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Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Wednesday, June 6, 2012

6:00 p.m. (Closed) | 7:30 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 (6:00 p.m. – 2 East Board Room) — Jordan Battani

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes

1. May 7, 2012 (Regular)

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. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions — Gov't Code Sec. 54957.6

G. Consultation with Legal Counsel Regarding Pending and Threatened Litigation — 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*.

2. Discussion of Hospital Trade Secrets applicable to long-term care expansion.

   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 7:30 p.m. – Dal Cielo Conference Room)

A. Announcements from Closed Session — Jordan Battani

VI. General Public Comment

VII. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

✔ 1) Approval of May 7, 2012 Regular Meeting Minutes
[enclosure] (PAGES 4-10)

✔ 2) Approval of Administrative Policies and Procedures
- No. 75 Patient Safety Program Plan

[enclosure] (PAGE 11)

✔ 3) Approval of Resolution 2012- 3J: Notice of General Election, November 6, 2012
[enclosure] (PAGES 12-15)

✔ 4) Approval of Application for Wound Care Privileges and Standardized Procedures for Nurse Practitioners
[enclosure] (PAGES 16-45)

B. Action Items

✔ 1) Acceptance of March 2012 Unaudited Financial Statements and May 30, 2012 Finance and Management Committee Report — Elliott Gorelick
[enclosure] (PAGES 46-66)

✔ 2) Approval of FY 2013 Operating Budget — Deborah E. Stebbins, Kerry Easthope
[enclosure] (PAGES 67-81)

3) Approval of Resolution 2012-6J: Extension of Spending Authority — Deborah E. Stebbins
[enclosure] [to be distributed]

✔ 4) Approval of FY 2013 Capital Budget — Deborah E. Stebbins, Kerry Easthope
[enclosure] (PAGES 82-85)

✔ 5) Approval Resolution 2012-5J: Use the Jaber Properties as Collateral for Loans with the Bank of Alameda — Deborah E. Stebbins, Kerry Easthope, Thomas Driscoll
[enclosure] (PAGES 86-91)

✔ 6) Approval of Resolution 2012- 4J: Levying the City of Alameda Health Care District Parcel Tax for the Fiscal Year 2012-2013 — Deborah E. Stebbins
[enclosure] (PAGES 92-93)

✔ 7) Approval of Certification and Mutual Indemnification Agreement — Thomas Driscoll
[enclosure] (PAGES 94-96)

C. District Board President Report INFORMATIONAL — Jordan Battani

D. Chief Executive Officer Report **INFORMATIONAL** — Deborah E. Stebbins

✔ 1) Monthly CEO Report

[enclosure] (PAGES 97-116)

- *Reports and Updates on: IGT / State Budget, Comprehensive Orthopedic Program Update, November 6, 2012 General Election, Wound Care Center, New Board Meeting Dates, HIPAA Education, FY 2013 Goals and Objectives, Kate Creedon Award & Annual Foundation Gala, Upcoming Events, May 2012 Key Statistics*

2) Monthly Quality Metrics

a) Pain Management **[enclosure] [to be distributed]**

E. Community Relations and Outreach Committee Report **INFORMATIONAL** — Stewart Chen, DC

1) May 22, 2012 Committee Meeting

F. Medical Staff President Report **INFORMATIONAL** — James Yeh, DO

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
Monday, May 7, 2012 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Stewart Chen, DC Robert Deutsch, MD Elliott Gorelick J. Michael McCormick	Deborah E. Stebbins Kerry J. Easthope Brian Jung	Thomas Driscoll, Esq.	N/A
		Medical Staff Present	Excused
		Jim Yeh, DO	Jordan Battani
Submitted by: Erica Poncé, Administrative Secretary			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:07 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 6:08 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 7:40 p.m.	

A. Announcements From Closed Session

Director Deutsch stated that the Executive Closed Session Minutes were reviewed and approved from the March 31, 2012 and April 2, 2012 meetings. The Board Quality Committee Report for February 2012 was reviewed and accepted as presented. The Board 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	
• Kenneth Economy, MD	Anesthesiology	Island Anesthesia	

Reappointments – Medical Staff

Name	Specialty	Staff Status	Appointment Period
• Faraz Berjis, MD	Gastroenterology	Courtesy	06/01/12 – 05/31/14
• Gary Cecchi, MD	Hematology / Oncology	Active	06/01/12 – 05/31/14
• Richard Kochenburger, MD	OB / Gyn	Active	06/01/12 – 05/31/14
• Liesl Pavlic, MD	Int Med / Hospitalist	Active	06/01/12 – 05/31/14

Reappointment - Allied Health Professional

• Catherine Dunning, PA-C	Physician Assistant		06/01/12 – 05/31/14

Resignations

There were no resignations submitted during the month of April.

VI. **General Public Comments** There were no public comments.

VII. Regular Agenda

A. Consent Agenda	Director McCormick made a motion to approve the Consent Agenda as presented. Director Chen seconded the motion. The motion carried.
1) Approval of April 2, 2012 Regular Meeting Minutes	
2) Approval of March 31, 2012 Special Meeting Minutes	
3) Acceptance of the 2011 Environment of Care Annual Report	
4) Approval of Revisions to the City of Alameda Health Care District Policy #2008-0b –	

Topic	Discussion	Action / Follow-Up
	Signature Authority	
	5) Approval to Enter into a Contract with MuirLab for Reference Lab Work	
	6) Approval of the 2012 Continuing Medical Education Program Mission Statement	
	7) Approval of Revisions to Medical Staff Rules: Article 2, Anesthesia Service	
B.	Action Items	
	1) Acceptance of March 2012 Unaudited Financial Statements and April 25, 2012 Finance and Management Committee Report. Director McCormick stated that the March 2012 unaudited financial statements were reviewed for discussion and analysis at the Finance and Management Committee meeting of April 25, 2012 and provided the following report and key points from the meeting. Gross revenues were below budget for the first time in two months. The District experienced a negative bottom line with $295,000 budgeted and a negative $401,000 realized. The YTD bottom line was a negative $1,112,000. Two unusual adjustments to contractual allowances pushed the financials to exceed budget by $631,000. A $35,000 reserve was established in anticipation of a potential State pay-back associated with this year's skilled nursing payments. In addition, the 2010 Medi-Cal cost report was settled with a payable of $203,000 which was greater than anticipated. Without these adjustments the bottom line would have been a negative $163,000. Lower activity contributed to the loss for the month which was also reflected in the revenue for the month. . Overall gross revenue was 11.1% below budget with inpatient revenue down 15.2% and outpatient revenue down 2.5%. This was largely due to $428,000 budgeted for the Wound Care Center, which has not opened. The Case Mix Index ran at 1.3071 which was above the YTD average. Expense activity was unusually high in purchased services including outside billing, information services, engineering and employee recruitment. However, YTD expenses are very near budget at $166,000. Cash on hand went from 12.4 days in February to 2.2 days in March. The current ratio ended the month at 1.0.	Director Gorelick made a motion to accept the March 2012 Unaudited Financial Statements and April 25, 2012 Finance and Management Committee Report as presented. Director Chen seconded the motion. The motion carried.

Topic	Discussion	Action / Follow-Up
	Director Gorelick asked for Management's opinion regarding the Hospital's ability to stay in compliance with the two covenants with the Bank of Alameda (current ratio and net assets). Mr. Easthope replied that the months with increased income will drive both the ratio and assets up due to their working relation with one another. Ms. Stebbins added that Management continues to maintain communication with Bank of Alameda regarding the loan covenants. Director Gorelick stated his concern for the draw down on the short-term construction loan for the Wound Center project. Mr. Easthope stated that the draw to date is approximately $145,000. Ms. Stebbins stated that they will continue to look at the loan and monitor the draw on the funds. Management will report on loan and project status at the next Finance and Management Committee Meeting scheduled for Wednesday, May 30, 2012.	
	2) Approval to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management Mr. Easthope presented the proposed the recommendation to enter into an agreement with Select Therapies as outlined on pages 75-82 of the Board Packet. Director McCormick recalled Mr. Easthope's statement that it is essential to establish a rehabilitation program for the impending orthopedic program to be successful, then asked if a rehab program would be successful even if the orthopedic program is not established. Mr. Easthope replied that a strong rehabilitation program is needed regardless of what occurs with orthopedics. He added that rehab in a long term care setting is unique and is different than inpatient or outpatient rehab care and that the Hospital's Long Term Care Administrator (Richard Espinoza) has stressed the importance of a strong rehab program in long term care. Director Chen asked if the rehab staff's concerns that were brought to the Board have been addressed. Mr. Easthope replied that there have been discussions with staff regarding the change and their concerns have been addressed. Ms. Stebbins also replied that the meetings that Management has had with the rehab staff have been positive, with Management communicating the need for staff development, program improvement, and change of care philosophy. Director Chen asked if alternatives short of outsourcing have been explored. Ms. Stebbins replied that this plan is the alternative plan, which consists of outsourcing only the long term care portion of rehab.	Director Chen made a motion to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management. Director McCormick seconded the motion. The motion carried.
	3) Approval of Revisions to the Terms and Conditions of the Orthopedic Professional	Director Gorelick made a motion to approve the Revisions to the Terms

Topic	Discussion	Action / Follow-Up
	Service Agreements and Authorization to Execute Such Agreements Tony Corica presented the proposed changes on pages 83-87 of the Board Packet, highlighting that there is an increase of $211,000 over the three-year term as compared to the initial proposal presented at the April 2, 2012 District Board Meeting. Director Gorelick asked if a commitment had been received from the orthopedists. Mr. Corica stated that the spine surgeon has given a tentative commitment and the sports medicine specialist is expected to give his response within one week. Director Gorelick asked if the orthopedists have visited the Hospital beyond their initial meeting, to which Mr. Corica replied that they have. A short discussion followed.	and Conditions of the Orthopedic Professional Service Agreements and Authorization to Execute Such Agreements. Director McCormick seconded the motion. The motion carried.
	4) Approval of Proposed FY 2012Executive Performance Metrics and Incentive Compensation Plan Directors McCormick and Gorelick worked together with management on an updated Incentive Compensation Plan, found on pages 88-89 of the Board Packet. Director Gorelick stated that the revised plan incorporated the concerns of the Board form the April 2, 2012 Board meeting and was cognizant of the work relating to Waters Edge. It has also been noted that in the future, more timely presentation of the performance metrics and incentive compensation plan would be ideal. It was suggested by Director McCormick that the next incentive proposal should be outlined in a simple format and brought to the Board in August 2012. Director Chen asked if any other Management personnel are included in this plan. Director Gorelick replied that the only two are the CEO and CFO. There has been discussion of opening it up to other executives, but at this time there are only two included in this structure. Director McCormick added that it would be beneficial to incorporate other members of Management in the future as well as restore the wage rollbacks and wage freezes throughout the Hospital staff.	Director Chen made a motion to approve the Proposed FY 2012 Executive Performance Metrics and Incentive Compensation Plan. Director Deutsch seconded the motion. The motion carried.
	C. Board President Report Director Deutsch reported in President Battani's absence. Director Deutsch, along with Attorney Tom Driscoll, briefly discussed a complaint received by the Fair Political Practices Commission in 2011 alleging that Dr. Deutsch had a conflict of interest and made governmental decisions that had a reasonably foreseeable material financial effect on a source of income to him. The Commission completed their investigation of the facts in this case and decided to close the case without further action.	

Topic	Discussion	Action / Follow-Up
D.	Chief Executive Officer Report 1) Monthly CEO Report Directed Board Members to pages 90-94 in Board Packet, highlighting Executive Re-Organization, Schedules and Events, Community Outreach, Local Hospitals, Wound Care, Seismic and Other Regulatory Compliance Planning Activities, and April Key Stats. Ms. Stebbins introduced Brian Jung as the new Chief Business Development Officer and announced Kerry Easthope's transition to Chief Financial Officer. She also invited District Board Members to attend Hospital events over the next week which highlight National Hospital Week and National Nurses Week.	
	2) District Board Meeting Scheduling Discussion Following discussion, a vote was taken regarding changing the meeting days for the District Board.	Director McCormick made a motion to approve the change of the City of Alameda Health Care District Board Meetings to the first Wednesday of each month for the remainder of 2012. Director Chen seconded the motion. Director Gorelick abstained. The motion carried.
E.	Medical Staff President Report James Yeh, DO, Medical Staff President, stated that the CME program for May is slated for May 22 with the following speaker presenting: • Ronnie Mimran, MD, Neurosurgeon, Pacific Brain and Spine Medical Group – "Minimally Invasive Spine Surgery"	No action taken.
F.	Community Relations and Outreach Committee Report Director Chen reported on the April 24, 2012 Community Relations and Outreach Committee noting the following: The committee heard a presentation from Michaele Baxter, Stroke Program Coordinator, about the certified stroke center. Last week, Alameda Hospital provided TB testing for Alameda Unified School District Employees. Alameda Hospital participated in a health fair for the Alameda Point Collaborative on	No action taken.

Topic	Discussion	Action / Follow-Up
	Friday, May 4. Upcoming events include: • Park Street Spring Festival on May 12 • Mastick Senior Center Senior Fitness Day on May 16 • Community Stroke Risk assessment on May 18 • South Shore Asian Pacific Islander Festival on May 20 • Senior Health Day at the Harbor Bay Club on May 30 Alameda Hospital will provide health screenings, health education, and information about Hospital services at these community events. Let's Move Alameda campaign to prevent childhood obesity continues. Alameda Hospital and its community partners: Girls Inc, Boys and Girls club, Alameda Recreation and Parks, and the schools are actively collecting healthy lifestyle pledges throughout the city. Tony Corica provided an update on the Comprehensive Orthopedic Program. The Alameda Hospital Foundation is presenting a special fundraiser: "Antique Adventures 2" at Michaan's Auctions on June 7, 4 to 7 p.m. District Board Members are invited to attend.	
VIII.	**General Public Comments** There were no additional comments.	
IX.	**Board Comments** There were no comments.	
X.	**Adjournment**	Being no further business, the meeting was adjourned at 8:46 p.m.

Attest:

Robert Deutsch, MD Acting President	Elliott Gorelick Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 24, 2012

For: June 6, 2012 District Board Meeting

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

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Administrative Policy No. 75 – Patient Safety Program Plan

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Recommendation:

Management requests approval of Administrative Policy No. 75 – Patient Safety Program Plan.

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 the Administrative Policies and Procedures. All policies and procedures will be brought to the Board of Directors for approval over the next 6 -10 months.

The policies and procedures have been either new or revised to reflect current practices, regulatory language / requirements and/or other pertinent information. 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.

Policy #	Type of Change	Policy Title & Purpose Statement
No. 75	Revision	**PATIENT SAFETY PROGRAM PLAN** **PURPOSE:** To provide a pro-active patient safety program designed to improve patient safety and reduce risks to patients in the pursuit of a high reliability organization. Recognizing that effective medical/healthcare risk reduction requires an integrated and coordinated approach, hospital leadership provides an organization-wide safety program that includes all activities within the organization which contribute to the maintenance and improvement of patient safety. *Note: Policy was revised to meet regulatory requirements and standards set forth by the Joint Commission.*

RESOLUTION NO. 2012-3J

BOARD OF DIRECTORS, CITY OF ALAMEDA HEALTH CARE DISTRICT

STATE OF CALIFORNIA

*** * ***

NOTICE OF GENERAL ELECTION

NOVEMBER 6, 2012

WHEREAS, the City of Alameda Health Care District submits to the Alameda County Registrar of Voters a Notice of General Election as applicable for the District Board of Directors whose terms that expire on the scheduled election year;

WHEREAS, on May 18, 2012 the District submitted, as attached herewith, to the Alameda County Registrar of Voters, the Notice of General Election specifying information on the offices, which will be voted on this election year.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the District that the elective offices of the District to be filled at the next general election for four (4) year terms, to be held Tuesday, November 6, 2012, are those offices now held by:

Jordan Battani
Joseph Michael McCormick

RESOLVED further that the District will not pay for the publication of the candidates' statement of qualifications; and

RESOLVED further that a map showing the boundaries of the District is attached hereto.

PASSED AND ADOPTED on June 6, 2012, by the following vote:

AYES: _____ NOES: _____ ABSENT: _____

_____
Jordan Battani
President

ATTEST:

_____
Elliott Gorelick
Secretary

NOTICE OF GENERAL DISTRICT ELECTION
(Election Code 10509, 10514, 10522)

City of Alameda Health Care District
DISTRICT

November 6, 2012
DATE OF ELECTION

ELECTIVE OFFICES

The purpose of said election is to elect 2 (two) officials for a FULL TERM to fill the offices presently held by the following officials whose terms expire December 3, 2012.

INCUMBENT NAME/OFFICE TITLE	DIVISION (If applicable)	APPOINTED YES/NO
Joseph Michael McCormick	N/A	No
Jordan Battani	N/A	No

The following section applies only if official(s) was/were appointed to fill a vacancy in an office, which is not normally scheduled to be voted on this year.

District will also elect _____ official(s) for a SHORT TERM ending _____.

NAME	DIVISION	DATE APPOINTED	OFFICIAL REPLACED

ISSUING AND FILING OF CANDIDATE NOMINATION DOCUMENTS

All Nomination documents will be issued and filed through the Registrar of Voters office.

1225 Fallon St. G-1
Oakland, CA 94612
510-272-6933

CANDIDATE STATEMENT OF QUALIFICATIONS (Check the appropriate box below):

(1) District will pay for candidate's statements upon billing ☐
(2) Candidates will pay total estimated cost upon submitting statement ☒
(3) Candidates **will deposit** estimated cost upon submitting statement ☐

(3) (a) Amount of Deposit: _____

Revised May 2012

NOTICE OF DISTRICT ELECTION AND PUBLICATION OF ELECTION NOTICE

Elections Code §12112 requires that we publish a notice of election providing information on the date of the election, offices for which candidates may file, qualifications required by your principal act, etc. In order for the Registrar of Voters to publish the Notice of Election, list below a local newspaper of general circulation.

Notice of Election to be published by Registrar of Voters in Alameda Journal.
(Local newspaper of general circulation)

CERTIFICATION OF MAPS AND BOUNDARIES

Elections Code §10522 requires that at least **125 days** before the election a current map and boundary description be delivered to the Registrar of Voters. For the November 6, 2012 Election, **the legal deadline is July 5, 2012**. If, however, there have been no boundary changes since your last election, you may certify the map and boundary description, which we have on file, as being current. You can do so, by checking the appropriate box below.

MAP OR BOUNDARY DESCRIPTION (REQUIRED) is enclosed:
NO boundary changes ☒
SEE boundary changes ☐

In addition, jurisdictions that elect by area or division must have their new area or division legal boundary descriptions and maps in our office by our **administrative deadline of May 18, 2012 (E-172)**

FORM 700 – STATEMENT OF ECONOMIC INTEREST

Does your district's Conflict of Interest require ***Candidates*** to file a Statement of Economic Interest form?
☐ **YES**
☒ **NO**

BALLOT MEASURES

If your district is contemplating placing a measure in the November 6, 2012 Election, please coordinate with our office at the earliest date possible. The deadline for a district measure to be consolidated with the November Election is August 10, 2012 (E-88). It is important for your district and our office to coordinate the details of what and how items need to be submitted to us. **All ballot measure materials must be submitted in an electronic format.** Listed below are the deadlines for submitting ballot measure materials:

August 10, 2012 (E-88) – District Resolutions (calling election, ballot measure questions, ballot measure full text)

August 17, 2012 (E-81) – Last day to submit Direct Arguments

August 24, 2012 (E-74) – Last day to submit Rebuttal Arguments

If any resolutions necessitate special requirements that the Elections' Office needs to fulfill, such requirements need to be listed in the resolution and attached to this notice.

(DISTRICT SEAL)
District has no seal.

Deborah E. Stebbins
SIGNED (District Administrator)

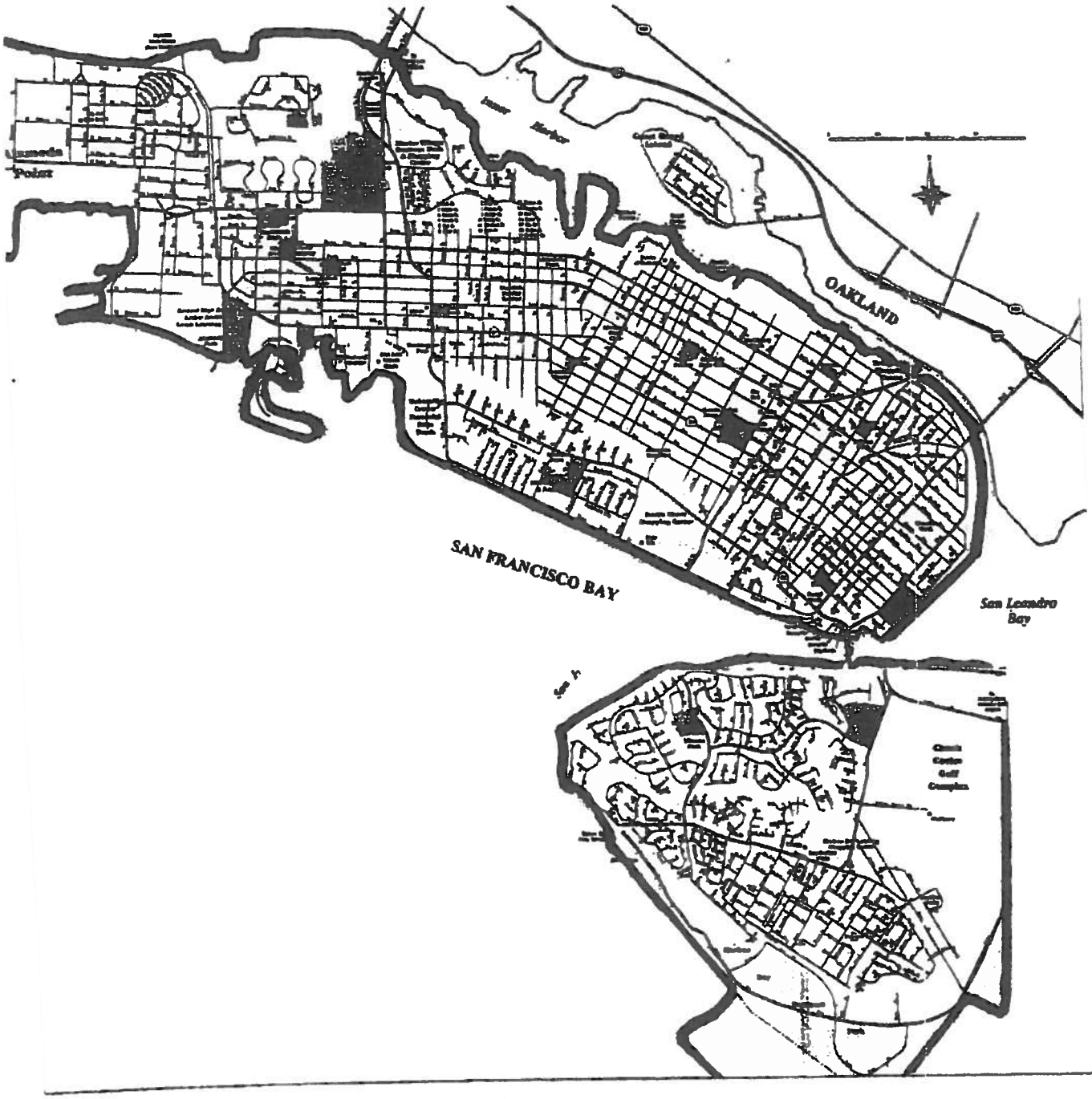
2070 Clinton Ave., Alameda, CA 94501
MAILING ADDRESS

510-814-4001
AREA CODE / PHONE NUMBER

Revised May 2012

EXHIBIT A

The boundaries of this health care district include the boundaries of the City of Alameda contained within zip codes 94501 & 94502.



Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 25, 2012

For: June 6, 2012 District Board Meeting

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

From: James Yeh, DO, President, Medical Staff

Subject: Approval of Application for Wound Care Privileges and Standardized Procedures for Nurse Practitioners

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The Medical Executive Committee respectfully requests your approval of the following:

1. **Application for Wound Care Privileges**

Applicants requesting privileges to treat patients at the Kate Creedon Center for Advanced Wound Care will be required to satisfy certain training requirements before submitting the application for privileges. Applicants also must be members of the Alameda Hospital Medical Staff.

The application is divided into two sections: Section A includes the procedures for treating wounds and Section B is for hyperbaric oxygen therapy (HBOT). Both sections require specific training and experience thereafter to maintain privileges.

This privilege delineation has been reviewed by members of the Service Committees and approved by the Medical Executive Committee.

2. **Standardized Procedures for Nurse Practitioners/SNF Unit**

Nurse practitioners (NP) do not have an additional scope of practice beyond the usual RN scope fof practice and must rely on standardized procedures for authorization to perform medical functions that overlap those performed by physicians. Thus, standardized procedures provide the legal authority for the NP to exceed the usual scope of RN practice. Each standardized procedure must be signed by the NP and the supervising physician(s).

Regulations governing standardized procedures can be found in the Business and Profession Code, Nursing Practice Action, Section 2725 and California Code of Regulation 1480.

The standardized procedures being submitted to you include those overlapping functions that may be performed by NPs for patients in a skilled nursing facility.

Application for Wound Care Privileges
Kate Creedon Center for Advanced Wound Care

☐ Initial application for wound care privileges

An applicant applying for wound care privileges must be a member of the Alameda Hospital Medical Staff with clinical privilege or be an applicant for Medical Staff membership and clinical privileges. Wound care privileges are contingent upon practitioner maintaining his/her Medical Staff membership and privileges at Alameda Hospital.

NAME: _____ **SPECIALTY:** _____

Wound care privileges include the care, treatment and/or services listed below. I specifically acknowledge that board certification alone does not qualify me to perform all privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualify me to perform each privilege I have requested.

A WOUND CARE PROCEDURES

Applicants will be requested to provide documentation of successful completion of a course in wound care medicine.

Wound Debridement		Approved	Denied
☐	Partial thickness	☐	☐
☐	Full thickness	☐	☐
☐	Subcutaneous Tissue	☐	☐
☐	Subcutaneous Tissue and Muscle	☐	☐
☐	Subcutaneous Tissue, Muscle and Bone	☐	☐

Other Procedures:

☐	I&D, Abscess, simple	☐	☐
☐	I&D, Abscess, complex	☐	☐
☐	Cauterization	☐	☐
☐	Biopsy, skin	☐	☐
☐	Biopsy, bone	☐	☐
☐	Preparation and application of skin substitutes	☐	☐
☐	Vacuum assisted closure devices	☐	☐

B. HYPERBARIC OXYGEN THERAPY PRIVILEGES

Initial Application for Privileges:

Minimal formal training: Applicants must be able to provide documentation of successful completion of a recognized hyperbaric medicine training program as established by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society; or completion of an ACGME/AOA accredited fellowship in hyperbaric medicine. Applicants with previous experience must be able to provide documented evidence they have provided hyperbaric medicine services for a minimum of 50 treatments in the last twelve (12) months.

Reappointment Application:

▪***Required previous experience:*** Applicants must be able to demonstrate that they have provided hyperbaric medicine services for at least 50 treatments annually since their last appointment.

Name: _____

Requested		Approved	Denied
☐	Hyperbaric Oxygen Therapy	☐	☐

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Wound Care Center.

_____ _____
Signature – Applicant Date

RECOMMENDATION(S)

I have reviewed the requested privileges for wound care and the supporting documentation for the above named applicant and have indicated my recommendation next to each procedure.

_____ _____
Service Committee Chair Date

I have reviewed the requested privileges for hyperbaric oxygen therapy and the supporting documentation for the above named applicant and have indicated my recommendation next to the procedure.

_____ _____
Medical Director of Hyperbaric Oxygen Therapy Date

ALAMEDA HOSPITAL

NURSE PRACTITIONER STANDARDIZED PROCEDURES

For the Provision of
Health Care in
Skilled Nursing Facilities

May 2012

TABLE OF CONTENTS

1. POLICY

This document is prepared in accordance with the legal requirements governing the practice of nurse practitioners ("NP") including California Business and Professions Code sections 2725 (nursing practice) and 2836.1 which requires that standardized procedures must be developed by the NP and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioners' educational preparation or for which clinical competency has been established and maintained. It was jointly prepared by nurse practitioners, supervising physicians, department chiefs and administrators.

By signing this Statement of Approval, the below named nurse practitioners, designated physicians, supervising physicians and administrators, agree to maintain a collaborative and collegial relationship, and abide by the Standardized Procedures and Protocols in theory and practice.

A. Development and Review

1. All Standardized Procedures are developed collaboratively by nurse practitioners, designated physicians, supervising physicians and a nurse administrator.
2. All Standardized Procedures are to be approved by the following personnel: nurse practitioners, designated physicians, supervising physicians and a nurse administrator.
3. All Standardized Procedures are to be kept in a file that includes approval sheets dated and signed by authorizing persons and by those nurse practitioners covered by the Standardized Procedures.
4. All Standardized Procedures are to be reviewed periodically at a minimum of every three years by Nurse Practitioners, designated physicians and the Director of Nursing or his/her designee.
5. Changes in or additions to the Standardized Procedures may be initiated by any of the signatories and must be approved by the authorizing personnel (e.g., Medical Staff Service Committee Chair, supervising physician, Director of Nursing, nurse practitioner) and accompanied by a dated, signed approval sheet.

2. STANDARDIZED PROCEDURE FUNCTIONS

1 Nurse Practitioners may perform the following functions within their training specialty area and consistent with their competency, experience and credentials:

a. assessment;
b. management and treatment of episodic illnesses, injuries;
c. management and treatment of chronic illnesses and end of life care;
d. health promotion; and
e. general evaluation of health status.

2. These may include but are not limited to:
   a. ordering laboratory and diagnostic imaging;
   b. ordering of therapeutic (e.g., physical therapy) modalities where legally authorized;
   c. ordering or furnishing drugs and devices;
   d. recommending diets;
   e. referring to specialty clinics, ordering and/or performing department specific diagnostic/therapeutic procedures.
   f. facilitating skilled nursing facility or hospital admission, transfer or discharge with an order from a physician or other authorized Licensed Independent Practitioner.

3. The scope of practice is determined by Standardized Procedures and Protocols and training and competencies.

4. Standardized Procedure functions are to be performed in areas which allow for the supervising or consulting physician to be available to the Nurse Practitioner by telephone, electronically, or in person where required.

5. Physician consultation or referral is to be obtained whenever situations arise which go beyond the competence or scope of practice of the NP or as specified under the following circumstances:

   a. emergent conditions requiring prompt medical intervention after stabilizing care has been initiated;
   b. acute decompensation of patient situation;
   c. problem which is not resolving as anticipated;
   d. unexplained historical, physical or laboratory findings; and
   e. upon request of patient, designated patient representative, nurse practitioner, or physician.

   A physician must care for the patient when the patient requests a physician, the patient presents with a condition that the NP is not authorized to treat, or the care to be provided is outside the NP's scope of practice.

3. REQUIREMENTS

1. The Standardized Procedures developed for use by the nurse practitioners are designed to describe the steps of care for given patient situations. They are to be used in the following circumstances:
   a. general evaluation of health status;
   b. management of acute illnesses and injuries;
   c. management of chronic illnesses;
   d. management of end of life care.

2. Disease specific guidelines may be used to supplement the patient care process and not to define it absolutely. Alterations and adjustments may be necessary in an individual patient's situation.

4. STANDARDIZED PROCEDURES FOR MAKING A DIAGNOSIS AND ESTABLISHING A TREATMENT PLAN

A. Subjective data collection

Perform symptom analysis and collect supporting data as appropriate to chief complaint or identified problem.

B. Objective data collection

Perform physical evaluation as indicated and review available medical, nursing and diagnostic data.

C. Assessment

Formulate a diagnosis based on A & B above.

D. Plan

1. Consultation: The nurse practitioner will manage conditions as outlined in this document. If a physician is to be consulted, a notation to that effect including the physician's name, must be made in the patient's medical record. Physician consultation will be sought for all the following situations and any others deemed appropriate:

2. Conditions for which the diagnosis and/or treatment are beyond the scope of the nurse practitioner's knowledge and/or skills.

3. Furnish/order appropriate drugs and/or devices

   The selection of pharmacological therapy may include, but is not limited to. consideration of the following factors:

   a. the determination of a history of allergies;
   b. current medications;
   c. medication order is appropriate to the problem identified;
   d. dosage adjustment to individual patient needs, within therapeutic range;
   e. determination of pregnancy and lactation status;
   f. discussion of drug side effects;
   g determination of alternative treatment modalities.

4 Order appropriate diagnostic studies.

5. Perform necessary procedures.

6 Monitor health maintenance and provide health education .

7. Recommend general treatment measures, local therapies, activities and rest, and symptomatic relief as appropriate (e.g., ice, heat, steam inhalation).

8 Refer patient or consult with other practitioners or specialties, as indicated (e.g.,Physical Therapy, Surgical Consultation, Chronic Conditions Management).

9. Follow-up for further evaluation and treatment, as indicated.

5 XPERIENCE AND/OR TRAINING AND EDUCATION

Each nurse practitioner performing Standardized Procedure functions must have a registered nursing license, be a graduate of an approved Nurse Practitioner Program, and be certified as a nurse practitioner by the California Board of Registered Nursing.[2]
Each nurse practitioner who furnishes/orders drugs and devices must have a furnishing number issued by the Board of Registered Nursing. Nurse practitioners who furnish/order controlled substances must also have a current Drug Enforcement Agency (DEA) registration certificate.

6. METHOD OF INITIAL AND CONTINUING EVALUATION

General competency following initial appointment to Allied Health Professional Status is evaluated during the probationary period by the supervising physician or designee. The nurse practitioner is assigned to and is supervised by a designated physician who is responsible to evaluate appropriateness of practice and clinical decision making. A QA review process is established to assure that compliance to standards relating to important aspects of care is maintained.

Continuing evaluations of nurse practitioner performance of Standardized Procedure functions will be done at the time of reappointment to Allied Health Professional Status, and more often if deemed necessary, in conjunction with existing or revised Medical Staff Rules and Regulations, and appropriate Quality Assurance and/or peer review-related activities.

7. PERSONS AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE FUNCTIONS

The current record of nurse practitioners authorized under the provisions of this Standardized Procedure is maintained by the Director of Nursing or designee.

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1 On and after January 1, 2008, nurse practitioners must possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the California Board of Registered Nursing. (Business and Professions Code section 2835.5)

2 On or after January 1, 2001, in order to meet Medicare Conditions of Participations, Nurse practitioners are required to possess national certification from one of four national certifying bodies (American Academy of Nurse Practitioners (AANP), American Nursing Credentials Center (ANCC), Pediatric Nursing Certification Board (PNCB) or National Certification Corporation for Obstetric, Gynecology and Neonatal Nursing Specialties (NCC). except that this requirement does not apply to Nurse practitioners who were determined eligible by CMS to meet Medicare conditions of participation before January 1, 2001 and/or NPs in "carve out" positions.

8. SCOPE OF SUPERVISION

Each nurse practitioner is to function under the supervision of a supervising physician. There is a limit of four NPs per supervising physician at one time to meet California drug and device furnishing requirements.

Standardized Procedure functions are to be performed in areas which allow for the supervising or consulting physician to be available to the Nurse Practitioner by telephone, electronically, or in person where required.

9. CIRCUMSTANCES IN WHICH NP IS TO COMMUNICATE WITH A PHYSICIAN

Physician consultation or referral or intervention is to be obtained whenever situations arise which go beyond the competence or scope of practice of the NP or as specified under the following circumstances:

a. emergent conditions requiring prompt medical intervention after stabilizing care has been started;
b. acute decompensation of patient situation;
c. problem which is not resolving as anticipated;
d. historical, physical or laboratory findings inconsistent with the clinical picture; and
e. upon request of patient, patient representative, nurse practitioner, or physician.

10. SETTINGS

Nurse Practitioners may perform the Standardized Procedures within their training, specialty area and consistent with their competency, experience and credentials. Standardized Procedure functions are to be performed in areas which allow for a supervising or consulting physician to be available to the Nurse Practitioner by telephone, electronically, or in person where required.

11. RECORD-KEEPING REQUIREMENTS

All interactions with patients are to be recorded in the medical record.

12. PERIODIC REVIEW

All Standardized Procedures are to be reviewed periodically at a minimum of every three years by Nurse Practitioners, designated physicians, and a Nurse Administrator.

Changes in or additions to the Standardized Procedures may be initiated by any of the signatories and must be approved by the authorizing personnel (e.g., department chief, supervising physician, Director of Nursing Practice, nurse practitioner) and accompanied by a dated, signed approval sheet.

The purpose of the signature of approval page is to assure that the nurse practitioners, designated physicians and administrators involved in a collaborative relationship providing patient care are familiar with the rules governing nurse practitioner practice and have agreed to abide by the Standardized Procedures and protocols in theory and practice.

SIGNATURES OF APPROVAL

Service Committee Chair	Date
Supervising Physician	Date
Nurse Practitioner	Date
Director of Nursing	Date
Interdisciplinary Committee Signature	Date

FURNISHING OF DRUGS AND DEVICES
DISEASE - SPECIFIC PHARMACOLOGIC THERAPIES

The nurse practitioner may furnish/order dangerous drugs, including Schedule II-V drugs, and devices, as authorized by Alameda Hospital in accordance with the law governing nurse practitioner furnishing practice, including Business Professions Code sections 2746.51 and B and P Section 2836.1 (a) which was amended to require that standardized procedures must be developed by the NP and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioners' educational preparation or for which clinical competency has been established and maintained.

See the attached "patient-specific protocols" for furnishing Schedule II and III drugs and devices.

The following is the disease and system categories for which drug furnishing is intended:

Allergies
Breast
Cancer
Cardiovascular
Chronic Pain
Dermatologic
End of Life Care
Endocrine
Gastrointestinal
Genitourinary
Gynecologic
Hematologic
HIV Disease
Infectious Disease
Mental Health/Behavioral
Musculoskeletal
Neurology
Nutrition Disorders
Obstetrics
Occupational Health
Ophthalmic
Orthopedic
Palliative Care
Pulmonary
Reproductive Health
Sexually Transmitted Disease
Skin Testing and Immunizations
Trauma
Vascular

_____ _____
Supervising Physician Date

_____ _____
Supervising Physician Date

_____ _____
Nurse Practitioner Date

PATIENT-SPECIFIC PROTOCOL FOR NURSE PRACTITIONER ORDERING/ FURNISHING SCHEDULE II DRUGS AND DEVICES

I POLICY

As it relates to the standardized procedure from which the NP is furnishing the Schedule II controlled substance, only nurse practitioners with current DEA registration authorizing the ordering of schedule II drugs and devices and a BRN issued furnishing numbers are permitted to order/furnish medication. Nurse practitioners may furnish/order Schedule II controlled substances in accordance with a patient specific protocol approved by the treating or supervising physician. No physician shall supervise more than four (4) nurse practitioners at one time. .

II PATIENT SPECIFIC PROTOCOL

1. Definition: This protocol includes assessment and management of patients but is not limited to the following conditions, illnesses, diseases, and/or symptoms: Acute traumatic injuries (e.g., sprains, strains, fractures):

   Acute abdominal/pelvic pain
   Acute infection (e.g., pelvic inflammatory disease, pyelonephritis)
   Behavioral conditions (e.g. ADHD)
   Chronic pain
   End of life care
   Hormonal imbalance
   Acute and chronic pain
   Musculoskeletal disorders (e.g., low back pain, neck pain)
   Neurological processes (e.g., severe headache, facial pain)
   Palliative care
   Urological processes (e.g., kidney stone)
   Post-surgical pain
   Procedural pain
   Respiratory infections

2. Database: Subjective and objective data collection - as described in the standardized procedure protocol.
   Assessment — Diagnosis formulated on subjective and objective information.
   Plan — As described in the standardized procedure protocol, including the furnishing of approved schedule II drugs as appropriate for management of the conditions(s) listed in the definition section above. Pursuant to Health & Safety Code section 11200 "no prescription for a Schedule II substance may be refilled." For furnishing purposes, "prescription" refers to the NP transmittal order. Order must be written on anti-fraud prescription pad.
3. The patient has a medical condition specified in this Protocol and otherwise meets criteria for which nurse practitioner furnishing or ordering of a Schedule II controlled substance is appropriate.

4. Prior authorization by supervising physician:

The use of the patient specific protocol must be authorized by the supervising physician prior to furnishing Schedule II drugs.

X_____ _____

Signature of Supervising Physician Date

X_____ _____

Signature of Supervising Physician Date

X_____ _____

Nurse Practitioner Date

STANDARDIZED PROCEDURES FOR NURSE PRACTITIONER

Schedule II Controlled Substance Authorization

The use of the patient specific protocol must be authorized by the supervising physician prior to the Nurse Practitioner furnishing Schedule II drugs.

_____	_____
Supervising Physician	Date
_____	_____
Supervising Physician	Date
_____	_____
Nurse Practitioner	Date

PATIENT-SPECIFIC PROTOCOL FOR NURSE PRACTIONER FURNISHING OF SCHEDULE III CONTROLLED SUBSTANCES

I POLICY

As it relates to the standardized procedure from which the NP is furnishing the Schedule III controlled substance, only nurse practitioners with current DEA registration and BRN issued furnishing numbers are permitted to order/furnish medication. Nurse practitioners may furnish/order Schedule III controlled substances in accordance with a patient specific protocol approved by the treating or supervising physician. No physician shall supervise more than four (4) nurse practitioners at one time.

Ⅱ PATIENT-SPECIFIC PROTOCOL

1 Definition: This protocol includes assessment and management of patients but not limited to the following conditions, illnesses, diseases, and/or symptoms:

Acute traumatic injuries (e.g., sprains, strains, fractures)
Acute infection (e.g., pelvic inflammatory disease, pyelonephritis)
Hormonal imbalance

Acute and chronic pain
Musculoskeletal disorders (e.g., low back pain, neck pain)
Neurological processes (e.g., severe headache, facial pain)
tlrological processes (e.g., kidney stone)

Post-surgical pain
Procedural pain
Respiratory infections
End of life care

Palliative care

Database: Subjective and objective data collection — as described in the standardized procedure protocol.

Assessment — Diagnosis formulated on subjective and objective information.

Plan — As described in the standardized procedure protocol, including the furnishing of approved schedule III drugs as appropriate for management of the conditions(s) listed in the definition section above. Pursuant to Health & Safety Code section 11200 "no prescription for a Schedule III (or IV) substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120 days supply." (For furnishing purposes, "prescription" refers to the NP transmittal order).

The patient, [name of patient], has a medical condition specified in this Protocol and otherwise meets criteria for which nurse practitioner furnishing or ordering of a Schedule III controlled substance is appropriate.

2. Prior authorization by supervising physician:

The use of the patient specific protocol must be authorized by the supervising physician prior to furnishing Schedule III drugs.

_____	_____
Signature of Supervising Physician	Date
_____	_____
Signature of Supervising Physician	Date
_____	_____
Nurse Practitioner	Date

STANDARDIZED PROCEDURES FOR NURSE PRACTITIONERS

Schedule III Controlled Substance Authorization

The use of the patient specific protocol must be authorized by the supervising physician prior to the Nurse Practitioner furnishing Schedule III drugs.

_____	_____
Supervising Physician	Date
_____	_____
Supervising Physician	Date
_____	_____
Nurse Practitioner	Date

STANDARDIZED PROCEDURE FOR CONSERVATIVE SHARP WOUND DEBRIDEMENT BY NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES

I POLICY

This standardized procedure is developed collaboratively and approved by nurse practitioners, supervising physicians and the Director of Nursing . It is reviewed every three years. It conforms to the general policies of the Standardized Procedures for Nurse Practitioners providing care to SNF patients.

II. PROTOCOL

Description—Sharp wound debridement is the removal of non-viable tissue from a wound bed with instruments, e.g. scalpel, forceps, or scissors with the goal of promoting wound healing.

Indication—It is known that necrotic material in wounds hinders wound healing and may promote deep infection. Enzymatic debriding agents are generally the treatment of choice for wounds with non-viable tissue, e.g. pressure ulcers. Sharp debridement is used when there is a large amount of non-viable tissue, or when the enzymatic debriding process is felt to be too slow, inviting infection due to presence of the necrotic material in the wound.

Method of maintaining written record of persons authorized to perform sharp debridement— Alameda Hospital will maintain records of nurse practitioners who have been certified to perform sharp debridement.

Who may perform sharp debridement--a licensed nurse practitioner whose competency to perform sharp debridement has been validated. Competency validation involves special training in sharp debridement with didactic and lab content by a WOCN, followed by sharp debridement procedures supervised by a physician or WOCN. Competency to be revalidated every year.

Physician consultation is recommended when:

- Patient has an ischemic wound covered with hard, dry ulcer
- Patient has a clotting disorder or is on anticoagulation
- Wound is grossly infected
- The wound requires extensive debridement of deep tissues with risk of bleeding and severe pain.
- The wound appears to require surgical referral

Physician communication: physician is to be available by telephone. The nurse practitioner is to contact the physician for any unexpected or untoward event as the result of a sharp debridement procedure e.g. severe bleeding.

Documentation in patient progress note—should include description of wound, indication for sharp debridement, procedure performed, and plan for continuing care of wound.

Provide for a method of periodic review—This standardized procedure is to be reviewed every 2 years.

Conservative Sharp Wound Debridement
Competency Validation

Competency: Conducts sharp wound debridement (CSWD) safely and effectively. Criteria

1. Reviews medical record for contraindications to CSWD _____
2. Assembles appropriate supplies per standardized protocol _____
3. Identifies loose avascular tissue for removal _____
4. Identified hard, dry eschar(s) to be left undisturbed _____
5. Identifies thick dry eschar(s) to be cross-hatched for enzymatic debridement _____
6. Evaluates need for premedication _____
7. Observes clean technique _____
8. Removes loose avascular tissue without intentional pain or bleeding _____
9. Identified appropriate interventions to achieve hemostasis: _____
    a. direct compression
    b. elevation
    c. cauterizing agents
    d. hemostatic agents
10. Handles and disposes of infectious waste safely/appropriately using universal precautions. _____
11. Documents procedure in the medical record. _____

_____ _____
Name/Title Date

_____ _____
Validator/Title Date

CSWD Competency Validation is to be kept on file and is considered valid for l year from the date above.

STANDARDIZED PROCEDURE FOR SUPRAPUBIC CYSTOSTOMY CATHETER CHANGE BY NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES

I. POLICY

This standardized procedure is developed collaboratively and approved by nurse practitioners, supervising physician, and nurse administrator in the Continuing Care/SNF Program. It is reviewed and revised every two years. It conforms to the general policies of the Continuing Care/SNF Standardized Procedures for Nurse Practitioners.

II PROTOCOL

Description: Suprapubic catheter change is required every 4 to 6 weeks in patients with cystostomies.

Indication: Suprapubic catheter change is necessary to avoid build up of debris and breakdown of catheter in those patients who require permanent, indwelling catheters in cystostomy site.

Urologist must perform the first catheter change with cystostomy.

Who may perform suprapubic catheter change: A licensed nurse practitioner whose competency to perform suprapubic catheter has been validated. Competency is revalidated every year.

Physician consultation is recommended when:

- Catheter is not easily removed.
- Catheter is not easily inserted.
- Patient is medically unstable for procedure.

Physician communication: physician and urologist to be available by telephone. The nurse practitioner is to contact the physician for any unexpected or untoward event as the result of suprapubic catheter change.

Documentation in progress note—should include catheter size and plan for repeat change.

Provide for a method of periodic review—This standardized procedure to he reviewed every two years.

COMPETENCY EVALUATION
FOR SUPRAPUBIC CATHETER CHANGE

Competency: removes old and inserts new suprapubic catheter safely and effectively.

1. Assembles appropriate supplies.
2. Removes old catheter safely.
3. Inserts new catheter safely.
4. Handles infectious waste appropriately.
5. Documents procedure in medical record, and assures timely future replacement in 4 to 6 weeks with established reminder system.

_____ _____

Name/Nurse Practitioner Date

_____ _____

Name/Physician Date

Competency Validation is to be kept on file and is considered valid for 1 year from the date above

GASTROSTOMY TUBE REMOVAL AND/OR EXCHANGE

DEFINITION: Gastrostomy feeding tubes require periodic replacement.
Replacing the feeding tube at the patient bedside as soon as possible after an accidental removal, malfunction, or at regular intervals to maintain feeding tube patency, improves patient comfort and facilitates care in the patient's usual setting--SNF.

Objective Data:
To safely exchange the gastrostomy feeding tube at the bedside, the tract through the abdominal wall into the stomach must be well established. Patients with gastrostomy feeding tubes may have conditions affecting healing, therefore bedside exchange/replacement by nursing staff should be limited to patients with stable tracts, that are at least 6 months old.

Physician Consultation:
- Before proceeding with gastrostomy tube exchange, confirm with patient, responsible patient representative, or by medical record review, that care is desired.
- Patient must have an established tract, at least 6 months old or older
- Report any redness, odor or unusual drainage
- Report elevated temperature.

Obtain Equipment:
- Gastrostomy tube l4fr, 16fr, or 18fr 20 ml Luer Lock syringe (for replacement)
- Sterile water, distilled water or normal saline
- Lubricant (water soluable)
- 2 pair non-sterile gloves
- Soap and water, wash cloth and towel
- Catheter tip syringe (usually available in 60 ml size)
- Stethoscope

Procedure:

STEPS	KEY POINTS
Review patient history, and reason for gastrostomy tube exchange.	Generally due to malfunction, accidental removal, or regular interval change
Explain procedure to patient	
Wash your hands.	
Check vital signs, including temperature. Assess skin and stoma, function of existing feeding tube, and size of feeding tube. Note length of time since initial tube placement and last feeding tube exchange.	Follow universal precautions using gloves to prevent contact with bodily secretions.
Open all equipment.	Usually the same size feeding tube is used for replacement. **The doctor's order for replacement of the feeding tube should include the size to be used and specify exchange by RN.**
Apply clean gloves.	
Test the new tube for ring function and balloon integrity. If a MIC tube will be used, move the Secur-Lok® ring to the end of the tube near the feeding port. Fill the balloon with 5 ml air. If the balloon sticks to the tubing, bend and "unstick" it and check for leaks. Deflate the balloon with the syringe after testing	The ring should be difficult to move up and down the tube.
Wash and dry the stoma and skin with Normal Saline and sterile guaze.	
Prefill the luer lock syringe for inflating the balloon with water or saline, in the amount specified by the catheter. Place the syringe on your working area.	Standard balloons hold up to 20 ml. Some literature suggests 7-10 ml; however, greater success in maintaining the tube in the stomach, minimizing accidental removal and reducing leakage is noted with using 15-20 ml.
Lubricate the tip of the new tube with water-soluble lubricant.	Do not use petroleum products for lubricant
Remove used tube from stomach: Withdraw the water from the balloon with a syringe. Place one hand flat and firmly against abdomen for counter pressure and remove the used tube with the other hand by gently and firmly pulling the tube out.	Patient should be lying as flat as possible for removal and insertion of the tube. Balloon port may be cut open after withdrawal of water with syringe and/or with any difficulty of withdrawing water from balloon. Proceed to inserting new tube without delay.

Hold the tube at a 90-degree angle to the abdomen. Gently but firmly insert the tube 2 to 3 inches into the gastric stoma.	If meeting resistance, remove the tube and try again. Stomas can close especially if tube was removed a number of hours before insertion. If you find gentle, but firm pressure is not enough to pass the tube through the stoma, **stop!** **Do not force the tube into the stoma, call the MD and assist with scheduling the patient for reinsertion under fluoroscopy.**

STEPS	KEY POINTS
Inflate the balloon with the pre-measured solution in the luer lock syringe.	Standard balloon use 15-20 ml of water or saline. Never use contrast material
Gently pull the tube up and away from the abdomen until the balloon contacts the inner stomach wall.	There will be resistance on the tube when the stomach inner wall is reached,
Cleanse and dry the stoma and surrounding skin,	Gastric leakage and/or slight local bleeding are normal.
Gently slide the Secur-Lok® ring to the skin level without putting tension on the tube. The ring should be 3 mm above the skin level.	3 mm is about the thickness of a dime. The ring should never be so tight that tension is created between the ring on the skin and balloon on the inner wall of the stomach as such tension can cause erosion and ulceration,
To ensure correct tube placement: Listen for air. Place a stethoscope against the abdominal wall halfway between the navel and the left nipple. Inject 10 to 20 ml of air from the catheter tip syringe into the feeding port and listen for the sound of air entering the stomach. Use the catheter tip syringe to withdraw stomach contents back into the syringe.	When withdrawing stomach contents to check placement, it may help to position the patient on the left side so stomach contents gravitate toward the tube tip. **If air can not be heard and no stomach contents can be withdrawn, the tube placement must be checked by the physician.** Tube feedings must **not** be given until proper placement is verified.
Check for moisture around the stomach. If there are any signs of gastric leakage check placement of Secur-Lok® ring. Fluid may be added to balloon in 1-2 ml increments to improve seal in stomach.	Secur-Lok® ring should be at skin level without tension. Tube should not slip in and out of gastrostomy stoma. Do not exceed balloon capacity of 20 ml.

COMPETENCY EVALUATION
FOR GASTROSTOMY TUBE CHANGE

Competency: removes old and inserts new gastrostomy safely and effectively.

1. Assembles appropriate supplies.
2. Removes old tube safely.
3. Inserts new tube safely.
4. Handles infectious waste appropriately.
5. Documents procedure in medical record, and assures timely future replacement in 4 to 6 weeks with established reminder system.

_____ _____

Name/Nurse Practitioner Date

_____ _____

Name/Physician Date

Competency Validation is to be kept on file and is considered valid for 1 year from the date above

APPENDIX A

Competency shall be initially established by observation of five (5) procedures by the supervising physician. Thereafter, annual chart review of three (3) procedures shall be performed by the supervising physician.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING APRIL 30, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
APRIL 30, 2012

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
APRIL, 2012

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 April 30, 2012 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

This month the hospital experienced a negative bottom line. For April a positive $131,300 was budgeted and a negative ($188,600) was realized. Year-to-date the hospital's bottom line is negative by ($1,300,300).

April activity was very close to budget on the inpatient and under budget on outpatient registrations. Inpatient revenues are down just 1.9% consistent with the patient days down 1%, and outpatient revenues are down 13.7% consistent with outpatient registrations. It is noted that half of this outpatient variance is due to the planned Wound Care Clinic that experienced a delay in implementation.

April discharges are above budget 9.7% and patient days were under budget 1.0%. In particular, discharges at South Shore increased as we have had a higher number of Medicare patients at the facility. Patients days in inpatient acute services were up 5.2%, while Sub-Acute were down 4.5% and Skilled Nursing was down 4.6%.

Overall outpatient activity was mixed this month. This month outpatient registrations were down 11.5%, of this 67 registrations were associated with the delay in Wound Care. Emergency Room visits were only 4 below budget or 0.3%. YTD outpatient registrations are 8.8% below budget while Emergency visits are just 0.7% below budget. Outpatient surgeries were below budget for the month by 17.4%, but continue above budget YTD by 3.5%.

Gross revenue in April is generally in line with activity. Overall gross revenues were 5.9% below budget, with the inpatient component down 1.9% and outpatient down 13.7%. The inpatient revenue variance is due to revenues being budgeted at a slightly higher volume than experienced. The outpatient budget includes $536,000 for the Wound Care Clinic. Without this budget item, outpatient revenues would be under budget 7.4%. Net patient revenues were 23.7% of Gross revenues. This is slightly above the YTD net to gross value of 22.8%. Net Revenue is April includes a onetime $156,000 adjustment for subacute rate increase retro to August 1st.

The Case Mix Index (CMI) ran above the YTD average. The overall CMI in April was 1.3201; up from last month's of 1.3071, and still above the YTD average.

There were a number of expenses categories that ran over budget this month. Productive salaries, employee benefit costs, professional fees, rents and leases, as well as other operating costs were over budget. Employee benefit costs include costs associated with employee health usage. These costs fluctuate according to their usage and in April there were a couple of large claims driving this additional expense. Professional fees were slightly high in general accounting and patient accounting. Rents and leases were high for the leases on new radiology equipment, new wound care center lease and additional equipment rental expense in central supply. Other operating expenses include annual expense for education fees for two off our union groups. On the other hand, supply costs and purchased services are below budget. Total expenses for the month are 5.5% over budget, or $301,000, while YTD expenses are only 0.8% over budget or $467,000.

Cash and Cash equivalents were $3.1 million at the end of April up from $429,000 at the end of March as the result of receiving the second parcel tax installment. In May, we will receive our IGT funds of about $1.5 million and in June we expect to receive approximately $480,000 in AB 915 funds for FY 2011 Outpatient Medi-Cal program.

Cash collections in April were $5.5M, again exceeding net revenues and causing net Accounts Receivable to decrease.

Accounts payable and other third party liabilities grew slightly by $104,901 from $8,937,239 to $9,042,140. AP days were 142.

This is down slightly from the previous month. The cash coming IGT and AB915 plus improved AR collections should allow for a significant reduction in AP and allow the hospital to set aside a reasonable cash reserve.

Lastly, the current ratio ended the month at .99 slightly below the required 1.0 of our bank covenants. We anticipate that this will increase above 1.0 by the end of the fiscal year end.

ACTIVITY

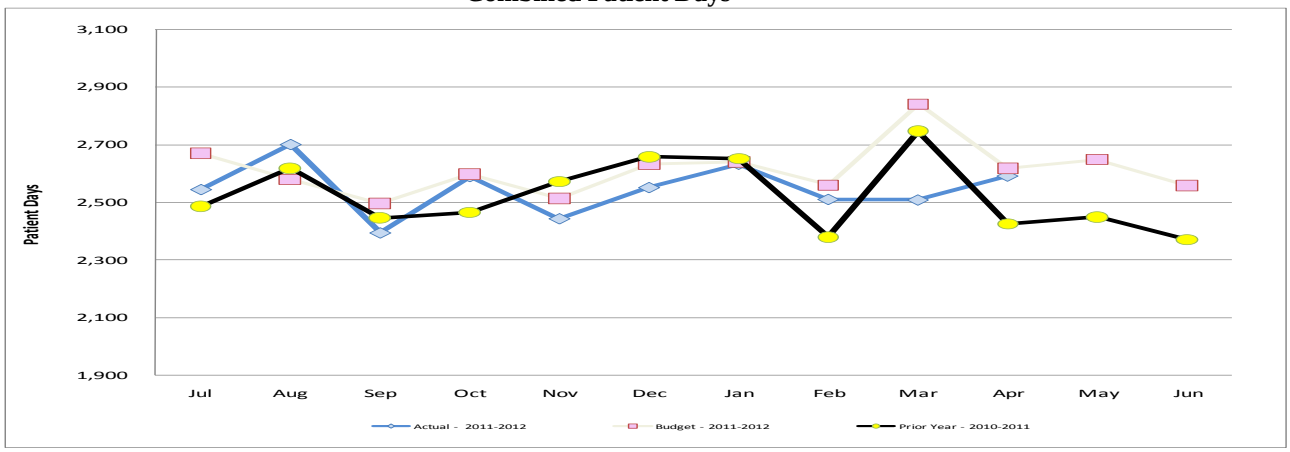
ACUTE, SUBACUTE AND SNF SERVICES

Patient days were below slightly budget for the month but above April of last year. This month's acute days were up 5.2%, Sub-Acute was down 4.5% and Skilled Nursing was down 4.6%. YTD days are now (2.6%) under budget.

April's acute care patient days were 49 days (5.2%) better than budget for the month and 21% above April 2011. The acute care program is comprised of the Critical Care Unit (5.1 ADC, above budget 15.0%), Definitive Observation Unit (14.3 ADC, 26.5% above budget) and Med/Surg Unit is below budget by 13.8 ADC or 12.8%.

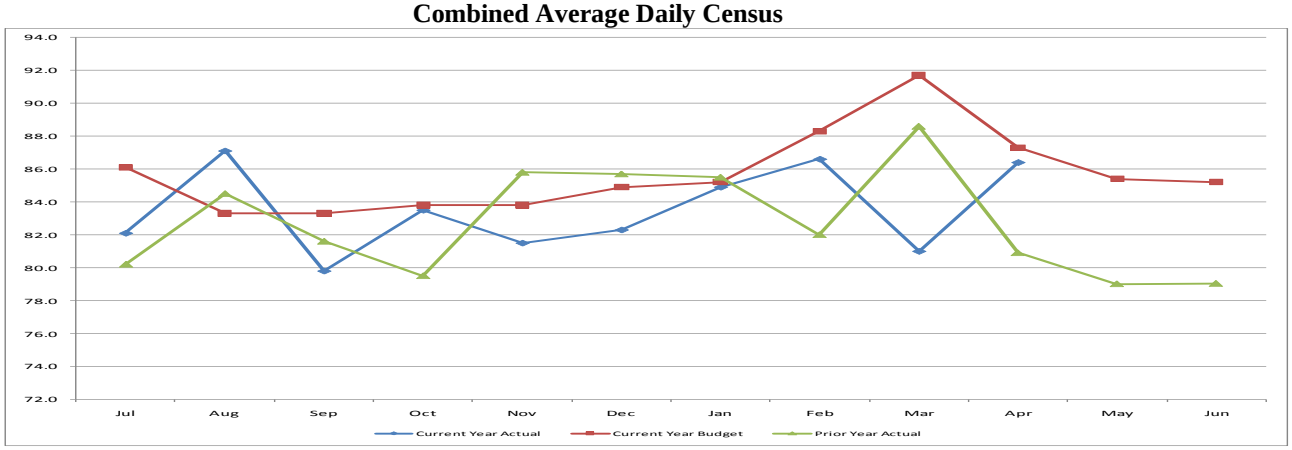
The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

Combined Patient Days



The graph below shows the average daily census for all inpatient services. The actual ADC was 86.4 versus budget of 87.3 an unfavorable variance of 1.0%.

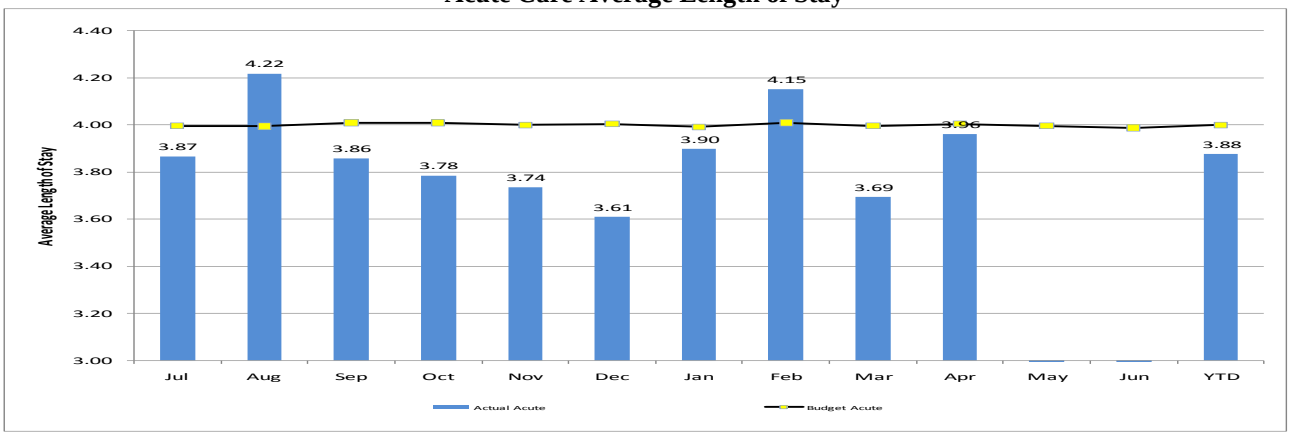
Combined Average Daily Census



The acute average length of stay (ALOS) increased from the low in March of 3.69 to 3.96 in April, but still below 4.0. The

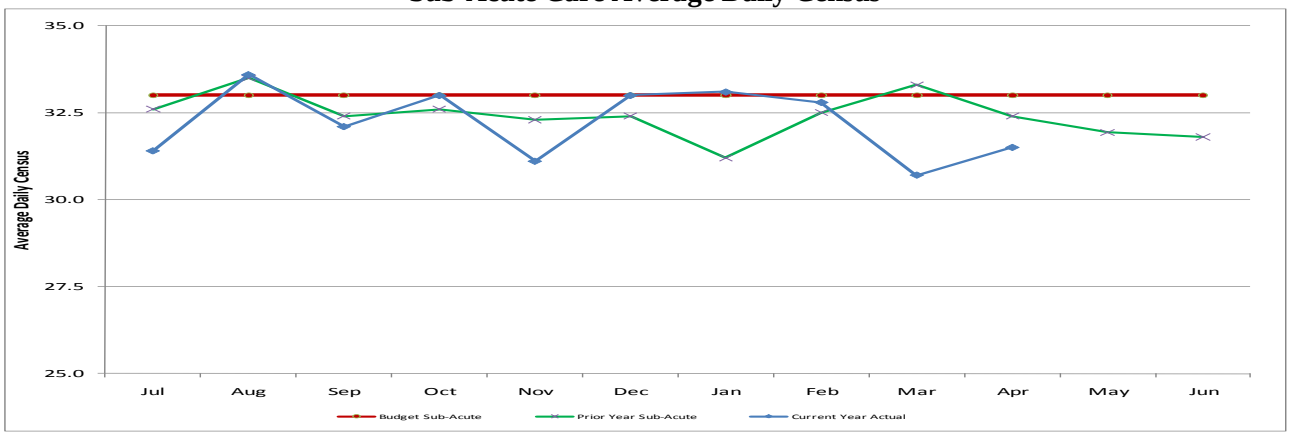
overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month compared to the budget.

Acute Care Average Length of Stay



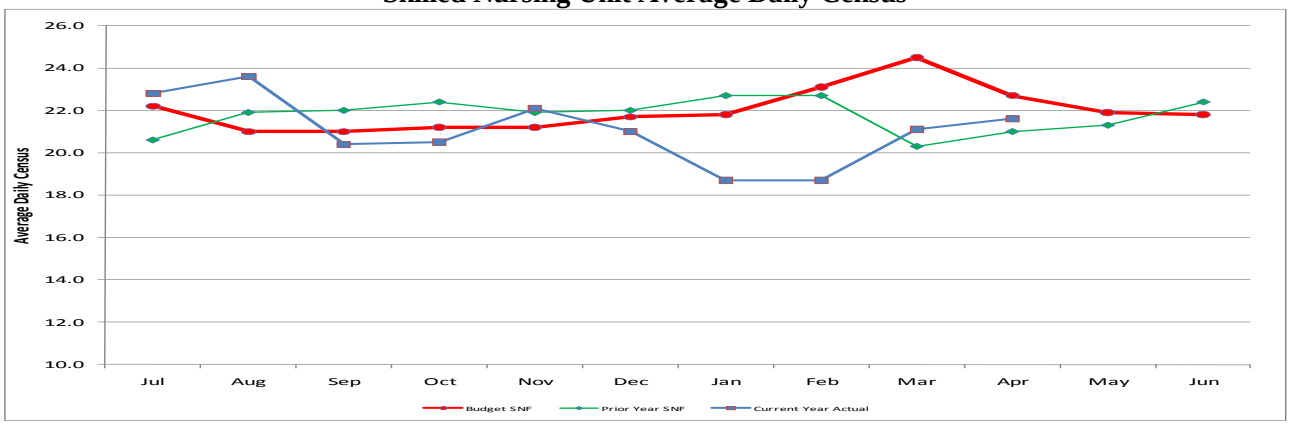
The Sub-Acute programs average daily census of 31.5 in April was below budgeted projections by1.5 ADC or 4.5%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



The Skilled Nursing Unit (South Shore) ADC was lower than budget by 1.0 or 4.6% for the month of April. YTD ADC is also down compared to both budget and the prior year. However, efforts to improve census have been fruitful as census has climbed back up from the lows of the prior few months. The graph, below, shows the Skilled Nursing Units monthly average daily census as compared to budget and the prior year. In April there was a greater number of Medicare A patients, which has resulted in a greater number of discharges. These skilled Medicare patients will also result in higher net revenues.

Skilled Nursing Unit Average Daily Census

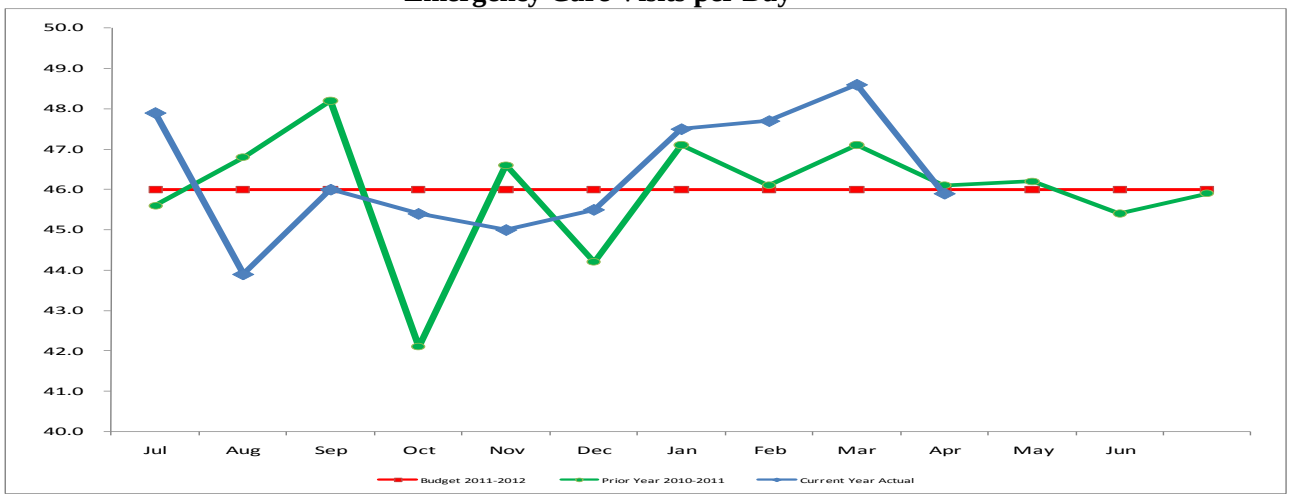


ANCILLARY SERVICES

Outpatient Services

Emergency Care Center visits in April were 1,376. This is 4 visits (0.3%) under the budget of 1,380. 18.4% of ECC visits resulted in inpatient admissions versus 17.3% in March. On a per day basis, the total visits represent a decrease of 5.6% from the prior month daily average. In April, there were 323 ambulance arrivals versus 315 in the prior month. Of the 323 ambulance arrivals in the current month, 212 or 65.6% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits per Day



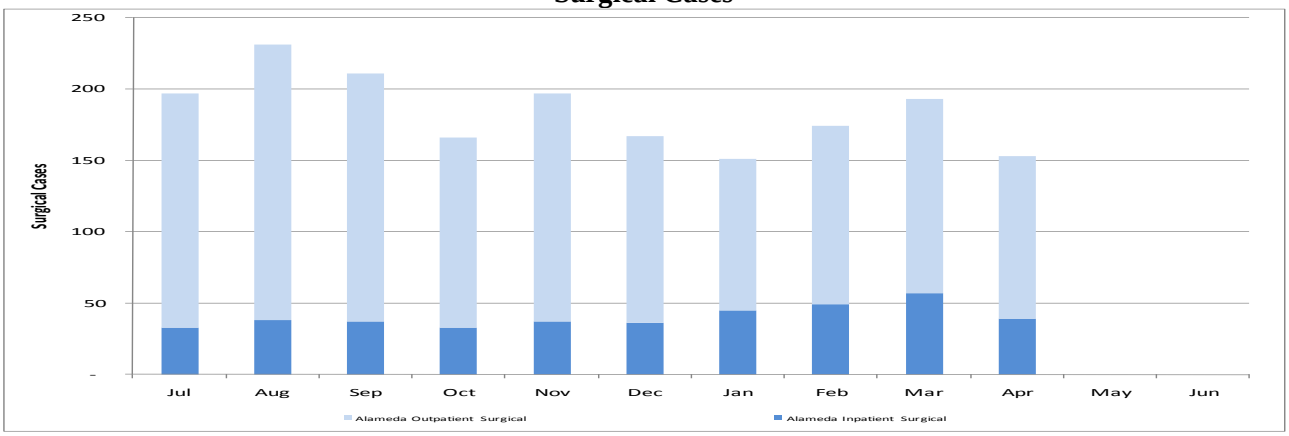
Outpatient registrations were 1,889, or 11.5% below budget. April's average daily registrations were 63.0 which were 2.8% higher than the prior month. This is in consistent with YTD outpatient registrations which are below budget by 8.8%. This month Laboratory and Radiology were down 162 and 32 visits respectively. On the other hand visits were up in MRI (17 visits), Physical Therapy (22 visits) and Occupational Therapy (19 visits). There were no Wound Care visits but visits were again budgeted as the program was expected to start in January. This equated to a total of 250 in April and 630 visits for the three months.

Surgery

The year-to-date surgery cases were 1,854 or 1.2% above the budget of 1,832 and also above last year. For the month, total surgery cases were below budgeted expectations by 16.8% at 153 cases versus the budget of 184 cases. Inpatient cases were below budget 7 (15.2%) while outpatient cases were 24 (17.4%) below budget. Inpatient and outpatient cases totaled 39 and 114 in April versus 57 and 136 during the prior month. The new Orthopedic Surgery program will add to growth in this service in the next fiscal year.

The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

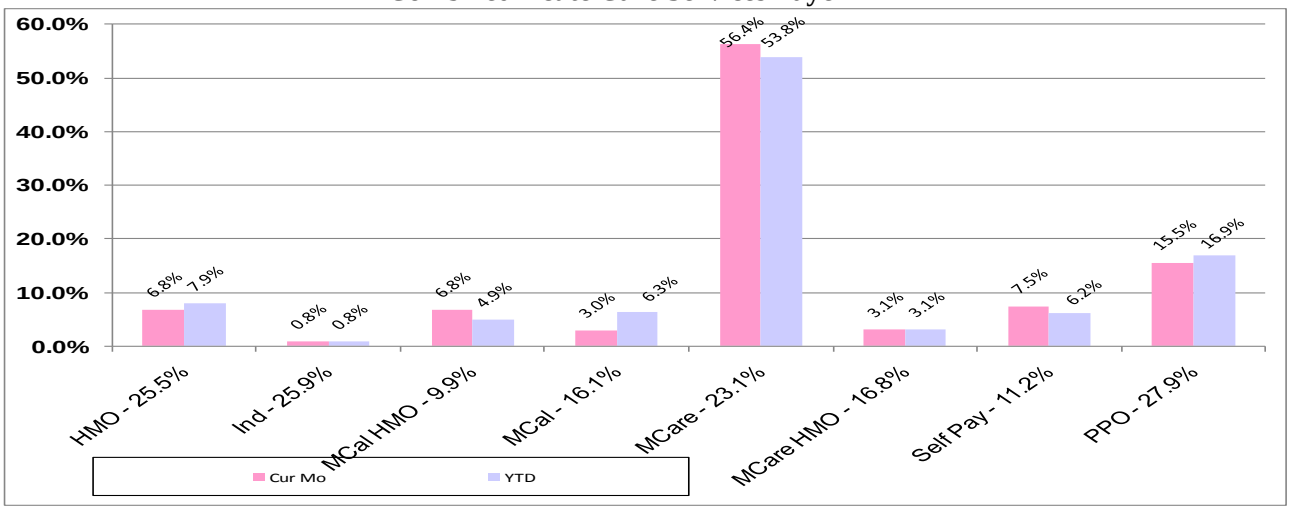
Surgical Cases



Payer Mix

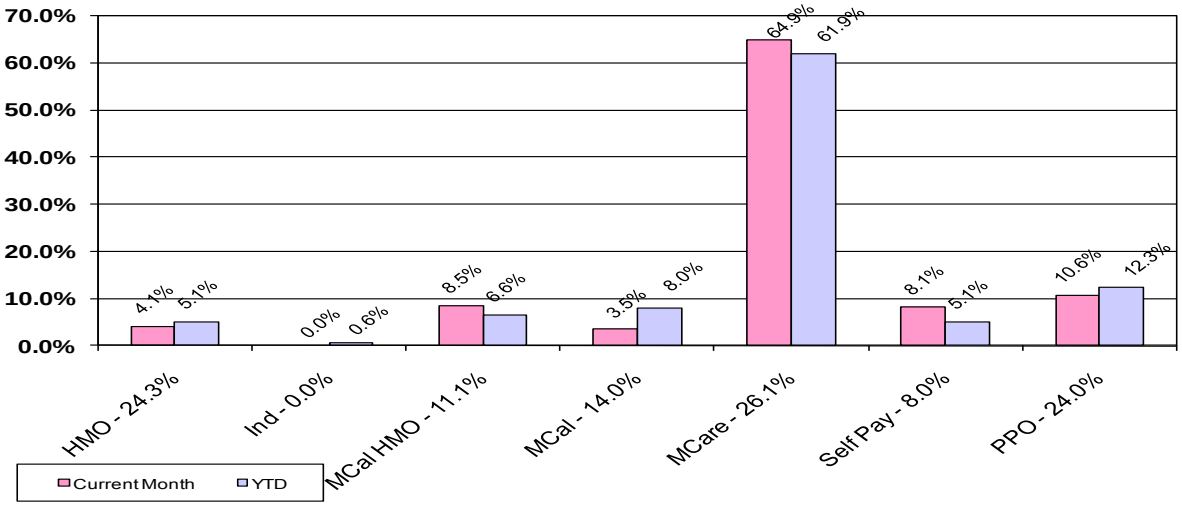
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in April made up 59.4% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 22.3%, Medi-Cal Traditional and Medi-Cal HMO utilization at 9.8% and self pay at 7.5%. The graph below shows the percentage of gross revenues generated by each of the major payers for the current month and fiscal year to date as well as the current month's estimated reimbursement for each payer for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payer Mix



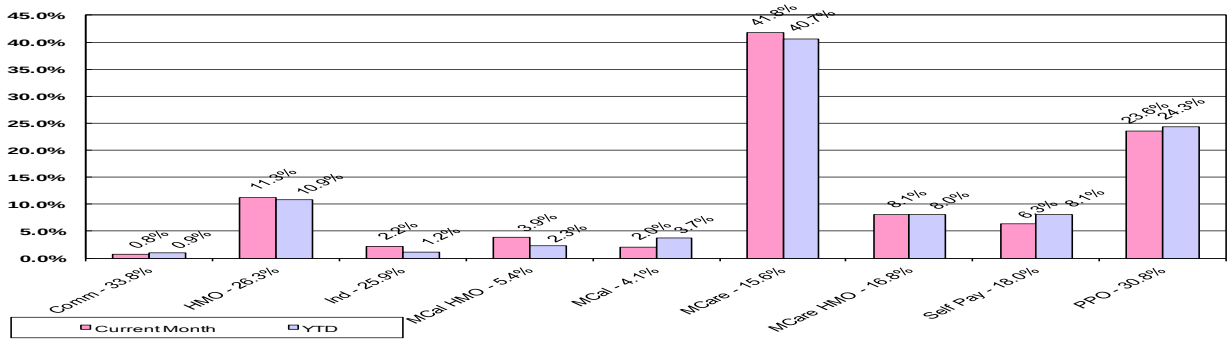
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 64.9% of our total inpatient acute care gross revenues followed by HMO/PPO at 14.7%, Medi-Cal and Medi-Cal HMO at 12.0% and Self Pay at 8.1% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.

Inpatient Acute Care Payer



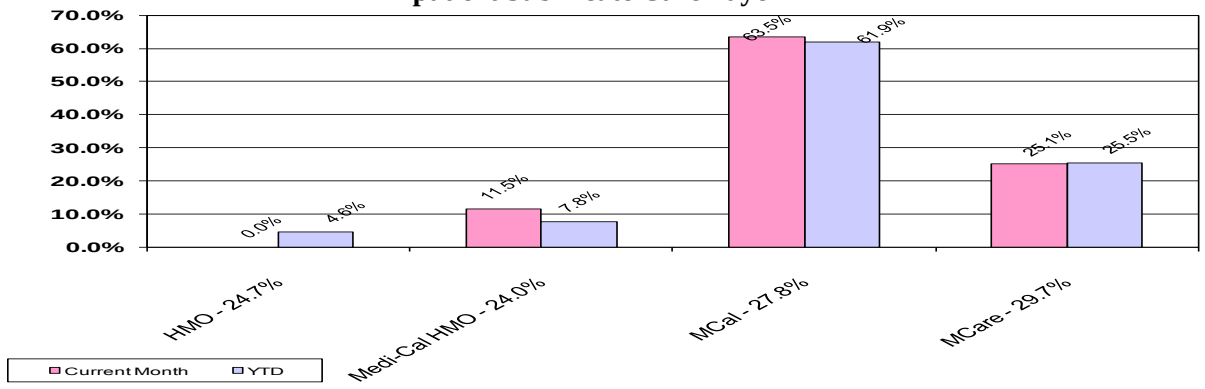
The outpatient gross revenue payer mix for April was comprised of 49.9% Medicare and Medicare Advantage, 35.6% HMO/PPO, 5.9% Medi-Cal and Medi-Cal HMO, and 6.3% self pay. The graph below shows the current month and fiscal year to date outpatient payer mix and the current months estimated level of reimbursement for each payer.

Outpatient Services Payer Mix



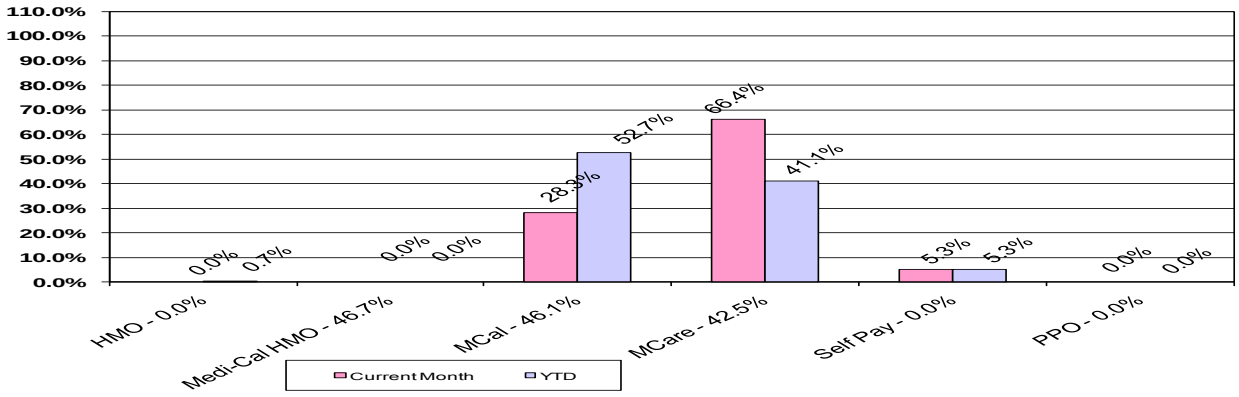
In April, the Sub-Acute care program again was dominated by Medi-Cal utilization of 74.9%. Medicare was 25.1% and no HMO/PPO patients. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payer.

Inpatient Sub-Acute Care Payer Mix



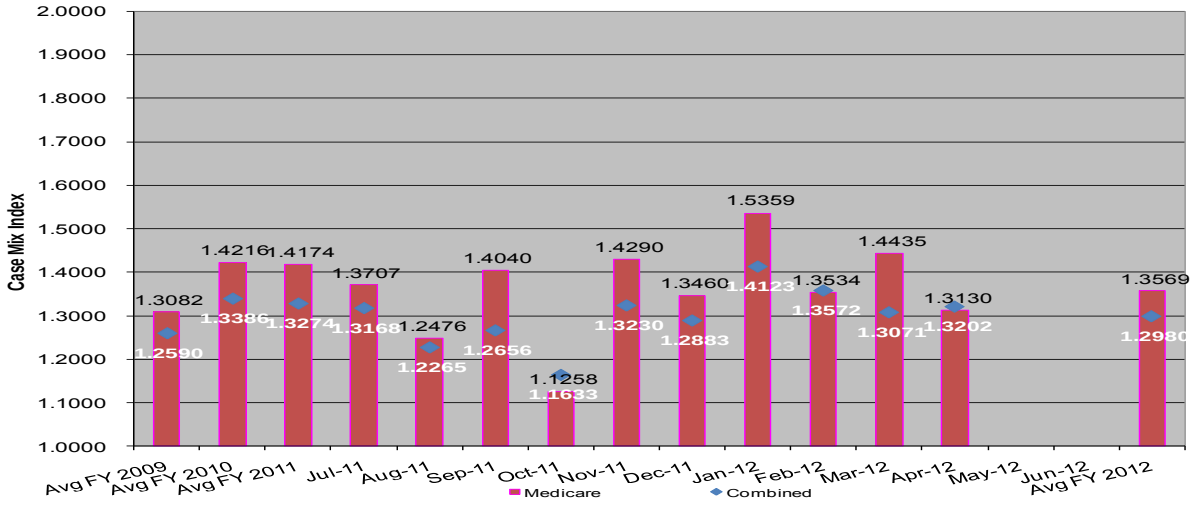
The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. Note the change in volumes between Medicare and Medi-Cal. This reflects the successful placement of an increasing volume of post-acute skilled patients (Medicare).

Inpatient Skilled Nursing Payer Mix



Case Mix Index

The hospital's overall Case Mix Index (CMI) for April was 1.3202, up from the prior months of 1.3071, and well above the April 2011 of 1.1636. The Medicare CMI decreased from the high of 1.4435 in March to 1.3130 in April. The graph below shows the Medicare CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.



The CMI at the time of forecasting this year's budget was 1.3758. Year-to-date April 2012 the CMI was 1.2998. This represents only a 4.5% decline compared to the same time frame last year, a percent that has been steadily improving through the year. Note that payers with lower volume can have substantial swings in CMI from one period to another. See the table below that compares the CMI by payer for the three periods.

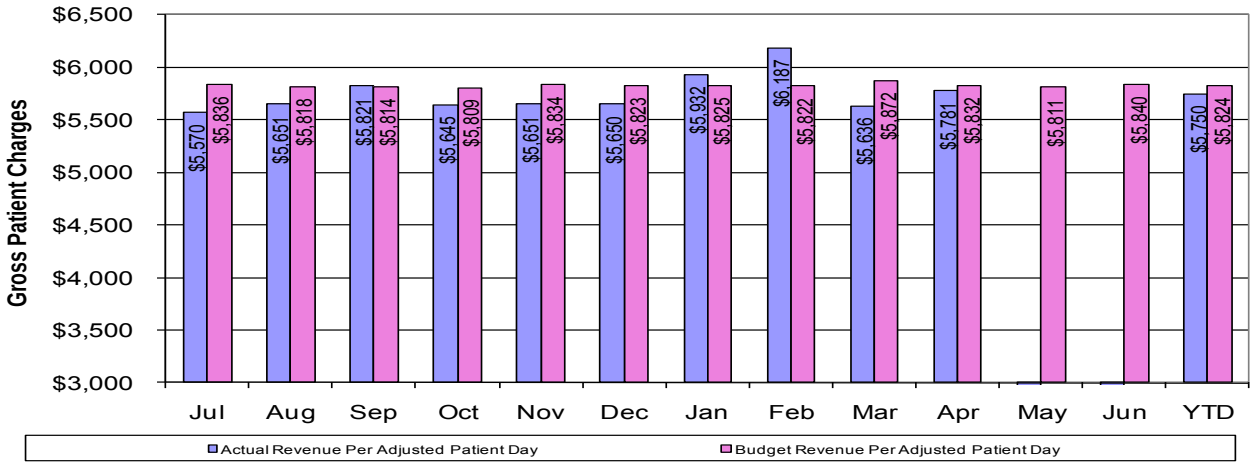
Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Apr 11 YTD	Apr 12 YTD	Apr 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.0919	1.0324	10
HMO	1.2522	1.1800	1.2687	103
Industrial	1.8373	1.6500	1.6603	9
Kaiser	1.8412	1.8446	1.6466	12
Medi-Cal HMO	1.0008	0.9907	1.1148	148
Medi-Cal	1.2724	1.2797	1.2627	118
Medicare	1.4724	1.4626	1.3627	1,257
Medicare HMO	1.3568	1.3123	1.3644	209
Personal Pay	1.0105	1.0292	1.1553	159
Medi-Cal Pending	1.8334	1.9052	1.8150	5
PPO	1.2613	1.2596	1.1142	257
VA	1.4051	1.3317	1.4179	49
Combined	**1.3758**	**1.3614**	**1.2998**	2,336

Revenue

Gross patient charges in April were below budget by $1.4 million, or 5.9%. Inpatient revenues were $290,000 below the budget and outpatient revenues were down almost $1.1 million; of this $536,000 was associated with the delayed opening of the Wound Care Clinic. Inpatient days were below budget by 1.0%, consistent with the inpatient gross revenue. Outpatient registrations were 11.5% under budget. Outpatient revenues were lower than budget as a result of the lower volume with Wound Care and Surgical Services ($691,000) being the largest contributors to this variance. On an adjusted patient day basis, total patient revenue was $5,781, just below the budget of $5,832 for the month of April but higher than March gross revenue per APD of $5,636. The table on the following page shows the hospital's monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2012 compared to budget.

Gross Charges per Adjusted Patient



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. As such net revenues as a percentage of gross revenues were very close to budget. A collection ratio of 22.2% was budgeted and 23.7% was realized. Contributing to April's Net Revenue percentage is a onetime adjustment of $156,000 for an increase in the subacute Medi-Cal rate that is retroactive to August 1, 2011. The collection ratio without this adjustment is 22.8%.

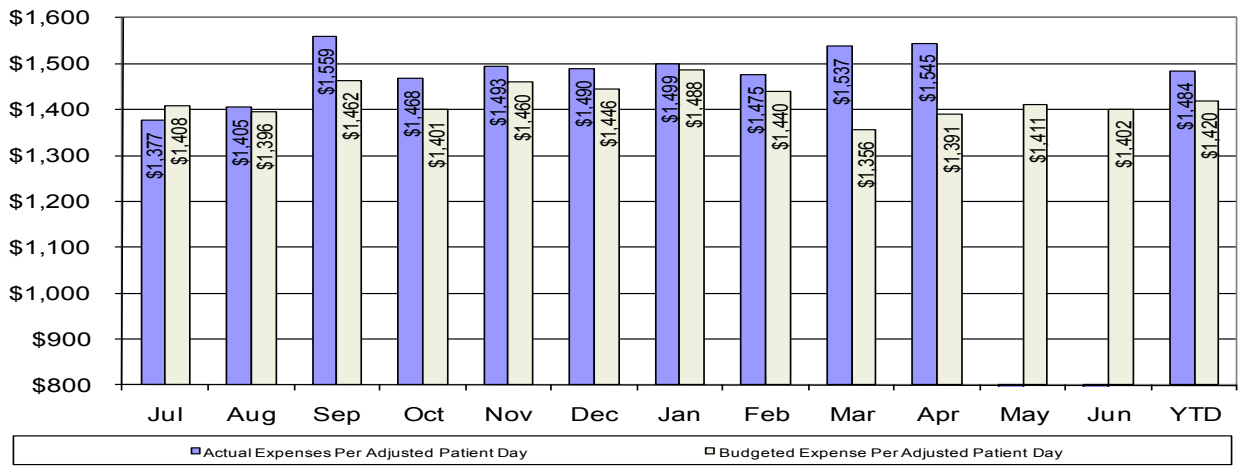
Expenses

Total Operating Expenses

Total operating expenses were higher than the fixed budget by $301, 000 or 5.5% and YTD is above budget by just 0.8%. Both salaries and benefits were above budget. Non-medical professional fees were not as high this month but several areas were up as discussed below.

The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget. Note that expenses per patient day were over budget again this month which is expected with lower volume and the fixed nature of many expenses.

Expenses per Adjusted Patient Day



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 $129,000 and were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $72 or 9.8%. Year to date salaries and agency expenses are running just above budget by 3.3% PAPD. During the month of April, there was additional overtime and premium pay in nursing services associated with the higher acute patient census and the availability of nursing personnel. The hospital has also added a couple of non-budgeted FTE's in preparation for the expansion of our long term care services with Waters Edge. In the mean time, subacute and south shore are benefiting from their efforts with higher census and improved payor mix.

Benefits

Benefits were unfavorable to the fixed budget by $181,000 or 22.8%, and over budget per adjusted patient day by 28.9%. We did have a couple of large employee health claims come through during April which accounts for the majority of this April variance. After closing the month, we did identify a $40,000 pension over accrual that will be reversed in the May financials. Year to date, benefit expense is $710,000 greater than budget.

Professional Fees

Professional fees which had been running over budget most of the year were unfavorable by only $6,000 this month. This will continue to be more in line with budget going forward now that less outside consultant time is being used in accounting and business office.

Supplies

Supplies were favorable to budget by $30,000 (3.9%). This is positive; however, the favorable supply cost variance was down again from previous months. This month the favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies associated with the IVT program (low IVT program volumes), and prosthetics.

Purchased Services

Purchased services were $50,000 below the fixed budget and $9 favorable PAPD. Year to date, purchased services are $101 higher than budget.

Rents and Leases

Rents and leases were above the fixed budget by $40,000, and above budget $12 PAPD in April. There were some additional equipment rental invoices totaling about $10,000, Lease expense associated with the Marina Village lease for the months of January thru March. We did not have rent expense these months, but per the contract were responsible for CAM fees. These were not invoiced until April ant totaled just over $9,000. The radiology equipment lease budget is understated by about $8,000 per month. This has been corrected in the FY 2013 budget.

Other Operating Expense

Other operating expenses were $27,000 over the fixed budget and $8 over the budget on a per adjusted patient day basis. This variance is attributed to a $12,254 education/ training fees required by two of our union agreements. Fees associated with our RAC appeals contract with EHR were also greater than budget during the month. In addition employee recruitment fees were about $6,000 over budget.

Balance Sheet

Total assets decreased almost $800K from the prior month, mostly due to the decrease in Net AR. The following items make up the decrease in current assets:

- Total unrestricted cash and cash equivalents for April increased by almost $2.7M and days cash on hand including restricted use funds increased to16 days on hand in April from 2.2 days on hand in March. This increase was due to receipt of our second and property tax installment payment. Patient collections in April averaged $185 per day the highest rate this fiscal year.

- Net patient accounts receivable decreased in April by $885,000. This decrease is the result of higher cash collection during the month ($5.5 million) and the total gross AR being reduced, as well as, additional reserves needed for ageing self pay and

some third party payor accounts that have not been written off to bad debt in several months. Self pay accounts are being worked through an early-out collection process. Once worked and deemed uncollectible, these accounts will be written off to bed debt over the next two to three months.

- Days in outstanding receivables were 58.8 at April month end, a decrease from March at 64.8 days. Collections in March were $5.5 million compared to $5.6 million in March.

- Other Receivables decreased by almost $2.5 million due to receipt of the property tax payment. Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $627,000 compared to an increase of $42,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable increased $56,000 in April to $8.46 million which equate to 135 AP Days . Accounts Payable and other accrued expenses are about $2.1 million higher than prior fiscal year end.

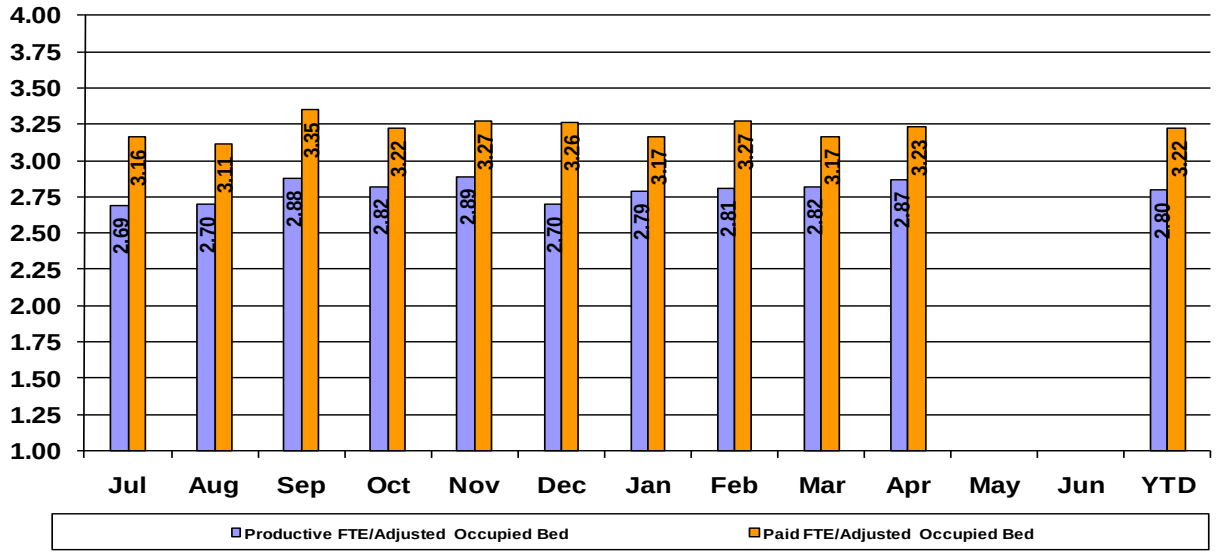
- Payroll related accruals decreased by $125,000 and remains fairly constant compared to prior year end.

- Deferred revenues decreased again by $477,000 due to the recognition of one-twelfth of the 2011/2012 parcel tax revenues of $5.7 million.

Key Statistics

FTE's per Adjusted Occupied Bed

On an adjusted occupied bed basis, productive FTE's were 2.87, above the budget of 2.65 FTE's by 8.4%, and paid FTE's were 3.23 or 6.4% above budget. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.



Current Ratio

The current ratio for April is 0.99. This is a decrease from last month's ratio of 1.0. Current ratio needs to be above 1.0 by quarter/year end to be in compliance with our bank covenants. In addition, Total Net Assets needs to be greater than $7.50

million and is currently at $7.53 million

A/R days

Net days in net Accounts Receivable are currently at 58.8. This is down from prior month. We are working hard to bring this number down to 51, which will help our cash position. He lower days is the result of two strong collection months plus additional reserves for self pay accounts that will be written off in the next couple of months.

Days Cash on Hand

Days cash on hand for April was16.3. This is an increase from prior month of 2.2 as a result of receiving the property tax installment. In the month of May we will be expecting receipt of the IGT transfer funds which will contribute to our cash reserve and allow us to pay additional accounts payable.

The following pages include the detailed financial statements for the ten (10) months ended April 30, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
APRIL 2012

	ACTUAL APRIL 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	APRIL 2011	YTD APRIL 2012	YTD FIXED BUDGET	VARIANCE	%	YTD APRIL 2011
Discharges:										
Total Acute	252	237	15	6.3%	211	2,377	2,342	35	1.5%	2,093
Total Sub-Acute	2	1	1	100.0%	1	22	15	7	46.7%	19
Total Skilled Nursing	17	9	8	88.9%	14	96	89	7	7.9%	93
	271	247	24	9.7%	226	2,495	2,446	49	2.0%	2,205
Patient Days:										
Total Acute	998	949	49	5.2%	825	9,213	9,371	(158)	-1.7%	8,899
Total Sub-Acute	945	990	(45)	-4.5%	971	9,832	10,065	(233)	-2.3%	9,917
Total Skilled Nursing	649	680	(31)	-4.6%	629	6,427	6,717	(290)	-4.3%	6,634
	2,592	2,619	(27)	-1.0%	2,425	25,472	26,153	(681)	-2.6%	25,450
Average Length of Stay										
Total Acute	3.96	4.00	(0.04)	-1.1%	3.91	3.88	4.00	(0.13)	-3.1%	4.25
Average Daily Census										
Total Acute	33.27	31.63	1.63	5.2%	27.50	30.21	30.72	(0.52)	-1.7%	29.18
Total Sub-Acute	31.50	33.00	(1.50)	-4.5%	32.37	32.24	33.00	(0.76)	-2.3%	32.51
Total Skilled Nursing	21.63	22.67	(1.04)	-4.6%	20.97	21.07	22.02	(0.95)	-4.3%	21.75
	86.40	87.31	(0.91)	-1.0%	80.83	83.51	85.75	(1.28)	-1.5%	83.44
Emergency Room Visits	1,376	1,380	(4)	-0.3%	1,382	14,130	14,030	100	0.7%	14,022
Outpatient Registrations	1,889	2,135	(246)	-11.5%	1,996	18,510	20,303	(1,793)	-8.8%	19,877
Surgery Cases:										
Inpatient	39	46	(7)	-15.2%	41	418	444	(26)	-5.9%	442
Outpatient	114	138	(24)	-17.4%	161	1,436	1,388	48	3.5%	1,405
	153	184	(31)	-16.8%	202	1,854	1,832	22	1.2%	1,847
Adjusted Occupied Bed (AOB)	125.54	132.27	(6.73)	-5.1%	120.18	122.76	127.39	(4.63)	-3.6%	124.24
Productive FTE	360.75	350.78	9.97	2.8%	365.20	346.03	344.90	1.13	0.3%	368.33
Total FTE	405.52	401.66	3.86	1.0%	421.72	397.65	405.02	(7.37)	-1.8%	425.11
Productive FTE/Adj. Occ. Bed	2.87	2.65	0.22	8.4%	3.04	2.82	2.71	0.11	4.1%	2.96
Total FTE/ Adj. Occ. Bed	3.23	3.04	0.19	6.4%	3.51	3.24	3.18	0.06	1.9%	3.42

City of Alameda Health Care District
Statements of Financial Position
April 30, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 3,094,319	$ 428,701	$ 1,784,141
Patient Accounts Receivable, net	9,426,641	10,311,955	7,249,185
Other Receivables	2,056,499	4,569,093	8,090,457
Third-Party Payer Settlement Receivables	626,363	661,578	150,000
Inventories	1,116,854	1,146,202	1,183,358
Prepaids and Other	182,412	222,070	262,359
Total Current Assets	16,503,088	17,339,599	18,719,500
Assets Limited as to Use, net	47,029	35,702	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,405,170	43,405,170	43,383,571
Construction in progress	3,659,003	3,570,359	2,921,048
Depreciation	(39,538,523)	(39,471,735)	(38,862,494)
Property, Plant and Equipment, net	8,403,595	8,381,739	8,320,070
Total Assets	**$ 24,953,712**	**$ 25,757,040**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,526,088	$ 1,552,815	$ 746,074
Accounts Payable and Accrued Expenses	9,042,140	8,937,239	6,987,765
Payroll Related Accruals	3,964,245	4,089,480	3,991,254
Deferred Revenue	955,513	1,432,594	5,725,900
Employee Health Related Accruals	630,657	629,895	343,382
Third-Party Payer Settlement Payable	526,952	631,035	(3,930)
Total Current Liabilities	16,645,595	17,273,058	17,790,445
Long Term Debt, net	768,365	806,915	1,142,109
Total Liabilities	17,413,960	18,079,973	18,932,554
Net Assets:			
Unrestricted	7,282,723	7,471,364	8,037,015
Temporarily Restricted	257,029	205,702	553,716
Total Net Assets	7,539,752	7,677,066	8,590,731
Total Liabilities and Net Assets	**$ 24,953,712**	**$ 25,757,040**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

April 30, 2012

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,592	2,619	(27)	-1.0%	2,425	25,472	26,153	(681)	-2.6%	25,450
Discharges	271	247	24	9.7%	226	2,495	2,446	49	2.0%	2,205
ALOS (Average Length of Stay)	9.56	10.60	(1.04)	-9.8%	10.73	10.21	10.69	(0.48)	-4.5%	11.54
ADC (Average Daily Census)	86.4	87.3	(0.90)	-1.0%	78.2	84	86.0	(2.24)	-2.6%	83.7
CMI (Case Mix Index)	1.3202				1.1636	1.2976				1.3524
Revenues										
Gross Inpatient Revenues	$ 14,984	$ 15,274	$ (290)	-1.9%	$ 12,561	$ 146,508	$ 152,334	$ (5,826)	-3.8%	$ 138,884
Gross Outpatient Revenues	6,787	7,791	(1,003)	-12.9%	6,379	69,314	73,458	(4,144)	-5.6%	67,462
Total Gross Revenues	21,771	23,064	(1,293)	-5.6%	18,940	215,822	225,792	(9,971)	-4.4%	206,346
Contractual Deductions	16,652	17,055	403	2.4%	14,463	162,066	166,448	4,382	2.6%	148,620
Bad Debts	(9)	716	725	101.2%	707	3,357	7,145	3,788	53.0%	6,551
Charity and Other Adjustments	-	173	173	100.0%	35	1,505	1,724	220	12.7%	1,481
Net Patient Revenues	5,128	5,120	8	0.2%	3,737	48,894	50,475	(1,581)	-3.1%	49,693
Net Patient Revenue %	23.6%	22.2%			19.7%	22.7%	22.4%			24.1%
Net Clinic Revenue	38	30	8	25.3%	36	374	207	167	80.6%	339
Other Operating Revenue	(31)	10	(41)	-410.2%	11	208	101	107	105.9%	102
Total Revenues	**5,135**	**5,161**	**(26)**	-0.5%	**3,784**	**49,476**	**50,784**	**(1,307)**	-2.6%	**50,134**
Expenses										
Salaries	2,881	2,757	(123)	-4.5%	2,891	28,495	28,259	(236)	-0.8%	29,647
Temporary Agency	156	150	(6)	-4.1%	211	1,207	1,492	285	19.1%	2,087
Benefits	974	793	(181)	-22.8%	897	8,671	7,961	(710)	-8.9%	8,152
Professional Fees	354	348	(6)	-1.7%	354	3,727	3,036	(691)	-22.7%	3,069
Supplies	729	759	30	3.9%	616	6,249	7,547	1,298	17.2%	7,205
Purchased Services	314	364	50	13.7%	326	3,785	3,684	(101)	-2.7%	3,657
Rents and Leases	156	116	(40)	-34.5%	85	1,003	949	(54)	-5.7%	702
Utilities and Telephone	66	65	(1)	-1.0%	64	654	649	(5)	-0.8%	630
Insurance	25	17	(8)	-45.2%	33	271	169	(102)	-60.5%	318
Depreciation and amortization	67	77	10	13.6%	79	712	719	7	0.9%	798
Other Opertaing Expenses	98	71	(27)	-37.6%	115	921	763	(158)	-20.7%	878
Total Expenses	**5,819**	**5,518**	**(301)**	-5.5%	**5,670**	**55,695**	**55,228**	**(467)**	-0.8%	**57,142**
Operating gain (loss)	**(684)**	**(357)**	**(327)**	-91.4%	**(1,886)**	**(6,218)**	**(4,444)**	**(1,774)**	39.9%	**(7,008)**
Non-Operating Income / (Expense)										
Parcel Taxes	490	478	12	2.4%	482	4,813	4,780	34	0.7%	4,789
Investment Income	0	0	0	36.3%	1	5	(126)	132	-104.2%	10
Interest Expense	(23)	(12)	(11)	-90.7%	(16)	(161)	(13)	(148)	1162.9%	(96)
Other Income / (Expense)	28	22	6	24.9%	22	261	224	37	16.5%	1,670
Net Non-Operating Income / (Expense)	**495**	**489**	**7**	**1.3%**	**488**	**4,918**	**4,864**	**54**	**1.1%**	**6,372**
Excess of Revenues Over Expenses	**$ (189)**	**$ 131**	**$ (320)**	**-243.6%**	**$ (1,398)**	**$ (1,300)**	**$ 420**	**$ (1,721)**	**-409.4%**	**$ (636)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

April 30, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,979	$ 3,862	$ 117	3.0%	$ 3,435	$ 3,904	$ 3,930	$ (25)	-0.6%	$ 3,673
Gross Outpatient Revenues	1,802	1,970	(168)	-8.5%	1,745	1,847	1,895	(48)	-2.5%	1,784
Total Gross Revenues	5,781	5,832	(51)	-0.9%	5,180	5,752	5,825	(73)	-1.3%	5,457
Contractual Deductions	4,422	4,312	(109)	-2.5%	3,955	4,319	4,294	(25)	-0.6%	3,930
Bad Debts	(2)	181	183	101.3%	193	89	184	95	51.5%	173
Charity and Other Adjustments	-	44	44	100.0%	9	40	44	4	9.8%	39
Net Patient Revenues	1,362	1,295	67	5.2%	1,022	1,303	1,302	1	0.1%	1,314
Net Patient Revenue %	23.6%	22.2%			19.7%	22.7%	22.4%			24.1%
Net Clinic Revenue	10	8	2	31.6%	10	10	5	5	86.6%	9
Other Operating Revenue	(8)	3	(11)	-425.7%	3	6	3	3	112.8%	3
Total Revenues	**1,363**	**1,305**	**59**	4.5%	**1,035**	**1,319**	**1,310**	**9**	0.6%	**1,326**
Expenses										
Salaries	765	697	(68)	-9.7%	791	759	729	(30)	-4.2%	784
Temporary Agency	41	38	(4)	-9.3%	58	32	38	6	16.4%	55
Benefits	259	201	(58)	-28.9%	245	231	205	(26)	-12.5%	216
Professional Fees	94	88	(6)	-6.8%	97	99	78	(21)	-26.8%	81
Supplies	194	192	(2)	-0.9%	168	167	195	28	14.5%	191
Purchased Services	84	92	9	9.3%	89	101	95	(6)	-6.1%	97
Rents and Leases	41	29	(12)	-41.2%	23	27	24	(2)	-9.2%	19
Utilities and Telephone	17	16	(1)	-6.1%	18	17	17	(1)	-4.2%	17
Insurance	7	4	(2)	-52.4%	9	7	4	(3)	-65.8%	8
Depreciation and Amortization	18	20	2	9.2%	22	19	19	(0)	-2.3%	21
Other Operating Expenses	26	18	(8)	-44.5%	31	25	20	(5)	-24.7%	23
Total Expenses	**1,545**	**1,395**	**(150)**	-10.7%	**1,551**	**1,484**	**1,425**	**(60)**	-4.2%	**1,511**
Operating Gain / (Loss)	**(182)**	**(90)**	**(91)**	-101.0%	**(516)**	**(165)**	**(114)**	**(51)**	44.6%	**(185)**
Non-Operating Income / (Expense)										
Parcel Taxes	130	121	9	7.6%	132	128	123	5	4.0%	127
Investment Income	0	0	0	43.2%	0	0	0	0	162.5%	0
Interest Expense	(6)	(3)	(3)	-100.3%	(4)	(4)	(3)	(1)	31.8%	(3)
Other Income / (Expense)	7	6	2	31.2%	6	7	6	1	20.4%	44
Net Non-Operating Income / (Expense)	**131**	**124**	**8**	**6.4%**	**134**	**131**	**126**	**5**	**4.1%**	**169**
Excess of Revenues Over Expenses	**$ (50)**	**$ 33**	**$ (83)**	-250.8%	**$ (382)**	**$ (34)**	**$ 11**	**$ (46)**	-400.7%	**$ (17)**

City of Alameda Health Care District
Statement of Cash Flows
For the Ten Months Ended April 30, 2012

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (188,641)	$ (1,300,297)
Items not requiring the use of cash:		
Depreciation and amortization	66,788	$ 712,338
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	885,314	(2,177,456)
Other Receivables	2,512,594	6,033,958
Third-Party Payer Settlements Receivable	(68,868)	54,519
Inventories	29,348	66,504
Prepaids and Other	39,658	79,947
Accounts payable and accrued liabilities	104,901	2,054,375
Payroll Related Accruals	(125,235)	(27,009)
Employee Health Plan Accruals	762	287,275
Deferred Revenues	(477,081)	(4,770,387)
Cash provided by (used in) operating activities	2,779,540	1,013,767
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,327)	436,687
Additions to Property, Plant and Equipment	(88,644)	(795,863)
Other	(0)	546,005
Cash provided by (used in) investing activities	(99,971)	186,830
Cash flows from financing activities		
Net Change in Long-Term Debt	(65,277)	406,270
Net Change in Restricted Funds	51,327	(296,687)
Cash provided by (used in) financing and fundraising activities	(13,950)	109,583
Net increase (decrease) in cash and cash equivalents	2,665,619	1,310,179
Cash and cash equivalents at beginning of period	428,701	1,784,141
Cash and cash equivalents at end of period	$ 3,094,320	$ 3,094,320

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 4/30/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.65%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.86%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-10.59%
Total Margin	-3.75%	1.03%	2.74%	-2.61%	-2.63%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	0.99
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	58.80
Days cash on hand (with restricted)	30.6	13.6	21.6	14.1	16.3
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	136.91%
Average pay period	58.93	58.03	57.11	62.68	75.43
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.25)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.23
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-17.25%
Debt to number of beds	20,932	13,481	10,482	11,515	14,251

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 4/30/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	25,472
Patient days (acute only)	11,276	11,787	10,579	10,443	9,213
Discharges(acute only)	2,885	2,812	2,802	2,527	2,377
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.88
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.51
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.87%
Average length of stay	3.91	4.19	3.78	4.13	3.88
Emergency Visits	17,922	17,337	17,624	16,816	14,130
Emergency visits per day	48.97	47.50	48.28	46.07	46.33
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	60.69
Surgeries per day - Total	14.78	16.12	13.46	6.12	6.04
Surgeries per day - excludes Kaiser	5.54	5.14	5.32	6.12	6.04

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

Fiscal Year 2013

Proposed Operating Budget Narrative

June 6, 2012
District Board Meeting

2070 Clinton Avenue • Alameda, CA 94501 • TEL (510) 522-3700 • www.alamedahospital.org

ALAMEDA HOSPITAL
FISCAL YEAR 2013
PROPOSED OPERATING BUDGET NARRATIVE

Prelude:

Attached is the Fiscal Year 2013 Alameda Hospital Operating Budget as prepared by hospital management. Upon approval by the City of Alameda Health Care District Board of Directors, this budget will constitute the spending authority for management for fiscal year 2013. Even though the City of Alameda Health Care District is a governmental agency, this budget should be considered a business plan and projection of what is anticipated for fiscal year 2013 rather than a fixed authority to spend.

There are several strategic impact issues and initiatives that have been built into the base FY 2013 operating budget. The summary budget delineates a baseline projection off FY 2012 forecast as well as the separate impact of each new initiative. These issues and initiatives include:

- **Acquisition of the Water's Edge Skilled Nursing Facility as a distinct part Skilled Nursing Unit of the hospital.**

  We are in the final stages of certification of the new distinct part Skilled Nursing Facility (SNF) with CMS. This process took longer than expected but we are anticipating taking the Water's Edge facility under the hospital umbrella by July 1, 2012. We have included assumptions of patient days, net revenue and expenses for bringing on the 120 beds and approximately 120 employees in the budget for FY 2013.

- **Addition of two new orthopedic physicians.**

  The two new orthopedic surgeons, with training in Sports Medicine and Spine, have accepted offers to establish a comprehensive orthopedic program at Alameda Hospital which compliments existing orthopedic resources. These physicians are expected to begin October 1, 2012. This will expand the scope of orthopedic services on the island and we will market aggressively to attract patients from off island as well. This additional orthopedic volume can be absorbed into our currently under-utilized operating room, imaging and therapy services. The program expansion will require an additional day per week of the MRI trailer to accommodate the increase in orthopedic procedures and referrals to the hospital from their clinic. We are also pursuing the possibility of a full time on-site MRI room to meet the increasing MRI needs from this program and from the community.

- **Implementation of the Outpatient Wound Care Clinic.**

  The Wound Care Clinic that was delayed due to licensing and construction issues is now scheduled to open for business on June 25, 2012. This clinic and related expenses have been incorporated into the budget for the full year. We have numerous physicians on the panel and much interest in the opening of this needed service. Comprehensive promotion and marketing plan has been developed to kick off the program.

As we have worked through the detail budgets for each of these new programs, there have been minor adjustments to certain revenue and expense line items. However, they all materially reflect the financial forecasts that have been presented and approved for each.

Fiscal Year 2013 Narrative:

The following sections discuss the key budget assumptions that have been incorporated into the FY 2013 Operating Budget

Utilization

Inpatient Acute Care Services

The hospitals acute average daily census (ADC) is projected to increase by 3.3% over the census levels experienced in FY 2012 (30.5) as a result of two key factors:

1. The addition of two new Orthopedic Surgeons, expected to begin on October 1, 2012. They are anticipated to bring in 72 new inpatient surgeries resulting in that same increase in admissions and an average length of stay of 4.4 days. This will increase our ADC by 0.9.

2. The addition of the Wound Care Center, expected to open on June 25, 2012, will also provide some marginal increase in inpatient admissions and has been projected to increase our average daily census by 0.1 patients per day.

3. Other than these two programs, our baseline inpatient acute volume budget is at the FY 2012 levels. We do anticipate splitting our medical unit (3west) into separate medical and surgical care units to better serve the clinical needs of these patients. There is some marginal additional staffing expense associated with this change.

Inpatient Long Term Care Services

The South Shore Skilled Nursing Unit is projected to have an ADC of 21.6 which approximates the levels experienced in fiscal year 2012. However, we are budgeting for an increase in Medicare Part A patients censes at South Shore from 2.1 in FY 2012 to 4.0 in FY 2013 based on a payor mix that we have already experienced as of the result of more organized referral system. With the increase in the utilization of therapy services provided to these patients, net revenues will increase as well.

The 35 bed Sub-Acute unit is projected to have an ADC of 32.6 which is also consistent with the current fiscal year's performance, although currently the unit has been full at 35 patients. Both programs are limited by the number of available beds in each of these units.

Outpatient Services

Total outpatient registrations are expected to increase by 12.5% over fiscal year 2012 projections. The change in outpatient registrations is driven by the following:

1. Volume in the imaging and rehabilitation services is projected to increase by 17.9% and 87.2% respectively due to referrals from the new orthopedic physicians. We expect the new physicians to be aggressive in ordering needed follow up tests and therapy. The additional registrations result in additional outpatient visits and we anticipate each orthopedic rehabilitation registration will result in 9 visits, and each imaging registration will result in one visit.

2. Beginning in June 25, 2012, an additional 250 registrations from the Wound Care Center will be added to the outpatient volume resulting in a projected 2,500 visits. In addition to the registrations at the Wound Care Clinic, an additional 446 registrations have been added for patients that will require other diagnostic services such as laboratory, radiology and rehab services in conjunction with their wound care visits and clinical care plan.

3. Outpatient surgeries are expected to increase for two reasons. First, the new orthopedic surgeons are planning to bring in an additional 41 outpatient surgeries from patients coming through their clinic. Second, the Wound Care program is expected to bring in 40 more outpatient surgeries in fiscal 2013. These two programs are expecting to see a 4.5% increase in outpatient surgeries

Emergency Care Services

Emergency visits have been projected to remain consistent with the same levels as experienced during fiscal year 2012 which have averaged 46.0 visits per day. Emergency room visits have remained at a constant level over the past few years and are not expected to change in FY 2013. However, as the result of better documentation, coding and select price increases for emergency room services, net revenues will increase in FY 2013.

Alameda Hospital Physicians (Medical Offices)

The Alameda Hospital Physicians volume is budgeted to remain consistent with FY 2012 levels. We currently have physicians practicing in general surgery, neurology and internal medicine in the 1206b clinic.

Gross Charges

The FY 2013 consolidated budget has Gross Charges increasing by $55 million over FY 2012. The hospital's three new programs: Waters Edge, Wound Care and the comprehensive orthopedic program will generate the majority of the increase in gross revenue. These areas are

expected to increase gross revenue by $34.6 million, $5.3 million and $7.7 million respectively. Increases in rehab services utilization at South shore, wound care spin off business (surgery, inpatient days, lab, imaging), and an increase in outpatient imaging volumes account for the majority of the remaining $3.5 million increase in the hospital's baseline operation. Lastly increased gross charges from service specific price increases total $3.9 million and will result in additional net revenue as discussed later.

Service specific price increase will be implemented effective July 1, 2012 which will result in an overall increase of 3.9 million 1.5%. These increases were targeted at areas where we were below market and /or where we could most effectively realize additional net revenue through our managed care contracts.

Net Revenue

Our overall estimated net patient revenue percentage is projected to increase to 23.7% in FY 2013 versus the current year's 22.4%. Some of the factors contributing to the increase in our projected net revenue percentage:

The three new programs will provide the following net revenues:

- Net patient revenue from the Water's Edge skilled nursing is projected to $13.8 million with payer mix of 76% Medi-Cal, 13% Medicare and 11% Private/Other. These estimates are consistent with the financial forecast presented last November. Because skilled nursing has a higher net revenue percentage (39.9%), this contributes to the overall net revenue increase from 22.4% to 23.5%.

- Net patient revenue from the Wound Care Clinic is projected to be $1.2 million.

- Net patient revenue for the orthopedic program expansion is estimated at $1.7 million for the hospital "spin-off" revenue, as well as an additional $498,000 in physician billing (other operating revenue). Once again, this is for about 9 months of the fiscal year.

Waters Edge Facility	$13.8 million
Wound Care Clinic	$1.2 million
Orthopedic Program	$2.2 million
Total New Programs	$17.2 million

There are several variables that will affect net revenue on our baseline operations which includes the following:

- Included in the net revenue assumptions is a potential decrease to acute inpatient Medi-Cal net revenue as currently proposed in the State budget. To be conservative, we have accounted for this decrease estimated at $120,000.

- We have not budgeted for any IGT funds since this program is also being considered for elimination in the State budget plan. In fiscal year 2012 this was about $673,000.

- While we have implemented an annual price increase to service specific charges, the projected increased reimbursement is estimated at only $486,000 since the majority of hospital payments are based upon fixed per diem rates or rates established by federal and state governments for Medicare and Medi-Cal programs. However, this price increase allows the hospital to maximize reimbursements allowed under contractual arrangements with the various managed care payors.

- We have recently completed negotiation of our most significant managed care contract and will be completing negotiation of three other contracts in the next couple of months. These new contract rates will contribute about $520,000 additional net revenue based upon current activity levels.

- Net patient revenue for the South Shore skilled nursing facility is projected at the new estimated Medi-Cal rate of $316 per day once Waters Edge becomes part of our license. This is a decrease from the current rate of $385 per day with an annualized reduction of $466,000. To help counter this, South Shore is budgeted for an increase of 1.0 ADC for Medicare patients. With the appropriate levels of therapy services, net revenue is budgeted to increase by $327,000.

- The sub-acute unit is predominantly Medi-Cal patients with about half of the patients on ventilators and half non-vent patients. The budget includes the new per diem rates that recently went into effect totaling $200,000 per year.

- Increase reserve allowance for additional self pay bad debt and charity reserves will decrease net revenue by about $360,000.

Acute Inpatient Medi-Cal Reimbursement	($220,000)
IGT Program Elimination	($673,000)
Targeted Service Price Increase	$486,000
Managed Care Contract Rate Increases	$520,000
Net Affect At South Shore (Medi-Cal/Medicare)	($139,000)
Increase For Sub-Acute Per Diem Rates	$200,000
Additional Bad Debt / Charity Care Reserves	($360,000)
Total Baseline Net Revenue Changes	($186,000)

In summary the increase in net revenue from fiscal year 2012 projected to fiscal year 2013 budget is approximately $17 million or 28.8%.

Labor and Benefits Expense

Overall labor costs are projected to increase by approximately $7.1 million over the projected fiscal year 2012. The FY 2013 budget proposal includes approximately 120 new employees at the Water's Edge facility as well as several support personnel in Human Resources, General Accounting and Information Systems necessary to support this new site. In addition, there are new positions required to support the Wound Care Clinic as well as the new Orthopedic Clinic.

Total full time equivalents for fiscal 2013 are budgeted at 541.4, an increase of 127.5 FTE's from the fiscal year 2012 forecasted total of 413.9 FTE's. This increase in FTE's will be supported by increased net revenue in the new programs and services. Attachment A summarizes the changes in FTE's in the fiscal 2013 budget.

Staffing for nursing departments has been based upon the budgeted patient days of the inpatient acute nursing units and the California mandated nurse staffing hour ratios for inpatient acute services. In addition, adjustments to ensure appropriate levels of coverage for break and lunch relief have been factored into the determination of the calculated required hours of nursing care. We have also set up job codes to be used to track the usage of Administration Days (used by RN's) and Sitter Hours (used by CNA's) in the nursing units.

The fiscal 2013 budget does not provide for any salary or wage increases for the existing represented or non-represented employees. It is important that the three new revenue programs come on line and that the actual to budget performance be tracked against the proposed budget. We do believe that we have been very conservative with our budget assumptions for these programs. In the event that we exceed the fiscal 2013 budget and the hospital is in a stronger financial position, management will come forth with a separate recommendation for salary and wage increases.

Benefits have been calculated consistent with the current year's experience. We have budgeted for the employer portion of FICA, health insurance, pension and the employee assistance program. Benefits are projected to increase in line with the increase in total salaries. Total benefits run approximately 28.9% of total salaries, well within industry standards. The hospital is self insured for employee health benefits and although there are stop loss limits for cumulative large cases, there is fluctuation in claim experience from year to year that make budget estimation challenging. The fiscal 2013 budget allows for a 5% increase in employee health benefit expense.

Non-Labor Expenses

The following are the assumptions for the various categories of the operating budget non-labor expense categories:

Professional Fees

Professional fees decreased by approximately $78,000 overall as a result of the following;

- Reduced utilization of HFS staff that has been used in accounting and business officer over most of the past fiscal year.

- Reduction in legal and consulting fees for Water's Edge, Orthopedic and Wound Care transitions.

- The new wound care program resulting in additional management fees to Accelcare for the management of the program in the amount of $584,000.

- One Orthopedic physician in a contracted relationship beginning October 1, 2012 in the amount of $237,000.

Supplies

Medical supply costs are projected to increase over current year projections as a result of the budgeted 3.3% increase in inpatient volumes due to the orthopedic program. There are also supply cost increases related to Water's Edge in both medical supplies and food supplies of approximately $1.2 million. The Wound Care program will also add approximately $91,000 of additional supply costs. Overall, supplies are projected to increase over the 2012 Forecast by $1.5 million or 20.8%.

Purchased Services

Purchased services expenses are projected to increase by $2.1 million or 45.7% due to:

- Outsourcing the hospital's long term care Rehab services to Select Therapies at an expense of $236,000, in conjunction with staff reductions to offset this expense

- Additional MRI trailer service day to support increased utilization with orthopedic program and other community physicians $180,000.

- Additional HIM coding expense for emergency room procedures and Wound Care procedures $100,000.

- Water's Edge purchased services totaling $1.6 million comprised of rehabilitation, laboratory, pharmacy and imaging services.

Rents and Leases

This category will increase by approximately $1.2 million (104.1%) over current year projected rent expenses. This expense is primarily the $919,000 rent expense of the Water's Edge facility but also includes additional nine months lease for the building at Marina Village ($112,000) and full year of imaging equipment/PACS lease payments ($170,000).

Insurance

Insurance expense is anticipated to increase $165,000 or 50.2% as a result of additional insurance needed for the Water's Edge facility. We are planning on needing $146,000 in expense for insurance related to this facility.

Utilities

Utilities expenses (including telephone) are planned to increase from the 2012 projections again due to the addition of Water's Edge and Wound Care clinic. Hospital utility expenses are only projected to increase slightly but will add $180,000 in utility expense for Water's Edge.

Depreciation and Amortization

This classification will decrease by $83,000 or 9.2% from FY 2012, as a result of additional assets reaching their fully depreciated cost basis during the fiscal year. Included in this decrease is the additional leasehold improvement depreciation for the build out of the Wound Care Center of approximately $59,000.

Other Expenses

Other expenses will increase by approximately $396,000 with $246,000 related to projected Water's Edge expenses, $87,000 related to Wound Care and $132,000 related to the Orthopedic program. Baseline hospital expenses will decrease by about $70,000 in fiscal year 2013.

Net Income:

After all of the herein discussed additional programs, changes in gross and net revenue and operating expenses the consolidated net income is budgeted at $682,000. This is comprised of a $1.5 million shortfall from the hospital's baseline operations; an improvement from the FY 2012 projected loss of $1.8 million. The Orthopedic program for the nine will have net income of $596,000, the Wound Care clinic $46,000 and Waters Edge $1.6 million.

Please see the following pages for the Income Statement comparison as well as the summary of volume projections.

Alameda Hospital
FTE Summary
FY 2013 Budget

	FTE's
FY 2012 Forecast	**413.9**
Additions:	
Water's Edge	119.1
Wound Care Clinic	2.5
Orthopedic Clinic	2.8
Nursing	4.3
Support (HR, Accounting, IT, Pharmacy)	5.5
Total Additions	134.2
Reductions:	
Rehabilitation	1.1
Support (Business Office)	5.6
Total Reductions	6.7
FY 2013 Budget	**541.4**

Alameda Hospital
Statement of Income and Expense
FY 2013 Operating Budget

	Actual FY 2011	Forecast FY 2012 (1)	Baseline Budget FY 2013	Ortho Program (2)	Wound Care	Water's Edge	Consolidated Budget FY 2013	Change from FY 2012	Percent Change
Net Patient Revenue	57,479	58,316	58,179	1,669	1,208	13,791	74,847	16,531	28.3%
Net Revenue Percent	23.6%	22.4%	21.6%	21.6%	23.0%	39.9%	23.7%	1.3%	5.9%
Other Operating Revenue	553	656	605	498	-	-	1,104	448	68.2%
Total Revenue	58,032	58,972	58,785	2,167	1,208	13,791	75,951	16,979	28.8%
Expenses									
Salaries and Agency	37,619	35,435	36,017	314	181	6,018	42,530	7,095	20.0%
Benefits	9,300	10,264	10,353	105	54	1,805	12,318	2,054	20.0%
Professional Fees	3,667	4,722	3,626	254	620	104	4,604	(118)	-2.5%
Supplies	8,125	7,383	7,145	507	91	1,174	8,917	1,534	20.8%
Purchased Services	4,318	4,622	4,907	219	-	1,606	6,732	2,110	45.7%
Rent	838	1,201	1,446	25	61	919	2,451	1,250	104.1%
Insurance	384	329	333	15	-	146	494	165	50.2%
Utilities & Telephone	770	784	826	-	9	180	1,015	231	29.5%
Depreciation	953	899	757	-	59	-	816	(83)	-9.2%
Other	1,080	1,077	1,008	132	87	246	1,473	396	36.8%
Total Expenses	67,053	66,716	66,419	1,571	1,162	12,198	81,350	14,634	21.9%
Operating Income/(Loss)	(9,021)	(7,744)	(7,634)	596	46	1,593	(5,399)	2,345	30.3%
Non-Operating	7,363	5,890	6,081	-	-	-	6,081	191	3.2%
Net Income/(Loss)	(1,658)	(1,854)	(1,553)	596	46	1,593	682	2,536	136.8%

(1) Forecast is using actual data through March 2012 YTD plus remaining months of budget adjusted for current year run rate
(2) Program expected to begin on October 1, 2012

Alameda Hospital
Inpatient Acute Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Ortho Program	Wound Care	Adjusted Budget FY 2013
Discharges - Acute	2,802	2,527	2,787	2,781	72	12	2,865
ALOS - Acute	3.8	4.1	4.0	4.0	4.4	3.0	4.0
Patient Days - Acute							
CCU	1,406	1,552	1,485	1,485	-	-	1,485
DOU	4,445	4,023	4,128	4,128	-	-	4,128
3 West	4,728	4,868	5,534		-	-	-
3 Medical				4,781	-	36	4,817
3 Surgical				730	317	-	1,047
Total Acute	10,579	10,443	11,146	11,124	317	36	11,477
Average Daily Census							
CCU	3.9	4.3	4.1	4.1	-	-	4.1
DOU	12.2	11.0	11.3	11.3	-	-	11.3
3 West	13.0	13.3	15.1		-	-	-
3 Medical				13.1	-	0.1	13.2
3 Surgical				2.0	0.9	-	2.9
Total Acute	29.0	28.6	30.5	30.5	0.9	0.1	31.4
Available Beds	66	66	66	66	-	-	66
Occupancy Percent	43.9%	43.3%	46.1%	46.2%			47.6%
CMI - Medicare	1.4174	1.4256	1.3594	1.3594			1.3798
CMI - Total	1.3398	1.3332	1.2955	1.2955			1.3149

Notes:
For comparability purposes, Kaiser volume has been excluded from prior years.

Alameda Hospital
Inpatient Long-Term Care Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013
Discharges				
Sub-Acute	13	24	52	52
South Shore	128	109	74	74
Water's Edge	-	-	-	156
Total Long Term Care Discharges	141	133	126	282
Patient Days				
Sub-Acute	11,977	11,861	11,898	11,898
South Shore	7,832	7,965	7,882	7,882
Water's Edge (1)	-	-	-	37,761
Total Long Term Care Days	19,809	19,826	19,780	57,541
Average Daily Census				
Sub-Acute	32.8	32.5	32.5	32.6
South Shore	21.5	21.8	21.5	21.6
Water's Edge (1)	0.0	0.0	0.0	103.5
Total Average Daily Census	54.3	54.3	54.0	157.6
Payer Mix				
Sub-Acute				
Medicare	1%	1%	1%	1%
Medi-Cal	94%	94%	96%	96%
Other	6%	6%	3%	3%
South Shore				
Medicare	14%	14%	14%	19%
Medi-Cal	85%	85%	85%	80%
Other	1%	1%	1%	1%
Water's Edge				
Medicare	n/a	n/a	n/a	13%
Medi-Cal	n/a	n/a	n/a	76%
Other	n/a	n/a	n/a	11%
Available Beds (1)	60	60	60	170
Occupancy Percent	90.5%	90.5%	90.1%	92.7%

1) Water's Edge to begin operation under Alameda Hospital license July 1, 2012 and 110 available beds

Alameda Hospital
Surgery & Outpatient
Fy 2013 Budget

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Ortho Program	Wound Care	Adjusted Budget FY 2013
ECC Visits	17,337	17,624	16,816	16,800	16,800	-	-	16,800
Outpatient Registrations	29,948	29,079	23,796	22,420	22,540	2,110	696	25,346
Per Day								
ECC	47.5	48.3	46.1	45.9	46.0	-	-	46.0
Registrations	82.0	79.7	65.2	61.3	61.8	5.8	1.9	69.4
Surgeries								
Inpatient	588	592	502	468	468	72	20	560
Outpatient	1,288	1,351	1,708	1,807	1,807	41	40	1,887
Total	1,876	1,943	2,210	2,275	2,275	113	60	2,448

Notes:

For comparability purposes, Kaiser volume has been excluded from prior years.

Alameda Hospital
Five Year Detail Trend of Outpatient Visits

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Ortho Program	Wound Care	Adjusted Budget FY 2013
ATC Satellite Lab	167	2,617	3,145	143	-	-		-
Cardio Fit	1,330	1,337	1	-	-	-		-
CT Scan	567	525	483	428	448	173		621
EEG	-	-	-	19	19			19
EKG	867	892	865	841	841			841
IV Therapy	2,027	1,676	1,132	885	885			885
IVT Other	-	386	735	789	789			789
Laboratory	9,830	6,560	5,800	7,407	7,407		200	7,607
MRI	479	454	501	556	556	431		988
Nutrition	22	12	14	31	31			31
Nuclear Medicine	213	125	161	136	136		38	174
Outpatient - Clinic	22	16	344	668	668			668
Occupational Therapy	472	451	479	333	333			333
Physical Therapy	3,515	3,381	3,046	3,160	3,160	3,100	30	6,290
Respiratory Therapy	80	177	73	75	75			75
Speech	75	20	28	60	60			60
Surgery	5,184	4,182	1,672	1,715	1,715	41	40	1,796
Ultrasound	33	1,194	1,200	1,213	1,213			1,213
Radiology	8,565	7,174	7,035	6,207	7,300	1,121	138	8,559
Wound Care	-	-	-	-	-		2,500	2,500
Other	83	1,587	30	4	4			4
Total Visits	33,531	32,766	26,744	24,668	25,642	4,866	2,946	33,454
				0				
O/P Registrations	29,951	29,082	23,796	-	22,540	2,110	696	25,346

Note: Ortho program assumes: Imaging = 1 visit per registration; Rehab = 9 visits per registration
Wound Care program assumes: Wound Care clinic 10 visits per registration; Ancillary/Surgery = 1 visit per registration

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Fiscal Year 2013

Proposed Capital Budget

June 6, 2012

District Board Meeting

2070 Clinton Avenue • Alameda, CA 94501 • TEL (510) 522-3700 • www.alamedahospital.org

City of Alameda Health Care District
Fiscal Year 2013
Capital Budget

As part of the District's annual budgeting process, it is required to submit and approve a capital budget in addition to the operating budget. As part of the capital budget process, input is solicited from all departments of the organization as well as from members of the medical staff.

For FY 2013, the total capital budget requests submitted was $4.65 million in the following general categories.

Engineering/Plant Operations	$2.4 million
Seismic / Regulatory	$950,000
Pharmacy	$6,000
Surgery	$287,000
Central Supply	$139,000
Information Technology	$370,000
Nursing	$6,000
Medical Staff	$150,000
Ortho Clinic Build-Out	$350,000

Provided with each request, is an explanation of why the request is being made and the degree of importance/urgency. Management then has the task of evaluating the submitted requests against the organizations ability to fund them throughout the fiscal year.

It is recognized that there are many capital expenditures needed given the age of our facilities and much of our equipment. Furthermore, there is a pressing need to continue to advance our technological capabilities both hardware and software to comply with Electronic Health Record and Meaningful Use as well as providing the tools needed by our physicians and clinicians. In addition, there are several regulatory and seismic compliance activities that need to be complete over the next fiscal year that will require scarce resources.

This past year we committed about $1.6 million over five years to upgrade our imaging equipment and implementation of a PACS system. We also installed a much needed telemetry system in Telemetry and CCU Units costing $300,000. To advance program development and new revenue, we have assumed a $900,000 loan for build-out and furnishing of the new Wound Care Center. It is important to note that Wound Care was also funded by a $100,000 contribution and a $125,000 loan from the Alameda Hospital Foundation.

Given the challenge of developing a positive FY 2013 operating budget and given the capital projects that have already been completed this past fiscal year or are in process, the amount of additional capital expenditures being recommended is very limited for Fiscal Year 2013.

For Fiscal Year 2013 we are recommending a total of $1.5 million with seismic and regulatory compliance totaling $950,000, upgrades/enhancements to information technologies/ systems totaling $300,000, $100,000 for replacement of the Washer Sterilizer

in Surgery and $150,000 for clinical equipment requested by the medical executive committee. (See the following capital budget detail below).

Once the new programs and services discussed in the operating budget narrative are up and running and meet or exceed the financial results that are anticipated, we will reevaluate our ability to recommend for approval additional capital budget expenditures at that time.

Funding:

To help fund these projects we recommend using the amount of depreciation expense in the operating budget to reinvest in capital expenditures. For Fiscal Year 2013, this amount is $816,000.

We will also be able to continue to use the income from the Jaber properties which will bring in about $120,000 per year. The hospital has also received annual contributions from the Auxiliary totaling $40,000 for FY 2012. In addition there have been discussions for new applications for funding through the Alameda Hospital Foundation for FY 2013.

Proposed FY 2013 Capital Budget Detail

Item Description	Comments	Amount
Bulk Oxygen Vessel Replacement	Seismic (NPC 2)	$400,000
Communication Systems Anchoring	Seismic (NPC 2)	$50,000
Emergency Lighting and Signage 1925 Building	Seismic (NPC 2)	$150,000
Sprinkler System Addition in Subacute	CMS Requirement	$200,000
Boiler Replacement	BAAQMD[1]	$150,000
Information Technology Upgrades	Various Projects	$300,000
Washer Sterilizer	Medical Staff / Surgery	$99,466
Vein Finder	Medical Staff/ ICU	$10,000
Glide Scope	Medical Staff / ICU	$12,000
ICU Bed	Medical Staff / ICU	$30,000
Adult Critical Care Ventilator	Medical Staff / ICU	$32,000
Med/Surg Patient Beds	Medical Staff /Medical	$8,000
Other Contingency	Medical Staff	$30,000
Total		$1,471,466

[1]Bay Area Air Quality Management District

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: May 30, 2012

For: June 6, 2012 District Board Meeting

Through: Finance and Management Committee

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

From: Deborah E. Stebbins, CEO
Kerry Easthope, CFO

Subject: Approval of Resolution 2012-5J: Authorizing a Loan from the Bank of Alameda, Secured by Real Property

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Recommendation:

The Finance and Managament committee and management recommend that the Board of Directors adopt the attached resolution regarding restructuring our existing line of credit loan with the Bank of Alameda (currently drawn down at $750,000) by replacing it with a long term loan with the Bank of Alameda which will be secured by the two parcels of real property owned by the District as a result of the Jaber Trust. The tentative terms are based on discussions with the Bank. In the event the final terms differ from what is presented in the resolution (Exhibit A) management will bring this issue back to the Board for further consideration prior to executing the loan.

Background/Discussion:

Management has been in discussions in the last few weeks with the Bank of Alameda with regard to restructuring our existing line of credit to be replaced by a long term loan using the two parcels of real property gifted to the Hospital and later transferred in title to the District, by the Jaber Trust. This allows us to convert a current liability into a long term liability, thereby improving our ratios and increases the funds available to the Hospital in a financially challenging period prior to cash flow being generated by our three new programs.

While the exact terms of the loan, including the total value, are subject to some additional steps, including obtaining an updated appraisal of the properties, the tentative terms we have discussed with the Bank are outlined in Exhibit A:

1. Loan amount be no more than 70% of commercial property assessed value. A 1% loan origination fee would apply that could be folded into this loan amount.

2. A 10 year loan term. The first 5 years at a fixed rate of 5.5%, then adjusted to Treasury rate plus 3.5% with a 5.5% floor for the remaining 5 years. Balloon payment or refinance at the end of 10 year term.

3. 25 year amortization of loan for payment purposes.

4. Income from commercial tenant needs to be 1.2 - 1.3 times monthly loan amount.

The last appraisal of the two properties in 2008 was $1.7 million. Local real estate resources have advised us that the current value may be as high as $1.9 million. An updated appraisal is being arranged by the Bank at our expense.

Resolution No. 2012 - 5J

**A RESOLUTION OF THE
CITY OF ALAMEDA HEALTH CARE DISTRICT
BOARD OF DIRECTORS**

*** * ***

Authorizing a Loan from the Bank of Alameda,

Secured by Real Property

* * *

WHEREAS, The District has negotiated tentative terms of a loan from the Bank of Alameda, the tentative terms of which are attached hereto as Exhibit A (the "Loan"). One of the terms of the Loan is that it be fully secured by real estate;

WHEREAS, Ms. Alice Jaber developed a personal interest in health care issues and the availability of quality health care in the Alameda community; and

WHEREAS, Ms. Jaber established her Trust in 1992, naming Alameda Hospital as a major beneficiary. Upon her death, and pursuant to the terms of the Trust, (1) certain Trust assets were distributed to the City of Alameda Health Care District, as the successor-in-interest to Alameda Hospital (the nonprofit corporation), and (2) those assets were placed in the "Abraham Jaber and Mary A. Jaber Memorial Fund" (the "Jaber Fund") in appreciation of the care given by Alameda Hospital; and

WHEREAS, Among the assets in the Fund are cash as well as two parcels of real property located in the City of Alameda, namely, 1359 Pearl Street, an apartment complex, and 2711 Encinal Street, a retail store (collectively, the "Jaber Properties"). Both Jaber Properties generate rental income that is placed back into the Fund and used, as specified in the original Trust (and as carried over to the Jaber Fund), to fund an annual distribution to the Hospital. Neither of the Jaber Properties is used in any way for the provision of any services provided by the District; and

WHEREAS, Pursuant to the terms of the Jaber Fund, Alameda Hospital annually receives certain cash distributions. Specifically, and except as noted in the next sentence, the Fund is to be used for the purchase of capital equipment directly related to the diagnosis and treatment of patients at Alameda Hospital. However, if the District Board of Directors determines, in its sole discretion, that that a greater amount of the Fund needs to be used to maintain Alameda Hospital at, or to restore Alameda Hospital to, its level of operation in its prior fiscal year, and there are no other reasonably available resources for this purpose, a greater amount of the Fund, up to the whole thereof, may be drawn upon to maintain or restore the level of operation. The Jaber Properties are part of the Fund, and the terms of the Fund do no prohibit the mortgaging of said properties as described herein; and

WHEREAS, As discussed previously by the Board, a number of unanticipated operational changes and uncontrollable reimbursement reductions have had an adverse effect on Alameda Hospital's financial condition and operations over the last two fiscal years; and

WHEREAS, Since there are no other reasonably available resources for this purpose, the Board of Directors of the City of Alameda Health Care District has determined, in the exercise of its sound discretion, that is in the best interests of Alameda Hospital, to utilize the Fund (as and to the extent described below) so as to restore Alameda Hospital to its level of operation in its prior fiscal years.

NOW THEREFORE BE IT RESOLVED, that upon approval of this resolution, the District is authorized to enter into the Loan and, in furtherance thereof, to secure the repayment of the Loan by granting deeds of trust on the Jaber Properties. The proceeds of the Loan shall be deposited into the Alameda Hospital operating account for use in restoring Alameda Hospital to its level of operation in its prior fiscal years; and

BE IT FURTHER RESOLVED, that any and all loan proceeds realized by the District in connection with such borrowing shall be used to restore Alameda Hospital to its level of operation in its prior fiscal years and, upon repayment of the Loan, the net equity in the Jaber Properties be restored to the Fund for future uses in accordance with the terms of the Jaber Fund; and

BE IT FURTHER RESOLVED, that in order to validate the terms of the Loan, the Loan shall not be made prior to sixty (60) days following the date of the approval of this Resolution; and

BE IT FURTHER RESOLVED, that the CEO of the District is, and those under her direction are, authorized and empowered to take such actions as may be necessary of convenient in order to effectuate the terms of this resolution.

PASSED AND ADOPTED on June 6, 2012 by the following vote:

AYES: _____ NOES: _____ ABSENT: _____

_____
Jordan Battani
President

ATTEST:

_____
Elliott Gorelick
Secretary

Attachment A

155 Grand Avenue, Suite 100, Oakland, CA 94612 * (510) 748-8800 * Fax (510) 748-8055

EXPRESSION OF INTEREST LETTER

May 25, 2012

City of Alameda Health Care District
2070 Clinton Avenue
Alameda, CA 94501
Attn: Kerry J. Easthope, Chief Financial Officer

Re: Proposed Commercial Real Estate Loan Secured by Real Properties located at (i) 2711 Encinal Avenue, Alameda, CA 94501 and (ii) 1359 Pearl Street, Alameda, CA 94501. Loan Amount: Up to 70% of Commercial Properties Assessed Value (Maximum Loan Amount: $1,400,000)

Dear Mr. Easthope:

The Bank of Alameda ("Bank") is pleased to consider establishing the following credit facility involving the following primary terms and conditions, it being understood that some additional terms and conditions may be required by the Bank before the final credit documentation is executed:

Borrower:	City of Alameda Health Care District
Amount:	Up to 70% of the appraised value on a collective basis of real properties located at (i) 2711 Encinal Avenue, Alameda, CA 94501 and (ii) 1359 Pearl Street, Alameda, CA 94501 (loan amount not to exceed $1,400,000)
Type of Facility:	Term Loan
Purpose:	To provide funds to (i) fully repay, terminate and cancel in its entirety the existing $750,000 revolving line of credit (Loan #1421338) and (ii) reduce trade payable balances and other working capital requirements.
Pricing:	5.50% Fixed (first 5 years); Readjusted to the then prevailing 5-Year CMT + 3.50% Fixed (6th year to Maturity). In no event shall the rate be less than 5.50% for the term of the loan.
Loan Fees:	1.00% of the total loan amount (payable solely to the Bank at Closing), plus all out-of-pocket expenses including appraisals (to be prepaid), appropriate environmental reports (to be prepaid), title insurance, recording, legal fees, and related charges, etc.
Prepayment Fees:	Yr. 1: 5.00%; Yr. 2: 4.00%; Yr. 3: 3.00%; Yr. 4: 2.00%; Yr. 5: 1.00%
Maturity:	10 years, amortizing over 25 years

Guarantors: N/A

Collateral: First Deeds of Trust on real properties located at
(i) 2711 Encinal Avenue, Alameda, CA 94501
(ii) 1359 Pearl Street, Alameda, CA 94501

Conditions: To include terms and conditions customary for transactions of this nature, including, but not limited to:

Borrower to submit the following reports and comply with the following:

(a) Completed and executed loan application;
(b) Satisfactory environmental review of the real properties;
(c) Appraisal reports acceptable in form and substance to the Bank;
(d) Loan amount not to exceed 70% of the appraised value of real properties collectively (Maximum: $1,400,000);
(e) Minimum Debt Service Coverage Ratio of 1.30:1.00 based on cash flow from pledged real properties collectively (calculated annually);
(f) Bank review and approval of all leases (including any and all amendments).

This letter constitutes an ***expression of interest*** in establishing the above facility for the Borrower, and should not be construed as a commitment. Outlined above are the proposed covenants and terms related to the credit facility, which may be subject to change.

This proposal shall expire at the close of business on June 15, 2012, unless prior to that time we have received your written acceptance and any appropriate payments required to be applied toward out-of-pocket expenses incurred by the Bank.

Sincerely,

Roger Chu
Vice President
Relationship Manager

CC: Troy Williams (COO and Chief Lending Officer)
Pat Young (Senior Vice President, Commercial Banking Team Leader)

Accepted by:

_____ _____
Kerry J. Easthope Date

NOTICE:
The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract), because all or part of the applicant's income is derived from any public assistance program, or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law concerning this creditor is the Federal Deposit Insurance Corporation, Consumer Response Center, 2345 Grand Boulevard, Suite 100, Kansas City, Missouri 64108.

RESOLUTION NO. 2012-4J

BOARD OF DIRECTORS, CITY OF ALAMEDA HEALTH CARE DISTRICT

STATE OF CALIFORNIA

*** * ***

LEVYING THE CITY OF ALAMEDA HEALTH CARE DISTRICT

PARCEL TAX FOR THE FISCAL YEAR 2012-2013

WHEREAS, the Alameda County Local Agency Formation Commission ("LAFCo") resolved on January 10, 2002 to present a ballot measure to the registered voters of the City of Alameda which, if approved, would authorize the formation of the new health care district within the boundaries of the City of Alameda and authorize the District to levy a parcel tax of up to $298.00 on each parcel and possessory interest within the proposed district; and

WHEREAS, on April 9, 2002, over two-thirds of the registered voters of the City of Alameda, who voted that day, voted in favor of creating a health care district authorized to tax each parcel and possessory interest within the district's boundaries in an amount up to $298.00 per year in order to defray ongoing hospital general operating expenses and capital improvement expenses; and

WHEREAS, the City of Alameda Health Care District (the "District") was formally organized and began its existence on July 1, 2002; and

WHEREAS, without tax revenue Alameda Hospital can not fulfill its mission to serve the health needs of the Alameda City Community due to a lack of sustained revenue sufficient to finance continued operation of all necessary hospital services; and

WHEREAS, the District operates Alameda Hospital; and

WHEREAS, without the levy of a parcel and possessory interest tax in the amount of $298.00, the District's revenue stream will be insufficient to allow the provision of continued local access to emergency room care, acute hospital care, and other necessary medical services; and

WHEREAS, the District is authorized under Section 53730.01 of the California Government Code to impose special taxes on all real property within its boundaries.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the District that the District hereby levies an annual tax on every parcel and possessory interest within the District's boundaries in the amount of Two Hundred Ninety-Eight Dollars ($298.00) per year (the "Parcel Tax") in order to defray ongoing hospital general operating expenses and capital improvement expenses; provided, however, that parcels or possessory interests that have an assessed value (real property and improvements combined) of less than $30,000 shall be automatically exempt from the Parcel Tax.

PASSED AND ADOPTED on June 6, 2012 by the following vote:

AYES: _____ NOES: _____ ABSENT: _____

_____
Jordan Battani
President

ATTEST:

_____
Elliott Gorelick
Secretary

DATE: May 24, 2012

FOR: **June 6, 2012 District Board Meeting**

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

FROM: Thomas Driscoll, Legal Counsel
Kristen Thorson, District Clerk

SUBJECT: Approval of Certification and Mutual Indemnification Agreement

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RECOMMENDATION:

It is recommended that the District Board approve the Certification and Mutual Indemnification Agreement and authorize District Legal Counsel to sign the documents.

BACKGROUND:

Attached is the cover letter for this year's Certification of Taxes, Assessments and Fees and a copy of the Certification and Mutual Indemnification Agreement from the Alameda County Auditor-Controller Agency. This agreement needs to be executed and returned to the Office of Auditor-Controller by August 10, 2012

In 2002, both hospital counsel at the time of the Asset Transfer (Hansen Bridgett) and County Counsel confirmed that the District's Special Assessment does meet the requirements of Proposition 218, which is an updated version of Proposition 13, and that this matter had been thoroughly researched during the due diligence process before Measure A was placed on the April 2002 ballot.

ALAMEDA COUNTY
AUDITOR-CONTROLLER AGENCY
PATRICK O'CONNELL
AUDITOR-CONTROLLER/CLERK-RECORDER

May 29, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
2070 Clinton Avenue
Alameda, CA 94501
ATTN: Jordan Battani, District Board President

CERTIFICATION OF TAXES, ASSESSMENTS & FEES

The collection of the Cities, Special Districts and Schools' special taxes, assessments and fees on the Secured Tax Roll requires a Certification and Mutual Indemnification Agreement with the County.

Please have the appropriate individuals sign the enclosed agreements and return the three originals to my attention, at the Office of Auditor-Controller, 1221 Oak Street, Room 249, Oakland, CA 94612. Our office will request the Board of Supervisors to sign the agreements and mail an executed original agreement to you.

Please return your signed certification statements along with your assessments' data to our office no later than **August 10th.** It is important to note that no assessments can be processed without the certification statements.

If you have any questions, please call me at (510) 272-6548.

Sincerely,

Carol S. Orth, Division Chief
Tax Analysis

Chief Deputy Auditor
Steve Manning
1221 Oak St., Rm 249
Oakland, CA 94612
Tel. (510) 272-6565
Fax (510) 272-6502

Assistant Controller
Connie Land
1221 Oak St., Rm 238
Oakland, CA 94612
Tel. (510) 272-6565
Fax (510) 267-9415

Certification and Mutual Indemnification Agreement

The CITY OF ALAMEDA HEALTH CARE DISTRICT (hereafter referred to as public agency), by and through its Attorney, hereby certifies that to its best current understanding of the law, the taxes, assessments and fees placed on the 2012/13 Secured Property Tax bill by the public agency met the requirements of Proposition 218 that added Articles XIIIC and XIIID to the State Constitution.

Therefore, for those taxes, assessments and fees which are subject to Proposition 218 and which are challenged in any legal proceeding on the basis that the public agency has failed to comply with the requirements of Proposition 218; the public agency agrees to defend, indemnify and hold harmless the County of Alameda, its Board of Supervisors, its Auditor-Controller/Clerk-Recorder, its officers and employees.

The public agency will pay any final judgment imposed upon the County of Alameda as a result of any act or omission on the part of the public agency in failing to comply with the requirements of Proposition 218.

The County of Alameda, by and through its duly authorized agent, hereby agrees to defend, indemnify and hold harmless the public agency, its employees, agents and elected officials from any and all actions, causes of actions, losses, liens, damages, costs and expenses resulting from the sole negligence of the County of Alameda in assessing, distributing or collecting taxes, assessments and fees on behalf of the public agency.

If a tax, assessment or fee is challenged under Proposition 218 and the proceeds are shared by both the public agency and the County of Alameda; then the parties hereby agree that their proportional share of any liability or judgment shall be equal to their proportional share of the proceeds from the tax, assessment or fee.

The above terms are accepted by the public agency and I further certify that I am authorized to sign this agreement and bind the public agency to its terms.

CITY OF ALAMEDA HEALTH CARE DISTRICT

Dated: _____

By: _____
(Signature)

_____
(Print Name)

_____
(Print Title)

COUNTY OF ALAMEDA

Dated: _____

By: _____
(Signature)

_____
(Print Name)

_____
(Print Title)

Approved as to form:

_____
John Thomas Seyman,
Deputy County Counsel

DATE: June 1, 2012

FOR: June 6, 2012 District Board Meeting

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

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: June CEO Report to the Board of Directors

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1. **IGT / State Budget Update**:

The State of California issued what has become known as the "May Revise" of the State budget a couple of weeks ago, in which the projected overall deficit has grown to about $16 billion. We have participated in lobbying efforts with both CHA and the District Hospital Leadership Forum (DHLF) to address what initially appeared to be a draconian impact on reimbursement for hospitals in general and disproportionately devastating for District Hospitals.

In the first proposals issued by DHCS, the Districts (whether under contract with Medi-Cal or not) would have had to change the mechanism for Medi-Cal reimbursement to be based on certified public expenditures (CPE's), similar to the reimbursement mechanism used for designated public hospitals, rather than on a DRG basis as originally planned for District hospitals. This would have resulted in a reduction for all District hospitals of $30 million. As a part of our membership on the DHLF Board we met with DHCS officials and provided information regarding the extensive impact this would have on all Districts, especially those providing critical access.

Based on this feedback, the Department actually revised their first proposals.
The DHLF Board and Staff made a compelling case that the impact on Districts was far more negative than for private or designated public hospitals. DHCS also committed to help the Districts to obtain additional waiver funds from the Federal Government which could help make the Districts whole in terms of the remaining State reductions. Because of Alameda Hospital's rather low volume of Medi-Cal patients, the impact of any State reimbursement changes is far less on us than many other District facilities. While these changes cause us to be cautiously optimistic, we remain cognizant that the budget deficit planning is far from finished and some concessions currently in play could still be reversed.

The Alameda Hospital budget currently includes some reductions in Medi-Cal reimbursement as best we can project them based on current discussions. It also includes no assumption for receipt of additional waiver funds or IGT revenue.

2. **Comprehensive Orthopedic Program Update**:

We are pleased to report that the professional service agreements have been finalized with both Drs. Nick Pirnia and James "Guido" DiStefano, both of whom will start September/October, 2012. We are using the intervening time to formulate and launch an active marketing plan while putting in place the organization of an efficient practice setting. Management is exploring financing sources for locating both the orthopedic practice and our outpatient rehabilitation program in a portion of the remaining vacant space next to the Wound Care Center at Marina Village. Dr. Pirnia has toured that space and feels it will work with minimal additional changes. We are in discussions with our other orthopedists to explore their interest in moving to the same location, hence creating a comprehensive orthopedic center.

3. **November 6, 2012 General Election Key Dates**:

The following are key dates relating to the election of District Board members. As a part of our FY 2013 budget, we included $50,000 that constitutes the District's participation in the November election.

July 16, 2012 - August 10, 2012	Nomination Period for the November 6, 2012 General Election. Candidate filing documents can be obtained Monday through Friday, 8:30 a.m. to 5:00 p.m. through the Alameda County Registrar of Voters.
August 11-15, 2012	Extension Period: If incumbent does not file a Declaration of Candidacy by the end of the nomination period, the seat will be extended for five calendar days.
August 16, 2012	Random Alphabet Drawing: Determines the order of the candidates' names to appear on the ballot.
November 6, 2012	Election Day
December 4, 2012	Certified Results: No later that this date, the registrar shall prepare a certified statement of the results and submit to governing body.

4. **Wound Care Center**:

Construction of the Wound Care Center is nearly complete at Marina Village and a "soft" opening will occur on June 25, 2012 with patients seen the following week. Don Stingen, M.D. has been selected as the Medical Director of the program with the following additional physicians participating in the clinic: Lorraine Bonner, MD, Jenna Brimmer, MD, Stephen Danne, MD, Robert Gingery, MD, Jag Khaira, MD, Christina Kwok-Oleksy, MD and Anthony Poggio, MD.

We have selected the name Kate Creedon Center for Advanced Wound Care – An Affiliate of Alameda Hospital as the name of the program. Our hope is that the name strikes a balance in branding the program to draw from a broader base of patients than Alameda residents while also linking it through its tag line as associated with the hospital. A press release on the new program is attached.

5. **New Board Meeting Dates through 2012**:

The District Board meetings through the end of calendar year 2012 will be held on Wednesdays on the dates indicated below. There will be no meeting in August. The distribution and posting scheduled for the Board agendas and packets will remain the same.

Wednesday, June 6, 2012
Wednesday, July 11, 2012
Wednesday, September 5, 2012
Wednesday, October 3, 2012
Wednesday, November 7, 2012
Wednesday, December 5, 2012

6. **HIPAA Education**:

The attached Health Insurance Portability and Accountability Act of 1996 (HIPAA) Handbook is provided to the Board of Directors as a reference tool. It is a general introduction to the privacy and security regulations established by the Federal Government. These regulations apply to all Alameda Hospital staff, physicians, volunteers, students, and other members of the workforce, including the Board of Directors.

7. **FY 2013 Goals and Objectives**:

Management focused on finalization of the budget and some key final stages of planning for new programs during the last month. We will present recommendations for FY2013 Goals and Objectives for the Hospital at the July Board meeting.

8. **Kate Creedon Award Nominee**:

The Alameda Hospital Foundation is pleased to announce that Jack Stehr, M.D. has been selected as this year's recipient of the Kate Creedon Award. Dr. Stehr completed his undergraduate work at UC Berkeley and obtained his M.D. from University of California, San Francisco. He has been an active member of the Medical Staff since 1978. Dr. Stehr will be honored at the Foundation's Annual Fall Gala on Saturday, September 15, 2012

9. **Upcoming Events:**

Foundation Event
There is still time to get your ticket to the Great Antique Adventure II which will be held at Michaan's Auctions on Thursday, June 7. For information about this event, call Dennis Eloe at 814-4600 or email deloe@alamedahospital.org.

Relay for Life
Relay for Life is an American Cancer Society (www.cancer.org) sponsored event that raises money and awareness for cancer. This 24-hour event is held in cities and small towns worldwide, and is coming to Alameda June 23-24. Teams of participants will camp overnight at Encinal High School; taking turns running or walking laps. The theme of 24 hours, non-stop participation is to recognize that when someone has cancer, it does not stop -- the cancer is present 24 hours a day and doesn't sleep. Since 1999, Alameda Hospital's Relay for Life Team has raised over $10,000 with this annual event. Lace up your shoes and sign up for a 30-minute time slot of your choice to join the Alameda Hospital SCRUBS in the fight against Cancer.

Fourth of July Parade
Celebrate Independence Day with us at the City of Alameda Mayor's Fourth of July Parade. Alameda Hospital Employees, Board of Directors, Foundation, Auxiliary, and Medical Staff are all invited join us on the Alameda Hospital Cable Car. If you'd like to participate, or have any questions, please call Louise Nakada at 814-4362 or email lnakada@alamedahospital.org. The parade starts at 10:00 a.m. and lasts for about two hours. The Cable Car leaves Alameda Hospital promptly at 8:45 a.m. and returns to the Hospital at about 12 noon. Bring your family! We need cable car riders and parade walkers to hand out goodies.

10. **Key Statistics for May, 2012:**

	May Preliminary	May Budget	% Δ compared to Budget	% Δ compared to April	April Actual
Average Daily Census	84.61	85.45	-1.0%	-2.1%	86.40
Acute	30.35	30.55	-0.6%	-8.8%	33.27
Subacute	34.13	33.00	3.4%	8.3%	31.50
South Shore	20.13	21.90	-8.1%	-6.9%	21.63
Patient Days	2,623	2,649	-1.0%	1.2%	2,592
ER Visits	1,434	1,426	0.6%	4.2%	1,376
OP Registrations	1,856	2,117	-12.3%	-1.7%	1,889
Total Surgeries*	Not Available	194	Not Available	Not Available	153
Inpatient Surgeries	Not Available	46	Not Available	Not Available	39
Outpatient Surgeries	Not Available	148	Not Available	Not Available	114
Case Mix Index	1.3701				1.2998

*Surgery Numbers were not available at time of distribution of the Board packet but will be reported at the June 6, 2012 District Board Meeting.

Kate Creedon Center for Advanced Wound Care
An Affiliate of Alameda Hospital

Healing Happens Here.

FOR IMMEDIATE RELEASE:

May 30, 2012

Kate Creedon Center For Advanced Wound Care Announces Medical Director and Physician Panel

Alameda Hospital is pleased to announce that Dr. Donato J. Stinghen has been appointed as Medical Director for the new Kate Creedon Center for Advanced Wound Care, scheduled to open at 815 Atlantic Avenue in Marina Village, Alameda the week of June 25th. Dr. Stinghen, who is Board Certified in General Surgery, brings a wealth of experience in wound care management. For thirty-two years, he has practiced general surgery at Alameda Hospital, most recently as a member of the General Vascular Surgery Medical Group. He has previously served the hospital as President of the Medical Staff, as well as Chairman of the Surgery Committee, and is well known as a consummate professional who is focused on the highest possible quality of patient care.

"Don's surgical and medical expertise, combined with his extraordinary leadership skills and passion for delivering the best possible outcomes make him an ideal fit for this critically important position," said Alameda Hospital's CEO, Deborah Stebbins.

Dr. Stinghen received his Doctor of Medicine from the Medical College of Wisconsin and graduated with honors from the University of California –Davis. He completed his internship and residency programs at Highland General Hospital in Oakland, California. As Medical Director at the Kate Creedon Center for Advanced Wound Care, his primary responsibilities are to lead the panel physicians, participate in marketing activities and provide governance over the utilization of clinical practice guidelines.

In addition to Dr. Stinghen, the Center's physician panel includes:

- Dr. Lorraine Bonner
- Dr. Jenna Brimmer
- Dr. Stephen Danne
- Dr. Robert Gingery
- Dr. Jag Khaira
- Dr. Christina Kwok-Oleksy
- Dr. Anthony Poggio

The Kate Creedon Center for Advanced Wound Care is an outpatient program of Alameda Hospital that focuses on chronic and non-healing wounds. Using advanced treatment modalities including hyperbaric oxygen therapy and a case management model in a multi-disciplinary environment, the Creedon Wound Center helps patients improve the quality of their lives.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

HIPAA HANDBOOK

Health **I**nsurance **P**ortability **and** **A**ccountability **A**ct **of 1996 (HIPAA)**

A Overview for All Staff, Physicians, Volunteers, Students, and Other Members of the Workforce

2070 Clinton Avenue • Alameda, CA 94501 • TEL (510) 522-3700 • www.alamedahospital.org

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER...

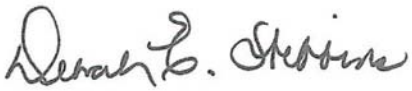
Enclosed is the Alameda Hospital Health Insurance Portability and Accountability Act of 1996 (HIPAA) Handbook, a general introduction to the privacy and security regulations established by the federal government. These regulations apply to all Alameda Hospital staff, physicians, volunteers, students, and other members of the workforce. It became effective April 14, 2003.

HIPAA was passed to protect the confidential medical and billing records of our patients. A particularly important element of HIPAA regulations pertains to the new patients' rights related to access and control of their medical information. We are counting on you to incorporate these HIPAA rules into your daily activities.

Please read this handbook to gain a basic understanding of HIPAA and how it affects what you do at Alameda Hospital. Mandatory Annual Training is available to all staff and volunteers. Training is presented at orientation and customized training is available.

Our patients have a right to privacy. We are committed to complying with HIPAA, not only because it is the law, but also because we value our patients and their privacy.

Sincerely,



Deborah Stebbins
Chief Executive Officer

HANDBOOK OBJECTIVES

This Handbook is a general introduction for all Alameda Hospital staff, physicians, volunteers, students, and other members of the workforce to the privacy and security regulations dictated by HIPAA, the Federal Health Insurance Portability and Accountability Act of 1996. You are expected to follow the policies outlined in the Confidentiality Statement (at the end of this Handbook) and the Hospital HIPAA Manual (located in your Department/Unit). In addition, your department or unit may have policies and procedures that supplement this document.

OVERVIEW: PRIVACY AND CONFIDENTIALITY

What is HIPAA and Who Must Comply?
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information. HIPAA applies to all "covered entities" such as hospitals, physicians and other providers and health plans as well as their employees, volunteers and other members of the workforce. Compliance with the HIPAA privacy rules is required by April 14, 2003. HIPAA privacy rules provide certain rights to patients.

Some of the rights and other protections in HIPAA have existed for years under California laws. HIPAA's new requirements include: requirements that healthcare organizations appoint a privacy officer/committee; establish administrative, technical and physical safeguards for protected information; respond to patient requests to learn who has accessed their information; and provide patients with a "Notice of Privacy Practices" at their first visit on or after April 14, 2003 to explain how Alameda Hospital will handle information.

Access to protected health information (PHI) by Alameda Hospital staff, physicians, students, volunteers and other members of the workforce is based on the general principle of "need to know" and "minimum necessary." Access only the patient information needed to get your job done.

What Are the Potential Consequences of Breaking the Law?
HIPAA also imposes penalties and fines for breaches of privacy. Breach of Alameda Hospital policies can result in discipline up to and including termination of employment or professional relationship with the Hospital.

External investigation of violations can result in serious penalties. For example, civil penalties for misuse are $100 per incident, up to $25,000 per person, per year for each standard violated. A person found guilty of releasing confidential information for personal gain (such as selling information to a newspaper) could be fined $250,000 and be imprisoned for 10 years.

Equally serious, a privacy violation will compromise the fine reputation of Alameda Hospital and could lead to costly lawsuits.

CONFIDENTIAL INFORMATION

What is considered confidential Protected Health Information (PHI)? What patient information must we protect?

PHI is that information which can be matched with a patient, is created in the process of caring for the patient, and is kept, filed, used or shared in an electronic, written or oral manner. Hospital staff must maintain the

confidentiality and security of PHI. The protection covers information relating to a person's health, the care received and payment for services. Examples of PHI include patient name and address, birth date, age, medical record number, phone and fax numbers, e-mail addresses, medical information (patient record, diagnoses, lab and other test results, x-rays, photos and images), prescriptions, billing records, claim data, referral authorizations, and explanation of benefits.

Who is authorized to *see* confidential PHI?

The doctors, nurses and other licensed providers in the health care team may access the entire medical record, based on their "need to know". All other members of our workforce have access only to the information needed to do their jobs. The Alameda Hospital "Notice of Privacy Practices" describes the ways in which we may use PHI without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations or **"TPO"** are permitted:

1. *Treatment* means providing, coordinating or managing a patient's care, including consultations between providers and referrals.
2. *Payment* of health care bills (claim submission, authorizations and payment posting)
3. *Health care Operations* include quality assessment; patient education and training; contracting for services; health care communications between a patient and their physician; hospital directory; legal services; auditing; and other business planning and management activities.

When are Written Authorizations Required?

To use or disclose PHI for almost any reason other than TPO or as required by law, you will need to obtain a written authorization from the patient prior to access or disclosure. The Hospital has an Authorization Form that meets both HIPAA and California requirements (located in the HIPAA Manual, Section 3).

Refer to the "Notice of Privacy Practices" or policy on "Authorization for Use or Disclosure of PHI" in the HIPAA Manual for a list of covered exceptions to the authorization requirement (related to disclosures required by law such as disease reporting, suspected abuse or law enforcement activities).

In general, after patient discharge, all disclosures of PHI will be handled by the Health Information Management Department. Contact the Release of Information Specialist in that Department for assistance. Disclosures may be made by individual departments/units for patient transfers, reporting results of tests, and as required by law during the patient encounter.

What is the Minimum Necessary Standard?

You are expected to apply the "minimum necessary" standard when you access PHI. For example, although physicians, nurses and care providers may need to view the entire record, a billing clerk might only need to see a specific report to determine the billing codes. An admissions staff member may not need to see the medical record at all, only an order form with the admitting diagnosis and identification of the admitting physician. Only access and use the patient information that you need to do your own job.
The same is true for requesting information from other providers. Except for patient care, only the minimum necessary to satisfy the need should be requested.

What PHI Can Students Access?

Access to PHI held by Alameda Hospital is limited to students/trainees in programs authorized by Alameda Hospital on the Alameda Hospital campus and affiliated sites. Students/trainees will be required to complete a privacy orientation and to sign a confidentiality agreement. Students and trainees may never remove any PHI from Alameda Hospital premises under any circumstances.

What if I see someone break the rules?

It is Alameda Hospital policy that each of us has a responsibility to prevent unauthorized or unapproved access to or disclosure of patient information. Report concerns to your supervisor, or the Alameda Hospital Privacy Officer (510-814-4039). Other reporting options include the Security Officer (510-814-4360) or the Compliance Officer (510-814-4081).

MEDICAL RECORD ACCESS AND CONTROL

Medical records are maintained for the benefit of the patient, medical staff, and the hospital and shall be available upon request of:

- The patient's physicians;
- Non-physicians involved with the patient's direct care (i.e. Nursing, Pharmacy);
- Any authorized employee of the Hospital or its Medical Staff (i.e. Risk Management, Case Management/Community Relations);
- Researchers as part of an approved Institutional Review Board (IRB) protocol that involves medical record review;
- Any other person authorized by law to make such a request (i.e. medical examiners, law enforcement, regulatory agencies); or
- Patient and/or patient's authorized representative.

The Hospital will maintain ownership of the Medical Record and it may be removed from the Hospital jurisdiction only by: a) subpoena, b) court order, or c) statute. Medical records are not to be removed from patient care areas except by authorized Staff. HIM Department is responsible for maintaining control of access to medical records and disclosure of PHI after discharge of the individual. An Authorization form may be required.

COMPUTER SYSTEMS & ELECTRONIC TRANSMISSIONS OF INFORMATION

Security Overview

Information Security is about protecting three things: confidentiality, integrity and availability.

- Confidentiality: ensuring that information doesn't fall into the wrong hands
- Integrity: ensuring that information is not damaged, corrupted or destroyed
- Availability: ensuring that information can be made continuously available to the right people, at the right time

What does HIPAA require for security?

HIPAA requires us to secure the electronic and physical access to PHI. All of us must help to safeguard access to electronic/computer systems so that others cannot see or use PHI inappropriately. The HIPAA security rule has four components:

1. Administrative Procedures to protect data and to manage the personnel conduct in relation to the protection of data.
2. Physical Safeguards: provides for the protection of physical computer systems and related buildings and equipment.
3. Technical Security Services: processes in place to protect information and control individual access to PHI.

4. Technical Security Mechanisms for Networks: processes that guard against unauthorized access to data that is transmitted over a communications network.

There are several steps that you must take to help protect the privacy and electronic security of health information:

- DO NOT SHARE OR POST PASSWORDS! Occasionally, to fix a problem, you may need to divulge passwords to Information Systems staff. Change your password immediately after the problem is resolved.
- Commit your password to memory
- You will be required to change your password regularly to the e-mail system. If you believe your password has been compromised, change it immediately.
- Log-off of computer stations when finished.
- Destroy all papers that contain PHI. ALWAYS follow the proper paper disposal procedure. Locked, shredder disposal bins are located throughout Alameda Hospital.
- Review and abide by the Alameda Hospital's Confidentiality Statement.
- File documents away when you have finished with them.
- If you need to keep documents available, keep documents off counters, tables, or other areas accessible by the public.
- If you print a document containing PHI, do not leave it in the printer. Retrieve it timely.
- Keep confidential or sensitive information locked away when not in use. Clear your workstation before leaving it.
- ALWAYS keep computers password protected or locked when not in use (such as a locked filing cabinet).
- ALWAYS follow the visitor security procedure.
- ALWAYS wear security badge/identity badge when at work.
- NEVER leave sensitive or confidential information in a trash bin.
- Be alert to recognize and correct privacy breaches.

E-MAIL and Groupware

Alameda Hospital's internal e-mail is encrypted and can only be viewed by the sender, recipient, system administrators, and those you have granted proxy. Assume normal e-mail systems are not secure unless you have clear information that the system is encrypted or in other ways secure.

- Be careful what you send via e-mail. Do not send confidential information unless you can de-identify it. Warn patients who communicate with you via email that their confidentiality cannot be ensured.
- Use the same care in sending e-mails that you would with a letter. Do not write anything in an e mail that you might regret later. E-mails are never erased.
- Do not send attachments containing protected health information without encryption.
- Confidential statements are added to every external e-mail.
- When choosing passwords, at a minimum, incorporate a combination of letters and numbers into the password.

Faxing PHI

- Internal faxes do not require a confidential fax coversheet.
- Use the Confidential Fax Coversheet found in the HIPAA Manual, Section 1 for all external faxes. Ensure that faxed PHI includes the date and time of fax, sender's name and telephone, authorized recipient's name, telephone and fax number, number of pages transmitted, and information regarding

verification of receipt of the fax.

- Locate fax machines that are used for PHI in lower-traffic areas that are less accessible to those who are not authorized to view PHI.
- Limit the faxing of PHI to urgent or non-routine requests when mail or other delivery is not acceptable or feasible.
- Stand by the fax to transmit or receive information
- Sensitive PHI, including but not limited to, AIDS/HIV, mental health, chemical ***dependency,*** sexually transmitted diseases and other highly personal information should not be faxed unless needed for emergency care or as required by law.
- Faxes should be promptly retrieved from the machine and placed in secure/confidential places. For example, do not leave in in-boxes in full view of passersby.
- Confirm the accuracy of fax numbers and if possible notify the recipient that a fax has been sent. Request verification of receipt.
- For faxes regularly sent to the same recipients, program these fax numbers into the machine, use **t**he speed-dial function, and establish a procedure to regularly test these numbers.
- In the event of a misdirected fax, ensure that the improperly faxed documents are either immediately returned and/or shredded by the recipient. Notify the Privacy Officer.
- Any documents included in a fax that contain PHI and are not original documents are to be shredded.

CONFIDENTIALLY SPEAKING

Respecting patient privacy and confidentiality is as important as providing any other aspect of care. Staff and physicians are sometimes overheard sharing patient information with each other in hallways, elevators, and other public areas. Even when we think we are discussing a patient without clear-cut identifiers, we may be breaching the patient's privacy.

Voice Mail/Answering Machines

- Leave only your name, the name of the hospital and ask the individual to call back. It is acceptable to leave information necessary to confirm an appointment without specifying what the appointment involves.
- Do not leave laboratory and test results, or any information that links a patient's name to a particular medical condition or the type of ancillary service or type of medical specialist.
- When hospital staff is replaying voice messages, either turn the volume down or use a headset to minimize the number of people hearing the message.

Telephone Communications

- Write and rehearse scripts for common or repetitive telephone tasks so staff is aware of what material is cleared for discussion and how conversations should flow. For example, if you cannot verify the identity of the caller, be prepared to say, *"We are sorry, but we cannot release information without proper name and date of birth. Please contact the family for more information."*
- Minimize telephone conversations, or judiciously screen content, especially when patients and visitors are within earshot.
- Use physical barriers when possible to help prevent conversations from being overheard. Examples include cubicle walls or dividers, telephones away from waiting areas, or potted plants.
- Speak as quietly as circumstances permit.
- Honor any requested restrictions the individual has requested on communications

Conversations and Announcements

- Keep voices low when discussing patient information
- Use private areas, not reception areas, to discuss a patient's condition with family and friends
- To the extent possible, use private areas for dictating patient information
- Verbal announcements such as calling a patient to an area for service or treatment or intercom messages should not contain any information other than patient name. As an example, the announcement should request the individual to go to the reception desk for further information

PATIENTS' RIGHTS

Patients' rights under HIPAA are described in the "Notice of Privacy Practices." The Notice will be made available to patients in many settings including Alameda Hospital's website. These rights include:

1. Right to receive the "Notice of Privacy Practices." This document informs patients of their rights and how to exercise them. Alameda Hospital is required to make this notice available to patients. We are required to make a good faith effort to obtain the patient's acknowledgement of receipt.
2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copies. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."
3. Right to Request an Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum to the patient's records.
4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their PHI, not specifically authorized by the patient. There are certain exceptions. The Notice describes how to request an accounting. The accounting may be for up to the previous six years although the accounting period starts April 14, 2003.
5. Right to Request Restrictions. Patients have the right to request restrictions on how we will communicate with the patient or release information. Generally, we will make every effort to try to accommodate reasonable requests for restrictions; however, the request could be denied.
6. Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint, either within or outside of Alameda Hospital.

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purpose's, for government functions, law enforcement and based on a judicial request or subpoena. Disclosures may also be made without authorization for treatment, payment, and health care operations (TPO).

If you are unsure about whether a request for information is authorized or may be disclosed, please check with your supervisor or the Release of Information Specialist in the Health Information Management (HIM) Department (510-814-4037). Since these disclosures may be subject to a request for an accounting, the requests need to be coordinated, tracked and archived by HIM Department.

Facility Patient Directories (Admitted Patients)

Alameda Hospital can use and disclose selected PHI, which includes name, location in the hospital, condition (e.g., good, fair, critical) and religious affiliation in order to create facility patient directories. These directories are for use by the clergy and for responding to those who ask for a patient by name.

No Disclosure

This designation means that no information may be released or divulged concerning an inpatient's diagnosis, condition, or presence in the Hospital. A patient may ask for this designation at registration or any time during their stay. Responses to inquiries for "No Disclosure Patients" whether made in person or by telephone, are to be answered, *"We are sorry, but we have no information concerning this patient. Please contact the family for more information "* If the caller persists, refer them to the Community Relations Director, Alameda Hospital, 2070 Clinton Avenue, Alameda, CA 94501. Telephone 510-814-4362.

Business Associates (BA)

The HIPAA Privacy Rule applies only to "covered entities" (health plans, health care clearinghouses and providers such as Alameda Hospital). However, most providers do not carry out all of their health care activities by themselves. They contract with other entities to assist with needed services. These contractors, whether an individual or a company, are business associates if they perform functions or activities *on behalf of the* Hospital that *involves the use or disclosure of PHI.*

Examples are contracted billing functions, medical transcription services, accounting services, shredding services, and legal services that involve PHI. This is not an all-inclusive list.

All vendors that qualify as a business associate must have *specific language* attached to and agreed upon in the contract. If you are unsure about whether a third party is a business associate, contact Administration (510-814-4001).

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR MARKETING, FUNDRAISING AND TO THE MEDIA

Marketing

In limited circumstances, Alameda Hospital may use PHI for marketing purposes to describe health products or services of nominal value which promote health-related services and/or for health insurance products if certain conditions are met. Communications relating to treatment options and health plan coverage are permitted. Example: If a hospital offered classes for patients on various health topics, sending a calendar of upcoming classes is allowed. Use of PHI for other marketing purposes will require the patient's prior written authorization. If you are unsure about what PHI may be disclosed for marketing purposes, call the Community Relations Director (510-814-4362).

Fundraising

Very limited PHI may be used in fundraising by the Hospital Foundation. In addition, the patient must have the opportunity to "opt out" of future fundraising efforts. Any fundraising activities must have Administrative approval.

Media

The Community Relations Director or designee is responsible for managing all media relations. If any reporters, photographers or other media representatives call you with questions, please refer them to the Community Relations Director (510-814-4362). Photographers and/or reporters may not directly access patients and even if authorization is obtained, they must be supervised by the Community Relations Director or designee.

FREQUENTLY ASKED QUESTIONS (FAQ'S)

1. Other than the patient's medical record, are there other types of PHI that we need to protect?

Alameda Hospital is required to make reasonable efforts to limit the amount of PHI used or disclosed to the minimum necessary to accomplish the intended use or disclosure. Examples of common healthcare activities involving PHI that must be protected (in addition to the medical record) are:

- Filled out prescription forms
- Faxed results from a reference laboratory and medical progress reports
- Copies of a consultant's report from another physician
- Face sheets with registration or other demographic information
- Medical billing records which identify the patient, e.g., UB-04 claims
- Explanation of medical benefit statements (EOMBs) received from a payer
- Components of the medical chart, such as the initial intake form, progress notes, drug history or records kept in the outpatient/clinic chart
- Financial disclosures and waivers signed by the patient
- Eligibility lists received from an HMO
- A letter requesting progress notes from a Medical Director of a Health Plan
- Correspondence from a malpractice carrier regarding a patient
- Referral authorizations received from health plans
- Collection agency reports
- E-mailed files from the transcriptionist
- X-rays and images

2. Who is authorized to see PHI?

Physicians and other healthcare providers who are directly involved in the care of the patient are authorized to see PHI for the purposes of treatment, payment and healthcare operations. These activities are described in the Notice of Privacy Practices. Physicians can disclose PHI to indirect care providers, such as consulting physicians, radiologists, and pathologists, but may not disclose PHI to clinicians who do not have direct or indirect treatment responsibilities. Providers and staff should exercise caution about disclosure of PHI to non-clinical staff members or providers who are not involved in the care of the patient. Access to PHI must be based on their job duties/roles.

Physicians and health care providers must make a reasonable effort to disclose only the minimum necessary amount of PHI in order for others to do their jobs. Providers may disclose information requested by other healthcare providers if the information is vital for treatment.

3. Why is an "incidental disclosure" of PHI not a violation of HIPAA?

Incidental uses or disclosures of PHI are not considered a violation of the HIPAA rules provided that

Alameda Hospital has met the reasonable safeguards and "minimum necessary" requirements. If these requirements are met, then hospitals may keep patient charts at bedside; doctors can talk to patients in semi-private rooms; providers can confer at nurses' stations without fear of violating the rule if overheard by a passerby.

4. **Under HIPAA can a hospital release PHI without authorization to another hospital when the patient is being directly transferred?**

Yes, assuming that the question is referring to the release of PHI without authorization. PHI is important to the coordination of health care among health care providers, and thus allowable under HIPAA's treatment guidelines. There is no problem under HIPAA with transferring a patient from one hospital to another for care, and the PHI can be transferred with the patient or disclosed to the receiving hospital by the transferring hospital.

In addition, in many instances, state laws may require the disclosure of relevant PHI when a patient is transferred from one hospital to another.

5. **For white boards or marker boards, what information can be listed?**

The use of last names and first initials on the board within the department is appropriate. Due to special considerations in the operating room, first and last names are used.

The important considerations are: if the board is visible to passers-by, does it contain PHI? If yes, are there other ways that the protected data (including demographic data) could be "reasonably limited to the minimum necessary to allow the unit to safely manage patient care?

CASE SCENARIOS

Case 1: A nurse you are friendly with asks you what type of surgery is being performed on one of your patients. She is concerned about the patient because it is her neighbor and a co-worker. What is the correct response to this situation under the new HIPAA privacy regulations?

Since the nurse asked for the patient by name, you may refer the nurse to the hospital operator to obtain whatever facility directory information is available, e.g., name, status condition, etc. The operator will check first to determine whether the patient is a "no disclosure" status. If you reveal the patient's diagnosis to this nurse without the prior oral and/or written consent from your patient, it is a breach of privacy. You could lose your job and be assessed fines!

Ask yourself the following questions before giving out <u>any</u> patient information to friends, patient's family members, or co-workers — *even* if the patient is a fellow employee:

1. Is the patient listed in the facility's records?
2. Has the patient consented to the release of directory information?
3. Does the requestor have a “need to know", e.g., treatment, payment, healthcare operations? If you are unsure, refer the requestor to the patient's treating physician or to the nurse manager in charge.
4. Do you have permission to disclose information to this visitor? If not, have you checked with the patient before giving out any information?
5. What is the minimum information necessary that you may provide?
6. Have you verified the visitor's identity before sending that person to the patient's room or disclosing information?

Case 2: You run into a former patient at the supermarket. She tells you that she had some cash flow problems and her bill was sent to collections. She mentions that her neighbor recently asked her if she was fully recovered from her surgery. Your patient is upset because she never mentioned her surgery to anyone. It turns out her neighbor's son works for the Alameda Hospital billing department. What do you do?

Report the incident to the Alameda Hospital Privacy Officer. The Hospital employee has violated HIPAA and the matter must be investigated. Disciplinary action up to and including termination could result from this unlawful disclosure.

Case 3: A patient's relative sent our department an e-mail to request insurance authorization. The e-mail contains protected health information. Can we respond to the e-mail?

No. There are a couple of issues to address in handling this request:

1. In order to comply with this consent, we need the patient's or the patient's designated representative's written authorization to share/disclose protected health information with a third-party.
2. We cannot transmit protected health information data over e-mail without the patient's written consent.

The department should call the relative to explain that we are not permitted to discuss the information without a written authorization from the patient. Advise the individual that the patient (or authorized representative) may call for the authorization and provide them with the telephone number to do so.

Case 4: The newspaper reported that a famous person has come to the hospital for treatment. You are curious if this is true. Should you ask around or look for records about this person?

No, you are not allowed to satisfy your curiosity.

Breach of patient confidentiality can result in disciplinary action up to and including termination of employment or professional relationship with Alameda Hospital. The entire workforce shares a responsibility in protecting confidential information. The workforce includes faculty, staff, students, trainees and volunteers, regardless of whether they are caring for patients. This rule applies to everyone.

Case 5: You are near the emergency department and you see that your neighbor has arrived after an accident. Your neighbor's wife works in another part of the hospital. Should you tell her that her husband is in the emergency department?

No. Instead of telling the wife yourself, tell the emergency department nursing staff that you know the patient and his wife and how to contact her. Even in these situations, we must respect the right of the individual to decide which of his family and friends, if any, should be told he is in the emergency room.

If your neighbor is unconscious or otherwise lacks decision-making capacity, the doctors and nurses caring for him will use their professional judgment about whether to notify his wife and whether you, as a neighbor and friend, should be involved in any way.

Case 6: A friend is worried because his girlfriend is in the hospital. He asks you to find out anything you can about her stay. Should you try to find the information for her friend?

No. You should not even tell or confirm that his girlfriend is in the hospital. Direct your friend to the hospital

care staff who are responsible for handling such requests

Case 7: You walk by a trash container and see a pile of medical records on top. What should you do?

First, assume that the records laid on top are not being thrown away. Take them to your supervisor or a supervisor in the area, or immediately notify the medical records unit.

Case 8: You see a room that contains PHI is unlocked and there seems to be no one inside. How should you respond?

Verify that no one is in the room. If there is no one, lock the door and notify the Privacy Officer.

Case 9: You have been asked to fax a patient's lab test result to a physician's office. It is after hours and none of the physician's office staff are available to receive the fax. What should you do?

Send faxes only to attended machines unless you have been assured that the fax is in a locked room or has a locked cover. If there is no way to be certain that the fax machine is secure, arrange to the results faxed by a person on another shift, and leave a message for the physician's office explaining when the results will be faxed. Be sure not to leave the patient's name or other identifying information on the message.

Case 10: Jane has worked nights and weekends, performing both her main job duties and covering for breaks for a secretary. Recently she changed to day shifts and no longer needs access to patient information required to cover for the secretary. What must Jane do?

Jane no longer has the need to know patient information required for the secretary position. Under HIPAA requirements, access to patient information is based on the minimum necessary required to perform the job function. She and her supervisor should limit her access to this information, and may require a request to Information Systems for change in access rights.

Case 11: Sally just found out through the grapevine that a fellow nurse is pregnant. She and her coworkers want to give her a baby shower, but they don't know when the baby is due or if it is a girl or a boy. Sally has access to this information, and her coworkers ask her to find out. Should Sally share this information?

No. Regardless of the good intentions, this is clearly unauthorized use of medical information. Use of this information is not for treatment, payment or operations.

Case 12: Jim complains to Frank about not being able to always remember his computer passwords. Frank suggests Jim do like his supervisor does and put his password on a yelloiv sticky and attach it to the computer. Frank also says he always remembers his passwords because he uses the first names of his children. Frank is proud of his children and all his coworkers know their names. What should Jim do?

Password security is everyone's responsibility. Not only should Jim not follow Frank's suggestions but also he should ask Frank and his supervisor to change their passwords immediately, and report the incident to the Security Officer in Information Systems (510-814-4360).

Case 13: You are called to fix something in a patient's room. You see that a nurse is discussing the patient's medicine. What do you do?

If you must do the job right away to properly care for the patient, ask whether you can interrupt. If the job can wait, explain that you will return in 15-20 minutes.

Case 14: You pass by a nurses' station where patients' names are listed on a white board. You spot the name of a close friend. Should you stop by her room?

No. If you learned of your friends hospital stay only by looking at the white board, you should not go into the room unless your job takes you there. If you find out from the patient or her family member about the patient's hospital stay, feel free to visit her and be sure to follow hospital visitor policies.

Case 15: You are approached by an individual who does not have an Alameda Hospital nametag who tells you that he is here to work on computers and wants you to open a door for him. How do you respond?

Ask the person who his contact is at the facility. Usually this will be Information Systems staff person. That individual can take the repairperson to the appropriate place. If he does not know the facility contact, contact the PBX operator, your supervisor, or security to assist the repairperson in finding the contact.