey.</p>	<p>Director Williams moved to accept the Finance and Management Committee Structure and Purpose as presented. Director Bonta seconded the motion. The motion carried unanimously.</p>
<p>7. General Public Comments</p>	<p>None at this time.</p>	
<p>8. Board Comments</p>		
<p>9. Adjournment</p>		<p>A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:37 p.m.</p>

Attest: _____ **Jordan Battani** President
 _____ **Robert Bonta** Secretary



Minutes of the Board of Directors
 March 16, 2010

Directors Present:

Jordan Battani
 Robert Bonta
 Robert Deutsch, MD
 J. Michael McCormick
 Leah Williams

Management Present:

Deborah E. Stebbins
 Kerry J. Easthope
 David A. Neapolitan

Medical Staff Present:

Alka Sharma, MD

Legal Counsel Present:

Thomas Driscoll, Esq.

Excused:

Submitted by:
 Kristen Thorson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 7:35 a.m.	
2. Roll Call	Kristen Thorson called roll, noting that all Directors were present.	
3. Adjourn into Executive Closed Session	At 7:36 a.m. the meeting adjourned to Executive Closed Session.	

<p>4. Reconvene to Public Session</p>	<p>A. Announcements from Closed Session</p> <p>Jordan Battani reconvened the meeting into public session at 9:52 a.m. and made the following announcement from Executive Closed Session.</p> <p>[1] Medical Executive Committee Report and Approval of Credentialing Recommendations as outlined below.</p>	<p>[1] Medical Executive Committee Report and Approval of Credentialing Recommendations</p>
--	--	---

Initial Appointments

Name	Specialty	Affiliation
○ Stephen Dane, MD	Plastic Surgery	Private Practice
○ Matthew Dixon, MD	General Surgery	Kaiser

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period
○ Timothy Binning, DPM	Podiatry	Courtesy	04/01/10 – 03/31/12
○ David Chang, MD	Orthopedics	Courtesy	04/01/10 – 03/31/12
○ Susie Choe, MD	General Surgery	Courtesy	04/01/10 – 03/31/12
○ Lindsay Clark, MD	Internal Medicine	Courtesy	04/01/10 – 03/31/12
○ Lawrence Gettler, MD	Emergency Medicine	Courtesy	04/01/10 – 03/31/12
○ Karen Herzog, MD	Radiology	Active	04/01/10 – 03/31/12
○ Mehra Hosseini, MD	Gastroenterology	Courtesy	04/01/10 – 03/31/12
○ Alka Sharma, MD	Internal Medicine	Active	04/01/10 – 03/31/12
○ Jeffrey Stern, MD	Gynecologic Oncologic Surgery	Courtesy	04/01/10 – 03/31/12
○ Allen Verne, MD	Ophthalmology	Courtesy	04/01/10 – 03/31/12
○ Kam Wong, DPM	Podiatry	Courtesy	04/01/10 – 03/31/12
○ Robyn Young, MD	Neurology	Active	04/01/10 – 03/31/12

Resignations

Name	Specialty
○ Jason Alexander, MD	Vascular Surgery (Kaiser)

<p>5. Consent Agenda</p>	<p>[A] Approval of Kitchen Relocation Planning with Ratcliff Architects</p> <p>[B] Approval to Enter in an Agreement with the California Medical Assistance Commission for a Selective Provider Contracting Program (SPCP)</p> <p>[C] Acceptance of Departmental Policy and Procedure Manuals</p> <ul style="list-style-type: none"> ▪ Diagnostic Imaging ▪ Nuclear Medicine ▪ Mammography <p>Mr. Easthope noted that the Diagnostic Imaging Department recently had a State of California Mammography recertification and received high marks for the inspection.</p>	<p>Director Bonta moved to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried unanimously.</p>
<p>6. General Public Comments</p>	<p>None at this time.</p>	
<p>7. Board Comments</p>	<p>None at this time.</p>	
<p>8. Adjournment</p>		<p>A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:55 a.m.</p>

Attest:

Jordan Battani
President

Robert Bonta
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING FEBRUARY 28, 2010

**CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
February 28, 2010**

<u>Table of Contents</u>	<u>Page</u>
Financial Management Discussion	1 – 13
Balance Sheet	14
Statement of Revenue and Expenses	15
Statement of Revenue and Expenses – Per Adjusted Patient Day	16
Key Statistics for Current Month and Year-to-Date	17

ALAMEDA HOSPITAL MANAGEMENT DISCUSSION AND ANALYSIS FEBRUARY, 2010

The management of the Alameda Hospital (the “Hospital”) has prepared this discussion and analysis in order to provide an overview of the Hospital’s performance for the period ending February 28, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management’s Discussion and Analysis for State and Local Governments*. The intent of this document is to provide additional information on the Hospital’s financial performance as a whole.

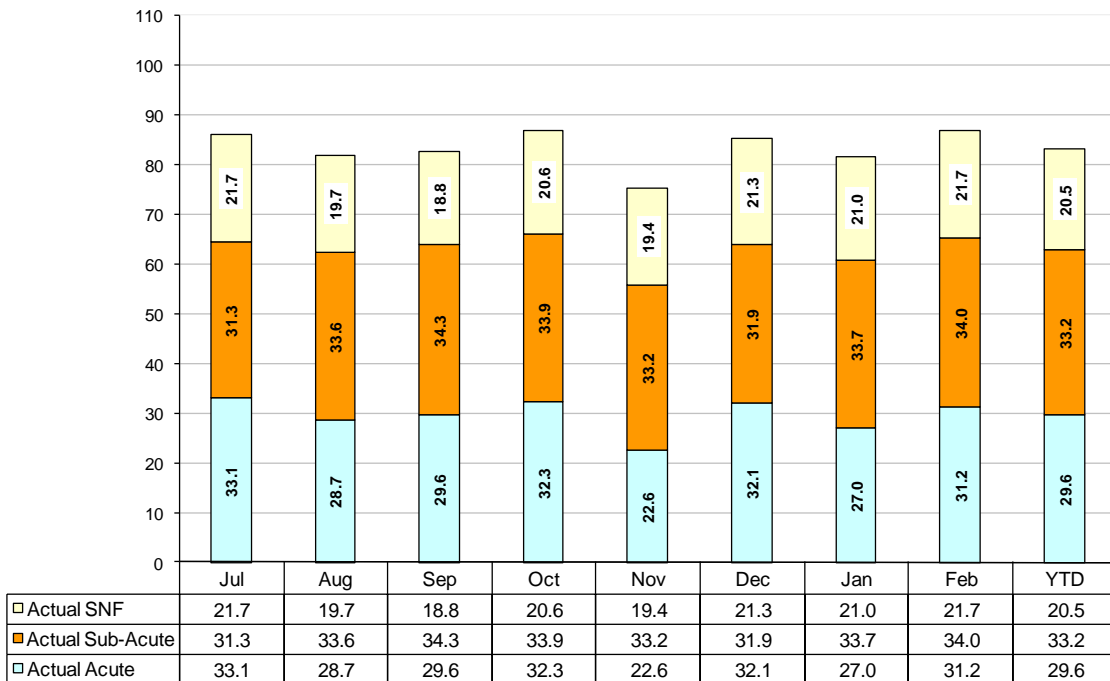
Financial Overview as of February 28, 2010

- Gross patient revenue was less than budget by \$2,572,000 or 10.0%. Inpatient revenue was less than budgeted by 11.3% and outpatient revenue was 8.4% less than budgeted. On an adjusted patient day basis gross patient revenue was 4.4% less than budgeted at \$5,406 compared to a budgeted amount of \$5,653.
- Total patient days were 2,433 compared to the prior month’s total patient days of 2,532 and the prior year’s 2,532 total patient days. The average daily acute care census was 31.2 compared to a budget of 38.6 and an actual average daily census of 27.0 in the prior month; the average daily Sub-Acute census was 34.0 versus a budget of 33.5 and 33.7 in the prior month and the Skilled Nursing program had an average daily census of 21.7 versus a budget of 21.5 and prior month census of 21.0, respectively.
- Emergency Care Center visits were 1,417 or 1.5% less than the budgeted 1,439 visits and were again virtually the same as the prior year’s visits of 1,389.
- Total surgery cases were 3.8% greater than budget, with Kaiser surgical cases making up 67.6% of the 469 total cases. Alameda physician surgical cases were 152 cases in February versus 128 cases in January.
- Outpatient registrations were 13.1% below budgeted targets at 2,524 but were 9.8% better than the prior year’s 2,298 registrations.
- Combined excess revenues over expense (profit) for February was \$44,000 versus a budgeted excess of revenues over expenses (profit) of \$72,000.
- Total assets decreased by \$365,000 from the prior month as a result of a decrease in current assets of \$398,000, an increase in net fixed assets of \$20,000 and a slight increase in restricted contributions of \$11,000. The following items make up the increase in current assets:
 - Total unrestricted cash and cash equivalents for February decreased by \$531,000. This decrease was the result of a decline in patient cash collections which totaled \$5,042,000 including \$800,000 received from Kaiser and the use of 1/12th allocation of the annual parcel tax funds. Day’s cash on hand decreased to 12.8 at February 28, 2010 from January’s 15.5 days.
 - Net patient accounts receivable increased in February by \$374,000 compared to an decrease of \$208,000 in January. Day’s in outstanding receivables increased slightly to 51.5 as compared to 51.2 in January.
 - Estimated third-party payer settlements receivable decreased \$180,000 as a result of the receipt of the tentative settlement for the 2009 Medicare cost report.

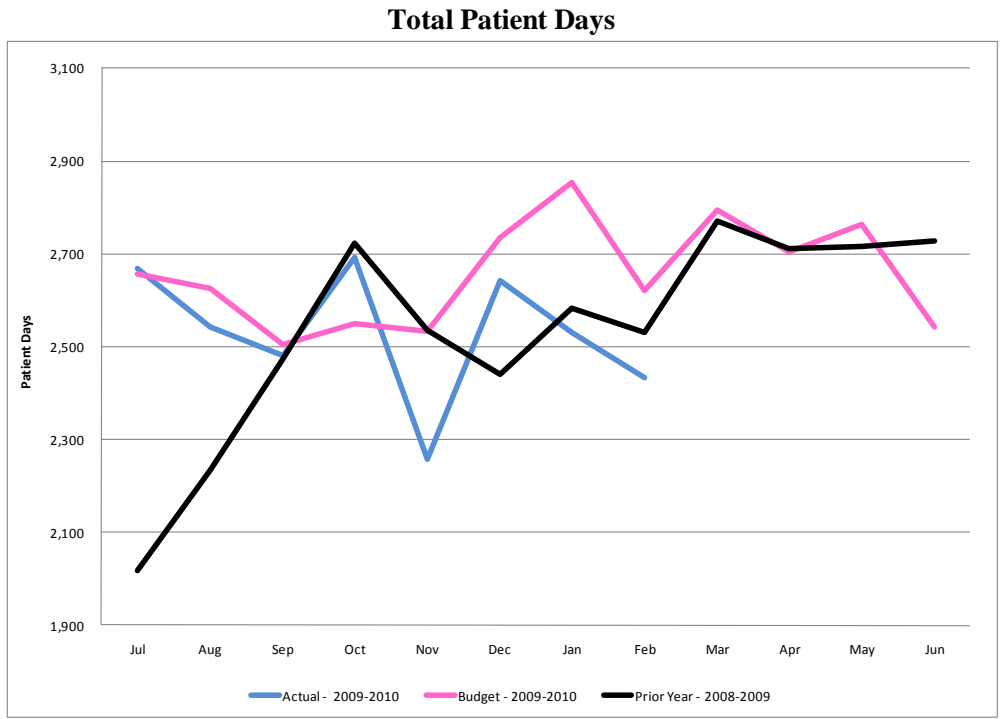
- Other assets decreased by \$54,000 as a result of the monthly amortization of various prepaid expenses.
- Total liabilities decreased by \$421,000 compared to an increase of \$572,000 in the prior month. This decrease was the result of the following:
 - Accounts payable decreased by \$234,000 from the prior month. As a result of this decrease offset by an increase in accrued payroll and benefits liabilities the average payment period increased slightly in February to 62.5 from 62.4 as of January 31, 2010.
 - Payroll and benefit related accruals increased by \$311,000 from the prior month. This increase was primarily the result of an increase in accrued time off accruals of \$151,000, increased payroll accruals of \$87,000 and additional accruals for group health benefit accruals of \$52,000.
 - Other liabilities decreased by \$493,000 primarily as a result of the amortization of one month's deferred revenue related to the 2009/2010 parcel tax revenues (\$477,000).

Volumes

The combined actual daily census was 86.9 versus a budget of 93.6. February's lower than budgeted census was primarily a result of lower than budgeted census in the acute care program which was 19.1% lower than budgeted with an average daily census of 31.2 versus the budgeted 38.6. The Sub-Acute and Skilled Nursing programs were each slightly greater than budgeted.



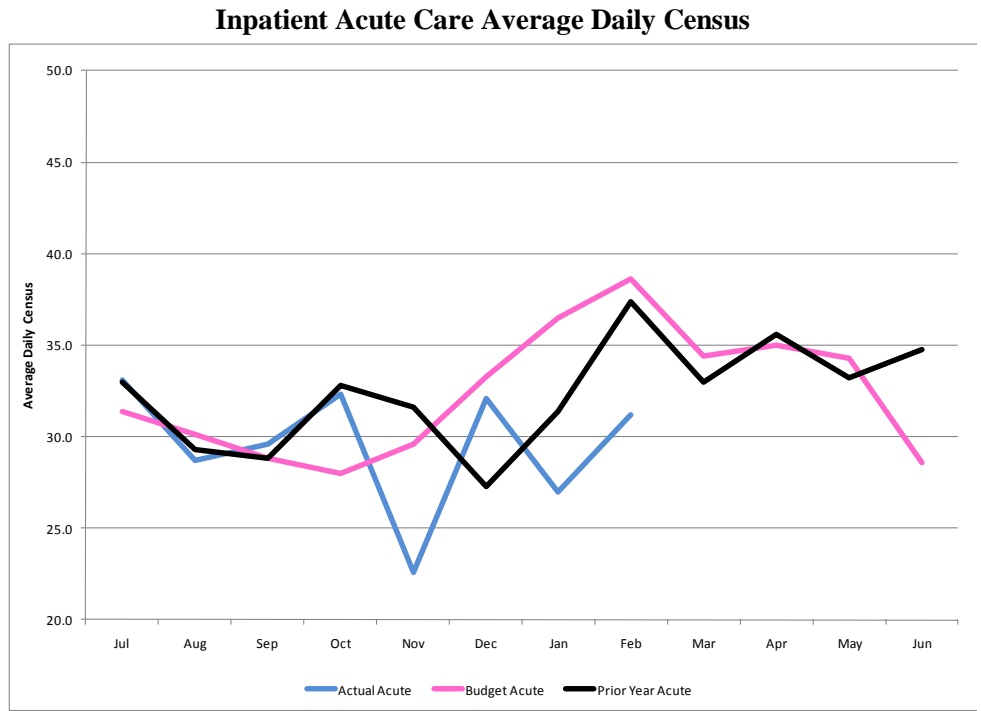
Total patient days in February were 7.2% less than budgeted and were 3.9% less than prior year volumes. The graph on the following page shows the total patient days by month for fiscal year 2010.



The various inpatient components of our volumes for the month of February are discussed in the following sections.

Acute Care

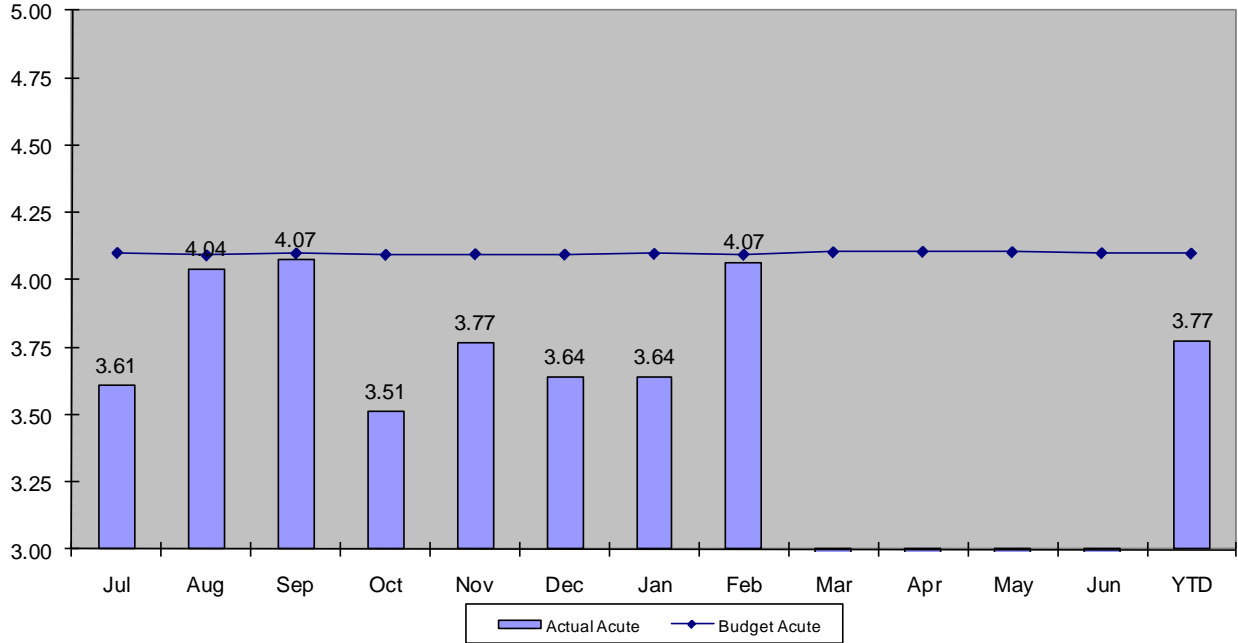
The acute care patient days were 19.1% (207 days) less than budgeted and were 16.4% less than the prior year’s average daily census of 37.4. The acute care program was comprised of Critical Care Unit (3.6 ADC, 17.7% unfavorable to budget), Definitive Observation Unit (9.4 ADC, 34.2% unfavorable to budget) and Med/Surg Units (20.0 ADC, 8.5% unfavorable to budget).



The average length of stay (ALOS) increased from that of the prior month at 4.07 days for the month of February.

This brings the year-to-date ALOS to 3.77 which remains lower than our projected year to date ALOS of 4.10, and is shown in the graph below.

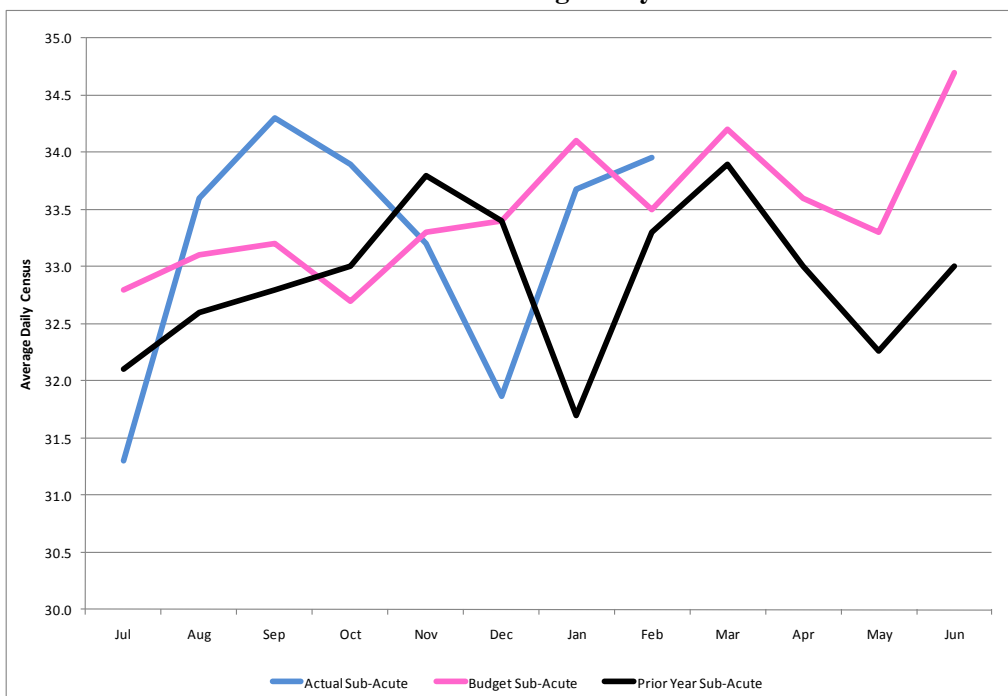
Average Length of Stay



Sub-Acute Care

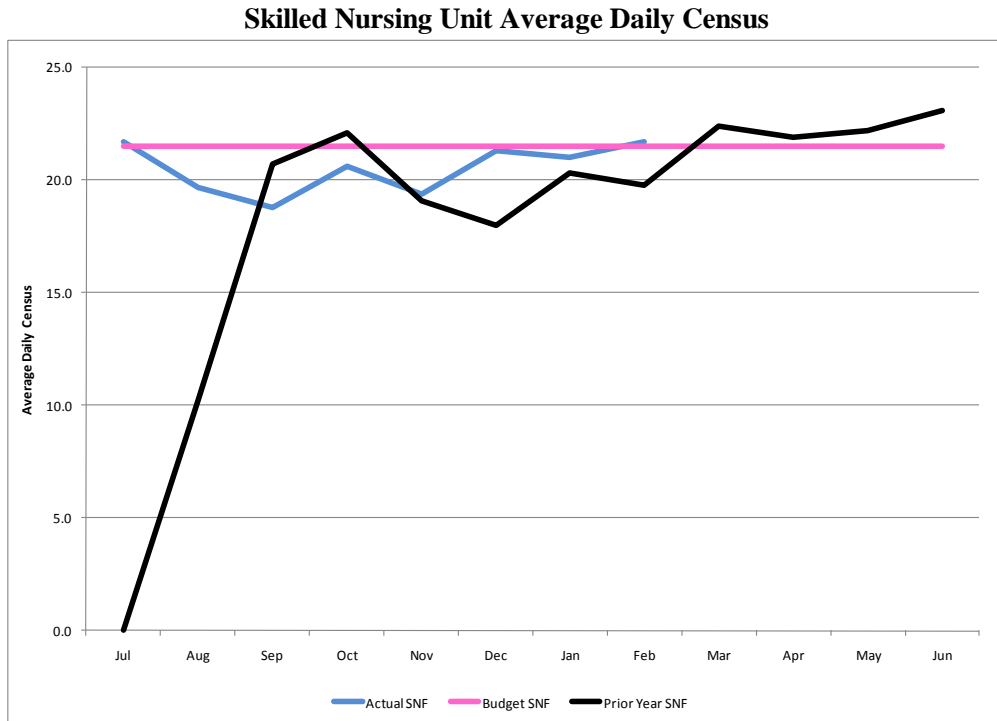
The Sub-Acute program patient days were slightly greater than budget by 1.2% or 12 patient days for the month of February. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



Skilled Nursing Care

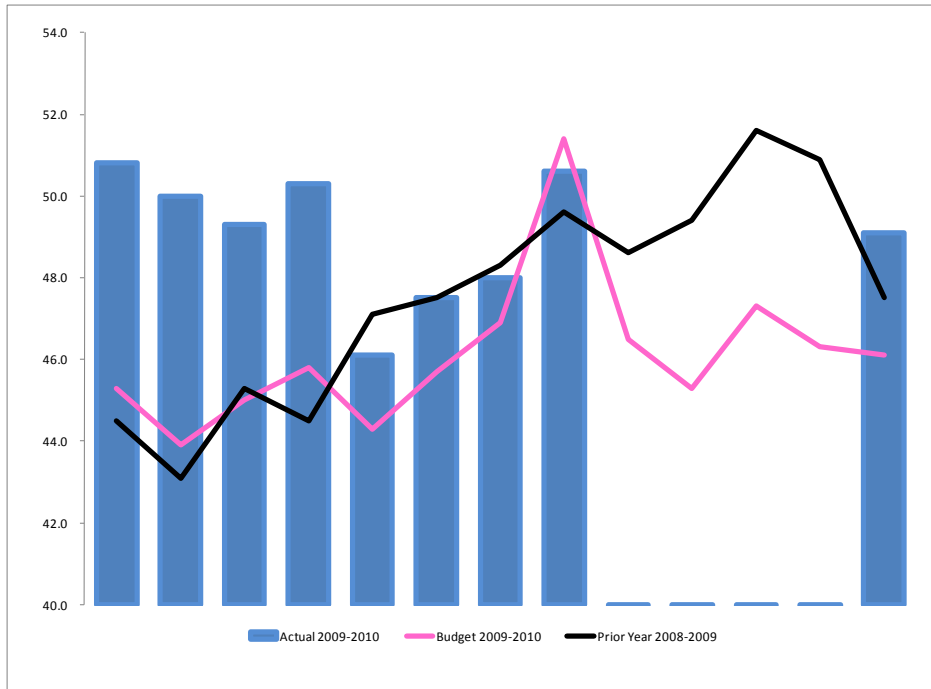
The Skilled Nursing Unit (South Shore) patient days were 1/0% or 6 days greater than budgeted for the month of February. Comparing performance to the prior year this program was better than February 2009 with an average daily census of 21.7 versus 19.8. The following graph show the Skilled Nursing Unit average daily census as compared to budget by month.



Emergency Care Center

Emergency Care Center visits at 1,417 were 1.5% less than budgeted for the month of February and 16.6% of these visits resulted in inpatient admissions versus 16.7% in January. In February there were 210 ambulance arrivals versus 242 in the month of January, a decrease of 13.2% from the prior month. Of the 210 ambulance arrivals 162 or 77.1% were from Alameda Fire Department ambulances. The graph on the following page shows the Emergency Care Centers average visits per day for fiscal year 2010 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day



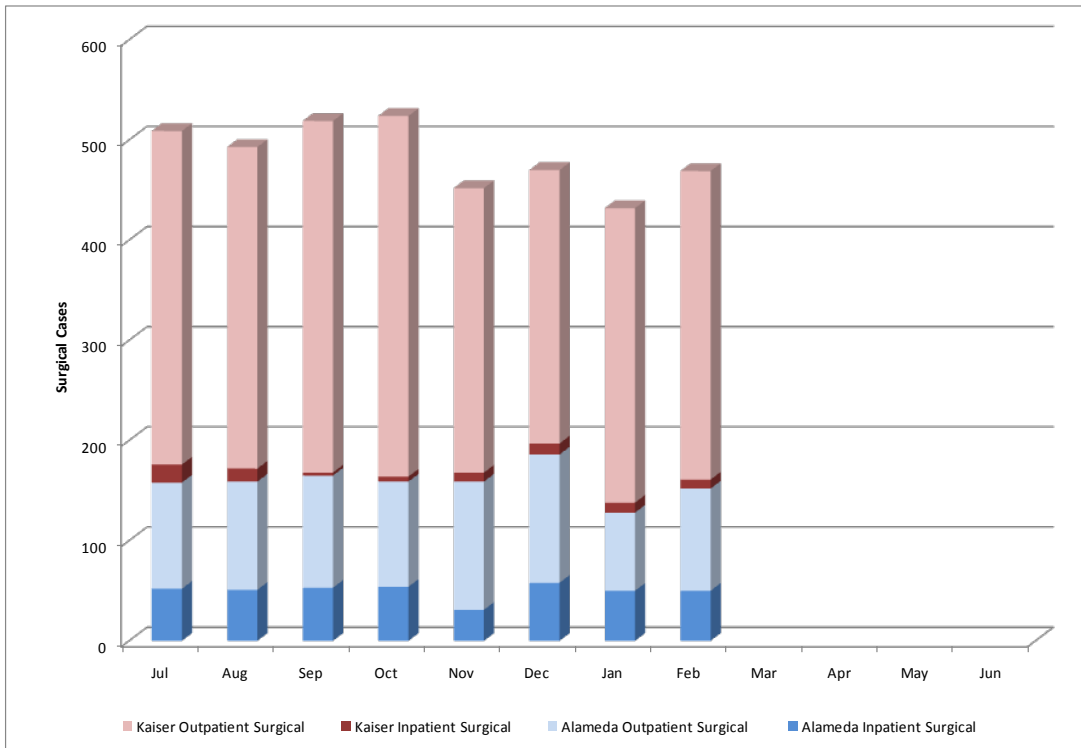
Surgery

Surgery cases were 469 versus the 452 budgeted and 468 in the prior year. In February, Alameda physician cases increased to 152 cases which were 18.8% greater than the prior month. The increase was primarily driven by outpatient cases which totaled 102 versus 78 in January. Inpatient cases were constant with January’s performance at 50 cases. The increase in outpatient cases was in virtually all specialties:

- Ophthalmology (11)
- General Surgery (7)
- Plastics (5)
- Pain Management (4)
- Podiatry (4)

Kaiser related cases in February increased slightly to 308 as compared to the 304 cases performed in January or 67.6% of the total surgical volume. However, despite this increase in Kaiser Same Day volume Kaiser Same Day surgery revenue decreased by \$120,000 from January and resulted in an increase in the Kaiser Same Day Surgery net revenue percentage to 23.0% from 22.3% in the prior month. The graph on the following page shows the number of surgical cases by month for fiscal year 2010.

Surgical Cases

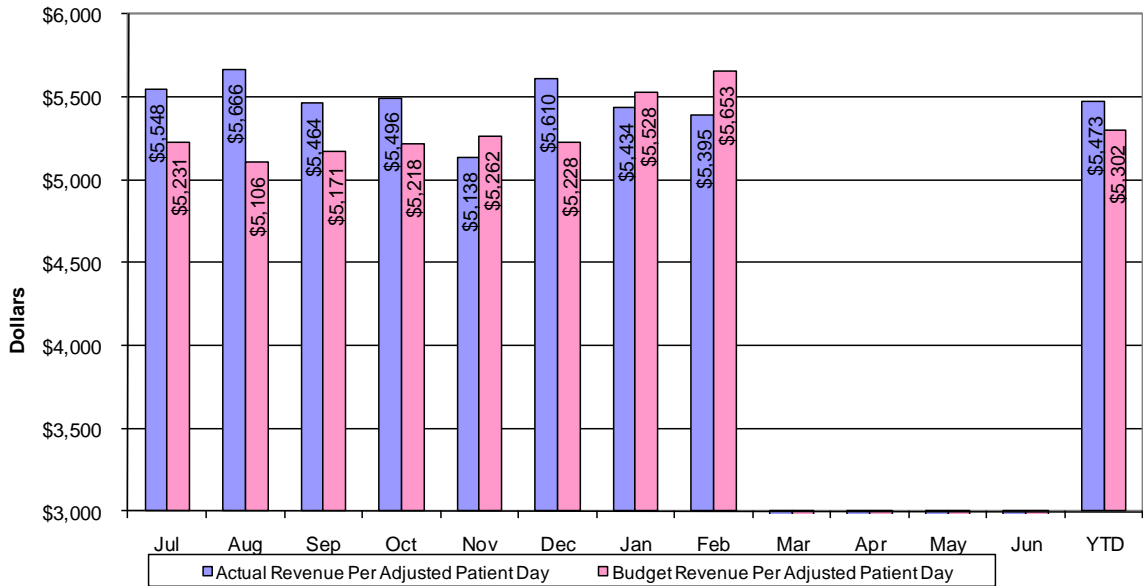


Income Statement

Gross Patient Charges

Gross patient charges in February were less than budgeted by \$2,572,000. This unfavorable variance was comprised of unfavorable variances of \$1,668,000 and \$904,000 in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was \$5,406 versus the budgeted \$5,653 or a 4.4% unfavorable variance from budget for the month of February. On a year to date basis charges per adjusted patient day are 3.3% better than budgeted

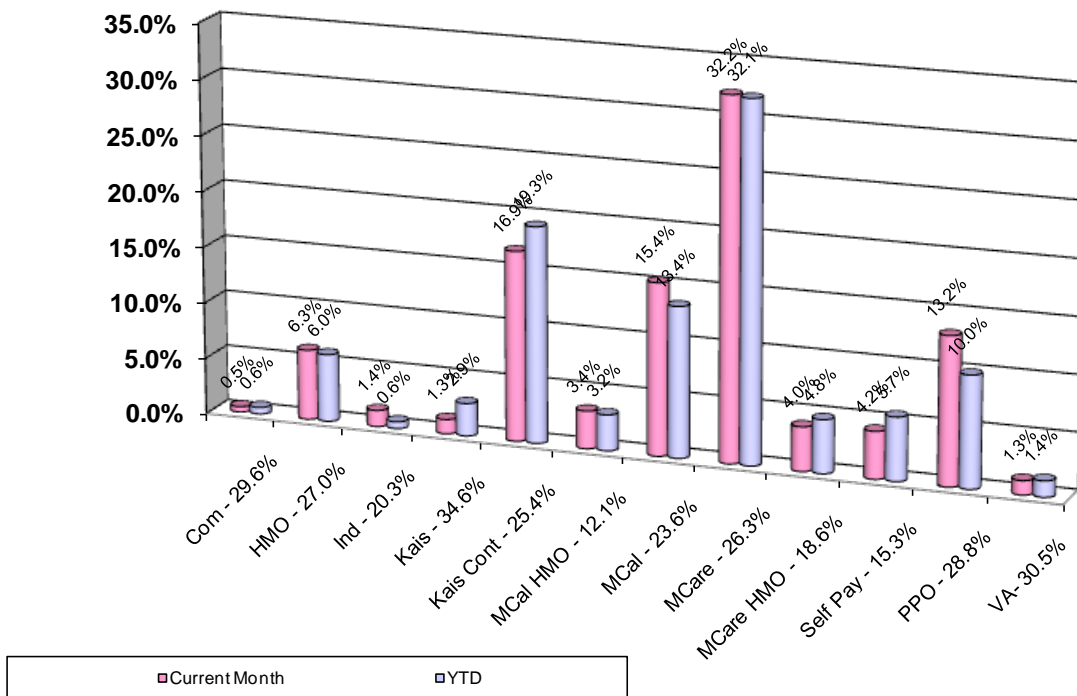
Gross Charges per Adjusted Patient Day



Payor Mix

Medicare Traditional total gross revenue in February made up 32.2% our total gross patient. HMO/PPO utilization moved into the second largest contributor of gross patient revenues in February at 19.5%. Kaiser followed with patient revenues of 18.2% and Medi-Cal utilization at 15.4%. The graph below shows the percentage of revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor.

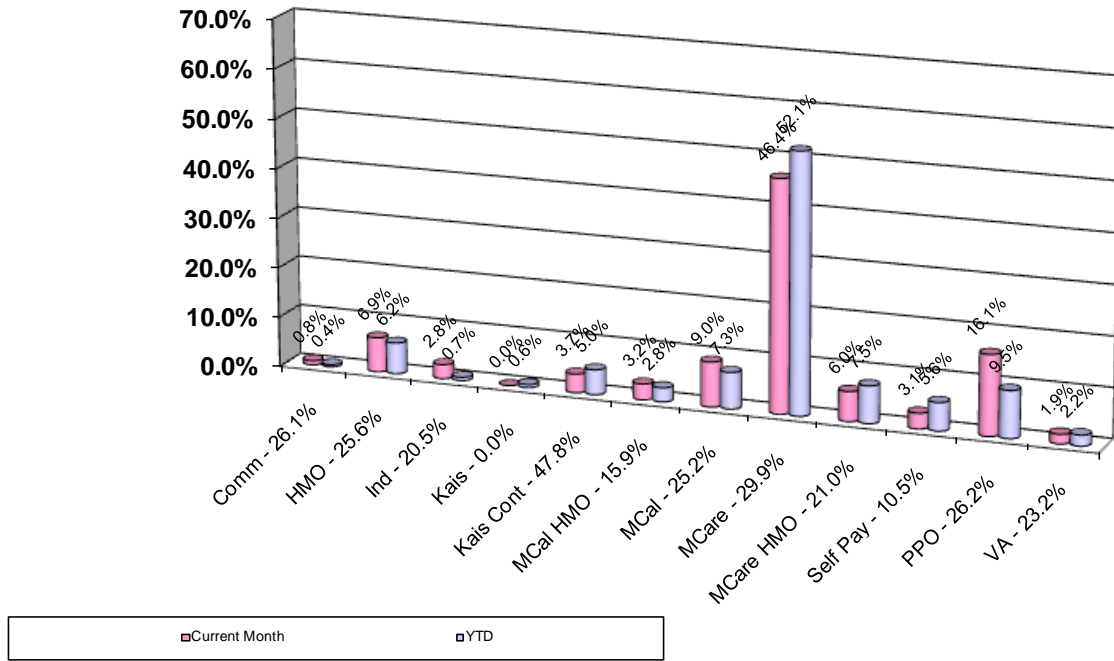
Combined Payor Mix



Current month gross Medicare charges made up 46.4% of our total inpatient acute care gross revenues followed by

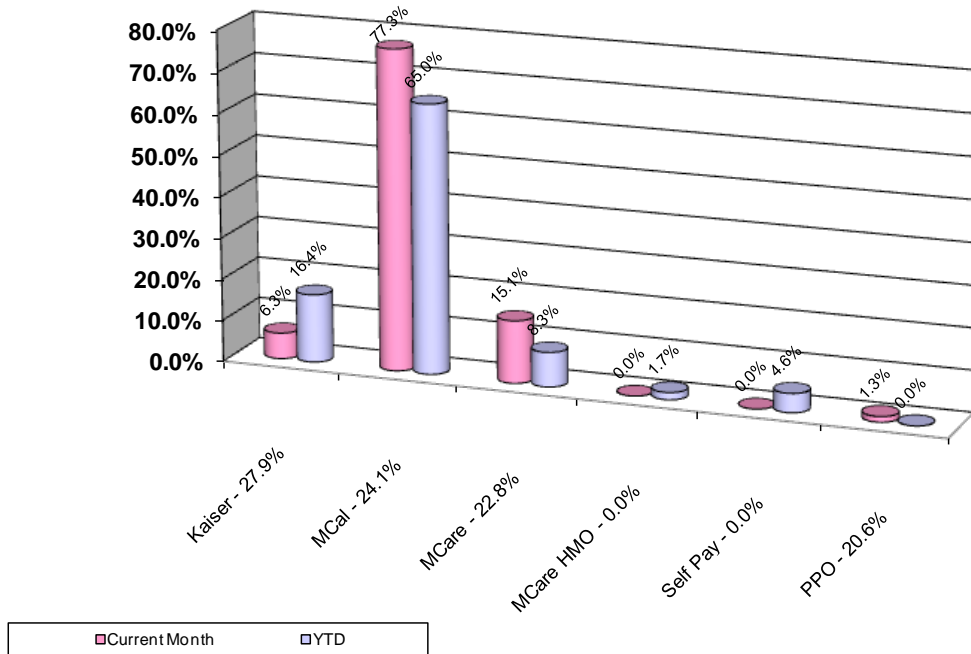
HMO/PPO at 23.0% and Medi-Cal at 9.0%. The hospitals overall Case Mix Index (CMI) increased to 1.3723 from 1.3205 in the prior month. The Medicare CMI also increased over the prior month from 1.3752 in January to 1.4047 in February. Despite, the increase in the Medicare CMI there were again no outlier cases in the month. The result of these items was an increase in overall Medicare reimbursement from January's estimate of 26.2% to 29.9% in February. The overall inpatient acute net patient revenue percentage improved from the prior month as a result of the improved payor mix and higher acuity level of inpatients treated in February resulting in the overall estimated inpatient acute care reimbursement at 24.1% in February versus 23.8% in January. The graph on the following page shows the current month and year to date payor mix and current month estimated net revenue percentage for fiscal year 2010.

Inpatient Acute Care Payor Mix



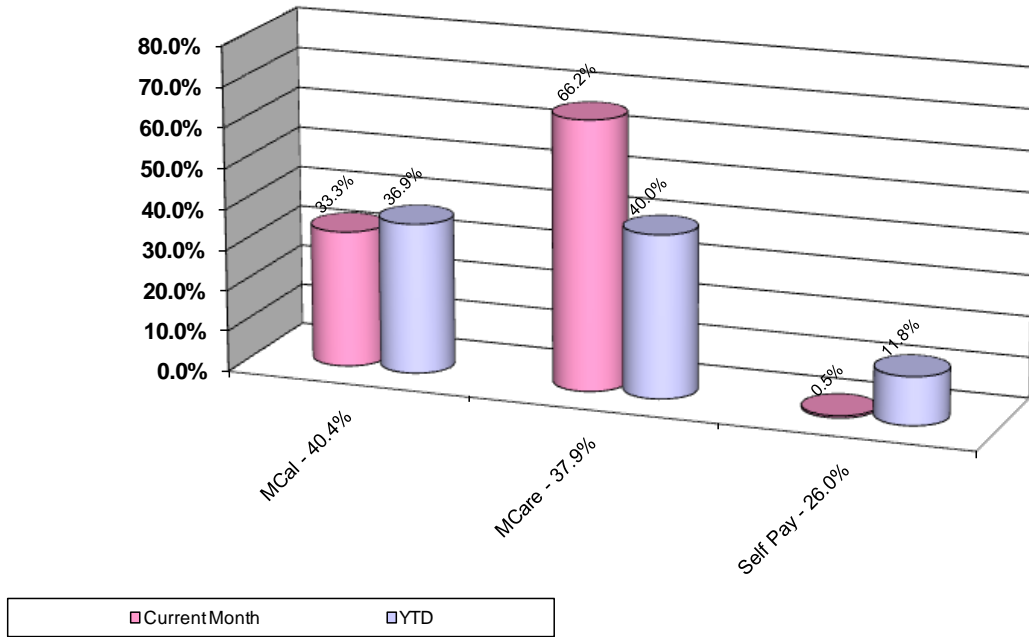
In February the Sub-Acute care program again was dominated by Medi-Cal utilization of 77.3% versus 77.5% in January. The following graph shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



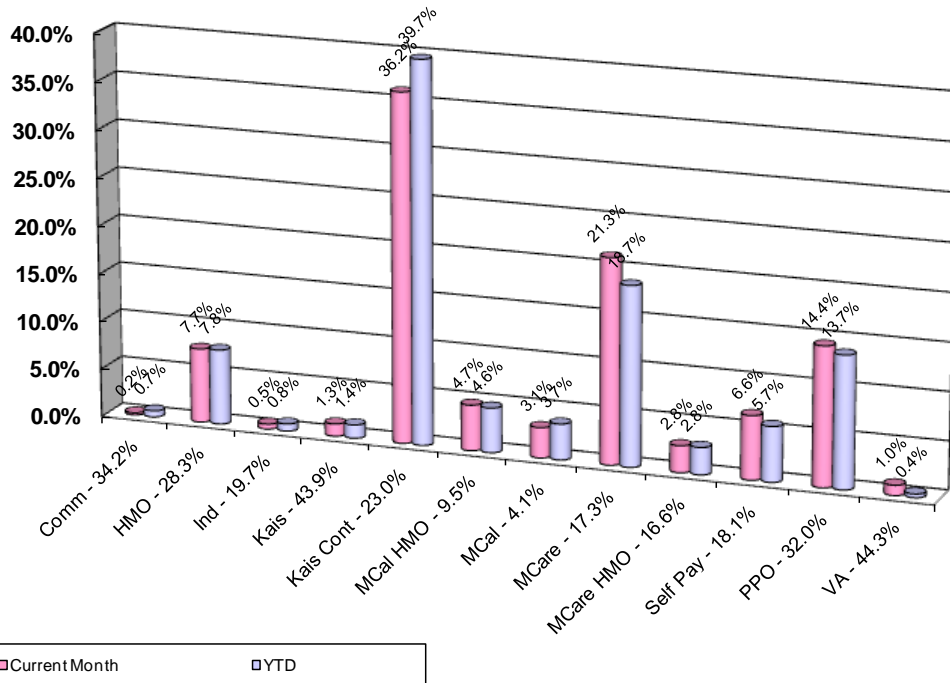
In February the Skilled Nursing program was again comprised of Medicare 66.2% and Medi-Cal 33.3%. The graph on the following page shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix



The outpatient gross revenue payor mix for February was comprised of 37.5% Kaiser, 21.3% Medicare, 14.4% PPO and 7.7% HMO. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



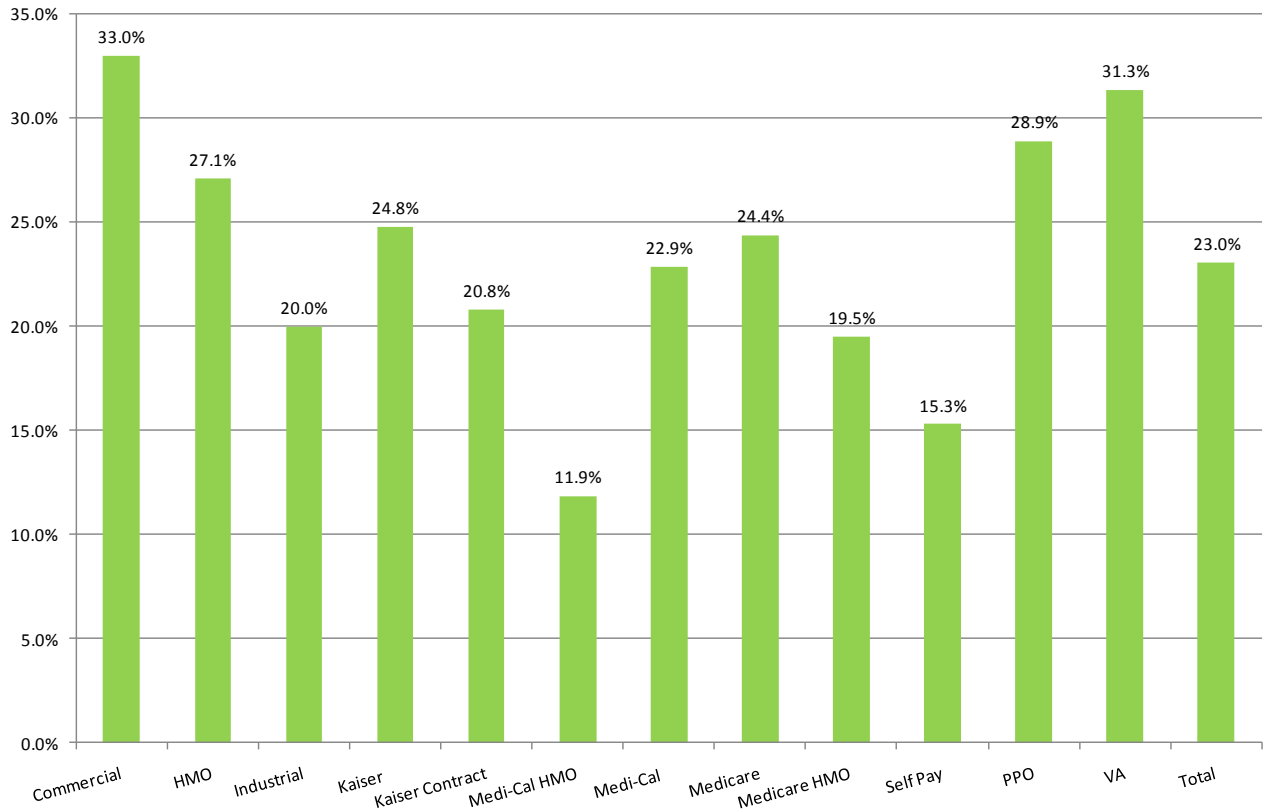
Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of February contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 76.7% versus the budgeted 79.0%. This improvement in contractual allowances was the result of the improved overall payor mix in the month, higher inpatient acuity levels, and the delay of the 5% annual budgeted price increase to July 1, 2010.

Net Patient Service Revenue

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph below shows the level of reimbursement that the Hospital has estimated for fiscal year 2010 by major payor category.

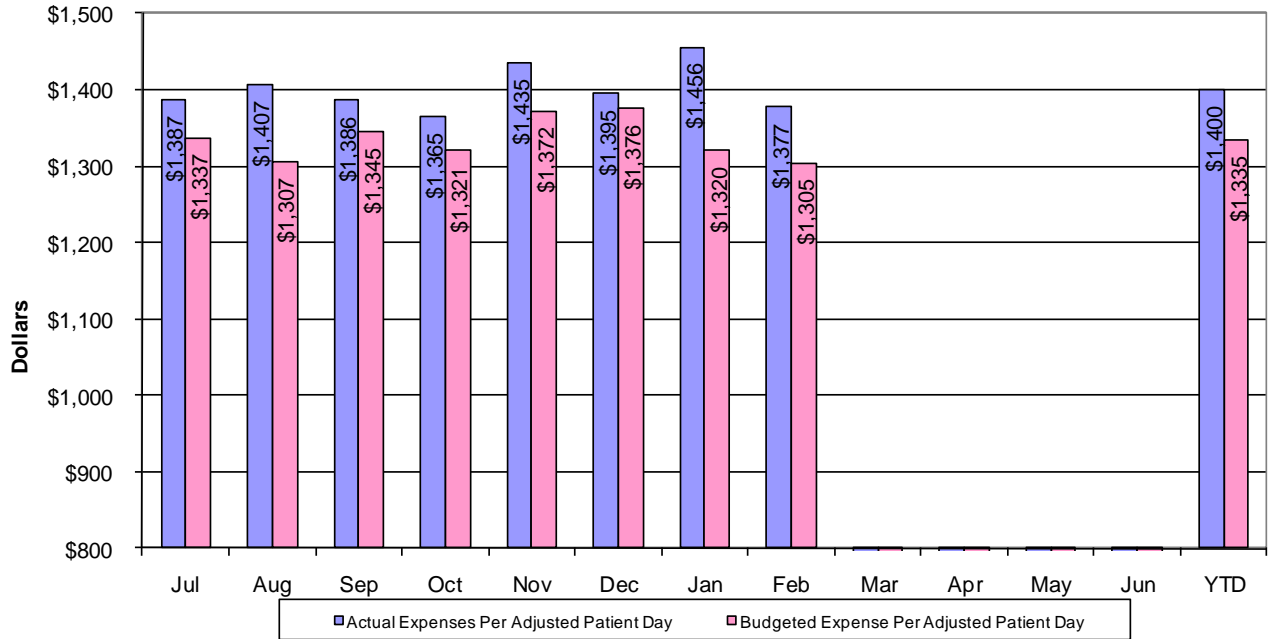
**Average Reimbursement % by Payor
 February 2010 Year-to-Date**



Total Operating Expenses

Total operating expenses were less than the fixed budget by \$40,000 or 0.7%. On an adjusted patient day basis, our cost per adjusted patient day was \$1,401 which was \$66 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in the benefits expense category. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2010 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.

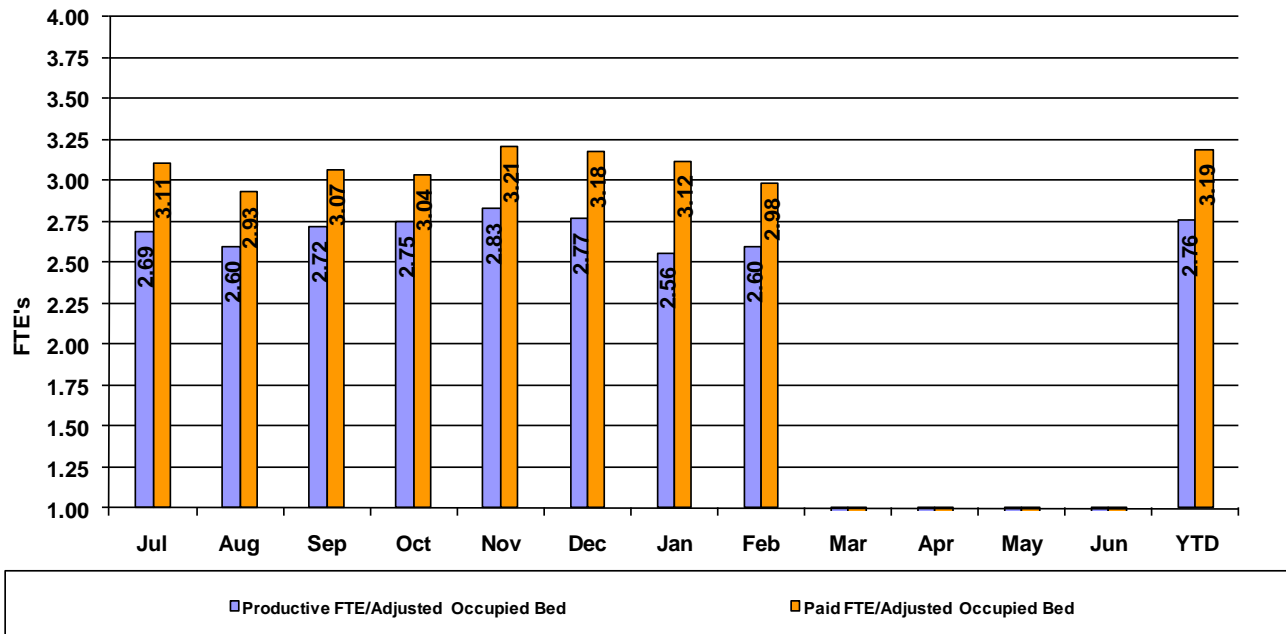
Expenses per Adjusted Patient Day



Salary and Registry Expenses

Salary and registry costs combined were favorable to the fixed budget by \$132,000 but were slightly unfavorable to budgeted levels on a per adjusted patient day basis in February by \$14. On an adjusted occupied bed basis, productive FTE's were 2.60 in February versus the budgeted 2.50. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2010 by month and year to date.

FTE's per Adjusted Occupied Bed

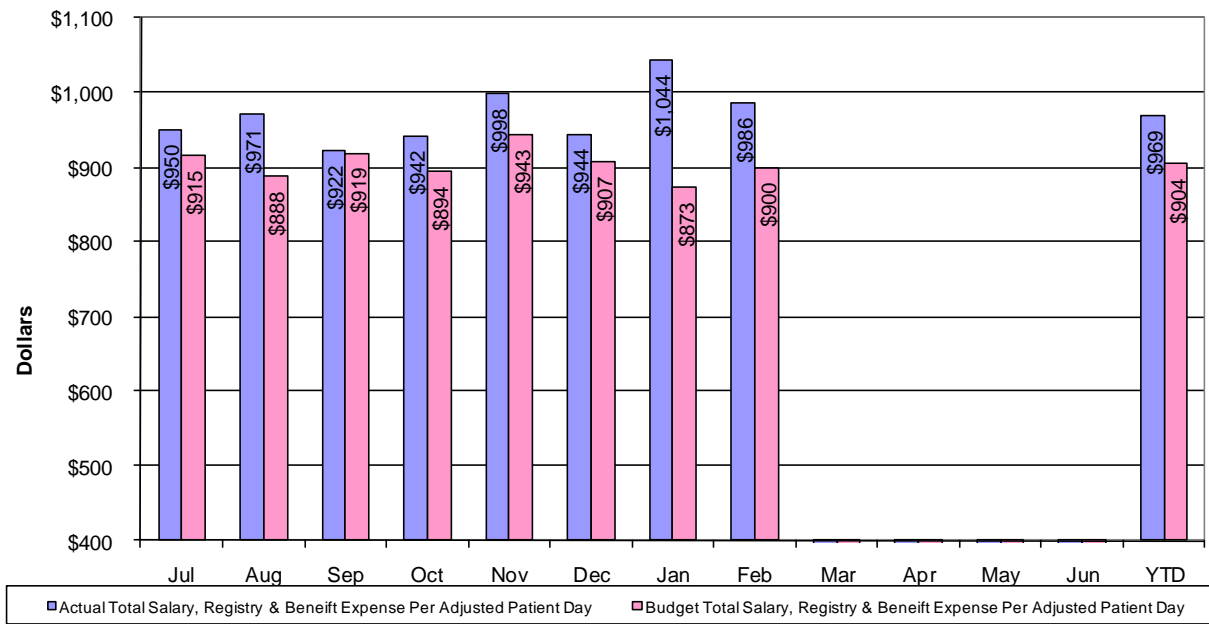


Benefits

Benefit costs were \$255,000 unfavorable to the fixed budget and were \$72 unfavorable to budget on an adjusted patient day basis in February. Benefit costs were unfavorable to the fixed budget as a result of increased health claims expense during the year that has averaged \$465,000 per month this fiscal year versus \$404,000 in the prior year. This has resulted in increased estimated claims expense in the month of \$70,000. Workers compensation expense was budgeted at lower levels than expected which has resulted in unfavorable variances from budget of approximately \$25,000 per month. In addition, certain accruals for potential wage adjustments plus related benefit cost impact are included in this expense category making up the remainder of the unfavorable variance in February benefit costs.

The following graph shows the combined salary, registry and benefit costs on an adjusted patient basis for FY 2010 by month.

Salary, Registry and Benefit Cost per APD



Professional Fees

Professional fees expense was favorable to budget by \$78,000. Favorable variances from budget were seen in physician fees (\$31,000), consulting and management fees (\$30,000) and legal fees (\$11,000).

Supplies

Supplies expenses were \$28,000 favorable to budgeted expectations. This favorable variance was split evenly between medical supplies and other supplies. Areas with the greatest variance were pharmaceutical supplies (\$17,000), radiology supplies (\$9,000) and other minor equipment (\$12,000). These favorable variances were offset by an unfavorable variance in surgical supplies which exceeded budget by \$12,000.

Purchased Services

Purchased services expenses were favorable to budget by \$37,000 as a result of lower than budgeted repairs and maintenance costs which accounted for \$18,000 of this favorable variance. The remainder was in the other purchased services expense category which was favorable to budget by \$25,000.

The following pages include the detailed financial statements for the seven months ended February 28, 2010.

ALAMEDA HOSPITAL
Balance Sheet
February 28, 2010

	February 28,2010	January 31, 2010	Audited June 30, 2009
Assets			
<i>Current assets:</i>			
Cash and cash equivalents	\$ 2,533,067	\$ 3,063,598	\$ 1,866,540
Net Accounts Receivable	9,960,616	9,586,718	10,069,536
Net Accounts Receivable %	23.44%	23.50%	22.15%
Inventories	1,300,332	1,308,014	1,291,072
Est.Third-party payer settlement receivable	344,386	523,974	351,648
Other assets	4,236,376	4,290,121	6,920,987
Total Current Assets	18,374,777	18,772,425	20,499,783
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate			
	553,789	542,329	468,209
Total Non-Current Assets	553,789	542,329	468,209
<i>Fixed Assets:</i>			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	5,753,338	5,732,515	6,029,967
Total fixed assets, net of accumulated depreciation	6,631,283	6,610,460	6,907,912
Total Assets	\$ 25,559,849	\$ 25,925,214	\$ 27,875,904
Liabilities and Net Assets			
<i>Current Liabilities:</i>			
Current portion of long term debt	\$ 427,364	\$ 431,872	\$ 436,733
Accounts payable and accrued expenses	6,450,622	6,684,620	6,244,967
Payroll and benefit related accruals	5,289,674	4,978,220	3,765,683
Est.Third-party payer settlement payable	193,412	193,412	306,588
Other liabilities	3,544,249	4,037,743	7,274,242
Total Current Liabilities	15,905,321	16,325,867	18,028,213
<i>Long-Term Liabilities:</i>			
Debt borrowings net of current maturities	1,448,404	1,448,404	1,733,631
Total Long-Term Liabilities	1,448,404	1,448,404	1,733,631
Total Liabilities	17,353,725	17,774,271	19,761,844
<i>Net Assets</i>			
Unrestricted Funds	7,585,659	7,541,939	7,615,851
Restricted Funds	620,464	609,004	30,000
Net Assets	8,206,123	8,150,943	7,645,851
Total Liabilities and Net Assets	\$ 25,559,849	\$ 25,925,214	\$ 27,407,695

City of Alameda Health Care District

Statements of Operations

February 28, 2010

\$'s in thousands

	Current Month			Year-to-Date			
	Actual	Budget	% Variance	Actual	Budget	% Variance	Prior Year
Revenues							
Gross Inpatient Revenues	\$ 13,153	\$ 14,822	-11.3%	\$ 110,902	\$ 111,795	-0.8%	\$ 102,884
Gross Outpatient Revenues	9,870	10,774	-8.4%	83,058	81,843	1.5%	77,533
Total Gross Revenues	23,023	25,596	-10.0%	193,961	193,637	0.2%	180,417
Contractual Deductions	16,902	19,625	13.9%	144,019	144,980	0.7%	133,588
Bad Debts	707	491	-44.0%	4,358	3,628	-20.1%	4,897
Charity and Other Adjustments	60	95	36.8%	424	702	39.5%	792
Net Patient Revenues	5,354	5,384	-0.6%	45,159	44,327	1.9%	41,140
Net Patient Revenue %	23.3%	21.0%	21.9%	23.3%	22.9%	22.8%	
Net Clinic Revenue	14	64	-78.8%	81	450	-82.0%	-
Other Operating Revenue	39	15	158.6%	371	121	207.0%	124
Total Revenues	5,407	5,464	-1.0%	45,611	44,898	1.6%	41,264
Expenses							
Salaries	2,879	3,048	5.5%	25,342	24,861	-1.9%	22,848
Registry	213	177	-20.9%	1,348	1,361	1.0%	1,682
Benefits	1,105	850	-30.0%	7,631	7,166	-6.5%	6,499
Professional Fees	237	315	24.6%	2,355	2,733	13.9%	2,411
Supplies	737	764	3.6%	6,885	6,210	-10.9%	5,968
Purchased Services	330	367	10.0%	3,084	3,145	1.9%	2,692
Rents and Leases	60	65	7.1%	536	560	4.3%	477
Utilities and Telephone	76	72	-5.5%	572	621	8.0%	573
Insurance	44	42	-4.8%	352	362	2.7%	338
Depreciation and amortization	103	121	15.0%	817	1,042	21.6%	971
Other Operating Expenses	75	80	5.3%	683	687	0.5%	605
Total Expenses	5,859	5,899	0.7%	49,605	48,748	-1.8%	45,064
Operating gain (loss)	(452)	(435)	-3.9%	(3,994)	(3,850)	3.7%	(3,801)
Non-Operating Income / (Expense)							
Net Non-Operating Income / (Expense)	496	507	-2.1%	3,964	4,055	-2.3%	3,930
Excess of Revenues Over Expenses	\$ 44	\$ 72	-39.1%	\$ (30)	\$ 205	-114.9%	\$ 130

City of Alameda Health Care District
Statements of Operations - Per Adjusted Patient Day
February 28, 2010

	Current Month				Year-to-Date					
	Actual	Budget	\$ Variance	% Variance	Prior Year	Actual	Budget	\$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	\$ 3,089	\$ 3,273	\$ (185)	-5.6%	\$ 3,222	\$ 3,131	\$ 3,061	\$ 70	2.3%	\$ 3,004
Gross Outpatient Revenues	2,318	2,379	(62)	-2.6%	2,194	2,345	2,241	104	4.6%	2,263
Total Gross Revenues	5,406	5,653	(247)	-4.4%	5,416	5,477	5,303	174	3.3%	5,267
Contractual Deductions	3,969	4,334	365	8.4%	4,098	4,067	3,970	(96)	-2.4%	3,900
Bad Debts	166	108	(58)	-53.1%	124	123	99	(24)	-23.9%	143
Charity and Other Adjustments	14	21	7	32.8%	6	12	19	7	37.6%	23
Net Patient Revenues	1,257	1,189	68	5.7%	1,188	1,275	1,214	61	5.0%	1,201
Net Patient Revenue %	23.3%	21.0%			21.9%	23.3%	22.9%			22.8%
Net Clinic Revenue	3	14	(11)	-77.4%	-	2	12	(10)	-81.5%	-
Other Operating Revenue	9	3	6	175.0%	2	10	3	7	216.6%	4
Total Revenues	1,270	1,207	63	5.2%	1,190	1,288	1,230	58	4.7%	1,205
Expenses										
Salaries	676	673	(3)	-0.4%	641	716	681	(35)	-5.1%	667
Registry	50	39	(11)	-28.5%	58	38	37	(1)	-2.1%	49
Benefits	259	188	(72)	-38.2%	209	215	196	(19)	-9.8%	190
Professional Fees	56	70	14	19.8%	47	66	75	8	11.2%	70
Supplies	173	169	(4)	-2.5%	169	194	170	(24)	-14.3%	174
Purchased Services	77	81	4	4.4%	81	87	86	(1)	-1.1%	79
Rents and Leases	14	14	0	1.2%	14	15	15	0	1.3%	14
Utilities and Telephone	18	16	(2)	-12.2%	17	16	17	1	5.2%	17
Insurance	10	9	(1)	-11.5%	12	10	10	(0)	-0.4%	10
Depreciation and Amortization	24	27	3	9.6%	27	23	29	5	19.2%	28
Other Operating Expenses	18	18	(0)	-0.7%	24	19	19	(0)	-2.6%	18
Total Expenses	1,376	1,303	(73)	-5.6%	1,299	1,401	1,335	(66)	-4.9%	1,316
Operating Gain / (Loss)	(106)	(96)	(10)	-10.5%	(109)	(113)	(105)	(7)	7.0%	(111)
Net Non-Operating Income / (Expense)	116	112	5	4.0%	114	112	111	1	0.8%	115
Excess of Revenues Over Expenses	\$ 10	\$ 16	\$ 6	-35.2%	\$ 4	\$ (1)	\$ 6	\$ (6)	-110.7%	\$ 4

ALAMEDA HOSPITAL
KEY STATISTICS
FEBRUARY 2010

	ACTUAL FEBRUARY 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	FEBRUARY 2009	YTD FEBRUARY 2010	YTD FIXED BUDGET	VARIANCE	%	YTD FEBRUARY 2009
Discharges:										
Total Acute	215	264	(49)	-18.6%	248	1,905	1,897	8	0.4%	1,860
Total Sub-Acute	1	3	(2)	-66.7%	2	11	29	(18)	-62.1%	27
Total Skilled Nursing	6	12	(6)	-50.0%	13	87	103	(16)	-15.5%	81
	222	279	(57)	-20.4%	263	2,003	2,029	(26)	-1.3%	1,968
Patient Days:										
Total Acute	874	1,081	(207)	-19.1%	1,046	7,186	7,771	(585)	-7.5%	7,623
Total Sub-Acute	951	939	12	1.3%	932	8,073	8,085	(12)	-0.1%	7,978
Total Skilled Nursing	608	602	6	1.0%	554	4,991	5,227	(236)	-4.5%	3,933
	2,433	2,622	(189)	-7.2%	2,532	20,250	21,083	(833)	-4.0%	19,534
Average Length of Stay										
Total Acute	4.07	4.09	(0.03)	-0.7%	4.22	3.77	4.10	(0.32)	-7.9%	4.10
Average Daily Census										
Total Acute	31.21	38.61	(6.68)	-17.3%	37.36	29.57	31.98	(2.41)	-7.5%	31.37
Total Sub-Acute	33.96	33.54	0.39	1.2%	33.29	33.22	33.27	(0.05)	-0.1%	32.83
Total Skilled Nursing	21.71	21.50	0.19	0.9%	19.79	20.54	21.51	(0.97)	-4.5%	19.79
	86.89	93.64	(6.10)	-6.5%	90.43	83.33	86.76	(2.46)	-2.8%	90.43
Emergency Room Visits										
	1,417	1,439	(22)	-1.5%	1,389	11,924	11,175	749	6.7%	11,221
Outpatient Registrations										
	2,524	2,904	(380)	-13.1%	2,298	20,428	22,227	(1,799)	-8.1%	19,740
Surgery Cases:										
Inpatient	59	54	5	9.3%	54	477	445	32	7.2%	447
Outpatient	410	398	12	3.0%	414	3,379	3,168	211	6.7%	3,350
	469	452	17	3.8%	468	3,856	3,613	243	6.7%	3,797
Kaiser Inpatient Cases										
Kaiser Eye Cases	9	6	3	-	10	78	68	10	-	70
Kaiser Outpatient Cases	164	131	33	25.2%	168	1,267	1,195	72	6.0%	1,258
	144	172	(28)	-16.3%	157	1,257	1,168	89	7.6%	1,248
Total Kaiser Cases	317	309	8	2.6%	335	2,602	2,431	171	7.0%	2,576
% Kaiser Cases	67.6%	68.4%			71.6%	67.5%	67.3%			67.8%
Adjusted Occupied Bed										
	151.79	161.71	9.92	6.1%	152.00	145.75	150.26	(4.51)	-3.0%	140.97
Productive FTE										
	395.80	404.37	8.57	2.1%	393.20	392.34	385.93	(6.41)	-1.7%	369.80
Total FTE										
	454.02	449.07	(4.95)	-1.1%	439.78	449.07	445.32	(3.75)	-0.8%	422.19
Productive FTE/Adj. Occ. Bed										
	2.61	2.50	(0.11)	-4.3%	2.59	2.69	2.57	(0.12)	-4.8%	2.62
Total FTE/Adj. Occ. Bed										
	2.99	2.78	(0.21)	-7.7%	2.89	3.08	2.96	(0.12)	-4.0%	2.99

DATE: April 12, 2010
TO: Board of Directors, City of Alameda Healthcare District
FROM: Kerry Easthope, Associate Administrator
SUBJECT: Acceptance of the 2009 Environment of Care Annual Report

Recommendation:

Management and the hospital's Safety Committee recommend that the Board of Directors accept the enclosed 2009 Environment of Care Annual Report.

Background / Discussion:

The Safety Committee meets bi-monthly. At these meetings, each subcommittee reports on its activities, progress towards achieving its goals and relevant events that require committee discussion and action. These activities are then summarized on an annual report that includes key accomplishments and goals for the upcoming year.

Enclosed are sub-committee annual reports covering the following areas of Environment of Care.

- Emergency Management
- Medical Equipment Management Plan
- Utilities Management
- Fire / Life Safety Management
- Human Resources Safety Plan
- Hazardous Materials and Waste Management (HAZMAT)
- Security Management
- Staff Education and Training

During this past year there has been a special focus on updating the Environment of Care Policy & Procedure manuals as there have been several changes and updates in this area as required by the Joint Commission.

There has also been an exerted effort to have greater employee involvement in emergency management education and exercises. Gloria Williams, RN has done a commendable job providing staff in each department with emergency management education throughout the year. In addition, Environment of Care was a key component in

the hospital-wide Safety Fair and Joint Commission Fair which were both well attended by employees.

With the recent restructuring of the hospital's Performance Improvement reporting structure, the Environment of Care is now one of the reporting functions. The committee's initial performance improvement initiative is: cleanliness of the hospital, as this is the single area that has the most opportunity for improvement within this function. The first report, under the new structure, was made in March 2010.

There have been several personnel changes during calendar year 2009 that have changed the composition of the Safety Committee. Although these personnel changes can be challenging, it also provides the opportunity for new employees to participate in the committee and bring new ideas, recommendations and energy. New participants include John Ellis (Director of Diagnostic Imaging), who reports on radiation safety within Diagnostic Imaging and Karmella Borashan (Director of Clinical Laboratory), who heads the HAZMAT sub-committee.

The committee meetings and activities are organized and well documented. It is our goal to maintain a high level of preparation and progress to ensure a safe environment of care during the 2010 calendar year and a successful Joint Commission survey.

**Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Emergency Management**

I. Summary of Effectiveness

The basis of the Alameda Hospital Emergency Management program is to provide a program that ensures effective mitigation, preparation, response & recovery in all disasters or emergencies affecting the environment. The hospital has developed an “all hazards” approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of the cause.

The Committee completed the objectives and planning in the six critical areas of emergency as identified by the Joint Commission: communication, resources & assets, safety & security, staff roles and responsibilities, utilities and clinical activities. This task was 80% completed in 2008 and totally completed in 2009. After revision update of the Alameda Hospital Emergency Operation Program and Emergency Operation Manual – hospital wide inservices and training programs were initiated.

Alameda Hospital collaborated with the City of Alameda to provide a full City Mass H1N1 Influenza Vaccine Clinic for high-risk population on 12/12/09. 1300 Alameda City residents were vaccinated.

Alameda Hospital was represented and participated in 5 all-day county wide HPP Strategic Planning Sessions to determine strategic directions & health preparedness. Many stakeholders participated in this planning including EMS, EBMUD, Oakland Fire Department, Public Health Department and most East Bay hospitals. Strategic planning included leadership, crisis communication, ongoing communications and plan effectiveness strengths and weaknesses.

H1N1 Influenza Pandemic

In March 2009, a new virus first case was reported in Mexico. California reported a first case in April. On April 25th WHO declared a global public health emergency. The incidence of Influenza like illness decelerated in June and then accelerated again in September. The Alameda Hospital E.O.P. was activated April 28th – May 14th and September 18th – December. The HIC addressed general safety measures, ensuring staff & patient education & safety, understanding appropriate precautions to take for H1N1 and providing appropriate resources & PPE. During this time Alameda Hospital initiated several vital steps:

A. Massive & concentrated education for patients, visitors and staff – Signs were posted throughout the hospital at all entrances, exits, elevator lobbies and in each unit. Educational information was posted on our Intranet. Instructional fliers were provided for patients, visitors & staff. A clinical newsletter was issued to the staff on a regular basis.

B. Continued assessment, monitoring and control of essential resources – regular masks, N95 respirators, ventilators, PPE, hand sanitizer & antiviral medications.

C. Continued monitoring of ILI patients visits to ECC & admissions.

D. Identification & exploration of critical service areas and essential functions.

During this time a table-top exercise was conducted on October 28th to assess and determine surge capacity & essential service capabilities. At this exercise, triggers for activation of surge policies were reviewed and the process for obtaining additional resources was also reviewed.

II. Scope

The scope of the Emergency Management Plan addresses issues for patients, visitors, personnel, volunteers, physicians, and property. Program administration is delegated by the Safety Committee to the Safety Officer, Emergency Management Coordinator, and Emergency Management Subcommittee. The Alameda Hospital EM program works in collaboration with the city of Alameda, Alameda County Emergency Medical Service Agencies, Bay Area hospitals, and other State and Federal agencies.

III. Objectives and Goals for 2009

2009 Specific Objectives and Goals	Status
Continue education & training of all staff to Alameda Hospital Emergency Management updated plan. Reinforce HICS & Decontamination training.	<p>Twelve hospital wide educational sessions were provided in February & March – 168 persons attended.</p> <p>Six self-learning training modules for review of E.O.P. & Emergency Manual were developed. Three training sessions have been 75% completed – Sessions 4, 5 & 6 are in progress and will be completed.</p> <p>Twenty-two staff persons were given a tour of the Disaster Storage Locker & Trailer.</p>
Participate in California Statewide Disaster exercises.	<p>The June 18th Statewide California Disaster Exercise was cancelled as we experienced the H1N1 Influenza event. The fall state exercise was cancelled & then actually rescheduled on a limited basis with minimal participation. Alameda Hospital did not participate as the communication was insufficient and the notification was after the fact.</p> <p>Alameda Hospital participated in the March 24th Alameda County Pandemic Flu Tabletop exercise.</p> <p>Alameda Hospital participated in the July 28th Alameda County “Operation Safe Movement” tabletop exercise with emphasis on evacuation.</p>

Implement CAHAN alerting system in Alameda Hospital.	Nine Alameda Hospital employees were activated on the CAHAN Alerting System.
Increase ReddiNet Capabilities at Alameda Hospital.	ReddiNet initiated a new web-based ReddiNet Version 5. We were able to increase ReddiNet capability by providing access to ReddiNet in the Staffing Office and HIC in addition to the ECC.
Conduct Internal Code drills for all internal code procedures.	Fourteen internal codes were conducted on all three shifts. In addition to regular Code Blue & Code Red, we conducted Code Gray, Code Silver, Code Purple and Utility Failure Codes

V Goals for 2010

- A. Continue education & training of all staff to Alameda Hospital Emergency Operations Plan. Reinforce HICS & Decontamination training. Complete training sessions 4, 5 & 6.
- B. Assist Business Office with review & revision of Hospital Disaster Plan.
- C. Participate in California Statewide Disaster exercises.
- D. Increase number of persons activated in the CAHAN Alerting System at Alameda Hospital.
- E. Maintain currency of inventory in the Disaster Trailer and Emergency medication order in the Pharmacy.
- F. Collaborate with Alameda County and the community for Mass Fatality Plan.
- G. Increase communication of Disaster Preparedness activities to Alameda Hospital Staff.

Alameda Hospital
2009 Annual Review
Of the
Medical Equipment Management Plan

Mission Statement

It is the mission of the Biomedical Engineering department to ensure that hospital clinical equipment is in an optimal and safe condition. We are responsible for the testing, repair, and scheduled maintenance of all contracted clinical equipment owned, leased and/or operated by the hospital, its employees, and physicians.

Goals and Objectives

Test and ensure the operating safety of all clinical equipment utilized in the Hospital according to the requirements set forth by JCAHO, NFPA, CAP, AOA, state law, and the manufacturer of the equipment.

Perform immediate service, timely repair, and proper documentation of all contracted clinical equipment found to be malfunctioning and/or operating outside of required safety standards.

Conduct and document appropriate preventive maintenance procedures on contracted equipment as scheduled.

Monitor and review any and all activity performed by outside contractors for the Biomedical Engineering department.

Provide professional advice for repair versus replacement decisions and for clinical equipment evaluations and pre-purchase activities.

Reduce the amount of Human Factor and Can Not Duplicate symptom service calls by obtaining or providing in-service education for all clinical areas regarding the safe and proper use of medical instrumentation.

Strive for a planned maintenance (PM) completion rate of at least 95%.

Planned Maintenance and Corrective Maintenance

For the calendar year 2009, there were 1478 completed Planned Maintenance (PM) actions of 1480 scheduled. An additional 46 PM actions were completed out of schedule bringing the annualized cumulative PM compliance up to 98.6%. This exceeded our set threshold of 95.0%.

	PM Scheduled	PM Completed	PM Carried Forward
1 st Quarter	398	398	0
2 nd Quarter	350	349	1
3 rd Quarter	314	313	1
4 th Quarter	418	418	0
Totals	1480	1478	2

273 Corrective Maintenance (CM) actions were completed during the year. 2 of these repair items were classified as Operator Error or Misuse. A total of 6 Can Not Duplicate (CND) errors were recorded for the year. No specific trends were identified within these CND and Operator Error failures. 1 item were coded as being Abuse. These mostly include pulled power cords or dropped equipment and are not necessarily considered as intentional in nature.

	CM Completed	CND Errors	Operator Errors	Device Abuse
1 st Quarter	54	1	1	0
2 nd Quarter	68	0	0	0
3 rd Quarter	80	2	0	0
4 th Quarter	70	3	1	1
Totals	273	6	2	1

Equipment Inventory and Service Documentation

At the close of 2009 there were 2916 items on the active equipment inventory. There were 181 items retired and 158 items added for the year. The majority of these changes were rental equipment entering and exiting the hospital.

As a continuing performance improvement standard and goal, Equipment Inventory accuracy continues to be addressed. Utilizing a PDA system, equipment make, model, serial number information, as well as location, and contract coverage levels are being verified and corrected on a monthly basis. As purchase information is provided by the hospital, initial purchase price and PO information is being included in the equipment records. New equipment control numbers are being added to existing equipment. These new identification tags identify the equipment within the GE Healthcare network and allow for nationwide tracking tying the equipment to our site.

Biomedical Engineering continues to support the hospital in their retirement and acquisition of medical equipment. End of Product Life (EOPL) letters are distributed through GE to help watch for items that are nearing the end of their serviceable life. As the manufacturers set End of Product Life dates, service & support or replacement options are discussed with the department directors.

Inspections

The Biomed program at Alameda Hospital did not received GE Healthcare internal inspections/audits in 2009. We are scheduled to have a GE Healthcare internal inspections/audits in 2010.

Summary

The Medical Equipment Management Program for Alameda Hospital was effective in 2009. The planned maintenance (PM) compliance percentage continually exceeded 95%. Biomedical Engineering continues to support the hospital capital equipment planning committee with recommendations for the replacement of obsolete/aged equipment. The use of the PDA has improved the capture and recall of information in the database with the ability to make timely updates to the data.

2009 Performance Improvement Standards and Goals

Maintain a Planned Maintenance (PM) completion rate of at least 97%

Continue to verify equipment inventory accuracy. Verify equipment make, model and serial numbers. Expanding out to include locations and contract coverage levels.

Verify Planned Maintenance (PM) schedules and coverage levels. Update department logbooks with current content on a semi-annual basis.

Improve implementation of both the GEHC and Hospital policies in regards to temporary equipment (Demo/Loaner/Rental) being brought into the facility.

**Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Utilities Management**

I. Summary of Effectiveness

The utility program continues to be diligent and successful with an active Safety Committee and support from Administration.

- A. All preventative maintenance (PM's) completed
- B. Extensive unplanned issues (see below) were evaluated and projects were developed to address the problems.

II. Scope

Alameda Hospital strives to maintain a Utilities System program which promotes a safe, controlled and comfortable environment of care for the benefit of patients, staff and visitors. Management of the Program is the responsibility of the Engineering Department.

It includes continuous monitoring, regular preventive maintenance, inspections, repairs, testing and corrective work orders. These activities continuously evaluate risks associated with utility systems and equipment and determine which factors, if any, need monitoring to assure proper performance. Services offered and sites covered by the plan remain essentially the same.

III. Objectives and Goals for 2009

Overall Goals:

- Assess and minimize the risks of utility failures
- Reduce the potential for hospital-acquired illness
- Ensure the operational reliability of utility systems through PM's

2009 Specific Objectives and Goals	Status
1. Seismic shut-off for natural gas	1. Too expensive at this time
2. Sprinkler pipe bracing	2. Expert reviewed; not necessary
3. Control air compressor replacement	3. Completed

IV. Performance Indicators 2009:

- A. Complete Preventative Building Maintenance: 100% complete
- B. Service all work order request and incident reports: 98% complete
- C. Projects:
 - Nurse Call for 2 South and Short Stay Unit: 100% complete
 - Lab Equipment installed 100% complete

Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Utilities Management

V. New Unplanned Issues in 2009

New unplanned issues addressed by the Safety Committee in 2009 include:

- A. 2 South and Short Stay Unit – new nurse call system complete
- B. ATC new phone system
- C. New steam boiler

VI. Objectives and Goals for 2010

- A. Main Electrical Distribution; Inspection PM and testing

VII. Performance Indicators for 2010

- A. Building Maintenance Program
- B. Work Orders
- C. Projects completed

**Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management**

I. Summary of Effectiveness

The Fire/Life Safety Program continues to be diligent and successful with an active Safety Committee, Fire subcommittee, Safety Officer and support from Administration.

- All fire safety exercises were conducted and evaluated with minimal intervention. In-service provided as needed. The need for Interim Life Safety Measures (ILSM) was appropriately evaluated and activated if determined necessary. No fire watches were required.

II. Scope

The scope of the Fire (and Life) Safety Plan addresses the protection of patients, staff, physicians, visitors and property from fire, smoke and other products of combustion by following established operational plans and systems. Alameda Hospital strives to meet the Life Safety Code (NFPA-101), JCAHO, State and local regulations. The Plan is administered by the Safety Committee, Fire Safety subcommittee, Safety Officer and Engineering Director. Sites, services and hours of operation have not materially changed.

III. Objectives and Goals for 2009

1. Ansul Replacement.
2. Review and update department specific plans.

2009 Specific Objectives and Goals	Status
1. Ansul replacement	Completed
2. Review and update department specific plans.	Completed

IV. Performance

Performance Indicators included:

- A. A system was developed to score/rate the performance at the fire site during an exercise and track outcome.
Overall rating for this year was: 1.5
1.3 for night
2.0 for days
1.3 for PM
- B. Increase staff knowledge each quarter: Questions 5 & 6
Life Safety and 3&5, Associate Knowledge target 95%,
Life Safety was 98%
Associate was 99%

Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management

V. New Unplanned Issues in 2009

1. PBX Fire Display Panel replaced

VI. Objectives and Goals for 2010

1. Change to new monitor sheet
- 2.

VII. Performance Indicators for 2010

1. Track and evaluate scoring of performance at the fire site during exercises.
2. Reinforce staff knowledge each quarter with regard to question #3 & 5, Life Safety and #5 & 6, Associate Knowledge with a goal of 95% compliance.

Date: January 28, 2010
To: Alameda Hospital Safety Committee
From: Barbara Corrick, Benefits Manager
CC: Phyllis J. Weiss, Director of Human Resources
Subject: 2009 Annual Evaluation - Human Resources Safety Plan

I. Summary of Effectiveness

The safety program continues to be diligent and successful with an active Safety Committee and support from Administration.

A. Employee Injury and Illness Subcommittee worked effectively to address occupational injury and illness such as the following:

- Worked with Managers and Engineering to fix any structural problems.
- Hazel Lau, Ergonomic Specialist, pro-actively performed ergonomic evaluations and in-service training (both departmentally and individually).
- Continued focus on prevention including accident site visits/assessments and employee training.

II. Scope

The scope of the Safety Management Plan encompasses all employees as well as registry, students, contracted employees, patients, volunteers, visitors and the medical staff. Services offered and sites covered by the plan remain essentially the same. The Plan is administered by a Safety Officer, Safety Committee and subcommittees.

Objectives and Goals for 2009

Overall Goals:

Continue to:

- Reduce number of injuries in the workplace
- Reduce amount of lost time due to injuries
- Educate and train employees and managers to proactively prevent injuries.

2009 Specific Objectives and Goals

Status

1. Continue ergonomics training for all departments	Ongoing. Hazel Lau, Ergonomics Specialist, continues to train employees regarding equipment.
2. Help manage usage of benchmark equipment	Monthly industrial injury reports were also reviewed with affected Department heads, to promote awareness and prevention.
3. Continue Manager and employee training regarding injury reporting procedures.	Human Resources incorporated injury reporting requirements in new hire orientation and new manager training.
4. Work with Liberty Mutual's Risk Engineering Department to assess and prevent risk, and to improve our benchmarking data.	Benefits Manager has begun actively utilizing Liberty Mutual's RiskTrac system to track the status of current claims. New injury/illness investigation forms have been introduced to the hospital and will be rolled out in 2010 to managers/supervisors.

IV. Performance

Performance indicators included:

Indicator	2005	2006	2007	2008	2009
# Staff in TAW	12	16	12	11	8
Total Hours Worked	1047	1990	1818.75	1442	896
Total Salary Paid	\$26,045	\$66,154	\$50,474.03	\$36,636	\$30,697

Track and improve employee injury rate.

- 2009: 1/4.2 Days
- 2008: 1/4.2 Days
- 2007: 1/4.7 Days
- 2006: 1/4.6 Days
- 2005: 1/5.9 Days

V. New Unplanned Issues in 2009

New unplanned issues addressed by the Safety Committee in 2009 include:

- Continued to create and provide temporary alternative work (TAW) to injured employees
- Manager awareness of safety issues within their functional areas.
- Working with Engineering and Hazel Lau, Ergonomics Specialist, to identify structural and other hazards.
- Employee awareness of patient lifting equipment and training. Hazel Lau continues to educate pro-actively, as well as in response to injury.
- Direct patient care for patient with meningitis resulted in 16 employee exposure reports (included in the performance indicators above). However, none of these employees were found to have contracted meningitis. Employees were seen in the ECC and/or sent to Alameda Centre Physicians for exam and preventative treatment.
- Hazel Lau, Ergonomic Specialist, continues with in-service training for the employees regarding body mechanics. Rosemarie Delahaye, continues to provide in-service training to employees regarding Infection Control including hand washing and personal protective equipment.
- New Benefits Manager hired Sept. 2009 with extensive Workers' Compensation and safety background introduced new injury/illness investigation forms, work status forms to Safety Committee.

VI. Objectives and Goals for 2010

1. Continue ergonomics training for all departments and new hires.
2. Help manage usage of equipment. – Staff awareness and training
3. Continue Manager and employee training regarding new injury reporting procedures.
4. Work with Liberty Mutual's RiskTrac to assess and prevent risk, and to improve our benchmarking data.

Performance Indicators for 2010

1. Track employee injury and exposure statistics.
2. Track injuries by type and department to find trends.
3. Track timeliness of workers' comp. reports to ensure compliance with legal reporting requirements.

Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Hazardous Materials and Waste Management

I. Summary of Effectiveness for 2009 Objectives and Goals

2009 Goals	Effectiveness
Training : <ul style="list-style-type: none"> • Proper packaging of Hazardous Materials • HazMat Manifest 	100% Stericycle training complete 100% training complete
Updated department chemical lists – MSDS online	100% complete Reviewed, completed and posted to the intranet
Continue to look for new training material	Ongoing
Develop mechanism to organize MSDS online by department	Completed
Define hazardous spill teams – responsibilities and goals	<ul style="list-style-type: none"> • Deferred to 2010 goals • NOTE: No hazardous spills in 2009

II. Scope

The scope of the Hazmat Committee is to ensure that hazardous materials and hazardous wastes are managed appropriately and that all employees are notified and trained in the safe use and disposal of these materials as it pertains to their job. Applicable personnel receive training in the proper management of all forms of wastes generated. The Plan is administered by the Hazardous Materials/Waste Management Subcommittee and Safety Officer under the direction of the Safety Committee. Services offered and sites covered by the Plan remain essentially the same.

III. 2009 Quality Performance Indicators

Quality Indicator	Performance and Goals	Evaluation and Effectiveness
Reviewed chemical inventory list and MSDS by department	100%	Completed
Number of new MSDS	0%	No new MSDS's
Major Hazard Spills	100%	No spills in 2009
RCRA Implementation	100%	Completed

IV. Objectives and Goals for 2010

1. Define hazardous spill teams – responsibilities and goals
2. New training for spill teams
3. Continue to look for published information
4. Track new MSDSs'
5. Inventory spill kits throughout facility

V. Performance Indicators for 2010

1. Major Hazardous Spills
2. Number of new MSDS sent to committee
3. New training completed

VI. Unplanned Issues for 2009

1. Clean Harbors – an environmental group for hazardous spill clean up; a contract was signed and stickers were distributed to all department managers.
2. 3-year review of HazMat procedures were updated.

Alameda Hospital
2009 Annual Evaluation of the Environment of Care Program
Security Management

1. Summary of Effectiveness

The Safety Program continues to be diligent and successful with an active Security Committee and support from Administration.

- A. Security officers' post orders were reviewed to ensure they meet current needs.
- B. The Hospital began a "stacked parking" program in October, 2003 after an in-depth evaluation of the effective means to meet the growing demand for parking spaces with no ability to expand. In 2005, an additional attendant was added. Parking attendants are on the campus Monday – Friday, 7:00am – 5:00pm. This program has provided an additional physical presence that enhances our security.
- C. A comprehensive security risk assessment was performed by Securitas Services in October, 2009. It showed that the area surrounding Alameda Hospital has a very low rating for potentials security incidents.
- D. The Security Management Plan and Program was reviewed. The low number of security incidents continued in 2009.
- E. There were a total of 12 reportable security incidents in 2009. While there were slight increases or reductions in the areas measured, the total number of reportable security incidents in 2009 totaled only twelve (12). No employees sustained an injury due to these incidents. Please see Section V., New Unplanned Issues Addressed in 2009, Article B, for the actions taken.

11. Scope

The scope of the Security Management Plan addresses security issues for patients, visitors, personnel, volunteers, physicians, and property. A close working relationship is maintained with Alameda Police Department. Hospital personnel, including the PBX Operator, are trained on how to summon help for emergency and non-emergency situations. Standardized codes facilitate widespread communication and trained security officers provide additional service. All incident reports are reviewed within 72 hours by the Security Subcommittee Chair. The Plan is administered by the Subcommittee Chair, Safety Committee, and Safety Officer.

The scope changed in late 2003 with the addition of stacked parking attendants and standardization of emergency codes to facilitate emergency communications. Those security enhancements were communicated and maintained during 2009. The Security Management Program was reviewed by Joint Commission Surveyors in May, 2007. No recommendations were made following their review.

111. Objectives and Goals for 2009

Overall Goals:

- A safe and secure environment for all persons associated with the facility,
- A facility equipped to meet the security needs of employees, patients, visitors, physicians, and volunteers.
- Compliance with state regulations, security standards and policies, procedures, and practices of the Hospital.

2009 Specific Objective and Goals**Status**

1. Continue compliance with AB508	A comprehensive risk assessment conducted in October 2009 showed a low threat level. There were only 12 reportable incidents in 2009.
2. Provide bi-monthly reports to Safety Committee supporting the Information Collection and Evaluation System (I.C.E.S.)	All reports completed and discussed at Safety Committee.
3. Increase employee security awareness with articles in the "Pulse," and the Hospital web site, and training in Orientation/ Mandatory Annual Training.	All these activities were completed. Self defense classes were held.
4. Reduce total reportable security incidents by 5%.	Total reportable incidents increased from 11 in 2008 to 12 in 2009. While the indicator was not met, security incidents remain low and no injuries by staff were sustained.
5. Reduce "Reported Problems with visitors loitering public/patients" by 5%.	These problems decreased from 8 to 6 in 2009. Standard was met. See V.B for actions taken.

IV. Performance

Performance indicators included the following (*Refer to attached graphs*).

<p>A. Increase in total reportable incidents:</p> <p>2000 – 27 incidents 2001 - 14 incidents 2002 - 10 incidents 2003 - 11 incidents 2004 - 10 incidents 2005 - 6 incidents 2006 - 10 incidents 2007 – 9 incidents 2008 - 11 incidents 2009 - 12 incidents</p>	<p>C. Increase in theft from individuals:</p> <p>2000 – 5 incidents 2001 – 1 incident 2002 – 3 incidents 2003 – 1 incident 2004 – 4 incidents 2005 – 3 incidents 2006 - 2 incidents 2007 – 1 incident 2008 - 3 incidents 2009 - 6 incidents</p>
<p>B. Decrease in problems with visitors, public, or patients:</p> <p>2000 – 20 incidents 2001 - 13 incidents 2002 – 7 incidents 2003 - 6 incidents 2004 - 4 incidents 2005 - 2 incidents 2006 - 3 incidents 2007 - 6 incidents 2008 – 8 incidents 2009 – 6 incidents</p>	<p>D. No theft of hospital equipment:</p> <p>2000 – 0 incidents 2001 - 0 incidents 2002 - 0 incidents 2003 - 3 incidents 2004 - 1 incident 2005 - 1 incident 2006 - 0 incidents 2007 - 1 incident 2008 - 0 incidents 2009 – 0 incidents</p>

<p>E. No Exterior/Lot Damage</p> <p>2000 – 1 incident</p> <p>2001 – 0 incidents</p> <p>2002 – 0 incidents</p> <p>2003 – 1 incident</p> <p>2004 – 1 incident</p> <p>2005 – 0 incidents</p> <p>2006 – 5 incidents</p> <p>2007 – 1 incident</p> <p>2008 – 0 incidents</p> <p>2009 – 0 incidents</p>	
--	--

V. New Unplanned Issues Addressed in 2009

New unplanned issues addressed by the Safety Committee in 2009 include:

- A. Several reported cases of personnel falsely representing themselves as Joint Commission (JC) representatives were reported to Hospitals. This was discussed at Management Staff meetings. All managers were instructed to contact Hospital Administration and Security should JC representatives appear. Photo identification would then be required and a call to the JC office to verify that an inspection had been authorized would be made before the inspection was begun. Hospital escorts (Administration or designee) would then accompany the surveyors.
- B. The decrease in the “Reported Problems with visitors, loitering public, and patients” may have been in part to the following actions being taken:
 - 1. Security Officer coverage has been extended from 7:00am to 7:30am. On weekdays, the Security Officer will not leave until the Parking Lot Attendant arrives. On weekends, the Security Officer will not leave until his relief officer arrives;
 - 2. Additional Detex system buttons have been installed in the parking lot. Regular security rounds of the Hospital now include the rear parking lot to the light standard near the lagoon to the parking office kiosk, as well as all floors within the Hospital;
 - 3. Security Officers will be stationed in the main parking lot from 5:30am – 7:30am;
 - 4. Alameda Police Department has agreed to more frequently patrol our parking area, and;
 - 5. Employees were asked to be increasingly vigilant regarding suspicious activity in the Parking Lot;
 - 6. Keypad locks installed on the entry doors at 4-East and 5-East, and at the 1-West rear perimeter entry.
- C. All elevators in the Hospital are now checked by the Security Office during their regular rounds by physically calling the individual cars to ensure they are in working order.

VI. Objectives and Goals for 2010

- A. Consider implementation of the recommendations of the December 2006 risk assessment (closed circuit TV recording capabilities).
- B. Increase security awareness with staff but utilizing various communication tools (Pulse, Orientation, MAT).
- C. Provide bi-monthly reports to Safety Committee with the objective of effective and timely resolution of security incidents.
- D. See improvement in the Performance Indicators identified in IV. Specifically a 5% reduction in reportable incidents and in theft from individuals, which increased slightly in 2009, will be sought.

ALAMEDA HOSPITAL
2009 Annual Evaluation of the Environment of Care Program
Security Management

Attachments



MEMORANDUM

TO: Kerry Easthope, Assistant Administrator

FROM: Tony Corica, Director of Physicians Relations

DATE: January 7, 2010

SUBJECT: Framework for security incident reporting and summary of reportable security incident for 2009

In order to assure a safe environment for patients, personnel, and visitors, Alameda Hospital has an integrated security program that encourages employee/visitor vigilance in reporting any situations that pose a threat to life, health and/or property. These reports may be generated via communication with Administration or any employee or visitor, via the Security Officer’s Daily Activity Report or a number of other sources. Reportable incidents, including theft, exterior building/parking lot/property damage and problems with loiterers/visitors/patients, etc., are communicated to the Safety Committee on a bi-monthly basis.

Summary of the reportable security incidents for 2009 is shown below. No employees sustained an injury due to a security incident in 2009.

2009 SUMMARY OF SECURITY INCIDENTS

	Reported Theft of Hospital Equipment	Thefts from individuals	Reported exterior building graffiti parking lot damage to property	Reported problems w/visitors/loitering public/patients/employees	Total # of reportable security incidents
2009 Total	0	6	0	6	12
Nov-Dec 09				1	1
Sept.- Oct 09		1		1	2
July – Aug 09				1	1
May – June 09		1		1	2
Mar – Apr 09		1			1
Jan – Feb 09		3		2	5

Cc: Tom Jones, Gina Arnone

Date: March 30, 2010

To: Kerry Easthope, Chairman of the Safety Committee
Safety Committee Members

From: Mary Bond, Executive Director for Nursing Services

Subject: 2009 Education Report

The Educational component of employment at Alameda Hospital is addressed in the Goals in support of the Hospital's Mission Statement:

“To attract and retain outstanding employees, to foster an environment where employees gain a sense of satisfaction and accomplishment from their work; and to create a safe and pleasant work setting.”

The Alameda Hospital Educational program remained de-centralized to individual departments in CY 2009. Nursing Managers, Supervisors, and staff provided nursing education. Individual department Managers or Directors provided educational material for their staff.

Executive Team members and all Department Directors/Managers attended leadership and management training beginning in March 2009. Managers and Directors took a total of nine (9) 5-hour modules. Topics included:

- Increasing Productivity
- Using Strategic Thinking
- Steps to Effective Delegation
- Dealing with Difficult People

Approximately 84 hospital employees attended the Patient Safety program held in March 2009 to re-enforce education on topics such as fire safety, medication safety, fall prevention, risk management, and infection prevention.

All clinicians began receiving a monthly “Clinical News and Views” newsletter in September 2009. Topics included:

- Cultural Diversity
- H1N1 Information and Use of N-95 Masks
- Pain Management
- Restraint Use
- CORE Measures

Additional nursing educational topics for 2009 included:

- Pre-op Use of Beta Blockers
- Rapid Response Team/SBAR Reporting
- Dilaudid/PCEA protocol
- CA Transplant Organ/Tissue Donation
- Therapeutic Induced Hypothermia Protocol
- SBAR for Handoff Communication

The Peri-Operative Services department held weekly educational programs for 35 of the 52 calendar weeks in 2009. Approximately 15 staff attended these ½ hour sessions. Topics included the use of new equipment, new techniques, wound management, medication disposal, and fire safety.

Other classes/in-services included instruction in BLS (Basic Life Support), Medication Errors, Wound Management, Acuity, Electronic Health Record Preparation, and H1N1 Information. Additionally off-site training occurred for required certification in ACLS (Advanced Cardiac Life Support) and PALS (Pediatric Advanced Life Support).

The Hospital provided ongoing education in Elder and Dependent Adult Abuse, Non-Violent Crisis Intervention, and Disaster Planning and Preparation.

Each department provided specific competency assessment programs for their staff. In total 285 nursing department staff reviewed and updated their skills for a total of slightly less than 930 hours.

All Hospital staff is required to take on-line Mandatory Annual Training (MAT). The on-line program includes sessions on:

- | | |
|-----------------------------------|----------------------------|
| • Compliance | • Life/ Safety/Fire Update |
| • Staff Safety | • Sexual Harassment |
| • Patient Safety | • Restraint Protocol |
| • Hazardous Materials and Waste | • Trans-Cultural Care |
| • Security | • Utility Failure |
| • Antiviolence | • Pain Management |
| • Confidentiality | |
| • HIPAA | |
| • Infection Control | |
| • TB | |
| • Body Mechanics | |
| • Disaster/Emergency Preparedness | |
| • Chemical & Biological Threats | |
| • Safe Medical Devices Act | |

On-line MAT requires 2-4 hours to complete. To meet compliance and risk issues (SB198) and to help ensure the competency of our staff, all active employees must complete on-line or attend MAT and pass competency assessments once a year. The employees are paid for their attendance at all mandatory classes.

Plans for 2010 include a subscription online program for continuously current Mandatory Training classes as well as departmental specific programs that will educate and evaluate competency. Expected start date is May 1, 2010.

The following table displays the number of employees attending some of the classes in 2009:

Class:	Number of Employees Attending:
Mandatory Annual Training (MAT)	623
Critical Thinking Seminar	13
Non-Violent Crisis Intervention	64
Basic Life Support (BLS)	139

Date: April 12, 2010

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Administrative Policies and Procedures

The following Administrative Policies and Procedures have been updated to reflect current practices, regulatory language and information. Policies and Procedures will be brought to the Board of Directors quarterly for approval. Management requests approval of the Administrative Policies and Procedures listed below.

Policy #	Policy Title & Purpose Statement
No. 01	Mission Statement / Vision Statement <ul style="list-style-type: none"> To communicate the mission, vision, and values of the City of Alameda Health Care District within the organization and to the community.
No. 04	Plan for the Provision of Patient Care Services <ul style="list-style-type: none"> To provide guidance to the District Board, hospital leadership, the Medical Staff and hospital staff to develop a framework to meet the healthcare needs of our patients.
No. 08	Performance Improvement Plan Integration <ul style="list-style-type: none"> To outline the performance improvement process involving the interaction and cooperation of hospital and medical staff committees. A detailed description of the scope and duties of each committee can be found in the Medical Staff Bylaws and Hospital Committee Purpose statements.
No. 10	Disposal of Surplus Property <ul style="list-style-type: none"> The District periodically finds that there is property that is no longer of use to the District in its normal operations. In such instances, that property may be declared "surplus" and be disposed of as set forth below. Property shall be declared surplus only after a finding that it is no longer in productive use and its fair market value has been ascertained.
No. 14	Interdisciplinary Practice Committee <ul style="list-style-type: none"> The Interdisciplinary Practice Committee is established in accordance with Section 70706 of Title 22. Specifically, in any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensees or certified health arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 of Title 22, there shall be an Interdisciplinary Practice Committee established by and accountable to the Governing Body.

Policy #	Policy Title & Purpose Statement
No. 16	<p>Patient's Rights and Responsibilities</p> <ul style="list-style-type: none"> To ensure that all patients and/or their designated decision maker are informed of their rights including how they can be involved in their care and the mechanisms available to issue complaints about their care.
No. 19a	<p>Identification of Surrogate Decision Makers</p> <ul style="list-style-type: none"> To provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision making capacity. The determination of who has the legal capacity to consent to medical treatment for a patient is based on an evaluation of the competency of the patient. If the patient is competent, the patient has the right to consent to or refuse the treatment. If the patient is incompetent, either by reason of statutory definition (for example, minority) or by reason of condition (for example, unconscious or later stage dementia), the determination of who may consent depends upon whether a third person has the legal capacity to consent to treatment on behalf of the patient. When there is no known or willing surrogate decision maker, decisions will be made in the patient's best interest.
No. 19b	<p>Authorization for a Third Party to Consent to Treatment of Minors Lacking Capacity to Consent</p> <ul style="list-style-type: none"> A non-parent adult relative with whom a minor is living may authorize medical care (for which the minor lacks capacity to consent) for the minor by signing a "Caregiver's Authorization Affidavit"
No. 20	<p>Consent for Blood Transfusions</p> <ul style="list-style-type: none"> To provide an opportunity for patients to make an informed decision regarding the use of blood transfusions.
No. 21	<p>Patient Identification and Communications for Clinical Care and Treatment</p> <ul style="list-style-type: none"> To ensure that all patients are properly identified prior to any care, treatment or services provided, and that appropriate communication processes are carried out to provide an environment that promotes safe and effective medical care
No. 24	<p>DNR Policy</p> <ul style="list-style-type: none"> The purpose of this DNR policy is to ensure that in such cases: (1) the rights and dignity of the patient and family are protected; (2) all caretakers, including the family and all members of the health care team, are informed of the decision and understand its implications; and (3) the decision is medically, ethically and legally valid.
No. 26a	<p>Physical Restraint Management Protocol – Non Behavioral</p> <ul style="list-style-type: none"> To outline nursing care and management of patients requiring non behavioral restraint.
No. 26a	<p>Non-Behavioral (Physical) Restraint Standards</p> <ul style="list-style-type: none"> To outline nursing care and management of patients requiring non-behavioral (physical) restraints.
No. 26b	<p>Behavioral Health Care Restraint Standards</p> <ul style="list-style-type: none"> To outline nursing care of patients requiring physical restraint for behavioral health care management.
No. 27	<p>Operative & other invasive procedures</p> <ul style="list-style-type: none"> To assure appropriate assessments in the selection of procedures, Patient preparation, care planning and monitoring for optimal outcomes and patient safety.
No. 28	<p>Sedation management</p>

Policy #	Policy Title & Purpose Statement
No. 29	<p>Organ & Tissue Donation Policy</p> <ul style="list-style-type: none"> To outline the management of patients receiving sedation for therapeutic and/or diagnostic procedures. Families of patients with imminent deaths and/or deceased patients determined to be medically suitable organ and/or tissue donors will routinely be afforded the opportunity to consent to donation.
No. 30	<p>Guidelines for Determination of Brain Death</p> <ul style="list-style-type: none"> A determination of brain death must be made in accordance with acceptable medical standards.
No. 31	<p>Code of Conduct</p> <ul style="list-style-type: none"> The Code of Conduct is the core of the Alameda Hospital Compliance Program and defines the Hospital's commitment to full compliance with the statutes, regulations, and written directives of Medicare, MediCal, and all other Federal health care programs.
No. 32	<p>Transfer Of Patients</p> <ul style="list-style-type: none"> To assure that hospitals meet the requirements established by the federal and state governments, for safe and timely transfer to another facility.
No. 35	<p>Patient Assessments</p> <ul style="list-style-type: none"> To identify the hospital-wide standards for patient assessment.
No. 36	<p>Patient Quality Assessment Survey</p> <ul style="list-style-type: none"> To elicit a response of Alameda Hospital's services directly from the recipient of those services. To assess the responses and use the data as part of the continuous improvement process to improve the patient's experience.
No. 37	<p>Guidelines for Immediate Response and Reporting to Risk Management</p> <ul style="list-style-type: none"> To identify factors for response and reporting that present injury or potential for injury, damage to hospital property or risk of hospital liability. Early identification of actual or potential risk can help to minimize adverse effects and help to ensure safe, quality patient care and promote the well-being of patients, visitors, employees, volunteers and physicians.
No. 39	<p>Health Record Content</p> <ul style="list-style-type: none"> To show responsibility for documentation and proper authentication in the medical record.
No. 41	<p>Critical Incident Defusing/Debriefing (Cid)</p> <ul style="list-style-type: none"> Critical incident defusing/debriefing provides a trained team to meet with staff following a "critical incident". A critical incident is an out of the ordinary event which is emotionally distressing, high powered and overwhelming, e.g., death of a child, multiple traumas, suicide, etc.
No. 42	<p>CODE GRAY/SILVER ASSISTANCE</p> <ul style="list-style-type: none"> To provide a system for rapidly mobilizing personnel in a <u>non-medical</u> emergency (such as a patient, visitor, or employee who needs to be prevented from injuring himself or others). To assure that help from the Alameda Police is obtained. <u>Exception:</u> If a patient, visitor or employee has or is suspected of having a weapon, dial 3333 and have the operator call APD. A Priority One will <u>not</u> be paged. (Refer to the Security Plan).
No. 43	<p>Hand Off Communication</p>

Policy #	Policy Title & Purpose Statement
No. 48	<p data-bbox="349 262 1461 399"> <ul style="list-style-type: none"> To ensure accurate information about a patient’s / client’s / resident’s care. Treatment and services, current condition and any recent or anticipated changes are communicated during “hand off” in order to get a complete picture of the patient’s situation, exchange important information and meet patient safety goals. </p> <p data-bbox="300 409 641 441">Clinical Abbreviation List</p> <p data-bbox="349 451 1461 766"> <ul style="list-style-type: none"> Clearly understood communications are essential in providing safe, quality personalized care and service to patients and families. Effective use of abbreviations and symbols enhance efficiency and save time and effort in verbal and written communications. However, potential errors may occur when abbreviations are not standardized and readily understood and when dangerous abbreviations are used. Dangerous abbreviations are those with a significant chance for misunderstanding. This policy establishes a list of approved abbreviations as well as a list of mandatory “Do Not Use” and recommended “Do Not Use” abbreviations. </p>
No. 49	<p data-bbox="300 777 657 808">Statement on Policy Review</p> <p data-bbox="349 808 1461 871"> <ul style="list-style-type: none"> To develop hospital/health care district policies and procedures, and to review them and revise them, as appropriate, on a regular basis. </p>
No. 51	<p data-bbox="300 882 901 913">Code Purple: Infant Abduction/Missing Patient</p> <p data-bbox="349 913 1461 1060"> <ul style="list-style-type: none"> Alameda Hospital strives to ensure a safe environment for all patients. It is the responsibility of all staff members and employees to take measures to prevent and /or respond appropriately to a patient missing due to abduction, kidnapping, or elopement. </p>
No. 55	<p data-bbox="300 1071 1063 1102">Complaint/Grievance Management: Tracking & Resolution</p> <p data-bbox="349 1102 1461 1417"> <ul style="list-style-type: none"> To establish a consistent, effective process for responding to patient complaints regarding care, abuse or neglect, compliance and billing. To assure patients, or their representatives that they have a right to resolution of complaints, either formally or informally. To assure patients, or their representatives that they may file a written or verbal complaint when the staff that is present cannot resolve the issue promptly and to their satisfaction. To identify trends in patient satisfaction issues that will drive performance improvement projects. </p>
No. 56	<p data-bbox="300 1428 836 1459">Medical Device Event Reporting Program</p> <p data-bbox="349 1459 1461 1648"> <ul style="list-style-type: none"> To identify, communicate and evaluate adverse events in a timely and effective manner, to standardize the review process and procedure for determining whether or not an event is reportable, and to provide procedures to assure the timely transmission of complete reports under the Safe Medical Device Act (21 USC Section 360i(6)). </p>
No. 58	<p data-bbox="300 1659 625 1690">Sentinel Event Response</p> <p data-bbox="349 1690 1461 1827"> <ul style="list-style-type: none"> To provide a mechanism for the identification and management of sentinel events emphasizing the importance of identifying, reporting and analyzing events to focus attention on underlying causes and risk reduction and to have a positive impact on improving patient care, treatment and services. </p>
No. 59	<p data-bbox="300 1837 787 1869">Patient Choice in Discharge Planning</p> <p data-bbox="349 1869 1461 1936"> <ul style="list-style-type: none"> To inform patients and their families of their freedom to choose among providers for their post-hospital home care. </p>

Policy #	Policy Title & Purpose Statement
No. 59b	In-home Assistance with Options in Discharge Planning <ul style="list-style-type: none"> To provide patients and families with a list of bonded insured agencies from which they may choose in-home assistance by non-licensed personnel.
No. 60	Mandatory Reporting of Adverse Events, Unusual Circumstances, and Disruption of Services. <ul style="list-style-type: none"> To establish reporting and disclosure (state and federal) requirements for adverse events, unusual occurrences and /or disruption of services as outlined in Title 22, CDR Section 70737(a) and California Health & Safety Code Sections 1279.1, 1279.2, 1280.1, 1280.3, SB541, SB1301.
No. 61	Responding To Victims Needing Medical Assistance On Hospital And Adjacent Grounds <ul style="list-style-type: none"> To give all hospital personnel guidance on the management of victims discovered, or reported to be needing medical assistance, on hospital and adjacent grounds.
No. 62	Procurement and Use of Computerized Information Systems <ul style="list-style-type: none"> To ensure the appropriate procurement and use of Alameda Hospital's computerized information systems.
No. 64	Code 4 – Rapid Deployment Plan <ul style="list-style-type: none"> Alameda hospital has in place a code 4, rapid deployment plan to delineate the authority, responsibilities, and procedures to be followed when current demands are outstripping immediately available resources. Causes to implement a code 4 are most frequently stimulated by a rapid influx of patients into an area, resulting in an overload situation and requiring immediate intervention and additional services of other specialty departments.
No. 65	Hospital Strategic Planning <ul style="list-style-type: none"> To define a process for continuous review and revision, if appropriate, of the Hospital's mission and vision, organizational values, and the development, review and revision of strategic, operational, programmatic and other plans and initiatives that enable the Hospital to achieve its mission and vision.
No. 65	Hospital Strategic Planning <ul style="list-style-type: none"> To define a process for continuous review and revision, if appropriate, of the Hospital's mission and vision, organizational values, and the development, review and revision of strategic, operational, programmatic and other plans and initiatives that enable the Hospital to achieve its mission and vision.
No. 67	Hospital Diversion <ul style="list-style-type: none"> To establish which conditions would negatively and profoundly impact the hospital's ability to provide safe patient care and allows the diversion of ambulance patients away from Alameda Hospital.
No. 68	Pain Management <ul style="list-style-type: none"> Pain can be a common part of the patient's experience; unrelieved pain has adverse physical and psychological effects. Pain management is part of a holistic approach to patient care management provided at alameda hospital. The staff plans, supports, and coordinates activities and resources to assure the pain of all patients is appropriately recognized and addressed. Severe pain is a life threatening condition that is approached by the health care team with the same resolve with which we approach all other threats to a patient's life
No. 69	New Born Abandonment <ul style="list-style-type: none"> Effective January 1, 2001, California Law (SB 1368) provides immunity from

Policy #	Policy Title & Purpose Statement
	<p>criminal prosecution to parents or persons with legal custody of newborns 72 hours old or younger who voluntarily surrender the child to an employee on duty at a public or private hospital emergency department, or to another location designated by the county.[Health and Safety Code §1255.7] Hospitals must designate the classes of employees authorized to take custody of these children [Penal Code §271.5]. No person or entity that accepts a surrendered child will be subject to civil, criminal or administrative liability for accepting and caring for the child in the good faith belief that accepting the child is required by the statute. This includes situations where the child may actually be older than 72 hours, or where the surrendering person did not have lawful physical custody of the infant. However, the statute does not provide immunity from personal injury or wrongful death, including malpractice claims. [Health and Safety Code §1255.7g]</p>
No. 7	<p>Performance Improvement Plan</p> <ul style="list-style-type: none"> ▪ To outline a plan in concert with Alameda Hospital’s mission, vision and values, to provide high quality and personalized care in a safe and trusted environment and to continuously improve processes and services relative to patient care and satisfaction. The plan provides an essential framework to ensure the delivery of the best care for all patients in a multidisciplinary environment.
No. 71	<p>Patient Billing for Clinical Studies</p> <ul style="list-style-type: none"> ▪ To establish a policy on the billing protocol for clinical studies for patients and/or insurers.
No. 73	<p>Health Information Retention Schedule</p> <ul style="list-style-type: none"> ▪ A health information retention schedule is established to ensure that patient information is available to meet the needs of continued patient care.
No. 74	<p>Business Information Retention Schedule</p> <ul style="list-style-type: none"> ▪ A business record retention schedule is established to ensure that information is available to meet the needs of the organization. Additionally, consideration should be given to legal, licensing, regulatory, and accreditation requirements; frequency of use; space constraints; and other legitimate uses.
No. 76	<p>Expense Reimbursement</p> <ul style="list-style-type: none"> ▪ To reimburse employees for legitimate business related expenses that they incur on behalf of Alameda Hospital.
No. 79	<p>Child Passenger Safety Seats</p> <ul style="list-style-type: none"> ▪ To provide information regarding Child Passenger Restraint Law to all parents/guardians of children treated at or discharged from Alameda Hospital. ▪ “Health & Safety Code Sections 1204.3, 1212, and 1268 require hospitals at the time of, or before the discharge of a child under the age of six years, or weighing less than 60 pounds to provide and discuss information on the law requiring child passenger restraint systems to the parent or to the person to whom the child is released.” ▪ The parents or legal guardian of infants and young children will be made aware of the law and provided with information regarding local car seat programs and risks of death/injury associated with nonuse and misuse of a child passenger safety seat.
No. 81	<p>Non-Discrimination Policy</p> <ul style="list-style-type: none"> ▪ To state the Hospital's non-discrimination policy related to employment, treatment or participation in program, services and activities.

Policy #	Policy Title & Purpose Statement
No. 84	<p>Color-Coded Wristband Use</p> <ul style="list-style-type: none">▪ To have a standardized process that complies with California state standards that identifies and communicates patient-specific risk factors or special needs by using color-coded wristbands based upon the assessment of the patient, the patient's wishes and medical status.
No. 85	<p>Anticoagulation Program</p> <ul style="list-style-type: none">▪ To implement a comprehensive interdisciplinary process for anticoagulant use through the adoption of recognized safe practices and evidence-based guidelines for the prescribing, administration and monitoring of therapeutic doses of heparin, low molecular weight heparin and warfarin to ensure appropriate dosing, effective monitoring and early detection and prevention of adverse reactions.

DATE: April 12, 2010
TO: City of Alameda Health Care District Board of Directors
FROM: Kerry Easthope, Associate Administrator
SUBJECT: Approval of Departmental Policies and Procedures

Recommendation:

Management recommends that the Board of Directors approve the policy and procedure manuals for the following Hospital Departments or Services:

1. Clinical Laboratory
 - a. Hematology
 - b. Urinalysis
 - c. Chemistry/Misc. Chemistry
 - d. Microbiology
 - e. Coagulation

Background:

Title 22 of the California Code of Regulations, and in some cases the Joint Commission, requires some hospital departments or services to have their department specific policies approved by the governing body. In order to comply with this regulation, and assist with the review process, we have attached the table of contents from each department's policy and procedure manual.

Discussion:

Each manual is available for your review at any time through Administration.

HEMATOLOGY MANUAL CONTENTS

<u>PROCEDURE</u>	<u>NUMBER</u>
Bone Marrow Aspiration / Biopsy	7.001
Buffy Coat Preparation	7.002
	7.003
Leukocyte Differential Count	7.004
RBC Morphology	7.005
Slide Scanning	7.006
Pathologist Slide Review Criteria	7.007
Erythrocyte Sedimentation Rate	7.008
Malarial Preparation	7.009
Manual Reticulocyte Count	7.010
Manual Platelet Count	7.011
Manual WBC Count	7.012
Downtime Procedure LH750	7.013
Downtime Procedure ACT 5	7.014
Wright Stain	7.015
	7.016
	7.017
Semen Analysis	7.018

Sperm Count	7.019
Pregnancy Testing	7.020
Urinalysis – Complete	7.021
Urinalysis – Dipstick	7.022
Clinitest	7.023
Bilirubin By Ictotest	7.024
Establishing Quality Control Ranges	7.025
Quality Control – Hematology Analyzers	7.026
Plasma Replacement	7.027
Cold Agglutinins	7.028
Spun Micro-Hematocrit	7.029

Urinalysis MANUAL CONTENTS

<u>PROCEDURE</u>	<u>NUMBER</u>
Urinalysis	7.001
Urinalysis with Reflex Policy	7.002
Reducing Substances	7.003
Ictotest	7.004
Urinalysis Quality Control	7.005

CHEMISTRY MANUAL CONTENTS

<u>PROCEDURE</u>	<u>NUMBER</u>
Acetaminophen	4.001
Albumin	4.002
Alkaline Phosphatase	4.003
Alanine Aminotransferase	4.004
Ammonia	4.005
Amylase	4.006
Aspartate Aminotransferase	4.007
Urea Nitrogen	4.008
Calcium	4.009
Carbamazepine	4.010
Chloride	4.011
Cholesterol	4.012
Creatine Kinase	4.013
Carbon Dioxide	4.014
Creatinine	4.015
Digoxin	4.016
Direct Bilirubin	4.017
Alcohol	4.018
Gentamicin	4.019
Y-Glutamyl Transferase	4.020
Glucose	4.021
Hemoglobin A1c2	4.022
HDL Cholesterol	4.023
Iron	4.024
Lactate	4.025
Lactate Dehydrogenase	4.026
Lipase	4.027
Potassium	4.028
Magnesium	4.029
Microalbumin	4.030

MISC. CHEMISTRY MANUAL CONTENTS

<u>PROCEDURE</u>	<u>NUMBER</u>
Beckman DXC 600i maintenance schedule	6.001
Beckman DXC 600i Daily	6.002
Beckman DXC 600i Weekly Maintenance	6.003
Beckman DXC 600i Twice-weekly Maintenance	6.004
Power Failure Procedure	6.006
Arterial Blood Gas	6.007
Venous Blood Gas	6.008
Ketone Testing	6.009
Triage Cal., QC, & patient testing	6.010

**ALAMEDA HOSPITAL
LABORATORY
DEPARTMENTAL POLICY AND PROCEDURE
TABLE OF CONTENTS
MICROBIOLOGY TESTS PROCEDURES**

I. General

1. Antimicrobial Susceptibility Testing
2. Microscan LAPRO Data Entry and Reporting
3. Microscan Gram Negative Panels
4. Microscan Gram Positive Panels
5. Microscan Microstrep
6. Prompt Inoculation
7. Microscan QC Charts
8. Beta Lactamase Test
9. Catalase Test
10. Indole Test
11. Oxidase Test

II. Stains

1. AFB Stain
2. Nocardia & Ascospore Stain
3. Gram Stain

III. Yeast Identification

1. India Ink Prep
2. Crypto LA Test
3. Bactocard Candida
4. Rapid Yeast Plus
5. Trehalose Assimilation Broth

IV. Enterics

1. Rapid NF
2. ESBL

V. Gardnerella

1. Reverse Satellite Test
2. V Agar

VI. Haemophilus

1. Haemophilus ID
2. ID Quad
3. Satellite Test
4. Haem. Test Medium

VII. Neisseria

1. Neisseria ID
2. M. Catarrhalis Disk

VIII. Staphylococcus

1. Staph ID
2. Coagulase Test
3. Bacti Staph Latex
4. MRSA
5. MH with Oxacillin

IX. Streptococcus

1. Strep ID
2. A Disk
3. Rapid Strep
4. Bactocard Strep
5. Bile Esculin
6. CAMP Test
7. P Disk
8. PYR test
9. Pathodx

- 10. Strep A Screen
- 11. VRE Confirmation
- 12. BHI with Va

X. Stools /Stool ID

- 1. Campylobacter
- 2. Hippurate
- 3. C. difficile Toxin A and B
- 4. E. coli 0157:H7
- 5. MacConkey Agar with Sorbitol
- 6. Salmonella – Shigella(Wellcolex)

XI. Saline Prep for Trichomonas & Yeast

XII. H. Pylori Antibodies

XIII. X/Pect Flu A and B

Reviewed by:		Reviewed by:	
Director of Laboratory Services	Date	Pathologist	Date

COAGULATION MANUAL CONTENTS

<u>PROCEDURE</u>	<u>NUMBER</u>
Quality Control - Coagulation	8.001
Operation of the Sysmex CA-560 (PT and APTT)	8.002
Internantional Normalized Ratio (INR)	8.003
Fibrinogen Determination	8.004
Fibrinogen Standard Curve	8.005
DIC Panel	8.006
Downtime Procedure – Coagulation	8.007
Critical Values	8.008

**CONTINUING MEDICAL EDUCATION PROGRAM
OF THE MEDICAL STAFF**

MISSION STATEMENT - 2010

GOALS:

The Medical Staff of Alameda Hospital is committed to providing Category I continuing medical education consistent with established accreditation standards which will update physicians' scientific knowledge, clinical knowledge and skills, practice efficiency, professional ethics, and knowledge and understanding of medical staff leadership. A coordinated linkage between quality improvement activities and the CME program will continue to generate opportunities for sustained improvements in clinical practice.

SCOPE:

The scope of the CME Program shall include:

- Health care issues related to patients admitted to Alameda Hospital as well as health care issues relative to our community patient population;
- Medico-legal topics, bioethics, behavioral education, socioeconomic and public health issues.
- Quality improvement, performance improvement, and utilization review

Except as may be exempt by State law, all courses shall include the appropriate cultural and linguistic competencies.

ADMINISTRATION:

The Chairman of the Continuing Medical Education Committee shall be responsible for overseeing all CME activities of Alameda Hospital.

Membership of the CME Committee shall include a broad physician representation of the physician constituency of the Medical Staff as well as representatives from Nursing, Quality Improvement and the Medical Library and other relevant professionals as may be appropriate. Members shall serve staggered terms to ensure continuity of the program.

ACTIVITIES:

The CME Program offers hospital-based conferences of one or two hours duration and may, based on need, offer courses lasting up to one or more days. Teaching methodology will include didactic, interactive, demonstration of techniques and panels.

EXPECTED RESULTS:

It is expected that participation in the CME activities at Alameda Hospital will result in improved medical knowledge, enhanced skills, practice improvement and overall ability to better provide the quality care expected by patients. It is expected that a significant number of learners will report that learning objectives have been met and/or that the learner intends to make a change in practice.

AUDIENCE:

Characteristics of potential participants in the CME Program shall include physicians who range in degree of specialization from tertiary care to specialists to primary care as well as other healthcare professionals.

>><<

Approved by: CME Committee: 02/03/10
Medical Executive Committee: 03/02/10
Board of Directors:



DATE: April 12, 2010
TO: Members of the Board of Directors
FROM: Alka Sharma, MD
Chairman, Medical Executive Committee
James Yeh, DO
Vice Chairman, Medical Executive Committee

SUBJECT: Proposed Revision to Medical Staff Rules and Regulations

The Medical Executive Committee respectfully requests your consideration in approving the proposed amendments to the following Medical Staff Rules and Regulations:

PROPOSED AMENDMENT

Table with 2 columns: TITLE and EFFECTIVE DATE. Row 1: ARTICLE 1: ADMISSION OF PATIENTS, 12/09/97, 06/12/01, 03/10/03, 10/06/08. Row 2: PAGE: 1 of 2

H. Dental and Podiatry Admissions

Dental and podiatry admissions require a history and physical examination written by a qualified physician with admitting privileges on the Medical Staff who will be responsible for the care of the patient's medical problems. The complete medical history and physical shall be recorded within one week prior to admission. Dentists and Podiatrists shall be responsible for recording the dental or podiatry medical history.

Explanation: Podiatrists are allowed by law to perform an admission history and physical. References to podiatry and/or podiatrist have been eliminated from this bylaw.

J. On-Call Hired Physicians

Physicians hired for on-call duty by members of the Alameda Hospital Medical Staff are intended to serve as a temporary but complete replacement for staff members insofar as the credentialing of on-call physicians allows. On-call physicians must be at least second year residents (PG2) with at least a rotating or medical internship. There must be a back-up staff physician available when an on-call physician is on duty.

Explanation: This practice is no longer in effect.

PROPOSED AMENDMENT:

Table with 2 columns: TITLE and EFFECTIVE DATE

ARTICLE 16: MEDICAL RECORDS	06/12/01 05/24/05 05/31/06 03/02/09 05/04/09
	PAGE: 1 of 5

H. ~~Attestation Statement~~

The DRG attestation statement is to be signed by the physician who has been most responsible for the care of the patient.

Explanation: CMS does not require physicians to sign DRG attestation statements.

K. Completion of Medical Record

The records of discharged patients are to be completed within fourteen (14) days following the date of discharge, with the following exceptions:

1. History and physical exam - completed within 24 hours of admission.
2. Procedure Report - completed immediately following the procedure
3. ~~Discharge Summary - completed within 14 days of discharge~~
4. ~~DRG Attestation - completed within 7 days of discharge~~
5. Post-op Anesthesia Note - completed within 72 hours after surgery, or prior to patient discharge, whichever occurs first.

Failure to meet these requirements results in the record becoming delinquent.

Explanation: Item #3 is redundant since records must be completed in 14 days; Item #4 is no longer required.

PROPOSED AMENDMENT:

TITLE:	EFFECTIVE DATE: 06/01/97
--------	-----------------------------

ARTICLE 20: ORDERS	06/12/01 05/12/03 11/10/03 07/12/04 07/09/07
	PAGE: 1 of 2

A. Requirements

4. All orders for medical care, for laboratory and X-ray examinations and for X-ray therapy, physical therapy and other types of treatment shall be in writing. Telephone orders are acceptable and must be dictated to an authorized person who must write the order, read back the order, and identify it as a telephone order per the Medical Staff member, who shall sign such orders within forty-eight (48) hours. **In those instances where the ordering practitioner may not be able to authenticate his or her telephone order(s), it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner.** Telephone orders shall reflect the date and time the orders are signed.

Explanation: The Joint Commission Standards have been revised to allow another physician who is also responsible for a patient's care to sign telephone orders made by another physician. Telephone orders are required by CMS and the Joint Commission to be signed within 48 hours. For various reasons, this was often difficult or impossible for the physician to sign his/her telephone order(s) within 48-hours. Now, however, the standards allow physician who is responsible for the patient's care to sign the telephone order.

C. Medication Orders

2. Certain drugs shall be automatically discontinued unless the order is renewed. The physician shall be notified prior to the discontinuation of any drug. The drugs and the time of discontinuation shall be determined by the Pharmacy and Therapeutics Committee.
- b. The following drugs shall be subject to automatic stop orders:
- 1) Narcotics: Seven (7) days
 - 2) Anticoagulants: Seven (7) days
 - 3) Antibiotics: Seven (7) days
 - 4) Ketorolac Injection: ~~Five (5)~~ **Three (3) days with a maximum course of therapy not to exceed five (5) days**
 - 5) All other drugs: Thirty (30) days

Explanation: Item #4 was revised to reflect the Pharmacy's policy on Ketorolac injection.

>><<

Date: April 12, 2010

To: City of Alameda Health Care District Board of Directors

From: Deborah Stebbins, Chief Executive Officer

Subject: Approval of Capital Expenditure for Acquisition of Kaiser Surgery Equipment

Recommendation:

Management recommends that the Board of Directors approve the capital expenditure of \$155,000 for surgery equipment purchased from Kaiser. This expenditure can be accommodated within the FY 2010 capital budget. The net cash impact of this expenditure will be \$81,050 due to offsetting reimbursement from Kaiser for prior purchases of surgical supplies.

Background:

As a part of the transition plan with Kaiser, management worked with the staff and physicians in Surgery to evaluate capital equipment that had been used by Kaiser during the term of the contract that would be useful for us to acquire and retain. For example, including an eye microscope, two phaco emulsifiers, and a video system, including a camera, monitor, light source. We were able to negotiate the acquisition of the equipment with Kaiser for a total price of \$155,000 which approximated fair market value for the used equipment but still represented a sizable savings for us compared to acquisition of the same equipment at today's prices.

At the same time, Kaiser owed us money for supplies we had purchased on their behalf during the end of the contract but remained unused. The total cost of supplies, which Kaiser took with them and for which we will be reimbursed was \$73,949.

Therefore the net cash owed to Kaiser by Alameda Hospital is \$81,050.