Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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DIRECTLY TO THE AGENDA ITEM MATERIALS IN THIS PDF

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Thursday, March 7, 2013

(PLEASE NOTE DATE AND START TIMES)

5:30 p.m. (CLOSED) | 8:00 p.m. (OPEN)

Location: Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501
Office of the Clerk: (510) 814-4001

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 (5:30 p.m. – Dal Cielo Conference Room) — J. Michael McCormick

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A.	Call to Order	
B.	Approval of Closed Session Minutes 1. January 9, 2013 2. February 6, 2013	
C.	Medical Executive Committee Report and Approval of Credentialing Recommendations	H & S Code Sec. 32155
D.	Board Quality Committee Report (BQC)	H & S Code Sec. 32155
E.	Discussion of Pooled Insurance Claims	Gov't Code Sec. 54956.95
F.	Consultation with Legal Counsel Regarding Pending and Threatened Litigation	Gov't Code Sec. 54957.6
G.	Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions	Gov't Code Sec. 54956.9(a)
H.	Discussion of Report Involving Trade Secrets	H & S Code Sec. 32106
	1. Discussion of Hospital Trade Secrets applicable to District's Strategy for Delivery of New Programs and Services No action will be taken. Estimated Date of Public Disclosure: *Not known at this time.*	
I.	Adjourn into Open Session	

V. Reconvene to Public Session (Expected to start at 8:00 p.m. – Dal Cielo Conference Room)

1

A. Announcements from Closed Session — J. Michael McCormick

VI. General Public Comment

VII. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

1) Approval of February 6, 2013 Meeting Minutes [enclosure] (PAGES 4-10)

✓ 2) Approval of Departmental Policies and Procedures [enclosure] (PAGES 11-24)

- Diagnostic Imaging
- Nuclear Medicine
- Mammography
- Infection Control

✓ 3) Approval of Administrative Policies and Procedures [enclosure] (PAGES 25-28)

- No. 4 - Plan for Provision of Patient Care Services
- No. 14 - Interdisciplinary Practice Committee
- No. 21 - Patient Identification and Communications for Clinical Care and Treatment
- No. 24 - Do Not Resuscitate (DNR)
- No. 26a - Non-Behavioral (Physical) Restraint Standards
- No. 26b - Behavioral Health Care Restraint Standards
  No. 28 - Sedation Management
- No. 32 - Transfer of Patients
- No. 43 - Hand-Off Communication
- No. 51 - Code Purple
- No. 54 Medical Staff Line of Responsibility
- No. 64 - Code 4 Rapid Deployment Plan
- No. 67 - Hospital Diversion
- No. 68 - Pain Management
- No. 69 - New Born Abandonment
- No. 84 - Color-Coded Wristband Use
- No. 90 - Universal Protocol

✓ 4) Approval of Annual Appointment to the Board Quality Committee for 2013
[enclosure] (PAGES 29-30)

✓ 5) Approval of Annual Appointment to the Finance and Management Committee for 2013
[enclosure] (PAGES 31-32)

B. Action Items

✓ 1) Acceptance of January 2013 Unaudited Financial Statements and February 27, 2013 Finance and Management Committee Report [enclosure] (PAGES 33-55) — Elliott Gorelick, Kerry Easthope

C. District Board President's Report INFORMATIONAL — J. Michael McCormick

D. Community Relations and Outreach Committee Report INFORMATIONAL — Jordan Battani

E. Medical Staff President Report INFORMATIONAL — Emmons Collins, MD

F. Chief Executive Officer Report INFORMATIONAL — Deborah E. Stebbins

✓ 1) Monthly CEO Report [enclosure] (PAGES 56-61)

- Employee Service Awards, Bay Area Bone and Joint Center, Capital Projects, Foundation/Community Relations and Outreach Update, Information Technology Update and Meaningful Use, Kate Creedon Center for Advanced Wound Care, DSRIP Report, Long Term Care, Stroke Program, Pharmacy, Quality / Risk Management, Fiscal Year 2013 Financial Forecast, Key Statistics – December 2012

✓ 2) Joint Commission Education [enclosure] (PAGES 62-73)

VIII. General Public Comments

IX. Board Comments

X. Adjournment

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Wednesday, February 6, 2013 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Robert Deutsch, MD J. Michael McCormick Elliott Gorelick Tracy Jensen*	Deborah E. Stebbins Kerry J. Easthope Brian Jung Karen Taylor, RN	Thomas Driscoll, Esq.	Lynn Bratchett Shubha Fanse Tracy Jensen* Terrie Kurrasch
		Medical Staff Present	Excused
		Emmons Collins, MD	
*Tracy Jensen was present for the meeting in its entirety but was not a Board Member until being officially sworn in.			
Submitted by: Erica Poncé, Administrative Secretary			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:01 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:02 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 6:05 p.m.	
A. Announcements from Closed Session Director Battani stated that the Board reviewed and approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken.			
Initial Appointments – Medical Staff			

Topic	Discussion		Action / Follow-Up	
	Name	Specialty	Affiliation	
	• Natalia Bruchanski-Gallagher, MD	Internal Medicine	AIM	
	• Carleton Nibley, MD	Cardiology	Private Practice	
Reappointments – Medical Staff				
	Name	Specialty	Staff Status	Appointment Period
	• Richard Brenner, MD	Radiology	Courtesy	03/01/13 – 02/28/15
	• Stephen Cady, MD	Emergency Medicine	Courtesy	03/01/13 – 02/28/15
	• Lisa Collins, MD	Anesthesiology	Active	03/01/13 – 02/28/15
	• Maria DeGuzman, MD	Anesthesiology	Courtesy	03/01/13 – 02/28/15
	• Robery Gingery, MD	Vascular Surgery	Active	03/01/13 – 02/28/15
	• Mei Po Kung, MD	Internal Medicine	Courtesy	03/01/13 – 02/28/15
	• Craig Leong, MD	Ophthalmology	Courtesy	03/01/13 – 02/28/15
	• B. Anne Parker, MD	Pediatrics	Active	03/01/13 – 02/28/15
	• Anthony Poggio, DPM	Podiatry	Active	03/01/13 – 02/28/15
	• Subhransu Ray, MD	Ophthalmology	Courtesy	03/01/13 – 02/28/15
	• Lee Shratter, MD	Radiology	Courtesy	03/01/13 – 02/28/15
	• Yong-Yong Tam, MD	Emergency Medicine	Courtesy	03/01/13 – 02/28/15
	• Jessie Xiong, MD	Pathology	Courtesy	03/01/13 – 02/28/15
Reappointments – Allied Health Professional Status				
	• Megan Palsa, PA-C	Physician Assistant		03/01/13 – 02/28/15
	• Jessie Xiong, MD	Pathology		03/01/13 – 02/28/15
Resignations				
	• Robbin Green-Yeh, DO	Internal Medicine		
	• Martha Tracy, MD	Hematology/Oncology		

Topic	Discussion	Action / Follow-Up
VI.	General Public Comments There were no comments.	
VII.	Interview and Appointment of New District Board Member Director Battani announced that candidates would be allowed to make an opening statement (up to three minutes), followed by a question period by the current Board of Directors. The candidates would also be allowed to make a closing statement (up to three minutes), at the conclusion of the interview. District Clerk, Kristen Thorson, drew names to determine interview order. Director Deutsch suggested that the discussion and decision process include a ranking of their individual choices for candidate appointment. Director Gorelick stated that there is no particular procedure which dictates the details of how the voting portion must happen.	Director Deutsch made a motion that Board Members vote for their choice of candidate by a rank order methodology, assigning a point value for their first pick for appointment as "1" and rank others in choice order, as an initial assessment. Director McCormick seconded the motion. Motion carried.
	A. Interview Candidates (in order of appearance) 1) Lynn Bratchett 2) Terrie Kurrasch 3) Shubha Fanse 4) Tracy Jensen During the interview phase, candidates were asked the following key questions regarding how their background lends to the strategic and business needs of the District (Director McCormick), how they would address someone who is of the opinion that the quality of care in the community would be better if the Hospital was closed (Director Gorelick), what role they see the District playing in the health and wellness of the community, solutions for the challenges the Hospital faces (Director Battani), and what challenges they have faced in the health care industry followed by what they learned and accomplished through those obstacles (Director Deutsch).	
	B. Discussion The existing Board Members discussed the candidates and various highlights of the interviews that influenced their ranking. They assigned the following ranking for their choice of candidate: Director Gorelick: 1. T. Jensen; 2. L. Bratchett; 3. T. Kurrasch; 4. S. Fanse Director McCormick: 1. T. Jensen; 2. T. Kurrasch; 3. L. Bratchett; 4. S. Fanse Director Deutsch: 1. T. Jensen; 2. L. Bratchett; 3. T. Kurrasch; 4. S. Fanse	

Topic	Discussion	Action / Follow-Up
	Director Battani: 1. T. Kurrasch; 2. T. Jensen; 3. L. Bratchett; 4. S. Fanse	
	C. After discussion as based on the ranked voting, the Board Members appointed Tracy Jensen to the Board of Directors.	Director Gorelick made a motion to appoint Tracy Jensen to fill the vacant seat on the Board of Directors. Director Deutsch seconded the motion. Motion carried.
	D. Swearing-In/Oath of Office of Appointed District Board Member District Clerk Kristen Thorson led the swearing-in, with newly appointed Director Jensen reading the Oath of Office.	
VIII.	**General Public Comments** There were no comments.	
Director Gorelick left the open session meeting after the interview and appointment process		
IX.	**Regular Agenda**	
	A. Consent Agenda 1) Approval of January 9, 2013 Meeting Minutes 2) Approval of Departmental Policies and Procedures • Respiratory Care Services • Rehabilitation Services • Respiratory Care Services • Rehabilitation Services 3) Approval of Administrative Policies and Procedures • No. 27 - Operative & Other Invasive Procedures • No. 39 – Health Record Content • No. 48 – Clinical Abbreviation List • No. 59a - Patient Choice in Discharge Planning • No. 59b - In-Home Assistance Options in Discharge Planning • No. 85 Anticoagulation Management Program 4) Acceptance of Report regarding Executive Performance Metrics and Incentive	Director Deutsch made a motion to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried.

Topic	Discussion	Action / Follow-Up
	Compensation Plan for FYE June 30, 2012: Special Project Incentive 5) Acceptance of December 2012 Unaudited Financial Statements	
B.	Action Items 1) Approval of Phase 2, Construction Expenses: Boiler Replacement Project to Comply with Bay Area Air Quality Management District regulations Brian Jung made a presentation to the Board, calling their attention to pages 43-50 of the Board Packet. Director McCormick asked if Management received bids from vendors in the City or County of Alameda. The vendor chosen has a main office in an outside county. Ms. Stebbins stated that there are a very limited number of vendors who specialize in this type of project. Director Jensen asked if the boiler would need to be replaced due to construction for seismic compliance. Management replied that the boiler will not need to be replaced due to construction and that the replacement of the boiler is long overdue. Director Jensen also asked if Management expects lower energy costs because of the new boiler. Mr. Jung replied that the new boiler is more energy efficient, more economical for the Hospital in the long-run, and releases fewer emissions. 2) Election of District Board Officers Director Battani worked with Board Members to establish a slate of Officers followed by a single vote. President – J. Michael McCormick 1st Vice President – Robert Deutsch, MD 2nd Vice President – Jordan Battani Treasurer – Elliott Gorelick Secretary – Tracy Jensen 3) District Board Committee Appointments Director Battani worked with Board Members to establish Committee Leadership, followed by a single vote. a. Community Relations and Outreach Committee	Director Jensen made a motion to approve the Phase 2, Construction Expenses: Boiler Replacement Project as presented. Director Deutsch seconded the motion. The motion carried. Director Battani made a motion to approve the Slate of Officers as stated. Director Deutsch seconded the motion. The motion carried. Director Battani made a motion to approve the District Board Committee Appointments as stated. Director Deutsch seconded the motion. The motion carried.

Topic	Discussion	Action / Follow-Up

- Jordan Battani, Chair
- Tracy Jensen, Voting District Board Member

b. Finance and Management Committee

- Elliott Gorelick, Chair
- Robert Deutsch, MD, Voting District Board Member

c. Board Quality Committee

- Robert Deutsch, MD, Chair
- Tracy Jensen, Voting District Board Member

C. Chief Executive Officer Report

1) Monthly CEO Report

Ms. Stebbins provided an overview of the information found in her written report (beginning on page 60 of the Board Packet): Bay Area Bone & Joint Center, Capital Projects, Community Relations and Outreach Update, Key Statistics – January 2012, Information Technology Update and Meaningful Use, Human Resources, Kate Creedon Center for Advanced Wound Care, DSRIP Report, and Long Term Care.

Ms. Stebbins added that the Hospital is expecting a Joint Commission survey in 2013, and preparations include a "Joint Commission Compass" booklet which will be printed and distributed to staff, volunteers, and District Board Members. There was a short discussion about Management exploring options for increased capacity of HBOT treatments at the Kate Creedon Center for Advanced Wound Care, including the addition of a third HBOT unit.

2) Ms. Stebbins provided an overview of the FY2013, 2nd Quarter Goals and Objectives Update, calling attention to pages 65-73 of the Board Packet. She highlighted that after only two quarters, the year-end objectives for Waters Edge are already being met. Quality core measures are being closely monitored and readmission rates are being tracked. Ms. Stebbins introduced Karen Taylor, the new Director of Quality Risk Management.

Topic	Discussion	Action / Follow-Up
	Ms. Stebbins thanked Director Battani for the time given as President of the District Board, adding that she enjoying learning from Director Battani's mentorship.	
F.	Medical Staff President Report Dr. Collins invited Board Members to the February CME programs for February. Each event begins at 12:30 p.m. in the Dal Cielo Conference Room. • Tuesday, February 12, 2013: "Blood So Mad, Feels Like Coagulating" by Bradley Lewis, MD • Tuesday, February 26, 2013: "Challenges and Opportunities for Tuberculosis Treatment and Control – Alameda County 2013" by Sandra Huang, MD	No action taken.
I.	**General Public Comments** There were no comments.	
II.	**Board Comments** Director Battani stated that although the incentive compensation was not awarded due to not meeting the financial metrics, the staff has made monumental efforts in this past year. The new programs which were put into place in the past year are doing well, with Waters Edge far surpassing expectations. Director Battani extended her gratitude to the Management Staff for their hard work and dedication. Director McCormick added his thanks to the Management staff who have worked tirelessly to get the newest programs started. Director Jensen announced that there will be a League of Women's Voters Health Care Forum on February 28, 2013 at 7:00 p.m. at the Mastick Senior Center in Alameda. Ms. Stebbins along with David Sayen, CMS Regional Administrator, and David Brown with Gallagher Insurance, will discuss what recent and future health care reform means to residents of Alameda.	
III.	**Adjournment**	Being no further business, the meeting was adjourned at 8:52 p.m.

Attest:

J. Michael McCormick
President

Tracy Jensen
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 27, 2013

FOR: March 7, 2013 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Deborah E. Stebbins, CEO
Kristen Thorson, District Clerk

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 Department / Service:

1. Diagnostic Imaging
2. Nuclear Medicine
3. Mammography (Quality Control / Quality Assurance)
4. Infection Control

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, table of contents from the department's policy and procedure manual is attached.

Discussion:

The Departmental Manuals are available for your review at any time through Administration.

ALAMEDA HOSPITAL
DEPARTMENT OF DIAGNOSTIC IMAGING

TABLE OF CONTENTS

Continued

PATIENT SAFETY

29. Safety – Patient & Visitor
30. Safety – Radiation
31. Fall Risks
32. Annunciator Protocol
33. Latex Allergies
34. ALARA Program
35. Radiation Safety Committee & Radiation Safety Officer
36. Radiation Safety Rules
37. Radiation Safety – Surgical Personnel
38. Radiation Safety – Nursing & Respiratory
39. Personnel Monitoring
40. Statements of Radiation Exposure
41. Statements Regarding Aprons & Gloves (Protective Equipment)
42. DHS Notice to Employees
43. Radiation Safety Instructions
44. Loss of Personal Dosimeter – Form
45. Acquisition of Dosimetry Records from Other Employers - Form

PERSONNEL

46. License
47. Qualifications
48. Personnel Retention
49. Surgical Protocol
50. Pregnancy Protocol
51. Department Security
52. Emergency Plan
53. Pyramid Phone System
54. Safe Work Practices in Imaging
55. Department & Hospital Personnel Policy
56. Safety – Departmental Personnel & Equipment
57. Safety – Electrical
58. Hospital Dress & Grooming Policy
59. Purchase Order Protocol
60. Daily Procedure Guide for Volunteers
61. Age Specific Competency test
62. Summary and Explanations Relating to Rad Tech Regs

Continued

MOBILE MRI

63. Alliance Imaging Services:

    a. Mission Statement
    b. MRI Guidelines
    c. Screening Forms
    d. Code Blue Response in the MRI Van
    e. Patient Safety and Personnel Safety
    f. Fire / Disaster
    g. Infection Prevention & Control
    h. Administration of Parenteral Medications
    i. Guidelines for the Use of Non-Ionics
    j. Pre-Medication Protocol
    k. Contrast Reaction Kit
    l. Diagnostic Contrast Material List
    m. Venipuncture
    n. Scope of Service
    o. Magnetic Field Strength Notification
    p. QA Plan

64. Certificate of Review & Approval for MRI P & P / QA Manual
65. Unit Information

INFORMATION MANAGEMENT

66. Patient Data
67. Patient Reports
68. Teleradiography Protocol
69. FAX Policy & Form
70. Film Release Procedures
    a. Copy Procedures
    b. Film Release Form
    c. Forms & Stickers Used
    d. Retention Statement

71. Film / Jacket Classifications & Labeling
72. Film Retrieval – Form

Continued

FORMS - Include, but are not limited to:

a. Consents
b. Invasive Procedures
c. Contrast Information
d. Mammography History
e. MRI Screening
f. Record Release
g. Authorization for Release of Films

CONTRAST

73. Control of Radiographic Contrast
74. Administration of Medication
    a. Guidelines for the Use of Non-Ionics
    b. Pre-Medication Protocol
    c. Metformin Notification
    d. Contrast Reaction Kit(s)

75. Diagnostic Materials List

CRASH CART

76. Emergency CRASH Cart
77. Procedures for Checking the Cart & Forms
78. Compresses Gas Memo

EDUCATION / ORIENTATION

79. Education – Hospital
80. In-Service Education – Hospital
81. Department Education
82. In-Services via Staff Meetings
83. Orientation of Personnel
84. Safety Training

Continued

EQUIPMENT

85. Lock-Out/Tag-Out Procedures
86. Equipment Safety
87. Preventive Maintenance
88. Electrical Safety
89. Equipment Disruptions
90. Utility Failures
91. Protocol for Modus Pressure Monitor, Rm 4 & Form
92. Medical Device Reporting
93. Medical Alerts & Drug Recalls
94. Operating and Emergency Procedures
95. Equipment List

QUALITY CONTROL

96. Quality Control in Imaging
97. Quality Assurance – Fluoroscopy
98. Quality Control Weekly Checks
99. Repeat Analysis
100. Mammography – refer to Mammo Binders

JOB DESCRIPTIONS

101. Director
102. Supervisor
103. Radiologic Technologist
104. Ultrasound Technologist
105. Nuclear Medicine Technologist
106. Bone Density Technician
107. Lead Radiology Aide
108. Imaging Receptionist
109. Radiology Aide

PATIENT PREPARATION – ADULT, Volume 2

PATIENT PREPARATION – CHILD, Volume 2

CONTINUOUS IMPROVEMENT – See CI Binder

INFECTION CONTROL – See Infection Prevention Binder

TABLE OF CONTENTS:
MAMMO QA BINDER

TABLE OF CONTENTS

MAMMOGRAPHY
QUALITY CONTROL

6	**Repeat Analysis** a. Forms b. Documents	
7	**Equipment** a. Equipment List b. Equipment Record Retention Policy c. Cassette List d. Error Indication List e. Kodak Service Bulletin – Processor f. Kodak Service Bulletin - Film	

ALAMEDA HOSPITAL
DEPARTMENT OF DIAGNOSTIC IMAGING
Nuclear Medicine Section

TABLE OF CONTENTS

Continued

RADIATION SAFETY PROCEDURES

27. Requirements for Maintaining the Laboratory
28. Radiation Safety Rules
29. ALARA Program
30. Radiation Safety Committee & Radiation Safety Officer
31. Control of Radiopharmaceuticals
32. Receipt of Radioactive Shipments
33. Transport of Radioactive Material
34. Preparation, Handling, and Administration of Radioactive Material
35. Storage/Staging of Radioactive Material
36. Radiation Waste Management
37. Waste Disposal Regulations
38. Personnel Monitoring
39. Personnel Monitoring – I-131
40. Management of Acute Radiation Exposure Accidents
41. Radioactivity Contamination – Emergency Room Orders
42. Radiation Accidents / Decontamination Procedures
43. Radiation Safety Precautions for 89-Sr / Radiation Notice
44. Management of Sealed Sources
45. I-131 Dose Preparation / Bioassay Procedure
46. Therapeutic Use of Radiopharmaceuticals
47. Misadministration Form
48. Notice to Employees
49. Loss of Personal Dosimeter – Form
50. Acquisition of Dosimetry Records from Other Employers - Form

NURSING INFORMATION

51. In-Patient Radioiodide Therapy – Nursing Instructions & Forms
52. Radiation Safety Procedures – Nursing & Respiratory

PERSONNEL

53. License
54. Qualifications
55. Personnel Retention
56. Pregnancy Protocol
57. Department Security
58. Hospital Dress & Grooming Policy
59. Nuclear Medicine Emergency Plan
60. Pyramid Phone System
61. Safe Work Practices in Imaging
62. Department & Hospital Personnel Policy
63. Safety – Departmental Personnel & Equipment

Continued

64. Safety – Electrical
65. Age Specific Competency Test
66. Competency & Appraisal Assessment Form
67. Technologist Qualification - Venipuncture
68. Daily Procedure Guide for Volunteers

CONTRACTED SERVICES

INFORMATION MANAGEMENT

69. Patient Data
70. Patient Reports
71. FAX Policy & Form
72. Film Release Procedures
    a. Copy Procedures
    b. Film Release Form
    c. Forms & Stickers Used
    d. Retention Statement

RECORD & FORMS - Include, but are not limited to:

a. Instructions for Use
b. QC Instructions
c. Patient Thyroid Scan Questionnaire
d. Patient Bone Scan Questionnaire
e. Worksheet / Forms / Department Map
f. Sealed Source Inventory Disposal - Form

EDUCATION / ORIENTATION

73. Education – Hospital
74. In-Service Education – Hospital
75. Department Education
76. In-Services via Staff Meetings
77. Orientation of Personnel
78. Safety Training

Continued

EQUIPMENT

79. Lock-Out/Tag-Out Procedures
80. Equipment Safety
81. Preventive Maintenance
82. Electrical Safety
83. Equipment Disruptions
84. Utility Failures
85. Protocol for Modus Pressure Monitor, Rm 4 & Form
86. Medical Device Reporting
87. Medical Alerts & Drug Recalls
88. Operating and Emergency Procedures
89. Equipment List

QUALITY CONTROL

90. Quality Control – General
91. Daily Survey List – Weekly Wipe Test
92. Nucelar Medicine Area Map
93. QA – Dose Calibrator

JOB DESCRIPTION

CONTINUOUS IMPROVEMENT – See CI Binder

INFECTION CONTROL – See Infection Prevention Binder

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 27, 2013

For: March 7, 2013 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer
Kristen Thorson, District Clerk

Subject: Approval of Administrative Policies and Procedures

Recommendation:

Management requests approval of the following Administrative policies and procedures.

No. 4 - Plan for Provision of Patient Care Services	
Minor changes to reflect current services.	
Purpose:	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. 14 - Interdisciplinary Practice Committee	
No changes.	
Purpose:	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.
No. 21 - Patient Identification and Communications for Clinical Care and Treatment	
Minor updates.	
Purpose:	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 - Do Not Resuscitate (DNR)	
No changes.	
Purpose:	The standard of care at this hospital requires initiating cardiopulmonary resuscitation whenever a patient suffers a cardiac or respiratory arrest

	unless there is a written order to the contrary pursuant to this policy. For some patients, especially those who suffer from a terminal illness and are incurable, resuscitation may be inappropriate. 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. Consideration of a patient's resuscitation status may be prompted by the patient, family, consensus of the attending physicians, or the nursing staff. In circumstances where there is a disagreement about whether DNR Orders should be written, a consultation with the Alameda Hospital Ethics Committee may be sought or Alameda County Office of the Public Guardian's Policy on End-of-Life Medical Decision-Making for Probate Conservatees
No. 26a - Non-Behavioral (Physical) Restraint Standards	
Updates to reflect current practices.	
Purpose:	To outline nursing care and management of patients requiring non-behavioral (physical) restraints.
No. 26b - Behavioral Health Care Restraint Standards No. 28 - Sedation Management	
No changes.	
Purpose:	To outline nursing care of patients requiring physical restraint for behavioral health care management
No. 32 - Transfer of Patients	
No changes.	
Purpose:	To assure that hospitals meet the requirements established by federal and state governments for safe and timely transfer to another facility.
No. 43 – Patient Experience Surveys	
Updates to reflect current practices.	
Purpose:	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. 43 - Hand-Off Communication	
No changes.	
Purpose:	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.
No. 51 - Code Purple	

Minor updates to reflect current practices.	
Purpose:	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.
No. 54– Medical Staff Line of Responsibility	
Annual update of Medical Staff Line of Responsibility	
Purpose:	To provide medical staff and hospital personnel with a current list of the names of the medical staff members to contact whenever questions or problems arise concerning medical staff matters.
No. 64 - Code 4 Rapid Deployment Plan	
Minor updates to reflect current practices.	
Purpose:	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. 67 - Hospital Diversion	
No changes.	
Purpose:	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	
Minor updates to reflect current practices.	
Purpose:	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	
Minor updates.	
Purpose:	Effective January 1, 2001, California Law (SSB Law) provides immunity from 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 stature does not provide immunity from personal injury or wrongful death, including malpractice claims. [Health and Safety Code §1255.7g]
No. 84 - Color-Coded Wristband Use	
No changes.	
Purpose:	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. 90 - Universal Protocol	
Updates to reflect current practices.	
Purpose:	To provide a standardized approach throughout the hospital to ensure correct identification of patients, correct procedures are performed, the correct procedural site is identified, and a timeout takes place which is documented.

BACKGROUND:

The Joint Commission tri-annual accreditation survey is scheduled for Spring, 2013. In preparation for this survey, the hospital has begun its review of all Administrative Policies and Procedures. All Administrative policies and procedures will be brought to the Board of Directors for approval.

The policies and procedures are either new or have been revised to reflect current practices, regulatory language / requirements and/or other pertinent information as indicated above. Each policy and procedure has been reviewed by the appropriate Medical Staff Committees, Hospital Committees, Management Team, and Administration.

Policies and Procedures are available for review upon request from Administration.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 27, 2013

For: March 7, 2013 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

Through: Board Quality Committee

From: Robert Deutsch, MD, Chair – Board Quality Committee

Subject: Recommendation for Annual Appointment to Board Quality Committee

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RECOMMENDATION:

The Board Quality Committee recommends the following slate of committee members be reappointed for calendar year 2013.

Medical Staff Representation	Name	Voting Member
Medical Staff President	Emmons Collins, MD	✓
Hospitalist Representative	Jim Yeh, DO	✓
QRM Medical Director	Alka Sharma, MD	✓
Medical Staff At-Large Representative	Joseph Marzouk, MD	✓

BACKGROUND:

The Board of Directors, on February 6, 2013, appointed myself, Robert Deutsch, MD as Chair of the committee and newly appointed District Board member Tracy Jensen as the second voting member from the Board of Directors. Per the approved committee structure, committee membership shall be appointed annually.

The following structure has been approved by this committee as well as the District Board of Directors.

1. Board Quality Committee:

    a. Primary Purpose:

        i. To review monitoring activity and accept or reject the periodic summary of performance improvement data submitted by the Performance Improvement Committee (PIC).

ii. To assure the measurements, assessments and improvements are consistent with the design of the Performance Improvement Program and the hospital's mission, vision and values.

b. Committee Composition and Voting Rights: The committee shall be comprised of the following members:

i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee.

ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting member, unless the President is serving as a voting member of the committee.

iii. Up to four members of the Alameda Hospital Medical Staff (physicians) all of whom shall be voting members of the committee as designated below. In instances where a physician qualifies as one or more of the following designations, an additional physician will not be needed.

1. Medical Staff President
2. Hospitalist Representative
3. Quality Resource Management Medical Director
4. Medical Staff At-Large Representative

iv. The City of Alameda Health Care District Chief Executive Officer, Chief Financial Officer, Associate Administrator, Director of Quality Resource Management, and Executive Director of Nursing Services, and other hospital management as delegated, who shall not be voting members of the committee.

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: Committee shall meet monthly.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 27, 2013

For: March 7, 2013 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

Through: Finance and Management Committee

From: Elliott Gorelick, Chair – Finance and Management Committee

Subject: Recommendation for Annual Appointment to Finance and Management Committee

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RECOMMENDATION:

The Finance and Management Committee recommends the following slate of committee members be reappointed to the Finance and Management Committee (FMC) for calendar year 2013.

	Name
Medical Staff Representative	William Sellman, MD
Medical Staff Representative	Emmons Collins, MD
At Large Representative	Ann Evans
At Large Representative	Ed Kofman

The Finance and Management Committee will be reviewing potential candidates for the third at-large representative position on the committee in future months.

BACKGROUND:

The Board of Directors, on February 6, 2013, appointed Elliott Gorelick as Chair of the committee and Robert Deutsch, MD as the second voting member from the Board of Directors. Per the approved committee structure, committee membership shall be appointed annually.

The following structure has been approved by this committee as well as the District Board of Directors.

1. Finance and Management Committee:

    a. Primary Purpose: The primary purpose of the Finance and Management Committee is to review and recommend the annual budget, review performance relative to budget, and review other aspects of the district's financial performance. The Committee shall also serve the function of reviewing the annual report from the Hospital's external auditor, including the annual presentation of audit findings. The committee may also review and advise regarding operational issues, management systems issues, management information systems, and other aspects of the district's overall operational management.

    b. Committee Composition and Voting Rights: The committee shall be comprised of the following members:

        i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee.

        ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting member, unless the President is serving as a voting member of the committee.

        iii. Two members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.

        iv. Up to three at large members chosen for expertise needed by the district each of whom shall be voting members of the committee.

        v. The City of Alameda Health Care District Chief Executive Officer, Chief Financial Officer, and other hospital management as delegated, who shall not be voting members of the committee.

    c. Terms: The committee shall be appointed annually.

    d. Meeting Frequency: Committee shall meet monthly.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING JANUARY 31, 2013

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
JANUARY 31, 2013

Table of Contents **Page**

ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
JANUARY, 2013

The management of 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 January 31, 2013 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.

Highlights

Overall for the month of January, the hospital experienced a combined negative net operating loss of $395,000 against a budgeted gain of $101,000. Year to date the hospital shows a loss of $1.06 million compared to a budgeted loss of $306,000. Waters Edge remains steady with a positive net contribution of $217,000 and a year to date contribution of almost $1.7 million. Wound Care had another busy month in January as the number of visits has increased. The program's net contribution however fell below budget by $9,505 in January but is still $34,623 better than budget year to date.

There are two major contributors to lower Net Revenue in January that will be discussed in more detail as part of the Revenue discussion section of this narrative. One adjustment was the result of notification of an overpayment ($485,000) from TriCare back in July 2012 for services provided in prior fiscal year, and the second is the true up of two specific payor accounts: HealthComp for hospital covered employee and dependents that receive care at Alameda Hospital ($134,000) and reclassification and valuation of Kaiser cosmetic cases performed at Alameda during the past 6 months ($173,000).

Off setting the above adjustments in part, is notification that the hospital has qualified for Acute Disproportionate Share Funds (DSH) for fiscal year 2010, that are to be paid in FY 2013 and a portion in October (FY 2014). The total amount to be received is $225,000 and this has been recorded as a receivable in January. The first $132,000 of this is scheduled to be paid in February.

January discharges were 25 or 9.2% above budget and total patient days were 21 or 0.4% greater than budget. More discharges and more patient days brings the acute ALOS back down below budget at 3.9. Total patient days for inpatient acute services were up 6.1%; subacute days were down 2.3%, skilled nursing days were up at South Shore by 11.2% and Waters Edge were down by 2.8%.

Overall outpatient activity was mixed again this month. Outpatient registrations were down 5.6% and emergency room visits were 256 or 18.0% above budget. Outpatient surgeries were below budget for the month by 19 or 13.6%.

The Wound Care program had 356 visits in January compared to a budget of 200, or 78.0% above budget. In January there were 57 HBO treatments compared to 76 in December.

Total gross and net revenue in January was generally in line with activity. The overall inpatient component was above budget by 2.2% and outpatient was up 4.2%.

The overall Case Mix Index (CMI) in January was 1.2999; lower than last month's of 1.3197 and below the FY 2013 year-to-date of 1.3475.

Overall expenses were almost $7.2 million in January, $180,000 or 2.6% above budget.

Temporary agency fees, benefits and professional fees were over budget while other categories were close to or just under budget. These variances will be discussed in more detail later in the narrative. As previously discussed, the FY2013 temporary agency budget was understated by about $40,000 per month and we will strive to overcome this variance with positive revenue and/or expense reductions as the year progresses.

The hospital did receive $365,000 from the State of California to help in the implementation of our electronic medical record. This is recorded under Other Operating Revenue on the Statement of Operations.

Cash and cash equivalents were $5 million at the end of January down from $6 million at the prior month end. Cash collections in January were $5.4 million. Net accounts receivable increased by $700,000 to $11.1 million.

Accounts payable and other accrued expenses decreased by $135,000 from $10.9 million to almost $10.8 million. Much of this increase is a result of the holiday and timing of processing accounts payable payments.

Lastly, the current ratio dropped slightly to .94 just below the required 1.0 of our bank covenants. Total Assets have dipped to $6.0 million from the 6.4 million at the end of the prior month.

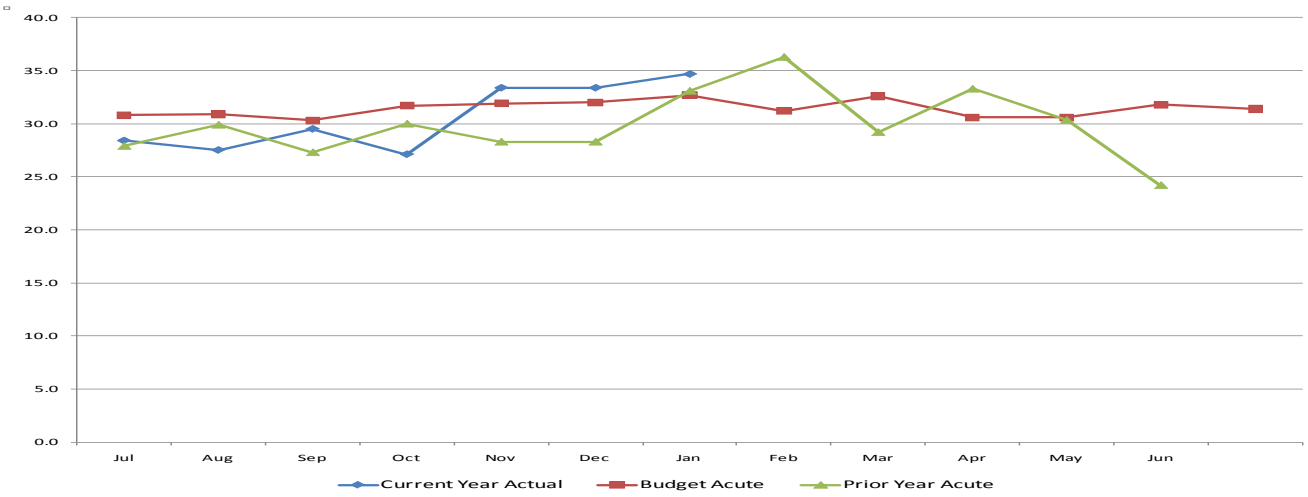
ACTIVITY

ACUTE, SUBACUTE AND SNF SERVICES

Overall, patient days were again 0.4% above budget for the month and just above January of last year. This month's acute days were above budget by 6.1%, Subacute was down 2.3%, South Shore was up 11.2% and Waters Edge was down 2.8%.

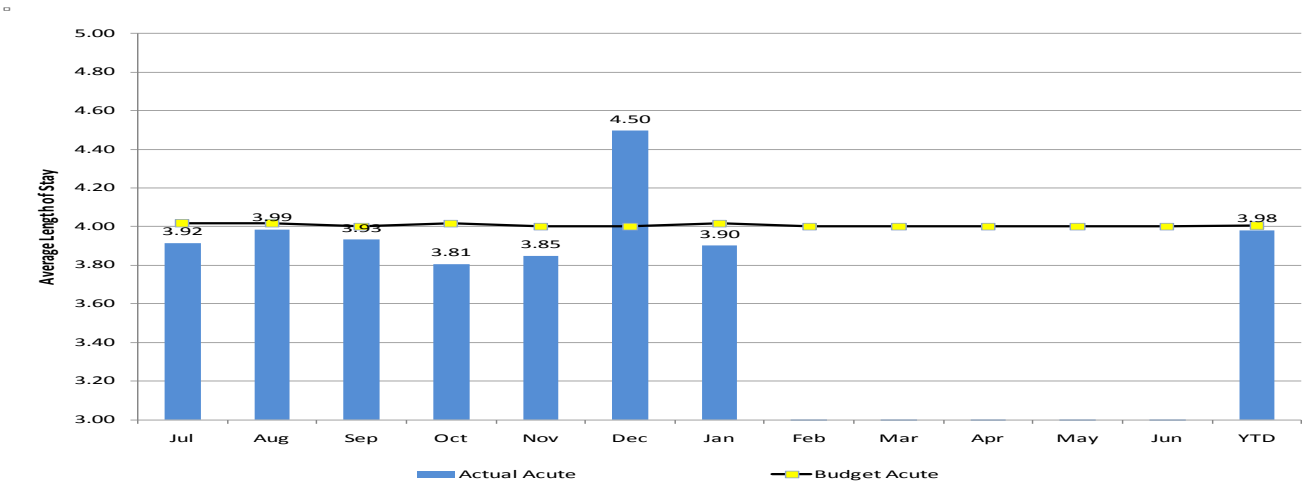
January's acute patient days were 62 days or 6.1% higher than budget for the month and 4.1% higher than January 2012. The acute care program is comprised of the Critical Care Unit (4.9 ADC, 6.3% above budget), Telemetry / Definitive Observation Unit (14.6 ADC, 24.9% above budget) and Med/Surg Unit (15.3 ADC, 7.2% below budget).

Acute Average Daily Census



The acute Average Length of Stay (ALOS) decreased from 4.5 in December to 3.9 in January and is below the budget of 4.02. The YTD acute ALOS for FY 2013 is 3.98. The graph below shows the ALOS by month compared to the budget.

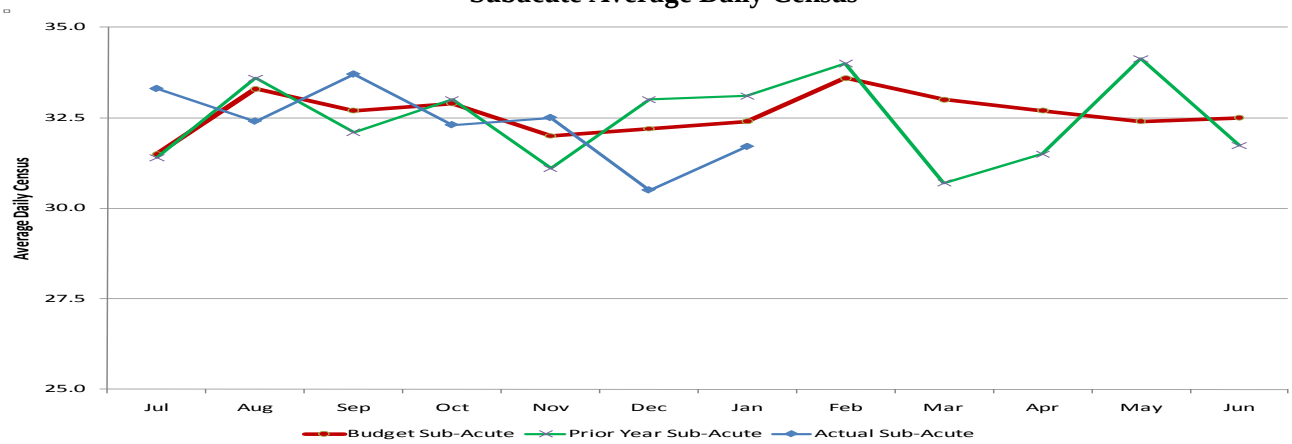
Acute Average Length of Stay



The Subacute program ADC of 31.68 was below budget by 0.74 ADC or 2.3%. The graph below shows the Subacute ADC for

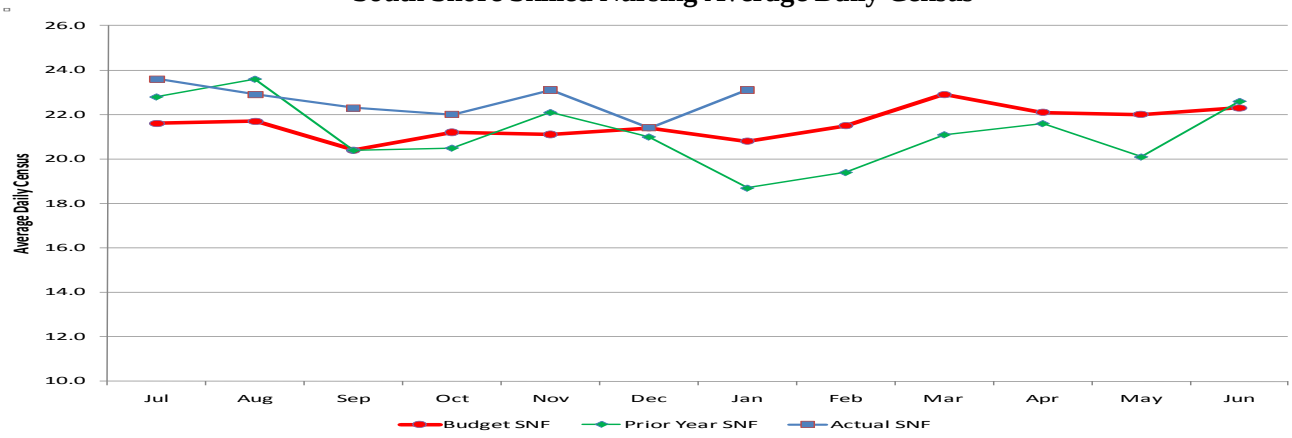
the current fiscal year as compared to budget and the prior year. We purposely postponed new admissions to the subacute unit during our week long annual State survey. Census has since resumed previous levels.

Subacute Average Daily Census



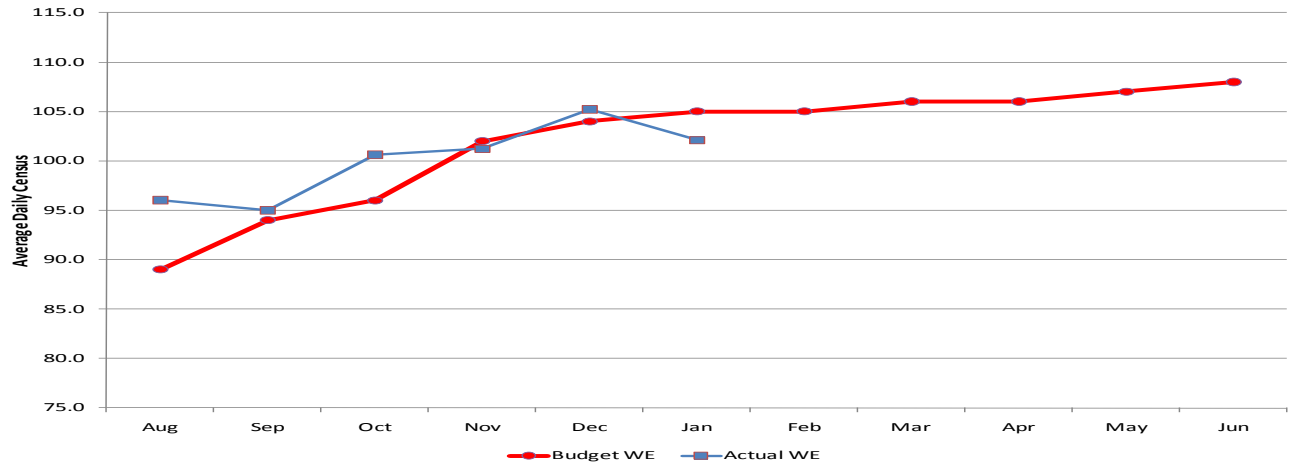
The South Shore ADC was above budget by 72 patient days (11.2%) for the month of January. The graph below shows the South Shore monthly ADC as compared to budget and the prior year. In January the number of Medicare A skilled patients was 2.35 ADC, up from 1.6 ADC in December but still lower than budget of 3.95.

South Shore Skilled Nursing Average Daily Census



Waters Edge census was 102.1 ADC or 2.8% below budget of 105 in January. The Medicare census was 10.5 ADC up from 9.4 ADC in the prior month, but below the Medicare ADC budget of 15.0.

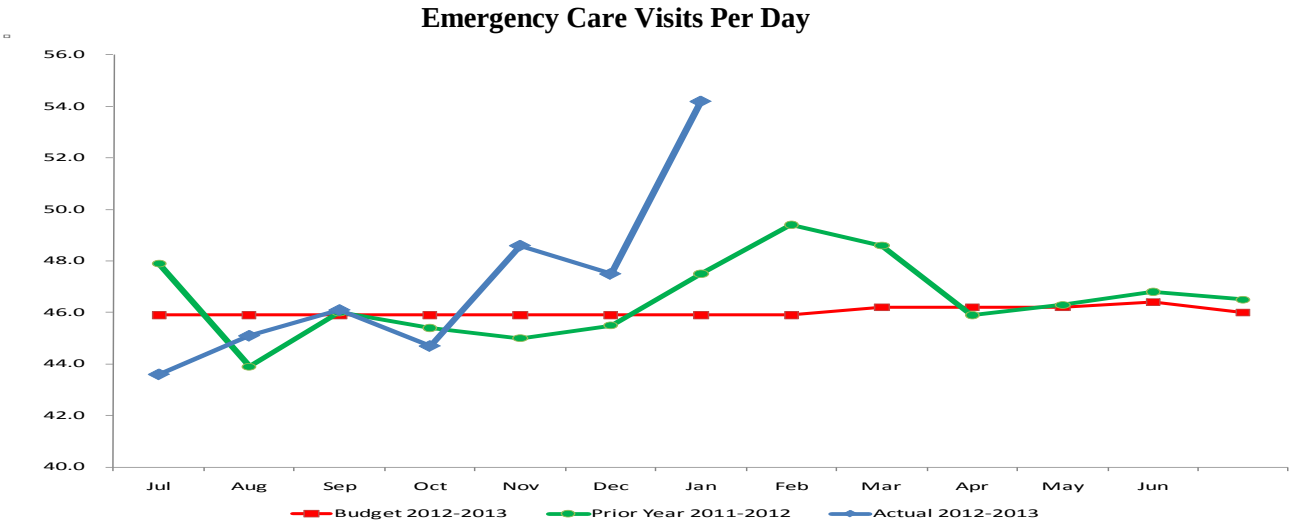
Waters Edge Skilled Nursing Average Daily Census



ANCILLARY SERVICES

Outpatient Services

Emergency Care Center (ECC) visits in January were 1,679, and 256 visits (18.0%) above the budget of 1,423. The inpatient admission rate from the ECC was 16.8% just down from the 17.4% in December. On a per day basis, the total visits represent an increase of 14.1% from the prior month daily average. In January, there were 384 ambulance arrivals versus 316 in the prior month. Of the 384 ambulance arrivals in the current month, 254 or 66.2% were from Alameda Fire Department (AFD).

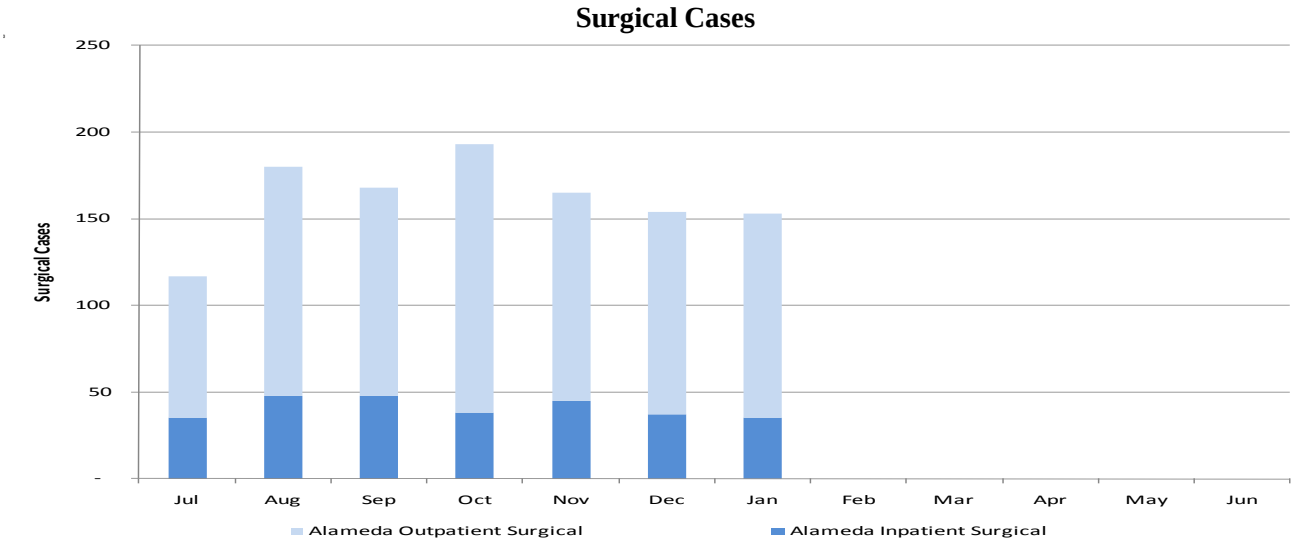


Outpatient registrations totaled 2,040 or 5.6% below budget. This month visits in Physical Therapy, CT, MRI and Radiology were down 216, 12, 26 and 289 visits respectively. However, visits were up in EKG (13 visits), Occupational Therapy (45 visits), and Wound Care (72 visits). Starting in December and going forward, the budget for Physical Therapy and Radiology Services assumes significant increases from referrals by our two new orthopedic physicians. Work is being done to help streamline the referral and registration process of orthopedic clinic patients needing follow up ancillary services at the hospital. In January there were 249 Therapy referrals and 101 Imaging referrals, up from 57 and 54 respectively in December.

In January, Wound Care again exceeded the budget of 200 with 356 visits, or 78% over budget. Hyperbaric Oxygen treatments accounted for 57 of those visits, compared to 76 in December.

Surgery

The surgery cases for January were 157 or 19.5% below the budget of 195 but above last year's case volume of 151. Inpatient cases were below budget by 19 cases (34.5%) and outpatient also had 19 cases (13.6%) below budget. Inpatient and outpatient cases totaled 36 and 121 respectively versus 37 and 117 during the prior month.



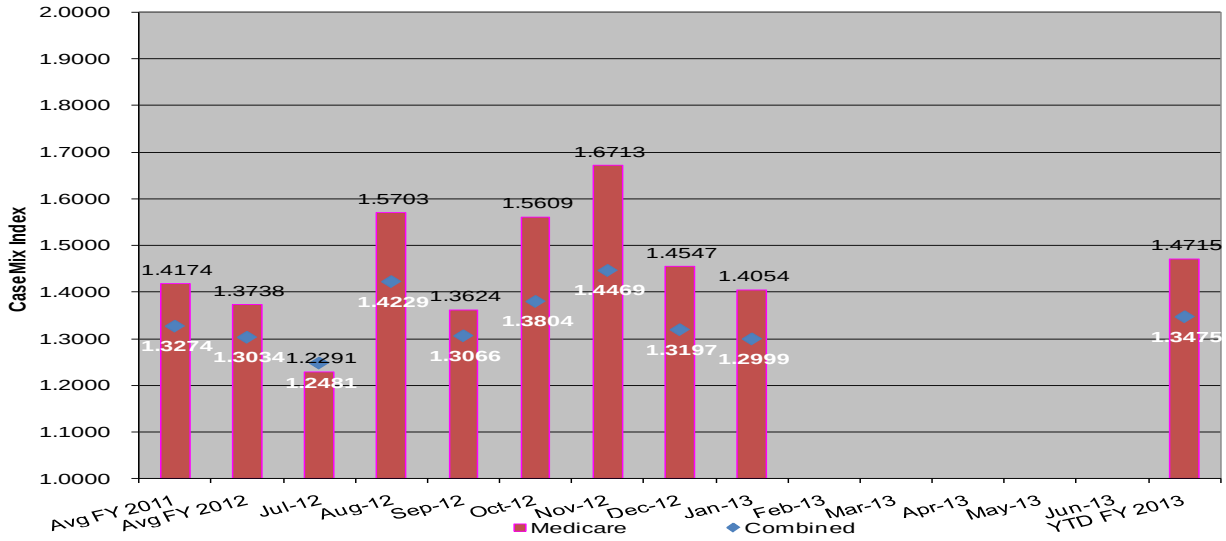
Payer Mix

The Hospital's overall payer mix compared to budget is illustrated below. This is inclusive of the Waters Edge revenue.

	Jan Actual	Jan Budget
Medicare	48.5%	46.4%
Medi-Cal	26.0%	27.4%
Managed Care	14.4%	15.9%
Other	2.7%	3.0%
Commerical	1.1%	2.9%
Self-Pay	7.2%	4.4%
Total	100.0%	100.0%

Case Mix Index

The Hospital's overall Case Mix Index (CMI) for January was 1.2999, down from the prior month of 1.3197. The Medicare CMI was 1.4054 in January. This is just below last month's but still a strong number. The graph below shows the Medicare CMI for the Hospital during the current fiscal year as compared to the prior two years.



Revenue

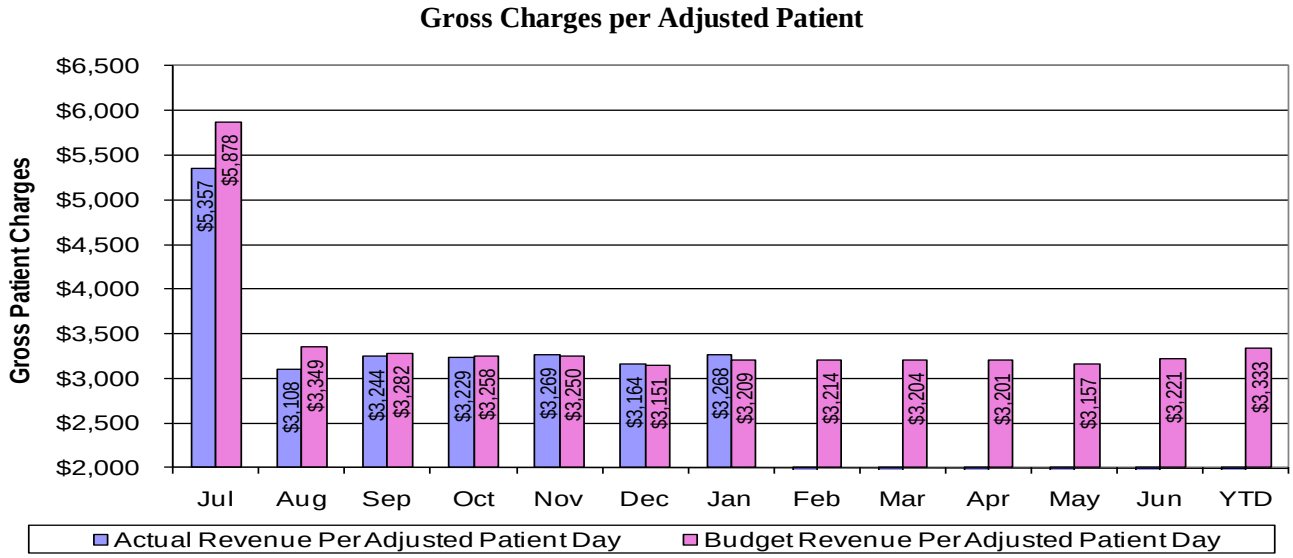
Gross patient charges in January were over budget by $763,000, or 2.8%. Inpatient revenues were $420,000 above budget and outpatient revenues were down $343,000. Acute inpatient days were above budget by 6.1% and acute gross revenue was up 4.1%. Overall inpatient ancillary service charges were mixed contributing to the inpatient gross revenue being higher than budget, charges for inpatient Medical Supplies, Laboratory and Respiratory Therapy were above budget while Surgery, Imaging and Rehab were down.

Waters Edge gross and net revenue were right below budget in January consistent with the volume. The ancillary revenue was lower than budget along with the routine daily room and board revenue, and net revenue came in under budget due to lower census overall and in particular for the Medicare patient activity, 30% below budget.

Outpatient gross revenues were higher than budget by $343,000 (4.2%). Pharmacy and Imaging were again below budget while the clinics (Wound Care in particular), Emergency and Laboratory were above budget. The new orthopedic practice anticipated increases in Imaging, Rehab Services and Surgery, these volumes and referral patterns are climbing. These areas have started a little slower than we have projected in the budget, but they are growing steadily.

Wound Care volume was above budget with the gross revenue exceeding budget by $128,000 due to another busy month, resulting in Net Revenue coming in again better than budget by $18,600 for the month, and $158,700 year to date.

On an adjusted patient day basis, total patient revenue was $3,268 just above the budget of $3,209 for the month of January. The table below shows the Hospital's monthly gross revenue per adjusted patient day by month and year-to-date for Fiscal Year 2013 compared to budget. Note the overall revenue per day dropped in August with the addition of Waters Edge days and revenue in the mix. Waters Edge provides a significant amount of days (almost double) yet these patients have primarily room and board charges and very little ancillary services compared to acute patients.



Contractual Allowances

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 payers such as Blue Cross. A collection ratio of 23.9% was budgeted and 21.0% was realized. Medi-Cal reimbursement at both South Shore and Waters Edge were calculated at a per diem rate of $316 which is consistent with budget and AB97 rate reduction.

Overall, Net Revenue was $6.28 million, $300,000 below budget of $6.58 million. Net Patient Revenue was below budget by $618,000 as a result of four material adjustments in the month – Tricare overpayment $485,000, Notification of DSH qualification a positive $225,000, true up of Healthcomp employee and beneficiary claims at Alameda ($134,000) and Kaiser cosmetic surgery A/R valuation adjustment ($173,000).

In February, we became aware of an overpayment from Tricare that was paid in July 2012, for services between September 2011 and February 2012. The hospital was reimbursed close to full billed charges versus the Medicare RUG rates applicable to subacute level of care for Tricare members. This overpayment was an error made by Tricare that was not detected by us when payment was received. We do have a number of questions that need to be resolved to validate and resolve this overpayment claim. We will also request an extended re-payment plan once the final amount overpayment amount is agreed to by both parties.

Disproportionate Share determination and funding occurs two years after the end of each fiscal year. In January, we received that based upon total medi-cal days for FY 2010, that Alameda Hospital did just qualify for DHS participation and that we are to receive $225,000 from the the State. The first payment of $132,000 coming in February, with subsequent partial payment scheduled between now and October 2013. This item was not reserved for in the financials.

The HealthComp and Kaiser cosmetic adjustements are one time adjustments in January that include claims that go back several months. Although most HealthComp claims get worked and flow through the system like any other claim, we do need to review this payor account each month to ensure that we have properly reserved any outstanding A/R balance for these accounts. This has been incorporated into our month end close processes.

Kaiser cosmetic valuation is associated with a contract that the hospital has had in place with Kaiser dating back to 2009 to perform

cosmetic surgery cases here at Alameda. For the first couple of years, no cases were performed here. However, activity picked up beginning in the fall of 2012 and between August and November 2012 we did 6 cases totaling $218,287 in charges. Since these cases are elective, they are paid through the Kaiser medical group and not the health plan as are most routine services. As such, they are to be billed and reimbursed differently. The accounts were erroneously registered as a regular Kaiser account (like we would a Kaiser ER patient) which are reimbursed at 85% of billed charges. A valuation adjustment of $173,000 was needed to properly value these accounts. They have been billed to the medical group and we espect payment of about $12,000 within the next couple of weeks. This will be properly accounted for going forward.

Waters Edge had Net Revenues of $1.046 million, $173,000 below the budget of $1.2 million. Lower than budgeted overall and medicare A census are driving this variance. Year to date, Waters Edge Net Revenue is $100,000 (1.6%) above budget, and consistent with patient census (1.7%) above budget.

The Wound Care program also resulted in a positive net revenue contribution of $18,600. However there are additional expenses associated with providing this additional revenue.

Other Operating Revenue is about $333,000 positive this month due to receiving EHR incentive funds from the State of California to help with our electronic medical record implementation ($365,000). Year to date, Other Operating Revenue is $88,000 higher than budget.

Expenses

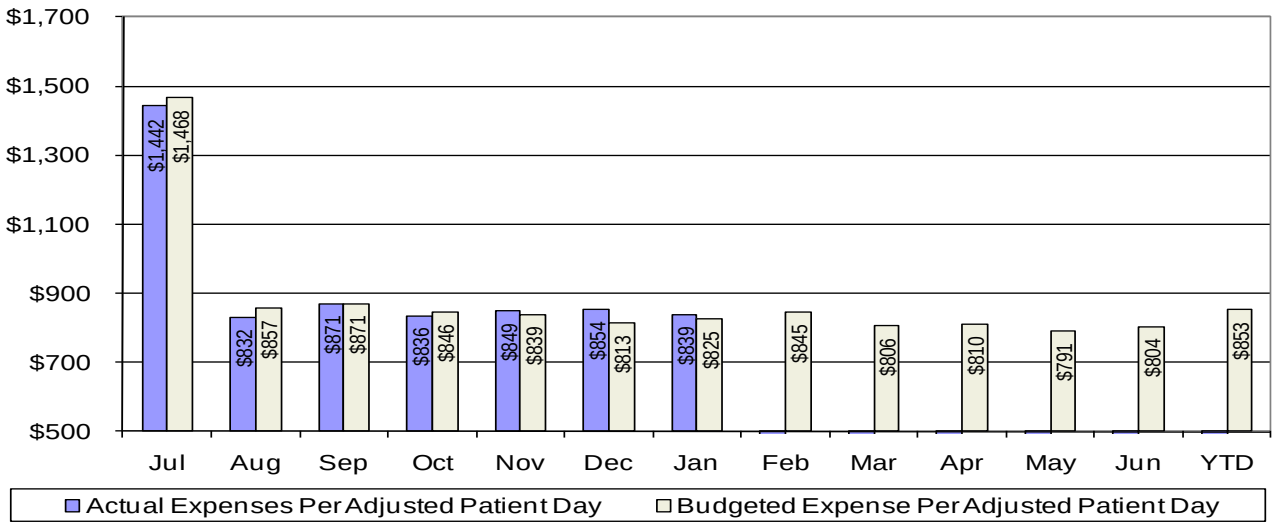
Total Operating Expenses

Total operating expenses were almost $7.2 million which was higher than the fixed budget by $180,000 or 2.6%. Temporary agency fees, benefits and professional fees were above budget while salaries and supplies were under budget. All other expense categories were reasonably close to budget. As mentioned at the July meeting the temporary agency budget is understated by $40,000 per month.

We are currently drilling down on those expense categories where we have a material year to date variance from budget to determine what changes can be made to mitigate these variances for the remainder of the fiscal year.

The graph on the next page shows the actual Hospital operating expenses on an adjusted patient day basis for the fiscal year by month as compared to budget. Note that expenses per patient day were very close to budget this month and last.

Expenses per Adjusted Patient Day



The following are explanations of the significant areas of variance that were experienced in the current month.

Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were unfavorable to the fixed budget by $78,000. While the temporary agency expenses were budgeted lower than they should have been, there are still several areas using temporary staff to replace vacant positions. The departments still utilizing temporary staff to replace budgeted vacant positions are Respiratory Therapy, Laboratory and General Accounting. In addition again the acute inpatient volume was high in CCU (6.3% above budget) and DOU (24.9% above budget) requiring more staffing including registry staffing.

We did have additional salary expense in pharmacy, as we have hired and are training new pharmacists. We are also working to expand the pharmacy service hours so there could be some additional salary expense in pharmacy going forward. However, it should reduce the amount paid for our contracted after hour pharmacy service.

We have also seen additional salary expense in environmental services as they strive to improve hospital cleanliness. This department has also assumed additional responsibility this year of operating room cleaning duties that have contributed to their expense variance.

We are also looking at salary and wage expenses in other areas that have unfavorable YTD variance, including subacute, emergency department, admitting, lab and primary care clinic.

Benefits

Benefits were above the fixed budget by $71,000 the majority of which was vacation / PTO accrual. Year to date is above budget by $149,000. This number fluctuates from month to month as employees take non-productive time off. Less time was taken in January than was budgeted.

Professional Fees

Professional fees were over budget by $29,000 or 7.0% partly due to the fees associated with the Interim Director in Information Systems. These fees were unanticipated but are offset by savings in salaries. In addition, there were higher management fees for the Wound Care program associated with the higher volumes and revenue, as well as extra legal fees in Administration associated with business development opportunies for the hospital.

Supplies

Supplies expense was $26,000 less than budget but year to date, supply expense is still $298,000 higher than budget. General pharmaceutical and Other Supply expenses was lower this month while cost of blood products and IVT Pharmaceuticals were up higher in the month, consistent with patient volumes.

Purchased Services

Purchased services were just $11,000 over budget for the month of January and year to date t are $146,000 over budget. Most departments were slightly over or under budget in January. Waters Edge pharmacy management expense was about $9,500 higher than budget, however total Waters Edge operating expenses are well below budget for the month and YTD.

Other Operating Expense

Other operating expenses were over budget this month by just $11,000. The most significant variance in January was recruitment fees for new management personnel.

Balance Sheet

Total assets decreased by about $36,500 from the prior month. The following items make up the decrease in current assets:

- Total unrestricted cash and cash equivalents for January decreased by almost $1 million and days cash on hand including restricted use funds decreased to 22.5 days cash on hand in January from the high of 27.0 days cash on hand in December. Patient collections in January averaged $175,000 per day, below prior month. Please note there is extra cash that is being held for repayment of LTC over payments since August 2012 and the addition of Waters Edge. The State of California is in the process of having this rate adjusted to mitigate this issue going forward, but as of January has not been corrected.

- Net patient accounts receivable was $11.1 million, up over $700,000 from $10.4 million at the end of December. We have seen payment delays from most payors during January, including Medi-Cal (LTC claims), Medicare and the Commercial payors. The increase in January net patient receivables is the result of lower cash collections during the month.

- Days in outstanding receivables were 57.6 at January month end, an increase from December of 53.7 days. Cash collections in January were $5.4 million compared to $6.8 million in December. The Christmas / New Years holiday season typically results in delayed claims processing. We do expect February and early March to be strong cash collection months, especially givent he higher acute censues over the past two to three months.

- Other Receivables increase by $249,000. Of this, $225,000 is the Disproportionate Share receivable from the State. The first cash is to be received in February.

- Inventories decreased by $55,000 during the month during the normal course of business.

Overall, total liabilities increased by about $348,000 as well from prior month.

- Accounts payable decreased by almost $135,000 in January to just under $10.8 million which equates to 153 AP Days, up from from 147 days in December. Slightly lower operating expenses per day in January results in the higher AP days, since total A/P decreased from prior month. .

- Payroll related accruals increased by $406,000 due to the timing the the pay periods in the month.

- Deferred revenues decreased by $477,000 due to the recognition of one-twelfth of the 2012/2013 parcel tax revenues.

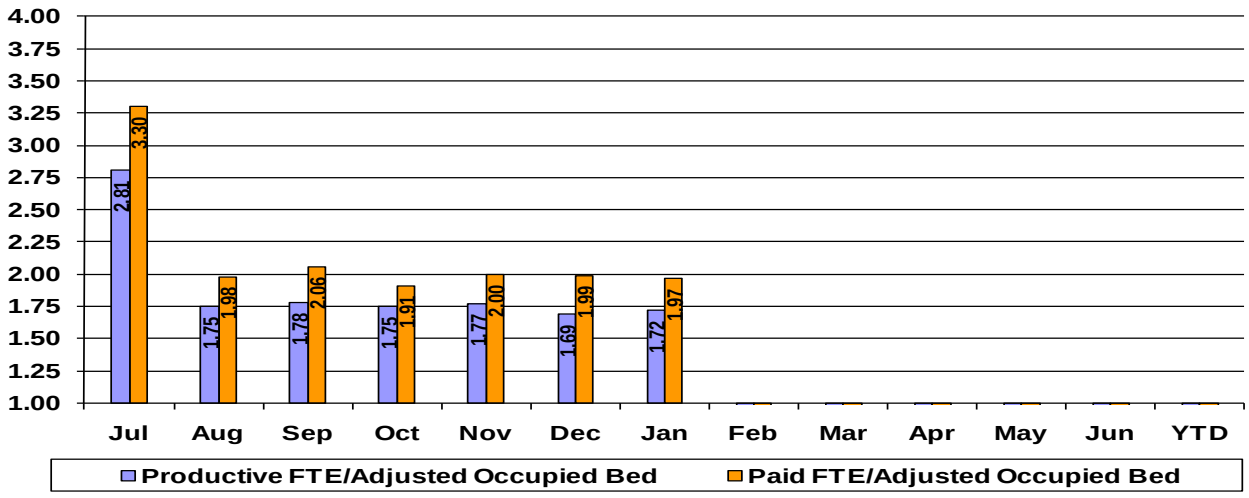
- Current Portion of Long Term Debt in the month of January decreased by about $54,000 as we continue to reduce short term liability to the State that ends this year.

- Third Party Payer Settlement is a combination of the $485,000 Tricare overpayment liability as well as additional accruals for Medi-Cal overpayment for skilled nursing days.

Key Statistics

FTE's Per Adjusted Occupied Bed

For the month of January Productive FTE's per Adjusted Occupied Bed were 1.72, just below the budget of 1.73 FTE's by 0.8%. Paid FTE's per Adjusted Occupied Bed were 1.97 or just 1.2% below the budget. The graph below shows the productive and paid FTE's per Adjusted Occupied Bed for FY 2013 by month.



Current Ratio

The current ratio for January is 0.94, down from .96 in December. We have met with representatives from the Bank of Alameda regarding these loan covenant ratios and other matters. We will be providing them with a loan covenant waiver request along with fiscal year end projections.

A/R days

Net days in net accounts receivable (A/R) are currently at 57.6. This is up from the prior month of 53.7. Net A/R days are up as the result of lower than normal cash collections in the month. We are taking actions to help ensure that A/R balances and cash flows to remain more constant in the weeks and months to come.

Days Cash on Hand

Days cash on hand for December were 22.5, a decrease from prior month of 27.0. While cash collections have improved, cash is also needed to pay down vendor balances as the property tax proceeds will be used to subsidize operations over the course of the fiscal year as well as other capital project commitments.

The following pages include the detailed financial statements for the seven (7) months ended January 31, 2013, of Fiscal Year 2013.

ALAMEDA HOSPITAL
KEY STATISTICS
JANUARY 2013

	ACTUAL JANUARY 2013	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	JANUARY 2012	YTD JANUARY 2013	YTD FIXED BUDGET	VARIANCE	%	YTD JANUARY 2012
Discharges:										
Total Acute	276	253	23	9.2%	263	1,651	1,689	(38)	-2.2%	1,635
Total Sub-Acute	3	1	2	200.0%	-	18	14	4	28.6%	12
Total South Shore	6	9	(3)	-33.3%	10	41	58	(17)	-29.3%	60
Total Waters Edge	16	13	3	23.1%	-	86	74	12	16.2%	-
	301	276	25	9.2%	273	1,796	1,835	(39)	-2.1%	1,707
Patient Days:										
Total Acute	1,077	1,015	62	6.1%	1,025	6,572	6,769	(197)	-2.9%	6,293
Total Sub-Acute	982	1,005	(23)	-2.3%	1,027	6,947	6,974	(27)	-0.4%	6,985
Total South Shore	716	644	72	11.2%	581	4,863	4,553	310	6.8%	4,582
Total Waters Edge	3,165	3,255	(90)	-2.8%	-	18,410	18,094	316	1.7%	-
	5,940	5,919	21	0.4%	2,633	36,792	36,390	402	1.1%	17,860
Average Length of Stay										
Total Acute	3.90	4.02	(0.11)	-2.8%	3.90	3.98	4.01	(0.03)	-0.7%	3.85
Average Daily Census										
Total Acute	34.74	32.74	2.00	6.1%	33.06	30.57	31.48	(0.92)	-2.9%	29.27
Total Sub-Acute	31.68	32.42	(0.74)	-2.3%	33.13	32.31	32.44	(0.13)	-0.4%	32.49
Total South Shore	23.10	20.77	2.32	11.2%	18.74	22.62	21.18	1.44	6.8%	21.31
Total Waters Edge	102.10	105.00	(2.90)	-2.8%	-	100.05	98.34	1.72	1.7%	-
	191.61	190.94	0.68	0.4%	84.94	185.55	183.43	(1.04)	-0.6%	83.07
Emergency Room Visits	1,679	1,423	256	18.0%	1,473	10,127	9,869	258	2.6%	1,473
Wound Care Clinic Visits	356	200	156	78.0%	-	1,445	950	495	52.1%	-
Outpatient Registrations	2,040	2,162	(122)	-5.6%	1,933	13,220	13,929	(709)	-5.1%	12,866
Surgery Cases:										
Inpatient	36	55	(19)	-34.5%	45	283	291	(8)	-2.7%	261
Outpatient	121	140	(19)	-13.6%	106	847	1,115	(268)	-24.0%	1,061
	157	195	(38)	-19.5%	151	1,130	1,406	(276)	-19.6%	1,322
Adjusted Occupied Bed (AOB)	275.37	272.90	2.48	0.9%	123.61	245.68	244.93	0.75	0.3%	121.63
Productive FTE	472.99	472.34	0.65	0.1%	344.61	449.70	447.29	2.41	0.5%	341.36
Total FTE	543.21	544.93	(1.71)	-0.3%	391.85	513.47	512.03	1.44	0.3%	395.32
Productive FTE/Adj. Occ. Bed	1.72	1.73	(0.01)	-0.8%	2.79	1.83	1.83	0.00	0.2%	2.81
Total FTE/ Adj. Occ. Bed	1.97	2.00	(0.02)	-1.2%	3.17	2.09	2.09	(0.00)	0.0%	3.25

City of Alameda Health Care District
Statements of Financial Position
January 31, 2013

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 5,019,811	$ 5,996,164	$ 3,327,884
Patient Accounts Receivable, net	11,140,157	10,428,899	8,835,256
Other Receivables	3,428,917	3,179,878	6,488,283
Third-Party Payer Settlement Receivables	-	-	-
Inventories	971,887	1,027,006	1,045,311
Prepaids and Other	692,317	705,778	416,371
Total Current Assets	21,253,089	21,337,725	20,113,105
Assets Limited as to Use, net	141,504	131,524	64,183
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	44,541,685	44,541,685	43,470,520
Construction in progress	3,752,486	3,642,033	4,102,468
Depreciation	(40,175,214)	(40,102,903)	(39,670,499)
Property, Plant and Equipment, net	8,996,902	8,958,760	8,780,434
Total Assets	**$ 30,391,495**	**$ 30,428,009**	**$ 28,957,722**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,054,889	$ 1,108,515	$ 1,724,249
Accounts Payable and Accrued Expenses	10,779,597	10,914,554	7,848,673
Payroll Related Accruals	5,684,717	5,278,857	4,307,924
Deferred Revenue	2,390,458	2,867,423	5,726,305
Employee Health Related Accruals	650,317	635,518	691,942
Third-Party Payer Settlement Payable	2,043,843	1,395,366	601,233
Total Current Liabilities	22,603,821	22,200,233	20,900,326
Long Term Debt, net	1,738,539	1,794,049	1,022,152
Total Liabilities	24,342,360	23,994,282	21,922,478
Net Assets:			
Unrestricted	5,697,631	6,092,203	6,761,061
Temporarily Restricted	351,504	341,524	274,183
Total Net Assets	6,049,135	6,433,727	7,035,244
Total Liabilities and Net Assets	**$ 30,391,495**	**$ 30,428,009**	**$ 28,957,722**

City of Alameda Health Care District

Statements of Operations

January 31, 2013

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	5,940	5,919	21	0.4%	2,633	36,792	36,390	402	1.1%	17,860
Discharges	301	276	25	9.2%	273	1,796	1,835	(39)	-2.1%	1,707
ALOS (Average Length of Stay)	19.73	21.47	(1.73)	-8.1%	9.64	20.49	19.83	0.65	3.3%	10.46
ADC (Average Daily Census)	191.6	190.9	0.68	0.4%	84.9	171.1	169.3	1.87	1.1%	83.1
CMI (Case Mix Index)	1.2999				1.4193	1.3475				1.3496
Revenues										
Gross Inpatient Revenues	$ 19,413	$ 18,994	$ 420	2.2%	$ 15,619	$ 123,920	$ 125,039	$ (1,119)	-0.9%	$ 101,849
Gross Outpatient Revenues	8,496	8,153	343	4.2%	7,113	54,318	53,072	1,246	2.3%	47,778
Total Gross Revenues	27,910	27,147	763	2.8%	22,732	178,238	178,111	127	0.1%	149,627
Contractual Deductions	21,208	19,730	(1,478)	-7.5%	16,942	127,770	130,547	2,776	2.1%	111,607
Bad Debts	675	749	75	10.0%	36	8,200	4,943	(3,256)	-65.9%	3,021
Charity and Other Adjustments	159	181	22	12.4%	133	684	1,195	511	42.8%	1,256
Net Patient Revenues	5,868	6,486	(618)	-9.5%	5,620	41,584	41,426	158	0.4%	33,742
Net Patient Revenue %	21.0%	23.9%			24.7%	23.3%	23.3%			22.6%
Net Clinic Revenue	27	42	(15)	-35.6%	40	275	292	(17)	-5.9%	248
Other Operating Revenue	383	50	333	661.2%	8	440	352	88	24.9%	216
Total Revenues	**6,278**	**6,578**	**(300)**	-4.6%	**5,668**	**42,298**	**42,070**	**229**	0.5%	**34,207**
Expenses										
Salaries	3,626	3,636	10	0.3%	2,896	23,581	23,905	324	1.4%	20,022
Temporary Agency	157	69	(88)	-126.6%	135	1,251	447	(804)	-180.2%	750
Benefits	1,113	1,042	(71)	-6.8%	899	6,720	6,572	(149)	-2.3%	6,005
Professional Fees	443	414	(29)	-7.0%	394	2,910	2,742	(168)	-6.1%	2,672
Supplies	717	742	26	3.4%	610	5,362	5,065	(298)	-5.9%	4,169
Purchased Services	576	565	(11)	-1.9%	520	3,831	3,684	(146)	-4.0%	2,517
Rents and Leases	205	205	(0)	-0.1%	122	1,357	1,351	(6)	-0.5%	579
Utilities and Telephone	95	87	(7)	-8.6%	70	537	594	57	9.6%	462
Insurance	35	42	6	15.3%	25	263	275	12	4.3%	192
Depreciation and amortization	72	68	(4)	-6.3%	69	508	476	(32)	-6.7%	511
Other Opertaing Expenses	124	113	(11)	-9.7%	99	719	813	94	11.6%	652
Total Expenses	**7,163**	**6,983**	**(180)**	-2.6%	**5,839**	**47,039**	**45,923**	**(1,116)**	-2.4%	**38,531**
Operating gain (loss)	**(885)**	**(405)**	**(480)**	-118.3%	**(170)**	**(4,741)**	**(3,853)**	**(887)**	23.0%	**(4,324)**
Non-Operating Income / (Expense)										
Parcel Taxes	477	500	(23)	-4.5%	478	3,360	3,499	(139)	-4.0%	3,368
Investment Income	1	-	1	0.0%	1	8	-	8	0.0%	4
Interest Expense	(16)	(8)	(8)	-100.4%	(15)	(78)	(56)	(22)	38.8%	(114)
Other Income / (Expense)	28	15	13	89.0%	38	394	105	290	277.1%	179
Net Non-Operating Income / (Expense)	**490**	**507**	**(17)**	**-3.3%**	**502**	**3,684**	**3,548**	**136**	**3.8%**	**3,437**
Excess of Revenues Over Expenses	**$ (395)**	**$ 101**	**$ (496)**	**-489.4%**	**$ 331**	**$ (1,057)**	**$ (306)**	**$ (751)**	**245.5%**	**$ (886)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

January 31, 2013

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 2,273	$ 2,245	$ 28	1.3%	$ 4,076	$ 2,342	$ 2,412	$ (71)	-2.9%	$ 3,882
Gross Outpatient Revenues	995	964	31	3.2%	1,856	1,026	1,024	3	0.3%	1,821
Total Gross Revenues	3,268	3,209	59	1.8%	5,932	3,368	3,436	(68)	-2.0%	5,703
Contractual Deductions	2,483	2,332	(151)	-6.5%	4,421	2,414	2,518	104	4.1%	4,254
Bad Debts	79	89	10	10.8%	9	155	95	(60)	-62.5%	115
Charity and Other Adjustments	19	21	3	13.2%	35	13	23	10	43.9%	48
Net Patient Revenues	687	767	(80)	-10.4%	1,467	786	799	(13)	-1.7%	1,286
Net Patient Revenue %	21.0%	23.9%			24.7%	23.3%	23.3%			22.6%
Net Clinic Revenue	3	5	(2)	-36.2%	10	5	6	(0)	-7.9%	9
Other Operating Revenue	45	6	39	654.0%	2	8	7	2	22.4%	8
Total Revenues	**735**	**778**	**(42)**	-5.5%	**1,479**	**800**	**812**	**(12)**	-1.5%	**1,304**
Expenses										
Salaries	425	430	5	1.2%	756	446	461	16	3.4%	763
Temporary Agency	18	8	(10)	-124.5%	35	24	9	(15)	-174.4%	29
Benefits	130	123	(7)	-5.8%	235	121	127	6	4.6%	229
Professional Fees	52	49	(3)	-6.0%	103	55	53	(2)	-3.9%	102
Supplies	84	88	4	4.3%	159	101	98	(4)	-3.7%	159
Purchased Services	67	67	(1)	-1.0%	136	72	71	(1)	-1.8%	96
Rents and Leases	24	24	0	0.9%	32	26	26	0	1.6%	22
Utilities and Telephone	11	10	(1)	-7.6%	18	10	11	1	11.5%	18
Insurance	4	5	1	16.1%	7	5	5	0	6.2%	7
Depreciation and Amortization	8	8	(0)	-5.3%	18	10	9	(0)	-4.5%	19
Other Operating Expenses	15	13	(1)	-8.7%	26	14	16	2	13.4%	25
Total Expenses	**839**	**825**	**(13)**	-1.6%	**1,524**	**883**	**886**	**3**	0.4%	**1,468**
Operating Gain / (Loss)	**(104)**	**(48)**	**(56)**	-116.3%	**(44)**	**(83)**	**(74)**	**(9)**	12.3%	**(165)**
Non-Operating Income / (Expense)										
Parcel Taxes	56	59	(3)	-5.4%	125	63	68	(4)	-6.0%	128
Investment Income	0	-	0	0.0%	0	0	-	0	0.0%	0
Interest Expense	(2)	(1)	(1)	-98.5%	(4)	(1)	(1)	(0)	36.0%	(4)
Other Income / (Expense)	3	2	2	87.3%	10	7	2	5	269.3%	7
Net Non-Operating Income / (Expense)	**57**	**60**	**(2)**	**-4.2%**	**131**	**70**	**68**	**1**	**1.7%**	**131**
Excess of Revenues Over Expenses	**$ (46)**	**$ 12**	**$ (58)**	-485.8%	**$ 86**	**$ (14)**	**$ (6)**	**$ (8)**	140.6%	**$ (34)**

Wound Care - Statement of Operations
January 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	356	200	156	78.0%	1,445	950	495	52.1%
Revenue								
Gross Revenue	548,718	420,784	127,934	30.4%	2,867,167	1,998,724	868,443	43.4%
Deductions from Revenue	438,974	324,172	114,802		2,255,002	1,539,817	715,185	
Net Revenue	109,744	96,612	13,132		612,165	458,907	153,258	
Expenses								
Salaries	13,447	15,232	1,785	11.7%	86,613	104,700	18,087	17.3%
Benefits	3,846	4,311	465	10.8%	22,961	29,630	6,670	22.5%
Professional Fees	70,837	49,703	(21,134)	-42.5%	334,587	242,838	(91,749)	-37.8%
Supplies	9,455	7,532	(1,923)	-25.5%	105,949	52,724	(53,225)	-101.0%
Purchased Services	4,457	2,083	(2,374)	-114.0%	30,316	14,582	(15,734)	-107.9%
Rents and Leases	5,992	5,080	(912)	-18.0%	37,840	35,560	(2,280)	-6.4%
Depreciation	8,685	4,900	(3,785)	-77.2%	43,905	34,300	(9,605)	-28.0%
Other	675	5,917	5,242	88.6%	12,217	41,419	29,202	70.5%
Total Expenses	117,394	94,758	(22,636)	-23.9%	674,388	555,753	(118,634)	-21.3%
Excess of Revenue over Expenses	(7,650)	1,854	(9,505)	512.6%	(62,223)	(96,846)	34,623	35.8%

Note: Of the 356 visits, 57 were hyberbaric oxygen treatment visits.

City of Alameda Health Care District
Waters Edge Skilled Nursing - Statement of Operations
January 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Patient Days								
Medicare	325	465	(140)	-30.1%	1,836	2,055	(219)	-10.7%
Medi-Cal	2,620	2,418	202	8.4%	14,891	13,985	906	6.5%
Managed Care	36	93	(57)	-61.3%	272	796	(524)	-65.8%
Self Pay/Other	184	279	(95)	-34.1%	1,411	1,258	153	12.2%
Total	3,165	3,255	(90)	-2.8%	18,410	18,094	316	1.7%
Revenue								
Routine Revenue	2,500,140	2,515,810	(15,670)	-0.6%	14,326,070	14,192,168	133,902	0.9%
Ancillary Revenue	305,177	436,783	(131,606)	-30.1%	1,762,684	2,592,458	(829,774)	-32.0%
Total Gross Revenue	2,805,317	2,952,593	(147,276)	-5.0%	16,088,754	16,784,626	(695,872)	-4.1%
Deductions from Revenue	1,759,153	1,733,172	(25,981)	-1.5%	9,537,241	10,358,824	821,584	7.9%
Net Revenue	1,046,164	1,219,421	(173,257)	-14.2%	6,551,513	6,425,802	125,712	2.0%
Expenses								
Salaries	465,213	518,666	53,453	10.3%	2,578,310	2,962,224	383,914	13.0%
Benefits	96,126	155,600	59,474	38.2%	564,938	888,667	323,729	36.4%
Professional Fees	5,441	8,999	3,558	39.5%	50,525	73,994	23,469	31.7%
Supplies	59,157	98,759	39,602	40.1%	399,584	588,186	188,602	32.1%
Purchased Services	100,540	137,355	36,815	26.8%	629,507	789,471	159,964	20.3%
Rents and Leases	76,733	76,552	(181)	-0.2%	462,135	459,312	(2,823)	-0.6%
Utilities	15,435	14,999	(436)	-2.9%	72,889	89,993	17,104	19.0%
Insurance	-	12,165	12,165	100.0%	14,098	72,990	58,892	80.7%
Other	10,813	20,031	9,218	46.0%	87,191	124,899	37,708	30.2%
Total Expenses	829,458	1,043,126	213,668	20.5%	4,859,177	6,049,736	1,190,559	19.7%
Excess of Revenue over Expenses	216,705	176,295	40,410		1,692,336	376,066	1,316,271	

City of Alameda Health Care District
Orthopedic Clinic - Statement of Operations
January 31, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	124	142	(18)	-12.7%	249	417	(168)	-40.3%
Revenue								
Gross Revenue	35,747	32,667	3,080	9.4%	72,846	108,538	(35,692)	-32.9%
Deductions from Revenue	25,023	25,167	(144)		49,739	83,618	(33,879)	
Net Revenue	10,724	7,500	3,224		23,107	24,920	(1,813)	
Expenses								
Salaries	32,021	33,064	1,043	3.2%	121,872	149,765	27,893	18.6%
Benefits	9,158	9,357	199	2.1%	34,804	42,383	7,580	17.9%
Professional Fees	24,577	25,000	423	1.7%	89,456	129,500	40,044	30.9%
Supplies	3,152	2,105	(1,047)	-49.7%	21,645	9,475	(12,170)	-128.4%
Purchased Services	6,792	3,895	(2,897)	-74.4%	29,511	17,525	(11,986)	-68.4%
Rents and Leases	9,320	2,632	(6,688)	-254.1%	19,692	11,840	(7,852)	-66.3%
Depreciation	-	-	-	0.0%	-	-	-	0.0%
Other	679	3,263	2,584	79.2%	24,965	54,687	29,722	54.3%
Total Expenses	85,699	79,316	(6,383)	-8.0%	341,945	415,175	73,231	17.6%
Excess of Revenue over Expenses	(74,975)	(71,816)	(3,159)	-4.4%	(318,838)	(390,255)	71,417	18.3%
Hospital Based Activity:								
Inpatient Days	12	35	(23)	-65.9%	19	97	(78)	-80.4%
Inpatient Surgeries	2	8	(6)	-75.0%	3	22	(19)	-86.4%
Outpatient Surgeries	10	4	6	150.0%	16	16	-	0.0%
Therapy Referred Volume	101	300	(199)	-66.3%	168	850	(682)	-80.2%
Imaging Referred Volume	101	133	(32)	-24.1%	193	412	(219)	-53.2%
Inpatient Gross Charges	202,063	495,200	(293,137)	-59.2%	302,885	1,361,800	(1,058,915)	-77.8%
Inpatient Net Revenue	29,743	111,200	(81,457)	-73.3%	47,747	305,800	(258,053)	-84.4%
Outpatient Gross Charges	369,574	260,085	109,489	42.1%	615,611	867,240	(251,629)	-29.0%
Outpatient Net Revenue	70,219	58,270	11,949	20.5%	116,966	193,300	(76,334)	-39.5%
Total Gross Charges	571,637	755,285	(183,648)	-24.3%	918,496	2,229,040	(1,310,544)	-58.8%
Total Net Revenue	99,962	169,470	(69,508)	-41.0%	164,713	499,100	(334,387)	-67.0%

City of Alameda Health Care District
Statement of Cash Flows
For the Seven Months Ended January 31, 2013

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (394,763)	$ (1,057,025)
Items not requiring the use of cash:		
Depreciation and amortization	72,311	$ 507,993
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(711,258)	(2,304,901)
Other Receivables	(249,039)	3,059,366
Third-Party Payer Settlements Receivable	648,477	1,442,610
Inventories	55,119	73,424
Prepaids and Other	13,461	(275,946)
Accounts payable and accrued liabilities	(134,957)	2,930,924
Payroll Related Accruals	405,860	1,376,793
Employee Health Plan Accruals	14,799	(41,625)
Deferred Revenues	(476,965)	(3,335,847)
Cash provided by (used in) operating activities	(756,956)	2,375,765
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(9,980)	(77,321)
Additions to Property, Plant and Equipment	(110,453)	(724,461)
Other	191	(6,405)
Cash provided by (used in) investing activities	(120,241)	(808,187)
Cash flows from financing activities		
Net Change in Long-Term Debt	(109,135)	47,028
Net Change in Restricted Funds	9,980	77,321
Cash provided by (used in) financing and fundraising activities	(99,156)	124,348
Net increase (decrease) in cash and cash equivalents	(976,353)	1,691,927
Cash and cash equivalents at beginning of period	5,996,164	3,327,884
Cash and cash equivalents at end of period	$ 5,019,813	$ 5,019,812

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2009	FY 2010	FY 2011	FY 2012	YTD 1/31/2013
Profitability Ratios					
Net Patient Revenue (%)	22.69%	24.16%	23.58%	22.90%	23.33%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	3.62%	4.82%	-1.01%	-1.48%	-1.48%
EBIDAP[Note 5]	-5.49%	-3.66%	-13.41%	-11.22%	-9.06%
Total Margin	1.03%	2.74%	-2.61%	-3.21%	-2.50%
Liquidity Ratios					
Current Ratio	1.15	1.23	1.05	0.96	0.94
Days in accounts receivable ,net	57.26	51.83	46.03	55.21	57.60
Days cash on hand (with restricted)	13.6	21.6	14.1	17.7	22.5
Debt Ratios					
Cash to Debt	115.3%	249.0%	123.3%	123.56%	184.77%
Average pay period (includes payroll)	58.03	57.11	62.68	72.94	78.95
Debt service coverage	3.87	5.98	(0.70)	(0.53)	(0.42)
Long-term debt to fund balance	0.20	0.14	0.18	0.28	0.32
Return on fund balance	8.42%	18.87%	-19.21%	-27.35%	-17.47%
Debt to number of beds	13,481	10,482	11,515	16,978	9,728

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2009	FY 2010	FY 2011	FY 2012	YTD 1/31/2013
Patient Care Information					
Bed Capacity	161	161	161	161	281
Patient days(all services)	30,463	30,607	30,270	30,448	36,792
Patient days (acute only)	11,787	10,579	10,443	10,880	6,572
Discharges(acute only)	2,812	2,802	2,527	2,799	1,651
Average length of stay (acute only)	4.19	3.78	4.13	3.89	3.98
Average daily patients (all sources)	83.46	83.85	82.93	83.19	171.13
Occupancy rate (all sources)	52.94%	52.08%	51.51%	51.67%	60.90%
Average length of stay	4.19	3.78	4.13	3.89	3.98
Emergency Visits	17,337	17,624	16,816	16,964	10,127
Emergency visits per day	47.50	48.28	46.07	46.35	47.10
Outpatient registrations per day[Note 1]	82.05	79.67	65.19	60.67	61.49
Surgeries per day - Total	16.12	13.46	6.12	6.12	5.27
Surgeries per day - excludes Kaiser	5.14	5.32	6.12	6.12	5.27

Notes:

1. Includes Kaiser Outpatient Sugercial volume in Fiscal Years 2008, 2009 and through March 31, 2010.
2. In addition to these general requirements a feasibility report will be required.
3. Based upon Moody's FY 2008 preliminary single-state provider medians.
4. EBIDA - Earnings before Interest, Depreciation and Amoritzation
5. EBIDAP - Earnings before Interest, Depreciation and Amortization and Parcel Tax Proceeds

Glossary of Financial Ratios

Term	What is it? Why is it Important?	How is it calculated?
EBIDA	A measure of the organization's cash flow	Earnings before interest, depreciation, and amortization (EBIDA)
Operating Margin	Income derived from patient care operations	Total operating revenue less total operating expense divided by total operating revenue
Current Ratio	The number of dollars held in current assets per dollar of liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend.	Current assets divided by current liabilities
Days cash on hand	Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive.	Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365.
Cash to debt	Measures the amount of cash available to service debt.	Cash plus investments plus limited use investments divided by the current portion and long-term portion of the organization's debt insruments.
Debt service coverage	Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g. work down of accounts receivable). Higher values indicate better debt repayment ability.	Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense.
Long-term debt to fund balance	Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive.	Long-term debt divided by long-term debt plus unrestricted net assets.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 1, 2013

FOR: March 7, 2013 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: CEO Report to the Board of Directors

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1. **Employee Service Awards**

   We will be honoring employees who are passing key service tenure marks on March 11, 2013 at 5:00 p.m. in Conference Room A. We invite all members of the Board to join us at the celebration. Your participation is always welcomed and appreciated by our employees.

2. **Bay Area Bone & Joint Center**

   Through February 22, 2013, the Bay Area Bone & Joint Center has had 460 patient visits, including 130 through February 22, representing an increase over the previous month and ahead of the YTD pro forma target. Seven surgeries were performed in February, month to date. YTD surgeries are currently at 60% of the pro forma target of 42.

   Drs. DiStefano and Pirnia have been active in the community. Their first community lecture at the end of January was well attended. Future lectures have been scheduled at the Hosptial monthly through July. They recently spoke at the Claremont Country Club (February 27) and will speak at the Mastick Senior Center on March 5. Their Marina Village office will be the site of a Chamber of Commerce Ribbon Cutting Ceremony on March 13 at 5:30 p.m., followed by the monthly Chamber Mixer for its members.

   Drs. DiStefano and Pirnia will participate in a “Meet the Orthopaedist” Saturday morning event on March 30 which will be publicized in the media and at the Hospital’s presence at the Lunar New Year Festival at Harbor Bay Isle in mid-March.

3. **Capital Projects**

   a) Seismic Anchoring

      Construction on the NPC-2 compliance of emergency lighting in the original

hospital is complete and awaiting physical site review and sign-off approval from OSHPD, scheduled for March 1.

Construction of the emergency communications NPC-2 compliance project, which entailed anchoring of existing systems is 98% complete with an OSHPD sign-off approval by mid-March.

b) Bulk Oxygen Tank

Management continues to wait for OSHPD approval of structural plans for the bulk oxygen tank replacement, which is expected sometime in March. Subsequently, two 30-day back check response periods are possible before the public bid process to select a construction vendor can begin, so completion of the project is projected to be July 2013. In the meantime, Management has secured the requisite use permits from OSHPD and the City of Alameda and is in the process of preparing for the public bid process to select a construction vendor once the structural plans have been approved.

c) SB90/SB499 Extension Report

The Hospital completed its application to extend the deadline to become SPC2 compliant beyond the current deadline of December 31, 2012 and continues to await a final decision from OSHPD.

d) CMS Sprinkler Mandate Report

This project is on schedule to be completed before the August 18, 2013 deadline. Management is working on plans to temporarily transfer existing patients to beds that are currently in suspension with the State of California Department of Public Health. The move is anticipated in May at the earliest. Completed plans were submitted to OSHPD and were officially logged into the state's project tracking system on January 2, 2013. A "rapid review" process by OSHPD is expected, and subsequent public bid process should allow the estimated 100 days or less of construction to be finished by the mandated deadline.

4. Foundation/Community Relations and Outreach Update

On March 18, 2013, the Hospital Auxiliary will host the East Bay Council, a collection of eight hospital volunteer organizations. The Auxiliary will showcase one of our special volunteers, Sadie. Sadie is a certified therapy dog who, along with one of her caregivers, is a member of our Auxiliary. The other hospitals are very interested in our therapy dog program and are looking forward to learning about how Sadie serves our patients.

5. Information Technology Update and Meaningful Use

a) Meaningful Use

The Information Technology Department continues to focus efforts toward the attainment of Meaningful Use Stage I. We successfully implemented EDMII on January 29 and have been supporting the staff since that time. This keeps us on track to attestation beginning in mid-2013. The IT Steering committee met on February 6 and reviewed the EDMII go-live status and discussed future development of Physician Order Sets for implementation with In-house CPOE. The next phase will involve nursing documentation as well as electronic medication administration. Currently schedules for super user training, beginning in March, are under development along with review of equipment requirements. Go-live is anticipated by the end of April.

b) Replacement of Existing NetFax System

Smart Route development and training for Radiology and Lab have been completed and the anticipated live date the week of February 25. Medical Records reports will be scheduled for a later date based on department availability.

c) New Electronic EKG Workflow

A new electronic EKG workflow software from Integrator is being implemented this week with the finalization of set-up and staff and physician training. This new workflow will replace the current manual system. The go-live date is still pending training and resolution of a hardware issue with the EKG equipment.

d) Waters Edge Infrastructure

A contractor has been selected to perform the wiring upgrade Waters Edge. The installation is being coordinated with Water's Edge management.

e) Staffing

A vacated Data Analyst remains open.

6. Kate Creedon Center for Advanced Wound Care

Since the inception of the program in mid July of 2012, 209 patients have been seen at the Center, and have been referred from a total of 94 referring physicians. This has resulted in 1836 clinic visits. A total of 609 ancillary referrals, including laboratory and surgery, have been made to Alameda Hospital departments. Seventy-four percent (74%) of the patients have been non-Alameda residents.

Month to date through February 25, 2013, there are 119 active patients. During the week of February 25 alone, there were 107 clinic visits. A total of 3007 HBOT treatments have been given, with eight patients under active HBOT treatment and two patients on the waiting list.

Overall, the variance from the patient volume forecasted in the original pro forma is a favorable 33%. The healing rate is 84.75% for 100% healing at 20 weeks of treatment.

7. DSRIP Report

The Hospital successfully submitted the requested criteria for two Category IV projects and continues to await a CMS decision on all criteria previously submitted regarding a three-year proposal for delivery system reform under California's Section 1115 Waiver's Delivery System Reform Incentive Pool (DSRIP) Program. DSRIP is designed to promote a higher quality of care and improved health of patients and families served by the California's non-designated public hospitals. DHCS has recommended to CMS that district hospitals not submit any projects for Category III: Population Focused Improvement, but that a minimum of two projects be submitted for Category IV: Patient Safety. Management is in the process of setting these proposed criteria, which were submitted in mid-January.

8. Long Term Care

Census remains favorable to budget for South Shore and Waters Edge for the month of February. Referrals have continued to increase from external hospitals as well as an increase in the number of short term rehabilitation residents we are serving. Currently, we have approximately 37% of the residents of Waters Edge receiving rehabilitation services with significant gains in their progress and levels of independence. We are currently introducing the use of Wii's for both rehabilitation and social activities and anticipate a favorable response from our residents.

Activity Coordinators at both South Shore and Waters Edge are currently planning to have joint outings for the month of March, with destinations being a local museum and park.

For the Sub Acute unit, we are intentionally keeping the census steady at 33. With the required CMS Sprinkler addition to the second floor for 2013, we must ensure that we do not exceed available bed accommodations in 2 South, which is where our residents will be moved once construction begins.

9. Stroke Program

The Hospital's Stroke Program treated 160 Stroke patients in CY2012. This is 43 patients more than the 117 treated in CY2011. Out of the Stroke patients treated, 59 were "Code Strokes" (those arriving through the EMS system by ambulance).

Alteplase (TPA) was administered five times in CY2011, 16 times in CY2012 and three times so far this year. Our "Door to Drug" times in CY2012 were under 60 minutes 63% of the time. Our best "Door to Drug" time so far is 25 minutes.

The Hospital applied for "Get with the Guidelines" Silver, Silver Plus, and Target Stroke Awards in January 2013. We continue to attend quarterly meetings with other Certified Stroke Centers and the Alameda County Emergency Medical System.

Claudine Dutaret, MD (Stroke Program Director) and Michaele Baxter, RN (Stroke Coordinator) attended the International Stroke Conference in early February 2013.

10. Pharmacy

The Pharmacy Department extended its hours of operation on February 11, 2013. It is now open until 10:30 p.m. on weeknights and until 7:00 p.m. on weekends and holidays. These additional hours will greatly improve the department's service to the physicians and nursing staff.

An upgrade to the Pyxis automated medication dispensing system and transfer of Nighthawk Pharmacy services from Cardinal to Pipeline will take place on April 1, 2013. These will enhance and improve our current systems as well as decrease our expenses.

11. Quality / Risk Management

A group of staff will identify and streamline inefficiencies related to ambulance transfers and billing. Using lean management performance improvement techniques and a volunteer facilitator, staff will improve throughput by reducing the time and communication issues with obtaining appropriate ambulance transport process. As a result of this project we will:

- Improve our efforts in identifying, scheduling, and ordering services
- Provide consistency in determining appropriate services for our patients
- Reduce the staff confusion by development of a process
- Educate staff
- Create or revise contracts to improve transport times, improve quality & reduce cost

12. Fiscal Year 2013 Financial Forecast

Following this report is a memo from Kerry Easthope that was reviewed at the February 27, 2013 Finance and Management Committee. The memo will be reviewed at the upcoming District Board Meeting.

13. Key Statistics – December 2012

Because of the timing needed to prepare materials prior to the end of the month, February monthly statistics will be presented at the Board meeting on March 7, 2013.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 28, 2013

For: March 7, 2013 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Joint Commission Survey Education

In preparation for the upcoming Joint Commission Survey, the following information is provided to District Board for reference and background as to the process of a Joint Commission Survey and leadership responsibilities during this survey.

Survey Logistics | Sample Agendas

There will be multiple surveyors from the Joint Commission, a physician from the Institute for Medical Quality **(**IMQ) and a Life Safety Code Specialist to conduct the two (2) day survey.

Attachments:
1. Sample Hospital Survey Agenda
2. Sample Life Safety Code Survey Agenda

Tracer Methodology

The Joint Commission's on-site survey process includes tracer methodology. Tracer methodology is an evaluation method in which surveyors select a patient, resident or client, and use that individual's record as a roadmap to move through an organization while assessing and evaluating the organization's compliance within selected standards, along with the organization's systems of providing care and services. Surveyors retrace the specific care processes that an individual experienced through observation and by interviewing staff within areas that the individual received care. As surveyors follow the complete treatment course, they assess the health care organization's compliance with Joint Commission standards. They conduct this compliance assessment as they review the organization's systems for delivering safe, quality health care.

While conducting tracer activities, the surveyor may identify compliance issues in one or more elements of performance. Surveyors will look for compliance trends that might point to potential system-level issues in the organization. The tracer activity also provides several opportunities for surveyors to provide education to organization staff

and leaders, as well as to share best practices from other similar health care organizations. The number of tracers completed depends on the length of the survey; however, the average three-day hospital survey with a team of three surveyors typically allows for completion of approximately 11 tracers. Tracer patients, residents or clients are primarily selected from an active patient list. Typically, individuals selected for the tracer activity are those who have received multiple or complex services. The surveyor may speak to the patient, resident or client during the tracer activity, if it is appropriate. As always, the surveyor asks for patient permission before speaking to him or her.

Attachment:
1. Individual Tracer Activity Outline

Leadership Responsibilities

Representatives from the District Board will be asked to participate in the Leadership Session. During this session, surveyors will explore (through organization-specific examples) leadership commitment to improvement of quality and safety, creating a culture of safety, robust process improvement, and observations that may be indicative of system-level concerns.

The surveyor facilitates discussion with leaders to understand their roles related to performance of organization-wide processes and functions. This discussion will be a mutual exploration of both successful and perhaps less successful organization performance improvement initiatives, or introduction of a new service or an optimal performing department, unit, or area versus one in need of improvement. Surveyors will want to hear how leaders view and perceive these successes and opportunities and learn what they are doing to sustain the achievements, as well as encourage and support more of the same success.

Attachment:
1. Leadership Session Outline

Joint Commission Compass

A Joint Commission Compass publication has been developed to help guide staff, physicians, Board members and volunteers through the accreditation process. The Compass highlights key areas and initiatives for quality improvement. A copy will be distributed to the Board of Directors at the March meeting.

SAMPLE TEMPLATE
California Hospital

DAY 1

Time	Joint Commission Surveyor	Joint Commission Surveyor	IMQ Physician	CDPH – Nurse	CDPH – Nurse	CDPH – Pharmacist	CDPH - Nutritionist
7:30 – 8:00 a.m.	Joint Commission, Institute for Medical Quality and California Department of Public Health Pre-Survey Meeting						
8:00 – 8:30 a.m.	Preliminary Planning Session						
8:30 – 9:00 a.m.	Opening Conference and Orientation to Organization						
9:00 – 9:30 a.m.							
9:30 – 10:00 a.m.	Continued Surveyor Planning Session						
10:00 – 10:30 a.m.	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	Pharmaceutical Services Management Interview	System Tracer – Dietetic Service, Food Service
10:30 – 11:00 a.m.							
11:00 – 11:30 a.m.							
11:30 – 12:00 p.m.							
12:00 – 12:30 p.m.	Surveyor Lunch						
12:30 – 1:00 p.m.	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	Individual Tracer Activity	System Tracer – Pharmaceutical Services	System Tracer – Dietetic Service, Food Service
1:00 – 1:30 p.m.							
1:30 – 2:00 p.m.							
2:00 – 2:30 p.m.							
2:30 – 3:00 p.m.	System Tracer – Data Management			System Tracer – Data Management		System Tracer – Data Management	
3:00 – 3:30 p.m.							
3:30 – 4:00 p.m.	Special Issue Resolution						
4:00 – 4:30 p.m.	Surveyor Team Meeting/Planning Session						
5:30 – 6:00 p.m.			Medical Staff Leadership Interview*				
6:00 – 6:30 p.m.							

Please Note: In the event that the Pharmacist and/or Nutritionist are not scheduled to participate in the survey, the DHS Nurses will integrate their survey activities.

*The IMQ Physician surveyor will collaborate with the organization to determine timing for this activity.

SAMPLE TEMPLATE
California Hospital

DAY 2

<table>
<tr><th>Time</th><th>Joint Commission Surveyor</th><th>Joint Commission Surveyor</th><th>IMQ Physician</th><th>CDPH – Nurse</th><th>CDPH – Nurse</th><th>CDPH – Pharmacist</th><th>CDPH - Nutritionist</th></tr>
<tr><td>8:00 – 8:30 a.m.</td><td colspan="7">Daily Briefing</td></tr>
<tr><td>8:30 – 9:00 a.m.</td><td colspan="2" rowspan="2">Leadership Session</td><td rowspan="2">Medical Staff Functions/CDPH Regulatory Review</td><td colspan="4" rowspan="2">Leadership Session</td></tr>
<tr><td>9:00 – 9:30 a.m.</td></tr>
<tr><td>9:30 – 10:00 a.m.</td><td rowspan="4">Individual Tracer Activity</td><td>Competence Assessment</td><td>Medical Staff Credentialing and Privileging</td><td>Competence Assessment</td><td rowspan="4">Individual Tracer Activity</td><td>System Tracer – Pharmaceutical Services</td><td>Individual Tracer Activity – Clinical Units</td></tr>
<tr><td>10:00 – 10:30 a.m.</td><td rowspan="3">Environment of Care</td><td rowspan="3">Individual Tracer Activity</td><td rowspan="3">Environment of Care</td><td colspan="2" rowspan="3">Performance Improvement Review</td></tr>
<tr><td>10:30 – 11:00 a.m.</td></tr>
<tr><td>11:00 – 11:30 a.m.</td></tr>
<tr><td>11:30 – 12:00 p.m.</td><td colspan="7">Surveyor Lunch</td></tr>
<tr><td>12:00 – 12:30 p.m.</td><td rowspan="2">Individual Tracer Activity</td><td rowspan="2">Emergency Management</td><td rowspan="2">Individual Tracer Activity</td><td rowspan="2">Emergency Management</td><td rowspan="2">Individual Tracer Activity</td><td rowspan="2">System Tracer Pharmaceutical Services, Surgery Department</td><td rowspan="2">System Tracer – Dietetic Services</td></tr>
<tr><td>12:30 – 1:00 p.m.</td></tr>
<tr><td>1:00 – 1:30 p.m.</td><td colspan="2" rowspan="4">Surveyor Report Preparation</td><td rowspan="3">Surveyor Preparation of Findings</td><td colspan="4">CDPH Meeting</td></tr>
<tr><td>1:30 – 2:00 p.m.</td><td colspan="4" rowspan="3">Surveyor Report Preparation</td></tr>
<tr><td>2:00 – 2:30 p.m.</td></tr>
<tr><td>2:30 – 3:00 p.m.</td></tr>
<tr><td>3:00 – 3:30 p.m.</td><td colspan="7" rowspan="2">CEO Exit Briefing and Organization Exit Conference</td></tr>
<tr><td>3:30 – 4:00 p.m.</td></tr>
<tr><td>4:00 – 4:30 p.m.</td><td colspan="7"></td></tr>
</table>

When possible, a Surveyor from Each Program will participate in the following activities, as applicable:
Daily Briefings and Leadership Session (All surveyors on site)
System Tracer – Data Management

SAMPLE TEMPLATE
Hospital

Day 1

Time	Life Safety Code Specialist	Life Safety Code Specialist
	Day 1 (Concurrent with full hospital team's Day 1)	**Day 1 (Occurs on day 2, 3 or 4 of the hospital survey)**
8:00 – 8:30 a.m.	Surveyor Planning Session - Facility Maintenance Review	Daily Briefing (introductions only)
8:30 – 9:00 a.m.		Surveyor Planning Session - Facility Maintenance Review
9:00 – 9:30 a.m.	Opening Conference (Introductions only)	
9:30 – 10:00 a.m.	Facility Orientation	Facility Orientation
10:00 – 10:30 a.m.	Life Safety Code® Building Tour	Life Safety Code® Building Tour
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.		
12:30 – 1:00 p.m.	Surveyor Lunch	Surveyor Lunch
1:00 – 1:30 p.m.	Life Safety Code® Building Tour, cont.	Life Safety Code® Building Tour, cont.
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.		
4:00 – 4:30 p.m.	Surveyor Team Meeting / Planning Session*****	Surveyor Team Meeting / Planning Session*****

***** Time for required interaction with Survey Team

SAMPLE TEMPLATE
Hospital

Day 2

Time	Life Safety Code Specialist	Life Safety Code Specialist
	Day 2 (Different than the last day of hospital survey)	**Day 2 (Occurs on last day of hospital survey)**
8:00 – 8:30 a.m.	Daily Briefing	Daily Briefing
8:30 – 9:00 a.m.	Surveyor Planning Session*	Surveyor Planning Session*
9:00 – 9:30 a.m.	Life Safety Code® Building Tour	Life Safety Code® Building Tour
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	Surveyor Lunch
12:30 – 1:00 p.m.	Life Safety Code® Building Tour	Life Safety Code® Building Tour
1:00 – 1:30 p.m.		Facility Maintenance Review
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.	Facility Maintenance Review	Document Findings
2:30 – 3:00 p.m.		
3:00 – 3:30	Document Findings	CEO Exit Briefing
3:30 – 4:00		Organization Exit Conference
4:00 – 4:30 p.m.	Surveyor Team Meeting / Planning Session*	

Applicable Programs
All programs

Individual Tracer Activity

Joint Commission, CDPH, and IMQ Participants
One or more surveyors per individual tracer as determined by the Joint Commission, CDPH, and IMQ survey team.

Organization Participants
Suggested participants include staff and management involved in the individual's care, treatment, and services.

Logistical Needs
The suggested duration of individual tracer activity varies but typically is 60-120 minutes. Care is taken by the surveyors to assure confidentiality and privacy. Surveyors may use multiple individual served/patient/resident records of care, treatment, or services during an individual tracer. The purpose of using the record is to guide the review, following the care, treatment or services provided by the organization to the individual served/patient/resident.

A surveyor may arrive in a setting/unit/program/service and need to wait for staff to become available. If this happens, the surveyor may use this time to evaluate environment of care issues or observe the care, treatment, or services being rendered.

Surveyors make every effort to avoid visiting areas at the same time as other surveyors and try to minimize multiple visits to the same location. However, an individual tracer does follow where the individual served/patient/resident received services.

Objective
The surveyor will evaluate your organization's compliance with standards as they relate to the care and services provided to individuals served/patients/residents.

Overview
The majority of your survey activity occurs during individual tracers. The term "individual tracer" denotes the survey method used to evaluate your organization's compliance with standards related to the care, treatment, and services provided to a individual served/patient/resident. Most of this survey activity occurs at the point where care, treatment, and services are provided.

Initially, the selection of individual tracer candidates is based on your organization's top Priority Focus Areas and Clinical Service Groups identified through the Priority Focus Process. As the survey progresses, the surveyors may select individuals served/patients/residents with more complex situations, which are identified through the system tracers, and whose care crosses programs.

The individual tracer begins in the setting/unit in where the individual served/patient/resident and his/her clinical/medical record are located. The surveyor starts the tracer by reviewing a record of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then begins the tracer by:

- Following the course of care, treatment, or services provided to the individual served/patient/resident from preadmission through post discharge.
- Assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the important functions in the care, treatment or services provided.
- Identifying issues that will lead to further exploration in the system tracers or other survey activities such as Environment of Care and Leadership Sessions.

During the individual tracer, the surveyor observes the following (includes but is not limited to):

- Care, treatment or services being provided to individuals served/patients/residents by clinicians, including physicians
- The medication process (e.g., preparation, administration, storage, control of medications);
- Infection control issues (e.g., techniques for hand hygiene, sterilization of equipment, disinfection, food sanitation, and housekeeping)
- The process for planning care, treatment or services
- The environment as it relates to the safety of individuals served/patients/residents and staff
- LAB: Quality control, maintenance and testing performance

During the individual tracer, the surveyor interviews staff about:

- Processes as they relate to the standards and PFAs
- Intradepartmental and interdepartmental communication for the coordination of care. (e.g., hand offs)
- The use of data
- Patient flow issues
- National Patient Safety Goals
- Individual served/patient/resident education
- Orientation, education, and competency of staff
- Other issues

During the individual tracer, the surveyor may speak with available licensed independent practitioners about:

- Organization processes that support or may be a barrier to individual served/patient/resident care, treatment and services
- Communications and coordination with other licensed independent practitioners (hospitalists, consulting physicians, primary care practitioners)
- Discharge planning, or other transitions-related resources and processes available through the organization
- Awareness of roles and responsibilities related to the Environment of Care, including prevention of, and response to incidents and reporting of events that occurred

During the individual tracer, the surveyor interviews individuals served/patients/residents and their families about:

- Coordination and timeliness of services provided
- Education, including discharge instructions
- Response time when call bell is initiated or alarms ring, as warranted by setting and services
- Perception of care, treatment or services
- Staff observance of hand-washing and verifying their identity
- Understanding of instructions (e.g., diet or movement restrictions, medication, discharge and provider follow-up), as applicable
- Rights of individuals served/patients/residents
- Other issues

Home Medical Equipment only: The surveyor requests the manufacturer, model, and serial numbers for all medical equipment provided by your organization.

Home Medical Equipment Mail Order: The surveyor traces mail order clients/patients in the same manner. They will utilize telephone support in lieu of patient home visits.

Home Medical Equipment Walk-in Business: The surveyor traces the client/patient services when they arrive at your organization. Due to the unscheduled nature of this business, survey activity is interrupted to accommodate tracers for walk-in clients/patients.

Using individual tracers for continuous evaluation

Many organizations find tracer activity helpful in the continuous evaluation of their services. If you choose to conduct mock tracers, in addition to clinical service groups (CSGs), consider the following criteria in selecting the individual served/patient/resident.

Selection Criteria

- Individuals served/patients/residents related to system tracers such as infection control and medication management.
- Individuals served/patients/residents who moves between programs (e.g. individuals served/patients/residents scheduled for a follow-up in ambulatory care, home care patients received from the hospital, long term care residents transferred from the hospital, individuals served in behavioral health care who are receiving ambulatory care services, and assisted living residents receiving home care services).
- Individuals served/patients/residents recently admitted.
- Individuals served/patients/residents due for discharge or recently discharged.
- Individuals served/patients/residents who cover multiple additional criteria listed below.

Ambulatory Health Care and Office Based Surgery:
Surgery/Anesthesia Services

- Operative and other procedures
- IV/Infusion therapy
- Blood/blood component administration
- Alternative complementary care
- Care for a terminal condition
- Pediatric or less than 18 year old care
- Geriatric care
- Pain Management

Medical/Dental Services:

- Maternal/child care
- Pediatric or less than 18 year old care
- Geriatric care
- Terminal condition
- Equipment maintenance

Bureau of Primary Health Care:

Care provided to:

- School-based health
- Homeless patients
- Migrant workers
- Individuals in public housing
- Individuals with HIV/AIDS

Other Services:

- Pain Management (uncontrolled pain)
- High risk areas
- Equipment Maintenance
- Cleaning, disinfection, and sterilization
- Point of Care Testing (CLIA Waived Testing)

Behavioral Health Care:
Care provided to:

- Programs and services
- High risk populations (restraint use, seclusion, suicidal)
- Vulnerable populations (very young, very old, reclusive, persons with developmental disabilities)
- Long length of stay (perhaps more complicated)

Home Care
Care provided to:

- A patient who is on a high-risk medication or piece of equipment.
- A patient receiving ventilator care.
- A pediatric patient or a patient < 18 years old.
- A patient receiving Maternal/Child care.
- A patient receiving IV/Infusion therapy.
- A patient receiving blood/blood component administration.
- A patient undergoing acute care re-hospitalizations.
- A patient receiving personal care and support services.
- A patient receiving alternative complementary care.
- A patient receiving oxygen therapy.
- A patient in a terminal condition.

Hospice Services:

- A patient receiving facility-based care within the past 12 months.
- A patient receiving continuous care/respite care.
- A patient to whom infusion therapy is being administered.
- A pediatric patient or a patient <18 years old.
- A patient receiving alternative complementary care.
- A patient undergoing pain management

Home Medical Equipment:
Patients who use:

- Custom adult wheelchairs (usually fixed frame requiring assessment and fitting).
- Custom pediatric wheelchairs (usually fixed frame requiring assessment and fitting).
- Custom seating systems associated with the provision of wheelchairs.
- Custom power wheelchairs (including power stretchers, etc).
- Standard adult and pediatric power wheelchairs (custom and non-custom).
- Custom adult and pediatric ambulatory aids (prone standers, circular walkers, etc).
- A customer receiving multiple types of equipment.
- A customer receiving clinical respiratory services.
- A customer receiving rehab technology services.
- A patient receiving customized orthotics or prosthetics.
- A patient using respiratory equipment.
- A patient using durable medical equipment.
- A patient using specialized equipment with supplies.

Pharmacy:
Care provided to patients on high-risk medication.

Hospitals and Critical Access Hospitals:

- A patient in the intensive care units (MICU, SICU, CVCU, etc.)
- A patient who entered the health care system through the emergency department.
- A patient in labor and delivery services (including patients scheduled for C-section).
- A patient who receives sedation and anesthesia (includes hand offs communication)
- A patient on a skilled nursing unit and/or subacute care.
- A patient who is a 23-hour admit
- A patient receiving dialysis.
- A psychiatric patient.
- A pediatric patient.
- A patient receiving radiology or nuclear medicine services.
- A patient receiving rehabilitation services.
- A patient who is a possible organ donor or transplant recipient.
- A patient receiving waived lab services
- A deceased patient or terminal patient
- A patient discharged (or retrospective review and interview of recently discharged patient)

Laboratory

- Patient receiving services from all specialties and sub-specialties provided.
- Patients receiving waived testing
- Outpatients

Long Term Care

- Resident receiving health services coordination (i.e., medication management, skin integrity, complex medical services).
- Resident not receiving health services coordination.
- Resident with limited mobility.
- Resident who smokes.
- Resident from a special population (dementia, children/young adults, neurologic ITBI, MR/DD).
- Resident receiving supervised assistance with one or more ADLs.
- Organization's quality indicators from MDS, if available.

Medicare/Medicaid Certification Option:

- Pain management
- Home goals
- End of life care
- Point of care testing/CLIA waived testing
- Rehabilitation therapy

Applicable Programs
All programs, except LAB

Leadership Session

Joint Commission and CDPH Participants
Surveyors

Organization Participants
Suggested participants include senior leaders who have responsibility and accountability for design, planning, and implementation of organization processes. Leaders typically include but are not limited to members of the governing body/trustee (at least one member), CEO, and elected and appointed leaders of the medical staff and clinical staff.

For **complex surveys**, there is a single Leadership Session that will include discussion of all programs and services being accredited at the time of this survey. Surveyors from all programs should participate in this session if they are still onsite. Your organization should have leadership representation from all programs undergoing survey.

Logistical Needs
The suggested duration of this session is approximately 60 minutes.

Objective
Surveyors will explore leadership's responsibility for creating and maintaining your organization's systems, infrastructure, and key processes which contribute to the quality and safety of care, treatment, or services.

Overview
During this session, surveyors will explore, through organization-specific examples,

- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust process improvement
- Observations that may be indicative of system-level concerns

The surveyor facilitates discussion with leaders to understand their roles related to performance of your organization-wide processes and functions. This discussion will be a mutual exploration of both successful and perhaps less successful organization performance improvement initiatives, or introduction of a new service or an optimal performing department, unit or area vs. one in need of improvement. Surveyors will want to hear how leaders view and perceive these successes and opportunities and learn what they are doing to sustain the achievements, as well as encourage and support more of the same success. Throughout the discussion surveyors will listen for examples of

- The planning process used
- How data is used once it is collected
- The approach used to change processes and work flow
- How information about newly implemented processes is communicated throughout your organization
- How leaders assess the culture of safety throughout the organization
- How leaders envision the performance of processes that are selected for improvement
- Leadership support and direction, including planning and resource allocation
- The degree to which the implementation is comprehensive and organization-wide
- The relationship of the function or process to patient/resident/individual served safety and quality
- How the effective performance of the function or process is evaluated and maintained