AGENDA

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, October 19, 2016

11:30 A.M.

BOARD TO RECONVENE

Board Members: Berjis, Bigler, McGauley, McLaughlin, Nilon, Pelz, Sistrunk
Roll Call:

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN COUNTY HOSPITAL AUTHORITY STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO MEMBER OF THE BOARD OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE BOARD CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

RECOGNITION

3) Presentation by Hospital Council of Northern and Central California of 2016 Innovation Challenge Award to Kern Medical in recognition of developing innovative approaches to improving the delivery of healthcare through the Patient Centered Medical Home for Medically Fragile Patients (REACH Clinic) –
MAKE PRESENTATION

ITEMS FOR CONSIDERATION

CA
4) Minutes for Kern County Hospital Authority Board of Governors regular meeting on September 21, 2016 –
APPROVE

CA
5) Proposed Resolution establishing meeting dates of the Kern County Hospital Authority Board of Governors for calendar year 2017 –
APPROVE; ADOPT RESOLUTION

CA
6) Proposed Amendment No. 1 to Agreement 2016-066 with Regional Anesthesia Associates, Inc., an independent contractor, for professional medical services in the Department of Anesthesiology, revising the description of services, and increasing the annual maximum payable by $383,292 –
APPROVE; AUTHORIZE CHAIRMAN TO SIGN

CA
7) Proposed Agreement for the lease of Suite 202 in a two story office building at 820 34th Street, Bakersfield, California 93301 for a term of 10 years to commence upon completion of tenant improvements, in an amount not to exceed $1,591,295 –
MAKE FINDING PROJECT IS EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15301 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVE; AUTHORIZE CHAIRMAN TO SIGN

CA
8) Proposed Agreement with Arman G. Froush, D.O., a contract employee, for professional medical services in the Department of Radiology from January 21, 2017 through January 20, 2020, in an amount not to exceed $1,880,000 –
APPROVE; AUTHORIZE CHAIRMAN TO SIGN

CA
9) Proposed Agreement with Tung Thanh Trang, M.D., a contract employee, for professional medical and administrative services in the Department of Surgery from November 13, 2016 through November 12, 2019, in an amount not to exceed $1,622,000 –
APPROVE; AUTHORIZE CHAIRMAN TO SIGN

CA
10) Proposed retroactive amended and restated Kern County Hospital Authority Defined Contribution Plan for Physician Employees, effective July 1, 2016 –
APPROVE; ADOPT RESOLUTION; AUTHORIZE CHAIRMAN TO SIGN PLAN DOCUMENT

11) Proposed Agreement with Anderson Group International, an independent contractor, for construction services related to the Pharmacy clean room remodel project, effective October 19, 2016, in an amount not to exceed $588,019 –
MAKE FINDING PROJECT IS EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15301 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVE; AUTHORIZE CHAIRMAN TO SIGN

12) Proposed Agreement with Black Hall Construction, Inc., an independent contractor, for construction services related to IT closets to support the nurse call system, effective October 19, 2016, in an amount not to exceed $252,313 –
MAKE FINDING PROJECT IS EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15301 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVE; AUTHORIZE CHAIRMAN TO SIGN

13) Presentation on California Medi-Cal 2020 Demonstration and proposed Whole Person Care Pilot Application and Agreement with the California Department of Health Care Services for participation of Kern Medical Center as Lead Entity in Kern County –
HEAR PRESENTATION; APPROVE; ADOPT RESOLUTION; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN APPLICATION AND AGREEMENT SUBJECT TO APPROVAL AS TO FORM BY COUNSEL

14) Kern County Hospital Authority Chief Executive Officer report –
RECEIVE AND FILE

15) Kern County Hospital Authority Chief Financial Officer report –
RECEIVE AND FILE

CA
16) Claims and Lawsuits Filed as of September 30, 2016 –
RECEIVE AND FILE

CA
17) Proposed corrections to minutes for Kern County Hospital Authority Board of Governors regular meetings –
APPROVE

ADJOURN TO CLOSED SESSION

CLOSED SESSION

18) Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) –

19) Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) –

20) CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Deputy County Counsel Karen S. Barnes and designated staff - Unrepresented Employee: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957.6) –

21) PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Chief Executive Officer (Government Code Section 54957) –

22) CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd and designated staff - Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) –

RECONVENE FROM CLOSED SESSION

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

ADJOURN TO WEDNESDAY, NOVEMBER 16, 2016, AT 11:30 A.M.

SUPPORTING DOCUMENTATION FOR AGENDA ITEMS

All agenda item supporting documentation is available for public review at Kern Medical Center in the Administration Department, 1700 Mount Vernon Avenue, Bakersfield, 93306 during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The Kern Medical Center Conference Room is accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Kern County Hospital Authority Board of Governors may request assistance at Kern Medical Center in the Administration Department, 1700 Mount Vernon Avenue, Bakersfield, California, or by calling (661) 326-2102. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

16) CLAIMS AND LAWSUITS FILED AS OF SEPTEMBER 30, 2016 – RECEIVE AND FILE

A) Claim in the matter of Tammy Arroyo v. County of Kern

17) PROPOSED CORRECTIONS TO MINUTES FOR KERN COUNTY HSOPITAL AUTHORITY BOARD OF GOVERNORS REGULAR MEETINGS – APPROVE

A) Minutes for meeting on March 30, 2016
B) Minutes for meeting on April 20, 2016
C) Minutes for meeting on May 4, 2016
D) Minutes for meeting on May 18, 2016
E) Minutes for meeting on June 22, 2016
F) Minutes for meeting on July 20, 2016
G) Minutes for meeting on August 17, 2016

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, September 21, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McLaughlin, Pelz, Sistrunk

Directors absent: McGauley, Nilon

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

Chairman Bigler read a recent article from The Bakersfield Californian which recognized Chief Executive Officer Russell Judd and his team for their work to turn around Kern Medical's financial performance

ITEMS FOR CONSIDERATION

3) Presentation of check for $578,000 from Kaiser Permanente to Kern Medical Center Foundation on behalf of Kern Medical for the "Up Sooner, Safer" patient mobility program –
MADE PRESENTATION

CA
4) Minutes for Kern County Hospital Authority Board of Governors regular meeting on August 17, 2016 –
APPROVED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
5) Proposed updated Conflict of Interest Code and Conflict of Interest policy for Kern County Hospital Authority –
APPROVED; REFERRED CONFLICT OF INTEREST CODE TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
6) Proposed Resolution approving the "pick-up" treatment of physician contributions to the Kern County Hospital Authority Pension Plan for Physician Employees as authorized under Internal Revenue Code Section 414(h)(2) –
APPROVED; ADOPTED RESOLUTION 2016-016
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
7) Proposed Resolution revising the Kern County Hospital Authority Pension Plan for Physician Employees' Pension Committee membership –
APPROVED; ADOPTED RESOLUTION 2016-017
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
8) Proposed retroactive Resolution revising the extension of excess medical professional liability coverage for Kern Medical employed and independent contractor physicians, effective July 1, 2016 –
APPROVED; ADOPTED RESOLUTION 2016-018
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
9) Proposed Agreement with Bhani K. Chawla-Kondal, M.D., a contract employee, for professional medical services in the Department of Surgery from October 3, 2016 through October 2, 2018, in an amount not to exceed $1,130,000, plus applicable benefits –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-067
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
10) Proposed Agreement for a triple net lease of a single story office building located at 2011 19th Street, Bakersfield, California 93301 for a term of two years, in an amount not to exceed $61,715, plus utilities, taxes, and operating expenses –
MADE FINDING PROJECT EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15320 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-068
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
11) Proposed Agreement with Aslan Ghandforoush, D.O., a contract employee, for professional medical services in the Department of Medicine, Division of Cardiology from October 1, 2016 through September 30, 2019, in an amount not to exceed $3,000,000, plus applicable benefits –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-069
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

12) Report from County of Kern Administrative Office, Human Resources Division on county health benefits programs –
HEARD PRESENTATION; RECEIVED AND FILED
Pelz-Sistrunk: 5 Ayes; 2 Absent - McGauley, Nilon

13) Report on Hospital Compare patient satisfaction for the period October 1, 2014 through September 30, 2015 –
RECEIVED AND FILED
Berjis-McLaughlin: 5 Ayes; 2 Absent - McGauley, Nilon

14) Kern County Hospital Authority Chief Executive Officer report -
RECEIVED AND FILED
Pelz-Sistrunk: 5 Ayes; 2 Absent - McGauley, Nilon

15) Kern County Hospital Authority Chief Financial Officer report -
RECEIVED AND FILED
McLaughlin-Berjis: 5 Ayes; 2 Absent - McGauley, Nilon

CA
16) Miscellaneous Documents –
RECEIVED AND FILED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
17) Claims and Lawsuits Filed as of August 31, 2016 –
RECEIVED AND FILED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

ADJOURNED TO CLOSED SESSION
Pelz-Berjis

CLOSED SESSION

18) Request for Closed Session regarding peer review of health practitioners
(Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

19) Request for Closed Session regarding peer review of health facilities
(Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

20) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION
(Government Code Section 54956.9(d)(1)) Name of case: Jasmin Delila Hernandez, et al. v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-277124 DRL – SEE RESULTS BELOW

21) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION
(Government Code Section 54956.9(d)(4).) Number of cases: One (1) Based on existing facts and circumstances, the Board of Governors has decided to initiate or is deciding whether to initiate litigation – SEE RESULTS BELOW

22) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION
(Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – SEE RESULTS BELOW

23) CONFERENCE WITH LABOR NEGOTIATORS – Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff – Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – SEE RESULTS BELOW

24) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – SEE RESULTS BELOW

25) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 DRL – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Sistrunk-McLaughlin

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 18 concerning a Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (2 ABSENT - MCGAULEY, NILON), THE BOARD APPROVED ALL PRACTITIONERS RECOMMENDED FOR INITIAL APPOINTMENT, REAPPOINTMENT, RELEASE FROM PROCTORING, ADVANCE IN STAFF STATUS, AND VOLUNTARY RESIGNATION OF PRIVILEGES

Item No. 19 concerning a Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 20 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Jasmin Delila Hernandez, et al. v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-277124 DRL – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 21 concerning CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(4).) Number of cases: One (1) Based on existing facts and circumstances, the Board of Governors has decided to initiate or is deciding whether to initiate litigation – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 22 concerning CONFERENCE WITH LEGAL COUNEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 23 concerning CONFERENCE WITH LABOR NEGOTIATORS – Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff – Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 24 concerning CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 25 concerning CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 DRL – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, OCTOBER 19, 2016 AT 11:30 A.M.
Pelz

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell E. Bigler
Chairman, Board of Governors
Kern County Hospital Authority

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Establish Regular Meeting Dates of the Kern County Hospital Authority Board of Governors for Calendar Year 2017

Recommended Action: Approve; Adopt Resolution

Summary:

The conduct of your Board is subject to the provision of the Brown Act. The Brown Act requires that your Board shall provide, by ordinance, resolution, bylaws, or by whatever other rule is required for the conduct of business by that body, the time and place for holding regular meetings.

Therefore it is recommended that your Board establish its schedule of regular meetings for calendar year 2017 in compliance with the Brown Act by adopting the attached resolution.

BEFORE THE BOARD OF GOVERNORS
OF THE KERN COUNTY HOSPITAL AUTHORITY

In the matter of: Resolution No. _____

ESTABLISHING THE REGULAR MEETING DATES OF THE KERN COUNTY HOSPITAL AUTHORITY BOARD OF GOVERNORS FOR CALENDAR YEAR 2017

I, RAQUEL D. FORE, Authority Board Coordinator for the Kern County Hospital Authority, hereby certify that the following Resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the Board of Governors of the Kern County Hospital Authority at an official meeting thereof on the 19th day of October, 2016, by the following vote, and that a copy of the Resolution has been delivered to the Chairman of the Board of Governors.

AYES:

NOES:

ABSENT:

RAQUEL D. FORE
Authority Board Coordinator
Kern County Hospital Authority

_____
Raquel D. Fore

RESOLUTION

Section 1. WHEREAS:

(a) The Brown Act (Gov. Code, § 54954, subd. (a)) requires that the legislative body of a local agency shall provide, by ordinance, resolution, bylaws, or by whatever other rule is required for the conduct of business by that body, the time and place for holding regular meetings; and

(b) Section 2.170.060 of the Ordinance Code of the County of Kern ("Ordinance") provides for a governing body, which shall be known as the Kern County Hospital Authority Board of Governors ("Board of Governors"); and

(c) Section 2.170.030 of the Ordinance provides that the Brown Act shall apply to the Kern County Hospital Authority; and

(d) The Board of Governors desires to establish its schedule of regular meetings for calendar year 2017 in compliance with the Brown Act.

Section 2. NOW, THEREFORE, IT IS HEREBY RESOLVED by the Board of Governors of the Kern County Hospital Authority, as follows:

1. This Board finds the facts recited herein are true, and further finds that this Board has jurisdiction to consider, approve, and adopt the subject of this Resolution.

2. Except as provided in paragraph 4 of this Resolution, the calendar year 2017 regular meetings of the Board of Governors shall be held as follows:

Wednesday, January 18, 2017	Regular Meeting
Wednesday, February 15, 2017	Regular Meeting
Wednesday, March 15, 2017	Regular Meeting
Wednesday, April 19, 2017	Regular Meeting
Wednesday, May 17, 2017	Regular Meeting
Wednesday, June 21, 2017	Regular Meeting
Wednesday, July 19, 2017	Regular Meeting
Wednesday, August 16, 2017	Regular Meeting
Wednesday, September 20, 2017	Regular Meeting
Wednesday, October 18, 2017	Regular Meeting
Wednesday, November 15, 2017	Regular Meeting
Wednesday, December 13, 2017	Regular Meeting

3. All meetings shall be held at Kern Medical Center, which is located at 1700 Mount Vernon Avenue, Bakersfield, California 93306. All meetings shall commence at the hour of 11:30 a.m., unless a different time is posted by the Authority Board Coordinator. Meetings so commenced may be continued from time to time until the disposition of all business before the Board.

4. Regular meetings shall be canceled or rescheduled whenever the Board of Governors unanimously finds good cause otherwise exists for cancellation, rescheduling, or scheduling of a regular meeting.

5. The Authority Board Coordinator shall provide copies of this Resolution to the following:

County Administrative Office
Office of County Counsel
Kern Medical Center
Clerk of the Board of Supervisors

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Amendment with Regional Anesthesia Associates, Inc.

Recommended Action: Approve; Authorize Chairman to sign

Summary:

Kern Medical entered into an Agreement with Regional Anesthesia Associates, Inc. on August 17, 2016 to provide Anesthesia services starting November 9, 2016. The Agreement is being amended to add another Anesthesiologist in the operating room at Kern Medical, Monday through Friday, to ensure adequate coverage. The additional annual subsidy amount for the additional Anesthesiologist is $383,292, in an amount not to exceed $5,661,792 annually.

AMENDMENT NO. 1
TO
AGREEMENT FOR PROFESSIONAL SERVICES
INDEPENDENT CONTRACTOR
(Kern County Hospital Authority – Regional Anesthesia Associates, Inc.)

This Amendment No. 1 to the Agreement for Professional Services is made and entered into this _____ day of _____, 2016, between the Kern County Hospital Authority, a county hospital authority ("Authority"), which owns and operates Kern Medical Center ("KMC"), and Regional Anesthesia Associates, Inc., a California professional medical corporation ("Contractor"), with its principal place of business located at 7370 N. Palm Avenue, Suite 102, Fresno, California 93711. Authority and Contractor are sometimes referred to herein, individually, as a "Party" and collectively, as the "Parties."

RECITALS

(a) Authority and Contractor have heretofore entered into an Agreement for Professional Services (Agt. #2016-066, dated August 17, 2016) ("Agreement"), for the period November 9, 2016 through November 8, 2019, for professional medical services in the Department of Anesthesiology at KMC; and

(b) It is the intent of the Parties to have the terms of the Agreement provide for the payment of all reasonably projected costs and expenses related to the services provided by Contractor; and

(c) The Parties agree to amend certain terms and conditions of the Agreement as hereinafter set forth; and

(d) The Agreement is amended effective November 9, 2016;

NOW, THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and incorporating by this reference the foregoing recitals, the Parties hereto agree to amend the Agreement as follows:

1. Section 4, Payment for Services, paragraph 4.6, Maximum Payable, shall be deleted in its entirety and replaced with the following:

> "4.6 Maximum Payable. The maximum payable under this Agreement will not exceed $16,985,376 over the three-year term of this Agreement."

2. Exhibit "A," Description of Services, shall be deleted in its entirety and replaced with Amendment No. 1 to Exhibit "A," Description of Services, attached hereto and incorporated herein by this reference.

3. Exhibit "B," Fee Schedule, shall be deleted in its entirety and replaced with Amendment No. 1 to Exhibit "B," Fee Schedule, attached hereto and incorporated herein by this reference.

4. All capitalized terms used in this Amendment and not otherwise defined, shall have the meaning ascribed thereto in the Agreement.

5. This Amendment shall be governed by and construed in accordance with the laws of the state of California.

6. This Amendment may be executed in counterparts, each of which shall be deemed an original, but all of which take together shall constitute one and the same instrument.

7. Except as provided herein, all other terms, conditions and covenants of the Agreement shall remain in full force and effect.

[Signatures follow on next page]

IN WITNESS TO THE FOREGOING, the parties have executed this Amendment No. 1 as of the day and year first written above.

REGIONAL ANESTHESIA ASSOCIATES, INC.

By_____
Oji A. Oji, M.D.
Its President

KERN COUNTY HOSPITAL AUTHORITY

By_____
Chairman
Board of Governors

APPROVED AS TO CONTENT:
KERN MEDICAL CENTER

By_____
Russell V. Judd
Chief Executive Officer

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL

By_____
Chief Deputy

Amend1.Regional Anesthesia Associates.101116

AMENDMENT NO. 1
TO
EXHIBIT "A"
Description of Services
Regional Anesthesia Associates, Inc.

1. Contractor shall adhere to the following operating room ("OR") coverage schedule:

Coverage	# of OR suites	Hours per day	OR hours	Total annual coverage hours
Monday - Friday (CRNA)	5	8	7 AM - 3 PM	10400
Monday - Friday (MD)	2	8	7 AM - 3 PM	4160
Monday - Friday (CRNA)	4	4	3 PM - 7 PM	4160
Monday - Friday (CRNA)	1	12	7 PM - 7 AM	3120
Saturday - Sunday (CRNA)	1 or 2	12	7 AM - 7 PM	2496
Total OR Hours				**24336**
Dedicated OB (CRNA)				
Monday - Sunday	1	24		8760
Dedicated OR Trauma (MD)				
Monday - Sunday	1	24		8760
Third Call Coverage (CRNA)				
Monday - Friday	1	12	7 PM - 7 AM	3120
Saturday - Sunday	1	24	7 AM - 7 PM	2496

2. Contractor shall use a combination of physicians and CRNA to staff the Department in accordance with coverage schedule set forth herein. Contractor shall meet or exceed a coverage ratio of one (1) full-time physician to every four (4) CRNA.

3. Contractor shall provide epidural anesthesia 24-hours per day through the use of dedicated provider around the clock. The dedicated provider will be responsible for placement and management of labor epidurals and for providing anesthesia care for elective and emergent caesarian sections.

4. Contractor shall provide in-house call coverage for the emergency department, critical care and trauma.

5. Contractor will take an active role in the management of pediatric and adult intensive care and direct observation patients. Contractor shall provide Group Physicians who are competent pediatric providers. Such Group Physicians shall be paneled with California Children's Services.

6. Contractor shall use its best efforts to minimize the after-hours caseload to avoid holding patients through the weekend while waiting for elective or nonemergency cases to be performed.

7. Contractor shall provide an alternative plan to the current staffing model that supports a growing case volume from the current 612 cases per month to greater than 650 cases per month, if requested by KMC.

8. Contractor shall minimally comply with the performance standards, guidelines, and practice parameters, as established by the American Society of Anesthesiologists.

9. Contractor shall assist KMC with marketing efforts to educate the public on the availability of programs developed by KMC and Contractor.

10. Contractor shall undertake strategic planning with KMC to identify a unique service line every 18 to 24 months, and lead the effort in, with and for KMC to achieve this designation for a given service line.

11. Contractor shall develop and manage a multidisciplinary acute and chronic pain management program, including the development of pain management protocols for inpatients and consultations for patients with acute and chronic pain issues. The development and management of this program as well as its goals, metrics, and operational measures shall be set forth in writing in a project plan to be mutually agreed upon by KMC and Contractor. The multidisciplinary acute and chronic pain management program project plan shall be completed within three (3) months of the Effective Date and operationalized such program within nine (9) months of the Effective Date.

12. Contractor shall develop a perioperative medical management program, to reduce case cancellations by 3% to 5% each year over the term of the Agreement and to lower the current 15% rate to 5% during the term of the Agreement. The perioperative medical management program project plan shall be completed and operationalized during calendar year 2017.

[Intentionally left blank]

AMENDMENT NO. 1
TO
EXHIBIT "B"
Fee Schedule
Annual Compensation
Regional Anesthesia Associates, Inc.

As consideration for the services provided by Contractor hereunder, Authority will pay Contractor in accordance with the fee schedule set forth below, as follows:

A. Year 1

Maximum payable per year:	$5,661,792
Monthly payment:	$471,816

B. Year 2

Maximum payable per year:	$5,661,792
Monthly payment:	$471,816

C. Year 3

Maximum payable per year:	$5,661,792
Monthly payment:	$471,816

Payment will be made in accordance with paragraph 4.5 of the Agreement. All services are payable in arrears.

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KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Agreement for a Modified Gross Lease for Medical Office Space

Recommended Action: Make Finding Project Exempt from further CEQA Review per Sections 15301 and 15061(b)(3) of State CEQA Guidelines; Approve; Authorize Chairman to sign

Summary:

Kern Medical requests approval to enter into a modified gross lease agreement for an approximate 6,536 rentable square foot medical office space located at 820 34th Street, Bakersfield, CA 93301, Suite 202 of a two-story building.

The proposed lease space will be used for a behavioral health patient centered medical home, which will be called the "GROW Clinic." The GROW Clinic is similar to the medical center's REACH Clinic, which has medically fragile patients assigned to it by Kern Health Systems who have historically sought episodic care in the emergency department or have had frequent hospital admissions due to chronic conditions. Patient centered medical homes care for patients in a team-based approach involving an array of care providers including a physician, pharmacist, social worker, nutritionist, and nurse to better manage patients and their disease process. The GROW Clinic will also have a psychologist, and at times a psychiatrist as part of the care team to treat patients that have a behavioral health component that complicates caring for their medical condition. Kern Medical partners closely with Kern Health System, which funds these medical homes.

The term of the lease is for 10 years commencing on the completion of tenant improvements. The lessor has agreed to a tenant improvement allowance of $327,961 based on agreed to specifications. The lessor will perform all the tenant improvements according to the specifications. The Kern County Hospital Authority has a one-time right to terminate the Agreement effective the end of the 5th lease year in accordance with the lease terms. The first year's total rental consideration shall be $11,567.45 per month and shall increase each year by three percent (3.0%).

AGREEMENT FOR THE LEASE OF SUITE 202 IN A TWO STORY OFFICE BUILDING AT 820 34th STREET, BAKERSFIELD, CA 93301

(Kern County Hospital Authority – James C. Eckmann Family Trust)

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AGREEMENT FOR THE LEASE
OF SUITE 202 IN A TWO STORY OFFICE BUILDING AT
820 34th STREET, BAKERSFIELD, CA 93301

(Kern County Hospital Authority – James C. Eckmann Family Trust)

THIS AGREEMENT ("Agreement") is executed in Bakersfield, California, on _____, 2016 ("**Execution Date**"), by and between the **KERN COUNTY HOSPITAL AUTHORITY**, a local unit of government ("**KCHA**"), which owns and operates Kern Medical Center (**"KMC"**), and **JAMES C. ECKMANN FAMILY TRUST** ("**Lessor**"). KCHA and Lessor are referred to individually as a "**Party**" and collectively as the "**Parties**."

RECITALS:

A. Lessor owns real property located at 820 34th Street, Bakersfield, County of Kern, State of California; and

B. Pursuant to Section 101855(a)(5) of the Health and Safety Code, KCHA may lease property of any kind necessary or convenient to perform its functions; and

C. KCHA desires to use Suite 202 of the two story office building consisting of approximately 5,683 usable / 6,536.28 rentable square feet for the provision of medical services; and

D. It is the desire of Lessor to lease Suite 202 of the two story office building located at 820 34th Street, Bakersfield, California to KCHA under the terms outlined in the following agreement.

AGREEMENT:

1. Premises: For and in consideration of the terms, covenants, and conditions contained in this Agreement, Lessor leases to KCHA, exclusive use of real property situated in the County of Kern, State of California, at 820 34th Street and non-exclusive use of all of the attached parking lot based on the current City of Bakersfield parking requirements of one (1) space for every 200 rentable square feet. ("**Premises**").

2. Term: The term of this Agreement shall commence upon the completion of Tenant Improvements ("**Commencement Date**") and terminate ten (10) years thereafter, unless sooner terminated as provided herein.

3. Option to Extend Term: Provided KCHA is not in default of any of the terms, covenants, or conditions of this Agreement, KCHA shall have one option to extend the term of this Agreement, for a five (5) year period. KCHA may exercise the option by giving Lessor, written notice of KCHA's desire to extend, not less than 360 calendar days prior to expiration of the then current term of this Agreement.

4. Right to Terminate: KCHA shall have the one-time right to terminate the Agreement at the end of the 5th lease year, provided i) KMC's budget warrants a reduction in service areas due to a non-profitable operation for the eighteen (18) months prior to the election to terminate and KCHA

provides Lessor reasonable evidence thereof in writing; and ii) KCHA provides Lessor a twelve (12) month prior written notice (i.e., such notice must be given by the end of the 4th year of the Term). Should KCHA exercise its termination right, KCHA shall pay to Lessor: i) a payment equal to the unamortized balance of the Tenant Improvement Allowance, which is the amount of $163,980.50; ii) payment equal to the unamortized balance of the Additional Tenant Improvement Allowance, which is the total actual amount of Additional Tenant Improvement Allowance divided by 10 years, then multiplied by 5 years, less the amount of principal paid by KCHA in repayment to Lessor of the Additional Tenant Improvement Expenses financed by Lessor; and (iii) a payment equal to Rent for the 12 months after the termination date (collectively, "**Termination Payment**"). One-half (50%) of the Termination Payment shall be paid to Lessor with the delivery of the termination notice, and the remaining half shall be paid to Lessor sixty (60) days prior to the termination date. Terms in this **Section 4** are further defined in **Section 9**.

5. **Hold Over:** If KCHA holds over after the initial term or the extension term, with the express or implied consent of Lessor, such holding over shall be a tenancy only from month to month and shall be governed by the terms, covenants, and conditions contained in this Agreement, except that KCHA shall pay Total Monthly Rent at a rate equal to either a) 105% of the rate in effect for the last month of the Term if Lessor has consented in writing to such hold over, or b) 125% of the rate in effect for the last month of the Term if Lessor has not consented in writing to such hold over. If the Parties are engaged in good faith written negotiations to extend the Term at the time of such holdover, then such negotiations shall constitute implied consent to hold over during the period in which negotiations continue.

6. **Rental Consideration:** As consideration for lease of the Premises during the initial term, KCHA shall pay to Lessor in lawful money of the United States without deduction or offset, to the James C. Eckmann, 1731 16th Street, Suite D, Bakersfield, CA 93301, or to such persons and at such places as may be designated from time to time by Lessor in writing to KCHA, the following sums:

a. **Term –** Beginning on the Commencement Date the total rental consideration shall be $11,567.45 per month ("**Total Monthly Rent**"). The Total Monthly Rent shall increase annually as provided below. Each month's rental payment shall only be in consideration for the right to possess, occupy and use the Premises for the subsequent month. As provided below, KCHA is also responsible for other payments to Lessor, separate and apart from rent, such the incremental increase to Lessor of the building operating expenses including property taxes. The Total Monthly Rent for the first month of the Term shall be paid within thirty (30) days of the date this Agreement is signed by both parties.

b. **No Aggregate Indebtedness –** In accordance with Article XVI, section 18 of the California Constitution, this Agreement creates no immediate indebtedness for the aggregate monthly rental payments, but rather confines the liability of KCHA to each month's rental payment as it falls due. Further, each month's rental payment shall only be in consideration for the right to possess, occupy and use the Premises for the subsequent month.

c. **Increased Rental Rate** – Each year on the anniversary of the execution date of the lease, the Total Monthly Rent shall increase by 3% over and above the previous period Total Monthly Rent.

d. **Broker Commission** – KCHA will not pay any broker commissions. Lessor will be responsible for paying all broker commissions.

7. **Purpose:**

a. **In General** - This Agreement is made for the purpose of allowing KCHA to utilize the Premises in order to provide medical services.

b. **No Nuisance** - KCHA shall not do or permit any act or thing to be done upon the Premises that will obstruct or interfere with the rights of Lessor or any others. KCHA shall not cause, maintain, or permit any nuisance or waste on or about the Premises, or allow the Premises to be used for any unlawful purpose.

8. **Condition of Premises:** KCHA has inspected the Premises and knows the extent and condition thereof and accepts same in its present condition, subject to and including all defects, latent and/or patent.

9. **Alterations:** Throughout the Term, KCHA shall have the right to make certain changes to the existing improvements on the Premises for the accommodation of KCHA's use and changing needs at its sole cost. Following KCHA taking possession of the Premises, any changes to the then-existing improvements in excess of $50,000 shall require KCHA to provide written notice to Lessor in advance. Lessor will provide KCHA a tenant improvement allowance of $327,961 ("**Tenant Improvement Allowance**") based on plans and specifications discussed, exchanged and agreed to by and between Lessor and KCHA. Lessor will perform all of the tenant improvements set required by those plans and specifications. The Tenant Improvement Allowance Lessor is providing is for the hard construction costs including architectural, engineering, and permits. Lessor is willing to perform additional Tenant Improvements ("Additional Tenant Improvement Expenses") on behalf of KCHA, and to advance the cost of such Additional Tenant Improvement Expense up to a maximum of $100,000. Such Additional Tenant Improvement Expenses shall result if and when KCHA elects to make any changes to the existing plans that increase the costs of construction, architectural, engineering, and/or permits will be provided by Lessor. KCHA agrees to repay Lessor for the Additional Tenant Improvement Expenses. KCHA agrees to pay interest in the amount of the Additional Tenant Improvement Expenses at the rate of 6.5% interest and agreed to pay monthly fully payments amortized over 10 years but all due and payable at the end of five years if KCHA has exercised its one-time right to terminate this Agreement at the end of the fifth lease year. Lessor shall contract for all tenant improvements including architectural and engineering. All Tenant Improvement will be completed by January 15, 2017, but Lessor will use reasonable efforts to complete all Tenant Improvements by December 15, 2016.

10. **Repair and Maintenance:**

a. **Responsibilities of KCHA** - During the term of this Agreement, and any extension thereof, KCHA shall, at its sole cost, repair and maintain the interior of the Building and any specialized improvements on the Premises in a sanitary and safe condition and in compliance with the terms, covenants and conditions of this Agreement and all applicable federal, state and local laws, rules and regulations ("**Applicable Laws**"). KCHA will not be responsible for any capital replacements (i.e. replacement of an air conditioning unit) unless

such replacement is required due to negligent acts of KCHA which surpass normal wear and tear.

b. Responsibilities of Lessor – During the term of this Agreement, and any extension thereof, Lessor shall, at its sole cost, repair and maintain the exterior of the premises, including, but not limited to, the roof, walls, all structural portions, landscaping and parking lots, HVAC, plumbing and electrical systems in a clean, sanitary and safe condition to the reasonable satisfaction of KCHA and in compliance with the terms, covenants and conditions of this Agreement and all Applicable Laws for a Class A medical office building. Such expenses incurred by Lessor shall be included in the calculation of the building operating expenses. Repairs or replacements caused by negligent acts of KCHA or their invitees shall be the responsibility of KCHA.

11. Utilities and Services; Modification of Utilities: KCHA shall pay, during the term of this Agreement or any holding over of the term, for all utilities used by KCHA in connection with its operations on the Premises. The term "utilities" for the purposes of this Agreement shall include, without limitation, gas, electricity, water, sewer, telephone service, and trash and refuse disposal services. KCHA shall be solely responsible for any medical and/or hazardous waste removal and disposal.

12. Janitorial – KCHA shall, at its sole cost, contract for janitorial services to the Premises.

13. Taxes and Assessments: Lessor shall be responsible for building operating expenses (including property taxes and operating expenses for the first year of the Term. KCHA shall be responsible to pay its proportionate share of the increase in building operating expenses (including property taxes and operating expenses) resulting from this Agreement beginning the second year of the Term. Lessor will be responsible for any other taxes and assessments not defined in this **section 13**.

a. If, during the Term of this Agreement, KCHA's proportionate share of operating expenses and property taxes for the Premises exceeds the amount of operating expenses and property taxes for the first base year, KCHA shall be responsible for the excess. Operating expenses for the base year, to which each subsequent lease years will be compared, will calculated on a grossed-up basis reflecting variable operating expenses as if the Building was 95% occupied.

14. Signs: KCHA, at its sole cost, shall have the right to install signs to identify the Premises, and such signs shall comply with all applicable laws, ordinances and regulations, including those of KCHA, and any installation of signage shall be approved by Lessor in writing prior to installation, which approval will not be unreasonably withheld. Any damage to the Premises caused by the installation and maintenance of any such sign, and the cost of removal or obliteration thereof, and any repairs necessitated, upon the expiration or termination of this Agreement, shall be paid by KCHA

15. Damage and Destruction: If the Premises shall be damaged or destroyed by fire or casualty, not the fault of KCHA or any person in or about the Premises with the express or implied consent of the KCHA, this Agreement shall be immediately terminated.

16. **Condemnation:** If all or any part of the Premises shall be taken as a result of the exercise of the power of eminent domain, this Agreement shall terminate as to the part so taken as of the date of taking, and, in the case of a partial taking, either Party shall have the right to terminate this Agreement as to the balance of the Premises by notice to the other Party within 30 days after such date.

17. **Right of Inspection:** Lessor shall have the right to enter upon the Premises with reasonable notice to KCHA, to inspect the Premises and KCHA's operations thereon.

18. **Hazardous Materials:**

a. **Receipt of Notice of Violation** - If either party becomes aware of or receives notice or other communications concerning any actual, alleged, suspected, or threatened violation of any Environmental Requirements, or liability of either party in connection with the Premises or past or present activities of any person thereon, then the noticed party shall deliver to the other party within 10 days of receipt of such notice or communication, a written description of said violation, liability, correcting information, or actual or threatened event or condition, together with copies of any documents evidencing same. Receipt of such notice shall not create any obligation on the part of the noticed party to defend or otherwise respond to any such notification. Environmental Requirements, as used in this Agreement, shall be defined as stated in **Exhibit "A."**

19. **Indemnification:**

a. **In General** – Each Party agrees to defend, hold harmless, and indemnify the other Party (and the other Party's officers, employees, trustees, agents, successors, assigns, and invitees, collectively referred to as the "**Indemnified Parties**") against all claims, suits, expenses (including staff time, reasonable attorney's fees, and fees of County Counsel), losses, penalties, fines, costs, and liability whether in contract, tort, or strict liability (including but not limited to personal injury, death at any time, and property damage) arising out of or made necessary by **i)** the indemnifying Party's breach of the terms of this Agreement; **ii)** the negligent or willful acts or omissions of the indemnifying Party and its Indemnified Parties in connection with performance of this Agreement; and **iii)** the presence of the indemnifying Party and its Indemnified Parties on the other Party's premises. In the event that any action or proceeding is brought against a Party by reason of any claim or demand discussed in this **Section 19**, upon reasonable notice from the other Party, the indemnifying Party shall defend the action or proceeding at the other Party's expense through counsel reasonably satisfactory to the other Party. The obligations to indemnify set forth in this **Section 19** shall include reasonable attorney's fees, investigation costs, and all other reasonable costs, expenses, and liabilities from the first notice that any claim or demand is to be made. The indemnifying Party's obligations under this **Section 19** shall apply regardless of whether the other Party or its Indemnified Parties are actively or passively negligent, but shall not apply to any loss, liability, fine, penalty, forfeiture, cost, or damage determined by an arbitrator or court of competent jurisdiction to be caused solely by the negligence or willful misconduct of the other Party and its Indemnified Parties.

b. **Environmental** - In addition, Lessor shall indemnify, hold harmless, and defend KCHA and the Indemnified Parties against any and all Claims arising out of or in any way connected with any deposit, spill, discharge, or other release of any Hazardous Materials at any time during KCHA's occupancy of the Premises to the extent such claims are not caused by KCHA) or to the extent such claims are caused by or are a result of Lessor's failure to provide any or all information, make any or all of its submissions, and take any or all steps

required by any governmental authority or court which has jurisdiction or by any Environmental Requirements.

c. **Survival of Indemnification Obligations -** The obligations under this **Section 19** shall survive the expiration or termination of this Agreement.

20. **KCHA Maintenance of Insurance:**

a. **KCHA's Insurance Requirements –** During the Term, KCHA shall maintain the following insurance coverage: **i)** Commercial General Liability Insurance, on an occurrence basis, with a combined single limit of not less than $2,000,000.00 per occurrence and $3,000,000.00 in the annual aggregate, including owners and contractors protective coverage, blanket contractual coverage, and personal injury coverage, covering the insuring provisions of this Agreement and the performance of KCHA of the indemnity and exemption of Lessor from liability agreements set forth herein; **ii)** a policy of standard fire, extended coverage and special extended coverage insurance (all risks), including a vandalism and malicious mischief endorsement, sprinkler leakage coverage and earthquake sprinkler leakage where sprinklers are provided in an amount equal to the full replacement value new without deduction for depreciation of all (A) Improvements, alterations, fixtures and other improvements in the Premises, and (B) trade fixtures, furniture, equipment and other personal property installed by or at the expense of KCHA; **iii)** Worker's Compensation coverage as required by law; and **iv)** business interruption, loss of income and extra expense insurance covering any failure or interruption of KCHA's business equipment (including, without limitation, telecommunications equipment) and covering all other perils, failures or interruptions sufficient to cover a period of interruption of not less than twelve (12) months. KCHA shall carry and maintain during the entire Term such other insurance policies covering the Premises and KCHA's operations therein, as may be reasonably required by Lessor.

b. .

c. **Waiver of Subrogation** – Lessor and KCHA each agree to require their respective insurers issuing the insurance with respect to the Property or Premises to waive any rights of subrogation that such companies may have against the other Party. KCHA hereby waives any right that KCHA may have against Lessor and Lessor hereby waives any right that Lessor may have against KCHA as a result of any loss or damage to the extent such loss or damage is insurable under such policies.

d. **KCHA Self-Insurance** – KCHA self-insures as a matter of normal business practice, and will continue to self-insure for the term of this Agreement in at least the minimum amounts necessary to meet reasonable risks. KCHA, upon request of Lessor, shall forward documentation to Lessor that demonstrates to Lessor's satisfaction that KCHA self-insures as a matter of normal business practice before commencing the Work. Lessor will accept reasonable proof of self-insurance comparable to the above requirements.

21. **Lessor Maintenance of Insurance:** In order to protect KCHA and the Indemnified Parties against Claims as a result of Lessor Acts, Lessor shall secure and maintain insurance as described below. Lessor shall obtain all insurance required under this **Section 21** and shall file the required certificates of insurance, and required endorsements with KCHA's authorized insurance representative. Receipt of evidence of insurance that does not comply with all applicable insurance

requirements shall not constitute a waiver of these insurance requirements. The required documents must be signed by the authorized representative of the insurance company shown on the certificate. Upon request by KCHA, Lessor shall supply proof that such person is an authorized representative thereof, and is authorized to bind the named company to the coverage, limits, and provisions shown thereon. Lessor shall promptly deliver a certificate of insurance, and blanket additional insured endorsements, with respect to each renewal policy, as necessary to demonstrate the maintenance of the required insurance coverage for the Term or as otherwise specified herein. Such certificates and endorsements shall be delivered to the KCHA's authorized insurance representative within 30 days of the expiration of any policy and bear a notation evidencing payment of the premium thereof if so requested. Lessor shall immediately pay any deductibles and self-insured retentions under all required insurance policies upon the submission of any claim by Lessor or KCHA as an additional insured.

a. Workers' Compensation and Employer's Liability Insurance Requirements –

1) Workers' Compensation Insurance - Lessor Employees. If Lessor has employees who may perform any services pursuant to this Agreement, Lessor shall provide workers compensation coverage as required by California law.

2) Workers' Compensation Insurance - Lessor Subcontractors. Lessor shall require any subcontractors to provide workers' compensation coverage as required by California law, unless the subcontractors' employees are covered by the insurance afforded by Lessor. If any class of employees engaged in work or services performed under this Agreement is not covered by California Labor Code section 3700, Lessor shall provide and/or require each subcontractor to provide adequate insurance for the coverage of employees not otherwise covered.

3) Employer's Liability Insurance. Lessor shall also maintain employer's liability insurance with limits of $1,000,000 each accident/disease/policy limit.

b. Liability Insurance Requirements –

1) In General – Lessor shall maintain in full force and effect, at all times during the Term, the following insurance:

(a) Commercial General Liability Insurance, including without limitation, Contractual Liability Insurance (specifically concerning the indemnity provisions of this Agreement with KCHA), Products-Completed Operations Hazard, Personal Injury (including bodily injury and death), and Property Damage for liability arising out of Lessor's performance of work under this Agreement. The Commercial General Liability insurance shall contain no exclusions or limitation for independent contractors working on the behalf of the named insured. Lessor shall maintain the Products-Completed Operations Hazard coverage for the longest period allowed by law following termination of this Agreement. The amount of said insurance coverage required by this Agreement shall be at least $1,000,000 each occurrence for bodily injury and property damage and $2,000,000 general aggregate.

(b) Automobile Liability Insurance, against claims of Personal Injury (including bodily injury and death) and Property Damage covering any vehicle and/or all owned, leased, hired, and non-owned vehicles used in the performance of services pursuant to this Agreement with coverage equal to the policy limits, which shall be at least $1,000,000 each occurrence.

2) **Additional Insureds –** The Commercial General Liability and Automobile liability Insurance required in this **Subparagraph b** shall include an endorsement naming KCHA and the Indemnified Parties as an additional insured for liability arising out of this Agreement and any operations related thereto. Said endorsement shall be provided using ISO forms or its substantial equivalent providing equal or broader coverage.

3) **Self-Insurance** –Lessor does not and will not for the Term of this Agreement self-insure.

4) **Claims-Made –** If any of the insurance coverages required under this Agreement is written on a claims-made basis, Lessor, at Lessor's option, shall either **(i)** maintain said coverage for at least three years following the termination of this Agreement with coverage extending back to the Execution Date; **(ii)** purchase an extended reporting period of not less than three years following the termination of this Agreement; or **(iii)** acquire a full prior acts provision on any renewal or replacement policy.

c. Fire and Casualty Insurance – Lessor shall, at its sole cost, maintain on the Premises a policy of standard fire and extended coverage insurance, with vandalism and malicious mischief endorsements, to the extent of at least 100% of full replacement value. The insurance policy shall be issued in the names of KCHA, Lessor, and any lender, as their interests appear. The insurance policy shall provide that any proceeds shall be made payable to Lessor, and Lessor shall apply and use such proceeds as required by **Section 15** subject to the priority rights of any lender. Such insurance shall satisfy the requirements of **Section 21.c**, and shall be issued by a company or companies satisfying the requirements of **Section 21.e**. On or before the Effective Date, Lessor shall deliver to KCHA certificates of insurance indicating that Lessor has complied with the provisions of this **Section 21.c**.

d. Cancellation of Insurance – The above-stated insurance coverages required to be maintained by Lessor shall be maintained until the completion of all of Lessor's obligations under this Agreement. Each insurance policy supplied by Lessor must be endorsed to provide that the coverage shall not be suspended, voided, cancelled, or reduced in coverage or in limits except after 10 days written notice in the case of non-payment of premiums, or thirty (30) days written notice in all other cases. Such notice shall be by certified mail, return receipt requested. This notice requirement does not waive the insurance requirements stated herein. Lessor shall immediately obtain replacement coverage for any insurance policy that is terminated, canceled, non-renewed, or whose policy limits have been exhausted or upon insolvency of the insurer that issued the policy.

e. Insurance Company Rating – All insurance shall be issued by a company or companies admitted to do business in California and listed in the current "Best's Key Rating Guide" publication with a minimum rating of A-; VII. Any exception to these requirements must be approved in writing by KCHA's Risk Manager, which may be granted or withheld at the KCHA's Risk Manager's sole discretion.

f. Lessor Self-Insured – If Lessor is, or becomes during the term of this Agreement, self-insured or a member of a self-insurance pool, Lessor shall provide coverage equivalent to the insurance coverages and endorsements required above. KCHA will not accept such coverage unless KCHA's Risk Manager determines by written acceptance, that the coverage proposed to be provided by Lessor is equivalent to the above-required coverages.

g. Primary Insurance – All insurance afforded by Lessor pursuant to this Agreement shall be primary to and not contributing to all insurance or self-insurance maintained by KCHA. An endorsement shall be provided on all policies, except professional liability/errors

and omissions, which shall waive any right of recovery (waiver of subrogation) against KCHA.

h. No Limitations by Policy Limits – Insurance coverages in the minimum amounts set forth herein shall not be construed to relieve Lessor for any liability, whether within, outside, or in excess of such coverage, and regardless of solvency or insolvency of the insurer that issues the coverage, or to preclude KCHA from taking such other actions as are available to it under any other provision of this Agreement or otherwise under Applicable Laws.

i. Failure to Maintain Insurance – Failure by Lessor to maintain all such insurance in effect at all times required by this Agreement shall be a material breach of this Agreement by Lessor. KCHA, at its sole option, may terminate this Agreement and obtain damages from Lessor resulting from said breach.

22. Liens and Encumbrances: KCHA shall keep the Premises free from any liens and encumbrances arising out of any work performed, material furnished, or obligations incurred by KCHA, or from any other cause.

23. Breach by Parties: In the event of a breach by either party of any term, covenant, or condition, the breaching party shall have 30 days to cure said breach after receiving written notice from the non-breaching party. If the breaching party fails to cure within the stated time periods, KCHA may exercise its remedies under **Section 2**.

24. Remedies:

a. Breach by KCHA - In the event of an uncured breach by KCHA, Lessor shall have the right to either terminate KCHA's right to possession of the Premises, by giving written notice of termination to KCHA, and thereby terminating this Agreement, or to have this Agreement continue in full force and effect with KCHA at all times having the right to possession of the Premises.

b. Breach by Lessor - In the event of an uncured breach by Lessor, KCHA shall have the right to terminate the Agreement by giving written notice of termination to Lessor or elects to have this Agreement continue in full force and effect in which, Lessor shall remain liable to perform all of its obligations under this Agreement and KCHA may enforce all of KCHA's rights and remedies. After the notice and cure period has expired and Lessor has failed to perform an obligation of Lessor, KCHA shall have the right to perform all of Lessor's obligations under this Lease to maintain, preserve and protect the Premises and to withhold rents to reimburse KCHA for all amounts reasonably expended by KCHA in connection with the maintenance, preservation, and protection of the Premises by the Lessor as outlined in this Agreement..

c. Remedies Not Exclusive - No right or remedy herein conferred upon or reserved to the parties is intended to be exclusive of any other right or remedy herein or by law, provided that each shall be cumulative and in addition to every other right or remedy given herein or now, or hereafter existing at law or in equity or by statute.

25. No Waiver of Breach: The waiver by the Parties of any term, covenant, or condition contained in this Agreement must be in writing and shall not be deemed to be a waiver of any subsequent breach of the term, covenant or condition contained in this Agreement, and no custom or practice that may arise between the Parties during the course of this Agreement shall be construed to

waive or lessen the right of a Party to the performance by the other Party in strict accordance with the terms of this Agreement.

26. Force Majeure:

a. Definition - Neither Party shall be held responsible or be deemed to be in default under this Agreement for any delay in performance or failure to perform any of its obligations, if such delay or failure is the result of causes beyond the control and without negligence of the Party. Such causes include, without limitation, acts of nature, strikes, lockouts, riots, insurrections, civil disturbances or uprisings, sabotage, embargoes, blockages, acts of war or terrorism, acts or failure to act by any governmental or regulatory body (whether civil or military, domestic or foreign), governmental regulations superimposed after the fact, communication line failures, power failures, fires, explosions, floods, accidents, epidemics, earthquakes, tsunamis, or other natural or man-made disasters ("**Force Majeure**"). Lack of funds shall not be a Force Majeure event.

b. Consequences - The Party affected by a Force Majeure event, upon giving prompt notice to the other Party, shall be excused from performance to the extent of such prevention, restriction, or interference, on a day-to-day basis until the Force Majeure event is removed, and the other Party shall likewise be excused from performance of its obligation which relate to the performance so prevented, restricted, or interfered with. The affected Party shall use its best efforts to avoid or remove the causes of nonperformance and to minimize the consequences thereof, and both Parties shall resume performance when the Force Majeure event is removed.

27. Quiet Possession: KCHA, in keeping and performing the terms, covenants and conditions herein contained on the part of KCHA to be kept and performed, shall at all times during the term of this Agreement peaceably and quietly have, hold, and enjoy the Premises.

28. Assignment and Subletting:

a. No Assignment or Subletting - KCHA shall not assign, transfer, mortgage, or otherwise convey this Agreement, or any of its rights and interests hereunder, including its leasehold rights and interests granted by this Agreement, without the prior written consent of the Lessor.

b. Change in Ownership – If Lessor sales, transfers, or in any way changes the ownership of the Premises, Lessor will provide KCHA adequate written notice of the change in ownership.

29. Surrender of Premises: On the last day of the term, or extension thereof, or sooner termination of this Agreement, KCHA shall peaceably and quietly leave, surrender, and yield up to Lessor the Premises, in as good a condition and state of repair as it existed on the Execution Date subject to damage by Force Majeure.

30. Notices: All notices herein provided to be given, or which may be given, by either Party to the other shall be deemed to have been fully given when made in writing and deposited with the United States Postal Service, certified mail, return receipt requested, postage prepaid, and addressed as follows:

To Lessor: James C. Eckmann Family Trust
1731 16th Street, Suite D

Bakersfield, CA 93301
Attn: James C. Eckmann, Trustee

To KCHA: Kern Medical Center
1700 Mount Vernon Avenue
Bakersfield, CA 93306
Attn: Chief Executive Officer

The address to which the notices shall be mailed to either Party may be changed by written notice given by such Party to the other, but nothing shall preclude the giving of any such notice by personal service.

31. Miscellaneous Provisions:

a. Negation of Partnership - KCHA shall not become or be deemed a partner or joint venturer with Lessor or associate in any relationship with Lessor other than that of landlord and tenant by reason of the provisions of this Agreement. Lessor shall not for any purpose be considered an agent, officer, or employee of KCHA.

b. Conflict of Interest - The Parties have read and are aware of the provisions of Section 1090 et seq. and Section 87100 et seq. of the Government Code relating to conflict of interest of public officers and employees. All Parties agree that they are unaware of any financial or economic interest of any public officer or employee of KCHA relating to this Agreement. It is further understood and agreed that if such a financial interest does exist as of the Execution Date, KCHA may immediately terminate this Agreement by giving written notice to Lessor. KCHA shall comply with the requirements of Government Code Section 87100 et seq. during the term of this Agreement.

c. Nondiscrimination - KCHA, in the use of the Premises and in the operations to be conducted under this Agreement, shall not discriminate or permit discrimination against any person or class of persons by reason of race, color, creed, religion, ancestry, sex, or national origin in any manner prohibited by federal, state, or local laws or policies.

d. Incorporation of Prior Agreements - This Agreement contains all agreements of the Parties with respect to any matter mentioned herein. No prior agreement or understanding pertaining to any such matter shall be effective.

e. Remedies not Exclusive - The use by either Party of any remedy specified herein for the enforcement of this Agreement is not exclusive and shall not deprive such Party of, or limit the application of, any other remedy provided by law, at equity, or otherwise.

f. Severability - If any part, term, portion, or provision of this Agreement is decided finally to be in conflict with any law of the United States or the State of California, or otherwise be unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to constitute the agreement which the Parties intended to enter into in the first instance.

g. Governing Law; Venue - The Parties agree that the provisions of this Agreement shall be construed pursuant to the laws of the State of California. If either Lessor or KCHA initiates an action to enforce the terms of this Agreement or declare rights hereunder, including actions on any bonds and/or surety agreements, the venue thereof shall be the County of Kern, State of California, it being understood that this Agreement is entered into, and will be performed, within the County of Kern.

h. **Compliance with Laws** - Lessor **s**hall, at its sole cost, promptly comply with all Applicable Laws, including Environmental Requirements, which may in any way apply to the use, operation, repair, maintenance, occupation of, or operations or construction on, the Premises.

i. **Successors** - Subject to **Section 27,** all terms, covenants, and conditions of this Agreement shall extend to, be binding upon, and inure to the benefit of the heirs, executors, administrators, successors, and assigns of the respective Parties.

j. **No Third Party Beneficiaries** - This Agreement is made for the sole benefit of the Parties and their respective heirs, executors, administrators, successors, and assigns, and no other persons shall have any right of action hereon.

k. **Covenants and Conditions** - Each provision of this Agreement performable by Lessor and KCHA shall be deemed both a covenant and a condition.

l. **Modification** - This Agreement may be modified or amended only by a written document signed by both Parties.

m. **Authorization** - Each individual executing this Agreement on behalf of either Party represents and warrants that he/she is duly authorized to execute and deliver this Agreement on behalf of that Party, and that this Agreement is binding upon both Parties in accordance with its terms.

n. **Construction** - The Parties acknowledge that each Party and its counsel have reviewed and revised this Agreement, and that the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting Party shall not be employed in the interpretation of this Agreement or any amendments or exhibits to this Agreement.

o. **Recitals** - Each of the recitals is incorporated in this Agreement by reference as if fully set forth in this Agreement at length, is deemed to be the agreement and a reflection of the intent of the Parties, and is relied upon by the Parties in agreeing to the provisions of this Agreement and in interpreting its provisions.

p. **Captions** - Paragraph headings in this Agreement are used solely for convenience, and shall be wholly disregarded in the construction of this Agreement.

q. **Exhibits** - All exhibits attached to this Agreement are incorporated into this Agreement by reference.

r. **Time of Essence** - Time is hereby expressly declared to be of the essence of this Agreement and of each and every provision thereof, and each such provision is hereby made and declared to be a material, necessary, and essential part of this Agreement.

The remainder of this page has been intentionally left blank.

The Parties have executed this Agreement on the Execution Date.

KERN COUNTY HOSPITAL AUTHORITY

By_____
Russell Bigler
Chairman, Board of Governors
"**KCHA**"

JAMES C. ECKMANN FAMILY TRUST

By_____
James C. Eckmann
Trustee
"**Lessor**"

APPROVED AS TO CONTENT:
Kern Medical Center

By_____
Scott Thygerson
Chief Strategy Officer

APPROVED AS TO FORM:
Office of County Counsel

By_____
Deputy

DEFINITION OF ENVIRONMENTAL TERMS

For the purpose of this Agreement, the following terms and words shall have the meaning given below:

1. **Environmental Requirements**. All applicable present and future statutes, regulations, rules, ordinances, codes, leases, permits, orders, approvals, plans, authorizations, and similar items of any governmental agency, department, commission, board, bureau, or instrumentality of the United States of America, California, or its political or municipal subdivisions, and all applicable judicial, administrative, and regulatory decrees, judgments, and orders relating to the protection of human life or the environment.

2. **Hazardous Materials**. All flammables, explosives, radioactive materials, asbestos, polychlorinated bipehenyls (PCBs), chemicals known to cause cancer or reproductive toxicity, pollutants, contaminates, hazardous waste, toxic substances or related materials, petroleum products, and any substances declared to be hazardous or toxic under any present or future Environmental Requirements or which requires investigation or remediation under any present or future federal, state, or local law, statute, regulation, environmental requirement, order, or rule.

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Agreement with Arman G. Froush, D.O.

Recommended Action: Approve; Authorize Chairman to sign

Summary:

Kern Medical requests approval to enter into an employment agreement with Arman G. Froush, DO. Dr. Froush will serve as Chief, Division of Vascular and Interventional Radiology within the Department of Radiology. Dr. Froush will replace Dr. Dhillon, who is the current chief of this division and is resigning in December 2016 to move back to the eastern United States. Dr. Froush completed his fellowship in Vascular and Interventional Radiology at Christiana Hospital – Thomas Jefferson University in Delaware and his radiology residency at Michigan State University – Oakwood Medical Center. Since completing his training, Dr. Froush has provided interventional radiology services in Phoenix, Arizona. Dr. Froush will relocate to Bakersfield and join the medical staff at Kern Medical effective January 21, 2017.

AGREEMENT FOR PROFESSIONAL SERVICES
CONTRACT EMPLOYEE
(Kern County Hospital Authority – Arman G. Froush, D.O.)

This Agreement is made and entered into this _____ day of _____, 2016, between the Kern County Hospital Authority, a county hospital authority ("Authority"), which owns and operates Kern Medical Center ("KMC"), and Arman G. Froush, D.O. ("Physician").

I.
RECITALS

(a) Authority is authorized, pursuant to section 101852 of Part 4 of Division 101 of the Health and Safety Code, to contract for special services with individuals specially trained, experienced, expert, and competent to perform those services; and

(b) Authority requires the assistance of Physician to provide professional medical services in the Department of Radiology at KMC (the "Department"), as such services are unavailable from Authority resources, and Physician desires to accept employment on the terms and conditions set forth in this Agreement; and

(c) Physician has special training, knowledge and experience to provide such services;

NOW, THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and incorporating by this reference the foregoing recitals, the parties hereto agree as follows:

II.
TERMS AND CONDITIONS

1. **Term.** The initial term of this Agreement ("Initial Term") shall be for a period of three (3) years, commencing as of January 21, 2017 (the "Commencement Date"). At the end of the Initial Term and each Renewal Term (as hereinafter defined), if any, this Agreement may be renewed for additional terms of two (2) years each ("Renewal Term"), but only upon mutual written agreement of the parties. As used herein, the "Term" of this Agreement shall mean the Initial Term and all Renewal Terms. As used herein, an "Employment Year" shall mean the annual period beginning on the Commencement Date and each annual period thereafter.

2. **Employment.** Authority hereby employs Physician for the practice of medicine in the care and treatment of patients at KMC, or at such other clinic sites as KMC may designate (collectively referred to as the "Practice Sites"). It is expressly understood and agreed that KMC shall have reasonable discretion to consolidate and relocate clinics operated by Authority and to re-designate Practice Sites served by Physician from time to time. Physician shall be subject to Authority's employment policies, directives, rules and regulations as promulgated by Authority from time to time, including, but not limited to, those pertaining to employees.

3. **Representations and Warranties.** Physician represents and warrants to Authority and KMC, upon execution and throughout the Term of this Agreement, as follows: (i) Physician is not bound by any agreement or arrangement which would preclude Physician from entering into, or from fully performing the services required under this Agreement; (ii) Physician's license to practice medicine in the state of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to the terms of probation or other restriction; (iii) Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction; (iv) Physician holds a valid Controlled Substance Registration Certificate issued by the Drug Enforcement Administration that has never been revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (v) Physician is not currently and has never been an Ineligible Person[1]; (vi) Physician is not currently the subject of a disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body; and (vii) Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in the state of California and staff membership and privileges at KMC.

4. **Obligations of Physician.**

4.1 Services. Physician shall engage in the practice of medicine on a full-time basis exclusively as an exempt employee of Authority. Physician shall render those services set forth in Exhibit "A," attached hereto and incorporated herein by this reference.

4.2 Use of Premises. Physician shall use the Practice Sites as designated by Authority or KMC exclusively for the practice of medicine in the care and treatment of patients and shall comply with all applicable federal, state, and local laws, rules and regulations related thereto.

4.3 Qualifications.

4.3.1 Licensure. Physician shall maintain a current valid license to practice medicine in the state of California at all times during the Term of this Agreement.

4.3.2 Board Certification. Physician shall be board certified by the American Osteopathic Association in diagnostic radiology-general certification with certification of added qualifications in vascular/interventional radiology, and maintain such certifications at all times during the Term of this Agreement.

4.3.3 Medical Staff Status. Physician shall at all times during the Term of this Agreement be a member in good standing of the KMC medical staff with "active" staff status and hold all clinical privileges on the active medical staff appropriate to the discharge of his obligations under this Agreement.

[1] An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the federal health care programs or in federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the range of activities described in 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

4.3.4 TJC and ACGME Compliance. Physician shall observe and comply with all applicable standards and recommendations of The Joint Commission and Accreditation Council for Graduate Medical Education.

4.4 Loss or Limitation. Physician shall notify KMC in writing as soon as possible (but in any event within three (3) business days) after any of the following events occur: (i) Physician's license to practice medicine in the state of California lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction; (ii) Physician's medical staff privileges at KMC or any other health care facility are denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or other restriction; (iii) Physician's Controlled Substance Registration Certificate issued by the Drug Enforcement Administration is revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (iv) Physician becomes debarred, excluded, or suspended, or if any other event occurs that makes Physician an Ineligible Person; (v) Physician becomes the subject of a disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body; or (vi) an event occurs that substantially interrupts all or a portion of Physician's professional practice or that materially adversely affects Physician's ability to perform Physician's obligations hereunder.

4.5 Standards of Medical Practice. The standards of medical practice and professional duties of Physician at designated Practice Sites shall be in accordance with the KMC medical staff bylaws, rules, regulations, and policies, the standards for physicians established by the state Department of Public Health and all other state and federal laws and regulations relating to the licensure and practice of physicians, and The Joint Commission.

4.6 Managed Care Organizations. For and on behalf of Physician, Authority shall have the sole and exclusive right and authority to enter into contractual relationships with HMOs, IPAs, PPOs, PHOs, employer groups, provider networks and other managed care organizations (collectively "Managed Care Organizations"). Physician shall provide the same quality of care to patients from Managed Care Organizations as is provided to other KMC patients. Upon request from Authority or KMC, Physician shall execute Managed Care Organization documents as "provider" if deemed necessary or advisable by Authority. Physician shall not contract with any Managed Care Organization without Authority's prior written consent in each instance.

4.7 Authorization to Release Information. Physician hereby authorizes Managed Care Organizations, government programs, hospitals and other third parties to release to KMC and its agents any information requested by KMC or its agents from time to time relating to Physician's professional qualifications or competency. Physician agrees to execute the Authorization to Release Information in the form set forth in Exhibit "B," attached hereto and incorporated herein by this reference, and to execute all other documents required by KMC from time to time and to otherwise fully cooperate with KMC to enable KMC and its agents to obtain such information from third parties.

4.8 Medical Records. Physician shall cause a complete medical record to be timely prepared and maintained for each patient seen by Physician. This record shall be prepared in

compliance with all state and federal regulations, standards of The Joint Commission, and the KMC medical staff bylaws, rules, regulations, and policies. Documentation by Physician shall conform to the requirements for evaluation and management (E/M) services billed by teaching physicians set forth in the Medicare Carriers Manual, Part 3, sections 15016–15018, inclusive. All patient medical records of Practice Sites, including without limitation, patient medical records generated during the Term of this Agreement, shall be the property of KMC subject to the rights of the respective patients. Upon the expiration or termination of this Agreement by either party for any reason, KMC shall retain custody and control of such patient medical records.

4.9 Physician Private Practice. Physician understands and agrees that he shall not enter into any other physician employment contract or otherwise engage in the private practice of medicine or provide similar services to other organizations, directly or indirectly, during the Term of this Agreement or any extensions thereof.

4.10 Proprietary Information. Physician acknowledges that during the Term of this Agreement Physician will have contacts with and develop and service KMC patients and referring sources of business of KMC. In all of Physician's activities, Physician, through the nature of his work, will have access to and will acquire confidential information related to the business and operations of KMC, including, without limiting the generality of the foregoing, patient lists and confidential information relating to processes, plans, methods of doing business and special needs of referring doctors and patients. Physician acknowledges that all such information is solely the property of KMC and constitutes proprietary and confidential information of KMC; and the disclosure thereof would cause substantial loss to the goodwill of KMC; and that disclosure to Physician is being made only because of the position of trust and confidence that Physician will occupy. Physician covenants that, except as required by law, Physician will not, at any time during the Term or any time thereafter, disclose to any person, hospital, firm, partnership, entity or organization (except when authorized in writing by KMC) any information whatsoever pertaining to the business or operations of KMC, any affiliate thereof or of any other physician employed by KMC, including without limitation, any of the kinds of information described in this paragraph.

4.11 Physician Covenants. Physician covenants that from the Commencement Date and continuing throughout the Term of this Agreement, Physician, unless otherwise permitted by the written consent of Authority shall not, on Physician's own account or as an employee, landlord, lender, trustee, associate, consultant, partner, agent, principal, contractor, owner, officer, director, investor, member or stockholder of any other person, or in any other capacity, directly or indirectly, in whole or in part: (i) engage in any activities that are in competition with KMC, including the operation of any medical practice or offering of any medical services that are similar to services offered at the Practice Sites; (ii) solicit or encourage the resignation of any employee of Authority or KMC with whom Physician had a working relationship during Physician's employment with Authority; (iii) solicit or divert patients with whom Physician had personal contact during such employment; or (iv) influence or attempt to influence any payer, provider or other person or entity to cease, reduce or alter any business relationship with Authority or KMC relating to the Practice Sites.

5. **Compensation Package.**

5.1 Annual Compensation. Physician shall work full time, which is a minimum of 40 hours per week, and will be compensated with cash and other value as described below in this paragraph 5.1 ("Annual Salary").

5.1.1 Annual Salary. Authority shall pay Physician an Annual Salary comprised of (i) a base salary for teaching and administrative duties and (ii) payment for care of KMC patients in the amount of $500,000 per year, to be paid as follows: Physician shall be paid $19,165.16 biweekly not to exceed $500,000 annually. Physician understands and agrees that (i) the Annual Salary set forth in this paragraph 5.1 is calculated based on the current Medical Group Management Association Physician Compensation and Production Survey ("MGMA Survey") for specialty and (ii) Physician will maintain a 50th percentile level of worked relative value units ("Worked RVU") based on the current MGMA Survey and fulfill all the duties set forth in Exhibit "A" during the Term of this Agreement.

5.1.2 Biweekly Payment. Physician shall be paid biweekly on the same schedule as regular Authority employees. The exact date of said biweekly payments shall be at the sole discretion of Authority. All payments made by Authority to Physician shall be subject to all applicable federal and state taxes and withholding requirements.

5.2 Excess Call Coverage. Authority shall pay Physician for excess call coverage (vascular/interventional radiology call only) as follows: (i) Physician shall be paid a fixed fee in the amount of $800 for every weekday night (Monday through Friday) of call coverage assigned in excess of one (1) week per month; (ii) Physician shall be paid a fixed fee in the amount of $1,600 per 24-hour day for every weekend (Saturday and Sunday) of call coverage assigned in excess of one (1) weekend per month.

5.3 Starting Bonus.

5.3.1 Bonus. Physician shall receive a starting bonus in the amount of $20,000, less all applicable federal and state taxes and withholdings, payable within 10 business days of the Commencement Date. Physician shall forfeit the starting bonus if he fails to report to work on the Commencement Date.

5.3.2 Repayment. In the event that Physician voluntarily terminates his employment with Authority for any reason whatsoever before the first anniversary of this Agreement, Physician will repay to Authority an amount equal to $20,000 multiplied by the fraction, the numerator of which is 365 less the number of days during which Physician was employed by Authority, and the denominator of which is 365. Such repayment shall be made by Physician in full within 30 days of the effective date of his termination of employment with Authority.

5.3.3 Offset. Physician hereby authorizes Authority to offset against and reduce any amounts otherwise due to him for any amounts in respect of the obligation to repay the starting bonus.

5.4 Retention Bonus.

5.4.1 Bonus. Physician shall be paid an annual retention bonus in the amount of $20,000, less all applicable federal and state taxes and withholdings, payable within 30 days of the end of each Employment Year. If the conditions for Physician to receive the retention bonus are met, the retention bonus would become payable to Physician on January 21, 2018, and each January 21 thereafter.

5.4.2 Repayment. In the event that Physician voluntarily terminates his employment with Authority for any reason whatsoever during an Employment Year in which a retention bonus is paid, Physician will repay to Authority an amount equal to $20,000 multiplied by the fraction, the numerator of which is 365 less the number of days during which Physician was employed by Authority, and the denominator of which is 365. Such repayment shall be made by Physician in full within 30 days of the effective date of his termination of employment with Authority.

5.4.3 Offset. Physician hereby authorizes Authority to offset against and reduce any amounts otherwise due to him for any amounts in respect of the obligation to repay the retention bonus.

5.5 Professional Fee Billing.

5.5.1 Assignment. KMC shall have the exclusive right and authority to set, bill, collect and retain all fees, including professional fees, for all direct patient care services provided by Physician during the Term of this Agreement. All professional fees generated by Physician during the Term of this Agreement, including without limitation, both cash collections and accounts receivable, capitated risk pool fees, professional retainer fees, honoraria, professional consulting and teaching fees, and fees for expert testimony (but excluding Physician's private investment and nonprofessional income, intellectual property developed or work on similar development projects prior to the Commencement Date, and industry consulting, which includes honoraria, cadaver labs, and professional speaking, expert witness, and teaching fees), will be the sole and exclusive property of KMC, whether received by KMC or by Physician and whether received during the Term of this Agreement or anytime thereafter. Physician hereby assigns all rights to said fees and accounts to KMC and shall execute all documents required from time to time by KMC and otherwise fully cooperate with KMC to enable KMC to collect fees and accounts from patients and third-party payers.

5.5.2 Remittance of Professional Fee Charges. Physician shall remit all professional fee charges to KMC within 45 days of the date direct patient care services are provided by Physician. Any professional fee charges not remitted by Physician to KMC within 45 days of the date of such service, or any charges for which relevant documentation has not been provided, will not be credited to Physician as Worked RVU.

5.6 Maximum Payable. The maximum compensation payable under this Agreement shall not exceed $1,880,000 over the three-year Initial Term of this Agreement.

6. **Benefits Package.**

6.1 Retirement. Physician shall participate in the Kern County Hospital Authority Defined Contribution Plan for Physician Employees (the "Plan"), a qualified defined contribution pension plan, pursuant to the terms of the instrument under which the Plan has been established, as from time to time amended. Physician is not eligible to participate in any other retirement plan established by Authority for its employees, including but not limited to the Kern County Employees' Retirement Association, and this Agreement does not confer upon Physician any right to claim entitlement to benefits under any such retirement plan(s).

6.2 Health Care Coverage. Physician shall receive the same health benefits (medical, dental, prescription and vision coverage) as all eligible Authority employees. The employee share of cost is 20% of the current biweekly premium. Physician is eligible for coverage the first day of the biweekly payroll period coincident with or next following the day he completes one (1) month of continuous service. Physician's initial hire date is the initial opportunity to enroll in the health plan. Physician must work at least 40 hours per biweekly pay period to be eligible for coverage.

6.3 Holidays. Physician shall be entitled to all paid holidays authorized as official holidays for Authority employees. A holiday occurring on a Sunday shall be observed on the following Monday and a holiday occurring on a Saturday shall be observed on the preceding Friday. In the event Physician is scheduled for and works on a holiday, he shall be entitled to an equivalent period of time off at a later date.

6.4 Vacation. Physician shall be credited with vacation leave of 6.15 hours for each pay period of service, for a maximum accrual of 160 hours per year. Vacation leave will accrue from the Commencement Date and may be taken at any time thereafter. Total unused vacation leave accumulated will not exceed a maximum of 320 hours. No further vacation leave will accrue as long as Physician has the maximum number of hours credited. The Department chair must approve all vacation leave in advance. Physician shall be paid for accrued and unused vacation leave, if any, upon termination or expiration of this Agreement calculated at Physician's current hourly rate (i.e., current Annual Salary divided by 2080 hours = hourly rate). All payments made by Authority to Physician under this paragraph will be subject to all applicable federal and state taxes and withholding requirements.

6.5 Sick Leave. Physician shall accrue sick leave in accordance with Authority policy, as amended from time to time. Physician will not be paid for accrued and unused sick leave upon termination of employment.

6.6 Education Leave. Physician shall receive 80 hours paid education leave annually. The first 80 hours will accrue on the Commencement Date. On each successive Employment Year, if any, an additional 80 hours paid education leave will accrue. Education leave must be used within the year that it is accrued. Physician will not be paid for unused education leave upon termination of employment. The Department chair must approve education leave in advance of use. Physician's participation in educational programs, services or other approved activities set forth herein shall be subordinate to Physician's obligations and duties under this Agreement.

6.7 CME Expense Reimbursement. Authority shall reimburse Physician for all approved reasonable and necessary expenditures related to continuing medical education in an amount not to exceed $2,500 per Employment Year, payable in arrears, in accordance with Authority policy, as amended from time to time. This amount may not be accumulated or accrued and does not continue to the following Employment Year.

6.8 Kern$Flex. Physician shall be eligible to participate in flexible spending plans to pay for dependent care, non-reimbursed medical expenses, and certain insurance premiums on a pre-tax basis through payroll deduction. This is a voluntary benefit that is paid by Physician if he elects to participate in the plan.

6.9 Attendance at Meetings. Physician shall be permitted to be absent from KMC during normal working days to attend professional meetings and to attend to such outside professional duties in the healthcare field as may be mutually agreed upon between Physician and the Department chair. Attendance at such approved meetings and accomplishment of approved professional duties shall be fully compensated service time and will not be considered vacation or education leave.

6.10 Unpaid Leave of Absence. Physician may take an unpaid leave of absence in accordance with Authority policies in effect at the time the leave is taken.

6.11 Social Security. Physician is exempt from payment of Social Security taxes as the Kern County Hospital Authority Pension Plan for Physician Employees is a qualified alternative to the insurance system established by the federal Social Security Act.

6.12 Deferred Compensation. Physician shall be eligible to participate in the Kern County Deferred Compensation Plan ("457 Plan") on a pre-tax basis. Physician shall make all contributions if he elects to participate in the 457 Plan.

6.13 Disability Insurance. Physician shall be eligible to purchase Long Term Disability or Short Term Disability insurance coverage through payroll deduction on a post-tax basis. This is a voluntary benefit that is paid by Physician if he elects to participate in the plan.

6.14 Employee Assistance/Wellness Programs. Physician shall be eligible to participate in any Authority-sponsored employee assistance and employee wellness programs.

6.15 Relocation Reimbursement. Authority shall reimburse Physician for actual relocation expenses (defined as the packing, moving and unpacking of household goods and vehicles) and travel expenses (defined as lodging, meals, mileage and incidental expenses) associated in moving to Bakersfield, California, in an amount not to exceed $7,500, payable in arrears, in accordance with Authority policy. Reimbursement of travel expenses will include per mile reimbursement for one (1) personal vehicle at the current privately owned vehicle (POV) mileage reimbursement rate established by the U.S. General Services Administration, meals and incidental expenses for Physician only at the current domestic per diem rates established by the U.S. General Services Administration for Kern County, and reasonable hotel accommodations not to exceed the maximum allowable reimbursement rate including taxes established by

Authority. Physician shall be deemed vested in reimbursement of relocation expenses in the amount of $208.34 per month beginning on the last day of the month in which the relocation expenses are reimbursed to Physician. In the event Physician's employment is terminated by either party, with or without cause, then, on the effective date of such termination, Physician shall repay to Authority all amounts received in which Physician has not yet become vested.[1]

6.16 Limitation on Benefits. Except as expressly stated herein, Physician shall receive no other benefits from Authority.

7. **Assignment.** Physician shall not assign or transfer this Agreement or his obligations hereunder or any part thereof. Physician shall not assign any money due or which becomes due to Physician under this Agreement without the prior written approval of Authority.

8. **Assistance in Litigation.** Upon request, Physician shall support and assist Authority as a consultant or expert witness in litigation to which Authority is a party.

9. **Authority to Bind Authority.** It is understood that Physician, in his performance of any and all duties under this Agreement, has no authority to bind Authority or KMC to any agreements or undertakings.

10. **Captions and Interpretation.** Paragraph headings in this Agreement are used solely for convenience, and shall be wholly disregarded in the construction of this Agreement. No provision of this Agreement shall be interpreted for or against a party because that party or its legal representative drafted such provision, and this Agreement shall be construed as if jointly prepared by the parties.

11. **Choice of Law/Venue.** This Agreement shall be construed and enforced under and in accordance with the laws of the state of California, with venue of any action relating to this Agreement in the County of Kern, state of California.

12. **Compliance with Law.** Physician shall observe and comply with all applicable Authority, local, state and federal laws, ordinances, rules and regulations now in effect or hereafter enacted, each of which is hereby made a part hereof and incorporated herein by reference.

13. **Confidentiality.** Physician shall maintain confidentiality with respect to information that he receives in the course of his employment and not use or permit the use of or disclose any such information in connection with any activity or business to any person, firm or corporation whatsoever, unless such disclosure is required in response to a validly issued subpoena or other process of law or as required by Government Code section 6250 et seq. Upon completion of the Agreement, the provisions of this paragraph shall continue to survive.

[1] By way of example only, in the event Physician terminates his employment after 12-months then Physician will be vested to the extent of $2,500 in the relocation expenses described herein and will be obligated to repay Authority the amount of $5,000. **In the event Physician fails to pay such amount to Authority, Physician expressly grants to Authority the right to offset any amounts owed to Authority against any payments made to Physician by Authority.**

14. **Conflict of Interest.** Physician covenants that he has no interest and that he will not acquire any interest, direct or indirect, that represents a financial conflict of interest under state law (Gov. Code, § 81000 et seq.) or that would otherwise conflict in any manner or degree with the performance of his services hereunder. It is understood and agreed that if such a financial interest does exist at the inception of this Agreement, Authority may immediately terminate this Agreement by giving written notice thereof.

15. **Counterparts.** This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

16. **Dispute Resolution.** In the event of any dispute involving the enforcement or interpretation of this Agreement or any of the rights or obligations arising hereunder, the parties shall first attempt to resolve their differences by mediation before a mediator of their mutual selection. If the parties are, after mutual good faith efforts, unable to resolve their differences by mediation, the dispute shall be submitted for trial before a privately compensated temporary judge appointed by the Kern County Superior Court pursuant to Article VI, section 21 of the California Constitution and Rules 3.810 through 3.830 of the California Rules of Court. All costs of any dispute resolution procedure shall be borne equally by the parties.

17. **Enforcement of Remedies.** No right or remedy herein conferred on or reserved to Authority is exclusive of any other right or remedy herein or by law or equity provided or permitted, but each shall be cumulative of every other right or remedy given hereunder or now or hereafter existing by law or in equity or by statute or otherwise, and may be enforced concurrently or from time to time.

18. **Indemnification.** Authority shall assume liability for and indemnify and hold Physician harmless from any and all claims, losses, expenses, costs, actions, settlements, attorneys' fees and judgments incurred by Physician or for which Physician becomes liable, arising out of or related to services rendered or which a third party alleges should have been rendered by Physician pursuant to this Agreement. Authority's obligation under this paragraph shall extend from Physician's first date of service to Authority and shall survive termination or expiration of this Agreement to include all claims that allegedly arise out of services Physician rendered on behalf of Authority; provided, however, that the provisions of this paragraph shall not apply to any services rendered at any location other than Practice Sites without approval by the Kern County Hospital Authority Board of Governors and, provided further, that Authority shall have no duty or obligation to defend, indemnify, or hold Physician harmless for any conduct or misconduct found to be intentional, willful, grossly negligent, or criminal.

19. **Invalidity of a Portion.** Should a portion, section, paragraph, or term of this Agreement be construed as invalid by a court of competent jurisdiction, or a competent state or federal agency, the balance of the Agreement shall remain in full force and effect. Further, to the extent any term or portion of this Agreement is found invalid, void or inoperative, the parties agree that a court may construe the Agreement in such a manner as will carry into force and effect the intent appearing herein.

20. **Modifications of Agreement.** This Agreement may be modified in writing only, signed by the parties in interest at the time of the modification.

21. **Non-appropriation.** Authority reserves the right to terminate this Agreement in the event insufficient funds are appropriated or budgeted for this Agreement in any fiscal year. Upon such termination, Authority will be released from any further financial obligation to Physician, except for services performed prior to the date of termination or any liability due to any default existing at the time this clause is exercised. Physician shall be given 30 days' prior written notice in the event that Authority requires such an action.

22. **Nondiscrimination.** No party to this Agreement shall discriminate on the basis of race, color, religion, sex, national origin, age, marital status or sexual orientation, ancestry, physical or mental disability, medical conditions, political affiliation, veteran's status, citizenship or marital or domestic partnership status or on the basis of a perception that an individual is associated with a person who has, or is perceived to have, any of these characteristics.

23. **Non-waiver.** No covenant or condition of this Agreement can be waived except by the written consent of Authority. Forbearance or indulgence by Authority in any regard whatsoever shall not constitute a waiver of the covenant or condition to be performed by Physician. Authority shall be entitled to invoke any remedy available to Authority under this Agreement or by law or in equity despite said forbearance or indulgence.

24. **Notices.** Notices to be given by one party to the other under this Agreement shall be given in writing by personal delivery, by certified mail, return receipt requested, or express delivery service at the addresses specified below. Notices delivered personally shall be deemed received upon receipt; mailed or expressed notices shall be deemed received four (4) days after deposit. A party may change the address to which notice is to be given by giving notice as provided above.

Notice to Physician:	Arman G. Froush, D.O. 3335 East Oregon Avenue Phoenix, Arizona 85035
Notice to Authority:	Kern Medical Center 1700 Mount Vernon Avenue Bakersfield, California 93306 Attn.: Chief Executive Officer

25. **Relationship.** Authority and Physician recognize that Physician is rendering specialized, professional services. The parties recognize that each is possessed of legal knowledge and skill, and that this Agreement is fully understood by the parties, and is the result of bargaining between the parties. Each party acknowledges their opportunity to fully and independently review and consider this Agreement and affirm complete understanding of the effect and operation of its terms prior to entering into the same.

26. **Severability.** Should any part, term, portion or provision of this Agreement be decided finally to be in conflict with any law of the United States or the state of California, or otherwise be unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to constitute the agreement which the parties intended to enter into in the first instance.

27. **Sole Agreement.** This Agreement contains the entire agreement between the parties relating to the services, rights, obligations, and covenants contained herein and assumed by the parties respectively. No inducements, representations, or promises have been made, other than those recited in this Agreement. No oral promise, modification, change, or inducement shall be effective or given any force or effect.

28. **Termination.**

28.1 Termination without Cause. Either party shall have the right to terminate this Agreement, without penalty or cause, by giving not less than 90 days' prior written notice to the other party.

28.2 Immediate Termination. Notwithstanding the foregoing, Authority may terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following events: (i) Authority determines that Physician does not have the proper credentials, experience, or skill to perform the required services under this Agreement; (ii) Authority determines the conduct of Physician in the providing of services may result in civil, criminal, or monetary penalties against Authority or KMC; (iii) Physician violates any federal or state law or regulatory rule or regulation or condition of accreditation or certification to which Authority or Practice Sites is subject; (iv) Physician engages in the commission of a material act involving moral turpitude, fraud, dishonesty, embezzlement, misappropriation or financial dishonesty against Authority or KMC; (v) the actions of Physician result in the loss or threatened loss of KMC's ability to participate in any federal or state health care program, including Medicare or Medi-Cal; (vi) Physician's license to practice medicine in the state of California lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction; (vii) Physician's medical staff privileges are denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or other restriction; (viii) Physician's Controlled Substance Registration Certificate issued by the Drug Enforcement Administration is revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (ix) Physician becomes debarred, excluded, or suspended, or if any other event occurs that makes Physician an Ineligible Person; (x) Physician fails to make a timely disclosure pursuant to paragraph 4.4; (xi) Physician engages in conduct that, in the sole discretion of Authority, is detrimental to patient care or to the reputation or operations of Authority and/or KMC; (xii) Physician breaches the confidentiality provisions of this Agreement; (xiii) Physician dies; (xiv) Physician fails to follow Authority's policies and procedures and other rules of conduct applicable to all employees of Authority, including without limitation, policies prohibiting sexual harassment; or (xv) Physician breaches any covenant set forth in paragraph 4.11.

29. **Effect of Termination.**

29.1 Payment Obligations. In the event of termination of this Agreement for any reason, Authority shall have no further obligation to pay for any services rendered or expenses incurred by Physician after the effective date of the termination, and Physician shall be entitled to receive compensation for services satisfactorily rendered, calculated on a prorated basis up to the effective date of termination.

29.2 Vacate Premises. Upon expiration or earlier termination of this Agreement, Physician shall immediately vacate KMC, removing at such time any and all personal property of Physician. KMC may remove and store, at the expense of Physician, any personal property that Physician has not so removed.

29.3 No Interference. Following the expiration or earlier termination of this Agreement, Physician shall not do anything or cause any person to do anything that might interfere with any efforts by Authority or KMC to contract with any other individual or entity for the provision of services or to interfere in any way with any relationship between KMC and any person who may replace Physician.

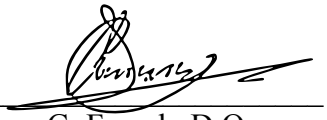
29.4 No Hearing Rights. Termination of this Agreement by Authority or KMC for any reason shall not provide Physician the right to a fair hearing or the other rights more particularly set forth in the KMC medical staff bylaws.

30. **Liability of Authority.** The liabilities or obligations of Authority with respect to its activities pursuant to this Agreement shall be the liabilities or obligations solely of Authority and shall not be or become the liabilities or obligations of the County of Kern or any other entity, including the state of California.

[Signatures follow on next page]

IN WITNESS TO THE FOREGOING, the parties have executed this Agreement as of the day and year first written above.

PHYSICIAN

By 
Arman G. Froush, D.O.

KERN COUNTY HOSPITAL AUTHORITY

By_____
Chairman
Board of Governors

APPROVED AS TO CONTENT:
KERN MEDICAL CENTER

By_____
Russell V. Judd
Chief Executive Officer

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL

By_____
Chief Deputy

Agreement.Froush.100716

EXHIBIT "A"
Job Description
Arman G. Froush, D.O.

The Department of Radiology ("Department") provides professional diagnostic and interventional radiology services to Kern Medical Center and oversees the administration and operation of the diagnostic and interventional radiology, ultrasound, nuclear medicine, and Department administrative services. Key duties center upon providing high quality, timely, and cost effective patient care, offering professional, comprehensive and safe clinical coverage for day-to-day operations, and working collaboratively with staff and hospital administration to ensure efficient workflow, adequacy of support equipment, and a superior patient experience. Physician work effort will be at a minimum 2,500 hours annually in teaching, administrative, and clinical activity.

Position Description: Reports to Chair, Department of Radiology; serves as Chief, Division of Vascular and Interventional Radiology; works collaboratively with the chief technologist in vascular radiology to ensure efficient workflow and adequacy of support equipment.

Essential Functions:

1. Clinical Responsibilities. Physician shall:
   - Provide radiology services on-site at KMC and in accordance with generally accepted professional standards
   - Provide professional services for all patients who present to KMC for treatment
   - Participate in special procedures and in rotations in the various departmental image reading queues
   - Provide weekday shift coverage, as assigned by the Department chair
   - Provide weekend shift coverage, as assigned by the Department chair
   - Provide call coverage weekday nights, as assigned by the Department chair
   - Provide 24-hour weekend call coverage, as assigned by the Department chair
   - Provide first call and backup call for vascular and interventional radiology, as assigned by the Department chair
   - Carry a pager when on call and respond to call within 10 minutes

2. Administrative Responsibilities. Physician shall:
   - Assist in clinical and administrative integration efforts across KMC as appropriate for the department, assisting with proper program planning, physician recruitment, faculty development, resource allocation, analysis, communication and assessment
   - Gather data through best practices and collaborate with other members of the Department to recommend services that will increase productivity, minimize duplication of services, increase workflow efficiency, and provide the highest quality of care to KMC patients
   - Support the Department Chair to develop monitoring tools to measure financial, access, quality and satisfaction outcomes
   - Participate in the preparation, monitoring, review, and performance of clinical activity in the Department

- Participate in the quality improvement and risk management activities, including peer review and quality control functions as assigned to services in the Department
- Complete medical records in a timely fashion and work to improve the quality, accuracy, and completeness of documentation
- Work collaboratively with other clinical departments to further develop a cohesive and collaborative environment across departments with a focus of enhancing access to patient care for inpatient and outpatient services
- Follow and comply with the medical staff bylaws, rules, regulations, and policies, Department rules, policies, and procedures, and Authority and KMC policies and procedures
- Attend department staff meetings and the annual medical staff meeting
- Attend and actively participate in medical staff and hospital committees, as assigned
- Participate in other clinical, academic, and administrative activities, as assigned by the Department chair
- Participate in the training of residents and medical students, including the review of active and past case material as required for patient care
- Participate in proficiency testing and performance improvement programs as required
- Pursue optimized interventional radiology services, development of a comprehensive interventional radiology program, and work cooperatively with other physician specialties that may access the Cath lab
- Participate in additional administrative responsibilities as required

Employment Standards:
Completion of an accredited residency program in diagnostic radiology; completion of a fellowship in vascular and interventional radiology; one (1) year of post-residency experience in diagnostic and interventional radiology
AND
Possession of a current valid Physician's and Surgeon's Certificate issued by the state of California
AND
Certification by the American Osteopathic Association in diagnostic radiology-general certification with certification of added qualifications in vascular/interventional radiology

Knowledge of: The principles and practices of modern medicine; current techniques, procedures, and equipment applicable to the field of diagnostic and interventional radiology; principles of effective supervision and program development.

[Intentionally left blank]

EXHIBIT "B"

AUTHORIZATION TO RELEASE INFORMATION

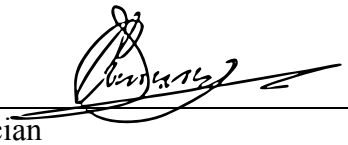
[See attached]

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned physician, hereby authorize Kern Medical Center ("KMC") and its duly authorized representatives to obtain information from time to time about my professional education, training, licensure, credentials competence, ethics and character from any source having such information. This information may include, without limitation, peer review information, DRG and RVU analyses, ancillary usage information and other utilization and quality related data.

I hereby release the Kern County Hospital Authority and KMC, its authorized representatives and any third parties from any liability for actions, recommendations, statements, reports, records or disclosures, including privileged and confidential information, involving me that are made, requested, taken or received by KMC or its authorized representatives to, from or by any third parties in good faith and relating to or arising from my professional conduct, character and capabilities.

I agree that this authorization to release information shall remain effective until termination of my employment by the Kern County Hospital Authority and KMC. A duplicate of this authorization may be relied upon to the same degree as the original by any third party providing information pursuant to this request.



Physician

10/11/2016

Date

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Agreement with Tung Thanh Trang, M.D.

Recommended Action: Approve; Authorize Chairman to sign

Summary:

Kern Medical requests approval to enter into an employment Agreement with Tung Thanh Trang, MD. Dr. Trang has served full-time at Kern Medical since July 2009 in the role as Chief, Division of Otolaryngology in the Department of Surgery. The Agreement is effective November 13, 2016 through November 12, 2019, in an amount not to exceed $1,650,000.

AGREEMENT FOR PROFESSIONAL SERVICES
CONTRACT EMPLOYEE
(Kern County Hospital Authority – Tung Thanh Trang, M.D.)

This Agreement is made and entered into this _____ day of _____, 2016, between the Kern County Hospital Authority, a county hospital authority ("Authority"), which owns and operates Kern Medical Center ("KMC"), and Tung Thanh Trang, M.D. ("Physician").

I.
RECITALS

(a) Authority is authorized, pursuant to section 101852 of Part 4 of Division 101 of the Health and Safety Code, to contract for special services with individuals specially trained, experienced, expert, and competent to perform those services; and

(b) Authority requires the assistance of Physician to provide professional medical services in the Department of Surgery at KMC (the "Department"), as such services are unavailable from Authority resources, and Physician desires to accept employment on the terms and conditions set forth in this Agreement; and

(c) Physician has special training, knowledge and experience to provide such services;

(d) Authority currently contracts with Physician as a contract employee for the provision of professional medical services in the Department and teaching services to resident physicians employed by Authority (Kern County Agt. #837-2012, dated November 12, 2012, as amended and assigned), for the period November 13, 2012 through November 12, 2016; and

(e) Each party expressly understands and agrees that Kern County Agt. #837-2012 is superseded by this Agreement as of the Commencement Date;

NOW, THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth and incorporating by this reference the foregoing recitals, the parties hereto agree as follows:

II.
TERMS AND CONDITIONS

1. **Term.** The initial term of this Agreement ("Initial Term") shall be for a period of three (3) years, commencing as of November 13, 2016 (the "Commencement Date"). At the end of the Initial Term and each Renewal Term (as hereinafter defined), if any, this Agreement may be renewed for additional terms of two (2) years each ("Renewal Term"), but only upon mutual written agreement of the parties. As used herein, the "Term" of this Agreement shall mean the Initial Term and all Renewal Terms. As used herein, an "Employment Year" shall mean the annual period beginning on the Commencement Date and each annual period thereafter.

2. **Employment.** Authority hereby employs Physician as Chief, Division of Otolaryngology and for the practice of medicine in the care and treatment of patients at KMC, or at such other clinic sites as KMC may designate (collectively referred to as the "Practice Sites"). It is expressly understood and agreed that KMC shall have reasonable discretion to consolidate and relocate clinics operated by Authority and to re-designate Practice Sites served by Physician from time to time. Physician shall be subject to Authority's employment policies, directives, rules and regulations as promulgated by Authority from time to time, including, but not limited to, those pertaining to employees.

3. **Representations and Warranties.** Physician represents and warrants to Authority and KMC, upon execution and throughout the Term of this Agreement, as follows: (i) Physician is not bound by any agreement or arrangement which would preclude Physician from entering into, or from fully performing the services required under this Agreement; (ii) Physician's license to practice medicine in the state of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to the terms of probation or other restriction; (iii) Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction; (iv) Physician holds a valid Controlled Substance Registration Certificate issued by the Drug Enforcement Administration that has never been revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (v) Physician is not currently and has never been an Ineligible Person[1]; (vi) Physician is not currently the subject of a disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body; and (vii) Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in the state of California and staff membership and privileges at KMC.

4. **Obligations of Physician.**

4.1 Services. Physician shall engage in the practice of medicine on a full-time basis exclusively as an exempt employee of Authority. Physician shall render those services set forth in Exhibit "A," attached hereto and incorporated herein by this reference.

4.2 Use of Premises. Physician shall use the Practice Sites as designated by Authority or KMC exclusively for the practice of medicine in the care and treatment of patients and shall comply with all applicable federal, state, and local laws, rules and regulations related thereto.

4.3 Qualifications.

4.3.1 Licensure. Physician shall maintain a current valid license to practice medicine in the state of California at all times during the Term of this Agreement.

[1] An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the federal health care programs or in federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the range of activities described in 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

4.3.2 Board Certification. Physician shall be board certified by the American Board of Otolaryngology in otolaryngology-general and maintain such certification at all times during the Term of this Agreement.

4.3.3 Medical Staff Status. Physician shall at all times during the Term of this Agreement be a member in good standing of the KMC medical staff with "active" staff status and hold all clinical privileges on the active medical staff appropriate to the discharge of his obligations under this Agreement.

4.3.4 TJC and ACGME Compliance. Physician shall observe and comply with all applicable standards and recommendations of The Joint Commission and Accreditation Council for Graduate Medical Education.

4.4 Loss or Limitation. Physician shall notify KMC in writing as soon as possible (but in any event within three (3) business days) after any of the following events occur: (i) Physician's license to practice medicine in the state of California lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction; (ii) Physician's medical staff privileges at KMC or any other health care facility are denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or other restriction; (iii) Physician's Controlled Substance Registration Certificate issued by the Drug Enforcement Administration is revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (iv) Physician becomes debarred, excluded, or suspended, or if any other event occurs that makes Physician an Ineligible Person; (v) Physician becomes the subject of a disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body; or (vi) an event occurs that substantially interrupts all or a portion of Physician's professional practice or that materially adversely affects Physician's ability to perform Physician's obligations hereunder.

4.5 Standards of Medical Practice. The standards of medical practice and professional duties of Physician at designated Practice Sites shall be in accordance with the KMC medical staff bylaws, rules, regulations, and policies, the standards for physicians established by the state Department of Public Health and all other state and federal laws and regulations relating to the licensure and practice of physicians, and The Joint Commission.

4.6 Managed Care Organizations. For and on behalf of Physician, Authority shall have the sole and exclusive right and authority to enter into contractual relationships with HMOs, IPAs, PPOs, PHOs, employer groups, provider networks and other managed care organizations (collectively "Managed Care Organizations"). Physician shall provide the same quality of care to patients from Managed Care Organizations as is provided to other KMC patients. Upon request from Authority or KMC, Physician shall execute Managed Care Organization documents as "provider" if deemed necessary or advisable by Authority. Physician shall not contract with any Managed Care Organization without Authority's prior written consent in each instance.

4.7 Authorization to Release Information. Physician hereby authorizes Managed Care Organizations, government programs, hospitals and other third parties to release to KMC and its agents any information requested by KMC or its agents from time to time relating to

Physician's professional qualifications or competency. Physician agrees to execute the Authorization to Release Information in the form set forth in Exhibit "B," attached hereto and incorporated herein by this reference, and to execute all other documents required by KMC from time to time and to otherwise fully cooperate with KMC to enable KMC and its agents to obtain such information from third parties.

4.8 Medical Records. Physician shall cause a complete medical record to be timely prepared and maintained for each patient seen by Physician. This record shall be prepared in compliance with all state and federal regulations, standards of The Joint Commission, and the KMC medical staff bylaws, rules, regulations, and policies. Documentation by Physician shall conform to the requirements for evaluation and management (E/M) services billed by teaching physicians set forth in the Medicare Carriers Manual, Part 3, sections 15016–15018, inclusive. All patient medical records of Practice Sites, including without limitation, patient medical records generated during the Term of this Agreement, shall be the property of KMC subject to the rights of the respective patients. Upon the expiration or termination of this Agreement by either party for any reason, KMC shall retain custody and control of such patient medical records.

4.9 Physician Private Practice. Physician understands and agrees that he shall not enter into any other physician employment contract or otherwise engage in the private practice of medicine or provide similar services to other organizations, directly or indirectly, during the Term of this Agreement or any extensions thereof.

4.10 Proprietary Information. Physician acknowledges that during the Term of this Agreement Physician will have contacts with and develop and service KMC patients and referring sources of business of KMC. In all of Physician's activities, Physician, through the nature of his work, will have access to and will acquire confidential information related to the business and operations of KMC, including, without limiting the generality of the foregoing, patient lists and confidential information relating to processes, plans, methods of doing business and special needs of referring doctors and patients. Physician acknowledges that all such information is solely the property of KMC and constitutes proprietary and confidential information of KMC; and the disclosure thereof would cause substantial loss to the goodwill of KMC; and that disclosure to Physician is being made only because of the position of trust and confidence that Physician will occupy. Physician covenants that, except as required by law, Physician will not, at any time during the Term or any time thereafter, disclose to any person, hospital, firm, partnership, entity or organization (except when authorized in writing by KMC) any information whatsoever pertaining to the business or operations of KMC, any affiliate thereof or of any other physician employed by KMC, including without limitation, any of the kinds of information described in this paragraph.

4.11 Physician Covenants. Physician covenants that from the Commencement Date and continuing throughout the Term of this Agreement, Physician, unless otherwise permitted by the written consent of Authority shall not, on Physician's own account or as an employee, landlord, lender, trustee, associate, consultant, partner, agent, principal, contractor, owner, officer, director, investor, member or stockholder of any other person, or in any other capacity, directly or indirectly, in whole or in part: (i) engage in any activities that are in competition with

KMC, including the operation of any medical practice or offering of any medical services that are similar to services offered at the Practice Sites; (ii) solicit or encourage the resignation of any employee of Authority or KMC with whom Physician had a working relationship during Physician's employment with Authority; (iii) solicit or divert patients with whom Physician had personal contact during such employment; or (iv) influence or attempt to influence any payer, provider or other person or entity to cease, reduce or alter any business relationship with Authority or KMC relating to the Practice Sites.

5. **Compensation Package.**

5.1 Annual Compensation. Physician shall work full time, which is a minimum of 40 hours per week, and will be compensated with cash and other value as described below in this paragraph 5.1 ("Annual Salary").

5.1.1 Base Salary. Authority shall pay Physician an Annual Salary comprised of the following: (i) a base salary for teaching and administrative services as Chief, Division of Otolaryngology in the amount of $52,336 per year; and (ii) payment for care of KMC patients using the current Medical Group Management Association Physician Compensation and Production Survey. KMC has chosen to use the full time physician compensation with more than one year in the specialty for all physicians section. This section is divided into four categories: 25th percentile, median, 75th percentile and 90th percentile. A conversion factor will be established by taking each category and dividing the physician compensation in that category by the worked relative value unit ("Worked RVU") in that category. Physician will be compensated for each Worked RVU by multiplying the Worked RVU by the median conversion factor for each KMC patient ("RVU Effort").

5.1.2 Salary Adjustment. KMC will establish an estimate ("Estimate") of Physician's RVU Effort using Physician's RVU Effort for the immediately preceding 12-month period annualized. The Estimate will be divided by the number of Authority payroll periods in a calendar year in order to calculate the amount of RVU Effort to be paid to Physician each payroll period (the "Paycheck Amount"). Within 30 days after the end of each quarter, KMC will calculate the RVU Effort for such immediately preceding quarter, and adjust the payment for RVU Effort accordingly (the "Actual Amount"). If the Estimate is lower than the Actual Amount, then such difference shall be paid to Physician within 30 days after such calculation has been completed, or as of the effective date of any termination of this Agreement, whichever occurs sooner. If the Estimate exceeds the Actual Amount, then Physician shall pay such difference to KMC: (i) in a lump sum within 30 days after such calculation has been completed; or (ii) through a reduction in the Paycheck Amount during the next quarter; or (iii) in a lump sum as of the effective date of any termination of this Agreement, whichever occurs sooner. The Estimate shall be reestablished as of each Employment Year. **Physician hereby expressly grants to KMC the right to offset any amounts owed to KMC against any payment to be made to Physician by KMC pursuant to this paragraph if Physician fails to pay such excess to KMC.**

5.1.3 Biweekly Payment. Physician shall be paid biweekly on the same schedule as regular Authority employees. The exact date of said biweekly payments shall be at the sole discretion of Authority. All payments made by Authority to Physician shall be subject to all applicable federal and state taxes and withholding requirements.

5.2 Limitations on Compensation. Authority shall exclude from payment for care of KMC patients any Worked RVU that is not reimbursed by Medicare or Medi-Cal, unless authorized in advance by KMC.

5.3 Call Coverage. Authority will pay Physician a fixed fee in the amount of $300 per 24-hour day for ENT emergency coverage when Physician is physically present at KMC but not assigned to be on call.

5.4 Professional Fee Billing.

5.4.1 Assignment. KMC shall have the exclusive right and authority to set, bill, collect and retain all fees, including professional fees, for all direct patient care services provided by Physician during the Term of this Agreement. All professional fees generated by Physician during the Term of this Agreement, including without limitation, both cash collections and accounts receivable, capitated risk pool fees, professional retainer fees, honoraria, professional consulting and teaching fees, and fees for expert testimony (but excluding Physician's private investment and nonprofessional income, intellectual property developed or work on similar development projects prior to the Commencement Date, and industry consulting, which includes honoraria, cadaver labs, professional speaking, expert witness, and teaching fees), will be the sole and exclusive property of KMC, whether received by KMC or by Physician and whether received during the Term of this Agreement or anytime thereafter. Physician hereby assigns all rights to said fees and accounts to KMC and shall execute all documents required from time to time by KMC and otherwise fully cooperate with KMC to enable KMC to collect fees and accounts from patients and third-party payers.

5.4.2 Remittance of Professional Fee Charges. Physician shall remit all professional fee charges to KMC within 45 days of the date direct patient care services are provided by Physician. Any professional fee charges not remitted by Physician to KMC within 45 days of the date of such service, or any charges for which relevant documentation has not been provided, will not be credited to Physician as Worked RVU.

5.4.3 Non-physician Medical Practitioners. KMC shall have the exclusive right and authority to set, bill, collect and retain all fees, including professional fees, for all billable services provided by non-physician medical practitioners (defined as physician assistants, nurse practitioners, and nurse midwives; pharmacists and all other allied health professionals are specifically excluded from the definition of non-physician medical practitioners) employed by Authority during the Term of this Agreement. KMC will pay Physician for supervision of physician assistants, nurse practitioners, and nurse midwives at 30% of professional fee net collections for supervision of direct patient care provided by these specific non-physician medical practitioners.

5.5 Maximum Payable. The maximum compensation payable under this Agreement shall not exceed $1,622,000 over the three-year Initial Term of this Agreement.

6. **Benefits Package.**

6.1 Retirement. Physician shall continue to participate in the Kern County Hospital Authority Defined Contribution Plan for Physician Employees (f/k/a the Kern County Pension Plan for Physician Employees) (the "Plan"), a qualified defined contribution pension plan, pursuant to the terms of the instrument under which the Plan has been established, as from time to time amended. Physician is not eligible to participate in any other retirement plan established by Authority for its employees, including but not limited to the Kern County Employees' Retirement Association, and this Agreement does not confer upon Physician any right to claim entitlement to benefits under any such retirement plan(s).

6.2 Health Care Coverage. Physician shall continue to receive the same health benefits (medical, dental, prescription and vision coverage) as all eligible Authority employees. The employee share of cost is 20% of the current biweekly premium. Physician's initial hire date is the initial opportunity to enroll in the health plan. Physician must work at least 40 hours per biweekly pay period to be eligible for coverage.

6.3 Holidays. Physician shall be entitled to all paid holidays authorized as official holidays for Authority employees. A holiday occurring on a Sunday shall be observed on the following Monday and a holiday occurring on a Saturday shall be observed on the preceding Friday. In the event Physician is scheduled for and works on a holiday, he shall be entitled to an equivalent period of time off at a later date.

6.4 Vacation. Physician shall retain his vacation leave credit balance, if any, as of the Commencement Date. Effective with the Commencement Date, Physician shall be credited with vacation leave of 6.15 hours for each pay period of service, for a maximum accrual of 160 hours per year. Vacation leave will accrue from the Commencement Date and may be taken at any time thereafter. Total unused vacation leave accumulated will not exceed a maximum of 320 hours. No further vacation leave will accrue as long as Physician has the maximum number of hours credited. The Department chair must approve all vacation leave in advance. Physician shall be paid for accrued and unused vacation leave, if any, upon termination or expiration of this Agreement calculated at Physician's current hourly rate (i.e., current Annual Salary divided by 2080 hours = hourly rate). All payments made by Authority to Physician under this paragraph will be subject to all applicable federal and state taxes and withholding requirements.

6.5 Sick Leave. Physician shall retain his sick leave credit balance, if any, as of the Commencement Date. Effective with the Commencement Date, Physician shall accrue sick leave in accordance with Authority policy, as amended from time to time. Physician will not be paid for accrued and unused sick leave upon termination of employment.

6.6 Education Leave. Physician shall receive 80 hours paid education leave annually. The first 80 hours will accrue on the Commencement Date. On each successive Employment Year, if any, an additional 80 hours paid education leave will accrue. Education leave must be

used within the year that it is accrued. Physician will not be paid for unused education leave upon termination of employment. The Department chair must approve education leave in advance of use. Physician's participation in educational programs, services or other approved activities set forth herein shall be subordinate to Physician's obligations and duties under this Agreement.

6.7 CME Expense Reimbursement. Authority shall reimburse Physician for all approved reasonable and necessary expenditures related to continuing medical education in an amount not to exceed $2,500 per Employment Year, payable in arrears, in accordance with Authority policy, as amended from time to time. This amount may not be accumulated or accrued and does not continue to the following Employment Year.

6.8 Kern$Flex. Physician shall be eligible to participate in flexible spending plans to pay for dependent care, non-reimbursed medical expenses, and certain insurance premiums on a pre-tax basis through payroll deduction. This is a voluntary benefit that is paid by Physician if he elects to participate in the plan.

6.9 Attendance at Meetings. Physician shall be permitted to be absent from KMC during normal working days to attend professional meetings and to attend to such outside professional duties in the healthcare field as may be mutually agreed upon between Physician and the Department chair. Attendance at such approved meetings and accomplishment of approved professional duties shall be fully compensated service time and will not be considered vacation or education leave.

6.10 Unpaid Leave of Absence. Physician may take an unpaid leave of absence in accordance with Authority policies in effect at the time the leave is taken.

6.11 Social Security. Physician is exempt from payment of Social Security taxes as the Kern County Hospital Authority Pension Plan for Physician Employees is a qualified alternative to the insurance system established by the federal Social Security Act.

6.12 Deferred Compensation. Physician shall be eligible to participate in the Kern County Deferred Compensation Plan ("457 Plan") on a pre-tax basis. Physician shall make all contributions if he elects to participate in the 457 Plan.

6.13 Disability Insurance. Physician shall be eligible to purchase Long Term Disability or Short Term Disability insurance coverage through payroll deduction on a post-tax basis. This is a voluntary benefit that is paid by Physician if he elects to participate in the plan.

6.14 Employee Assistance/Wellness Programs. Physician shall be eligible to participate in any Authority-sponsored employee assistance and employee wellness programs.

6.15 Limitation on Benefits. Except as expressly stated herein, Physician shall receive no other benefits from Authority.

7. **Assignment.** Physician shall not assign or transfer this Agreement or his obligations hereunder or any part thereof. Physician shall not assign any money due or which becomes due to Physician under this Agreement without the prior written approval of Authority.

8. **Assistance in Litigation.** Upon request, Physician shall support and assist Authority as a consultant or expert witness in litigation to which Authority is a party.

9. **Authority to Bind Authority.** It is understood that Physician, in his performance of any and all duties under this Agreement, has no authority to bind Authority or KMC to any agreements or undertakings.

10. **Captions and Interpretation.** Paragraph headings in this Agreement are used solely for convenience, and shall be wholly disregarded in the construction of this Agreement. No provision of this Agreement shall be interpreted for or against a party because that party or its legal representative drafted such provision, and this Agreement shall be construed as if jointly prepared by the parties.

11. **Choice of Law/Venue.** This Agreement shall be construed and enforced under and in accordance with the laws of the state of California, with venue of any action relating to this Agreement in the County of Kern, state of California.

12. **Compliance with Law.** Physician shall observe and comply with all applicable Authority, local, state and federal laws, ordinances, rules and regulations now in effect or hereafter enacted, each of which is hereby made a part hereof and incorporated herein by reference.

13. **Confidentiality.** Physician shall maintain confidentiality with respect to information that he receives in the course of his employment and not use or permit the use of or disclose any such information in connection with any activity or business to any person, firm or corporation whatsoever, unless such disclosure is required in response to a validly issued subpoena or other process of law or as required by Government Code section 6250 et seq. Upon completion of the Agreement, the provisions of this paragraph shall continue to survive.

14. **Conflict of Interest.** Physician covenants that he has no interest and that he will not acquire any interest, direct or indirect, that represents a financial conflict of interest under state law (Gov. Code, § 81000 et seq.) or that would otherwise conflict in any manner or degree with the performance of his services hereunder. It is understood and agreed that if such a financial interest does exist at the inception of this Agreement, Authority may immediately terminate this Agreement by giving written notice thereof.

15. **Counterparts.** This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

16. **Dispute Resolution.** In the event of any dispute involving the enforcement or interpretation of this Agreement or any of the rights or obligations arising hereunder, the parties

shall first attempt to resolve their differences by mediation before a mediator of their mutual selection. If the parties are, after mutual good faith efforts, unable to resolve their differences by mediation, the dispute shall be submitted for trial before a privately compensated temporary judge appointed by the Kern County Superior Court pursuant to Article VI, section 21 of the California Constitution and Rules 3.810 through 3.830 of the California Rules of Court. All costs of any dispute resolution procedure shall be borne equally by the parties.

17. **Enforcement of Remedies.** No right or remedy herein conferred on or reserved to Authority is exclusive of any other right or remedy herein or by law or equity provided or permitted, but each shall be cumulative of every other right or remedy given hereunder or now or hereafter existing by law or in equity or by statute or otherwise, and may be enforced concurrently or from time to time.

18. **Indemnification.** Authority shall assume liability for and indemnify and hold Physician harmless from any and all claims, losses, expenses, costs, actions, settlements, attorneys' fees and judgments incurred by Physician or for which Physician becomes liable, arising out of or related to services rendered or which a third party alleges should have been rendered by Physician pursuant to this Agreement. Authority's obligation under this paragraph shall extend from Physician's first date of service to Authority and shall survive termination or expiration of this Agreement to include all claims that allegedly arise out of services Physician rendered on behalf of Authority; provided, however, that the provisions of this paragraph shall not apply to any services rendered at any location other than Practice Sites without approval by the Kern County Hospital Authority Board of Governors and, provided further, that Authority shall have no duty or obligation to defend, indemnify, or hold Physician harmless for any conduct or misconduct found to be intentional, willful, grossly negligent, or criminal.

19. **Invalidity of a Portion.** Should a portion, section, paragraph, or term of this Agreement be construed as invalid by a court of competent jurisdiction, or a competent state or federal agency, the balance of the Agreement shall remain in full force and effect. Further, to the extent any term or portion of this Agreement is found invalid, void or inoperative, the parties agree that a court may construe the Agreement in such a manner as will carry into force and effect the intent appearing herein.

20. **Modifications of Agreement.** This Agreement may be modified in writing only, signed by the parties in interest at the time of the modification.

21. **Non-appropriation.** Authority reserves the right to terminate this Agreement in the event insufficient funds are appropriated or budgeted for this Agreement in any fiscal year. Upon such termination, Authority will be released from any further financial obligation to Physician, except for services performed prior to the date of termination or any liability due to any default existing at the time this clause is exercised. Physician shall be given 30 days' prior written notice in the event that Authority requires such an action.

22. **Nondiscrimination.** No party to this Agreement shall discriminate on the basis of race, color, religion, sex, national origin, age, marital status or sexual orientation, ancestry, physical or mental disability, medical conditions, political affiliation, veteran's status, citizenship or marital

or domestic partnership status or on the basis of a perception that an individual is associated with a person who has, or is perceived to have, any of these characteristics.

23. **Non-waiver.** No covenant or condition of this Agreement can be waived except by the written consent of Authority. Forbearance or indulgence by Authority in any regard whatsoever shall not constitute a waiver of the covenant or condition to be performed by Physician. Authority shall be entitled to invoke any remedy available to Authority under this Agreement or by law or in equity despite said forbearance or indulgence.

24. **Notices.** Notices to be given by one party to the other under this Agreement shall be given in writing by personal delivery, by certified mail, return receipt requested, or express delivery service at the addresses specified below. Notices delivered personally shall be deemed received upon receipt; mailed or expressed notices shall be deemed received four (4) days after deposit. A party may change the address to which notice is to be given by giving notice as provided above.

Notice to Physician:	Notice to County:
Tung Thanh Trang, M.D. 8805 Montmedy Court Bakersfield, California 93311	Kern Medical Center 1700 Mount Vernon Avenue Bakersfield, California 93306 Attn.: Chief Executive Officer

25. **Relationship.** Authority and Physician recognize that Physician is rendering specialized, professional services. The parties recognize that each is possessed of legal knowledge and skill, and that this Agreement is fully understood by the parties, and is the result of bargaining between the parties. Each party acknowledges their opportunity to fully and independently review and consider this Agreement and affirm complete understanding of the effect and operation of its terms prior to entering into the same.

26. **Severability.** Should any part, term, portion or provision of this Agreement be decided finally to be in conflict with any law of the United States or the state of California, or otherwise be unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to constitute the agreement which the parties intended to enter into in the first instance.

27. **Sole Agreement.** This Agreement contains the entire agreement between the parties relating to the services, rights, obligations, and covenants contained herein and assumed by the parties respectively. No inducements, representations, or promises have been made, other than those recited in this Agreement. No oral promise, modification, change, or inducement shall be effective or given any force or effect.

28. **Termination.**

28.1 Termination without Cause. Either party shall have the right to terminate this Agreement, without penalty or cause, by giving not less than 120 days' prior written notice to the other party.

28.2 Immediate Termination. Notwithstanding the foregoing, Authority may terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following events: (i) Authority determines that Physician does not have the proper credentials, experience, or skill to perform the required services under this Agreement; (ii) Authority determines the conduct of Physician in the providing of services may result in civil, criminal, or monetary penalties against Authority or KMC; (iii) Physician violates any federal or state law or regulatory rule or regulation or condition of accreditation or certification to which Authority or Practice Sites is subject; (iv) Physician engages in the commission of a material act involving moral turpitude, fraud, dishonesty, embezzlement, misappropriation or financial dishonesty against Authority or KMC; (v) the actions of Physician result in the loss or threatened loss of KMC's ability to participate in any federal or state health care program, including Medicare or Medi-Cal; (vi) Physician's license to practice medicine in the state of California lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction; (vii) Physician's medical staff privileges are denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or other restriction; (viii) Physician's Controlled Substance Registration Certificate issued by the Drug Enforcement Administration is revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way; (ix) Physician becomes debarred, excluded, or suspended, or if any other event occurs that makes Physician an Ineligible Person; (x) Physician fails to make a timely disclosure pursuant to paragraph 4.4; (xi) Physician engages in conduct that, in the sole discretion of Authority, is detrimental to patient care or to the reputation or operations of Authority and/or KMC; (xii) Physician breaches the confidentiality provisions of this Agreement; (xiii) Physician dies; (xiv) Physician fails to follow Authority's policies and procedures and other rules of conduct applicable to all employees of Authority, including without limitation, policies prohibiting sexual harassment; or (xv) Physician breaches any covenant set forth in paragraph 4.11.

29. **Effect of Termination.**

29.1 Payment Obligations. In the event of termination of this Agreement for any reason, Authority shall have no further obligation to pay for any services rendered or expenses incurred by Physician after the effective date of the termination, and Physician shall be entitled to receive compensation for services satisfactorily rendered, calculated on a prorated basis up to the effective date of termination.

29.2 Vacate Premises. Upon expiration or earlier termination of this Agreement, Physician shall immediately vacate KMC, removing at such time any and all personal property of Physician. KMC may remove and store, at the expense of Physician, any personal property that Physician has not so removed.

29.3 No Interference. Following the expiration or earlier termination of this Agreement, Physician shall not do anything or cause any person to do anything that might interfere with any efforts by Authority or KMC to contract with any other individual or entity for the provision of services or to interfere in any way with any relationship between KMC and any person who may replace Physician.

29.4 No Hearing Rights. Termination of this Agreement by Authority or KMC for any reason shall not provide Physician the right to a fair hearing or the other rights more particularly set forth in the KMC medical staff bylaws.

30. **Liability of Authority.** The liabilities or obligations of Authority with respect to its activities pursuant to this Agreement shall be the liabilities or obligations solely of Authority and shall not be or become the liabilities or obligations of the County of Kern or any other entity, including the state of California.

[Signatures follow on next page]

IN WITNESS TO THE FOREGOING, the parties have executed this Agreement as of the day and year first written above.

PHYSICIAN

By_____
Tung Thanh Trang, M.D.

KERN COUNTY HOSPITAL AUTHORITY

By_____
Chairman
Board of Governors

APPROVED AS TO CONTENT:
KERN MEDICAL CENTER

By_____
Russell V. Judd
Chief Executive Officer

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL

By_____
Chief Deputy

Agreement.Trang.101216

EXHIBIT "A"
Job Description
Tung Thanh Trang, M.D.

Position: Chief, Division of Otolaryngology.

Position Description: Reports to Chair, Department of Surgery; serves as the chief physician responsible for efficient, key program development, day to day operations and resident education within the Department for the otolaryngology division at KMC; serves as a full-time faculty member in the Department.

Essential Functions:

1. Clinical Responsibilities.
    - Serves as attending physician in the Division of Otolaryngology
    - Supervises residents and medical students assigned to the otolaryngology service
    - Performs otolaryngology procedures
    - Inpatient rounds – five (5) days per week
    - ENT clinic – two (2) days per week, one (1) clinic session per day up to a maximum of 40 weeks
    - ENT call coverage – weekday coverage, Monday through Thursday, one (1) in four (4) weekdays up to a maximum of 52 weekday call shifts per year and weekend coverage of one (1) in four (4) weekends up to a maximum of 13 weekends per year

2. Administrative Responsibilities.
    - Serves as Chief, Division of Otolaryngology
    - Serves as Director, Otolaryngology Consultative Service
    - Serves as Director, Otolaryngology Clinic Service
    - Serves as Director, Otolaryngology Quality Program
    - Determines equipment needs for the otolaryngology surgical service
    - Trains ancillary personnel assigned to the otolaryngology service
    - Attends and actively participates in assigned medical staff and hospital committee

3. Teaching Responsibilities.
    - Serves as director of otolaryngology education
    - Serves as director of otolaryngology research
    - Prepares residents for oral boards and reviews case logs
    - Assists in resident mentoring, counseling, and evaluation
    - Didactic talks/lectures – a minimum of six (6) per year

Employment Standards:
One (1) year of post-residency experience in otolaryngology
AND
Possession of a current valid Physician's and Surgeon's Certificate issued by the state of California
AND

Certification by the American Board of Otolaryngology in otolaryngology-general

Knowledge of: The principles and practices of modern medicine; current techniques, procedures, and equipment applicable to otolaryngology; principles of effective supervision and program development.

Ability to: Plan, organize, direct and coordinate otolaryngology services; perform invasive otolaryngological endoscopic and surgical procedures; supervise and instruct professional and technical personnel; develop and present educational programs for interns, residents and ancillary medical staff; maintain records and prepare comprehensive reports; work effectively with staff, patients, and others.

[Intentionally left blank]

EXHIBIT "B"

AUTHORIZATION TO RELEASE INFORMATION

[See attached]

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned physician, hereby authorize Kern Medical Center ("KMC") and its duly authorized representatives to obtain information from time to time about my professional education, training, licensure, credentials competence, ethics and character from any source having such information. This information may include, without limitation, peer review information, DRG and RVU analyses, ancillary usage information and other utilization and quality related data.

I hereby release the Kern County Hospital Authority and KMC, its authorized representatives and any third parties from any liability for actions, recommendations, statements, reports, records or disclosures, including privileged and confidential information, involving me that are made, requested, taken or received by KMC or its authorized representatives to, from or by any third parties in good faith and relating to or arising from my professional conduct, character and capabilities.

I agree that this authorization to release information shall remain effective until termination of my employment by the Kern County Hospital Authority and KMC. A duplicate of this authorization may be relied upon to the same degree as the original by any third party providing information pursuant to this request.

_____ _____

Physician Date

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed retroactive amended and restated Kern County Hospital Authority defined contribution Plan for Physician Employees

Recommended Action: Approve; Adopt Resolution; Authorize Chairman to Sign Plan Document

Summary:

The County of Kern established the Kern County Pension Plan for Physician Employees (the "Plan"), effective August 1, 1980, in order to provide retirement and other incidental benefits to eligible physician employees of Kern Medical. The Plan is a defined contribution, money purchase pension plan, intended to meet the applicable requirements of Section 401(a) of the Internal Revenue Code. The Plan was most recently restated effective January 1, 2013.

In June 2016, the Plan was transferred to and assumed by the authority, as Plan sponsor effective July 1, 2016, in connection with the transfer of ownership of Kern Medical to the authority by the county.

In 2015, the county applied for an updated favorable determination of the Plan's tax-qualified status. On September 15, 2016, the IRS issued a favorable determination letter for the Plan. This favorable determination is conditioned on your Board adopting a restatement of the Plan on or before December 14, 2016.

Therefore it is recommended that your Board approve the restated Plan as the Kern County Hospital Authority Defined Contribution Plan for Physician Employees, effective July 1, 2016, adopt the attached resolution, and authorize the Chairman to sign the restated Plan document.

BEFORE THE BOARD OF GOVERNORS
OF THE KERN COUNTY HOSPITAL AUTHORITY

In the matter of: Resolution No. _____

APPROVAL OF KERN COUNTY HOSPITAL AUTHORITY DEFINED CONTRIBUTION PLAN FOR PHYSICIAN EMPLOYEES (AS AMENDED AND RESTATED EFFECTIVE JULY 1, 2016)

I, RAQUEL D. FORE, Authority Board Coordinator for the Kern County Hospital Authority, hereby certify that the following Resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the Board of Governors of the Kern County Hospital Authority at an official meeting thereof on the 19th day of October, 2016, by the following vote, and that a copy of the Resolution has been delivered to the Chairman of the Board of Governors.

AYES:

NOES:

ABSENT:

RAQUEL D. FORE
Authority Board Coordinator
Kern County Hospital Authority

_____
Raquel D. Fore

RESOLUTION

Section 1. WHEREAS:

(a) The County of Kern, a political subdivision of the state of California, established the Kern County Pension Plan for Physician Employees (the "Plan"), effective August 1, 1980, in order to provide retirement and other incidental benefits to eligible physician employees of the Kern Medical Center; and

(b) The Plan was most recently restated effective January 1, 2013; and

(c) The Plan was transferred to and assumed by the Kern County Hospital Authority, a political subdivision of the state of California, as Plan sponsor effective July 1, 2016, in connection with the transfer of ownership of the Kern Medical Center to the Kern County Hospital Authority by the County of Kern; and

(d) The Plan is again hereby restated in its entirety, effective July 1, 2016 (except as otherwise stated therein), as the Kern County Hospital Authority Defined Contribution Plan for Physician Employees; and

(e) The Plan is a defined contribution, money purchase pension plan, intended to meet the applicable requirements of Section 401(a) of the Internal Revenue Code.

Section 2. NOW, THEREFORE, IT IS HEREBY RESOLVED by the Board of Governors of the Kern County Hospital Authority, as follows:

1. This Board finds the facts recited herein are true, and further finds that this Board has jurisdiction to consider, approve, and adopt the subject of this Resolution.

2. This Board hereby approves and adopts the Kern County Hospital Authority Defined Contribution Plan for Physician Employees (As Amended and Restated Effective July 1, 2016).

3. The Authority Board Coordinator shall provide copies of this Resolution to the following:

Office of County Counsel
Kern Medical Center
Pension Committee
Wells Fargo Bank, National Association
RBC Wealth Management
TIAA-CREF

KERN COUNTY HOSPITAL AUTHORITY
DEFINED CONTRIBUTION PLAN FOR PHYSICIAN EMPLOYEES

(As Amended and Restated Effective July 1, 2016)

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KERN COUNTY HOSPITAL AUTHORITY
DEFINED CONTRIBUTION PLAN FOR PHYSICIAN EMPLOYEES

(As Amended and Restated Effective July 1, 2016)

ARTICLE 1

INTRODUCTION

The County of Kern, a political subdivision of the state of California, established the Kern County Pension Plan for Physician Employees (the "Plan"), effective August 1, 1980, in order to provide retirement and other incidental benefits to eligible Physicians. The Plan was most recently restated effective January 1, 2013. The Plan was transferred to and assumed by the Kern County Hospital Authority as Plan sponsor effective July 1, 2016, in connection with the transfer of ownership of the Kern Medical Center to the Hospital Authority by the County of Kern. The Plan is again hereby restated in its entirety, effective July 1, 2016 (except as otherwise stated herein), as the Kern County Hospital Authority Defined Contribution Plan for Physician Employees. The Plan is a defined contribution, money purchase pension plan, intended to meet the applicable requirements of Section 401(a) of the Code. Capitalized terms used in the Plan are defined in Article 2.

ARTICLE 2

DEFINITIONS

2.1 "Account" means the account established for a Participant to reflect the Participant's interest under the Plan and to which any Employer Contributions, Mandatory Employee Contributions and any attributable investment income and gains are credited, and any allocable expenses, investment losses and distributions are debited.

2.2 "Affiliate" means a member of a controlled group of corporations (as defined in Code section 414(b)), a group of commonly controlled trade or business (as defined in Code section 414(c)), or an affiliated service group (as defined in Code section 414(m)) of which the Hospital Authority is a member, and any other entity required to be aggregated with the Hospital Authority pursuant to Code section 414(o). For purposes of applying the limitation on Annual Additions in Section 4.7, Code sections 414(b) and (c) are modified by Code section 415(h).

2.3 "Alternate Payee" means any Spouse, former Spouse, child or other dependent of a Participant, who is recognized by a QDRO as having a right to receive all, or a portion of, the benefits payable with respect to a Participant.

2.4 "Annuity Contract" means a written contract issued by an Insurer in accordance with Code sections 401(f) and (g) pursuant to which the Insurer will hold, administer and distribute all or a portion of the Plan assets.

2.5 "Beneficiary" means the person or persons designated by the Participant in writing, at the time and manner specified by the Pension Committee, to receive the Participant's Account balance upon the Participant's death. In order to be valid, a Beneficiary designation must be received by the Pension Committee or its designee prior to the Participant's death. The Participant has a right to change or revoke a Beneficiary designation from time to time by filing a new designation or notice of revocation. If the Participant has a Spouse or Domestic Partner, the Participant's designation of a Beneficiary other than the Spouse or Domestic Partner is valid only if the Participant files the written notarized consent of the Spouse or Domestic Partner at the specified time and manner. If a Participant marries or enters into a registered domestic partnership, the Participant's prior designation of a Spouse or Domestic Partner will automatically terminate. If a Participant ceases to be married to, or in a domestic partnership with, a designated Beneficiary, the Participant must file a new Beneficiary designation in order to designate a different Beneficiary. If no designated Beneficiary survives the Participant, the portion of the Participant's Account balance which otherwise would have been distributed to the designated Beneficiary will be paid to the contingent Beneficiary, if any, designated by the Participant in accordance with the requirements of this section. If the Participant does not have a valid Beneficiary designation on file with the Pension Committee or its designee at the time of the Participant's death, or no designated Beneficiary or contingent Beneficiary survives the Participant, the Beneficiary will be the Participant's surviving Spouse or Domestic Partner or, if there is no surviving Spouse or Domestic Partner, the Participant's estate.

2.6 "Code" means the Internal Revenue Code of 1986, as amended.

2.7 "Compensation" means wages, salaries, fees for professional services and other amounts paid by the Hospital Authority to a Participant for his or her services as an Eligible Physician, to the extent amounts are includible in gross income (or to the extent amounts would have been received and includible in gross income but for an election under Code sections 125(a), 132(f)(4), 402(e)(3), 402(h)(1)(B), 402(k) or 457(b)). Compensation will be taken into account for any Plan Year for which it is earned, regardless of when paid. A Participant's Compensation is determined subject to the following provisions:

(a) Compensation includes:

(1) amounts described in Code sections 104(a)(3), 105(a), or 105(h), but only to the extent the amounts are includible in the gross income of the Physician;

(2) amounts paid or reimbursed by the Hospital Authority for moving expenses incurred by a Physician, but only to the extent that at the time of the payment it is reasonable to believe that these amounts are not deductible by the Physician under Code section 217;

(3) amounts includible in the gross income of a Physician upon making the election described in Code section 83(b); and

(4) amounts that are includible in the gross income of a Physician under the rules of Code section 409A or 457(f)(1)(A) or because the amounts are constructively received by the Physician.

(b) Compensation excludes:

(1) contributions (other than elective contributions described in Code sections 402(e)(3), 408(k)(6), 408(p)(2)(A)(i) or 457(b)) made by the Hospital Authority to a plan of deferred compensation (including a simplified employee pension described in Code section 408(k) or a simple retirement account described in Code section 408(p), and whether or not qualified) to the extent that the contributions are not includible in gross income of the Physician for the taxable year in which contributed;

(2) any distributions from a plan of deferred compensation (whether or not qualified) regardless of whether such amounts are includible in the gross income of the Physician when distributed; provided, however, that any amounts received by a Physician pursuant to a nonqualified unfunded deferred compensation plan are includible in Compensation in the year the amounts are actually received, but only to the extent such amounts are includible in the Physician's gross income;

(3) other amounts which receive special tax benefits, such as premiums for group term life insurance (but only to the extent the premiums are not includible in the gross income of the Physician and are not salary reduction amounts described in Code section 125); and

(4) other items of remuneration that are similar to any of the items listed in paragraph (1) through (3) of this subsection.

(c) The annual Compensation of each Participant taken into account for any Plan Year may not exceed $200,000, as adjusted for cost-of-living increases in accordance with Code section 401(a)(17)(B); provided, however, that the annual Compensation limit does not apply to any Participant who first became a Participant prior to August 1, 1994. If a Plan Year consists of fewer than 12 months, the annual Compensation limit is an amount equal to the otherwise applicable annual Compensation limit multiplied by a fraction, the numerator of which is the number of months in that short Plan Year, and the denominator of which is 12.

2.8 "Determination Period Compensation" means with respect to each Full-Time Physician for a Plan Year:

(a) If the Full-Time Physician was an Eligible Physician during the entire preceding Plan Year, the Full-Time Physician's Compensation during the immediately preceding Plan Year;

(b) If the Full-Time Physician was an Eligible Physician during only part of the preceding Plan Year, the product of (1) the Full-Time Physician's Compensation in the first regular pay period commencing in such Plan Year, and (2) the number of pay periods commencing in such Plan Year; or

(c) If the Full-Time Physician becomes a Full-Time Physician during the Plan Year and was not an Eligible Physician during any part of the preceding Plan Year, the product of (1) the Full-Time Physician's Compensation during the first full pay period during which the Full-Time Physician receives Compensation as a Full-Time Physician after becoming a Full-Time Physician, and (2) the number of pay periods in such Plan Year.

2.9 "Domestic Partner" means a person who has entered into a registered domestic partnership with a Participant or a former Participant in accordance with Division 2.5 of the California Family Code, as amended.

2.10 "Eligible Physician" is defined in Section 3.1.

2.11 "Employer Contributions" means the amounts the Hospital Authority is required to contribute to the Plan on behalf of Participants as determined under Section 4.1.

2.12 "Full-Time Physician" means an Eligible Physician who is scheduled to work more than 50% of a full-time schedule.

2.13 "Hospital Authority" means the Kern County Hospital Authority, a political subdivision of the state of California established pursuant to the Kern County Hospital Authority Act.

2.14 "Insurer" means an insurance company qualified to do business in the state of California with which the Hospital Authority or the Participant has entered into an Annuity Contract.

2.15 “Mandatory Employee Contributions” means the amounts Participants are required to contribute to the Plan, as determined under Section 4.2.

2.16 “Normal Retirement Age” means age 65.

2.17 “Part-Time Physician” means an Eligible Physician who is scheduled to work no more than 50% of a full-time schedule.

2.18 “Participant” means an Eligible Physician who has satisfied the requirements to participate in the Plan in Section 3.2 and whose participation in the Plan has not terminated under Section 3.4.

2.19 “Pension Committee” means the committee of five members appointed by the Hospital Authority in accordance with Article 8.

2.20 "Physician" means an individual who:

(a) is compensated by the Hospital Authority for services rendered to the Hospital Authority and who is classified by the Hospital Authority as a common law employee. The term Physician does not include any individual who is classified by the Hospital Authority as an independent contractor, consultant or a “leased employee,” as defined in Code section 414(n), even if a court or administrative agency later determines that such individual is a common law employee;

(b) is not a resident or fellow; and

(c) is designated by the Hospital Authority as a Physician.

2.21 “Plan” means this Kern County Hospital Authority Defined Contribution Plan for Physician Employees.

2.22 “Plan Year” means the 12-consecutive month period beginning each January 1st and ending December 31st.

2.23 “Qualified Domestic Relations Order” or “QDRO” means a domestic relations order described in Section 8.13.

2.24 “Severance From Employment” means that a Participant has ceased to be an employee of the Hospital Authority and all Affiliates. A Participant does not have a Severance From Employment if, in connection with a change of employment, the Participant’s new employer maintains the Plan with respect to the Participant.

2.25 "Spouse" means the individual to whom a Participant is lawfully married under California law, including an individual of the same-sex with whom the Participant has validly entered into a marriage in another state, the District of Columbia, a United States territory or a foreign jurisdiction whose laws authorize the marriage of two individuals of the same sex even if the Participant and the individual are domiciled in a jurisdiction that does not recognize the validity of same-sex marriage. "Spouse" excludes an individual with whom a Participant has entered into a registered domestic partnership, civil union, or other similar formal relationship, whether opposite-sex or same-sex, recognized under

the law of another jurisdiction that is not denominated as a marriage under the laws of that jurisdiction.

2.26 "Trust" means the Trust established pursuant to the Trust Agreement between the Hospital Authority and the Trustee to hold, administer and distribute all or a portion of the Plan's assets.

2.27 "Trust Agreement" means the separate agreement entered into by and between the Hospital Authority and the Trustee, as it may be amended from time to time, which sets forth the terms and conditions applicable to the Trustee with respect to the Trust, and any successor agreement thereto.

2.28 "Trustee" means the person(s) or entity, and any successors thereto, named in the Trust Agreement, who is appointed by the Hospital Authority to hold, administer and distribute all or a portion of the Plan assets held in the Trust pursuant to the terms and conditions of the Trust Agreement.

2.29 "Valuation Date" means the last day of each Plan Year and any other date or dates which the Pension Committee, or its designee in accordance with procedures established by the Pension Committee, deems necessary or advisable for the valuation of Participants' Accounts, including, but not limited to, the date or dates on which Plan assets that are readily tradable on an established market are valued and the Trustee is conducting business.

ARTICLE 3

PLAN PARTICIPATION

3.1 Eligible Physician. "Eligible Physician" means each Physician who is employed by the Hospital Authority for, or through, Kern Medical Center, but excludes any Physician who:

(a) is employed by a department of the Hospital Authority other than Kern Medical Center; or

(b) participates in the Kern County Employees' Retirement Association.

3.2 Commencement of Participation. Each Participant in the Plan as in effect immediately before July 1, 2016, will remain a Participant. On and after that date, each Physician becomes a Participant on the date he or she becomes an Eligible Physician.

3.3 Mandatory Participation. An Eligible Physician's participation in the Plan is mandatory. No Eligible Physician may elect not to participate in the Plan.

3.4 Termination of Participation. If a Participant ceases to be an Eligible Physician, his or her participation in the Plan will cease upon the earlier of his or her death, or the date on which the Participant's Account balance is equal to zero.

3.5 Resumption of Participation. A person whose participation in the Plan has terminated under Section 3.4 will, upon again becoming an Eligible Physician, immediately become a Participant.

ARTICLE 4

CONTRIBUTIONS AND ALLOCATIONS

4.1 Employer Contributions. Each Plan Year, the Hospital Authority will contribute an Employer Contribution to the Plan on behalf of each Participant equal to:

(a) Full-Time Physicians. If the Participant is paid Compensation for services performed as a Full-Time Physician during any pay period commencing in the Plan Year, $17,500 multiplied by a fraction, the numerator of which is the number of pay periods commencing in the Plan Year during which the Participant performs services as a Full-Time Physician for which the Participant is paid Compensation, and the denominator of which is the total number of pay periods commencing in the Plan Year; or

(b) Part-Time Physicians. If the Participant is paid Compensation for services performed as a Part-Time Physician during any pay period commencing in the Plan Year, $8,000 multiplied by a fraction, the numerator of which is the number of pay periods commencing in the Plan Year during which the Participant performs services as a Part-Time Physician for which the Participant is paid Compensation, and the denominator of which is the total number of pay periods commencing in the Plan Year.

A Participant is entitled to an Employer Contribution with respect to any pay period beginning in the Plan Year under only one of subsections (a) or (b) of this section. If a Participant would otherwise be entitled to an Employer Contribution with respect to a pay period under more than one of these subsections, the Hospital Authority will determine the subsection used to calculate the Employer Contribution with respect to that pay period in accordance with Section 4.3.

4.2 Mandatory Employee Contributions. Each Plan Year, the Hospital Authority will automatically withhold from each Participant's Compensation and contribute to the Plan on behalf of the Participant a Mandatory Employee Contribution equal to:

(a) Full-Time Physicians. If the Participant is paid Compensation for services performed as a Full-Time Physician at any time during the Plan Year:

(1) If the Participant's Determination Period Compensation is $115,000 or less, $12,500;

(2) If the Participant's Determination Period Compensation is more than $115,000, but less than $132,000, $18,500;

(3) If the Participant's Determination Period Compensation is at least $132,000, but less than 190,000, $22,500; or

(4) If the Participant's Determination Period Compensation is at least $190,000, the maximum amount permitted under Code section 415(c)(1) for the Plan Year, reduced by the Participant's Employer Contributions for the Plan Year;

multiplied by a fraction, the numerator of which is the number of pay periods which commence in the Plan Year during which the Participant performs services as a Full-Time Physician for which the Participant is paid Compensation, and the denominator of which is the total number of pay periods commencing in the Plan Year; or

(b) Part-Time Physicians. If the Participant is paid Compensation for services performed as a Part-Time Physician at any time during the Plan Year, $2,000 multiplied by a fraction, the numerator of which is the number of pay periods which commence in the Plan Year during which the Participant performs services as a Part-Time Physician for which the Participant is paid Compensation, and the denominator of which is the total number of pay periods commencing in the Plan Year.

A Participant is entitled to a Mandatory Employee Contribution with respect to any pay period beginning in the Plan Year under only one of subsections (a) or (b) of this section. If a Participant would otherwise be entitled to a Mandatory Employee Contribution with respect to a pay period under more than one of these subsections, the Hospital Authority will determine the subsection used to calculate the Mandatory Employee Contribution with respect to that pay period in accordance with Section 4.3.

(c) Withholding of Mandatory Employee Contributions. The Hospital Authority will withhold the Mandatory Employee Contributions for a Plan Year for each Participant in approximately equal amounts from the biweekly payment of Compensation to the Participant during each pay period.

(d) Pick-Up Contributions. The Hospital Authority will pay all Mandatory Employee Contributions to the Plan on behalf of each Participant in accordance with the rules governing pick-ups under section 414(h)(2) of the Code, including but not limited to the following:

(1) The Hospital Authority will pay the Mandatory Employee Contributions directly to the Plan on behalf of the Participant in lieu of the amounts deducted from the Participant's Compensation.

(2) The Participant may not choose to directly receive the amounts deducted from his or her Compensation instead of having them paid by the Hospital Authority to the Plan on the Participant's behalf.

4.3 Partial Pay Periods. If a Participant is paid Compensation for services performed as a Full-Time Physician or a Part-Time Physician during only a portion of a pay period beginning in the Plan Year, the pay period will be taken into account in the numerator of the fraction in subsection (a) or (b) of Sections 4.1 and 4.2 only if (i) the Participant is paid Compensation for services performed as a Full-Time Physician (in the case of subsection (a)) or a Part-Time Physician (in the case of subsection (b)) on the last day of the pay period, or (ii) the Participant commences employment, terminates employment, or begins or ends an unpaid leave of absence during the pay period. If after applying the preceding sentence, a Participant would otherwise still be entitled to an Employer Contribution or Mandatory Employee Contribution with respect to a pay period under more than one of subsections (a) or (b) of Sections 4.1 and 4.2, then the Participant will be entitled to an Employer Contribution or Mandatory Employee Contribution with

respect to the pay period only as determined under the one of these subsections that yields the highest such contribution with respect to that pay period.

4.4 No Other Contributions Permitted. The Plan provides only for the Employer Contributions and Mandatory Employee Contributions. The Plan does not permit any other types of contributions, including employee voluntary after-tax contributions or rollover contributions. For purposes of this section, the term "contributions" does not include inter-fund transfers, any other transfers between investments held by the Trustee or Insurer under the Plan or any transfers between the Trustee and the Insurer of assets held under the Plan.

4.5 Time for Payment of Contributions. The Hospital Authority will pay Employer Contributions and Mandatory Employee Contributions for each Plan Year to the Trustee or the Insurer on a biweekly basis during the Plan Year, or as soon thereafter as administratively practicable.

4.6 Allocation of Employer Contributions and Mandatory Employee Contributions. Employer Contributions and Mandatory Employee Contributions will be allocated to the Account of each eligible Participant in accordance with Sections 4.1 and 4.2.

4.7 Limitation on Allocations.

(a) Effective Date. The limitations of this Section apply in Limitation Years beginning on or after July 1, 2007, except as otherwise provided herein.

(b) Annual Additions Limit. Notwithstanding any Plan provision to the contrary, the total Annual Additions credited to a Participant's Account under the Plan for a Limitation Year, when added to the Annual Additions credited to the Participant's accounts under all other qualified defined contribution plans required to be aggregated with this Plan pursuant to Section 4.7(c) for the Limitation Year, must not exceed the lesser of:

(1) $40,000, as adjusted for increases in the cost-of-living under section 415(d) of the Code; or

(2) 100% of the Participant's Section 415 Compensation for the Limitation Year;

provided, however, that the limit described in paragraph (2) of this subsection does not apply to any contribution made for medical benefits (within the meaning of section 419A(f)(2) of the Code) after separation from service which is treated as an Annual Addition.

If a Limitation Year consists of fewer than 12 months, the dollar limitation set forth in paragraph (1) of this subsection will be adjusted by multiplying it by a fraction, the numerator of which is the number months in the short Limitation Year and the denominator of which is 12.

(c) Aggregation With Other Defined Contribution Plans. All qualified defined contribution plans (as defined in section 1.415(c)-1(a)(2) of the Treasury regulations and whether or not terminated) maintained by the Hospital Authority

or an Affiliate will be aggregated with this Plan and treated as one defined contribution plan in applying the limitations of this section.

(d) Participation in Other Defined Contribution Plans. If a Participant participates in another defined contribution plan of the Hospital Authority or of an Affiliate that is a tax-qualified defined contribution plan, contributions or allocations that would otherwise be made on behalf of the Participant to the other plan shall first be reduced to the extent necessary to avoid exceeding the limitations of this section.

(e) Definitions.

(1) "Annual Additions" means the sum of the amounts credited to a Participant's Account under the Plan, and to the Participant's accounts under all other qualified defined contribution plans required to be aggregated with this Plan pursuant to Section 4.7(c) for the Limitation Year, described in subparagraph (A) and excludes all of the amounts described in subparagraph (B) of this paragraph.

(A) Annual Additions includes:

(i) Employer contributions;

(ii) Employee contributions (after-tax), including mandatory contributions (as defined in section 411(c)(2)(C) of the Code and Treasury regulations issued thereunder) to a defined benefit plan, as well as voluntary employee contributions used to purchase permissive service credit (as defined in Code section 415(n)(3)) under a defined benefit plan if an election is made to treat those amounts as Annual Additions in the year contributed pursuant to Code section 415(n)(1);

(iii) Forfeitures; and

(iv) Amounts allocated to the Participant's individual medical account (within the meaning of section 415(l)(2) of the Code), which is part of a pension or annuity plan maintained by the Hospital Authority or an Affiliate, except that such amounts are not included in Annual Additions for purposes of applying the 100% of compensation limit.

(B) The term "Annual Additions" excludes:

(i) Repayments of cash-outs as described in section 415(k)(3) of the Code (for example, to purchase restoration of an accrued benefit under a defined benefit plan that was lost when employee contributions were previously cashed out) for the Limitation Year in which the restoration occurs;

(ii) Catch-up contributions made in accordance with Code section 414(v);

(iii) Restorative payments described in Treasury regulations section 1.415(c)-1(b)(2)(ii)(C);

(iv) Excess deferrals that are distributed in accordance with Treasury regulations section 1.402(g)-1(e)(2) or (3);

(v) Rollover contributions (as described in sections 401(a)(31), 402(c)(1), 403(a)(4), 403(b)(8), 408(d) and 457(e)(16) of the Code);

(vi) Loan repayments;

(vii) Employee contributions to a qualified cost-of-living arrangement described in Code section 415(k)(2)(B);

(viii) Employee contributions to a defined benefit plan that are picked up by the Hospital Authority or Affiliate under Code section 414(h)(2);

(ix) Make-up contributions attributable to a period of qualified military service, as defined in Code section 414(u), with respect to the year in which the contribution is made (but not with respect to the year to which the contribution relates);

(x) Employee contributions to purchase permissive service credit (as defined in Code section 415(n)(3)) under a defined benefit plan if an election is made to treat the accrued benefit derived from all such contributions as an annual benefit subject to the limits of Code section 415(b);

(xi) direct transfers of contributions from another plan; and

(xii) deductible contributions to a simplified employee pension plan.

(2) "Section 415 Compensation" means wages, salaries, fees for professional services and other amounts received (without regard to whether an amount is paid in cash) by a Physician for personal services actually rendered in the course of the Physician's employment in any capacity with the Hospital Authority, to the extent amounts are includible in gross income (or to the extent amounts would have been received and includible in gross income but for an election under Code sections 125(a), 132(f)(4), 402(e)(3), 402(h)(1)(B), 402(k) or 457(b)). These amounts include, but are not limited to, commissions paid to salespersons, compensation for services based on a percentage of profits, commissions on insurance premiums, tips, bonuses, fringe benefits, and reimbursements, or other expense allowances under a nonaccountable plan as described in Treasury regulations section 1.62-2(c). A Participant's Section 415 Compensation is determined subject to the following provisions:

(A) Section 415 Compensation includes:

(i) amounts described in Code sections 104(a)(3), 105(a), or 105(h), but only to the extent the amounts are includible in the gross income of the Physician;

(ii) amounts paid or reimbursed by the Hospital Authority for moving expenses incurred by a Physician, but only to the extent that at the time of the payment it is reasonable to believe that these amounts are not deductible by the Physician under Code section 217;

(iii) amounts includible in the gross income of a Physician upon making the election described in Code section 83(b); and

(iv) amounts that are includible in the gross income of a Physician under the rules of Code section 409A or 457(f)(1)(A) or because the amounts are constructively received by the Physician.

(B) Section 415 Compensation excludes:

(i) contributions (other than elective contributions described in Code sections 402(e)(3), 408(k)(6), 408(p)(2)(A)(i) or 457(b)) made by the Hospital Authority to a plan of deferred compensation (including a simplified employee pension described in Code section 408(k) or a simple retirement account described in Code section 408(p), and whether or not qualified) to the extent that the contributions are not includible in gross income of the Physician for the taxable year in which contributed;

(ii) any distributions from a plan of deferred compensation (whether or not qualified) regardless of whether such amounts are includible in the gross income of the Physician when distributed; provided, however, that any amounts received by a Physician pursuant to a nonqualified unfunded deferred compensation plan are includible in Section 415 Compensation in the year the amounts are actually received, but only to the extent such amounts are includible in the Physician's gross income;

(iii) other amounts which receive special tax benefits, such as premiums for group term life insurance (but only to the extent the premiums are not includible in the gross income of the Physician and are not salary reduction amounts described in Code section 125); and

(iv) other items of remuneration that are similar to any of the items listed in paragraph (i) through (iii) of this subsection.

(C) For Plan Years beginning on or after January 1, 2008, in order to be taken into account for a Limitation Year, Section 415 Compensation must be paid or treated as paid to a Physician during the Limitation Year, and prior to the Physician's Severance From Employment; provided, however, that:

(i) Section 415 Compensation includes amounts earned during the Limitation Year, but not paid during that Limitation Year solely because of the timing of pay periods and pay dates if:

(I) These amounts are paid during the first few weeks of the next Limitation Year;

(II) The amounts are included on a uniform and consistent basis with respect to all similarly situated Physicians; and

(III) No Section 415 Compensation is included in more than one Limitation Year.

(ii) Section 415 Compensation includes regular compensation for services during the Physician's regular working hours, or compensation for services outside the Physician's regular working hours (such as overtime or shift differential), commissions, bonuses, or other similar payments paid after the Physician's Severance From Employment if:

(I) The compensation is paid by the later of 2½ months after the Physician's Severance From Employment, or the end of the Limitation Year that includes the date of the Physician's Severance From Employment with the Hospital Authority;

(II) The compensation would have been included in Section 415 Compensation if it were paid prior to the Physician's Severance From Employment; and

(III) The payments would have been paid to the Physician if the Physician had continued in employment with the Hospital Authority or an Affiliate.

Any payments not described above must not be considered Compensation if paid after Severance From Employment, even if paid by the later of 2½ months after the date of Severance From Employment or the end of the Limitation Year that includes the date of Severance From Employment, except as provided in subparagraph (D) of this paragraph.

(D) Effective January 1, 2009, Section 415 Compensation includes differential wage payments (as defined in section 3401(h)(2) of the Code).

(E) Section 415 Compensation includes all amounts paid by an Affiliate that would be considered Section 415 Compensation if paid by the Hospital Authority.

(F) The annual Section 415 Compensation of each Participant taken into account in determining the limitation on Annual Additions pursuant to this section for any Limitation Year must not exceed $200,000, as adjusted for cost-of-living increases in accordance with Code section 401(a)(17)(B); provided, however, that the annual Section 415 Compensation limit does not apply to any Participant who first became a Participant prior to August 1, 1994. If a Limitation Year consists of fewer than 12 months, the annual compensation limit is an amount equal to the otherwise applicable annual compensation limit multiplied by a fraction, the numerator of which is the number of months in that short Limitation Year, and the denominator of which is 12.

(3) "Limitation Year" means the Plan Year.

ARTICLE 5

ACCOUNTING AND VALUATION

5.1 Accounts. A separate Account will be established and maintained for each Participant. The Hospital Authority will allocate the Employer Contributions and Mandatory Employee Contributions made on behalf of Participants to these Accounts in accordance with Article 4.

5.2 Valuation of Accounts.

(a) As of each Valuation Date, the value of each Participant's Account comprising the Trust or Annuity Contract will be determined based on the fair market value of the assets held in the Account as of that date after adjusting the Account to reflect any contributions, attributable investment income and gains credited to the Account and any allocable expenses, investment losses and distributions debited to the Account since the last Valuation Date. Earnings, gains and losses in a pooled investment in which all or a portion of the Participant's Account is invested shall be allocated to the Participant's Account proportionately based on the Participant's share of the pooled investment. Earnings, gains and losses in a segregated investment in which the Participant's Account is invested shall be allocated separately.

(b) In determining the value of any publicly traded securities in the Account with respect to a transaction initiated before the latest time at which the securities can be traded on a Valuation Date, the prices at which the securities are last traded on the Valuation Date will be used. In determining the value of any publicly traded securities in the Account with respect to a transaction initiated at or after the latest time at which the security can be traded on a Valuation Date, the prices at which the securities are last traded on the next Valuation Date on which such securities are traded will be used.

(c) If, in making such valuations, it is determined that an investment consists, in whole or in part, of property not traded freely on a recognized market, or that information necessary to ascertain the fair market value thereof is not readily available, the Pension Committee or the investment manager who has been granted the authority to manage the property may be asked to provide instructions as to the fair market value of such property. Upon such request, the Pension Committee or the investment manager, at the direction of Pension Committee, will determine and provide instructions as to the fair market value of the property and such value shall be conclusive and binding for all purposes under the Plan and the Trust. If the Pension Committee or the investment manager fails to comply with a request for instructions regarding the value of the property, any such action as deemed necessary or advisable may be taken to ascertain the fair market value of such property, including the retention of counsel and independent appraisers.

ARTICLE 6

VESTING

The balance in each Participant's Account will be 100% vested all times.

ARTICLE 7

DISTRIBUTION OF BENEFITS

7.1 Timing of Distributions. Each Participant is entitled to receive a distribution of the Participant's Account balance following the earliest of:

(a) The Participant's Severance From Employment; or

(b) The Participant's attainment of age 70½.

If a Participant dies before the Participant's total Account balance has been distributed to the Participant, the Participant's Beneficiary is entitled to receive a distribution of the Participant's Account balance.

If a Participant or Beneficiary who is entitled to receive a distribution pursuant to this section elects in writing, at the specified time and manner, the Participant's Account balance will be distributed to the Participant or Beneficiary as soon as administratively feasible following the event entitling the Participant or Beneficiary to the distribution and the receipt of the election.

7.2 Forms of Distribution. A Participant's Account balance will be distributed to the Participant or the Participant's Beneficiary entitled to receive a distribution of that Account balance under Section 7.1 in the form of a single lump sum payment. In lieu of the normal form of payment described in the preceding sentence, the Participant or Beneficiary may irrevocably elect in writing at the specified time and manner and received prior to the time that distributions commence to have the Participant's Account balance distributed to the Participant or Beneficiary in the form of an annuity which is the amount of benefit that can be purchased from an insurance company licensed to do business in the state of California with the Participant's Account balance.

7.3 Direct Rollovers.

(a) In General. A Distributee may elect, at the specified time and manner, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover.

(b) Definitions.

(1) "Direct Rollover" means the payment by the Plan of an Eligible Rollover Distribution to the Eligible Retirement Plan specified by the Distributee.

(2) "Distributee" means:

(A) a Physician or former Physician;

(B) a Physician's or former Physician's surviving Spouse;

(C) a Physician or former Physician's Spouse or former Spouse who is an Alternate Payee under a Qualified Domestic Relations Order with respect to the interest of the Spouse or former Spouse; or

(D) effective for Plan Years beginning on or after January 1, 2010, a Participant's non-Spouse designated Beneficiary (as defined in Code section 401(a)(9)(E)). In the case of a non-Spouse designated Beneficiary, the direct rollover may be made only to an individual retirement account or annuity described in section 408(a) or 408(b) of the Code ("IRA") that is established on behalf of the designated Beneficiary and that will be treated as an inherited IRA pursuant to the provisions of section 402(c)(11) of the Code. Also, in this case, the determination of any required minimum distribution under section 401(a)(9) of the Code that is ineligible for rollover will be made in accordance with Notice 2007-7, Q&A-17 and 18, 2007-5 I.R.B. 395 (or its successor).

(3) "Eligible Retirement Plan" means:

(A) an individual retirement account described in Code section 408(a);

(B) an individual retirement annuity described in Code section 408(b) (other than an endowment contract);

(C) a qualified trust described in Code section 401(a) of a defined contribution plan that accepts Eligible Rollover distributions;

(D) an annuity plan described in Code section 403(a);

(E) an eligible deferred compensation plan described in Code section 457(b) which is maintained by an eligible employer described in Code section 457(e)(1)(A);

(F) an annuity contract described in Code section 403(b); or

(G) effective for distributions after December 31, 2007, a Roth IRA described in Code section 408A,

that accepts the Distributee's Eligible Rollover Distribution.

(4) "Eligible Rollover Distribution" means any distribution of all or any portion of the balance to the credit of a Distributee, except that an Eligible Rollover Distribution does not include:

(A) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made (i) for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and the Distributee's designated Beneficiary or (ii) for a specified period of 10 years or more;

(B) any distribution to the extent such distribution is required under section 401(a)(9) of the Code; or

(C) the portion of any distribution that is not includible in gross income; provided, however, that this paragraph does not apply to the distribution if the plan to which the distribution is transferred:

(i) is an individual retirement account or annuity described in section 408(a) or (b) of the Code;

(ii) for taxable years beginning after December 31, 2001, and before January 1, 2007, is a qualified trust which is part of a defined contribution plan that agrees to separately account for the amounts so transferred, including separately accounting for the portion of the distribution which is includible in gross income and the portion of the distribution that is not so includible; or

(iii) for taxable years beginning on or after December 31, 2006, is a qualified trust or an annuity contract described in section 403(b) of the Code, if such trust or contract provides for separate accounting for amounts so transferred (including interest thereon), including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible.

7.4 Required Minimum Distributions.

(a) General Rules.

(1) Precedence and Effective Date. The requirements of this section will apply to any distribution of a Participant's interest and will take precedence over any inconsistent provisions of the Plan. Unless otherwise specified, the provisions of this section apply to calendar years beginning after December 31, 2002.

(2) Requirements of Regulations Incorporated. All distributions required under this section will be determined and made in accordance with section 401(a)(9) of the Code, including the incidental death benefit requirement in section 401(a)(9)(G) of the Code and the Treasury regulations thereunder.

(3) Limits on Distribution Periods. As of the first Distribution Calendar Year, distributions to a Participant, if not made in a single sum, may only be made over one of the following periods:

(A) the life of the Participant;

(B) the joint lives of the Participant and a Designated Beneficiary;

(C) a period certain not extending beyond the Life Expectancy of the Participant; or

(D) a period certain not extending beyond the joint life and last survivor expectancy of the Participant and a Designated Beneficiary.

(b) Time and Manner of Distribution.

(1) Required Beginning Date. The Participant's entire interest will be distributed, or begin to be distributed, no later than the Participant's Required Beginning Date.

(2) Death of Participant Before Distributions Begin. If a Participant dies before distributions begin, the Participant's Account Balance will be distributed, or begin to be distributed, no later than as follows:

(A) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, then, except as provided in Section 7.4(d)(3), distributions to the Surviving Spouse will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died, or by December 31 of the calendar year in which the Participant would have attained Age 70½, if later.

(B) If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, then, except as provided in Section 7.4(d)(3), distributions to the Designated Beneficiary will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died.

(C) If there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, the Participant's entire interest will be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(D) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the surviving Spouse dies after the Participant but before distributions to the surviving Spouse begin, this Section 7.4(b)(2), other than Section 7.4(b)(2)(A), will apply as if the surviving Spouse were the Participant.

For purposes of this Section 7.4(b) and Section 7.4(d), unless Section 7.4(b)(2)(D) applies, distributions are considered to begin on the Participant's Required Beginning Date. If Section 7.4(b)(2)(D) applies, distributions are considered to begin on the date distributions are required to begin to the surviving Spouse under Section 7.4(b)(2)(A). If distributions under an annuity purchased from an insurance company irrevocably commence to the Participant before the Participant's Required Beginning Date (or to the surviving Spouse before the date distributions are required to begin to the surviving Spouse under Section 7.4(b)(2)(A)), the date distributions are considered to begin is the date distributions actually commence.

(3) Forms of Distribution. Unless the Participant's Account Balance is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the Required Beginning Date, as of the first Distribution Calendar Year distributions must be made in accordance with Sections 7.4(c) and 7.4(d). If the Participant's Account Balance is distributed in the form of an annuity purchased from an insurance company, distributions thereunder must be made in accordance with the requirements of Code section 401(a)(9) and section 1.401(a)(9) of the Treasury regulations.

(c) Required Minimum Distributions During Participant's Lifetime.

(1) Amount of Required Minimum Distribution For Each Distribution Calendar Year. During the Participant's lifetime, the minimum amount that must be distributed for each Distribution Calendar Year is the lesser of:

(A) the quotient obtained by dividing the Participant's Account Balance by the distribution period in the Uniform Lifetime Table set forth in section 1.401(a)(9)-9, Q&A-2, of the Treasury regulations using the Participant's age as of the Participant's birthday in the Distribution Calendar Year; or

(B) If the Participant's sole Designated Beneficiary for the Distribution Calendar Year is the Participant's Spouse, the quotient obtained by dividing the Participant's Account Balance by the number in the Joint and Last Survivor Table Set forth in section 1.401(a)(9)-9, Q&A-3, of the Treasury regulations using the Participant's and the Spouse's attained ages as of the Participant's and Spouse's birthdays in the Distribution Calendar Year.

(2) Lifetime Required Minimum Distributions Continue Through Year of Participant's Death. Required Minimum Distributions shall be determined under this Section 7.4(c) beginning with the first Distribution Calendar Year and up to, and including, the Distribution Calendar Year that includes the Participant's date of death.

(d) Required Minimum Distributions After Participant's Death.

(1) Death On or After Date Distributions Begin.

(A) Participant Survived by Designated Beneficiary. If the Participant dies on or after the date distributions begin and there is a Designated Beneficiary, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the longer of the remaining Life Expectancy of the Participant or the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as follows:

(i) The Participant's remaining Life Expectancy is calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

(ii) If the surviving Spouse is the Participant's sole Designated Beneficiary, the remaining Life Expectancy of the surviving Spouse is calculated for each Distribution Calendar Year after the year of the Participant's death using the surviving Spouse's age as of the Spouse's birthday in that year. For Distribution Calendar Years after the year of the surviving Spouse's death, the remaining Life Expectancy of the surviving Spouse is calculated using the age of the surviving Spouse as of the Spouse's birthday in the calendar year of the Spouse's death, reduced by one for each subsequent calendar year.

(iii) If the Participant's Spouse is not the Participant's sole Designated Beneficiary, the remaining Life Expectancy of the Surviving Spouse is calculated using the age of the Beneficiary in the year following the year of the Participant's death, reduced by one for each subsequent year.

(B) No Designated Beneficiary. If the Participant dies on or after the date distributions begin and there is no Designated Beneficiary as of September 30 of the year after the year of the Participant's death, the minimum amount that must be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the Participant's remaining Life Expectancy calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

(2) Death Before Distributions Begin.

(A) Participant Survived by Designated Beneficiary. Except as provided in Section 7.4(d)(3), if the Participant dies before the date distributions begin and there is a Designated Beneficiary, the minimum amount that must be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as provided in Section 7.4(d)(1).

(B) No Designated Beneficiary. If the Participant dies before the date distributions begin and there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, distribution of the Participant's entire interest must be completed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(C) Death of Surviving Spouse Before Distributions to Surviving Spouse Are Required to Begin. If the Participant dies before the date distributions begin, and the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, and the surviving Spouse dies before distributions are required to begin to the surviving Spouse under section 7.4(b)(2)(A), this Section 7.4(d)(2) will apply as if the Spouse were the Participant.

(3) Participants or Beneficiaries May Elect the 5-Year Rule. Participants or Designated Beneficiaries may elect in writing on an individual basis whether the five-year rule or the life expectancy rule in Sections 7.4(b)(2) and 7.4(d)(2) applies to distributions after the death of the Participant who has a Designated Beneficiary. The election must be made no later than the earlier of September 30 of the calendar year in which the distribution would be required to begin under Section 7.4(b)(2) of the Plan, or by September 30 of the calendar year which contains the fifth anniversary of the Participant's (or, if applicable, the surviving Spouse's) death. If neither the Participant nor the Designated Beneficiary makes an election under this paragraph, distributions will be made in accordance with Sections 7.4(b)(2) and 7.4(d)(2).

(e) Definitions.

(1) "Designated Beneficiary" means the individual who is designated by the Participant (or the Participant's surviving Spouse) as the Beneficiary of the Participant's interest under the Plan pursuant to Section 2.5 of the Plan and is the Designated Beneficiary under section 401(a)(9) of the Code and section 1.401(a)(9)-4 of the Treasury regulations.

(2) "Distribution Calendar Year" means a calendar year for which a minimum distribution is required. For distributions beginning before a Participant's death, the first Distribution Calendar Year is the calendar year immediately preceding the calendar year which contains the Participant's Required Beginning Date. For distributions beginning after a Participant's death, the first Distribution Calendar Year is the calendar year in which distributions are required to begin pursuant to Section 7.4(b)(2). The required minimum distribution for the Participant's first Distribution Calendar Year must be made on or before the Participant's Required Beginning Date. The required minimum distribution for other Distribution Calendar Years, including the required minimum distribution for the Distribution Calendar Year in which the Participant's Required Beginning Date occurs, will be made on or before December 31 of that Distribution Calendar Year.

(3) "Life Expectancy" means life expectancy as computed by use of the Single Life Table in section 1.401(a)(9)-9, Q&A-1, of the Treasury regulations.

(4) "Participant's Account Balance" means the Account balance as of the last Valuation Date in the calendar year immediately preceding the

Distribution Calendar Year ("Valuation Calendar Year") increased by the amount of any contributions made and allocated or forfeitures allocated to the Account as of dates in the Valuation Calendar Year after the Valuation Date and decreased by distributions made in the Valuation Calendar Year after the Valuation Date. The Participant's Account Balance for the Valuation Calendar Year includes any amounts rolled over or transferred to the Plan either in the Valuation Calendar Year or in the Distribution Calendar Year if distributed or transferred in the Valuation Calendar Year.

(5) "Required Beginning Date" means April 1 of the calendar year following the later of:

(A) the calendar year in which the Participant attains age 70½; or

(B) the calendar year in which the Participant has a Severance From Employment.

(f) TEFRA Section 242(b)(2) Elections. Notwithstanding any other requirements of this Section, distributions may be made under a designation made before January 1, 1984, in accordance with section 242(b)(2) of the Tax Equity and Fiscal Responsibility Act ("TEFRA") and the provisions of the Plan that relate to section 242(b)(2) of TEFRA.

7.5 Latest Benefit Payment Date.

Unless the Participant otherwise elects, payment of benefits must commence on or before the 60th day after close of the calendar year in which occurs the latest of:

(a) the Participant's Severance From Employment;

(b) the Participant's Normal Retirement Age; or

(c) The 10th anniversary of the year in which the Participant commenced participation in the Plan;

provided, however, that the failure of a Participant to request a distribution shall be deemed to be an election to defer the commencement of any payment sufficient to satisfy this section.

7.6 Distributions to Alternate Payees. The Pension Committee or its designee will direct the Trustee or the Insurer to distribute the amount of a Participant's benefits assigned to an Alternate Payee on the date specified in the QDRO, without regard to whether the Participant has satisfied the requirements in Section 7.1 to receive a distribution from the Plan.

7.7 Distributions to Minors or Legally Incompetent Persons. If a person who is entitled to receive a distribution under the Plan is legally disabled or incapacitated so as to be unable to manage the person's financial affairs, the Pension Committee or its designee may direct the Trustee or Insurer to make the distribution to such person's legal representative, or, if the person has no legal representative, to apply such distribution for

the benefit of such person. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

7.8 Missing Participants or Beneficiaries. The Pension Committee or its designee will contact any person entitled to a distribution under the Plan at the last address of such person appearing in the Hospital Authority's records with respect to the Plan. If such person fails to claim such or to make his or her whereabouts known in writing to the Hospital Authority, then the unclaimed distribution will escheat as of the earliest date permitted under the unclaimed property law of the state of California set forth in Title 10 of Part 3 of the California Code of Civil Procedure, as may be amended from time-to-time.

ARTICLE 8

PLAN ADMINISTRATION

8.1 Pension Committee Membership. The Hospital Authority Board of Governors will appoint a Pension Committee consisting of five members. Any person serving as a member of the Pension Committee may resign or may be removed by the Hospital Authority. A resignation will be effective 30 days after the Hospital Authority's receipt of a written notice of such resignation, or sooner at the Hospital Authority's discretion. A removal will be effective upon the member's receipt of a written notice of such removal from the Hospital Authority, or later at the Hospital Authority's discretion. Upon such resignation or removal, the Hospital Authority will appoint a successor to fill the vacant position.

8.2 Pension Committee Action.

(a) The Pension Committee shall choose a Secretary from among its members (hereinafter referred to as "Secretary") whose duties shall include, but are not limited to, executing certificates, written directions and other documents on behalf of the Committee and keeping minutes of the Committee's proceedings and all records and documents pertaining to its administration of the Plan. Any action of the Pension Committee shall be taken pursuant to a majority vote, or to the written consent of a majority of its members and such action shall constitute the action of the Pension Committee and be binding on the same as if all members had joined therein. A quorum of the Pension Committee shall consist of a majority of its then acting members. All directions to the Trustee or Insurer shall be in writing signed by the Secretary or other person or persons duly authorized to sign by the Pension Committee. The Trustee, the Insurer or any third person dealing with the Pension Committee may conclusively rely upon any certificate or other written direction so executed.

(b) A member of the Pension Committee shall not vote or act upon any matter which relates solely to himself as a Participant. If a matter arises affecting one of the members of the Pension Committee as a Participant and the other members of the Pension Committee are unable to agree as to the disposition of such matter, the Hospital Authority will appoint a substitute member to the Pension Committee in the place and stead of the affected member, for the sole and only purpose of passing upon and deciding the particular matter.

8.3 Rights and Duties. In accordance with Article 16, section 17, of the California Constitution, the Pension Committee has the sole and exclusive fiduciary responsibility over the assets of the Plan, to administer the Plan in a manner that will assure prompt delivery of benefits and to hold the Plan's assets for the exclusive purposes of providing benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan. The Pension Committee has all of the powers and duties necessary to accomplish these purposes, including, but not limited to:

(a) To interpret the provisions of the Plan and to determine all questions arising in the administration and application of the Plan;

(b) To determine all questions relating to the eligibility of Physicians to participate in the Plan;

(c) To compute and certify, or determine the method for computing and certifying, to the Trustee or Insurer the amount and kind of benefits payable to Participants and their Beneficiaries;

(d) To authorize, or determine the method for authorizing, disbursements for the payment of benefits under this Plan by the Trustee from the Trust or by the Insurer;

(e) To recommend to the Hospital Authority Board of Governors the appointment or removal of the Trustee;

(f) To recommend to the Hospital Authority Board of Governors the appointment of one or more investment managers described in Section 9.5 to direct the Trustee with respect to the investment of Trust assets; to review periodically the performance of the Trustee or an investment manager; and to reappoint, remove or change such an investment manager;

(g) To recommend to the Hospital Authority Board of Governors the appointment or removal of any service provider which the Pension Committee determines is necessary or desirable in connection with the administration of the Plan or the Trust, including by way of example, and not by way of limitation, attorneys, investment advisors, accountants, and auditors;

(h) To make any change in the Participant-directed investment options or investment providers under the Plan;

(i) To maintain all necessary records for the administration of the Plan other than those maintained by the Trustee or Insurer;

(j) To make and publish such rules for the regulation of the Plan which are not inconsistent with the terms hereof;

(k) To establish claims procedures for presentation of claims by Participants and Beneficiaries for Plan benefits, consideration of such claims, review of claim denials and issuance of decisions on review;

(l) To render such reports and statements to Participants, Beneficiaries and government agencies as shall be prescribed by the Code, and applicable laws and regulations;

(m) To review and approve any financial reports or investment reviews or other reports prepared by any party with respect to the Plan or Trust; and

(n) To make any findings of fact the Pension Committee deems necessary or advisable for proper Plan administration.

8.4 Finality of Administrative Decisions. The Pension Committee's interpretation of the provisions of the Plan, including the resolution of any ambiguity or apparent ambiguity in

the Plan, and any findings of fact, including but not limited to, eligibility to participate and eligibility for benefits, are final and binding on the Hospital Authority and the Physicians and all parties claiming under or through the Physicians and shall not be subject to "de novo" review.

8.5 Delegation. The Pension Committee may review and recommend to the Hospital Authority Board of Governors that any of its responsibilities under the Plan be delegated to any other person. Such delegation shall be accomplished by a written instrument executed by the Hospital Authority Board of Governors specifying the responsibilities delegated and the fiduciary responsibilities allocated to such delegate. The allocation of such responsibilities shall be effective upon the date specified in the delegation subject to written acceptance by the delegate. Any such delegation of responsibilities under this section shall provide for reports, no less often than annually, by such delegate to the Pension Committee of such information necessary to fully inform the Pension Committee of the status and operation of the Plan and of the delegate's discharge of the responsibilities delegated.

8.6 Transmittal of Information. In order to enable the Pension Committee to perform its functions under the Plan, the Hospital Authority shall supply full and timely information to the Pension Committee or its delegate on all matters relating to the compensation of all Participants, their employment, retirement, death, or the cause for termination of employment and such other pertinent facts as may be required.

8.7 Duty of Care. The members of the Pension Committee shall discharge their duties under the Plan in the interest of, and for the exclusive purposes of providing benefits to, Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with these matters would use in the conduct of an enterprise of a like character and with like aims.

8.8 Compensation and Expenses. The members of the Pension Committee will receive no compensation for the services they provide under the Plan. To the extent not paid by the Hospital Authority, all expenses of Plan and Trust administration, including but not limited to Pension Committee expenses, may be paid by the Trustee or Insurer from Plan assets to the extent allowed under the Code. Such expenses include, but are not limited to, any expenses incidental to the functioning of the Plan, such as fees of advisers, professionals and other specialists, and other costs of administering the Plan and investing Plan assets. Plan administration expenses will be allocated to Participant Accounts on a per capita basis; provided, however, that all expenses incurred in the administration of the Trust will be allocated to the Accounts of Participants invested in the Trust on a per capita basis and all expenses incurred in the administration of Annuity Contracts will be allocated to the Accounts of Participants invested in Annuity Contracts on a per capital basis. The costs, fees and expenses incurred in processing a QDRO will be charged to the Participant's Account to which the QDRO relates.

8.9 Reliance on Reports and Certificates. The members of the Pension Committee and any delegates of the Pension Committee may rely upon all tables, valuations, certificates, reports and opinions furnished by the Trustee, Insurer, an accountant, legal counsel or any other service provider duly appointed by the Pension Committee.

8.10 Correcting Administrative Errors. The Pension Committee will take such steps as it considers necessary and appropriate to remedy any error under the Plan that results from incorrect information received or communicated in good faith, or administrative or operational error. Such steps may include, but shall not be limited to, the following:

(a) Taking any action required under the Employee Plans Compliance Resolution System (Revenue Procedure 2013-12) or in any subsequent Revenue Procedure or guidance issued by the Internal Revenue Service;

(b) Reallocating assets held pursuant to the Plan;

(c) Adjusting the amounts of future payments to Participants, Beneficiaries or Alternate Payees; and

(d) Instituting and prosecuting actions to recover benefit payments made in error or on the basis of incorrect or incomplete information.

8.11 Promulgating Notices and Procedures. The Pension Committee may promulgate written notices, policies or procedures under the terms of the Plan and disseminate the same to the Participants, and the Pension Committee may do so by the preparation of any such notice, policy or procedure in a written form which can be published and communicated to Participants in the manner that the Pension Committee deems necessary or advisable.

8.12 Claims Procedures.

(a) Initial Claim. The Pension Committee or its designee (the "Claims Administrator") shall make all initial determinations as to the right of any person to benefits under the Plan. If the Claims Administrator denies a Participant's or Beneficiary's claim for benefits under the terms of the Plan it will deliver or mail a written notice of denial to the Participant or Beneficiary within 60 days of the Claims Administrator's receipt of the Participant's or Beneficiary's written claim, which will set forth:

(1) the specific reasons for the denial, written to the best of the Claims Administrator's ability in a common sense manner that may be understood by the Participant or Beneficiary; and

(2) The procedures for appealing the denied claim.

(b) Appeal of Denied Claim. A Participant or Beneficiary whose claim has been denied may appeal the denial by filing a written appeal with the Hospital Authority within 30 days of the Participant's receipt of the Claims Administrator's written notice of denial. The Pension Committee will deliver its written decision on the appeal to the Participant or Beneficiary within 30 days after the Pension Committee receives the Participant's or Beneficiary's written appeal. The Pension Committee's decision will be final and binding upon all persons.

8.13 Qualified Domestic Relations Orders.

(a) QDROs In General. The Pension Committee or its designee must follow the terms of a Qualified Domestic Relations Order issued with respect to a Participant's Account. A "Qualified Domestic Relations Order" or "QDRO" is any judgment, decree or order, including the approval of a property settlement or agreement, that:

(1) Relates to the provision of child support, alimony or marital property rights and is made pursuant to state domestic relations or community property laws;

(2) Creates or recognizes the existence of an Alternate Payee's right to receive all or a portion of a Participant's Account balance;

(3) Specifies the name and last known mailing address of the Participant and each Alternate Payee covered by the order;

(4) Specifies the amount or percentage of the Participant's Account balance to be paid to each Alternate Payee or the manner in which the amount or percentage is to be determined;

(5) Specifies the number of payments or the period to which the order applies;

(6) Specifically names the Plan as the plan to which the order applies;

(7) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan;

(8) Does not require the Plan to provide increased benefits; and

(9) Does not require the payment of benefits to an Alternate Payee which are required to be paid to another Alternate Payee under another order previously determined by the Pension Committee or its designee to be a Qualified Domestic Relations Order.

(b) QDRO Procedures. The Pension Committee or its designee will determine whether a domestic relations order meets the requirements of a QDRO set forth above and administer any order that it determines is a QDRO in accordance with the following procedures:

(1) The Pension Committee or its designee must not treat any judgment, order or decree as a Qualified Domestic Relations Order, unless it meets all of the requirements set forth above. If the order meets all of these requirements, the Pension Committee or its designee must follow the terms of the order whether or not this Plan has been joined as a party to the legal proceeding out of which the order arises.

(2) The Participant and the purported Alternate Payee under the order may designate a representative to receive copies of future notices with respect to the qualified status of the order.

(3) To the extent an order calls for benefits to be paid to an Alternate Payee before the order is determined to be qualified, the Alternate Payee's share of the benefits must be separately accounted for.

(4) The Pension Committee or its designee will notify the Participant and the Alternate Payee, or their designated agents, in writing of its (A) receipt of the order, and (B) need to determine the qualified status of the order in accordance with this section within 14 days of its receipt of the order,.

(5) Within 14 days of its receipt of the order, the Pension Committee or its designee will instruct the Trustee or Insurer to place a hold on distributions from the portion of the Participant's Account which would have been payable to the Alternate Payee pursuant to the order. The hold will begin on the date of such notice and end on the date that the Pension Committee or its designee instructs the Trustee or Insurer to either (A) release the hold on the Account, or (B) segregate and distribute the Alternate Payee's share of the Account in accordance with the order, whichever applies based on its determination regarding the qualified status of the order.

(6) The Pension Committee or its designee will determine whether the order satisfies the requirements of a QDRO within 60 days after it provides the notice described in Section 8.13(b)(4).

(7) The Pension Committee or its designee will notify the Participant and the Alternate Payee, or their designated agents, in writing whether the order is a QDRO. If the order is not a QDRO, such notice will explain why the order is not a QDRO.

(8) The Participant, the Alternate Payee, or their designated agents may submit a revised domestic relations order to correct any deficiencies described in the Committee's notice within the 18-month period beginning on the date the original order first requires payment. The Pension Committee or its designee will notify the Participant and the Alternate Payee, or their designated representatives, in writing of its determination of whether the revised order is a QDRO within 14 days after it receives the revised order.

(9) If the Pension Committee or its designee determines that the order is not a QDRO, or the issue as to whether the order is a QDRO has not been resolved within the 18 month period beginning on the date the original order first requires payment, the Pension Committee or its designee will instruct the Trustee or Insurer to remove the hold on the Participant's Account. Thereafter, the Participant's Account will be held, administered and distributed in accordance with the Plan without regard to the order.

(10) The Trustee or Insurer will distribute the Alternate Payee's share of the Participant's Account pursuant to a QDRO to the Alternate Payee as soon as administratively feasible after the Pension Committee or its designee notifies it that the order is a QDRO or, if later, the date that the QDRO requires payment. The Trustee or Insurer will withhold any required federal and state taxes from such distributions.

(11) If an order that the Pension Committee or its designee determines is a QDRO does not provide for immediate payment to an Alternate Payee, the Pension Committee or its designee will establish a subaccount to segregate the Alternate Payee's interest in the Participant's Account. The Alternate Payee will be permitted to direct the investment of amounts credited to the subaccount described in the preceding sentence in accordance with Section 9.8; provided, however, that an Alternate Payee is not eligible for a loan from the Plan.

(12) The costs, fees and expenses incurred in processing and administering a QDRO will be charged to the Participant's Account to which the QDRO relates.

The Pension Committee may establish additional policies or procedures that it determines are necessary or advisable to determine the qualified status of a domestic relations orders or to administer QDROs.

8.14 Indemnification. To the maximum extent permitted by law, the Hospital Authority shall indemnify the members of the Pension Committee from the effects or consequences of their acts or omissions concerning the Plan. Such indemnity includes all liability, including judgments, settlements and costs of defense. The Hospital Authority may purchase insurance for the members of the Pension Committee to cover such potential liability.

ARTICLE 9

PLAN ASSETS

9.1 In General. In accordance with Article 16, section 17, of the California Constitution, the Pension Committee has the sole and exclusive fiduciary responsibility over the assets of the Plan, and to hold the Plan's assets for the exclusive purposes of providing benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan. Pursuant to such authority and responsibility, the Pension Committee may recommend to the Hospital Authority Board of Governors the appointment of a Trustee to hold the Plan assets received by it in a Trust or an Insurer to hold Plan assets received by it under the terms of an Annuity Contract, both of which must meet the requirements of this Article.

9.2 Trust. Upon the recommendation of the Pension Committee, the Hospital Authority Board of Governors may enter into a Trust Agreement with the Trustee providing for the investment of the Trust and prescribing the powers, duties, obligations and functions of the Trustee with respect to the Plan. The Trust Agreement shall form a part of this Plan, and any rights and benefits of any Participant or Beneficiary under the Plan whose Accounts are invested in the Trust shall be subject to all of the terms of the Trust Agreement. However, in the case of any conflict between the Plan and the Trust Agreement, the Plan shall govern. In no event shall any part of the Trust revert to the Hospital Authority, except as provided in the Plan. The Trustee must be one or more banks or other fiduciaries recommended by the Pension Committee and appointed by the Hospital Authority Board of Governors to hold and administer assets of the Plan. In its discretion, the Pension Committee may recommend that the Hospital Authority Board of Governors terminate the Trustee, appoint new Trustees, and authorize the Pension Committee to instruct the Trustee to transfer assets to a successor Trustee or Trustees or to the Insurer. The Trustee must hold the Plan assets received by it in Trust pursuant to the terms of the Trust Agreement for the exclusive benefit of Participants and their Beneficiaries and defraying the reasonable expenses of administering the Plan.

9.3 Annuity Contract. Upon the recommendation of the Pension Committee, the Hospital Authority Board of Governors or the Participant may enter into an Annuity Contract with the Insurer to hold and invest Plan assets pursuant to the terms of the Annuity Contract. In accordance with section 401(f) of the Code, the Annuity Contract must, except for the fact that it is not a trust, by its terms satisfy the requirements for a qualified trust under Section 401(a), including the requirement that the Plan assets be held by the Insurer pursuant to the terms of the Annuity Contract for the exclusive benefit of Participants and their Beneficiaries and defraying the reasonable expenses of administering the Plan. In addition, in accordance with section 401(g) of the Code, the Annuity Contract must not be transferrable if any person other than the Trustee of the Trust is the owner of such Annuity Contract.

9.4 Investment Policy. The Pension Committee will establish and maintain an investment policy for the Plan, and will review that policy at least annually. In establishing and maintaining the Plan's investment policy, the Pension Committee will review all pertinent Plan and Participant information and data and may consult with any professional advisors as it deems necessary or appropriate, and shall consider matters such as the following: the Plan's objectives and the best method to accomplish those objectives,

including the range of investment alternatives that should be available to Participants and their Beneficiaries in order to accomplish those objectives; the party or parties responsible for the selection and monitoring the Plan's investment alternatives and the policies and procedures to be followed in that selection and monitoring, including benchmarks and other performance criteria, as well as investment fees and expenses; and the liquidity of Plan assets. The investment policy shall be communicated to the Hospital Authority, the Trustee, the Insurer and any investment manager for the Plan. Any contract with any professional advisor must be entered into by the Hospital Authority Board of Governors upon the recommendation of the Pension Committee.

9.5 Investment Manager. Upon the recommendation of the Pension Committee, the Hospital Authority Board of Governors may appoint one or more investment managers to manage (including the power to acquire and dispose of) any assets of the Plan. Only a person who is a registered investment advisor under the Investment Advisors Act of 1940, a bank or an insurance company qualified to do business in the state of California may be an investment advisor under the Plan. The Trustee or the Insurer may be an investment manager.

9.6 Investments, Miscellaneous Rules. Assets of the Plan may be invested in bank deposits which bear a reasonable interest rate, whether or not the bank is the Trustee. Cash temporarily awaiting investment or payment of benefits or expenses of the Plan may be retained in non-interest bearing deposits or cash balances with a bank which is the Trustee.

9.7 Investment Funds. The Trustee and the Insurer will establish and maintain investment funds designated by the Pension Committee or an investment manager recommended by the Pension Committee and designated by the Hospital Authority Board of Governors. The assets of each investment fund will be managed by the Trustee, the Insurer or by one or more investment managers, as designated, except for (i) participant-directed investments, such as self-directed brokerage accounts, that permit Participants to direct the investment of some or all of the assets in their Account in specific investments, or (ii) funds established to segregate the portion of a Participant's Account balance used as security for Plan loans to the Participant and to receive loan repayments.

9.8 Participant-Directed Investments.

(a) In General. In accordance with this section and any policies or procedures established by the Pension Committee, each Participant or Beneficiary (including for this purpose an Alternate Payee to the extent that the Alternate Payee has the authority under the terms of the Qualified Domestic Relations Order to direct the investment of assets allocated to a separate account) may direct the Pension Committee, or its designee, in writing or otherwise, and at the time and in the manner established by the Pension Committee, to invest their Accounts in specific assets, specific investment funds or other investments permitted under the Plan. If a Participant or Beneficiary fails to designate the assets, investment fund or other investments permitted under the Plan in which contributions credited to the Participant's Account are invested, the contributions credited to his Account will be invested in the investment fund designated by the Pension Committee.

(b) Liability Limitation. To the extent Participants and Beneficiaries are permitted to direct the investment of their Accounts, the Plan is intended to constitute a plan described in section 53213.5 of the California Government Code. As such, no Plan fiduciary, including the Hospital Authority, the Trustee, the Insurer or the Pension Committee, is liable for any losses which are the direct and necessary result of investment instructions by a Participant or Beneficiary to the extent the Pension Committee, or its designee, complies with the communication and education requirements similar to those prescribed in section 404(c) of the Employee Retirement Income Security Act of 1974, as amended.

(c) Procedures. The Pension Committee or its designee will establish policies or procedures setting forth the permissible investment options, the time and manner for making investment elections, the permitted frequency of investment elections and any other provisions or limitations that it deems necessary or advisable for the proper administration of Participant-directed investments.

(d) Fees and Expenses. Any fees or expenses incurred in connection with a Participant's investment direction and any fees or expenses associated with a particular investment option selected by a Participant, including but not limited to brokerage, investment advisor and management fees, will be charged to the Participant's Account.

9.9 Participant Loans. The Pension Committee or its designee may make loans from the Plan to Participants only if all of the requirements set forth in this Section are met.

(a) Enforceable Agreement. Each Participant loan must be evidenced by a legally enforceable written promissory note which sets forth the terms of the loan, including but not limited to the date, amount (including interest), interest rate, and repayment schedule of the loan.

(b) Reasonable Rate of Interest. The Plan must charge a rate of interest for each Participant loan that is commensurate with the interest rates charged by persons in the business of lending money for loans under similar circumstances, as determined by the Pension Committee. The interest rate may be variable based on a commercially-recognized benchmark if this is reasonable under the circumstances.

(c) Adequate Security. A Participant loan must be secured by the portion of the Participant's Account balance that is equal to the amount of the loan; provided, however, that no more than 50% of the Account balance, as determined immediately after the origination of each loan, may be used as security for the loan.

(d) Maximum Repayment Term. The Participant loan terms must require repayment of the loan within five years (10 years in the case of a loan for the purchase of the Participant's principal residence) from the date of the loan.

(e) Level Amortization and Periodic Repayment. The Participant loan must provide for level amortization, with repayments required not less frequently than quarterly, over the term of the loan. Repayments will be made by payroll

deduction, personal check or such other method determined by the Pension Committee to be necessary or advisable.

(f) Maximum Loan Amount. The Plan must not make a loan to a Participant to the extent that the loan, when added to the outstanding balance of all other loans to the Participant from the Plan and all other qualified plans maintained by the Hospital Authority or an Affiliate, exceeds the lesser of:

(1) $50,000 reduced by the excess (if any) of:

(A) the highest outstanding balance of loans to the Participant from the Plan and all other qualified plans maintained by the Hospital Authority or an Affiliate during the one-year period ending on the day before the date on which such loan was made, over

(B) the outstanding balance of loans to the Participant from the Plan and all other qualified plans maintained by the Hospital Authority or an Affiliate on the date on which such loan is made; or

(2) one-half of the Participant's vested Account balance under the Plan and all other qualified plans maintained by the Hospital Authority or an Affiliate.

(g) Maximum Number of Loans. A Participant may not have more than one Participant loan outstanding at any time. To the extent permitted by the Trustee or the Insurer, a Participant may renegotiate a loan by replacing the loan with a new loan without violating the limit on the number of loans, provided that the replacement loan is treated as a new loan which must separately satisfy the requirements of this section. If the repayment term of the replacement loan ends after the latest permissible repayment term of the replaced loan (i.e., 5 years, or 10 years in the case of a loan for the purchase of the Participant's principal residence, from the date of the original loan), the replaced loan must be taken into account in determining whether the replacement loan satisfies the amount limit of Section 9.9(f), treating both the replaced loan and the replacement loan as outstanding at the same time. If the replacement loan's repayment term ends on or before the latest permissible repayment period of the replaced loan, however, the replaced loan is disregarded in determining whether the replacement loan satisfies the amount limit of Section 9.9(f).

(h) Suspension of Loan Repayments. A Participant's loan repayments may be suspended as permitted under Code section 414(u) during any part of a period during which the Participant is performing services in the uniformed services (as defined in chapter 43 of title 38, United States Code). No such suspension will be taken into account for purposes of Code section 72(p) or 401(a).

(i) Participant-Directed Investment. All Plan loans to a Participant will be considered a Participant-directed investment of the Participant's Account and will be credited only to the Account of such Participant. Upon repayment of the loan or any portion thereof, the repayment amounts shall be invested in accordance with the Participant's most recent investment election under Section 9.8.

(j) Loan Default. A Participant loan will be in default if any scheduled repayment with respect to the loan is not made when due under the terms of the loan. A Participant may cure such a default, however, by making the scheduled repayment by the last day of the calendar quarter following the calendar quarter in which the scheduled repayment was due. Unless the scheduled repayment is made by such date, the Participant's Account balance will be reduced by the entire outstanding balance of the loan, including accrued interest, as of such date, to the extent a distribution is permitted under Section 7.1, and such amount will be reported on an IRS Form 1099-R as a taxable distribution for the year in which the default occurs. If a distribution is not permitted under Section 7.1 at the time of the default, then the outstanding loan balance, including accrued interest, will be reported on an IRS Form 1099-R as a deemed distribution for the year in which the default occurs. After such a deemed distribution, interest continues to accrue on the amount in default until the time of the Participant loan is offset or, if earlier, the date the Participant loan repayments are made current. A subsequent offset on the amount in default is not reported as a taxable distribution, except to the extent the taxable portion of the default amount was not previously reported by the Plan as a taxable distribution. The post-default accrued interest included in the Participant Loan offset is not reported as a taxable distribution at the time of the offset.

(k) Loan Fee. A sum not to exceed $500 may be charged to the borrowing Participant's Account for each Participant Loan.

9.10 Limitation of Liability. Neither the Hospital Authority nor the Pension Committee shall have any liability whatsoever for the acts of the Trustee or the Insurer, or any agent or employee of the Trustee or Insurer; and to the extent provided in the Trust Agreement or the Annuity Contract, the Hospital Authority and the Pension Committee will be indemnified and held harmless by the Trustee and the Insurer with respect to any losses, costs, attorney's fees, or other expenses incurred by the Hospital Authority or Pension Committee with respect to claims based upon the conduct of the Trustee or the Insurer.

9.11 Benefits Supported Only by Plan Assets. Anyone who has any claim under the Plan shall look for satisfaction solely to Plan assets held in the Trust or by the Insurer pursuant to the Annuity Contract. Subject to the provisions of the Plan, the Hospital Authority's liability extends only to payment of contributions under the Plan. No one (including but not limited to the Hospital Authority, the Pension Committee, the Trustee or the Insurer) shall have any liability whatsoever for the payment of any benefit or any other amount under this Plan, except to the extent that there are Plan assets held in the Trust or by the Insurer pursuant to the Annuity Contract that are available for the payment of that benefit.

9.12 Discretionary Indemnification. To the extent permitted by law, the Hospital Authority may indemnify any person dealing with Plan assets.

ARTICLE 10

AMENDMENT, TERMINATION AND MERGER

10.1 Amendment.

(a) General Rule. The Hospital Authority Board of Governors may amend the Plan at any time, including, without limitation, retroactive amendments necessary or appropriate to qualify the Plan or Trust under the provisions of the Code. However, except as permitted by applicable law, no such amendment may:

(1) Cause any part of the Plan and Trust assets to revert to, or be recoverable by, the Hospital Authority or to be used for or diverted to purposes other than the exclusive benefit of the Participants and their Beneficiaries, except as required to pay taxes and reasonable Plan or Trust administration expenses;

(2) Deprive any Participant or Beneficiary of any portion of a Participant's Account balance to which he or she is entitled under the terms of the Plan as it exists prior to such amendment; or

(3) Change the duties or liabilities of the Trustee without its written consent.

(b) Technical Amendments. The Counsel for the Hospital Authority has the authority to adopt only amendments that are necessary or desirable to:

(1) Obtain or maintain the tax-qualified status of the Plan and Trust under Code sections 401(a) or 501(a);

(2) Comply with applicable state or federal law;

(3) Conform the Plan to its operation; correct punctuation, spelling grammar, usage, expression, inaccurate cross-references; or reorganize or renumber provisions; or

(4) Clarify the meaning of the Plan.

10.2 Termination. The Hospital Authority intends that the Plan be permanent; nevertheless, the Hospital Authority is not under any obligation to continue its contributions to the Plan or to maintain the Plan for any length of time. The Hospital Authority may, at any time, discontinue its contributions to or terminate the Plan, without any liability for such discontinuance or termination, subject to the payment of all amounts accrued under the Plan as of the effective date of such termination.

10.3 Merger. The Hospital Authority may merge or consolidate the Plan or the Trust with, or transfer its assets or liabilities to, another qualified plan or trust upon such terms and conditions as the Hospital Authority determines.

ARTICLE 11

MISCELLANEOUS PROVISIONS

11.1 Exclusive Benefit. The assets of the Plan are trust funds that will be held by the Trustee in the Trust or by the Insurer pursuant to the terms of the Annuity Contracts for the exclusive purpose of providing benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan and Trust. It will be impossible, at any time before the satisfaction of all liabilities with respect to Participants and their Beneficiaries under the Plan and Trust, for any part of the Trust or Annuity Contracts, other than such part as is required to pay taxes and the reasonable expenses of administering the Plan and Trust, as provided in Section 8.8, to be used for, or diverted to, purposes other than for the exclusive benefit of the Participants and their Beneficiaries; provided, however, that notwithstanding this or any other provision of this Plan, contributions made by the Hospital Authority because of a good faith mistake in fact may be returned to the Hospital Authority within one year of the date of the contribution.

11.2 Spendthrift Provision. No right or claim to, or interest in, any part of the Plan, the Trust or Annuity Contract, or any payment from the Trust or Annuity Contract is assignable, transferrable or subject to sale, mortgage, pledge, hypothecation, commutation, anticipation, garnishment, attachment, execution, or levy of any kind, nor will any portion of the Trust or Annuity Contract be made subject to the bankruptcy estate of any Participant or Participant's Beneficiary under the Plan, except as specifically permitted by the Plan or required by law. The Pension Committee, the Trustee and the Insurer will disregard any attempt to assign, transfer, sell, mortgage, pledge, hypothecate, commute, anticipate, garnish, attach, execute upon or levy against any portion of the Trust or Annuity Contract, except to the extent specifically permitted by the Plan and only as directed by the Pension Committee, required by law or directed by a court of competent jurisdiction. The restriction in the preceding sentence will not apply to:

(a) A Participant's pledge or grant of all or a portion of the Participant's Account to the Trustee or Insurer as security for a Plan loan to the Participant; or

(b) A Qualified Domestic Relations Order, as defined in Section 8.13.

11.3 No Contract of Employment. The Plan does not constitute a contract between any Physician and the Hospital Authority, and nothing in the Plan gives any Physician the right to be retained in the employ of the Hospital Authority.

11.4 Qualified Military Service. Notwithstanding any provision of the Plan to the contrary, effective December 12, 1994, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with Code section 414(u). If a Participant dies on or after January 1, 2007, while performing qualified military service (as defined in section 414(u) of the Code), the Participant's surviving Spouse or Beneficiaries are entitled to any additional benefits (other than contributions or allocations relating to the period of qualified military service) provided under the Plan had the Participant resumed and then terminated employment on account of death.

11.5 Governing Law. The Plan and Trust will be governed by the applicable laws of the state of California (without regard to its choice of law principles) to the extent not preempted by applicable federal law; provided, however, that if any provision of the Plan or Trust is susceptible to more than one interpretation, such interpretation will be given thereto as is consistent with this Plan being a qualified pension plan within the meaning of section 401(a) of the Code.

11.6 Severability. If any provision of the Plan is held by a court of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability will not affect any other provision of the Plan, and the Plan will be construed and enforced as if such provision had not been included.

ARTICLE 12

PENSION REFORM

12.1 Application and Interpretation. Effective January 1, 2013, this Article 12 takes precedence over any conflicting provision of the Plan. To the extent unchanged by this Appendix, the remaining provisions of the Plan remain in full force and effect. The provisions of this Article will be interpreted and administered in accordance with the applicable requirements of the California Public Employees' Pension Reform Act of 2013, which are codified in Article 4, Chapter 21 of Division 7 of Title 1 of the California Government Code, as amended from time to time ("PEPRA").

12.2 Felony Convictions. If a Member who is subject to sections 7522.70, 7522.72 or 7522.74 of the California Government Code is convicted of a felony described in the applicable section or sections, he or she will forfeit his or her accrued rights and benefits, and will not accrue further benefits, in the Plan to the extent provided in the applicable section or sections. This subsection will be interpreted and administered in accordance with the requirements of Sections 7522.70, 7522.72 and 7522.74 of the California Government Code, including, but not limited to, any applicable rules governing return of Participant contributions, notice, and reversal of conviction, which requirements are herein incorporated by this reference.

IN WITNESS WHEREOF, the Hospital Authority has caused this Plan to be executed on this 19th day of October, 2016.

KERN COUNTY HOSPITAL AUTHORITY

By: _____
Chairman
Board of Governors

Approved as to Content:

KERN MEDICAL CENTER

By: _____
Russell V. Judd
Chief Executive Officer

Approved as to Form:

OFFICE OF COUNTY COUNSEL

By: _____
Karen S. Barnes, Chief Deputy

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Agreement with Anderson Group International for Pharmacy USP 797 Clean Room Modifications - Construction

Recommended Action: Make Finding Project Exempt from further CEQA Review per Sections 15301 and 15061(b)(3) of State CEQA Guidelines; Approve; Authorize Chairman to sign

Summary:

Proposed Agreement with Anderson Group International, to provide all labor, material and equipment necessary for the construction of Pharmacy USP 797 Clean Room Modifications, in the amount of $588,018.07.

DOCUMENT 00500

AGREEMENT

THIS AGREEMENT, dated this **19th** day of **October 2016,** is by and between **Anderson Group International** whose place of business is located at **P.O. Box 80306, Bakersfield, CA 93380** ("Contractor"), and the KERN COUNTY HOSPITAL AUTHORITY, a political subdivision of the State of California (hereinafter "Owner"), acting under and by virtue of the authority vested in Owner by the laws of the State of California

WHEREAS, in consideration for the promises and payment to be made and performed by Authority, and under the conditions expressed in the incorporated Bid Proposal (Bid), bonds and related papers, Contractor agrees to do all the work and furnish all the materials at the expense of Contractor (except such as the Specifications state will be furnished by Authority) necessary to construct and complete in a good and workmanlike manner to the satisfaction of the Chief Executive Officer for the Kern County Hospital Authority all the work shown and described in the plans and specifications for the project known as:

Pharmacy USP 797 Clean Room Modifications (1250.10926)

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth, Contractor and Owner agree as follows:

ARTICLE 1 - SCOPE OF WORK OF THE CONTRACT

1.01 Work of the Contract

A. Contractor shall complete all Work specified in the Contract Documents, in accordance with the Specifications, Drawings, and all other terms and conditions of the Contract Documents (**Work**).

1.02 Price for Completion of the Work

A. Owner shall pay Contractor the following Contract Sum, **five hundred eight-eight thousand, eighteen dollars and 07 cents,** for completion of Work in accordance with Contract Documents as set forth in Contractor's Bid, attached hereto.

ARTICLE 2 - COMMENCEMENT AND COMPLETION OF WORK

2.01 Commencement of Work

A. Contractor shall commence Work on the date established in the Notice to Proceed (**Commencement Date**).

B. Owner reserves the right to modify or alter the Commencement Date.

2.02 Completion of Work

A. Contractor shall achieve Final Completion of the entire Work **165 Working** Days, as defined in Document 01422, from the Commencement Date.

ARTICLE 3 - LIQUIDATED DAMAGES FOR DELAY IN COMPLETION OF WORK

3.01 Liquidated Damage Amounts

A. As liquidated damages for delay Contractor shall pay Owner two thousand dollars ($2,000.00) for each Calendar Day that expires after the time specified herein for Contractor to achieve Final Completion of the entire Work, until achieved.

3.02 Scope of Liquidated Damages

A. Measures of liquidated damages shall apply cumulatively.
B. Limitations and stipulations regarding liquidated damages are set forth in Document 00700 (General Conditions).

ARTICLE 4 - CONTRACT DOCUMENTS

4.01 Contract Documents consist of the following documents, including all changes, Addenda, and Modifications thereto:

Document 00001	Title Page
Document 00100	Notice to Contractors
Document 00200	Instruction to Bidders
Document 00300	Geotechnical Data and Existing Conditions
Document 00410	Bid Form
Document 00412	Bidder Registration Form
Document 00431	Subcontractors List
Document 00452	Non-Collusion Declaration
Document 00453	Iran Contracting Act Certification
Document 00455	Bidder Certifications
Document 00500	Agreement
Document 00501	Proposed Contract Documents Transmittal
Document 00601	Construction Performance Bond
Document 00602	Construction Labor and Material Payment Bond
Document 00603	Guaranty
Document 00590	Release of Claims
Document 00620	Withheld Contract Funds Certification
Document 00700	General Conditions
Document 00738	Apprenticeship Programs
Document 00800	Supplementary Conditions – Insurance
Master Specifications	Divisions 1 through 16
Drawings	

4.02 There are no Contract Documents other than those listed above. The Contract Documents may only be amended, modified or supplemented as provided in Document 00700 (General Conditions).

ARTICLE 5 – LIABILITY OF AUTHORITY

5.01 The liabilities or obligations of Authority with respect to its activities pursuant to this Agreement shall be the liabilities or obligations solely of Authority and shall not be or become the liabilities or obligations of the County of Kern or any other entity, including the State of California.

ARTICLE 6 – MISCELLANEOUS

6.01 Terms and abbreviations used in this Agreement are defined in Document 00700 (General Conditions) and Section 01422 (Definitions) and will have the meaning indicated therein.

6.02 It is understood and agreed that in no instance are the persons signing this Agreement for or on behalf of Owner or acting as an employee, agent, or representative of Owner, liable on this Agreement or any of the Contract Documents, or upon any warranty of authority, or otherwise, and it is further understood and agreed that liability of Owner is limited and confined to such liability as authorized or imposed by the Contract Documents or applicable law.

6.02 In entering into a public works contract or a subcontract to supply goods, services or materials pursuant to a public works contract, Contractor or Subcontractor offers and agrees to assign to the awarding body all rights, title and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. §15) or under the Cartwright Act (Chapter 2 (commencing with §16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, services or materials pursuant to the public works contract or the subcontract. This assignment shall be made and become effective at the time Owner tenders final payment to Contractor, without further acknowledgment by the parties.

6.03 This project is subject to prevailing wage laws. Copies of the general prevailing rates of per diem wages for each craft, classification, or type of worker needed to execute the Contract, as determined by Director of the State of California Department of Industrial Relations, are deemed included in the Contract Documents and on file at Owner's Office, and shall be made available to any interested party on request. Pursuant to California Labor Code §§ 1860 and 1861, in accordance with the provisions of Section 3700 of the Labor Code, every contractor will be required to secure the payment of compensation to his employees. Contractor represents that it is aware of the provisions of Section 3700 of the Labor Code which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of that Code, and Contractor shall comply with such provisions before commencing the performance of the Work of the Contract Documents.

6.04 This Agreement and the Contract Documents shall be deemed to have been entered into in the County of Kern, State of California, and governed in all respects by California law (excluding choice of law rules). The exclusive venue for all disputes or litigation hereunder shall be in the Superior Court for the County of Kern.

IN WITNESS WHEREOF the parties have executed seven original Agreements on the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By _____
Shannon Hochstein, Deputy County Counsel

KERN COUNTY HOSPITAL AUTHORITY

By _____
Russell Bigler, Board of Governors - Chairman

"AUTHORITY"

APPROVED AS TO CONTENT:
KERN MEDICAL HOSPITAL

By _____
Russell Judd, Chief Executive Officer

By _____
Jared Leavitt, Chief Operating Officer

Contractor's Name

Type of Entity
(corporation, partnership, sole proprietorship)

By _____
Signature

_____
Typed Name

_____
Title of Individual Executing
Document on behalf of Firm

"CONTRACTOR"

NOTICE: CONTRACTORS ARE REQUIRED BY LAW TO BE LICENSED AND ARE REGULATED BY CONTRACTORS' STATE LICENSE BOARD. QUESTIONS CONCERNING A CONTRACTOR MAY BE REFERRED TO THE REGISTRAR OF THAT BOARD, WHOSE ADDRESS IS: CONTRACTORS' STATE LICENSE BOARD, 1020 "N" STREET, SACRAMENTO, CALIFORNIA 95814.

END OF DOCUMENT

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed Agreement with Black Hall Construction, Inc. for IDF Closets 4C; 4D and 3C - Construction

Recommended Action: Make Finding Project Exempt from further CEQA Review per Sections 15301 and 15061(b)(3) of State CEQA Guidelines; Approve; Authorize Chairman to sign

Summary:

Proposed Agreement with Black Hall Construction, Inc., in the amount of $252,313, to provide all labor, material and equipment necessary for the construction of IDF Closet upgrades at 4C; 4D and 3C.

DOCUMENT 00500

AGREEMENT

THIS AGREEMENT, dated this **19th** day of **October, 2016**, is by and between **Black Hall Construction, Inc.** whose place of business is located at **P.O. Box 445, Taft, CA 93268** ("Contractor"), and the KERN COUNTY HOSPITAL AUTHORITY, a political subdivision of the State of California (hereinafter "Owner"), acting under and by virtue of the authority vested in Owner by the laws of the State of California

WHEREAS, in consideration for the promises and payment to be made and performed by Authority, and under the conditions expressed in the incorporated Bid Proposal (Bid), bonds and related papers, Contractor agrees to do all the work and furnish all the materials at the expense of Contractor (except such as the Specifications state will be furnished by Authority) necessary to construct and complete in a good and workmanlike manner to the satisfaction of the Chief Executive Officer for the Kern County Hospital Authority all the work shown and described in the plans and specifications for the project known as:

IDF Room Upgrades at 4C 4D and 3C (1250.10924)

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth, Contractor and Owner agree as follows:

ARTICLE 1 - SCOPE OF WORK OF THE CONTRACT

1.01 Work of the Contract

A. Contractor shall complete all Work specified in the Contract Documents, in accordance with the Specifications, Drawings, and all other terms and conditions of the Contract Documents (**Work**).

1.02 Price for Completion of the Work

A. Owner shall pay Contractor the following Contract Sum two hundred fifty-two thousand, three hundred thirteen dollars for completion of Work in accordance with Contract Documents as set forth in Contractor's Bid, attached hereto.

ARTICLE 2 - COMMENCEMENT AND COMPLETION OF WORK

2.01 Commencement of Work

A. Contractor shall commence Work on the date established in the Notice to Proceed (**Commencement Date**).

B. Owner reserves the right to modify or alter the Commencement Date.

2.02 Completion of Work

A. Contractor shall achieve Final Completion of the entire Work **120 Working** Days, as defined in Document 01422, from the Commencement Date.

ARTICLE 3 - LIQUIDATED DAMAGES FOR DELAY IN COMPLETION OF WORK

3.01 Liquidated Damage Amounts

A. As liquidated damages for delay Contractor shall pay Owner two thousand dollars ($2,000.00) for each Calendar Day that expires after the time specified herein for Contractor to achieve Final Completion of the entire Work, until achieved.

3.02 Scope of Liquidated Damages

A. Measures of liquidated damages shall apply cumulatively.
B. Limitations and stipulations regarding liquidated damages are set forth in Document 00700 (General Conditions).

ARTICLE 4 - CONTRACT DOCUMENTS

4.01 Contract Documents consist of the following documents, including all changes, Addenda, and Modifications thereto:

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Document 00410	Bid Form
Document 00412	Bidder Registration Form
Document 00431	Subcontractors List
Document 00452	Non-Collusion Declaration
Document 00453	Iran Contracting Act Certification
Document 00455	Bidder Certifications
Document 00500	Agreement
Document 00501	Proposed Contract Documents Transmittal
Document 00601	Construction Performance Bond
Document 00602	Construction Labor and Material Payment Bond
Document 00603	Guaranty
Document 00590	Release of Claims
Document 00620	Withheld Contract Funds Certification
Document 00700	General Conditions
Document 00738	Apprenticeship Programs
Document 00800	Supplementary Conditions – Insurance
Master Specifications	Divisions 1 through 16
Drawings	

4.02 There are no Contract Documents other than those listed above. The Contract Documents may only be amended, modified or supplemented as provided in Document 00700 (General Conditions).

ARTICLE 5 – LIABILITY OF AUTHORITY

5.01 The liabilities or obligations of Authority with respect to its activities pursuant to this Agreement shall be the liabilities or obligations solely of Authority and shall not be or become the liabilities or obligations of the County of Kern or any other entity, including the State of California.

ARTICLE 6 – MISCELLANEOUS

6.01 Terms and abbreviations used in this Agreement are defined in Document 00700 (General Conditions) and Section 01422 (Definitions) and will have the meaning indicated therein.

6.02 It is understood and agreed that in no instance are the persons signing this Agreement for or on behalf of Owner or acting as an employee, agent, or representative of Owner, liable on this Agreement or any of the Contract Documents, or upon any warranty of authority, or otherwise, and it is further understood and agreed that liability of Owner is limited and confined to such liability as authorized or imposed by the Contract Documents or applicable law.

6.02 In entering into a public works contract or a subcontract to supply goods, services or materials pursuant to a public works contract, Contractor or Subcontractor offers and agrees to assign to the awarding body all rights, title and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. §15) or under the Cartwright Act (Chapter 2 (commencing with §16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, services or materials pursuant to the public works contract or the subcontract. This assignment shall be made and become effective at the time Owner tenders final payment to Contractor, without further acknowledgment by the parties.

6.03 This project is subject to prevailing wage laws. Copies of the general prevailing rates of per diem wages for each craft, classification, or type of worker needed to execute the Contract, as determined by Director of the State of California Department of Industrial Relations, are deemed included in the Contract Documents and on file at Owner's Office, and shall be made available to any interested party on request. Pursuant to California Labor Code §§ 1860 and 1861, in accordance with the provisions of Section 3700 of the Labor Code, every contractor will be required to secure the payment of compensation to his employees. Contractor represents that it is aware of the provisions of Section 3700 of the Labor Code which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of that Code, and Contractor shall comply with such provisions before commencing the performance of the Work of the Contract Documents.

6.04 This Agreement and the Contract Documents shall be deemed to have been entered into in the County of Kern, State of California, and governed in all respects by California law (excluding choice of law rules). The exclusive venue for all disputes or litigation hereunder shall be in the Superior Court for the County of Kern.

IN WITNESS WHEREOF the parties have executed seven original Agreements on the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By _____
Shannon Hochstein, Deputy County Counsel

KERN COUNTY HOSPITAL AUTHORITY

By _____
Russell Bigler, Board of Governors - Chairman

"AUTHORITY"

APPROVED AS TO CONTENT:
KERN MEDICAL HOSPITAL

By _____
Russell Judd, Chief Executive Officer

By _____
Jared Leavitt, Chief Operating Officer

Contractor's Name

Type of Entity
(corporation, partnership, sole proprietorship)

By _____
Signature

_____
Typed Name

_____
Title of Individual Executing
Document on behalf of Firm

"CONTRACTOR"

NOTICE: CONTRACTORS ARE REQUIRED BY LAW TO BE LICENSED AND ARE REGULATED BY CONTRACTORS' STATE LICENSE BOARD. QUESTIONS CONCERNING A CONTRACTOR MAY BE REFERRED TO THE REGISTRAR OF THAT BOARD, WHOSE ADDRESS IS: CONTRACTORS' STATE LICENSE BOARD, 1020 "N" STREET, SACRAMENTO, CALIFORNIA 95814.

END OF DOCUMENT

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Presentation on the Medi-Cal 2020 Demonstration and proposed Whole Person Care Pilot Application with California Department of Health Care Services for participation of Kern Medical Center as Lead Entity in Kern County

Recommended Action: Hear Presentation; Approve; Adopt Resolution; Authorize Chief Executive Officer to sign application subject to Approval as to Form by Counsel

Summary:

A presentation will be provided on the status of the implementation of the Medi-Cal 2020 Demonstration Waiver.

In addition, in implementing the Medi-Cal 2020 Demonstration Waiver, Kern Medical has applied as the Lead Entity to participate in the Whole Person Care (WPC) Pilot. As noted in the Standard Terms and Conditions of the Medi-Cal 2020 Demonstration Waiver, the Lead Entity must formally accept or decline the approved application within 10 days of notification from California Department of Health Care Services (DHCS). DHCS will notify lead entities of approval no later than October 24, 2016. Due to the rapid turnaround required, this is to request your Board adopt the attached resolution authorizing Chief Executive Officer Russell V. Judd to sign the final approved WPC pilot application and to enter into the agreement with the DHCS.

Attached for your review is the WPC application submitted to DHCS including the application narrative outlining the proposed interventions and services to be provided, the proposed budget detailing funding for each year of the program, and a diagram depicting the flow of funds from DHCS to the participating entities.

KernMedical | *Health for Life.*

Medi-Cal 2020 Waiver

Medi-Cal Waiver Programs

- PRIME
- Global Payment Program
- Whole Person Care

Cash Flow (in thousands)

	FY16	FY17	FY18	FY19	FY20	FY21	Total
PRIME		47,561	31,707	30,122	26,396	12,128	147,914
GPP	21,140	29,035	27,050	25,470	24,132	5,944	132,772
WPC	0	15,735	15,735	15,735	15,735	15,735	78,673
Total	21,140	92,330	74,491	71,327	66,263	33,807	359,358

Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME)

- Aims to transform care to improve the quality and value of care
- Program is data-driven, and success is measured by metric attainment
- Kern Medical has committed to implementing 9 PRIME Initiatives
  - 6 required, 3 optional
- 1st report due September 30, 2016

PRIME

- Funds are earned based on metric reporting (P4R) or metric performance (P4P)
- Funds in Year 1 were earned for having application accepted (25%) and submitting baseline values (75%

P4R	P4P
Alcohol and Drug Misuse (SBIRT)	Comprehensive Diabetes Care
Specialty Care Touches via non-face to face encounter	Controlling Blood Pressure
Medication Reconciliation	Tobacco Assessment and Counseling

Global Payment Program (GPP)

- Provides for funding of uninsured services
- Services are assigned point values:
  - 100 points per Primary Care visit
  - 964 points per ICU day
  - 75 points per telephone consultation
- Funds are capped based on a point threshold assigned to each Public Hospital
- 2016 Threshold - 3,633,669
- 2016 Preliminary Report – 4,298,508

Kern Medical Wellness Program

- Allows Kern Medical to be proactive in managing the care of the uninsured
- Services are limited to Kern Medical facilities
- Individuals are enrolled in the Wellness Program only after we have determined that there is no other funding source available
- Regularly review members for alternative sources of funding
- Approximately 800 members

Whole Person Care Pilot (WPC)

- Whole Person Care focuses on the coordination of health, behavioral health, and social services
- The goal is to improve beneficiary health and well-being through more efficient and effective use of services coordinated across partnering organizations
- Submitted proposal focusing on High-Utilizers, Recently Incarcerated and Homeless

Target Population - High Utilizers

- Data sharing and collaboration
- Increased communication across organizations
- Patient specific plans of care
- Non-traditional services
  - Pharm D
  - Health Coach
  - Lifestyle Education
  - Career assistance

Target Population - Homeless

- Housing Navigation Services
- Individualized housing support plans
- Lifestyle Education
- Coordinated referrals
- Barrier identification and resolution
- Ensuring living environment is safe and ready for move-in

Target Population - Recently Incarcerated

- Wellness check upon release
- Medication Reconciliation
- Assistance with applying for eligible programs
- 90 Life Skills Transition Education
  - Crime Theory
  - Anger Management
  - Coping Skills

Timeline

- Final application submitted September 23
- DHCS will notify entities no later than October 24
- Formal acceptance due within 10 days of notification of acceptance

Questions?

Action

Adopt Resolution

Authorize CEO to sign the final approved WPC pilot application on behalf of the Lead Entity and to enter into the agreement with the DHCS on behalf of the Lead Entity

BEFORE THE BOARD OF GOVERNORS
OF THE KERN COUNTY HOSPITAL AUTHORITY

In the matter of: Resolution No. _____

AUTHORIZING CHIEF EXECUTIVE OFFICER RUSSELL V. JUDD TO ACCEPT APPROVAL OF THE DHCS WHOLE PERSON CARE APPLICATION AND SIGN AND ENTER INTO THE WHOLE PERSON CARE AGREEMENT

I, RAQUEL D. FORE, Authority Board Coordinator for the Kern County Hospital Authority, hereby certify that the following Resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the Board of Governors of the Kern County Hospital Authority at an official meeting thereof on the 19th day of October, 2016, by the following vote, and that a copy of the Resolution has been delivered to the Chairman of the Board of Governors.

AYES:

NOES:

ABSENT:

RAQUEL D. FORE
Authority Board Coordinator
Kern County Hospital Authority

_____
Raquel D. Fore

RESOLUTION

Section 1. WHEREAS:

(a) On December 30, 2015, the Centers for Medicare & Medicaid Services ("CMS") approved the state's request to extend the section 1115(a) demonstration project, entitled "California Medi-Cal 2020 Demonstration" ("Waiver"). This extension allows California to extend its safety net care pool for five years, in order to support the state's efforts toward the adoption of robust alternative payment methodologies and support better integration of care; and

(b) The Waiver authorizes the Whole Person Care initiative ("WPC"), a five-year pilot program, to test locally-based initiatives that will coordinate physical health, behavioral health, and social services, as applicable, in a patient-centered manner for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and continue to have poor outcomes with the goals of improved beneficiary health and well-being through more efficient and effective use of resources; and

(c) Kern Medical Center has applied as a Lead WPC Pilot Entity ("Lead Entity") of a consortium of Kern County departments and community-based organizations; and

(d) On May 13, 2016, the Department of Health Care Services ("DHCS") received approval from the CMS on the WPC Pilots Program protocols and documents including the Waiver special terms and conditions; and

(e) The approved WPC pilot application will become the agreement between the DHCS and the Lead Entity with supplementary terms and provisions; and

(f) Within 10 days of final approval of the WPC pilot application, the Lead Entity must formally accept or decline approval of the application. The DHCS anticipates notifying lead entities of application approval no later than October 24, 2016; and

(g) In accordance with the WPC application process, the authorized signatory must be duly authorized in a resolution adopted by the governing body of the Lead Entity, as having authority to sign on behalf of the Lead Entity and designated to sign and enter into the WPC agreement with the DHCS on behalf of the Lead Entity.

Section 2. NOW, THEREFORE, IT IS HEREBY RESOLVED by the Board of Governors of the Kern County Hospital Authority, as follows:

1. This Board finds the facts recited herein are true, and further finds that this Board has jurisdiction to consider, approve, and adopt the subject of this Resolution.

2. This Board hereby authorizes Chief Executive Officer Russell V. Judd to sign the final approved WPC pilot application and agreement on behalf of the Lead Entity and to enter into the WPC agreement with the DHCS on behalf of the Lead Entity.

3. The Authority Board Coordinator shall provide copies of this Resolution to the following:

Kern Medical Center
Office of County Counsel
California Department of Health Care Services

Whole Person Care Pilot Application

Application due July 1, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	Kern Medical Center
Type of Entity (from lead entity description above)	Hospital Authority
Contact Person	Tyler Whitezell
Contact Person Title	Interim Vice President Administrative Services
Telephone	661-326-2760
Email Address	tyler.whitezell@kernmedical.com
Mailing Address	1700 Mt. Vernon Avenue Bakersfield, CA 93306

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Kern Health Systems (KHS)	Emily Duran Director of Provider Relations	• Managed care provider • Referring agency • Steering Committee • Data sharing • Collaborative Committee
2. Health Services Agency/Department	Kern Medical Center	Tyler Whitezell Interim Vice President Administrative Services	• Lead Entity • Hospital Authority • Steering Committee • Direct service provider • Data sharing • WPC financial management • Collaborative Committee • Care Coordination PMPM • Post-Incarceration PMPM • Employment Services PMPM
3. Specialty Mental Health Agency/Department	Kern County Mental Health (KCMH)	Brad Cloud Deputy Director	• County Mental Health Provider • Steering Committee • Direct service provider • Data sharing • Collaborative Committee • Care Coordination PMPM Bundle
4. Public Agency/ Department (if housing services are provided, must include the public housing authority)	Housing Authority of Kern County (HA)	Cristina Provencio Housing Specialist II	• Provider of affordable housing • Collaborative Committee • Direct service provider • Data sharing • Housing Navigation PMPM Bundle
5. Community Partner 1	Community	Cheryl Nelson	• Provider of child care and

	Connection for Child Care (CCCC)	Director	development • Collaborative Committee • Direct service provider • Data sharing • FFS Provider
6. Community Partner 2	Golden Empire Gleaners	Jim Wheeler Executive Director	• Local food bank • Collaborative Committee • Direct service provider • PMPM Bundle
Additional Organizations (Optional)	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
7. Community Partner 3	Kern County Homeless Collaborative	Christine Lollar Director of Homeless Resources	• Community based organization • Collaborative Committee • Data Sharing
8. Public Agency	Kern County Public Health (KCPH)	Claudia Jonah, M.D. Health Officer	• County health organization • Collaborative Committee • Direct service provider • Data sharing • Nurse Assessment FFS provider
9. Public Agency	Kern County Sherriff's Office (KCSO)	Anthony Gordon Detentions Lieutenant	• County detention facility provider • Steering Committee • Direct service provider • Data sharing • Referring agency • Collaborative Committee • Post-Incarceration PMPM Bundle
10. Public Agency	Kern County Probation	Rebecca Jamison Division Director, Fiscal, Research & Planning	• County probation • Collaborative Committee • Direct service provider • Data sharing • Care Coordination PMPM Bundle
11. Public Agency	KC Aging & Adult Services (AAS)	Jeremy Oliver Program Director	• County advocate for older adults and disabled individuals • Collaborative Committee • Direct service provider • Data sharing
12. Public Agency	Kern County Employers' Training Resource (ETR)	Aaron Ellis Deputy Director	• County workforce training provider • Collaborative Committee • Direct service provider • Data sharing • Employment Services PMPM Bundle
13. Medi-Cal managed care health plan 2	Health Net Community Solutions, Inc.	Abbie Totten Director, Government Programs Policy and Strategic Initiatives	• Managed care provider • Referring agency • Collaborative Committee • Data sharing

14. Public Agency	KERN County Department of Human Services (DHS)	Cindy Uetz Chief Deputy	• County Safety Net Program Provider • Collaborative Committee • Direct service provider • Data Sharing

Although only 3 community partners are included in this pilot, it includes the support of 6 additional county departments as well as an additional Managed Care Plan. Noting the current lack of infrastructure for such a global program, it is critical to success that the pilot is built upon a firm foundation. As this foundation is established, additional community partners will be added in the future.

1.3 Letters of Participation and Support

Attached

Section 2: General Information and Target Population

2.1 General Information

Kern County is located in Central California. According to the most recent information from the U.S. Census Bureau, the county has a total area of 8,163 square miles and a population of 839,631. The population is dispersed widely in urban, suburban, rural, and remote areas. Bakersfield, California, home to Kern Medical Center, represents the largest city in Kern County with a population of 529,169, or 63% of the total county population. The main staples of the local economy include large-scale warehousing, chemical refineries, oilfield operations, and agriculture. Due to the extensive agriculture the area is subject to significant population shifts in migrant farm workers.

According to United States Census Bureau, 24.5% of the population lives in poverty, compared to 16.4% statewide. Historically, a large percentage of the population was uninsured; however, with the passage of the Affordable Care Act, the number of uninsured has dropped considerably, to 14.5% of the population, comparable to the statewide rate of 14.0%. The population has low levels of education relative to the rest of California with only 73.0% of individuals with a high school or higher level of education and 15.2% with a bachelor's degree or higher, compared to 81.5% and 31.0%, respectively. Low education levels combined with a high rate of non-native speakers of English greatly impacts the health literacy of the population, precipitating the need for personalized care plans.

Populations with low levels of health literacy are more likely to overlook preventive services which can lead to an increase in preventable hospital visits and use of emergency rooms, where costs are far greater. This leads to overcrowding of both the inpatient setting, as well as emergency rooms, which yields excessive waiting times for other non-avoidable visits. This low level of health literacy also contributes to the County's health care disparities which can be summarily describe as follows:

- 50.4% of adults are obese compared to 27% statewide
- 13.5% diabetes rate compared to 10.5% statewide
- 9.4% adults are diagnosed with heart disease compared to 6.1% statewide
- 43.7% have lower respiratory disease compared to 35.3% statewide
- 17.1% of adults experienced psychological distress compared to 7.7% statewide
- 41% of adults reported having engaged in binge drinking during the previous year, compared to 32.6% statewide

The county is home to five state prisons and four county detention centers which include a juvenile hall. Kern Medical Center currently provides medical care for all county detention centers. In 2015, inmates from these institutions accounted just over $22 million in healthcare costs and over one third of this population suffers from chronic illness. While incarcerated these individuals receive regular medical care, however upon release, many fail to continue this care. Additionally, many of these individuals are released to homelessness.

The 2015 Homeless Collaborative point-in-time census identified 953 individuals. In this same report 79 individuals reported being discharged to homeless after being released from incarceration.[1] A study in the New England Journal of Medicine found that homeless individuals spend approximately four days longer per hospital visit than a comparable non-homeless visit which leads to a substantial increase in costs.[2] Of the more than 25,000 lives assigned to Kern Medical Center from KHS, those homeless or at risk of homelessness accounted for 16% of Emergency Room costs and 15% of inpatient costs in 2015. The point-in-time census further found that the majority of the homeless population suffers from mental, physical or social ailments, respectively:

- 109 Have been hospitalized for mental issues
- 401 Admitted to substance use disorder
- 65 Are infected with Hepatitis
- 28 Are infected with Valley Fever
- 19 Are infected with Tuberculosis
- 2 Persons have HIV/AIDS
- 77 Reported being victims of domestic violence

Partners within the community have attempted to address these health care disparities, most recently with the Kern Get Connected (KGC) initiative launched by the Kern County Public Health Department in 2014. This program aimed to decrease avoidable-utilization of emergency services through case management and coordination of care across various services throughout the community. Using data from various sources, EMS and local hospitals identified eighteen beneficiaries who accounted for 241 emergency room visits in the prior six months or approximately 2 visits per individual, per month. Common conditions that were not being addressed were identified among these individuals, including behavioral health, substance use disorder, poor disease management, homeless or at risk of homelessness, negligible support from family, no reliable transportation and a general lack of health education.

Based upon their needs, each beneficiary was linked to one or more of the following services:

- Primary care provider linkage
- Health insurance services
- Life skills programs
- Behavioral health services
- Housing advocacy
- Disease management

KGC realized significant improvements for program beneficiaries, including a reduction in ER visits by 68%, a decrease in average cost per patient visit by 89%, and administrative success over the first year.

[1] United States. Kern County Homeless Collaborative. *2015 Homeless Census Report*. N.p.: n.p., n.d. Print.

[2] Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. New England Journal of Medicine 1998; 338: 1734-1740.

The KGC program displayed the value of case management and the importance of inter-agency communication. Notwithstanding the benefits that this program precipitated, turnover, lack of resources and waning support caused the program to stall.

With the announcement of the WPC program, Kern Medical Center created the WPC Committee consisting of community partners desiring to enhance care coordination throughout the community and reduce redundancy in services provided with the overarching goal of improving the health of the entire patient. This committee met on a regular basis to discuss shortfalls within the community, brainstorm solutions to those shortfalls and create a strategy that would be implemented through the WPC Pilot program.

The target population for the WPC pilot program will consist of high utilizers of emergency and inpatient services, with an emphasis on those who are homeless or at risk of becoming homeless, and those recently released from incarceration. The pilot will initially receive referrals from the two managed care partners and from Kern Medical Center, who contracts with the County for correctional medicine services. These beneficiaries will opt-in to the WPC program, and will be assigned to one of Kern Medical Center's Patient Center Medical Homes (PCMH) or Patient Centered Specialty Practices (PCSP) based on their specific needs and where they fall in our four-quadrant model.

These PCMHs and PCSPs will function as hosts and central hubs for WPC care coordination teams. In addition to hosting, the PCMHs and PCSPs will also provide logistical and other supportive services for the WPC care coordination teams. Within these homes, beneficiaries will be assigned a WPC care coordination team who will develop a unique health action plan (HAP). The partnering organizations will use shared case management software, allowing for the sharing of social determinants across the organizations. For recently incarcerated individuals, a clinic will be established right outside the gates of the jail facility where individuals will be receive a medication reconciliation and have a follow-up appointment scheduled with a primary care provider. Those homeless or at risk of homelessness will be assigned a Housing Navigator who will assist them through the housing process.

The WPC Committee will meet on a regular basis throughout the pilot to review the performance of the pilot and use the Plan, Do, Study, Act (PDSA) approach to performance improvement. The committee will adapt to lessons learned from the established strategies and take necessary steps to quality and process improvement. As over-utilization is reduced, the partners will come together to identify opportunities for alternative payment methodologies (APM) based upon the financial savings of the program. It is anticipated that the APMs will sustain the program beyond the pilot.

2.2 Communication Plan

Through the strategic building process, Kern Medical Center created two governing WPC Committees consisting of all participating entities listed in Section 1.1.2. These committees will meet regularly to evaluate the WPC program and share information. These committees are:

- Steering Committee – Responsible for overall direction and strategy. This committee has the ultimate decision making authority.
    - Kern Family Health Systems
    - Kern County Sherriff's Office
    - Kern County Mental Health
    - Health Net
    - Kern Medical Center
- Collaborative Committee – Implements and facilitates services, care coordination support and identifies ways to improve data sharing
    - Health Net
    - Kern County Department of Human Services
    - Kern Family Health Systems
    - Kern County Sherriff's Office
    - Kern County Mental Health
    - Kern County Public Health
    - Kern County Probation
    - Kern Medical Center
    - Kern County Employer's Training Resources
    - Kern County Aging & Adult Services
    - Community Connection for Child Care
    - Housing Authority of Kern County
    - Golden Empire Gleaners

A barrier identified early in the planning process was that throughout Kern County there is a lack of foundational infrastructure necessary for successful sharing of data across organizations. Noting this weakness, the partnering organizations felt that it would be more manageable and practical to begin with a manageable group of partnering organizations. As the program grows and future needs are identified, it is anticipated that additional community partners will be incorporated.

Kern Medical Center's, Director of Whole Person Care is the main point of contact for the partnering organizations and will be responsible for coordinating continued planning and support for WPC program committees. This point of contact will administer the day-to-day operations of the program, have the authority to make decisions, and create an atmosphere of regular communication amongst participants.

Through the program, each partnering organization will have an individual assigned to work at their organization. This individual will be the point of contact for day-to-day operational items and for accepting and administering referrals. Committees will meet regularly to monitor progress, discuss issues and concerns and share lessons learned.

Communication is critical to the success of the pilot, and participation in committees will be incentivized to ensure greater participation. Each meeting will have standing agenda items which will include, but not limited to:

1. Review of previous month's data on all performance metrics.
2. Evaluation of existing processes using the Plan, Do, Study, Act process to identify inefficiencies and improve existing processes. This will occur on a revolving basis allowing for processes to be revisited regularly.
3. Introduction of new processes necessary for program success.
4. Lessons learned and program successes.
5. Challenges and barriers identified.

Care coordination teams will huddle on a daily basis discuss beneficiaries with appointments that day, and to ensure that the health action plan has been updated with their most recent labs, review prior visits and discuss barriers to care, enhance team communication, and improve beneficiary flow and planning efforts. These huddles help to reduce surprises and frustration amongst team members, which in turn contribute to improved beneficiary communication and outcomes.

2.3 Target Population(s)

During initial WPC Committee meetings, the partnering organizations met together frequently to discuss shortfalls and disparities within the community and to identify the target population that would be best served by addressing these shortfalls. The committee's methodology for identifying our target population consisted of research and review of the following information and data:

- Review of the past program outcomes – The KGC pilot program was initiated by Kern County Public Health and shared similar objectives as whole person care and provided invaluable insight into the challenges and possible outcomes of such programs. The pilot focused on case management of high utilizers of emergency and inpatient services, but yielded drastic reductions in avoidable utilization.

  As mentioned above, KGC identified common attributes that might have been addressed, but there was no centralized hub coordinating the services. This led to inefficiencies in the provision of care, and lack of follow-through. Through case management, KGC realized significant improvements in the quality of life for beneficiaries through the elimination of barriers to health care and linkages to social support services.

  The specific needs of the population which the KGC program was unable to meet included:
    - Integration of behavioral health services
    - Integrated data systems allowing true case management across agencies
    - Methods for identifying and engaging the homeless population
    - Staffing resources needed to meet additional referrals from EMS and hospitals
    - Integration of CBOs into the care coordination process

- Existing managed care plan (MCP) provider data – Kern Family Health Systems, the largest MCP in Kern County, provided data indicating 5% of their membership contributed to 64% of their costs. Of the 25,000 lives assigned to Kern Medical Center, 6% accounted for 87% of the costs

associated with medical care accounting for more than $26 million in 2015.

- 2016 Bakersfield Memorial Hospital Community Health Needs Assessment – Review of this needs assessment found several areas of focus which also contributed to the committee's methodology in identifying our target population:
    - Significant Health Needs – The following significant health needs were determined:
        - Access to care
        - Asthma
        - Cancer
        - Cardiovascular disease
        - Dental Health
        - Diabetes
        - Environmental health
        - Lung disease
        - Maternal and infant health
        - Mental health
        - Overweight and obesity
        - Sexually Transmitted Infections
        - Substance Abuse

    - Mental Health Needs – this community assessment identified that 17.1% of adults in Kern County experienced some form of behavioral health distress and 21.4% of adults needed help for emotional, mental health, alcohol or drug issues and 85.5% of those who sought help did not receive it.

    - Food Insecurity – Among the entire population in Kern County, 15.1% experience food insecurity.

    - Homeless – Of the reported homeless population, 41.8% are unsheltered.

- Incarceration Data – As the county provider of health care services for County Facilities, Kern Medical Center has access to utilization data of this population while they are incarcerated. Through discussions with medical staff at these facilities, often times, individuals are released with little prior notification, and there is no smooth transition of care. While incarcerated healthcare was brought to these individuals. Meds were passed on a regular schedule, Physicians and nurses went to the facility to see the patients, and if a situation was escalated, the individual would be transported to a hospital. This structure becomes a way of life, but post-release this rigid structure vanishes with little education or preparation. Discussions with Kern County Sheriff's Office and Probation both reinforced this lack of transition. Individuals are released from incarceration with insufficient, if any, medications, and are expected to provide for themselves, when they don't know how. In turn, these individuals consistently forego medications and filling prescriptions, they do not make appointments to see a primary care provider, and they end up in the emergency room when their ailments become too great. This leads to higher costs, crowded emergency rooms, and although the ailments might be

addressed, the root cause is not. These individuals receive little if any follow-up, and they leave with the same level of health education as they had prior, creating a vicious cycle of overutilization.

Using both qualitative and quantitative analyses, the partnering organizations determined that the target population will consist of, high utilizers of emergency and inpatient services, with an emphasis on those who are homeless or at risk of becoming homeless, and those recently released from incarceration. All individuals taking part in the program will be Medi-Cal beneficiaries, and initial referrals will come directly from the Managed Care Organizations.

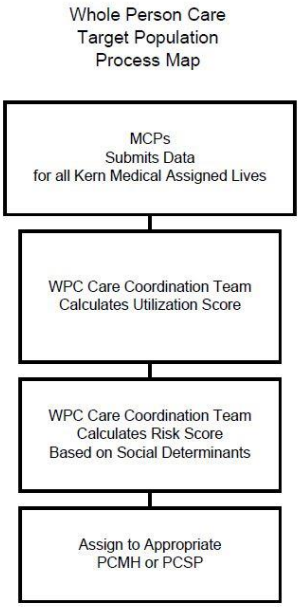
The care coordination teams will be stationed within Patient Centered Medical Homes to provide for care coordination. This pilot will have an enrollment cap of 1,500 beneficiaries. The largest restraint in capacity is our ability to establish and administer Patient Centered Medical Homes (PCMH). Currently, Kern Medical Center has one established, NCQA certified PCMH with plans to open an additional PCMH in the coming months. The medical center also has established specialty clinics, which we will continue to develop into Patient Centered Specialty Practices (PCSP).

The capacity on each of the PCMHs is 1,000 and the capacity of each of the PCSPs will be 50 for the HIV clinic, 250 in the Hypertension clinic and 350 in the Diabetes clinic. By the end of the program, we expect total enrollment in these clinics to reach just under 2,000 lives. We have based a conservative estimate that 75% of the individuals within these clinics will opt-in to Whole Person Care, thus the enrollment cap of 1,500. In order to account for the additional 25% enrollment in the clinics that will not be paid for with WPC funds, positions have been excluded from our PMPM bundles and the positions within the bundles that will crossover have been reduced accordingly. Initial analysis has shown that approximately 20%, or 400 of these individuals will be homeless, or at risk of homelessness. Although we anticipate 400 to be homeless or at risk of homelessness, capacity for the enhanced housing navigation will be capped at 40 beneficiaries at any given time. All beneficiaries in need of housing will be referred to agencies able to provide that assistance, but the housing navigation services are for those who are in the greatest need. Traditional services help individuals up to the point of habitation, but housing navigation services go far beyond. Housing navigators will follow these individuals through the entire continuum of care, ensuring that once individuals are placed in a home, that they have the resources and support necessary to remain in the home. Understanding the level of resources, time and commitment necessary to provide these services, this cap will allow for focused coordination, leading to successful results. After individuals have remained in a home for one year, the level of resources necessary will drop substantially, and a new beneficiary will begin receiving these services. There is no additional cap on enrollment of individuals recently incarcerated, apart from the overarching constraint on medical homes. Understanding that there are shared services with Targeted Case Management, the budgets for care coordination have been adjusted accordingly.

The MCP partners will provide a beneficiary list of all beneficiaries assigned to Kern Medical Center. The WPC care coordination team will evaluate the referred beneficiaries and apply an algorithm which will

produce a utilization score for each of the individuals based on their utilization practices and medical conditions. Once the utilization score has been established, the care coordination team will apply a risk algorithm which will provide an overall score incorporating not only utilization, but also social determinants of homeless, transportation support, employment status, incarceration within past six months, etc. which will help to identify the individuals who will benefit most from the WPC program. In order to ensure that these algorithms will produce the desired target population without overlooking other high utilizers, the homeless and recent incarceration social determinants will be over weighted. Over time the algorithms will be re-evaluated using the PDSA methodology, to ensure the program is providing the maximum benefit.

Target Population Process Map



Once beneficiaries are identified, they will be assigned to a PCMH or PCSP based on their specific needs using a modified four quadrant model. Developed in 2006 by the National Council for Behavioral Health, the four quadrant model "describes the levels of integration in terms of primary care complexity and risk and MH/SU complexity and risk."[3] Kern Medical Center has tailored this model to fit the needs of the WPC program. Modifications to the model include standardization of established screening tools, services to be rendered, support services, and established trigger points (see below). The beneficiary's enrollment period will include the full month in which they opt-in to the program and the full month in which they opt-out, or graduate, from the program.

[3] "Four Quadrant Model" *SAMHSA-HRSA Center for Integrated Health Solutions*. N.p., n.d. Web. 28 June 2016.

High

----------Behavioral Health (MH/SA) Risk/Complexity----------→

Low

Quadrant II BH↑ PH↓	Quadrant IV BH↑ PH↑
Main Care Setting: Specialty Mental Health **Care Levels** ❖ Primary Care Level 1 and 2 ❖ MH Level 3 and 4 ❖ SA Level 3, 4 and 5 **Triggers** ❖ 1 PEC Visit ❖ Psychiatric inpatient admission ❖ 2+ ED visits for MH or SUD related symptoms ❖ Substance Abuse Disorder Treatment: Rehab/OP ❖ MET Team **Support Services** ❖ KCMH Case Manager ❖ Behavioral Health Coordinator ❖ PCP with use of Kern County Universal Screening tool ❖ Community Support Services ❖ GATE Team	**Main Care Setting:** Specialty Mental Health with Coordinated Primary Care Treatment **Care Levels** ❖ Primary Care Level 3 and 4 ❖ MH Level 3 and 4 ❖ SA Level 3, 4 and 5 ❖ OMM (Outpatient Methadone Maintenance) **Triggers** ❖ Multiple chronic diseases, uncontrolled ❖ Inpatient admission ❖ Psychiatric inpatient admission ❖ 2+ PEC visits ❖ 3+ ED visits for PH and/or BH within 6 Months ❖ MHRC ❖ MET Team **Support Services** ❖ KCMH Case Manager ❖ PCP with use of Kern County Universal Screening tool ❖ Behavioral Health Coordinator ❖ Assigned Care Manager within Primary Care ❖ Community Support Services ❖ Conservator ❖ IPU Medical Social Worker ❖ KCMH Inpatient Liaison ❖ Primary Care Case Manager ❖ GATE Team
Quadrant I **BH↓ PH↓**	**Quadrant III** **BH↓ PH↑**
Main Care Setting: Primary Care **Care Levels** ❖ Primary Care Level 1 and 2 ❖ MH Level 1 and 2 ❖ SA Level 1 **Support Services** ❖ Kern County Universal Screening Tool ❖ Onsite BH Services in Primary Care ❖ Behavioral Health Coordinator ❖ Psychiatric Consultation ❖ Community Support Services	**Main Care Setting:** Primary Care **Care Levels** ❖ Primary Care Level 2, 3 and 4 ❖ MH Level 1 and 2 ❖ SA Level 1 **Triggers** ❖ New PH diagnosis – Stabilization Phase ❖ Multiple chronic diseases ❖ Inpatient and/or SDS ❖ 2+ ED visits for PH within 6 months ❖ Home Health **Support Services** ❖ Kern County Universal Screening Tool ❖ Behavioral Health Coordinator ❖ Assigned Care Manager within Primary Care ❖ Psychiatric consultation ❖ Community Support Services ❖ Primary Care Case Manager ❖ Onsite Behavioral Health Services

----------Physical Health Risk/Complexity ----------→

Low High

It is estimated that enrollment will be approximately 700-800 beneficiaries by the end of program year 2 and the program will continue to increase enrollment to the established cap. The member cap is necessary due to restraints on infrastructure and the desire to maintain sustainable growth. Historically, there has been little data collaboration amongst departments within the county, and the initiatives and processes developed within this pilot will be new for many. Given this, much of the WPC pilot program will be spent building, monitoring, and proving the benefit of this initiative. Given the program objectives to accurately evaluate the impacts of providing true wrap around services to increase health outcomes, this pilot is cautious to overextend beyond its reasonable capabilities. As the pilot reaches capacity, a wait list will be established so that individuals in need will have a future chance at these benefits.

Once at capacity, the WPC Committee will first work with the Managed Care Organizations to identify alternative services within the community through which eligible individuals will still be able to receive an enhanced level of care coordination, including Targeted Case Management. Individuals referred to, eligible for, and desirable to participate in Whole Person Care will be placed on a wait list. As members disenroll or graduate out of the program, individuals from the wait list will be contacted for participation in the program. On semi-annual basis beneficiaries will be reviewed and those who are meeting goals, are medically stable and no longer meet the criteria of the program will be graduated from the program. The wait list will be prioritized based on level of need, as identified by the calculated risk scores. For individuals on the wait list, the risk score will be regularly reviewed in order to reprioritize, and to identify continued eligibility for the program.

Section 3: Services, Interventions, Care Coordination, and Data Sharing

3.1 Services, Interventions, and Care Coordination

This pilot will focus on high utilizers of emergency and inpatient services, with an emphasis on those homeless or at risk of homelessness and on those recently incarcerated. While all beneficiaries will be eligible to receive services for high utilizers, enhanced services will be provided to those recently incarcerated and to those homeless or at risk of homelessness.

High Utilizers

Through the analysis and determination of the target population, the WPC committee was quick to ascertain a lack of coordination of services within the community to meet this population's needs. Although many services are being provided, they are not coordinated across organizations. This lack of coordination has led to redundancy in services provided and a lack of follow-through on referrals outside of the referring agency. To address these shortfalls, this pilot will provide the following services, available to all WPC beneficiaries:

- Information sharing across partnering organizations
- Wellness Education including hygiene, healthy eating, women's health, fitness, risk factor reduction interventions, preventive medicine counseling and behavior change interventions
- Lifestyle Education including personal finance, home care, parenting, resume building, employment training
- Care Coordination
- Personalized care plans
- Frequent in home care and assessments
- Regular Mental Health screenings
- Telephone visits
- PharmD Medication therapy management services
- Health Coach
- Panel Management

- Home Nursing visits for acute or chronic disease management, including history taking, physical exam, phlebotomy, assessment of ADL and adjustment of diet, activity level or medications
- Podiatry Services

As many of the positions providing the services above will also be providing services reimbursable by Medi-Cal, budgeted positions within this proposal have been adjusted accordingly so that services are not being reimbursed multiple times. These services are meant to improve upon the health of the whole individual by addressing the physical, behavioral and social elements contributing to the health of each beneficiary.

Care coordination plays a critical role in the success of this pilot and is used to refer to non-clinical functions including establishing and maintaining a care coordination plan, transition management, logistical assistance, timely and accurate transfer of patient information, referral tracking and follow-up, identifying and adjusting for barriers to care, being a source of support and point of contact for all beneficiaries. Care coordinators will be involved with population health management, needs assessments, resource brokerage and panel management. The qualifications required for a care coordinator does not exceed beyond a bachelor's degree, and this position will not be a registered nurse. The care coordinator will be the main point of contact for beneficiaries; they will build relationships of trust with beneficiaries, which will lead to more successful outcomes. The frequency of care coordination will be much higher than is currently reimbursed by Medi-Cal, which the partnering organizations feel is critical to the success of this pilot.

The REACH clinic was established in 2014 through collaboration between Kern Medical Center and a local Managed Care Organization, and is an NCQA certified patient centered medical home. The results precipitated throughout the two years of operation have far exceeded expectations, including a reduction of ED visits by 42.6% and the associated costs of those visits by 46% as well as a reduction in acute inpatient hospitalizations by 28.1% and the associated costs by 13.9%. Building upon that foundation, prior to the announcement of the Whole Person Care pilot program, Kern Medical Center had begun discussions to establish a behavioral health medical home (GROW), which provides for all of the same services found within REACH, but includes specialized behavioral health service through a partnership with Kern County Mental Health. To address very specific conditions prevalent within the community, Kern Medical Center has a number of patient centered specialty practices which follow the model of a PCMH, but for specialty practices and provide enhanced services focused on specific ailments, namely Diabetes, Hypertension and HIV/AIDS.

Whole Person Care will expand upon this proven model by integrating a greater level of care coordination across various organizations addressing more than physical and behavioral health, but also social determinants of health. The services provided within the patient centered medical homes positions them perfectly as hosts to whole person care coordination teams. By locating the entire care coordination team in these medical homes and creating a beneficiary focused mission of whole person care, services provided will be exponentially enhanced and truly patient centric. A hallmark of this patient centered approach is the presence of a single, multidisciplinary, integrated Health Action Plan (HAP), which is tailored to serve each patient's unique needs.

Through the analysis of this population, it was identified that there are often barriers that prevent individuals from attending their appointments. These barriers can range from lack of transportation to lack of desire. In order to address these concerns, this pilot will develop a mobile team capable of providing on site services, which are otherwise not reimbursable through Medi-Cal. This team will provide home nursing visits by RNs to patients at home for acute or chronic disease management. These visits may include taking a history, physical exams, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level or medications. Nursing visits will also include skilled services by an RN for management and evaluation of the plan of care (HCPCS G0162). These mobile teams will be dynamic in staffing, dependent on the needs of the patients scheduled on a given day. At times these visits will simply provide social

support, life coaching, supportive interventions and hygiene coaching, which will not require a licensed professional. Staffing for the mobile teams will be comprised of:

- Nurse Practitioner
- Registered Nurse
- Medical Assistant
- Behavioral Health Specialist
- Substance Abuse Specialist
- Probation Officer – Probation Officers will be necessary for mobile team visits of beneficiaries on parole or recently released from incarceration

It is anticipated that mobile visits will occur frequently upon initial enrollment into the program. As beneficiaries become stabilized and reliable, these visits decline, replaced by in office visits. Notwithstanding an increase in reliability, the target population is often unable to attend appointments or services due to a lack of child care. The Community Connection for Child Care (CCCC) is a local child care advocacy group. Through this pilot, CCCC will provide beneficiaries with child care services for physical and behavioral health appointments, lifestyle education, job training courses and employment interviews.

The information gained through mobile visits will be invaluable to each beneficiary's plan of care. This pilot has partnered with a local food bank, Golden Empire Gleaners, to provide food for those individuals who have shown evidence of inability to properly nourish themselves. As the need is provided for, education will also be given both within and without of the home on food preparation and proper food handling.

As chronic conditions can make consistent employment difficult, the pilot has partnered with Kern County Employers' Training Resource (ETR) to provide workforce training on personal finance, resume building and interview skills. Through discussions with ETR a concern was voiced that often more extensive services are provided with little to no benefit, as the individuals are still building basic life skills. For that purpose, the general education services will be provided to all beneficiaries, but for those who consistently meet their goals and who are medically stable, and have a desire, will receive more enhanced individualized services to build interviewing skills, assistance in developing a resume, help with finding and applying for jobs, and all other items needed in order to be prepared for interviews. Once employed, these individuals will have a resource for questions and advice for a duration of at least six months. Dependent on the specific needs of the beneficiary, this resource can be extended in order to ensure long term employment.

Many individuals included in the identified target population are eligible for existing services but do not understand or cannot locate sources for gaining access to these services. Care coordinators will make referrals to the Department of Human Services (DHS), who will provide education on and assistance in enrolling in eligible programs and services, such as, Safety Net Programs, CalFresh, and/or CalWORKs to WPC beneficiaries.

Of patients currently enrolled in the REACH clinic 18% exceed 60 years in age. This pilot will work with Kern County Aging and Adult Services (AAS) to provide referrals for WPC beneficiaries who would benefit from AAS's services which include social support through group events, meals on wheels, and non-medical in-home support services. These services will not be funded with WPC funding.

Kern County Public Health (KCPH) was the originator of the KGC program which provided many lessons learned that are incorporated in this WPC strategy. Given this, KCPH will be used to train the Mobile Care Team in whole health

assessment skills which will provide the Mobile Care Team the ability to assess not only the patient but the entire environment and its impacts on the beneficiary's health.

Homeless or at Risk of Homelessness

The Kern County Housing Authority is a public corporation focused on providing safe housing for homeless persons. They are a contributing member of the Kern County Homeless Collaborative (KCHC) and the local Continuum of Care (COC). The KCHC is a network of nonprofit service providers, businesses, charitable and faith-based organizations, volunteers, homeless or formally homeless individuals, and working together to end homelessness. During the Housing & Health Care Coordination Initiative in Southern California, members of the Kern County COC along with the Director of WPC participated in a strategic planning session attempting to address the homeless problem within Kern County. Through this planning session, the group determined that implementing a Housing Navigator position within the community would drastically improve the opportunity for individuals to not only find, but remain in housing.

Housing navigators will work closely with care coordinators to identify barriers to provide communication on housing efforts and to share any foreseen obstacles that would have an impact on future care. Housing Navigators will assist beneficiaries with the entire housing process, and continue to assist beneficiaries after housing has been secured. This ongoing support will help beneficiaries build relationships with property owners and create a stable atmosphere. Specific services can be categorized into two groups, transition services – finding and securing housing, and sustaining services – creating long-term housing solutions.

Individual Housing Transitions Services:

- Conducting tenant screening and housing assessments
- Developing individualized housing support plans
- Assisting with the housing application and/or search process
- Identifying and securing resources to cover expenses allowable the abovementioned CMCS bulletin
- Ensuring that the living environment is safe and ready for move-in
- Assisting in the move by identifying moving resources
- Developing a crisis plan that includes prevention and early intervention services when housing is jeopardized

Individual Housing and Tenancy Sustaining Services:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Educating and training on the role, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers
- Assisting in resolving disputes with landlords and/or neighbors
- Advocating and linking individuals to community resources when housing may become jeopardized
- Continuing training on being a good tenant

As the workload and resources required for this initiative are so intensive, housing navigation services will be capped at 20 individuals at a given time. Once an individual has remained in housing for 6 months, they will no longer be assigned to a housing navigator, and regular checkups will be performed by the care coordinator. These positions will be funded through the Housing Authority of Kern County; no WPC funds will be used to staff these positions. In accordance with

STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities.

Recently Incarcerated

Incarcerated individuals often suffer from medical, behavioral, or substance abuse conditions. While incarcerated, their medical and behavioral health needs are routinely provided for, with little effort required by the individual. Doctors are brought to the individual, medications are circulated on a regular schedule without cost to the individual, and there is consistent follow-up. Unfortunately, when these individuals are released from incarceration they are subsequently cut off from the care provided during that time. With freedom comes an extra responsibility of taking care of one's self, but this is often overlooked due to time and financial constraints, or lack of adequate skills. Also, as mentioned above, some of these individuals are released to homelessness. Given these challenges this pilot will provide for an enhanced level of care coordination for 90 days.

In order to address the needs of this population, this pilot will establish a clinic directly outside of the facility so that upon release, prisoners who have obtained presumptive Medi-Cal eligibility can obtain an immediate wellness check. Two PharmDs will reside in the clinic to provide medication reconciliations, medication education regarding chronic diagnosis management, and ensure that these individuals have two weeks of prescriptions and means to retrieve these prescriptions. Two registered nurses will work in the clinic to provide for comprehensive discharge planning. The nurses will complete a full health risk assessment, provide any specialized medical training, and evaluate needs for durable medical equipment. Working closely with office staff, the nurses will provide for a smooth transition of care to the primary care environment through scheduling a two-week checkup. Office staff in the clinic will assist the beneficiaries in identifying and applying for programs for which they are eligible, enroll the individuals in Whole Person Care and facilitating the scheduling of a follow-up appointment.

In coordination with our Health Education Department we will offer during this 90 day period a variety of Life Skills Transition Classes, geared to lower recidivism amongst this very fragile population. In conjunction with their initial post incarceration visit, a post incarceration liaison will be added to the care coordination team to help assess the member's specific transitional course needs. The post incarceration liaison will also be tasked with tracking the status of class enrollment and attendance, transportation needs, reincarceration status, as well as members that disenroll, or graduate. Some examples of our Life Skills Transition Classes may include, Crime Theory - Breaking the Cycle, Anger Management, Coping Skills, Co-Dependency, Parenting, and Relapse Prevention. These courses will assist the beneficiaries in building structure with the challenges of post-incarceration.

At the conclusion of 90 days this post incarceration team will assess the members' success and provide a report for our Quality review team to assess monthly for system improvement.

These beneficiaries will receive an enhanced care coordination PMPM for 3 months post release in addition to the standard complex care coordination PMPM bundle. These beneficiaries will count as one member month for the entire calendar month in which they enroll in Whole Person Care, and will be counted for a maximum of 3 member months.

3.2 Data Sharing

Coordinating data sharing across organization was identified early in the process as a challenge. Implementing a new software system within any organization can be a major feat, and attempting to implement a software system across multiple organizations can be near impossible. This requires changes in workflows, processes and behaviors. As a result of these challenges, we have developed a thorough approach to data sharing, maintaining a level of control at the lead entity, and offering incentives. The success of this pilot will help to perpetuate the support of this initiative across organizations.

Currently the WPC program plans on deploying the Pieces Plexus and Pieces Iris software systems Developed by PCCI. PCCI is a non-profit research and development company in Dallas, TX focused on real-time predictive and surveillance analytics for healthcare. PCCI's software interprets EMR data in real time and translates it into useful intervention warning tools that assist physicians and hospitals on complex clinical decisions in every field of medicine to better treat patients. The Pieces platform uses electronic medical record (EMR) for data collection, early disease detection and monitoring and care coordination for patients with chronic medical conditions (CMC). Pieces helps patients get care sooner to reduce hospitalizations, unplanned readmissions, and cardiovascular events and deaths.

Iris is case/care management software and Plexus is the central hub, which also includes data analytics and predictive modeling services. The Iris software will be used (web based) by each participating organization and the information they collect will be shared across all WPC participating organizations. See Figure 3 below. This platform will provide for bi-directional data sharing across the partnering organizations.

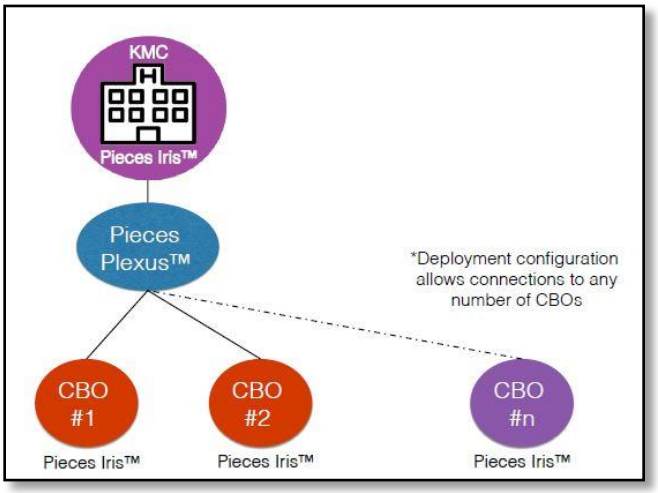


Figure 3

The participating agencies can be classified in two category types: medical and support providers. Supportive providers (i.e. DHS, Housing Authority, ETR, etc.), those that to do not clinically care for beneficiaries, will capture social determinant data on WPC beneficiaries. Social determinant data includes:

- Education level
- Employment status
- Dietary status
- Housing situation
- Disabilities
- Legal status
- Family life
- Social services support needs
- Transportation needs

Medical support providers will capture their customary patient care data within their respective EHR and a data migration will occur into the Plexus platform where future risk and predictive modeling can occur.

WPC Data Exchange Implementation Timeline		
Mo.#	**Month**	**Product/Service**
1	November'16	Pieces DS
2	December'16	Model configuration
3	January'17	
4	Februar'17	Pieces DS launch
5	March'17	Iris Implementation
6	April'17	Iris Launch

The largest data challenge the WPC program will face is strict local, state, and federal laws associated with the sharing of PHI. This includes FBI and DOJ information from participating organizations such as KCSO and Probation or in the case of behavioral health systems certain mental health and substance use disorders. Given this, each respective organization will only be able to view data pertinent to their area of participation. For example, the food bank agency does not need to know, nor can they see what any particular individual is being treated for; they only need to see that the individual is eligible, and has been referred, for food bank services. Regardless, and to comply with local, state, and federal law, each participating organization will enter into a business associate agreement (BAA) to cover the confidentiality of PHI.

In addition to the execution of BAAs, and since the WPC program is an opt-in program, the WPC program will develop standardized consent forms for all participating agencies in order to obtain the beneficiary's permission for care coordination and for the sharing of data. In addition to the consent from, the WPC program will develop standardized templates and questionnaires to be used by all WPC participating agencies. This will be necessary to build data integrity which will be critical to the success of the program.

An additional data challenge the WPC program will encounter is the need to alter/customize the established data system to meet the changing needs of the program as it continues to develop. Because of unforeseen data system modification needs, the WPC program will build data system change contingency costs in the budget. The vendor has provided us with an hourly rate for additional changes to the system. This will allow us to build a true data integration process which will contribute to the success and sustainability of the program.

A challenge that was identified early on is the ability of the partnering organizations to use this software concurrently with their already established systems. For those organizations whose system is capable, funds have been budgeted in order to establish an interface between their data system and Iris. In addition, for the initial partners, funds are being budgeted to provide for a position to be stationed at each partnering agency to assist in implementing processes throughout the partnering organization and providing support to ensure maintenance and integrity of the data. These positions will report directly to the lead entity, and will allow for accountability with regards to data sharing. Without proper safeguards on data sent to the database, a program of this magnitude is bound to fail. For this reason the WPC program will enlist the expertise of a database analyst and a health systems analyst to monitor and extract usable data pertinent to the objectives of the program. These two positions will also be critical in monitoring and assuring true data integrity and assuring a garbage-in/garbage-out (GI/GO) condition is not created.

Evolution of the data system is another challenge and will occur as changes are needed and deficiencies are identified. One early evolution of the data system will be realized in the referral process. Initially, only the MCPs will be able to refer WPC beneficiaries. However, as the program progress agencies will need to be able to refer WPC beneficiaries. Given this, this function will be built into the software package allowing for an easy transition.

Data governance for the system will be maintained through the steering committee. Before additional data is incorporated into the system, the steering committee must approve the addition, and identify sources of data. Staff located at each partnering organization will work to ensure the proper flow of data into the Pieces system and along with the database team, they will work to validate data and work with each organization to incorporate this additional data into their workflows. Although each partner will independently govern their own respective data systems, it is critical that any changes to how data is collected, or where data is stored, are communicated quickly so that changes to the external mapping can be adjusted.

Section 4: Performance Measures, Data Collection, Quality Improvement and Ongoing Monitoring

4.1 Performance Measures

Performance measures have been established within the pilot to measure progress and to allow for accountability across the organizations.

The following performance measures have been created for all WPC participating agencies.

- It is expected that each participating agency will be actively involved in the identification of barriers and resolution of those barriers. This will be measured based on attendance to respective committee meetings, as noted in the minutes of the meeting. Those unable to attend committee meetings who receive prior approval from the Director of Whole Person Care and who submit notes and suggestions prior to meeting will be counted as successfully fulfilling this metric.
- It is expected that information regarding program beneficiaries will be updated timely and accurately within the data sharing system. Details should be entered within the system within 30 days of service. This will be measured by comparing the record creation date within the system to the date of service provided. Performance targets will be 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5

The following performance measures will be monitored by the steering committee to determine the effectiveness of pilot efforts:

- Housing Authority: WPC beneficiaries referred to housing navigation services are contacted by navigator within 30 days: 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5.The purpose of this performance measure is to measure ability and capacity of Housing Navigation staff, as well as responsiveness.
- KCPO: Parole Officers provide security to Mobile Care team while in the field assessing WPC beneficiaries currently on parole or recently released from incarcerations no less than 50% of the time. The purpose of this performance measure it to assure security for the Mobile Team while in the field only for individuals on probation or recently released from incarceration.
- GEG: WPC beneficiaries referred for food bank services receive identified food box provisions within 2 weeks: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric will measure the efficiency and ability of care teams to work with community partners to achieve timely results.
- ETR: Enhanced employment training outreach within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.

- CCCC: Child care outreach within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.
- KCMH: PHQ-9 form used on all WPC beneficiaries referred for behavioral health interventions for the following annual benchmarks: Maintain baseline PY2 PY3-5 5% improvement over prior year, if the 90 percent is achieved, performance will be achieved through maintenance of 90%. The purpose of this performance measure is to measure and promote the use of the PHQ-9 evaluation.
- AAS: Contact made within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.
- KCPH: Referral response within 2 weeks of receiving referral. 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.

The following performance measures have been created for the WPC program:

- Reduction in ER usage. This performance measure will have the following annual targets: PY2 maintain baseline, in each subsequent year, reduce ER utilization by 5%. Reductions in ER utilization are critical to the overall success of this project. Overutilization of the ER leads to higher healthcare costs, crowded waiting rooms and low patient satisfaction. A reduction in ER visits will save costs and provide for better healthcare.

- Reduction in inpatient utilization. This performance measure will have the following annual targets: PY2 maintain baseline, in each subsequent year, reduce inpatient utilization by 5%. This metric will gauge overall success of the pilot. Healthcare delivery is most expensive within the inpatient setting, and a reduction in utilization will yield significant cost savings and provide for better care to beneficiaries.

- Follow-up after hospitalization for mental illness (NCQA). Targets for this metric are to maintain the baseline in PY 2, and then in each subsequent year improve performance by 5% over the prior year, if the 90th percentile is achieved, then performance will be achieved through maintenance of the 90th percentile. Follow-up visits after hospitalization allows for a more seamless transition to the home and work environment, and encourages retention of gains made during hospitalization.

- Initiation and engagement of alcohol and other dependence treatments (NCQA). Performance targets have been set to maintain the baseline in PY 2, and in each subsequent year improve performance by 5%, if the 90th percentile is achieved, then performance will be achieved through maintenance of the 90th percentile. These dependencies are one of the most preventable health conditions, and evidence has shown that improving upon alcohol and other drug dependencies can drastically improve health and social outcomes, as well as creating a large source of financial savings.

- Proportion of participating beneficiaries with a comprehensive care plan, accessible by the care team within 30 days. This metric will have a target of 60% in PY2, 65% in PY3, 70% PY4 75% PY5. The purpose of the measure it to assure timely access to the care plan to the entire care coordination team so that team members are apprised of beneficiary needs and goals and updates can be made.

- Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5 (NQF 0710). In PY 2 the target will be to maintain the baseline, in each subsequent year improve upon prior year by 5%. Those with a diagnosis of depression are significantly more likely to have cardiovascular disease, diabetes, asthma and obesity, be a

smoker and be physically inactive and to drink heavily. Standardized and regular use of the Patient Health Questionnaire (PHQ-9) will help to identify symptoms and begin early treatment and interventions preventing more severe diagnoses later.

During the 2016 Community Needs Assessment, research identified 17.1% of adults in Kern County experienced some form of behavioral health distress and 21.4% of adults needed help for emotional, mental health, alcohol or drug issues and 85.5% of those who sought help did not receive it. Also, through medical cart audits of Kern Medical Center records, it was learned that many incarcerated individuals also suffer from behavioral health conditions. Additionally, during the 2015 Homeless Census Report, it was learned that 109 individuals were hospitalized for behavioral health conditions. Finally, lessons learned from the KGC program also indicated many high utilizers of emergency services suffer from behavioral health conditions.

Given the identified disparity in behavioral health needs compared to actual services provided, it is important to accurately identify and address local behavioral health conditions. Moreover, our WPC care coordination integration with behavioral health providers has great potential in addressing these deficiencies.

- Comprehensive diabetes care, percentage of individuals with a diagnosis of diabetes who had an Hba1C <8.0% during the year. PY2 target will be to maintain the baseline, each subsequent year will improve by 2% over the prior year, if the 90th percentile is achieved, future year targets will be to maintain the 90th percentile. Diabetes is recognized as a leading cause of death within the US, and further complications include poor circulation, damaged nerves in the feet as well as damage to the kidneys.

  Per Healthy Kern County, during the 2010 Kern County Community Needs Assessment, "Kern County placed in the bottom quartile of California counties for *all* diabetes-related indicators. The age-adjusted diabetes death rate averaged over 3 years (2006-2008) is nearly 34 per 100,000 compared to the State value of 21 per 100,000.

  Kern County ranks in the bottom ten percent for all hospital utilization rates due to diabetes-related admissions and emergency room visits. During the 2006-2008 measurement period, the hospitalization rate due to diabetes was 28.4 hospitalizations per 10,000 population and ranked 55 out of 58 California counties. The hospitalization rate due to long-term and short-term complications of diabetes was 17.2 and 8.9 hospitalizations per 10,000 population, respectively – ranking 52nd and 54th out of 58 California counties."

  Given the above measurements, this metric will help the WPC program understand the performance of this pilot in addressing this need within the county. Additionally, early diagnosis and education on diabetes management will prevent downstream complications, improving the overall health of the WPC population.

- Hypertension is a comorbidity for diabetes and heart disease. In the 2016 Community Health Needs Assessment, research identified 40.3% of adults in Kern County have been diagnosed with hypertension. These rates were higher than the state average of 28.5%. Given the high number of diabetes and heart disease diagnoses in Kern County this is not a surprise.

  Given the focus of the WPC program, the county health needs, and the connection with other diseases, such as diabetes, it is important to accurately identify and address this health condition within our WPC population. Moreover, our WPC care coordination integration with specialty centers provides great potential in addressing this medical condition and improves health outcomes for our population.

PY2 target will be to maintain the baseline, each subsequent year will improve by 5% over the prior year, if the 90th percentile is achieved, future year targets will be to maintain the 90th percentile. Preventive medicine has been proven to be more effective and efficient than diagnostic treatment. By encouraging and completing regular screenings for those at risk, this pilot aims to address possible complications as soon as possible.

4.1.a Universal Metrics

- **X Health Outcomes Measures**
- **X Administrative Measures**

4.1.b Variant Metrics

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness
	This measure is tied to budgeted meeting incentives. The rationale behind this metric is that through past experiences, we have seen support for multi-departmental projects such as this wane after the initial launch. This metric allows for incentivizing partnering agencies to continue to participate not just in the operation of the pilot, but also in the overarching strategic discussions and process improvements throughout the entire process. We understand that regular communication across entities is critical to the success of this pilot. This metric will be measured by percentage of partnering agencies in attendance at the meetings, with exceptions for those excused with prior notice, and will be reported with minutes from the meetings covering items discussed, lessons learned and action items.				
Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) or Alternative Metric	HbA1C Poor Control <8%	HbA1C Poor Control <8%	HbA1C Poor Control <8%	HbA1C Poor Control <8%	HbA1C Poor Control <8%
Depression Remission at Twelve Months or Alternative	PHQ-9 Depression Remission at 12 Months NQF	PHQ-9 Depression Remission at 12 Months NQF	PHQ-9 Depression Remission at 12 Months NQF	PHQ-9 Depression Remission at 12 Months NQF	PHQ-9 Depression Remission at 12 Months NQF

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Metric (NQF 0710)	0710	0710	0710	0710	0710
Controlling High Blood Pressure	Controlling High Blood Pressure	Controlling High Blood Pressure	Controlling High Blood Pressure	Controlling High Blood Pressure	Controlling High Blood Pressure
Housing-Specific Metric (if applicable)	Percent of homeless participants receiving housing services in PY that were referred for housing services	Percent of homeless participants receiving housing services in PY that were referred for housing services	Percent of homeless participants receiving housing services in PY that were referred for housing services	Percent of homeless participants receiving housing services in PY that were referred for housing services	Percent of homeless participants receiving housing services in PY that were referred for housing services

4.2 Data Analysis, Reporting and Quality Improvement

Currently existing sources of data are diverse and decentralized; each respective participating organization has their own data system. This diversity in data systems creates a great deal of variability and challenges. These data systems vary in sophistication just as much as they vary in the amount and type of data collected. Due to this diversity initial data aggregation, reporting, and analysis will rely heavily on manual methods of sharing data as an automated approach is established.

Initially, and absent an established data exchange or health information exchange, data collection processes for the Kern County WPC project will use simple forms of data sharing. The referring MCPs will simply provide referral sheets in an Excel spreadsheet via SFTP. PCMH and PCSP care coordination staff will access these referral sheets and, upon initial beneficiary assessment, will enter WPC beneficiary's pertinent information into Kern Medical Center's EHR. The PCMH and PCSP care coordination staff will then refer beneficiaries to any services provided by our participating organizations.

Referrals for WPC services provided by participating agencies will initially be accomplished by a simple form which will be sent with the beneficiary to the participating agency to program coordinators stationed at each participating entity. The care coordination team will capture these referrals in the notes of the EHR. Participating agencies will capture referral and pertinent information from the form in simple Excel spreadsheets for tracking purposes. On a monthly basis, participating agencies will provide copies of their spreadsheets to the lead entity for aggregation and analysis. This process will continue until a true data exchange can be established.

As noted earlier, Kern Medical Center has evaluated several integrated data exchange systems (see Section 3.2 for anticipated project timeline). Currently the WPC program plans on deploying the Pieces Plexus and Pieces Iris software systems. Iris is case management software and Plexus is the central hub which also includes data analytics and predictive modeling. Plexus will be able to provide predictive modeling on beneficiaries who are at risk of greater illness as well as which beneficiaries will likely generate the most health care costs in the future. The Iris software will be used (web

based) by each participating organization and the information they collect will be shared across all WPC participating organizations.

Finally, having the entire WPC beneficiary data housed in one location will facilitate the ability of the program to generate custom reports using common reporting tools. The success of the reporting capabilities will also be greatly increased with the inclusion of a Data Analyst, Healthcare Analyst, and Research Director positions and other committees.

Initially, in PY 2, reports will be run and analyzed on a weekly basis. For PY 3-5 reports will be run and analyzed on a monthly basis. Initial analysis of the reports will focus on the validity of data integrity, reports, and current processes. During this process all aspects of the WPC program will be evaluated using the PDSA. The PDSA principles can be applied to any process or functions within an organization and is essential to eliminating process variance. The PDSA approach is cyclical in the sense that the monitoring and necessary adjustments are conducted on revolving process; each process is reevaluated on a regular basis.

In conjunction with the abovementioned data practices, Kern Medical Center has established collaborative advisory/oversight committees, departments, and work groups tasked with assisting in more completely and cohesively aligning the combined goals, objectives, and metrics of PRIME with other quality-based initiatives and improvements. These committees (includes WPC committees), departments, and work groups, listed below, will be leveraged for the WPC program:

- An OP Quality Department tasked with implementing rapid-cycle improvement plans and comprehensive, continuous quality assurance/improvement methodologies ;

- A Care Coordination Department tasked with establishing the methodologies/protocols necessary to achieve respective core components/metrics;

- An Outpatient Integration Team tasked with further aligning our resources and competencies with the corresponding objectives of WPC realization;

- A LEAN Six Sigma-centered Performance Improvement Team tasked with using said principles and practices towards identifying respective gaps in process, flow, and outcomes.

As process variations are identified using the processes above, the same committees, departments, and work groups will develop strategies for implementing the necessary changes and the PDSA process will be repeated. Once an established process has been determined to be functioning properly, that process will be reevaluated on a quarterly basis and identified variation will be addressed.

4.3 Participant Entity Monitoring

This application provides a robust plan of coordination across multiple organizations. The level of work and attention required to make this pilot a success is substantial, and as such, processes will be in place to monitor entities to ensure the program is producing the anticipated outcomes. Each participating agency, and WPC program as a whole, will be required to submit regularly scheduled data reports providing the details necessary to evaluate performance. Should any of the following conditions occur, an in-depth evaluation of the participating agency will be conducted.

- Any performance measures not being met in four consecutive months
- Any outcomes not being met by a margin greater than 20% in four consecutive months
- Failure to provide information for 4 consecutive months
- Any combination of two or more of the abovementioned not being met in two consecutive months
- Intentional violation of established policies and/or procedures

The evaluation of the participating agency will be conducted by an ad hoc Evaluation Committee consisting of:

- WPC Director from the lead entity
- One member of the WPC Collaborative Committee
- One of the Care Coordinators from one of the PCMH or PCSP
- LEAN Six Sigma team member

The Evaluation Committee will review all applicable processes and data in an attempt to identify the source of unanticipated results. Upon completion of the review, the evaluation committee will provide the WPC Committee with a summary report consisting of:

- Review/conclusion of established processes
- Review/conclusion of established data practices and reports
- Review/conclusion of established performance measures
- Review/conclusion of established outcomes
- Summary of review findings (i.e. data structure inadequate, performance measure unrealistic, etc.)
- Evaluation Committee recommendation/s

The Evaluation Committee will be vested with the authority to recommend any one, or a combination of, the following actions:

1. Revision Requested – Evaluation of area in question requires the revision to an existing policy, process, data processes, performance measure, outcome, or incentive due to poor design or evolutions in the WPC program landscape.
2. Review Meeting – Meeting with participating agency, or WPC Lead Entity, to review identified issues and formulate strategies to resolve the issue and prevent reoccurrences.
3. Recommendation for Remediation – Should deficiencies by a participating agency be identified, the agency will have sixty days to provide a written plan of action for correcting the deficiencies. The plan of action will be reviewed and approved by the Evaluation Committee. Should consensus not be met, the plan may be revised and delivered within thirty days.
4. Recommendation for Removal – Based on evaluated processes and evidence, Evaluation Committee can recommend the participating agency be removed from the WPC program. Should this occur, the participating agency, or program, will have an opportunity to appeal the decision of the Evaluation Committee to the WPC Committee after providing a corrective action plan to address the identified deficiencies.

Section 5: Financing

5.1 Financing Structure

The lead entity will work to develop MOU's with the participating entities to establish a formal agreement regarding the

flow of funds between the organizations. Upon the completion of these MOU's, the entities will have the ability to invoice the lead entity for services provided on a monthly basis. The finance department of the lead entity will provide oversight of the funds, and, with the approval of the Director of Whole Person Care and their direct superior, be authorized to make payments on behalf of the pilot. Partnering agencies will have the ability to invoice for incentive payments twice annually, after they have received written notification from the WPC committee indicating whether or not the incentives have been earned.

The lead entity will request funds twice annually through the submission of the Mid-year and Annual reports. The lead entity will then respond to DHCS' request for the necessary intergovernmental transfer amounts from DHCS pursuant to Attachment GG within 30 days of the determination of payment due based on the mid-year or annual reports.

As indicated in the attached budget, this WPC pilot budget has a diverse payment structure.

Incentive payments, Pay -for-Reporting and Pay-for Performance metrics will be drawn down twice annually based on attainment, or partial of attainment, of the metrics at the time of the mid-year and annual reports. With each of these categories, partial attainment is allowed based on percentage of completion of the total goal.

Administrative Infrastructure provides for items that are truly administrative. The majority of these costs are related to database governance and program administration.

In addition, we have incorporated a mix of both Fee-For-Service (FFS) and Per Member Per Month (PMPM) service bundles. Through the development of this budget, we identified a number of items that were truly dependent on the volume of services provided, and there is an associated cost for each service. These funds will be requested on a claims based system and the tracking of these services will be initiated by the referral of the care coordinator. These referrals will require an element of follow-up, and in order for the participating entity to receive the associated funds, they will be required to invoice for these services, no more than once per month. Based upon these invoices and after reconciliation with care coordination referrals, the lead entity will draw these funds semi-annually.

Our PMPM bundled services will be invoiced based on enrollment. For any given member, a full member month will be counted for the entire month in which they enroll in the program. Upon disenrollment or graduation out of the pilot, a full member month will be counted for the month in which the disenrollment is effective. We have identified 5 tiers of PMPM. Care Coordination services which all members will receive; Mobile outreach and engagement which all members will receive, upon graduation from the care coordination program, beneficiaries will still have follow-up from the mobile outreach team; Housing Navigator services which those who are homeless or at risk of homelessness will receive; specialized employment services, for those with a desire to, are physically able, and have been meeting care goals to obtain employment; and 90-Day post incarceration coordination which will meet the needs of individuals who have recently been released from incarceration for 90 days and then they will transition into the abovementioned standardized services. Within Iris, these individuals will be tracked based on the service bundles that they are receiving, and these payments for these individuals will be scheduled each half-year based upon reported enrollment. Funds will be drawn down semi-annually based on member months for the 6 months of the year.

As we monitor the beneficiaries, we will continually monitor utilization of inpatient services as well as utilization across various organizations. Results from our REACH clinic have already proved the benefit of medical homes, and it is anticipated that over time this model will provide for a drastic reduction in inpatient services, which in turn will provide for a drastic reduction in costs. We will continually compare the amounts saved to the amount of funding provided on their behalf. As we identify net savings, we will work with the managed care organizations to develop alternative payment methodologies which would have the potential to sustain this model post pilot.

5.2 Funding Diagram

Attached

5.3 Non-Federal Share

All participating public agencies will be providing the non-federal share for their respective incentive payments. For those unable to contribute non-federal share, the Lead Entity will provide the non-federal share. The Lead Entity will compile these funds, and submit 1 IGT to DHCS for the entire requested amount:

- Kern Health Systems
- Housing Authority of the County of Kern
- County of Kern

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

Kern County's Whole Person Care application is currently limited to Medi-Cal beneficiaries. As such, it is not anticipated that any of these funds will be used for non Medi-Cal beneficiaries. The infrastructure budgeted for this pilot will be used exclusively for Whole Person Care beneficiaries. Generally, funding will be received after services have been provided. Payments will be clearly identified, and there should be little question as to whether monies have been earned.

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, Activities of daily living, obtaining and maintaining safe housing, assisting with employment readiness (A comprehensive service in regards to how to search for a job, providing resume building assistance, coaching around proper interview attire and process, etc); social skills and family life services and supports; managing finances; benefits management (ie assisting in the application process for SSI, food stamps, housing assistance, or other eligible benefits); conducting needs assessments and providing referrals to community resources based upon identified needs extending beyond the scope provided for within TCM; and providing counseling and coaching to the patients identified support system in as much as the patient consents and/ or allows their involvement. These services depart significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between this specialized WPC team and patients/clients/members as they are not outlined in the services covered under the TCM program. Additionally, services included in the WPC project that do mirror services provided under the TCM program would not be eligible for reimbursement, as the workers either would not meet the educational/experience requirements for TCM case workers or the team members would be in a supervisory role and would have few, if any, direct contact with clients. In addition, there will not be a180 day time limit in which services, including those provided under the TCM benefit, are provided.

Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support, trust-building, motivational supports, disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as those mentioned above. Specifically, the program is to provide intensive social support services that are not covered under either the TCM benefit, or billable under Medi-Cal. This population of patients are at high risk for homelessness therefore a great amount of focused support surrounding that problem are included in this program. For instance, support to obtain and maintain safe housing, followed by working one on one with patients in their effort to remain safely housed is included. This would include tasks such as promoting health and hygiene with proper coaching and assisting around house cleaning to ensure the home environment is safe and free of bugs etc, laundering clothing, budgeting, grocery shopping and food preparation, providing coaching around safe food hygiene such as putting away grocery items needing refrigeration timely, cooking items safely to avoid illness, etc. For these reasons, we have

concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. However, in response to concerns of duplication of payment, we have applied a TCM budget adjustment of 5% to the care coordination PMPM from 495 to 470 PMPM. Each TCM budget adjustment can be found in the corresponding service description.

5.5 Funding Request

Project Year 1 Budget Narrative

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	32,987,300
Approved Application (75%)	24,740,475
Submission of Baseline Data (25%)	8,246,825

For Budget Year 1, the requested funding is for the submission of the application and the required baseline data.

Project Year 2-5 Administration Budget Narrative

For project years two through five the Kern County WPC Lead Entity requests funding for the following administration budget items:

- Director of Whole Person Care (1 FTE): This position is responsible for the day-to-day operations, oversight and fulfillment of the WPC program responsibilities to the lead agency, County of Kern, and DHCS. His/hers role is to provide program oversight; maintain partnering agency engagement; identify and promote the inclusion of new partnering agencies; ensure performance measures are being met; conduct regularly scheduled meetings; program evaluation and improvement using PDSA; identify program barriers and implement solutions; supervise applicable staff; conduct data analysis; submit required reports and metrics; budget administration; and keep the WPC program running smoothly. The requested funding for this position is $200,000 annually ($1,000,000 for five-year program) which includes salary and benefits.
- PCMH and PCSP Director (REACH, GROW, Diabetes, Hypertension, and HIV/AIDS clinics) (0.5 FTE): This position is responsible for day-to-day oversight and operations of all the WPC PCMH and PCSP clinics. As care coordination teams will be housed within the PCMH, this position will spend a considerable amount of time providing oversight to care coordinators and their teams. This position will assist in policy creation and implementation. In addition, this individual will have operational responsibility of meeting targets outlined within this application. As this individual plans and executes that plan, a considerable amount of time will be spent directly serving the WPC pilot. This position works closely with the Director of WPC to develop care coordination HAPs for WPC program beneficiaries. The requested funding for position is $100,000 annually ($500,000 for five-year program) which includes salary and benefits.
- Director of Community Health Education (0.75 FTE): Responsible for developing plans for community-based health programs aimed at the prevention of disease and promotion of health. This individual develops and implements curriculum for various courses within WPC and monitors attendance and satisfaction. Based on feedback and results, the director will make changes to the curriculum to meet specific needs. Recommends community health initiatives, policy implications and best practices after reviewing health literature and statistics. Identifies community health programs related to identified WPC grant deliverables. Manages specific community health programs from planning and design through implementation and evaluation. This position works closely with the Director of WPC and the PCMH/PCSP Director to develop content relative to the WPC

program beneficiaries. The requested funding for position is $150,000 annually ($750,000 for five-year program) which includes salary and benefits.

- Database Analyst II (0.75 FTE): This position develops and maintains database modeling, access and file structure requirements through discussion with users and other technical staff. Prepares related documentation addressing design, data relationships, operational procedures, and programming procedures for databases. Assures logical and physical data models meet County standards for naming, metadata and other common data structures. Participates in systems analysis, design and implementation and advises and consults with application programmers during systems analysis. Implements and maintains major mainframe, internet or beneficiary server database environments; and maintains the security and integrity of the database. Reviews database utilization and performs tuning to ensure optimal performance; and responds to system problems that may affect the database. Implements and insures adherence to database backup, restart, recovery, and reorganization standards. Analyzes database management systems software and develops recommendations for acquisition as appropriate. Evaluates new applications to determine compatibility with existing applications, hardware and software. Trains staff in the use of database tools and techniques. Develops and maintains data warehouse design and mining. Implements disaster recovery procedures. Stays abreast of new trends and innovations in the field of data network operations. The requested funding for position is $112,500 annually ($562,500 for five-year program) which includes salary and benefits.
- Information System Specialist II (0.75 FTE): This position is responsible for identifying and coordinating departmental data processing activities to ensure that quality and quantity of input and output are met. Assists in the design and the development of systems on a department's mini, microcomputer or mainframe. Assists with network system requirements and assists in determining solutions to network computer problems. Assists in the maintenance of network servers including installing and configuring user accounts and peripheral devices. Researches, designs and develops small, less complex application programs on departmental computers; installs and configures unmodified package software and utility programs for departmental mini or micro-computers. Oversees the implementation and maintenance of the data processing systems within the department and configures, maintains and installs PC hardware and software including network cards. Provides technical advice to staff, trains staff in the use of computer hardware and software. Maintains inventory of computer equipment, software and licenses. The requested funding for position is $112,500 annually ($562,500 for five-year program) which includes salary and benefits.
- Research Director (0.5 FTE): This position is responsible for directing and managing all activities of research, including overseeing the development, implementation, and evaluation of research to meet the goals of the WPC pilot program. Developing and preparing the WPC pilot program long-term goals for research including creation of a research plan. Data mining and evaluation of existing data analysis and improvement programs implemented by the collaborative advisory/oversight committees, departments, and work groups. Planning, organizing, coordinating, directing, and managing research, both internally and externally, and including monitoring new and existing projects' content, staffing, and timeliness; for external research, responsibilities extend to oversight of contract obligations and payments. In proving the benefit of this WPC model, active research into the results will prove invaluable and identify areas into which the services can be expanded. Disseminating the results of completed research, as appropriate, to the public and various internal and external stakeholders. The requested funding for position is $100,000 annually ($500,000 for five-year program) which includes salary and benefits.
- Research Assistant (0.5 FTE): This position is responsible for assisting with academic research; assisting with the editing and preparation of manuscripts. Assists with duties related to the production of academic journals. Performs research work in archives, through interviews, online, or whatever may be appropriate to assist the assistant’s supervisor. Prepares literature reviews. Gathers and analyzes data. The requested funding for position is $75,000 annually ($375,000 for five-year program) which includes salary and benefits.
- Onsite Program Coordinator (12 FTE): For this WPC pilot program Kern County is requesting funding for twelve (12) onsite program coordinators. These positions will be located at all participating agencies and are responsible for entering and maintaining care coordination data within the integrated data exchange system. These positions will also serve as referral intake for WPC beneficiaries at each respective participating agency.

They will be responsible for cross system verification between the host agency and the WPC data exchange. In addition to these tasks this role is also responsible for responding to requests for information from the general public, other internal departments, and employees; researches and resolves discrepancies with information. Performs various clerical duties. Prepares routine documents and information; compiles data for routine reports. Prepares meeting agendas; assembles agenda packets; attends meetings and takes minutes; distributes meeting minutes to appropriate individuals. The requested annual funding for these positions is $1,080,000 (12 FTEs with individual annual salaries of $90,000) annually ($4,950,000 for five-year program) which includes salary and benefits.

- Printing and Office: Printing and office supplies are estimated at $24,000 per year ($120,000 for five-year program). This budget line item is based on estimated costs distributed across existing programs and departments as well as strategic planning activities conducted thus far during PY 1.
- Meeting Budgets: As part of the WPC program monitoring and deliverables, regularly scheduled meetings with participating agencies are required and essential when evaluating the program through the PDSA methodology. Meeting budgets for the WPC program are estimated at $300 per meeting, $7,200 annually ($36,000 for five-year program). Like printing and office supplies, this budget line item is based on estimated costs distributed across existing programs and department as well as strategic planning meetings conducted thus far during PY 1.
- Travel: One requirement of the WPC program is attendance by all participating agencies at DHCS's Learning Collaborative Meetings to be held twice a year. Travel is based on average mileage/airfare, lodging, and meal per diem for fifteen travelers (one representative from each participating agency and WPC administrative staff) for one night and one day. No meeting location has been provided so estimated costs are for participating agency representatives to travel to Sacramento. The requested annual funding for this budget line item is $24,000 ($120,000 for five-year program).
- HIE Costs: One of the objectives of the WPC pilot program is the development and processes of sharing data. For this, the Kern County WPC will be implementing an integrated data exchange using the Pieces Iris and Pieces Plexus systems by PCCI (see description above). The following pricing for these services was obtained from PCCI: Implementation and first year (PY 2) software license agreement and participating agency HIE integration at $460,000. The following project year license agreements were quoted at $350,000 annually. The total HIE costs requested for the five-year program is $1,510,000. It must also be noted that data exchange costs are not stable and as data integration processes are be implemented the likelihood of encountering additional unknown and unbudgeted costs are high. Because of this, the WPC will use funds from the indirect costs budget line item to cover these unknown events during the implementation of the data exchange system.
- Indirect Costs: Indirect costs for the WPC program is estimated at $1,600,000 annually ($8,000,000 for the five-year program). This budget line item is used to cover any variable/unknown items which cannot be predicted in conceptual programs. The lessons learned, research, and possible outcomes for the WPC program are far too important to allow program failure for lack of funding for unknown circumstances.
- Finance Support (0.3 FTE): The lead entity will be receiving and tracking invoices, making payments, and managing the other financial aspects of this pilot. Finance support accounts for the financial accounting team within the lead entity, including director of finance (0.1 FTE $180,000), treasury (0.1 FTE $150,000), as well as accounts payable (0.1 FTE $70,000) positions.

Project Year 2-5 Delivery Infrastructure Budget Narrative

There are no anticipated Delivery Infrastructure budget items for this WPC pilot program. However, should circumstances change funds from indirect costs can be used to cover these items.

Project Year 2-5 Incentive Payments Budget Narrative

Included in the WPC pilot program budget are allowable incentive payments estimated at $3,682,600 annually and a total five-year estimation of $21,382,000. These incentive payments will be paid for the following categories and amounts:

- Managed Care Plan Referrals: As the Managed Care Plans have information on the total cost of healthcare, this pilot intends to make these organizations the main source of referrals. This budget item has been created in order to incentivize referrals from the plans
    - In order to be eligible for this incentive a managed care plan must make 10 referrals to the pilot each month.
    - The managed care plans will be the recipient of this incentive, $20,000/month. Managed Care Plans can request this money twice annually, once performance has been measured.
- Mental Health Reporting Incentive: Regular and timely reporting of WPC and HEDIS data is critical to the successful monitoring and improvement of established processes. However, the staff costs and time spent generating reports can place burdens on the reporting agency. Because of this, the Kern County WPC program is requesting funding incentive payments to our mental health provider estimated at $240,000 annually. This includes monthly (12) reporting annually, for each program year of critical referral, utilization, and other quality improvement data. The five-year estimation for this budget line item is $1,200,000.
    - The Mental Health Department is expected to submit monthly reports timely and accurately to the Lead Entity
    - In order to be eligible for this incentive, the managed care provider must submit their monthly reports to the Lead Entity within 30 days after the previous month. If the required report is not submitted within the allotted timeframe, no payment shall be requested/issued for that month.
    - The Mental Health Department will be the recipient of this incentive, $20,000/report each month.
- Bi-Weekly Learning Collaborative Call Attendance: Attendance at the bi-weekly learning collaborative calls is a requirement of the WPC program for all participating organizations. However, attendance on these calls require staff time which decrease production in other areas of their respective agencies. Secondary to this, the Kern County WPC program is requesting funding incentive payments to our participating agencies for call attendance at $62,400 annually (twenty-four (24) calls annually with twelve (13) participating organizations). The five-year estimation for this budget line item is $312,000.
    - Each participating organization is expected to attend bi-weekly learning collaborative conference calls with DHCS.
    - The Lead Entity will participate in a roll call for all participating organizations for these calls. In order to be eligible for this incentive, each participating organization must attend each learning collaborative call. Calls missed by a participating organization will result in no payment being requested/issued for that call.
    - Each participating organization will be the recipient of these incentive funds, $200/call for each participating organization.
- DHCS Learning Collaborative Meeting Attendance: Attendance at DHCS learning collaborative in-person meetings, held twice a year, is a requirement of the WPC program for all participating agencies. However, attendance at these meetings places a great burden on participating organizations. Staff members will have to travel out of county for attendance which includes an overnight stay. This will result in two days of lost productivity for the respective participating agencies. Secondary to this, the Kern County WPC program is requesting funding incentive payments to our participating agencies for meeting attendance at $26,000 annually. The five-year estimation for this budget line item is $130,000.
    - Each participating organization is expected to attend learning collaborative meetings with DHCS twice a year.
    - The Lead Entity will conduct a roll call at each learning collaborative meetings. In order to be eligible for this incentive, each participating organization must attend each learning collaborative meeting.

Meetings missed by a participating organization will result in no payment being requested/issued for that meeting.
    - Each participating organization will be the recipient of these incentive funds, $1,000/meeting for each participating organization.
- Timely Submission and Data Integrity for Social Determinants/Care Coordination: Accurate and timely care coordination data submission is extremely critical to WPC program success. Without accurate and timely data WPC programs will not be able to provide accurate reporting establishing the benefit of the WPC approach. Tracking of data elements and their associated integrity will be extremely labor intensive. In order to promote timely and accurate submission of data, the Kern County WPC program is requesting funding incentive payments for the timely and accurate submission of data in the care coordination data system at $1,560,000 annually (monthly (12) data submission by twelve (13) participating agencies). The five-year estimation for this budget line item is $7,800,000.
    - Each participating organization is expected to maintain data integrity for WPC beneficiary encounters.
    - For each beneficiary encounter, each participating organization should enter beneficiary encounter data in the Pieces Iris care coordination software within 30 days of encounter. The deliverable for each month will be the percentage of compliance with updates to beneficiaries as compared to the date of service. This will be tracked by the Data Analyst and Care Coordinators as they track the progress of the beneficiary through the referral system. Payment requests/issuance for participating organizations who do not enter encounter data for each WPC beneficiary will not processed.
    - Performance targets will be 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5
    - Each participating organization will be the recipient of these incentive funds, $10,000/month for each participating organization

- Active involvement in barrier identification and resolution: It is expected that each participating agency will be actively involved in the identification of barriers and resolution of those barriers. This will be measured based on attendance to respective committee meetings, as noted in the minutes of the meeting. Those unable to attend committee meetings who receive prior approval from the Director of Whole Person Care and who submit notes and suggestions prior to meeting will be counted as successfully fulfilling this metric. Critical to the success of the WPC program is the early identification and resolution to all identified barriers to services. Failure to address barriers to services will critically hamper the programs ability to fill WPC beneficiary needs, as well as create negative experiences associated with the program. Identification of these barriers is also critical to the PDSA process. To encourage this process, and ensure reporting, the Kern County WPC program is requesting funding incentive payments to our participating organizations for the active involvement in barrier identification, reporting, and resolution of program barriers at $1,560,000 annually. The five-year estimation for this budget line item is $7,800,000.
    - During the WPC Pilot Program it is expected that each participating organization identify, capture, and propose solutions to encountered barriers. This will allow for process improvement of the WPC program through the PDSA process.
    - This will be accomplished by the capturing and reporting of identified barriers, and associated solutions, at WPC Committee meetings. Additionally, the WPC Committee will capture participating organization attendance, identified barriers and their associated solutions, in the meeting minutes. These meeting minutes will be reviewed and discussed at each WPC Committee meeting.
    - Each meeting agenda will include a PDSA line item for barrier process improvement. The Committee will review each barrier report; plan strategies for addressing identified barriers; implement corrective actions to address each barrier; monitor the applied corrective actions for efficacy; and adjust each corrective action according to the observed results.

- All of these items will be captured in the meeting minutes. Performance for this incentive will be measured based on attendance to WPC meetings as documented in meeting minutes.
- Should a participating organization fail to provide the above information or fail to attend that month's WPC Committee meeting, no payment shall be requested/issued for that month.
- Each participating organization will be the recipient of these incentive funds, $10,000/month for each participating organization.

- Partners with Data Sharing Software Implemented: Data sharing is integral to the success of this pilot. It is anticipated that bringing multiple organizations online will be a considerable effort taken on by the lead entity to work with the software vendor and each partnering agency's IT. Due to the scope of this, coordination will require additional other staff, including IT Project Managers working concurrently with these parties. This measure will be self-reported by the lead entity with signed verification by the software vendor as well as the representative at the partnering organization for whom the software was implemented. This total request is $871,100 or $67,008 for each installation and this request is only for the second year of the pilot, as such, the total pilot request is $871,100. Upon successful installation, the partnering agencies will work to further collaborate and integrate across the shared system.

Project Year 2-5 FFS Budget Narrative

Included in the WPC pilot program budget are allowable FFS estimated at $681,000 for PY 2, $900,000 for PY 3 – 5. The total FFS requested budget for the five-year program is $3,381,000. The following services are proposed for the five-year pilot program:

- Child Care Support Services - Care Center: This FFS will be used to provide Community Connection for Child Care for child care support of WPC beneficiaries while they attend wellness classes, employment training classes, locating employment opportunities, attending interviews, and other social appointments. According to the California Department of Education the current rate for part-time hourly child care market ceiling is 11.93/hr. However, this same department indicated that a 10% increase of this rate is expected within this year brining the hourly rate to 13.12. Given that the hourly rate is variable and dependent on, full-time vs. part-time, child age, and care provider, this value has been rounded up to $15/hr. The FFS is estimated at $15/hr., for 1.5 hours per visit, 3 visits a month, for 12 months, 2 children per family, and 400 members (43,200 rounded down to 43,000) for an annual estimated total of $645,000 for PY 2. For PY 3 – 5 the max units allowed has been increased to 60,000 to account for increased in beneficiary enrollment for an annual estimated total of $900,000 annually and a five-year estimation of $3,990,000.

- Public Health – In Home Assessment Training: This FFS was established to provide mobile team members with the necessary training and skills to expand their beneficiary assessment skills. Using staffing and training costs data from Public Health these classes were estimated at $3,000 per class with max units of 12 classes for an annual estimated total of $36,000. These classes will consist of an entire day of training on the environment of care assessment skills and will be taught by public health nurses.

Project Year 2-5 PMPM Budget Narrative

Included in this WPC program budget is allowable estimated PMPM bundled services estimated at $5,441,000 for PY 2, $7,346,000 for PY 3, $9,523,500 for PY 4, and $11,448,500 for PY 5. The total PMPM bundled requested budget for the five-year program is $37,580,000. The following PMPM Bundles are proposed for the five-year pilot program:

- Housing Navigation: Housing Navigation services go above and far beyond traditional housing placement services. Housing Navigators assist in barrier identification and assist beneficiaries in overcoming those barriers to housing.

During WPC Committee strategy meetings, discussion with local Continuum of Care (COC) members, and discussions at the Housing and Health Care Coordination in Southern California meeting, it was discovered that many individuals face many barriers to actually obtaining housing. These barriers are numerous and often too insurmountable to overcome. It is not uncommon for individuals, who have a housing voucher, to unsuccessfully obtain housing because of a lack of available homes, requirements for up-front payment of first and last month's rent and other costs necessary to acquire housing.

In addition to the abovementioned barriers, some individuals who are fortunate enough to obtain housing often encounter living conditions which are not conducive to their health and safety given their respective medical conditions. The simple addition of a wheelchair ramp, improving ventilation/cooling so common respiratory exacerbations don't occur, and other living condition changes are solutions to barriers this population faces. This bundled PMPM seeks to identify and remove these barriers through the WPC program and the creation of Housing Navigator positions.

In this WPC program the Housing Authority of Kern County will hire two Housing Navigators funded through this pilot program. This bundle will also support these Housing Navigators by providing funds for supportive resources for this segment of the population. In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities."

This PMPM Bundle has an annual estimated value of $230,400 for PY 2 – 5. The total PMPM bundle requested budget for the five-year program is $1,152,000. This bundled PMPM is estimated at $430/member with a max member months of 480. The estimated PMPM is based on average costs for items allowed under the abovementioned CMS bulletin necessary to create a housing environment conducive to the beneficiary's health and safety. The annual salary of a Housing Navigator inclusive of benefits is $90,000. These Housing Navigators will be solely dedicated to Whole Person Care, and the Housing Authority will invoice the lead entity monthly to receive these funds. Additional costs eligible for funding through Whole Person Care based on the CMS Informational Bulletin "Coverage of Housing-Related Activities and services for Individuals with Disabilities" are $50,000, or $1,250 per beneficiary per year. These costs range from $450 to $1,800 for security deposits, in addition to other costs. These funds will help beneficiaries secure and maintain long-term housing.

Item	QTY	Cost	Total	%	WPC
Housing Navigator	2	$90,000	$180,000	100%	$180,000
Expenses to obtain/retain housing	1	$50,000	$50,000	100%	$50,000
		Max Member Months		Total	$230,000
		480		PMPM	$480

Care Coordinators will refer homeless, or those at threat of becoming homeless to the Housing Authority of Kern County, Housing Navigators. Housing Navigation services provided by the Housing Authority of Kern County, for the homeless, or at treat of becoming homeless, include, but are not limited to:

Individual Housing Transitions Services by:

- Conducting tenant screening and housing assessments
- Developing an individualized housing support plan
- Assisting with the housing application and/or search process

- Identifying and securing resources to cover expenses allowable the abovementioned CMCS bulletin
- Ensuring that the living environment is safe and ready for move-in
- Assisting in the move by identifying moving resources
- Developing a crisis plan that includes prevention and early intervention services when housing is jeopardized

Individual Housing and Tenancy Sustaining Services by:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Educating and training on the role, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers
- Assisting in resolving disputes with landlords and/or neighbors
- Advocating and linking individuals to community resources when housing may become jeopardized
- Continuing training in being a good tenant

Unlike other listed bundles, the max units in this bundle will remain constant at 480/members per month for PY 2-5. The constant units are necessary due to position capability limitations of 20 members per month for two Housing Navigators. Our member months are based on current data indicating approximately 20% of WPC referrals have been identified as homeless, or at risk of becoming homeless. Member months will begin to be counted for a full month for the month in which a member is assigned a housing navigator and will extend until beneficiary has obtained continuous housing for 6 months, at this time, the housing navigator will be assigned a new beneficiary, and that care coordinator will coordinate regular assessments of housing. An individual placed in housing who is at risk of losing housing can return to the housing navigation pool, as determined by the care coordinator, housing navigator and director of WPC.

- Employment Services: One objective of the WPC program is to assist individuals in becoming self-sufficient. Because of this, the WPC Committee established a process that would assist WPC beneficiaries who are capable, or become capable through the WPC program, with employment opportunities through Kern County ETR.

  Through WPC Committee strategy sessions, ETR's expertise and involvement was requested in order to assist in meeting the abovementioned objective. ETR provides workforce training for the needs of the local economy and provides assistance in the business hiring process. Through ETR's experience and recommendations, the WPC Committee created the Employment Services PMPM bundle to assist WPC beneficiaries in obtain workforce training and employment. These services will go beyond the personal finance and employment classes offered through the care coordination bundle, but will extend to support in locating and applying for opportunities, assistance to and from interviews, and ongoing mentoring and support. Individuals chronically unemployed often encounter difficulties remaining employed due to the increased pressures and constraints they encounter. Having individuals available to offer that support will be invaluable throughout their process to employment.

  ETR will provide WPC beneficiaries job/skills training, resume building classes, assistance locating employment opportunities, assistance applying, assistance attending interviews, and other supportive services providing for all things necessary to be prepared for interviews. Costs incurred are expected to be heavier upon initial enrollment as this will require the greatest efforts educating, training and building a profile of each candidate.

Item	Cost	Unit Per Month	Extended Price Per Month
Assistance with job search and applications	$25/Hour	3	$75
Skills Training (ETR)	$50/class	1	$50
Interview Preparation	$200	.3	$60
Mentoring and Support	$25/Hour	2	$50

This line item is estimated at $600,000 for PY 2 – 4 and $620,000 for PY 5. The total PMPM bundle requested budget for the five-year program is $3,020,000. This bundled PMPM is estimated at $200/member with max member months of 3,000 for PY 2-4 and 3,100 for PY 5. Member months will begin to be counted the month in which the beneficiary is approved for the extended services and will extend until six months of successful, continuous employment. Based upon the specific needs of the beneficiary and the level of support required, these 6 months can be extended, as approved by the Director of WPC and WPC Steering Committee. This PMPM will be in addition to the care coordination PMPM.

- WPC Care Coordination: While traditional case management focuses mainly on physical health issues, care coordination as provided within this pilot is much more comprehensive, covering not only physical health, but mental health and social issues, and coordinating care across multiple organization to reduce redundancy and overutilization. Care coordination is more in depth and focuses on other aspects or factors that contribute to poor health outcomes. It is because of these other factors that we are striving to implement programs such WPC. However, due to the close overlap between the two approaches it is prudent to discuss them here. The Care Coordination services provided within this WPC pilot extend far beyond the Medi-Cal billable codes for Case Management and Targeted Case Management Services.

  These Care Coordination teams will be housed within one of the PCMHs at the lead entity, where the following Within the WPC program it is more appropriate to think of care coordination under the PCMH framework and their key concepts:
  - Link patients with community resources to facilitate referrals and respond to social service needs
  - Integrate behavioral health and specialty care into care delivery through co-location or referral protocols
  - Track and support patients when they obtain services outside the practice
  - Follow-up with patients within a few days of an emergency room visit or hospital discharge
  - Communicate test results and care plans with patients/families

  It is these distinct characteristics that separate case management from care coordination. Through care coordination WPC beneficiaries will be assigned a care coordination team which will provide the following:

  - Evaluation and assessment of current medical and social health. These services will be performed by clinical and non-clinical staff which are not covered by Medi-Cal. Only assessment of medical condition is covered by Medi-Cal and only for physicians, physician assistant, or nurse practitioners.
  - Evaluation and assessment of current living environment by mobile team members – these services are not covered by Medi-Cal.
  - Provision of security by probation officers for mobile team members for WPC beneficiaries who were recently released from incarceration and who are on probation. These services are not covered by Medi-Cal.

- Medication reconciliation – these services are not covered by Medi-Cal.
- Referral and connection to established social services offered through participating organizations within the WPC program. These services are not covered by Medi-Cal.
- Linking beneficiaries with other community resources and the associated follow-up and coordination with these resource providers. These services are not covered by Medi-Cal
- Assistance attending wellness classes, ETR classes, identifying housing, and other WPC services other than medical care. These services are not covered by Medi-Cal.
- Providing information and logistical support to WPC beneficiaries. These services are not covered by Medi-Cal.
- Frequent visits by mobile teams for follow up assessments and environmental conditions assessments. These services will be performed by clinical and non-clinical staff which are not covered by Medi-Cal.
- Access to behavioral health and substance abuse professionals
- Identification and resolutions to barriers encountered for all WPC services. These services are not covered by Medi-Cal.
- Information sharing across partnering organizations
- Wellness education
- Lifestyle Education
- PharmD Medication Therapy Management Services
- Telephone Visits
- Health Coaches
- Panel Management
- Home Nursing visits for acute or chronic disease management, including history taking, physical exam, phlebotomy, assessment of ADL and adjustment of diet, activity level or medications
- Podiatry Services.

Acknowledging that some of the services provided within the clinics are covered by Medi-Cal, the allocation of positions and expenses has been adjusted to ensure that funding is not being duplicated. The care coordination team will be involved in every aspect of the WPC beneficiaries care inside and outside of the clinical setting. Given the objectives of this program it is expected that the bulk of the care coordination will occur outside of the clinical setting which is not covered under Medi-Cal.

Given the main objective of the WPC program is to provide complete wrap around coordinated services using novel solutions, only an extremely small percentage of care coordination will be conducted by physicians. Instead, care coordination will be conducted by Care Coordinators, supervised by Registered Nurses, Medical Assistants, Pharmacists, and other clerical positions whose services are not reimbursable by Medi-Cal, or are extremely limited. The majority of these positions and their functions within the WPC framework are not eligible for reimbursement through Medi-Cal and the services provided will far exceed the allowable reimbursement limitations.

In addition, along with the efforts currently underway with the Global Payment Program, a number of non-traditional services will be provided through this bundle, including nursing visit for management and evaluation of the plan of care (HCPCS G0162) facilitated by one of two mobile teams. These mobile teams will be dynamic in staffing, dependent on the needs of the patients scheduled on a given day. At times these visits will simply provide social support, life coaching, supportive interventions and hygiene coaching, which will not require a licensed professional, which is why mobile teams are dynamic in nature. It is expected that these mobile services will be provided more frequently upon initial enrollment and wane as beneficiaries become stabilized and reliable.

This bundled PMPM is estimated at $473 per member per month; however we have applied a TCM budget adjustment to this PMPM of 5%, resulting in a PMPM of $450 with a max member months of 7,000 for PY 2, 10,000 for PY 13,500 for PY 4, and 16,500 for PY 5. The estimated annual values are $3,150,000 for PY 2,

$4,500,000 for PY 3, $6,075,000 for PY 4, and $7,425,000 for PY 5. The total PMPM bundle requested budget for the five-year program is $29,268,000 (inclusive of year 1). This bundle is the focal point of the pilot, as this is the true hub for care coordination, service referrals, follow-up care, data coordination and these staff will build lasting relationships with the beneficiaries. All beneficiaries of the WPC program will be included in this bundle. Months will begin being counted as a full month for the month in which the beneficiary enrolls, and will end with a full month for the month during which the beneficiary disenrolls or graduates out of the program. The following costs are estimated for year 1:

Item	QTY	1 year Cost	Total	% Ask	Net Budget
Pharm D	3	$ 250,000	$ 750,000	80%	$ 600,000
Chiropractor	1	$ 250,000	$ 250,000	80%	$ 120,000
Nurse Practitioners	3	$ 200,000	$ 600,000	20%	$ 120,000
Registered Nurses	5	$ 175,000	$ 875,000	20%	$ 175,000
Registered Nurses (Mobile Team)	2	$ 175,000	$ 350,000	75%	$ 262,500
Care Coordinators	5	$ 75,000	$ 375,000	85%	$ 318,750
Medical Assistants	5	$ 80,000	$ 400,000	80%	$ 320,000
Licensed Certified Social Workers	5	$ 150,000	$ 750,000	75%	$ 562,500
Mental Health Therapists	3	$ 150,000	$ 450,000	50%	$ 225,000
Substance Abuse Counselors	3	$ 100,000	$ 300,000	50%	$ 150,000
Certified Diabetic Educators	3	$ 100,000	$ 300,000	20%	$ 60,000
Dietetic Technician	3	$ 80,000	$ 240,000	75%	$ 180,000
Director of Health Education	1	$ 180,000	$ 180,000	75%	$ 247,500
Health Educators	3	$ 110,000	$ 330,000	75%	$ 150,000
Community Liaison	2	$ 100,000	$ 200,000	75%	$ 220,000
Probation Officers	2	$ 110,000	$ 220,000	100%	$ 300,000
Office Service Technicians	4	$ 75,000	$ 300,000	100%	$ 60,000
WPC Graduates	3	$ 20,000	$ 60,000	100%	$ 414,000
Contracted Amounts	1	$ 414,000	$ 414,000	100%	$ 62,500
Van (w-wheelchair ramp)	2	$ 31,250	$ 62,500	100%	$ 75,000
Van	4	$ 18,750	$ 75,000	100%	$ 450,000
Light Vehicle Drivers	6	$ 75,000	$ 450,000	100%	$ 250,000
Wellness/Lifestyle Education	1	$ 250,000	$ 250,000	100%	$ 550.40
DELL Desktop PC	4	$ 172	$ 688	80%	$ 598
IBM Laptop PC	2	$ 374	$ 748	80%	$ 448
HP Network Printer	2	$ 280	$ 560	80%	$ 17,600
Access Points (POE)	80	$ 275	$ 22,000	80%	$ 7,598
Wireless Controller (MT Van)	2	$ 3,799	$ 7,598	100%	$ 1,150
Vehicle laptop mount (MT Van)	2	$ 575	$ 1,150	100%	$ 15,000
Van Maintenance ($2500/yr)	6	$ 2,500	$ 15,000	100%	$ 16,800
vehicle Insurance @4% per annum	6	$ 2,800	$ 16,800	100%	$ 12,000
Engagement Materials	4000	$ 3	$ 12,000	100%	$ 6,713
Single Ride Bus Passes	4475	$ 2	$ 6,713	100%	$ 60,429
Taxi Fare (Miles)	20143	$ 3	$ 60,429	100%	$ 52,500
Fuel (6 Vans)	15000	$ 4	$ 52,500	100%	
Total					$ 5,514,136

The positions within this bundle are reflective of the education emphasis of the pilot. 2.4 (3 at 80%) PharmDs have been budgeted to provide med reconciliations and education on chronic disease management and medication therapy management.

.8 (1 at 80%) Chiropractors have been budgeted to assist with mandibular, extremity and head treatments, which are not covered by Medi-Cal.

.6 (3 at 20%) Nurse Practitioners, will increase the diversity of the care team and add an additional level of primary care support through wellness education and reinforcement, management of chronic disease and conditions, and integration of care. Additionally, there is growing support and data indicating primary care provided by nurse practitioners is more cost effective. Given one of the objectives of the WPC pilot program is to explore novel and cost effective sources of care delivery, this position will assist in evaluating this role as an option.

The budget calls for a quantity of 5 Registered nurses to assist with care coordination, however due the level at which these nurses will be assisting, only 20%, or 1 total FTE was included in the budget. This nurse will provide supervisorial support for care coordinators and assist with discharge planning and transitions of care.

1.5 (2 at 75%) additional Registered nurses have been budgeted to assist with mobile teams to perform the services identified above.

4.25 (5 at 85%) Care Coordinators have been budgeted. As previously discussed, care coordinators are central to this pilot in coordinating services across various organizations and building relationships with the beneficiaries.

4 (5 at 80%) Medical Assistants will function in an administrative and clinical capacity and will increase the overall pilot capacity by assisting care coordinators and taking part in mobile teams.

3.75 (5 at 75%) Licensed Certified Social Workers will provide a level of oversight and coordination of services to assist with integration of behavioral and physical health.

1.5 (3 at 50%) Mental Health Therapists will provide focused behavioral health assistance including, recovery sessions, goal setting, stress reduction, eating disorder management, post-traumatic stress disorder, depression management, and behavior modifications necessary for improved health outcomes.

1.5 (3 at 50%) Substance Abuse Counselors will provide therapies to include establishing treatment goals, providing coping methods, advocating self-help programs, crisis interventions, and family counseling.

.6 (3 at 20%) Certified Diabetic Educators are essential to effective self-management for individuals with diabetes. These educators will provide individualized education, self-management goals, focused interventions for self-management, monitor self-management goal progression, and continued support.

2.25 (3 at 75%) Dietetic Technicians will develop individualized nutritional plans, counseling sessions for beneficiaries and family members, educate care coordination team members, nutrition therapy and other dietary functions necessary for improved health outcomes.

.75 (1 at 75%) Director of Health Education has been budgeted. This individual will have responsibility over developing curriculum and managing all aspects of health and wellness courses, monitoring attendance, and tailoring topics to the needs of beneficiaries.

2.25 (3 at 75%) Health Educators promote wellness and behavior changes necessary for better lifestyle outcomes and will assist with life skills courses offered to beneficiaries. This will be accomplished by developing and implementing health improvement and lifestyle strategies, goals, and counseling for WPC beneficiaries and their families.

1.5 (2 at 75%) Community Liaisons have been budgeted to promote the pilot program, and work with new organizations desirous to join the program.

2 (2 at 100%) Probation officers have been budgeted to assist with the mobile team. The officers will attend site visits with the mobile teams to continue to build enhanced relationships while performing their regular duties.

4 (4 at 100%) Office Service Technicians have been budgeted for, who will assist with coordination of the mobile team, specifically with scheduling and logistics for appointments. These individuals will also be critical in scheduling appointments and assisting with various other office tasks. A hallmark of this pilot is the inclusion of

3 (3 at 100%) positions for Whole Person Care Graduates. These individuals will join the community outreach team in promoting the program, and they will act as a support for those currently enrolled in the program.

Additionally, the above table includes single items purchases for: 2 vans with wheelchair ramps; 4 vans, 4 DELL Desktop PCs, 2 IBM Laptop PCs, 2 HP Network Printers, 80 Access Points, 2 wireless controllers, and 2 vehicle laptop mounts. The total cost of these items has been spread across the duration of the pilot program. The positions noted above have been adjusted based on estimates that there will be a 75% opt-in rate to WPC, noting that care coordinators were adjusted to 85% as it is anticipated that the WPC population will require a disproportional share of their time compared to standard clinic beneficiaries as the level of care coordination with outside agencies will require substantially greater time.

Also included in the Care Coordination PMPM are Health Wellness and Lifestyle Education Classes. These are group classes available to all WPC beneficiaries. Classes will be scheduled regularly and reviewed regularly by the director of Health Education. Attendants will be given opportunities for participation and feedback in order to continue to develop these classes to the needs of beneficiaries. Attendance at these classes will be measured, as well as satisfaction, which will allow the pilot to adapt to provide classes and curriculum that yield results. Classes to be included can be found below:

- Healthy Living
- Personal Finance
- Food Preparation
- Parenting
- Diabetes Management
- Hypertension Management
- Smoking Cessation
- Safe Sleep
- Breast Health
- Men’s Health
- Women’s Health
- Domestic Violence
- Care Giver
- Fitness
- Risk Factor Reduction Interventions
- Home Care
- Resume Building

The mobile outreach and engagement team will represent and promote the WPC program, its benefits, accomplishments, and proven methods to the community and WPC eligible persons. This mobile outreach and engagement is designed to engage the community and enlist/refer additional WPC beneficiaries to the program. An additional function of this group will be to identify and engage community business organizations for inclusion in the WPC program as participating organizations. Finally, this group will work with local organizations promoting the benefits of the WPC program and enlisting their assistance in establishing WPC sustainment support and strategies.

- 90 Day Post Incarceration Coordination: Incarcerated individuals often suffer from medical, behavioral, or substance abuse conditions. While incarcerated, their medical and behavioral health needs are routinely provided for, with little effort required by the individual. Doctors are brought to the individual, medications are circulated on a regular schedule without cost to the individual, and there is consistent follow-up. Unfortunately, when these individuals are released from incarceration they are subsequently cut off from the care provided during that time. With freedom comes an extra responsibility of taking care of one's self, but this is often overlooked due to time and financial constraints, or lack of adequate skills. Also, as mentioned above, some of these individuals are released to homelessness. Given these challenges this pilot will provide for an enhanced level of care coordination for 90 days.

  In order to address the needs of this population, this pilot will establish a clinic directly outside of the facility so that upon release, prisoners who have obtained presumptive Medi-Cal eligibility can obtain an immediate wellness check. Two PharmDs will reside in the clinic to provide medication reconciliations, medication education, and ensure that these individuals have adequate prescriptions and a plan to retrieve these prescriptions. Two registered nurses will work in the clinic to provide for comprehensive discharge planning. The nurses will complete a full health risk assessment, provide any specialized medical training, and evaluate needs for durable medical equipment. Working closely with office staff, the care team will provide for a smooth transition of care to the primary care environment through scheduling a two-week checkup. Office staff in the clinic will assist the beneficiaries in identifying and applying for programs, for which they are eligible, enroll the individuals in Whole Person Care and facilitating the scheduling of a follow-up appointment. For security, a detention deputy will reside at the clinic. In addition, this team will work to identify group homes, support groups and provide referrals for MAT groups.

  In coordination with our Health Education Department we will offer during this 90 day period a variety of Life Skills Transition Classes, geared to lower recidivism amongst this very fragile population. In conjunction with their initial post incarceration visit, a post incarceration liaison will be added to the care coordination team to help assess the member's specific transitional course needs. The post incarceration liaison will also be tasked with tracking the status of class enrollment and attendance, transportation needs, reincarceration status, as well as members that disenroll, or graduate. Some examples of our Life Skills Transition Classes may include, Crime Theory - Breaking the Cycle, Anger Management, Coping Skills, Co-Dependency, Parenting, and Relapse Prevention. These courses will assist the beneficiaries in building structure with the challenges of post-incarceration.

  At the conclusion of 90 days this post incarceration team will assess the members' success and provide a report for our Quality review team to assess monthly for system improvement.

  These beneficiaries will receive enhanced care coordination PMPM for 3 months post release in addition to the standard complex care coordination PMPM bundle. These beneficiaries will count as one member month for the entire calendar month in which they enroll in Whole Person Care, and will be counted for a maximum of 3 member months. Beneficiaries will be enrolled in the care coordination bundle concurrently for the three months of enhanced post-incarceration, after which time, these individuals will be reviewed for eligibility to the program for continued consideration.

This bundled PMPM is estimated at $1,800/member based off a total 2,700 member months for PY 2-5. This bundled PMPM has an estimated annual value for $1,216,000 for PY 2-5. The total PMPM bundled requested for the five-year program is $6,080,000.

QTY	Item	Cost	Total	%	Annual Cost
1	Detention Deputy	$ 125,000	$ 125,000	80%	$ 100,000
2	Registered Nurse	$ 175,000	$ 350,000	80%	$ 280,000
2	Pharm D	$ 250,000	$ 500,000	80%	$ 400,000
1	Office Staff Bundle	$ 160,000	$ 160,000	80%	$ 128,000
1	Liaison	$ 90,000	$ 90,000	100%	$ 90,000
2	Medical Assistants	$ 80,000	$ 160,000	80%	$ 128,000
1	Office Space	$ 60,000	$ 60,000	80%	$ 48,000
1	Office Supplies/Equipment	$ 52,500	$ 52,500	80%	$ 42,000
				Total Value	**$ 1,216,000**

Project Year 2-5 Pay for Reporting Budget Narrative

Included in this WPC program budget is allowable estimated Pay for Reporting estimated at $6,735,600 for PY 2, $6,735,600 for PY 3, $7,006,100 for PY 4, and $7,015,100 for PY 5. The total PMPM bundled requested budget for the five-year program is $34,228,000 (counting PY2 twice to incorporate year 1). Pay for reporting is based on required universal and variant reporting metrics. The following reporting metrics are proposed and required metrics:

Reporting Metric	PY 2	PY 3	PY 4	PY 5
Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment	350,000	350,000	350,000	350,000
Administrative: Care Coordination, case management, and referral infrastructure	350,000	350,000	350,000	350,000
Administrative: Data and information sharing infrastructure	350,000	350,000	350,000	350,000
Administrative: WPC Committee Meeting Effectiveness measured by attendance 70% with the exception of pre-approved	350,000	350,000	350,000	350,000

absences.				
PHQ-9 Depression Remission at 12 months (GROW) NQF 0710	500,000	500,000	500,000	500,000
Housing – Housing Services	500,000	500,000	500,000	500,000
Mental Health Reporting: Screening, Brief Intervention and Referral to Treatment (SBIRT)	500,000	500,000	500,000	500,000
Health Outcome: Ambulatory Care – Emergency Department Visits (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Inpatient Utilization – General Hospital/Acute Care (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Follow-up After Hospitalization for Mental Illness (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Adult Body Mass Index (BMI) Assessment (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Controlling High Blood Pressure (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: HbA1c Poor Control <8%	500,000	500,000	500,000	500,000
Administrative: Wellness/Lifestyle Class Attendance	335,600	335,600	500,000	500,000

The above metrics were selected and established based on interviews and input from participating agencies. Additionally, the rationale behind the metric choices clearly aligns with the WPC project strategies and objectives of the

program. Furthermore, the metrics are also closely related to the mission and objectives of not only the WPC program but the PCMH and PCSP mission and objective as well.

Payment for the reporting will be made to Kern Medical Center and are based on the level of staff expertise; estimated staff time necessary to generate the reports; estimated staff time and resources to monitor the progress and assure the reports are accurate and on time; and the required systems and mechanisms required to extract the data necessary for the metrics.

Initially, in PY 2, reports will be run and analyzed on a weekly basis. For PY 3-5 reports will be run and analyzed on a monthly basis. Initial analysis of the reports will focus on the validity of data integrity, reports, and current processes. During this process all aspects of the WPC program will be evaluated using PDSA principles. These reports and their respective data elements will be critical to the PDSA methodology. Information within these reports will be used to evaluate the program and take necessary corrective actions should the desired results not be achieved.

Half of the annual budgeted amounts may be drawn down upon submission of the mid-year report, and the remaining funds may be drawn down upon successful submission of year-end report.

Project Year 2-5 Pay for Outcomes Budget Narrative

Included in this WPC program budget is allowable estimated Pay for Outcomes estimated at $10,376,000 for PY 2, $9,518,100 for PY 3, $7,402,600 for PY 4, and $5,753,600 for PY 5. The total Pay for Outcomes requested budget for the five-year program is $43,426,300 (counting PY2 twice to incorporate year 1). All performance metrics have the ability to pay out partial payments, based upon percentage of attainment (i.e., if 95%of goal attained, 95% of incentive will be earned). The recipient of these pay for outcomes will be the Lead Entity: Kern Medical Center. Pay for outcomes are based on required universal and variant reporting metrics. The following reporting metrics are proposed and required metrics:

Pay for Outcomes (PY 2 description)	PY 2	PY 3	PY 4	PY 5
5% Improvement Over PY in ER Utilization	900,000	1,000,000	600,000	450,000
5% Improvement Over PY in Inpatient Utilization	876,000	862,000	600,000	450,000
5% Improvement Over PY for Follow-up After Hospitalization for Mental Illness	800,000	700,000	600,000	400,000
5% Improvement Over PY for Initiation and Engagement of ETOH and Other Dependence Tx	750,000	700,000	500,000	400,000
5% Improvement Over PY for PHQ-9 Depression Remission at 12 Months NQF 0710	750,000	700,000	500,000	400,000
2% Improvement in PY of HbA1C Poor Control <8%	750,000	700,000	500,000	500,000
5% Improvement Over PY for Preventative Care Measures of WPC beneficiaries	750,000	700,000	500,000	400,000

40% Post-Incarceration Primary Care Visit Within 60 Days of Release	750,000	700,000	500,000	453,600
30 Day All Cause Readmissions 5% decrease in PY	800,000	900,000	624,000	400,000
Screening, Brief Intervention and Referral to Treatment (SBIRT) 5% improvement over PY	750,000	700,000	500,000	300,000
Overall Beneficiary Health 5% improvement over PY	750,000	700,000	500,000	400,000
Controlling Blood Pressure 5% improvement over PY	750,000	356,100	500,000	400,000
Med Reconciliation Completed within 30 days enrollment: 70%	500,000	300,000	478,600	400,000
70% of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days	500,000	500,000	500,000	400,000

At its very core, the WPC program was designed, and its focus is to truly determine if preventative care measures outside of the clinical setting truly contribute to healthier outcomes. Kern County answered this question with a resounding "Yes" based on information gathered and learned from the KGC program. As stated above, in the *Geographic Area* and *Target Population* sections, the KGC pilot showed substantial reduction in emergency service use, 68% decrease in ER visits by enrolled members with a decrease in average cost per member by 89%, by simply linking high utilizers to existing services. However, due to increasing staffing shortages; county budgeting crisis; limited resources; partnering agency service limitations; lacking infrastructure; and no real sustainable methods to continue to drive the pilot, the program stalled. This evidence shows the importance of successful implementation of the WPC program.

Given the abovementioned identified challenges in the KGC pilot program, the Kern County WPC program proposes these pay for outcomes incentives for our program. We believe these outcomes provide the most incentives to mitigate the barriers identified in the KGC pilot program.

Our rationale for choosing these performance outcomes is their direct relationship and focus on identified key causes of ER overcrowding; increased medical costs; and increased insurance costs. Additionally, these outcomes align with the mission of many of our partnering agencies and overall county wide issues.

Up to one half of the designated funds may be drawn down upon the submission of the mid-year report, based on 50% attainment of the metric target. At the year-end report, all remaining funds may be drawn down based on metric attainment.

Section 6: Attestations and Certification

6.1 Attestation

I certify that, as the representative of the WPC pilot lead entity, I agree to the following conditions:

- The WPC pilot lead entity will help develop and participate in regular learning collaboratives to share best practices among pilot entities, per STC 119.
- The intergovernmental transfer (IGT) funds will qualify for federal financial participation per 42 CFR 433, subpart B, and will not be derived from impermissible sources, such as recycled Medicaid payments, federal money excluded from use as a state match, impermissible taxes, and non-bona fide provider-related donations, per STC 126.a. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid
- Within 30 days of the determination of the interim payment due based on the mid-year and annual report, DHCS will issue requests to the WPC pilot for the necessary IGT amounts. The WPC pilot shall make IGT of funds to DHCS in the amount specified within 7 days of receiving the state's request. If the IGTs are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.
- The WPC pilot lead entity will enter into an agreement with DHCS that specifies the requirements of the WPC pilot, including a data sharing agreement per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Application. Many of the provisions in the DHCS boilerplate BAA apply only to BAA-covered information that is shared by DHCS to the pilot specifically for the purpose of Whole Person Care pilot operation and evaluation. DHCS does not anticipate that BAA-covered information will be shared with pilots for the purpose of Whole Person Care pilot operation or evaluation. DHCS anticipates limited, or no, BAA-covered information sharing from the pilot to DHCS. However, DHCS will include a BAA in the case that data need to be shared. The BAA will apply to the transfer of BAA-covered information should the need arise.]
- The WPC pilot will report and submit timely and complete data to DHCS in a format specified by the state. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the state.
- The WPC pilot shall submit mid-year and annual reports in a manner specified by DHCS and according to the dates outlined in Attachment GG. The WPC pilot payments shall be contingent on whether progress toward the WPC pilot requirements approved in this application has been made.
- The WPC pilot will meet with evaluators to assess the WPC pilot.
- Federal funding received shall be returned if the WPC pilot, or a component of it as determined by the state, is not subsequently implemented.
- Payments for WPC pilots will be contingent on certain deliverables or achievements, and will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables (STC 126).
- The lead entity will respond to general inquiries from the state pertaining to the WPC pilot within one business day after acknowledging receipt, and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by DHCS. DHCS will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.
- The lead entity understands that the state of California must abide by all requirements outlined in the STCs and Attachments GG, HH, and MM. The state may suspend or terminate a WPC pilot if corrective action has been imposed and persistent poor performance continues. Should a WPC pilot be terminated, the state shall provide notice to the pilot and request a close-out plan due to the state within 30 calendar days, unless significant harm

to beneficiaries is occurring, in which case the state may request a close-out plan within 10 business days. All state requirements regarding pilot termination can be found in Attachment HH.

☒ **I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of WPC pilot program participation requirements as specified in the Medi-Cal 2020 waiver STCs, Attachments GG, HH and MM, and the DHCS Frequently Asked Questions document.**

Russell V. Judd **7-1-16**

Signature of WPC Lead Entity Representative

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Kern Medical Center (Kern County)

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	15,734,650	15,734,650	31,469,300

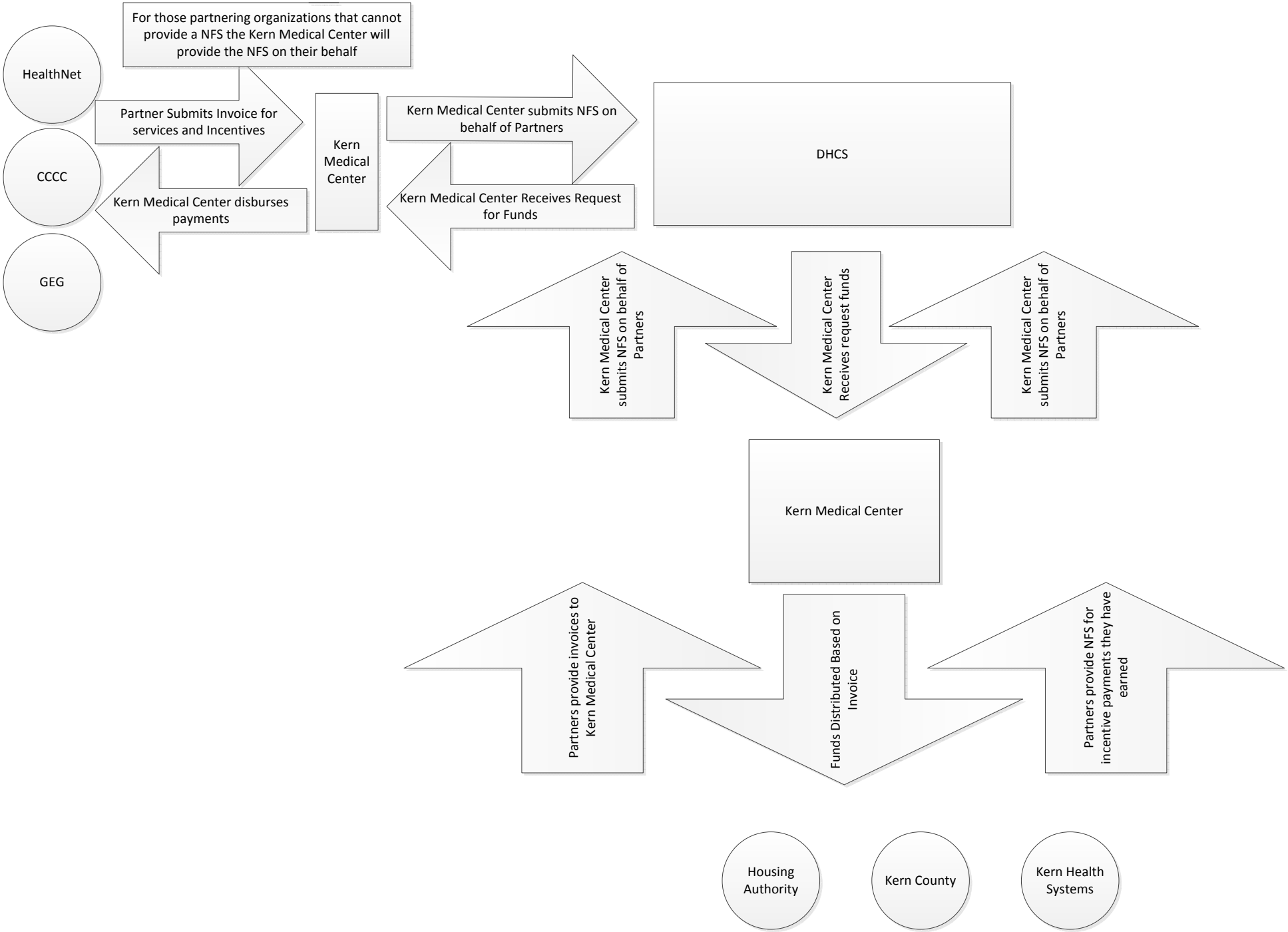
PY 1 Budget Allocation (Note PY 1 Allocation is	
PY 1 Total Budget	31,469,300
Approved Application (75%)	23,601,975
Submission of Baseline Data (25%)	7,867,325
PY 1 Total Check	OK

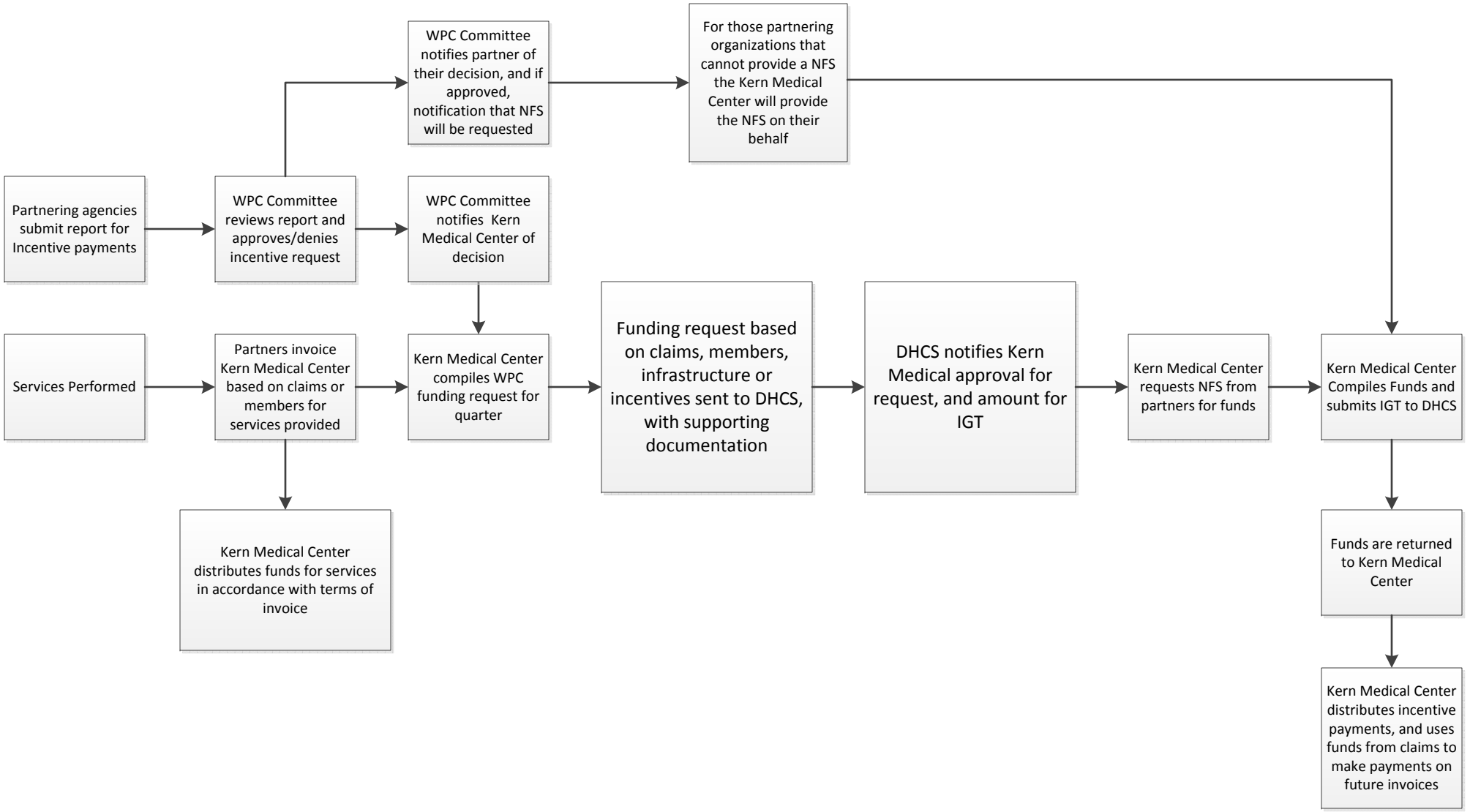
PY 2 Budget Allocation	
PY 2 Total Budget	31,469,300
Administrative Infrastructure	4,086,800
Delivery Infrastructure	0
Incentive Payments	4,799,500
FFS Services	681,000
PMPM Bundle	4,790,400
Pay For Reporting	6,735,600
Pay for Outomes	10,376,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	6,410,400
Pay For Reporting	6,735,600
Pay for Outomes	9,518,100
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	8,255,400
Pay For Reporting	7,006,100
Pay for Outomes	7,402,600
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	9,895,400
Pay For Reporting	7,015,100
Pay for Outomes	5,753,600
PY 5 Total Check	OK


For those partnering organizations that cannot provide a NFS the Kern Medical Center will provide the NFS on their behalf
HealthNet
CCCC
GEG
Partner Submits Invoice for services and Incentives
Kern Medical Center disburses payments
Kern Medical Center
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center Receives Request for Funds
DHCS
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center Receives request funds
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center
Partners provide invoices to Kern Medical Center
Funds Distributed Based on Invoice
Partners provide NFS for incentive payments they have earned
Housing Authority
Kern County
Kern Health Systems


WPC Committee notifies partner of their decision, and if approved, notification that NFS will be requested
For those partnering organizations that cannot provide a NFS the Kern Medical Center will provide the NFS on their behalf
Partnering agencies submit report for Incentive payments
WPC Committee reviews report and approves/denies incentive request
WPC Committee notifies Kern Medical Center of decision
Services Performed
Partners invoice Kern Medical Center based on claims or members for services provided
Kern Medical Center compiles WPC funding request for quarter
Funding request based on claims, members, infrastructure or incentives sent to DHCS, with supporting documentation
DHCS notifies Kern Medical approval for request, and amount for IGT
Kern Medical Center requests NFS from partners for funds
Kern Medical Center Compiles Funds and submits IGT to DHCS
Kern Medical Center distributes funds for services in accordance with terms of invoice
Funds are returned to Kern Medical Center
Kern Medical Center distributes incentive payments, and uses funds from claims to make payments on future invoices

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Kern County Hospital Authority, Chief Executive Officer Report

Recommended Action: Receive and File.

Summary:

Chief Executive Officer will provide an update on hospital operations.

KernMedical

POSITIONS ON 2016 BALLOT INITIATIVES IMPACTING HOSPITALS

October 19, 2016

CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

PROP 52: Medi-Cal Hospital Fee Program

Extends indefinitely an existing statute that imposes fees on hospitals to fund Medi-Cal health care services, care for uninsured patients, and children's health coverage. Fiscal Impact: Uncertain fiscal effect, ranging from relatively little impact to annual state General Fund savings of around $1 billion and increased funding for public hospitals in the low hundreds of millions of dollars annually.

PROP 55: Tax Extension to Fund Education and Healthcare

Extends by twelve years the temporary personal income tax increases enacted in 2012 on earnings over $250,000, with revenues allocated to K-12 schools, California Community colleges, and, in certain years, healthcare. Fiscal Impact: Increased state revenues - $4 billion to $9 billion annually from 2019-2030 – depending on economy and stock market. Increased funding for schools, community colleges, health care for low-income people, budget reserves, and debt payments.

PROP 56: Cigarette Tax to Fund Healthcare, Tobacco Use Prevention, Research, and Law Enforcement

Increases cigarette tax by $2,000 per pack, with equivalent increase on other tobacco products and electronic cigarettes containing nicotine. Fiscal Impact: Additional net state revenue of $1 billion to $1.4 billion in 2017-18, with potentially lower revenues in future years. Revenues would be used primarily to augment spending on health care for low-income Californians.

Patient Centered Medical Home for Medically Fragile Patients

Meridian Healthcare Partners, Kern Medical, and Kern Health Systems:

A Collaboration in

Unifying the Integrated Delivery Network

Kern Medical Center Then

MERIDIAN
HEALTHCARE PARTNERS

KERN
MEDICAL
CENTER


MERIDIAN
HEALTHCARE PARTNERS

Kern Medical Now

MERIDIAN HEALTHCARE PARTNERS

KernMedical | Health for Life.

Meridian Assessment Results

- 3 primary issues that needed to be addressed:

Governance Structure

Leadership Philosophy

Financial Solvency

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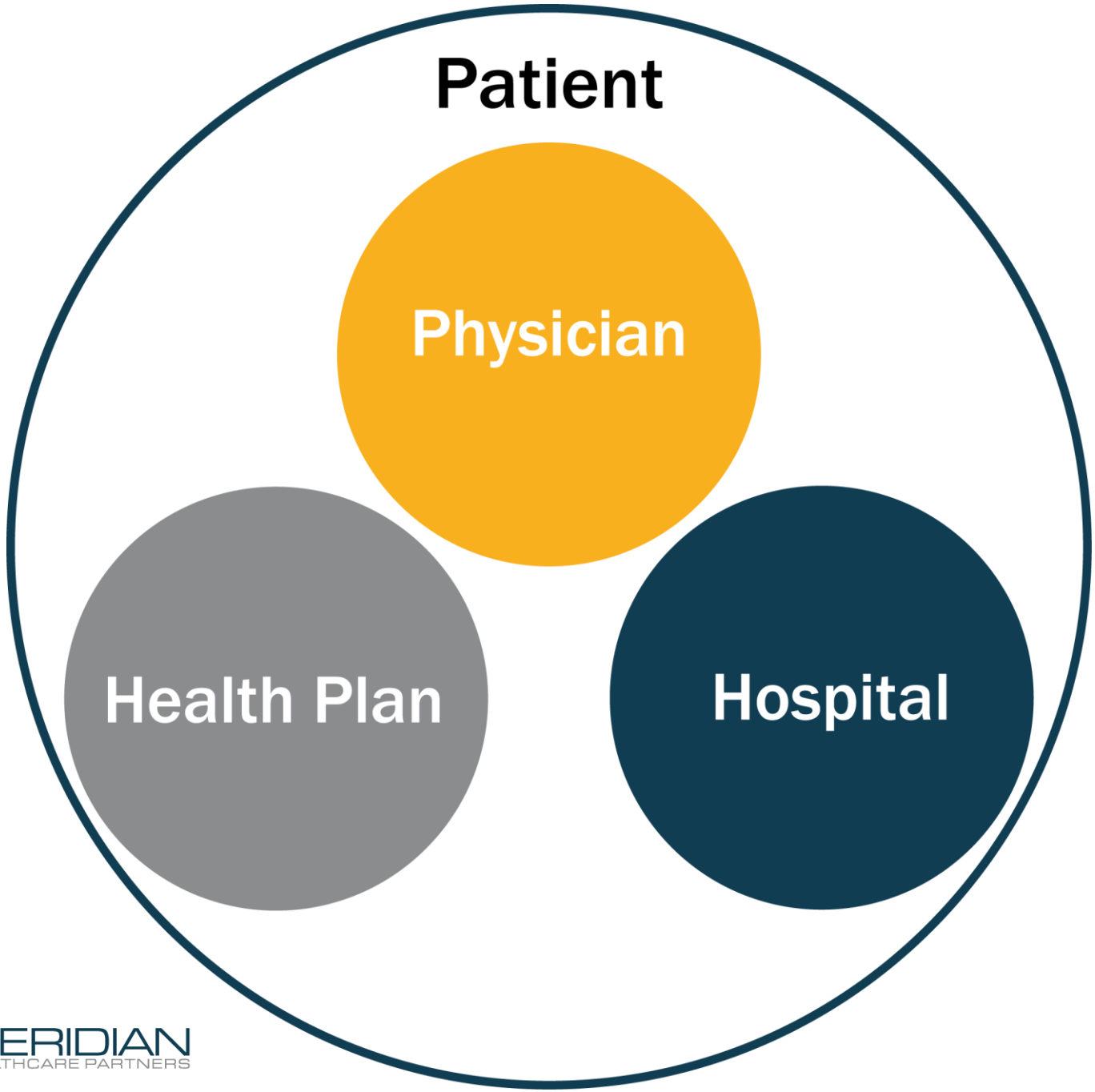
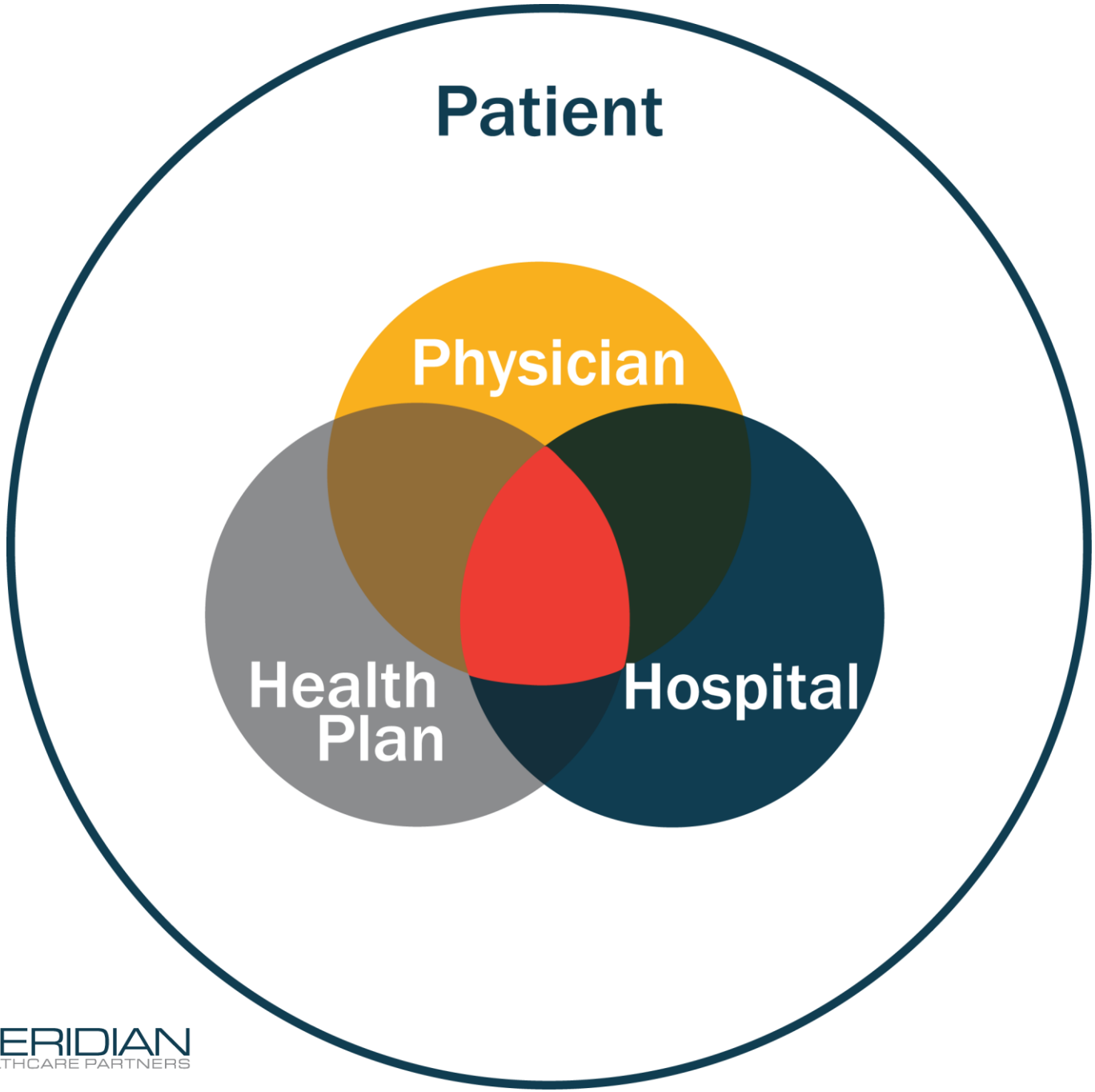


MERIDIAN
HEALTHCARE PARTNERS



MERIDIAN
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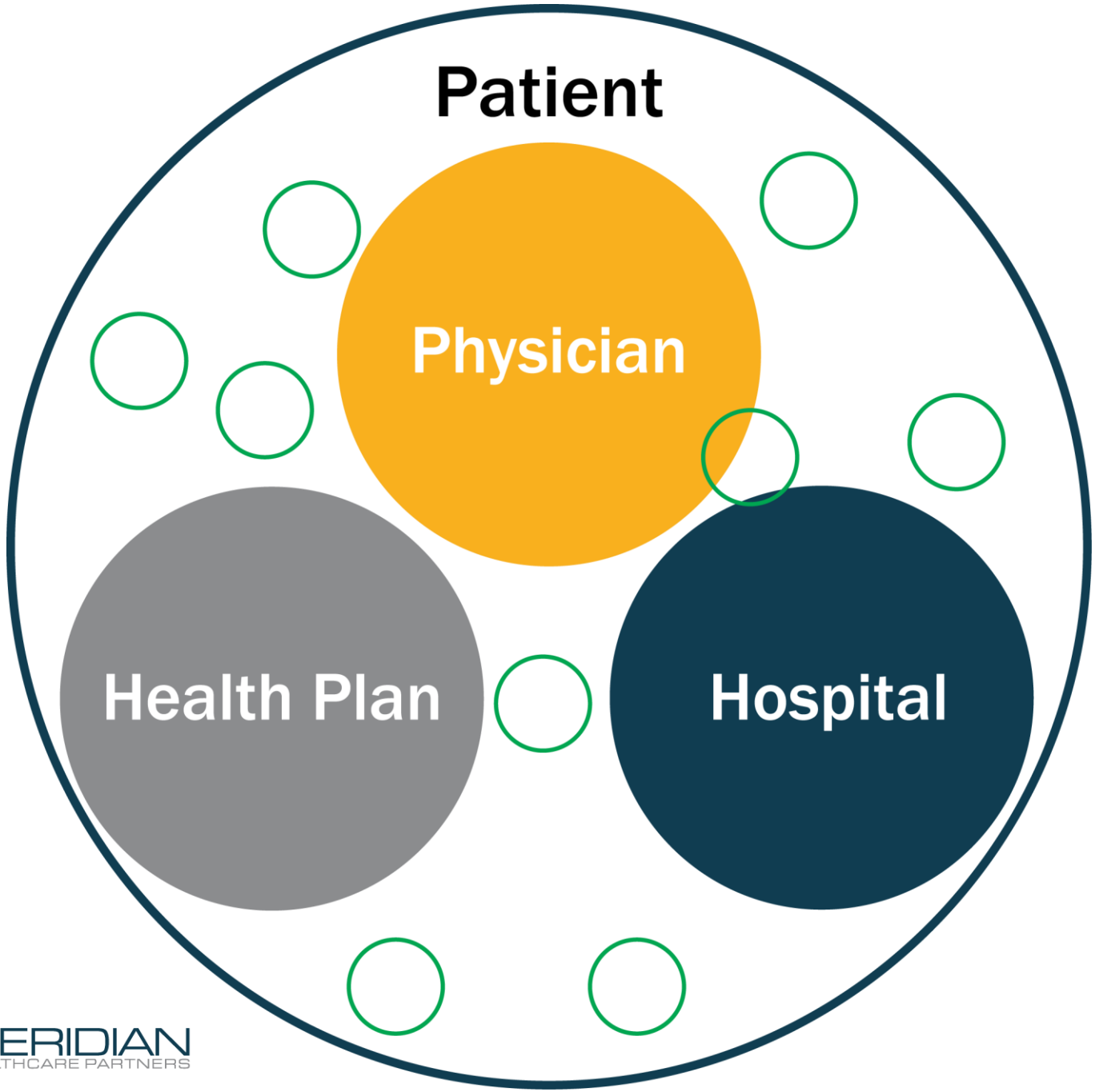
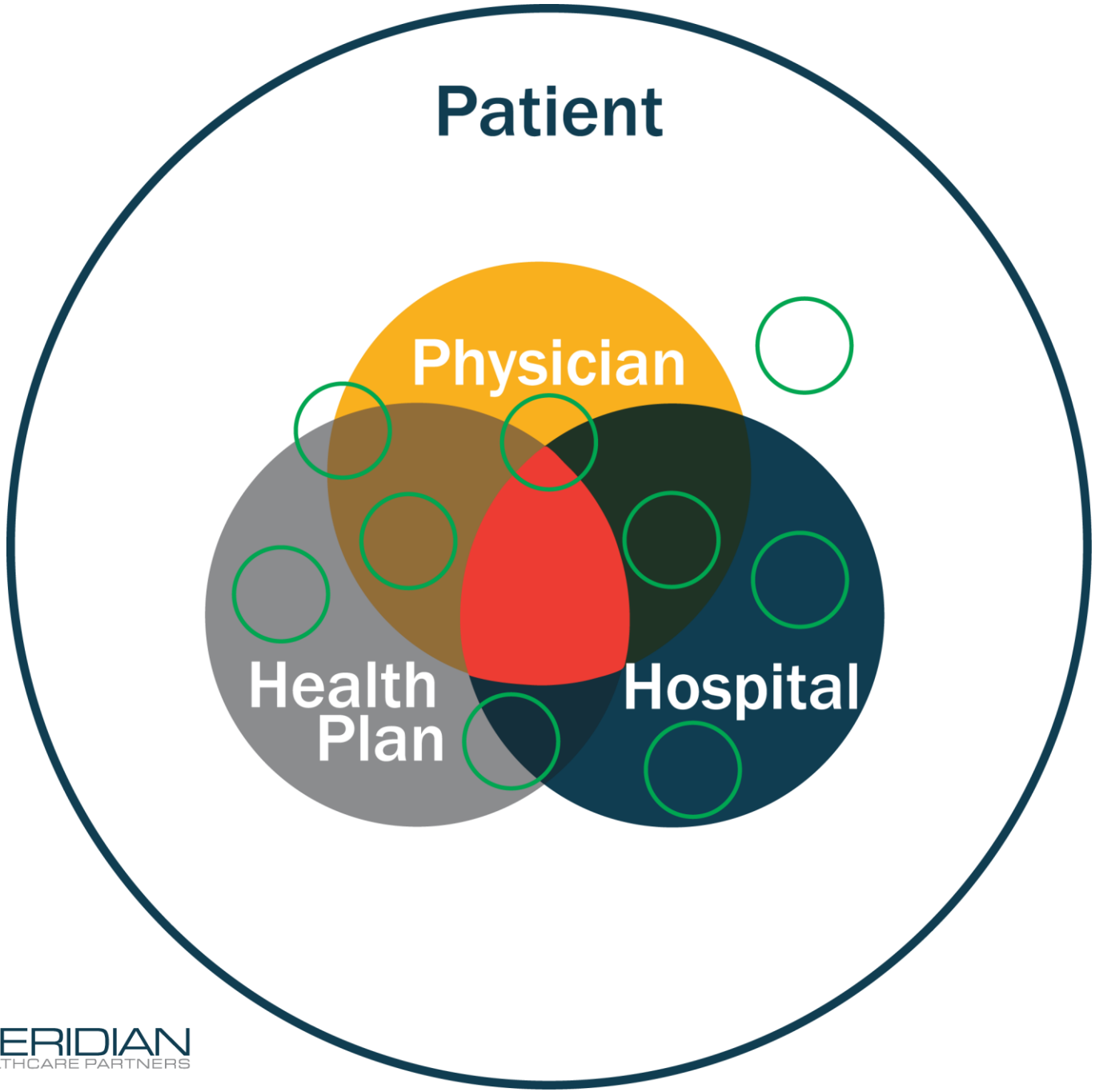


MERIDIAN
HEALTHCARE PARTNERS



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Current System

- Physician – Episodic – Do Something – Get Paid
- Hospital - Episodic – Pay Grouped – DRG – Per Diem
- Health Plan – Total Risk-Monthly Payment – Limit Episodes

Not Aligned - Adversarial

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Emergency Room Visits

- Health Plan - Avoid
- Physician – Direct to ER
- Hospital – More Visits, More Revenue

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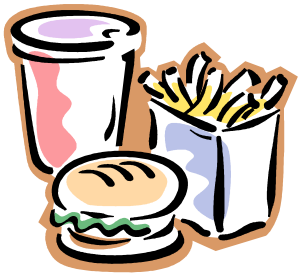
Patient is admitted to the hospital for complications related to uncontrolled Diabetes

She is seen by a doctor who doesn't know the patient or her previous history

Patient has trouble understanding her discharge instructions, and they are not tailored to her personal situation

No Medical Home

Patient is given medications but stops taking them, because compliance is too difficult



Patient doesn't understand why she was told to change her lifestyle, so she engages in unhealthy habits.

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Collaboration and Partnership

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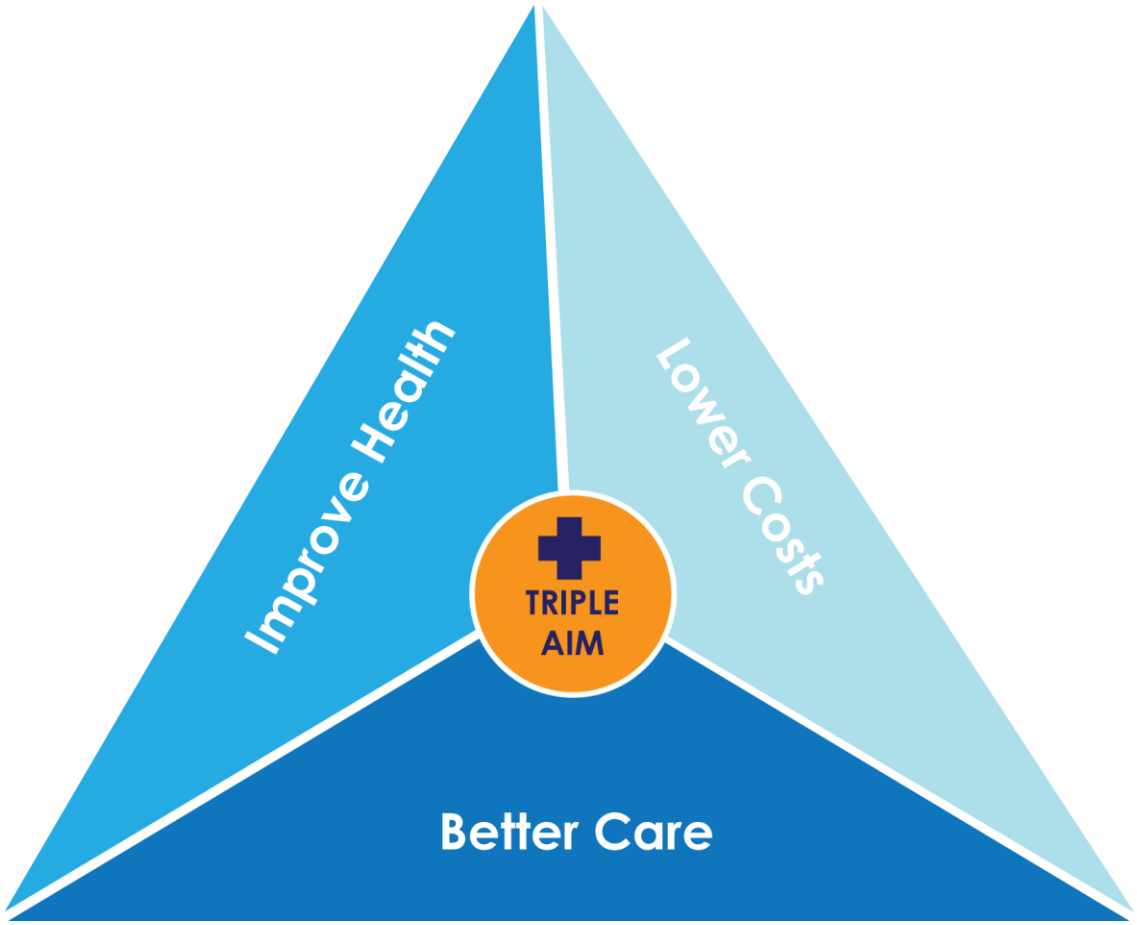
The Triple Aim



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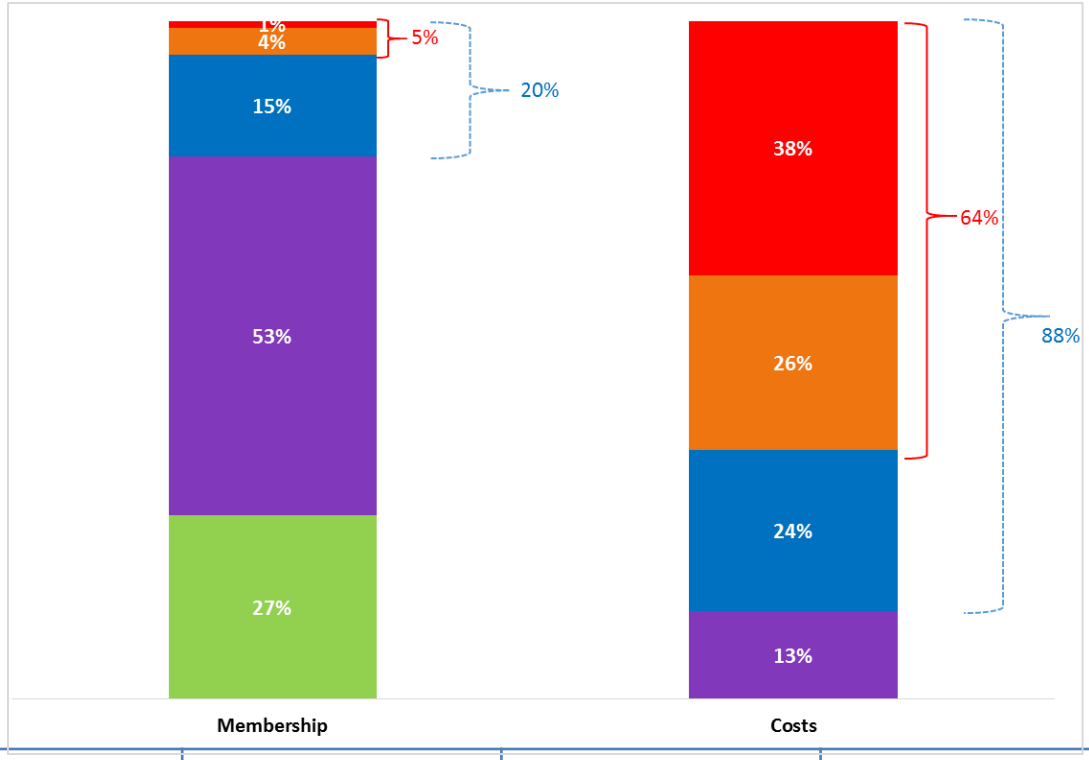
Kern Family Health Statistics

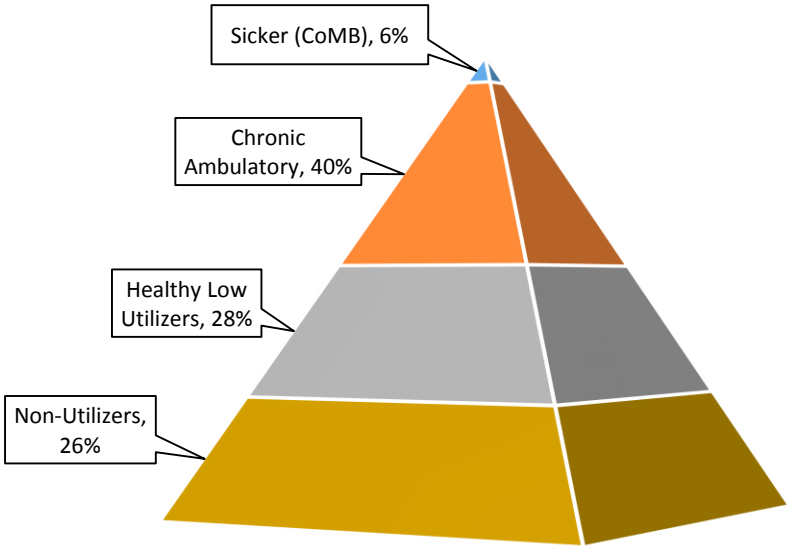
KHS reported in May 2015 that 5% of their members contributed to 64% of their costs



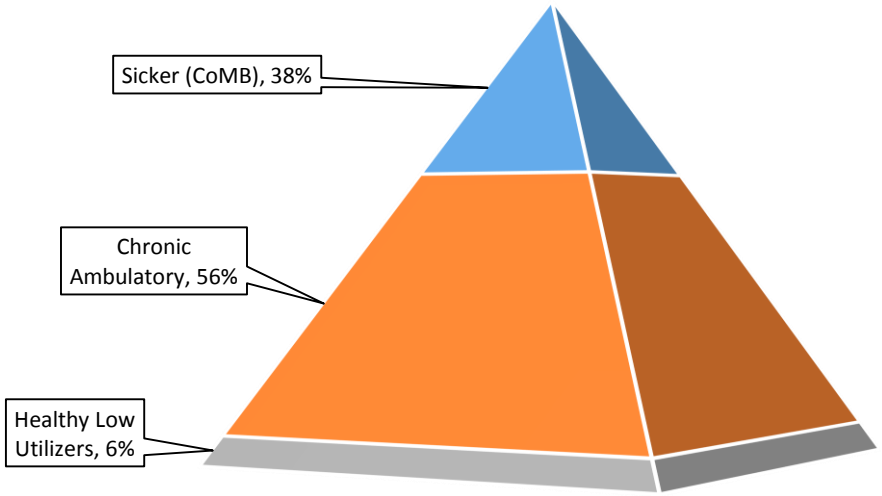
% of Members	Members	% of Costs	Total Costs
1%	2,096	35%	$108,273,437.24
4%	8,382	26%	$74,665,452.07
15%	31,063	24%	$68,962,593.53
53%*	110,616	13%	$36,693,569.69
27%	57,391	0%	$0.00
100%	**209,548**	**Totals**	**$288,595,052.53**

MERIDIAN HEALTHCARE PARTNERS

Care Gradient Analysis by Members and Costs



Members

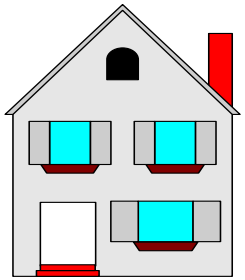


Costs

MERIDIAN HEALTHCARE PARTNERS

Emerging Delivery System and Payment Reform Models

Institute for Healthcare Improvement Triple Aim
- Improve the Health of the Population
- Enhance Patient Experience (quality, access, reliability)
- Reduce (or at least) Control Costs



Person Centered HC Homes

Increase Preventive Care

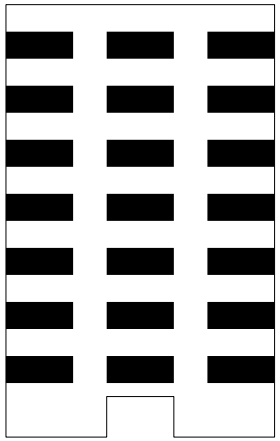
Expand the use of Evidence-Informed Care

Promote Early Intervention

Decrease Overuse and Underuse of Services

Improve the Coordination of Care

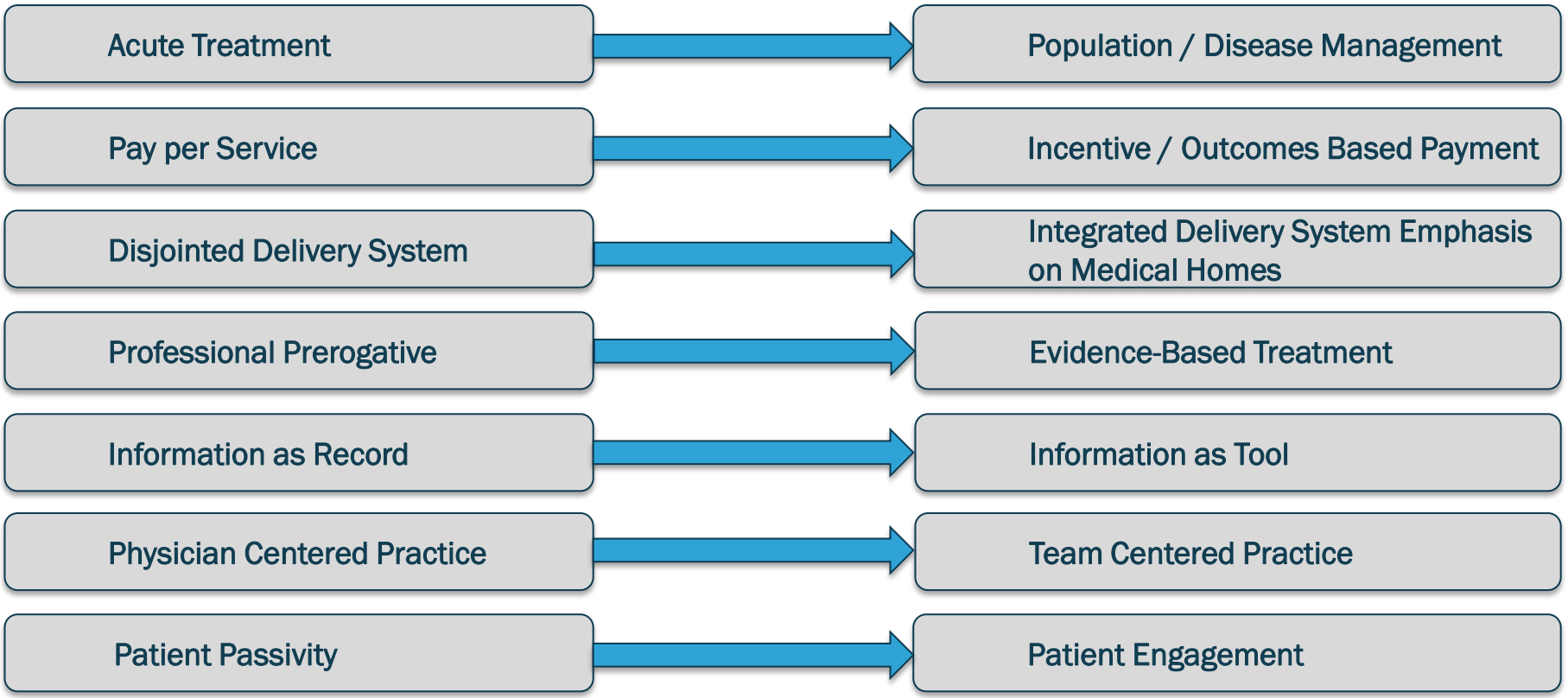
Reduce Error Rates



Inpatient: Reducing Errors & Waste

MERIDIAN HEALTHCARE PARTNERS

HEALTH CARE TRANSITIONS / AREAS FOR COLLABORATION



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The Patient Centered Medical Home

Patient-centered | Physician-directed

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Patient Testimonial

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REACH Clinic Remodel and Ribbon Cutting Ceremony

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BEFORE

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AFTER

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REACH Clinic

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REACH Clinic Launch- Challenges

Kern Medical
REACH

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REACH Clinic Services

- Personalized Care
- 24-Hour Nurse Advice
- Extended Hours
- Patient Education
- Preventive Care
- Prescription Renewals
- Transportation
- Community Resource Referrals
- Behavioral Health Services
- Care Coordination
- Urgent Care
- Chronic Condition Management
- Health Management Tools
- Same Day Appointments

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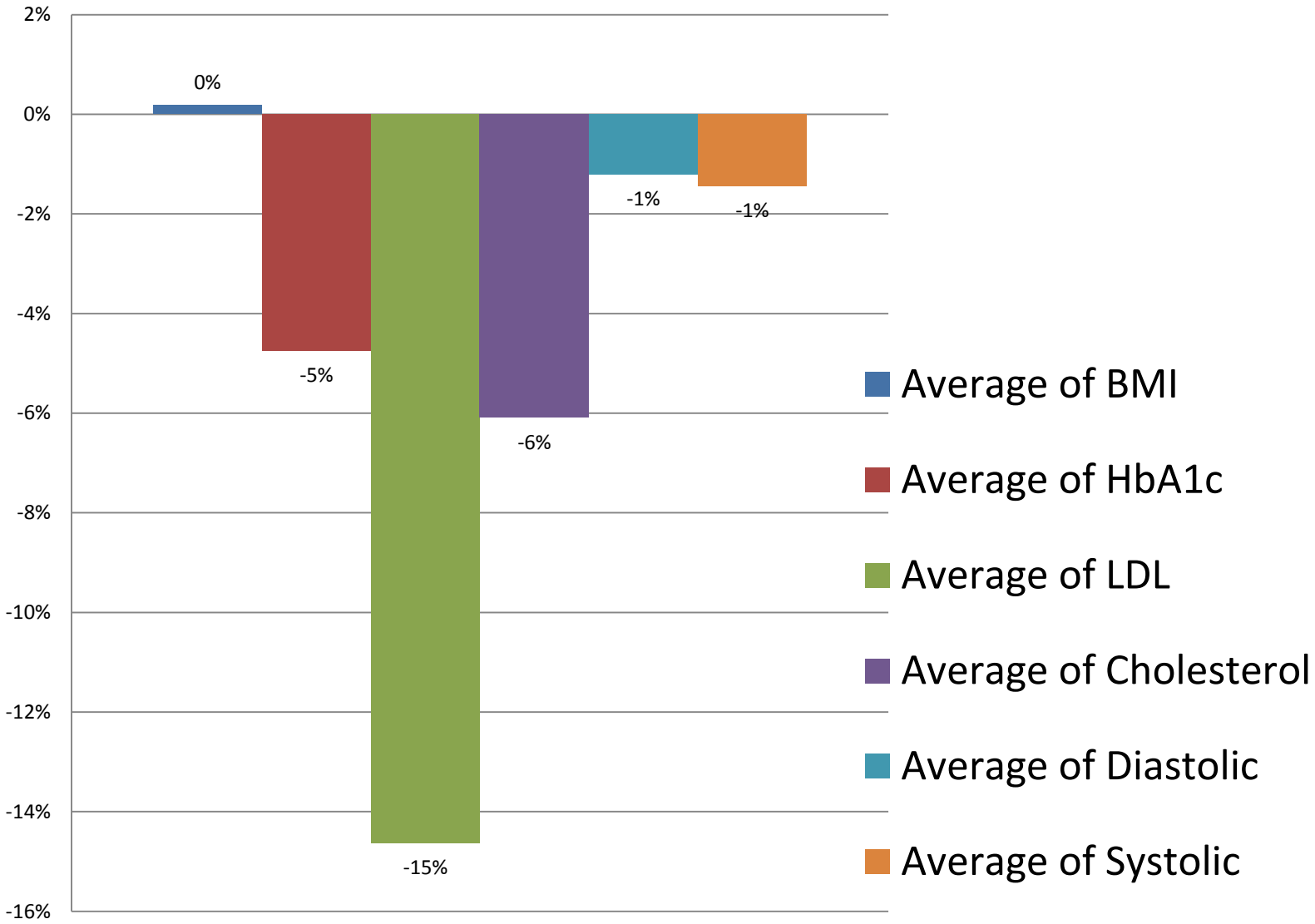
2016 REACH Clinic Health Outcomes



MERIDIAN HEALTHCARE PARTNERS

REACH Clinic Statistics 08/2016

	ER	INPATIENT
PRE Cost	$217,581.80	$1,334,063.40
POST Cost	$117,416.65	$1,149,216.58
$ Difference	**($100,165.15)**	**($184,846.82)**
% Difference	**-46.0%**	**-13.9%**
PRE Events	665	114
POST Events	382	82
# Difference	**-283**	**-32**
% Difference	**-42.6%**	**-28.1%**

Pre - Post Comparisons

Event	Costs	PMPM	Events	% Change In Costs	% Change In PMPM	% Change In Events
ER	($100,165.15)	($82.64)	(283)	-46.0%	-46.0%	-42.6%
HOME HEALTH	$6,351.38	$5.24	(8)	14.0%	14.0%	-11.0%
INPATIENT	($184,846.82)	($152.51)	(32)	-13.9%	-13.9%	-28.1%
OUTPATIENT	$61,243.35	$50.53	219	54.8%	54.8%	38.1%
PHARMACY	$230,054.30	$189.81	50	54.7%	54.7%	1.9%
PROFESSIONAL	($177,356.22)	($146.33)	(449)	-38.4%	-38.4%	-16.9%
URGENT CARE	$63,766.39	$52.61	852	1876.1%	1876.1%	2130.0%
TOTAL	($100,952.77)	($83.29)	349	-3.9%	-3.9%	5.1%

Note: Total of 101 member months both Pre and Post.

MERIDIAN
HEALTHCARE PARTNERS

REACH Clinic Patient Satisfaction Survey Questions

REACH CLINIC SURVEY	Quarter 2- 2016
1) Ability to get into the clinic to be seen	94%
2) The hours the clinic is open	89%
3) The Clinic location convenience	83%
4) Prompt return on phone calls	86%
5) Time in the waiting room	80%
6) Time in the Exam Room	83%
7) Waiting for Tests to be Performed	89%
8) Waiting for Test Results	71%
9) Listens to you	100%
10) Takes enough time with you	91%
11) Explains what you want to know	94%
12) Gives good advice and treatment	97%
13) Friendly and Helpful to you	97%
14) Answers your Questions	100%
15) Self-Management Support	77%
16) Coordination of Care and Services	83%
17) Neat and Clean Building	97%
18) Ease of Finding where to go	91%
19) Comfort and Safety while waiting	94%
20) Privacy and dignity	100%
21) Keep my personal information private	100%
22) On a scale of 1-10 (1 being the worst and 10 being the best) please rate your Provider (Physician or Nurse Practitioner):	97%
23) I would refer my friend or family member without hesitation to the REACH Clinic	100%

MERIDIAN HEALTHCARE PARTNERS

NCQA Certification Achieved May 2016

PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. ***Patient-Centered Appointment Access**	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	**5**
E. Implement Evidence-Based Decision-Support	4
	20

Scoring Levels

Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

***Must Pass Elements**

NCQA Measuring quality. Improving health care.

MERIDIAN HEALTHCARE PARTNERS

The Future: GROW Clinic

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The Future: Medical Neighborhoods

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HEALTHCARE PARTNERS

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ER	($100,165.15)	($82.64)	(283)	-46.0%	-46.0%	-42.6%
HOME HEALTH	$6,351.38	$5.24	(8)	14.0%	14.0%	-11.0%
INPATIENT	($184,846.82)	($152.51)	(32)	-13.9%	-13.9%	-28.1%
OUTPATIENT	$61,243.35	$50.53	219	54.8%	54.8%	38.1%
PHARMACY	$230,054.30	$189.81	50	54.7%	54.7%	1.9%
PROFESSIONAL	($177,356.22)	($146.33)	(449)	-38.4%	-38.4%	-16.9%
URGENT CARE	$63,766.39	$52.61	852	1876.1%	1876.1%	2130.0%
TOTAL	($100,952.77)	($83.29)	349	-3.9%	-3.9%	5.1%

Note: Total of 101 member months both Pre and Post.

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Financial Alignment

- Hospital
- Physician
- Health Plan

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Bakersfield, CA 93306
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Contact us to learn how we can help you!!

KernMedical

3-Month Trend Analysis: Volume and Strategic Indicators

August 31, 2016

	JUNE	JULY	AUGUST	BUDGET AUGUST	VARIANCE POS (NEG)	PY AUGUST
VOLUME						
Adjusted Admissions (AA)	1,456	1,500	1,682	1,465	15%	1,409
Adjusted Patient Days	6,904	7,945	7,512	8,121	(8%)	7,505
Admissions	757	787	852	784	9%	784
Average Daily Census	129	134	123	140	(12%)	135
Patient Days	3,872	4,168	3,805	4,347	(12%)	4,177
Available Occupancy %	60.3%	62.8%	57.4%	65.5%	(12%)	63.0%
Average LOS	5.1	5.3	4.5	5.5	(19%)	5.3
Surgeries						
Inpatient Surgeries (Main Campus)	201	214	215	210	3%	200
Outpatient Surgeries (Main Campus)	277	249	273	266	3%	276
Total Surgeries	478	463	488	476	3%	476
Births	220	231	231	262		198
ER Visits						
Admissions	363	390	409	325	26%	394
Treated & Released	3,480	3,574	3,536	2,977	19%	3,103
Total ER Visits	3,843	3,964	3,945	3,302	19%	3,497
Outpatient Clinic Visits						
Total Clinic Visits	10,253	9,056	11,576	8,920	30%	9,725

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PAYOR MIX - Charges						
Commercial FFS	4.9%	3.6%	5.1%	11.0%	(54%)	4.6%
Commercial HMO/PPO	5.4%	6.4%	5.3%	4.1%	29%	6.9%
Medi-Cal	29.7%	24.2%	29.9%	29.0%	3%	30.0%
Medi-Cal HMO - Kern Health Systems	25.2%	27.8%	28.6%	21.1%	36%	21.2%
Medi-Cal HMO - Health Net	11.5%	11.3%	11.6%	5.5%	109%	11.3%
Medi-Cal HMO - Other	0.6%	0.7%	0.7%	13.2%	(95%)	0.7%
Medicare	9.1%	10.9%	5.9%	4.6%	30%	9.8%
Medicare - HMO	2.1%	3.0%	1.3%	0.7%	76%	2.4%
County Programs	3.7%	3.2%	2.4%	0.9%	158%	5.2%
Workers' Compensation	0.6%	0.4%	0.3%	1.3%	(77%)	0.8%
Self Pay	7.3%	8.5%	8.9%	8.5%	5%	7.1%
Total	100.0%	100.0%	100.0%	100.0%	0%	100.0%

KernMedical

3-Month Trend Analysis: Volume and Strategic Indicators

August 31, 2016

	ACTUAL FYTD	BUDGET FYTD	VARIANCE POS (NEG)	PY FYTD	PY VARIANCE POS (NEG)
VOLUME					
Adjusted Admissions (AA)	3,182	2,950	8%	2,969	7%
Adjusted Patient Days	7,734	8,121	(5%)	7,902	(2%)
Admissions	787	784	0%	779	1%
Average Daily Census	129	140	(8%)	135	(5%)
Patient Days	3,987	4,347	(8%)	4,177	(5%)
Available Occupancy %	60.1%	65.5%	(8%)	63.0%	(5%)
Average LOS	5.1	5.5	(9%)	5.4	(6%)
Surgeries					
Inpatient Surgeries (Main Campus)	429	438	(2%)	423	1%
Outpatient Surgeries (Main Campus)	522	531	(2%)	558	(6%)
Total Surgeries	951	969	(2%)	981	
Births	447	538	(17%)	412	8%
ER Visits					
Admissions	1,181	316	274%	376	214%
Treated & Released	10,667	2,900	268%	3,121	242%
Total ER Visits	11,848	3,216	268%	3,497	239%
Outpatient Clinic Visits					
Total Clinic Visits	20,632	18,342	12%	19,895	4%

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PAYOR MIX - Charges					
Commercial FFS	4.2%	8%	(49%)	5.2%	(18%)
Commercial HMO/PPO	6.1%	4.9%	26%	5.3%	16%
Medi-Cal	29.2%	27.9%	5%	32.1%	(9%)
Medi-Cal HMO - Kern Health Systems	28.2%	22.4%	26%	22.8%	24%
Medi-Cal HMO - Health Net	11.5%	7.6%	51%	11.9%	(4%)
Medi-Cal HMO - Other	0.7%	9.6%	(93%)	0.8%	(13%)
Medicare	8.4%	7.0%	20%	8.0%	5%
Medicare - HMO	2.4%	1.6%	52%	1.7%	41%
County Programs	2.4%	1.0%	133%	3.8%	(37%)
Workers' Compensation	0.4%	1.5%	(75%)	0.8%	(55%)
Self Pay	6.6%	8.4%	(22%)	7.7%	(14%)
Total	100.0%	100.0%		100.0%	

KernMedical

3-Month Trend Analysis: Labor and Productivity Metrics

August 31, 2016

	JUNE	JULY	AUGUST	BUDGET AUGUST	VARIANCE POS (NEG)	PY AUGUST
Labor Metrics						
Productive FTEs	1,341.06	1,353.63	1,373.75	1,375.14	(0.1%)	1,320.25
Non-Productive FTEs	232.42	208.13	191.59	182.09	5%	179.65
Contract Labor FTEs	57.47	61.66	64.25	50.66	27%	30.75
Total FTEs	1,573.48	1,561.75	1,565.34	1,557.23	1%	1,499.89
FTE's Per AOB Paid	6.34	6.09	6.47	5.94	9%	6.20
FTE's Per AOB Worked	5.40	5.28	5.68	5.25	8%	5.45
Labor Cost/FTE (Annualized)	85,559.32	134,604.94	129,136.58	134,420.85	(4%)	122,756.52
Benefits Expense as a % of Labor Expense	77%	67%	68%	73%	(6%)	71%
Salaries & Benefits as % of Net Patient Revenue	34%	66%	61%	66%	(7%)	67.7%

KernMedical

3-Month Trend Analysis: Labor and Productivity Metrics

August 31, 2016

	ACTUAL FYTD	BUDGET FYTD	VARIANCE POS (NEG)	PY FYTD	PY VARIANCE POS (NEG)
Labor Metrics					
Productive FTEs	1,351.78	1,404.52	(4%)	1,299.96	4%
Non-Productive FTEs	201.09	185.98	8%	217.55	(8%)
Contract Labor FTEs	56.80	52.08	9%	30.96	83%
Total FTEs	1,553.82	1,590.51	(2%)	1,517.52	2%
FTE's Per AOB Paid	5.09	6.07	(16%)	5.95	(15%)
FTE's Per AOB Worked	4.79	5.36	(11%)	5.10	(6%)
Labor Cost/FTE (Annualized)	116,312.04	133,628.64	(13%)	127,198.45	(9%)
Benefits Expense as a % of Labor Expense	68%	73%	(7%)	71%	(5%)
Salaries & Benefits as % of Net Patient Revenue	45%	65.9%	(169%)	68.0%	(167%)

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Kern County Hospital Authority, Chief Financial Officer Report

Recommended Action: Receive and File.

Summary:

Kern County's Hospital Authority Chief Financial Officer will provide a report.

KernMedical

3-Month Trend Analysis: Revenue & Expense

August 31, 2016

	JUNE	JULY	AUGUST	BUDGET AUGUST	VARIANCE POS (NEG)	PY AUGUST
Gross Patient Revenue	$ 64,305,039	$ 65,986,271	$ 67,350,655	$ 69,382,411	(3%)	$ 59,603,856
Contractual Deductions	(47,093,733)	(48,963,457)	(49,608,498)	(52,941,574)	(6%)	$ (46,532,171)
Net Revenue	17,211,306	17,022,814	17,742,157	16,440,837	8%	13,071,685
Indigent Funding	10,567,115	6,360,863	6,539,937	6,876,298	(5%)	7,560,471
Correctional Medicine	3,515,692	1,942,469	2,085,414	1,942,468	7%	406,155
County Contribution	304,057	297,260	284,101	297,261	(4%)	629,684
Incentive Funding	1,750,000	849,315	849,315	833,333	2%	1,000,000
Net Patient Revenue	33,348,170	26,472,721	27,500,924	26,390,197	4%	22,667,995
Other Operating Revenue	952,827	1,115,814	818,462	1,301,413	(37%)	1,452,696
Other Non-Operating Revenue	691,863	62,803	90,438	22,188	308%	(28,559)
Total Operating Revenue	34,992,860	27,651,338	28,409,824	27,713,798	3%	24,092,132
Expenses						
Salaries	9,770,594	11,687,472	11,050,401	11,203,282	(1%)	10,041,312
Employee Benefits	311,390	5,048,433	4,946,937	5,571,944	(11%)	5,022,247
Contract Labor	1,136,821	782,414	847,847	668,456	27%	279,926
Medical Fees	1,338,792	1,198,506	1,492,090	1,391,775	7%	1,366,058
Other Professional Fees	1,428,564	1,589,837	1,779,175	1,546,280	15%	1,455,598
Supplies	4,836,758	3,448,646	4,477,435	3,815,678	17%	3,022,687
Purchased Services	1,661,121	1,110,954	1,125,044	1,214,738	(7%)	1,082,140
Other Expenses	2,250,148	1,677,645	1,361,033	1,619,052	(16%)	1,138,142
Operating Expenses	22,734,188	26,543,907	27,079,962	27,031,205	0%	23,408,109
Earnings Before Interest, Depreciation, and Amortization (EBIDA)	12,258,672	1,107,432	1,329,862	682,593	95%	684,023
EBIDA Margin	35%	4%	5%	2%	90%	3%
Interest	3,317,333	18,808	19,529	49,972	(61%)	33,716
Depreciation	459,491	450,376	464,060	399,666	16%	387,422
Amortization	68,122	21,125	18,418	49,798	(63%)	48,259
Total Expenses	26,579,134	27,034,216	27,581,969	27,530,641	0%	23,877,506
Operating Gain (Loss)	8,413,726	617,123	827,855	183,157	352%	214,626
Operating Margin	24%	2%	3%	1%	341%	1%

KernMedical

3-Month Trend Analysis: Revenue & Expense

August 31, 2016

	ACTUAL FYTD	BUDGET FYTD	VARIANCE POS (NEG)	PY FYTD	PY VARIANCE POS (NEG)
Gross Patient Revenue	$ 133,336,926	$ 142,669,682	(7%)	$ 116,856,083	14%
Contractual Deductions	(98,571,955)	(108,833,974)	(9%)	$ (89,889,722)	10%
Net Revenue	34,764,971	33,835,708	3%	26,966,361	
Indigent Funding	12,900,800	13,752,595	(6%)	14,723,936	(12%)
Correctional Medicine	4,027,883	3,884,937	4%	2,343,167	72%
County Contribution	581,361	594,521	(2%)	1,262,828	(54%)
Incentive Funding	1,698,630	1,666,667	2%	2,000,000	(15%)
Net Patient Revenue	53,973,645	53,734,428	0%	47,296,292	14%
Other Operating Revenue	1,934,276	2,602,828	(26%)	2,917,157	(34%)
Other Non-Operating Revenue	153,241	44,375	245%	(16,916)	(1,006%)
Total Operating Revenue	56,061,162	56,381,631	(1%)	50,196,533	12%
Expenses					
Salaries	22,737,873	22,716,261	0%	21,192,218	7%
Employee Benefits	9,995,370	11,332,143	(12%)	10,329,727	(3%)
Contract Labor	1,630,261	1,374,432	19%	648,985	151%
Medical Fees	2,690,596	2,783,549	(3%)	2,576,067	4%
Other Professional Fees	3,369,012	3,092,560	9%	3,118,578	8%
Supplies	7,926,080	7,846,144	1%	6,267,651	26%
Purchased Services	2,235,998	2,429,916	(8%)	2,444,268	(9%)
Other Expenses	3,038,679	3,280,412	(7%)	2,331,182	30%
Operating Expenses	53,623,868	54,855,417	(2%)	48,908,675	10%
Earnings Before Interest, Depreciation, and Amortization (EBIDA)	2,437,294	1,526,214	60%	1,287,858	89%
EBIDA Margin	4%	3%	61%	3%	69%
Interest	38,337	99,945	(62%)	56,647	(32%)
Depreciation	914,436	799,334	14%	767,687	19%
Amortization	39,544	99,595	(60%)	96,518	(59%)
Total Expenses	54,616,185	55,854,291	(2%)	49,829,527	10%
Operating Gain (Loss)	1,444,977	527,340	174%	367,006	294%
Operating Margin	3%	1%	176%	1%	253%

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3-Month Trend Analysis: Cash Indicators

August 31, 2016

	JUNE	JULY	AUGUST	BUDGET AUGUST	VARIANCE POS (NEG)	PY AUGUST
CASH						
Total Cash	9,855,835	34,170,088	15,095,805	21,408,654	(29%)	788,479
Days Cash On Hand	13	40	17	25	(30%)	1
Days In A/R - Gross	79.3	87.7	87.7	76.0	15%	79.7
Patient Cash Collections (in 000's)	$ 18,713	$ 15,634	$ 15,456	$ 16,318	(5%)	$ 14,439
Patient Cash Goal	$ 17,211	$ 16,126	$ 16,318	$ 16,318	0%	$ 15,668
Projected Year End Cash Balance	38,451,563	33,108,369	26,830,244	38,451,563	(30%)	N/A

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3-Month Trend Analysis: Cash Indicators

August 31, 2016

	ACTUAL FYTD	BUDGET FYTD	VARIANCE POS (NEG)	PY FYTD	PY VARIANCE POS (NEG)
CASH					
Total Cash	49,265,893	21,408,654	130%	12,980,568	280%
Days Cash On Hand	28	12	135%	8	246%
Days In A/R - Gross	87.7	76.0	15%	79.7	10%
Patient Cash Collections (in 000's)	$ 31,091	$ 17,023	83%	$ 29,387	6%
Patient Cash Goal	$ 32,444	$ 32,444	0%	$ 29,563	10%
Projected Year End Cash Balance	38,451,563	38,451,563	0%	0	0%

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3-Month Trend Analysis: Operating Metrics

August 31, 2016

	JUNE	JULY	AUGUST	BUDGET AUGUST	VARIANCE POS (NEG)	PY AUGUST
Operating Metrics						
Total Expense per Adjusted Admission	18,255	18,020	16,398	18,796	(13%)	16,951
Total Expense per Adjusted Patient Day	3,850	3,403	3,672	3,390	8%	3,182
Supply Exspense per Adjusted Admission	3,322	2,299	2,662	2,605	2%	2,146
Supply Expense per Surgery	1,471	1,518	2,879	1,731	66%	1,384
Supplies as % of Net Patient Revenue	15%	13%	16%	14%	13%	13%
Pharmaceutical Cost per Adjusted Admission	1,912	950	884	1,149	(23%)	848
Net Revenue Per Adjusted Admission	$ 11,821	$ 11,347	$ 10,548	$ 11,225	(6%)	$ 9,280

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3-Month Trend Analysis: Operating Metrics

August 31, 2016

	ACTUAL FYTD	BUDGET FYTD	VARIANCE POS (NEG)	PY FYTD	PY VARIANCE POS (NEG)
Operating Metrics					
Total Expense per Adjusted Admission	17,163	18,936	(9%)	16,785	2%
Total Expense per Adjusted Patient Day	7,062	6,878	3%	6,306	12%
Supply Exspense per Adjusted Admission	2,491	2,660	(6%)	2,111	18%
Supply Expense per Surgery	2,216	1,748	27%	1,381	61%
Supplies as % of Net Patient Revenue	15%	15%	1%	13%	11%
Pharmaceutical Cost per Adjusted Admission	917	1,181	(22%)	861	6%
Net Revenue Per Adjusted Admission	$ 10,925	$ 11,471	(53%)	$ 18,299	(40%)

KernMedical

APPENDIX A

INDIGENT PATIENT CARE FUNDING - MTD & YTD

FOR THE MONTH AUGUST 31, 2016

MTD ACT	MTD BUD	VAR $ FAV/(UNFAV)	VAR %	DESCRIPTION	YTD ACT	YTD BUD	VAR $ FAV/(UNFAV)	VAR %
311,379	345,977	-34,598	-10.0%	**MEDI-CAL HOSPITAL QUALITY ASSURANCE FEE**	622,758	691,954	-69,196	-10.0%
868,070	950,974	-82,904	-8.7%	**MEDI-CAL EXPANSION REVENUE FROM HMO**	1,723,946	1,901,948	-178,002	-9.4%
363,137	196,257	166,880	85.0%	**COUNTY REALIGNMENT FUNDS**	559,394	392,514	166,880	42.5%
1,016,900	960,366	56,534	5.9%	**MEDI-CAL SUPPLEMENTAL FUNDING**	2,033,800	1,920,732	113,068	5.9%
2,181,474	2,423,861	-242,387	-10.0%	**PRIME - NEW WAIVER**	4,362,948	4,847,721	-484,773	-10.0%
1,798,977	1,998,863	-199,886	-10.0%	**GPP - NEW WAIVER**	3,597,954	3,997,726	-399,772	-10.0%
6,539,937	6,876,298	-336,361	-4.9%	**SUB-TOTAL - GOVERNMENTAL REVENUE**	12,900,800	13,752,595	-851,795	-6.2%
2,085,414	1,942,468	142,946	7.4%	**CORRECTIONAL MEDICINE**	4,027,883	3,884,937	142,946	3.7%
284,101	297,261	-13,160	-4.4%	**COUNTY CONTRIBUTION**	581,361	594,521	-13,160	-2.2%
8,909,452	9,116,027	-206,575	-2.3%	**TOTAL INDIGENT CARE & COUNTY FUNDING**	17,510,044	18,232,053	-722,009	-4.0%

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OTHER REVENUE

FOR THE MONTH AUGUST 31, 2016

	MTD ACTUAL	MTD BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
PARKING LOT REVENUE	1,154	509	645	1,654	1,019	635
OTHER COUNTY DEPARTMENT REIMBURSEMENT	19,605	14,235	5,370	38,160	28,469	9,691
EMS REVENUE (SB-612)	0	71,264	(71,264)	87,883	142,528	(54,645)
FEDERAL INMATE REVENUE	(96,261)	54,598	(150,859)	(47,071)	109,196	(156,267)
MEDICAL RECORDS FEES	2,969	1,999	970	5,414	3,998	1,416
MEDICAL SCHOOL STUDENT FEES	333,587	383,615	(50,028)	667,173	767,231	(100,058)
CANCELLED OUTLAWED WARRANTS	30,443	2,754	27,689	26,031	5,508	20,523
PROFESSIONAL FEES	260,864	501,010	(240,146)	706,729	1,002,019	(295,290)
CAFETERIA SALES	77,941	72,822	5,119	144,142	145,646	(1,504)
GRANTS	527	0	527	527	0	527
MENTAL HEALTH MOU	187,606	191,986	(4,380)	303,042	383,971	(80,929)
REBATES & REFUNDS	28	6,621	(6,593)	593	13,243	(12,650)
TOTAL OTHER OPERATING REVENUE	818,462	1,301,413	(482,951)	1,934,276	2,602,828	(668,552)
OTHER NON-OPERATING REVENUE						
INTEREST ON COLLECTIONS	20,274	12,881	7,393	32,337	25,762	6,575
OTHER MISCELLANEOUS REVENUE	66,155	4,154	62,001	111,805	8,307	103,498
INTEREST ON FUND BALANCE	4,008	5,153	(1,145)	9,099	10,306	(1,207)
TOTAL OTHER NON-OPERATING REVENUE	90,438	22,188	68,250	153,241	44,375	108,866

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APPENDIX C

CORRECTIONAL MEDICINE P&L - MTD & YTD

FOR THE MONTH AUGUST 31, 2016

MTD ACT	MTD BUD	VAR $ FAV/(UNFAV)	VAR %	DESCRIPTION	YTD ACT	YTD BUD	VAR $ FAV/(UNFAV)	VAR %
2,085,414	1,942,468	142,946	7.4%	**COUNTY INMATE REVENUE**	4,027,883	3,884,937	142,946	3.7%
(96,261)	54,598	196,257	359.5%	**FEDERAL INMATE REVENUE**	(47,071)	109,196	(156,267)	-143.1%
1,989,153	1,997,066	(7,913)	-0.4%	**TOTAL REVENUE**	3,980,812	3,994,133	(13,321)	-0.3%
				DIRECT INMATE EXPENSES				
1,014,458	1,139,474	(125,016)	-11.0%	**SALARIES & BENEFITS**	2,127,562	2,278,947	(26,702)	-0.4%
261,519	42,152	219,367	520.4%	**SUPPLIES & OTHER EXP**	491,577	84,304	343,281	201.5%
1,275,977	1,181,626	94,351	8.0%	**TOTAL DIRECT INMATE EXPENSES**	2,619,139	2,363,251	255,888	10.8%
				ALLOCATED INMATE EXPENSES				
131,070	166,111	(35,041)	-21.1%	**INPATIENT**	319,078	332,221	(13,143)	-4.0%
310,677	293,773	16,904	5.8%	**OUTPATIENT**	604,111	587,546	16,565	2.8%
441,747	459,884	(18,137)	-3.9%	**TOTAL ALLOCATED INMATE EXPENSES**	923,189	919,767	3,422	0.4%
124,312	134,288	(9,976)	-7.4%	**AMBULANCE/OTHER HC PROVIDER EXPENSES**	221,759	269,313	(47,553)	-17.7%
1,842,036	1,775,798	66,238	3.7%	**TOTAL EXPENSES**	3,764,087	3,552,331	211,756	6.0%
147,117	221,268	(74,151)	-33.5%	**NET INCOME**	216,725	441,802	(225,077)	-50.9%

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING

October 19, 2016

Subject: Proposed corrections to minutes for Kern County Hospital Authority Board of Governors regular meetings

Recommended Action: Approve

Summary:

Revised minutes for the following meetings - to include Agreement numbers.

March 30, 2016
April 20, 2016
May 4, 2016
May 18, 2016
June 22, 2016
July 20, 2016
August 17, 2016
September 21, 2016

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, March 30, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, Bynum, McGauley, McLaughlin, Nilon, Sistrunk

Directors absent: None

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

CHAIRMAN BIGLER RECOGNIZED DIRECTOR SISTRUNK AND WELCOMED HER TO THE BOARD OF DIRECTORS

CHAIRMAN BIGLER ANNOUNCED HE WILL BE ABSENT FROM THE REGULAR MEETING ON APRIL 20, 2016

3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on March 16, 2016 –
APPROVED WITH THE FOLLOWING CORRECTIONS: ITEM 7 CONCERNING THE RESOLUTION ESTABLISHING THE REGULAR MEETING DATES OF THE KERN COUNTY HOSPITAL AUTHORITY BOARD OF GOVERNORS FOR CALENDAR YEAR 2016, THE RESOLUTION WILL BE NUMBERED 2016-001; ITEM 10 CONCERNING THE RESOLUTION RECOGNIZING EMPLOYEE ORGANIZATIONS, THE RESOLUTION WILL BE NUMBERED 2016-002
Nilon-McGauley: All Ayes

4) Proposed Resolution for inclusion of the Kern County Hospital Authority in the Kern County Employees' Retirement Association (KCERA) and approval of Employer Participation Agreement with KCERA –
APPROVED; ADOPTED RESOLUTION 2016-003; AUTHORIZEED CHAIRMAN TO SIGN SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
Nilon-McLaughlin: All Ayes

5) Proposed Resolution delegating authority to the Chief Executive Officer of the Kern County Hospital Authority to enter into contracts and to secure and pay for certain professional and special services –
CONTINUED; REFERRED TO COUNSEL FOR A LEGAL OPINION ON AUTHORITY OF THE BOARD TO ACT ON THE REQUEST
Nilon-McLaughlin: All Ayes

6) Proposed administrative policy on the development of policies and procedures –
APPROVED POLICY
Nilon-McGauley: All Ayes

7) Proposed Memorandum of Understanding (MOU) with CSAC Excess Insurance Authority for participation in the CSAC excess workers' compensation program –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-004***
McLaughlin-Sistrunk: All Ayes

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

8) Proposed presentation on Kern Medical Center Foundation –
HEARD PRESENTATION; RECEIVED AND FILED
Nilon-McGauley: All Ayes

9) Miscellaneous Documents –
RECEIVED AND FILED
McGauley-Sistrunk: All Ayes

A) Letter to Kern County Board of Supervisors requesting approval of initial appointment of Russell V. Judd as Chief Executive Officer of Kern County Hospital Authority

ADJOURNED TO WEDNESDAY, APRIL 20, 2016 AT 11:30 A.M.
Bynum

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell E. Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, April 20, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, McGauley, McLaughlin, Nilon

Directors absent: Bigler, Sistrunk

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

DIRECTOR MCGAULEY ANNOUNCED SHE ATTENDED A KERN MEDICAL EMPLOYEE FORUM AND PRAISED MR. JUDD FOR HIS COMMUNICATION STYLE

DIRECTOR MCGAULEY MADE A REFERRAL TO STAFF TO REPORT ON KEY FACTORS THAT CAUSED THE KERN MEDICAL FINANCIAL CRISES OVER THE PAST FEW YEARS AND FUTURE MAJOR RISK AREAS
McGauley-Nilon: 4 Ayes; 2 Absent - Bigler, Sistrunk

VICE CHAIR MCLAUGHLIN ANNOUNCED THE RESIGNATION OF DIRECTOR BYNUM, EFFECTIVE APRIL 13, 2016, AND HIS REQUEST TO BE CONSIDERED AS A DIRECTOR ON THE BOARD OF THE KERN MEDICAL CENTER FOUNDATION; STAFF DIRECTED TO FORWARD THE RESIGNATION LETTER TO THE CLERK OF THE BOARD OF SUPERVISORS FOR VACANCY POSTING

DIRECTOR NILON MADE A REFERRAL TO STAFF TO PLACE AN ITEM ON THE NEXT BOARD AGENDA TO APPOINT A NOMINATING COMMITTEE TO NOMINATE A REPLACEMENT FOR MR. BYNUM
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

ITEMS FOR CONSIDERATION

CA
3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on March 30, 2016 –
APPROVED
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CA
4) Proposed Resolution appointing Russell V. Judd, Andrew J. Cantu, Alton Scott Thygerson, Jared W. Leavitt, Glenn E. Goldis, M.D., and Antoinette C. Smith, RN, MSN, to serve as initial officers of the Kern County Hospital Authority –
APPROVED; ADOPTED RESOLUTION 2016-004
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

5) Proposed Agreement with the County of Kern for employee benefit services –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-006***
McGauley-Berjis: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

6) Proposed presentation by the Kern Medical Chief Medical Officer regarding overview of the Medical Staff and related departments –
HEARD PRESENTATION; RECEIVED AND FILED
Berjis-Nilon: 4 Ayes; 2 Absent - Bigler, Sistrunk

7) Proposed approval of Medical Staff and related department policies –
APPROVED POLICIES
Berjis-Nilon: 4 Ayes; 2 Absent - Bigler, Sistrunk

8) Introduction of elected officers of the Medical Staff of Kern Medical Center –
INTRODUCED ELECTED OFFICERS; RECEIVED AND FILED
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

9) Proposed approval of transitional credentialing process of members of the Medical Staff of Kern Medical Center who are in good standing –
APPROVED; ADOPTED RESOLUTION 2016-005
Berjis-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

10) Proposed approval of the Bylaws of the Medical Staff of Kern Medical Center –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-007***
Nilon-Berjis: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
11) Proposed Resolution creating a separate Allied Health Professional (AHP) status for practitioners who are not eligible for Medical Staff membership and recognizing five categories of AHP –
APPROVED; ADOPTED RESOLUTION 2016-006
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CA
12) Proposed Agreement with the County of Kern for sharing of practitioner information to facilitate the credentialing of current Medical Staff members (Fiscal Impact: None) –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-2008***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

13) Request to establish an interest-bearing fund and budget unit in the County of Kern financial management system for the Kern County Hospital Authority –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN CORRESPONDENCE REQUESTING ESTABLISHMENT OF FUND
McGauley-Nilon: 4 Ayes; 2 Absent - Bigler, Sistrunk

14) Proposed administrative policy on purchasing and budgetary controls –
WITHDRAWN

15) Proposed approval of Office of Pharmacy Affairs Hospital Certification of Ownership/ Operation by a Local Unit of Government to meet eligibility requirements –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN
McGauley-Berjis: 4 Ayes; 2 Absent - Bigler, Sistrunk

CA
16) Proposed Agreement with the County of Kern for joint use of the common area at the Mount Vernon medical complex which includes Kern Medical, parking lots, parking lot lights, signage, landscaping, and utilities –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-011***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
17) Proposed Agreement with the County of Kern for lease of a portion of the Kern Medical Campus Pharmacy within the Coroner's building, for outpatient pharmacy –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-012***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
18) Proposed Agreement with the County of Kern for lease of office trailers, for use by the Kern Medical Human Resources Department –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-013***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
19) Proposed Agreement with the County of Kern for lease of a portion of the multi-purpose warehouse, for materials management storage space –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-014***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
20) Proposed Agreement with the County of Kern for lease of a portion of the office space at 2700 "M" Street, for use by the Kern Medical Finance Department –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-015***
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
21) Proposed correspondence in support of SB 815 and AB 1568 regarding California's 1115 Medicaid waiver, titled Medi-Cal 2020 –
APPROVED; AUTHORIZED VICE CHAIRMAN TO SIGN CORRESPONDENCE IN SUPPORT
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

CA
22) Miscellaneous Documents –
RECEIVED AND FILED
Nilon-McGauley: 4 Ayes; 2 Absent - Bigler, Sistrunk

A) Tracking Page of letter sent from Russell E. Bigler, Chairman, Kern County Hospital Authority Board of Governors, to Kern County Board of Supervisors approving the initial appointment of Russell V. Judd as Chief Executive Officer of Kern County Hospital Authority on April 5, 2016 –

ADJOURNED TO CLOSED SESSION
McGauley-Nilon

CLOSED SESSION

23) Request for Closed Session for the purpose of discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Nilon-Berjis

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item 23 concerning Request for Closed Session for the purpose of discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, MAY 4, 2016 AT 11:30 A.M.
Nilon

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, May 4, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McGauley, McLaughlin, Nilon

Directors absent: Sistrunk

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

DIRECTOR BERJIS EXTENDED AN INVITATION TO THE BOARD MEMBERS AND PUBLIC TO ATTEND THE KERN MEDICAL RESIDENT RESEARCH FORUM ON THURSDAY, MAY 5, 2016

ITEMS FOR CONSIDERATION

CA
3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on March 30, 2016 –
APPROVED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
4) Proposed Resolution for continued participation of eligible employees in the California State Disability Insurance program –
APPROVED; ADOPTED RESOLUTION 2016-007
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

5) Proposed Master Contract for the Transfer of Health Facilities with County of Kern for the transfer of ownership of Kern Medical Center to Kern County Hospital Authority, effective July 1, 2016, and Resolution providing for the approval of the Master Contract (Fiscal Impact: None) –
MADE FINDING PROJECT IS EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15320 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVED; ADOPTED RESOLUTION 2016-008; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-017 SUBJECT*** TO APPROVAL ***AS TO FORM*** BY COUNSEL
Berjis-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

6) Proposed presentation by the Kern Medical Chief Nursing Officer regarding overview of the Nursing and related departments –
HEARD PRESENTATION; RECEIVED AND FILED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

7) Proposed approval of Nursing and related department policies –
APPROVED POLICIES
McGauley-Nilon: 5 Ayes; 1 Absent - Sistrunk

8) Proposed presentation by the Kern Medical Vice President of Ambulatory Services regarding overview of the clinics and other outpatient services –
HEARD PRESENTATION; RECEIVED AND FILED
McGauley-Nilon: 5 Ayes; 1 Absent - Sistrunk

9) Proposed approval of ambulatory care service policies –
APPROVED POLICIES
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
10) Proposed approval of Kern County Hospital Authority Conflict of Interest policy –
APPROVED POLICY
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
11) Proposed approval of Kern County Hospital Authority Conflict of Interest Code –
APPROVED; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
12) Proposed Agreement with County of Kern for workers' compensation claims administration services –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-018***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
13) Proposed retroactive Business Associate Agreement with County of Kern for Medical Staff data sharing including protected health information, effective May 3, 2016 (Fiscal Impact: None) –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-019***
Nilon-McGauley: 5 **Ayes;** 1 **Absent - Sistrunk**

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

14) Appoint a nominating committee to recommend nominees to fill one open Director position –
APPOINTED DIRECTORS McGAULEY, McLAUGHLIN AND NILON
Berjis-Nilon: 5 Ayes; 1 Absent - Sistrunk

CA

15) Request to establish a budget unit in the County of Kern financial management system for capital projects –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN CORRESPONDENCE REQUESTING ESTABLISHMENT OF BUDGET UNIT
Nilon-McGauley: 5 Ayes; 1 Absent – Sistrunk

16) Response to referral to report on key factors that caused the Kern Medical Financial crisis over the past few years and future major risk areas (from April 20, 2016) –
RECEIVED AND FILED
McLaughlin-McGauley: 5 Ayes; 1 Absent - Sistrunk

17) Kern County Hospital Authority Chief Executive Officer report –
RECEIVED AND FILED
McLaughlin-Berjis: 5 Ayes; 1 Absent - Sistrunk

ADJOURNED TO CLOSED SESSION
Nilon-McGauley

CLOSED SESSION

18) CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff - Employee organization: SEIU Local 521 (Government Code Section 54957.6) –
SEE RESULTS BELOW

19) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
(Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1)
Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection-
SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
McGauley-Berjis

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 18 concerning CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff - Employee organization: SEIU Local 521 (Government Code Section 54957.6) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 19 concerning CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, MAY 18, 2016 AT 11:30 A.M.
Berjis

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, May 18, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McGauley, McLaughlin, Nilon

Directors absent: Sistrunk

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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EAST BAKERSFIELD HIGH SCHOOL PRESENTED KERN MEDICAL WITH A PLAQUE AS A SHOW OF APPRECIATION FOR YEARS OF SERVICE TO STUDENT ATHLETES

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))
NO ONE HEARD

ITEMS FOR CONSIDERATION

CA
3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on May 04, 2016 –
APPROVED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

4) Proposed presentation by the Kern Medical Chief Financial Officer regarding areas of responsibility -
HEARD PRESENTATION; RECEIVED AND FILED
Berjis-McGauley: 5 Ayes; 1 Absent - Sistrunk

5) Proposed approval of finance, patient financial services, medical records, patient registration and purchasing policies –
APPROVED POLICIES
McLaughlin-McGauley: 5 Ayes; 1 Absent - Sistrunk

6) Proposed Kern County Hospital Authority operating and capital budget for Fiscal Year 2016-2017 –
APPROVED; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL
Nilon-Berjis: 5 Ayes; 1 Absent - Sistrunk

CA
7) Response to referral for opinion on the proposed delegation of authority to the Chief Executive Officer to enter into contracts and to secure and pay for certain professional and special services (from March 30, 2016) –
RECEIVED AND FILED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
8) Proposed Resolution delegating authority to the Chief Executive Officer to enter into contracts and to secure and pay for certain professional and special services and proposed appointment of Chief Executive Officer as Purchasing Agent and Agency Designated Representative for labor negotiations –
APPROVED; APPOINTED CHIEF EXECUTIVE OFFICER AS PURCHASING AGENT OF KERN COUNTY HOSPITAL AUTHORITY; APPOINTED CHIEF EXECUTIVE OFFICER AS AGENCY DESIGNATED REPRESENTATIVE FOR LABOR NEGOTIATIONS WITH EMPLOYE ORGANIZATIONS SUBJECT TO DIRECTION FROM THE BOARD OF GOVERNORS; ADOPTED RESOLUTION 2016-009
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

9) Proposed presentation by the Kern Medical Chief Operating Officer regarding areas of responsibility –
HEARD PRESENTATION; RECEIVED AND FILED
Berjis-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

10) Proposed approval of ancillary and support services policies –
APPROVED POLICIES
McLaughlin-Nilon: 5 Ayes; 1 Absent - Sistrunk

11) Proposed presentation by the Kern Medical Vice President of Administrative Services regarding areas of responsibility –
HEARD PRESENTATION; RECEIVED AND FILED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
12) Proposed Agreement with County of Kern, as represented by the Kern County Sheriff's Office-Coroner Section, for storage and transportation services from July 1, 2016 through June 30, 2018–
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-020***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
13) Proposed Transition Services Agreement with the County of Kern for purchase of certain specified transition administrative services from July 1, 2016 through June 30, 2017, and proposed designation of Chief Executive Officer or designee as Authority Contracting Officer –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-021***; DESIGNATED CHIEF EXECUTIVE OFFICER OR DESIGNEE AS AUTHORITY CONTRACTING OFFICER
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
14) Proposed Agreement with the County of Kern and Kern County Treasurer-Tax Collector for adoption of the County of Kern Deferred Compensation Plan (Plan 1) and the County of Kern Deferred Compensation Plan – Part-time, Seasonal, Temporary Employees (Plan 2), effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-022***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
15) Proposed Agreement with the County of Kern, as represented by the Department of Child Support Services, for paternity-related services from July 1, 2016 through June 30, 2021 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-023***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
16) Proposed Agreement with the County of Kern, as represented by the Department of Human Services, for professional medical services for children at A. Mariam Jamison Children Center from July 1, 2016 through June 30, 2018 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-024***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
17) Proposed Agreement with the County of Kern, as represented by the Kern County Public Health Services Department-Emergency Medical Services Division, for EMS Base Hospital services from July 1, 2016 through June 30, 2019 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-025***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
18) Proposed Agreement with the County of Kern, as represented by the Kern County Public Health Services Department and Kern County Sheriff's Department-Probation, for public health and related services from July 1, 2016 through June 30, 2019 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-026***
Nilon-McGauley: 5 Ayes; 1 Absent – Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
19) Proposed Interfacility Transfer Agreement with the County of Kern, as represented by the Kern County Public Health Services Department, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-027***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
20) Proposed Agreement with the County of Kern and Civil Service Commission, County of Kern regarding the resolution of appeals pending before the Civil Service Commission, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-028***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

21) Proposed recommendation of nominees to fill one open Director position –
MADE RECOMMENDATION; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS FOR APPOINTMENT
Berjis-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

22) Kern County Hospital Authority Chief Executive Officer report –
RECEIVED AND FILED
Berjis-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

ADJOURNED TO CLOSED SESSION
Nilon-McGauley

CLOSED SESSION

23) Request for Closed Session for the purpose of discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) –
SEE RESULTS BELOW

24) PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957) –
SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Nilon-McGauley

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 23 concerning a Request for Closed Session for the purpose of discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 24 concerning PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957) – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, JUNE 22, 2016 AT 11:30 A.M.
Berjis

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, June 22, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McGauley, McLaughlin, Nilon

Directors absent: Sistrunk

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

BERNICE BONIAS, CALIFORNIA ALLIANCE FOR RETIRED AMERICANS, HEARD IN SUPPORT OF A STABLE WORKFORCE; BRIAN HOLT, INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, AND JIM ELROD, HEARD IN SUPPORT OF SEIU FOR AN EXPERIENCED WORKFORCE; DELIA SERRANO, SEIU, COMMENDED KERN MEDICAL STAFF FOR IMPROVEMENTS TO THE HOSPITAL

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

DIRECTOR NILON THANKED MEMBERS OF THE PUBLIC FOR TAKING TIME TO ADDRESS THE BOARD OF GOVERNORS

DIRECTOR McGAULEY RECOGNIZED CHIEF EXECUTIVE OFFICER RUSSELL V. JUDD AND STAFF FOR THEIR EFFORTS TO IMPROVE THE FINANCIAL CONDITION OF KERN MEDICAL AND REDUCE DEBT

ITEMS FOR CONSIDERATION

CA
3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on May 18, 2016 –
APPROVED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
4) Proposed approval of Administrative policies for correctional medicine, tumor registry, and information technology services –
APPROVED POLICIES
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

5) Proposed presentation by the Kern Medical Chief Strategy Officer regarding areas of responsibility –
HEARD PRESENTATION; RECEIVED AND FILED
McGauley-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

6) Proposed approval of media relations and marketing policies –
APPROVED POLICIES
Berjis-Nilon: 5 Ayes; 1 Absent - Sistrunk

7) Proposed Agreement with Hammel, Green and Abrahamson, Inc., an independent contractor, for the development of a master facility plan from July 1, 2016 through June 30, 2017, in an amount not to exceed $504,120 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-029***
McLaughlin-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
8) Proposed Agreement with Valley Neurosurgery and Neurorestoration Center, a Medical Corporation, an independent contractor, for professional medical services in the Department of Surgery from July 1, 2016 through June 30, 2021, in an annual amount not to exceed $1,824,085 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-030***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
9) Proposed Agreement with S. Sara Yegiyants, M.D., a contract employee, for professional medical services in the Department of Surgery from July 1, 2016 through June 30, 2019, in an annual amount not to exceed $538,012, plus applicable benefits–
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-031***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
10) Proposed Agreement with Andrew P. Cassidenti, M.D., a contract employee, for professional medical services in the Department of Obstetrics and Gynecology from September 1, 2016 through August 31, 2021, in an annual amount not to exceed $500,000, plus applicable benefits policy –
APPROVED; AUTHOIRIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-032***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
11) Proposed Agreement with CSS Staffing, LLC dba CSS Consulting Group, an independent contractor, for healthcare supply chain consulting services from July 1, 2016 through June 30, 2017, in an amount not to exceed $534,320 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-033***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
12) Request to establish an interest-bearing fund and budget unit in the County of Kern financial management system for the Kern County Hospital Authority specific to the Kern Health Systems Excess Reserves/Capital –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN CORRESPONDENCE REQUESTING ESTABLISHMENT OF FUND
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
13) Proposed Agreement with the County of Kern for the provision of healthcare services, finance and support, effective July 1, 2016, in the amount of $22,950,493 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-035***
Nilon-McGauley: 5 **Ayes;** 1 **Absent – Sistrunk**

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

14) Proposed Agreement Cerner Corporation, an independent contractor, for purchase of the PeopleSoft core financial system from July 1, 2016 through June 30, 2023, in an amount not to exceed $3,400,000 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-036***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

15) Proposed presentation by the Kern Medical Vice President of Human Resources regarding areas of responsibility –
HEARD PRESENTATION; RECEIVED AND FILED
Berjis-Nilon: 5 Ayes; 1 Absent - Sistrunk

16) Proposed approval of Human Resources policies –
APPROVED POLICIES
Berjis-McLaughlin: 5 Ayes; 1 Absent - Sistrunk

CA
17) Proposed acceptance of assigned contracts from the County of Kern –
ACCEPTED ASSIGNMENT
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
18) Proposed Agreement with the County of Kern, as represented by the Administrative Office, Human Resources Division, for the provision of health benefits to Kern County Hospital Authority employees and retirees, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-037***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
19) Proposed application with state of California, Department of Industrial Relations and certification of consent to self-insure for workers' compensation liabilities –
APPROVED; ADOPTED RESOLUTION 2016-010
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
20) Proposed Resolution providing for authorized volunteers to be employees of Kern County Hospital Authority for purposes of workers' compensation coverage –
APPROVED; ADOPTED RESOLUTION 2016-011
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
21) Proposed Agreement with the County of Kern, as represented by the Department of Human Services, for the provision of Medi-Cal eligibility services from July 1, 2016 through October 31, 2018 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-039***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
22) Proposed Agreement with County of Kern, as represented by the Administrative Office, Kern County Sheriff's Office, and Department of Human Services for the provision of forensic pediatric services from July 1, 2016 through June 30, 2017, in an amount not to exceed $165,000 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-040***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
23) Proposed Agreement with the County of Kern, as represented by the Administrative Office, Kern County Sheriff's Office, and Kern County Probation Department for the provision of correctional medicine services to in-custody inmates and juvenile wards from July 1, 2016 through June 30, 2018, in the amount of $23,112,537 for Fiscal year 2016-2017 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN **AGREEMENT 2016-041** SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
24) Proposed Agreement with Trans-West Security Services, Inc., an independent contractor, for the provision of security services from July 1, 2016 through June 30, 2018, in an amount not to exceed $2,412,834 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-042***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
25) Proposed Agreement with the County of Kern for the provision of a mutual, nonexclusive easement in support of the access, ingress and egress rights granted under the Joint Use Agreement, effective July 1, 2016 –
MADE FINDING PROJECT IS EXEMPT FROM FURTHER CEQA REVIEW PER SECTION 15301 OF STATE CEQA GUIDELINES; APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-043*** SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
26) Proposed renewal and binding of insurance coverages for hospital professional liability, general liability and umbrella/excess liability, workers' compensation and employers liability, automobile liability, helipad liability, directors and officers liability, employment practices liability, crime, cyber liability, premises pollution liability, underground storage tank liability, and property from July 1, 2016 through June 30, 2017, in an amount not to exceed $2,364,822 –
APPROVED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
27) Proposed Resolution providing for the extension of excess medical professional liability coverage for Kern Medical employed and independent contractor physicians, effective July 1, 2016 –
APPROVED; ADOPTED RESOLUTION 2016-012
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
28) Proposed Resolution providing for the assumption and adoption of the Kern County Pension Plan for Physician Employees –
APPROVED; ADOPTED RESOLUTION 2016-013
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CA
29) Proposed rescission of Agreement ***2016-018*** with the County of Kern, as represented by the Office of County Counsel, Risk Management Division, for workers' compensation claims administration services (from May 4, 2016) –
APPROVED
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
30) Proposed Agreement with Tristar Risk Management, an independent contractor, for the provision of claims administration under the Kern County Hospital Authority self-insured retention program, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-044*** SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
31) Proposed Agreement with Script Care, Ltd., an independent contractor, for the provision of third party administrative services related to the 340B drug pricing program from July 1, 2016 through June 30, 2019, with an annual user fee of $11,000 and projected annual net revenue of $901,000 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-045***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
32) Proposed Agreement with the County of Kern, as represented by Kern County Mental Health, for involuntary care under section 5150 of the Welfare and Institutions Code, inpatient psychiatric services, and reimbursement for Chair of Psychiatry and resident physicians from July 1, 2016 through June 30, 2021, in the amount of $4,350,000 for Fiscal Year 2016-2017 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-046***
Nilon-McGauley: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
33) Proposed Agreement with the County of Kern, as represented by the Office of County Counsel for the provision of legal services to the Kern County Hospital Authority, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-047***
Nilon-McGauley: 5 Ayes; 1 Absent – Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

34) Proposed Amendment No. 8 to Agreement (Kern County Agt. #185-2011) with Weatherby Locums, Inc., for temporary physician staffing services, increasing the maximum payable by $750,000, from $2,950,000 to $3,700,000, to cover the term – APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-048*** SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
McGauley-Berjis: 5 Ayes; 1 Absent - Sistrunk

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

35) Kern County Hospital Authority Chief Executive Officer report – RECEIVED AND FILED
McLaughlin-Berjis: 5 Ayes; 1 Absent - Sistrunk

ADJOURNED TO CLOSED SESSION
McGauley-Berjis

CLOSED SESSION

36) PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957) – SEE RESULTS BELOW

37) Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

38) CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff - Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – SEE RESULTS BELOW

39) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Service Employees International Union, Local 521 v. Kern County Hospital Authority, et al., PERB Case No. LA-CE-1084-M – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Nilon-McGauley

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 36 concerning PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 37 concerning a Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – HEARD; ALL PRACTITIONERS RECOMMENDED FOR INITIAL CREDENTIALING ON THE MEDICAL STAFF OF KERN MEDICAL CENTER AS OWNED AND OPERATED BY THE KERN COUNTY HOSPITAL AUTHORITY WERE APPROVED BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK); DIRECTOR BERJIS ABSTAINED FROM VOTING ON BERJIS

Item No. 38 concerning CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff - Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 39 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Service Employees International Union, Local 521 v. Kern County Hospital Authority, et al., PERB Case No. LA-CE-1084-M – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, JULY 20, 2016 AT 11:30 A.M.
McLaughlin

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, July 20, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McGauley, McLaughlin, Sistrunk

Directors absent: Nilon, Pelz

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

NO ONE HEARD

ITEMS FOR CONSIDERATION

3) Certificates of Recognition honoring George Bratton, RN, Valorie Farquharson, RN, Jesika Henry, RN, and Lucinda Sager, RN, for their volunteer efforts to evacuate and transport patients during the Erskine fire –
MADE PRESENTATION

CA
4) Minutes for Kern County Hospital Authority Board of Governors regular meeting on June 22, 2016 –
APPROVED
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CA
5) Proposed Amendment No. 5 to Agreement 194-2012 with Ravi Patel, M.D., doing business as Comprehensive Blood and Cancer Center, an independent contractor, for medical practice management services at Kern Medical-leased clinics, extending the term for one year from August 1, 2016 through July 31, 2017, and increasing the maximum payable by $573,000, from $1,573,000 to $2,146,000, to cover the extended term –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-049***
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
6) Proposed Agreement with Oracle America, Inc., an independent contractor, for purchase of a perpetual software license in conjunction with the PeopleSoft core financial system (Fiscal Impact: None) –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-050***
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
7) Proposed Resolution authorizing Counsel for the Kern County Hospital Authority to settle claims pursuant to Government Code Section 935.4 –
APPROVED; ADOPTED RESOLUTION 2016-014
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CA
8) Proposed Agreement with Mission Linen Supply, an independent contractor, for linen supply items from August 1, 2016 through July 31, 2018, in an amount not to exceed $1,880,000 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-051***
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
9) Proposed retroactive Agreement with Best Electric, an independent contractor, for C wing emergency power distribution upgrade, in an amount not to exceed $669,800, effective July 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-052***
McGauley-Berjis: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

10) Kern County Hospital Authority Chief Executive Officer report -
RECEIVED AND FILED
McLaughlin-Sistrunk: 5 Ayes; 2 Absent - Nilon, Pelz

11) Kern County Hospital Authority Chief Financial Officer report -
RECEIVED AND FILED
McGauley-McLaughlin: 5 Ayes; 2 Absent - Nilon, Pelz

12) Proposed retroactive Agreement with Kapsis Investments, Inc., doing business as Kapsis Technical Services, an independent contractor, for temporary staffing of information technology personnel from July 1, 2016 through June 30, 2017, in an amount not to exceed $1,650,000 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT ***2016-053***; AUTHORIZED CHIEF FINANCIAL OFFICER TO SIGN STATEMENTS OF WORK
Berjis-McGauley: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

13) Proposed Premium Finance Agreement with IPFS Corporation of California, doing business as IPFS Corporation, an independent contractor, for financing of insurance premiums, effective August 1, 2016, in an amount not to exceed $778,268 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN ***AGREEMENT 2016-054***
Berjis-McLaughlin: 5 Ayes; 2 Absent - Nilon, Pelz

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

ADJOURNED TO CLOSED SESSION
Sistrunk-McGauley

CLOSED SESSION

14) Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

15) Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

16) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 – SEE RESULTS BELOW

17) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Winston v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280158 LHB – SEE RESULTS BELOW

18) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Jackson v. County of Kern, Kern County Superior Court Case No. BCV-15-101497 SPC – SEE RESULTS BELOW

19) Request for Closed Session for the purpose of discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) – SEE RESULTS BELOW

20) PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Financial Officer (Government Code Section 54957) – SEE RESULTS BELOW

21) CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd and designated staff - Unrepresented Employee: Kern County Hospital Authority Chief Financial Officer (Government Code Section 54957.6) – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Berjis-McLaughlin

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 14 concerning a Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (2 ABSENT - NILON, PELZ), THE BOARD APPROVED ALL PRACTITIONERS RECOMMENDED FOR INITIAL APPOINTMENT, REAPPOINTMENT, RELEASE FROM PROCTORING, AND TERMINATION OF PRIVILEGES (AUTOMATIC AND VOLUNTARY); THERE WERE NO ABSTENTIONS

Item No. 15 concerning a Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 16 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 17 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Winston v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280158 LHB – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 18 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Jackson v. County of Kern, et al., Kern County Superior Court Case No. BCV-15-101497 SPC – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 19 concerning a Request for Closed Session regarding discussion or taking action on authority trade secrets (Health and Safety Code Section 101855(e)(1)) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 20 concerning PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 21 concerning CONFERENCE WITH LABOR NEGOTIATORS – Agency designated representatives: Chief Executive Officer Russell V. Judd and designated staff – Unrepresented Employee: Kern County Hospital Authority Chief Financial Officer (Government Code Section 54957.6) – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, AUGUST 17, 2016 AT 11:30 A.M.
Berjis

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, August 17, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McGauley, Nilon, Pelz, Sistrunk

Directors absent: McLaughlin

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

NON-AGENDA ITEM

MOTION TO CONSIDER NON-AGENDA ITEM NO. 21: MADE FINDING THAT THE NEED TO TAKE ACTION ON NON-AGENDA MATTER OCCURRED AFTER THE AGENDA WAS POSTED ON AUGUST 12, 2016. ON AUGUST 17, 2016, THE AUTHORITY RECEIVED A DEMAND TO CEASE AND DESIST FROM AWARDING THE ANESTHESIA CONTRACT TO REGIONAL ANESTHESIA ASSOCIATES, INC. (ITEM NO. 13) WITH THE THREAT OF LITIGATION. DUE TO THE IMPACT ON OPERATIONAL ISSUES AND THE ECONOMIC CONSEQUENCES OF NOT APPROVING THE AGREEMENT ON AUGUST 17, 2016, IT WAS NECESSARY FOR THE AUTHORITY TO CONFERENCE WITH LEGAL COUNSEL IN CLOSED SESSION REGARDING THE THREAT OF LITIGATION.
Nilon-McGauley: 6 Ayes; 1 Absent - McLaughlin

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

Director Berjis recognized the passing of Dr. David Lujan this past week. Dr. Lujan was a mentor, a role model, and a driving force for resident physician and medical student education at Kern Medical. His presence will be missed by all who knew him.

ITEMS FOR CONSIDERATION

3) Recognition honoring Elsa Martinez, Chief Deputy County Administrative Officer, for her expertise and direction in forming Kern County Hospital Authority –
MADE PRESENTATION

CA
4) Minutes for Kern County Hospital Authority Board of Governors regular meeting on July 20, 2016 with a revision to reconvene from Closed session motion made by Berjis-McLaughlin –
APPROVED
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CA
5) Proposed retroactive Amendment No. 7 to Agreement 042-2015 with Cantu Management Group, Inc., for Chief Financial Officer and healthcare financial management services, modifying certain terms to clarify the non-solicitation, immediate termination, renewal and termination provisions, and incorporating performance measures for FY 2016-2017, effective July 1, 2016; and adding four positions, deleting one position, increasing the monthly management fee by $51,189, from $267,478 to $318,666, and increasing the maximum payable by $1,586,843, from $11,057,071 to $12,643,914, effective August 1, 2016 –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-~~005~~***055***
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

CA
6) Proposed Agreement with Tom Chao, M.D., a contract employee, for professional medical services in the Department of Surgery, Division of Orthopedic Surgery from September 3, 2016 through September 2, 2019, in an amount not to exceed $2,762,500, plus applicable benefits –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-056
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CA
7) Proposed letter from Moss-Adams, LLP, an independent contractor, regarding the audit of Kern Medical financial statements –
RECEIVED AND FILED
Berjis-Pelz: 6 Ayes; 1 Absent – McLaughlin

CA
8) Proposed Amendment No. 2 with Armanino LLP doing business as AMF Media Group, an independent contractor, for communications consulting services, extending the term through August 17, 2017, amending the description of services, and increasing the maximum payable by $1,461,000, from $1,560,000 to $3,021,000, to cover the extended term –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-058
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CA
9) Proposed Amendment No. 6 to Agreement 1324502 with Vantage Technology Consulting Group, an independent contractor, for construction management services related to completion of the 2 Center Nurse Call project, increasing the maximum payable by $40,810, from $295,426.19 to $336,236.19, to cover the additional services –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-059
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CA

10) Proposed Agreement with IBM Credit LLC, an independent contractor, for financing of PeopleSoft core financial system, effective August 17, 2016, in an amount not to exceed $1,449,237 –
APPROVED; APOPTED RESOLUTION 2016-015; AUTHORIZED CHAIRMAN TO SIGN AGREEMENTS 2016-060, 2016-061, 2016-062, AND 2016-063; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

CA

11) Proposed Amendment No. 4 to Agreement 679***-2012*** with Ishaan S. Kalha, M.D., a contract employee, for professional medical services in the Department of Medicine, extending the term from September 15, 2016 through December 9, 2016, and increasing the maximum payable by $135,000, from $2,150,000 to $2,285,000, to cover the extended term –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-064
Berjis-Pelz: 6 Ayes; 1 Absent – McLaughlin

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

12) Proposed Operating Agreement of Kern Medical Surgery Center, LLC, by Kern County Hospital Authority, in its capacity as the sole member, with an initial cash capital contribution of $1,500,000 –
MADE FINDING THAT THE AGREEMENT COMPLIES WITH INTERNAL REVENUE SERVICE PLR-138562-15, DATED MAY 25, 2016, AND CHAPTER 2.170 OF THE KERN COUNTY ORDINANCE CODE; APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-065 SUBJECT TO APPROVAL AS TO FORM BY COUNSEL
Berjis-Sistrunk: 5 Ayes; 1 No - McGauley; 1 Absent - McLaughlin

13) Proposed Agreement with Regional Anesthesia Associates, Inc., an independent contractor, for professional medical services in the Department of Anesthesiology from November 9, 2016 through November 8, 2019, in an amount not to exceed $15,835,500 –
NO ONE HEARD; APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-066
Pelz-Sistrunk: 6 Ayes; 1 Absent - McLaughlin

14) Kern County Hospital Authority Chief Executive Officer report -
RECEIVED AND FILED
Nilon-McGauley: 6 Ayes; 1 Absent - McLaughlin

15) Kern County Hospital Authority Chief Financial Officer report -
RECEIVED AND FILED
Pelz-McGauley: 6 Ayes; 1 Absent - McLaughlin

CA

16) Claims and Lawsuits Filed as of July 31, 2016 – RECEIVED AND FILED
Berjis-Pelz: 6 Ayes; 1 Absent - McLaughlin

ADJOURNED TO CLOSED SESSION
Sistrunk-Pelz

CLOSED SESSION

17) Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

18) Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

19) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Stenerson v. Nguyen, et al., Kern County Superior Court Case No. BCV-15-101357 LHB – SEE RESULTS BELOW

20) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(1).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: Facts and circumstances that might result in litigation against the Authority but which the Authority believes are not yet known to a potential plaintiff or plaintiffs, which facts and circumstances need not be disclosed – SEE RESULTS BELOW

21) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Nilon-McGauley: 6 Ayes; 1 Absent - McLaughlin

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 17 concerning a Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - McLAUGHLIN), THE BOARD APPROVED ALL PRACTITIONERS RECOMMENDED FOR INITIAL APPOINTMENT AND REAPPOINTMENT, RELEASE FROM PROCTORING, AND VOLUNTARY TERMINATION OF PRIVILEGES; THERE WERE NO ABSTENTIONS

Item No. 18 concerning a Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – NOT HEARD

Item No. 19 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Stenerson v. Nguyen, et al., Kern County Superior Court Case No. BCV-15-101357 LHB – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 20 concerning CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2)) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: Facts and circumstances that might result in litigation against the Authority but which the Authority believes are not yet known to a potential plaintiff or plaintiffs, which facts and circumstances need not be disclosed – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 21 concerning CONFERENCE WITH LEGAL COUNEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, ~~AUGUST 17~~***SEPTEMBER 21***, 2016 AT 11:30 A.M.
McGauley

CORRECTION PER SUMMARY OF OCTOBER 19, 2016, ITEM 17

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell E. Bigler
Chairman, Board of Governors
Kern County Hospital Authority

SUMMARY OF PROCEEDINGS

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS

Kern Medical
1700 Mount Vernon Avenue
Conference Room 1058
Bakersfield, California 93306

Regular Meeting
Wednesday, September 21, 2016

11:30 A.M.

BOARD RECONVENED

Directors present: Berjis, Bigler, McLaughlin, Pelz, Sistrunk

Directors absent: McGauley, Nilon

NOTE: The vote is displayed in bold below each item. For example, Nilon-McLaughlin denotes Director Nilon made the motion and Vice Chair McLaughlin seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

Chairman Bigler read a recent article from The Bakersfield Californian which recognized Chief Executive Officer Russell Judd and his team for their work to turn around Kern Medical's financial performance

ITEMS FOR CONSIDERATION

3) Presentation of check for $578,000 from Kaiser Permanente to Kern Medical Center Foundation on behalf of Kern Medical for the "Up Sooner, Safer" patient mobility program –
MADE PRESENTATION

CA
4) Minutes for Kern County Hospital Authority Board of Governors regular meeting on August 17, 2016 –
APPROVED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
5) Proposed updated Conflict of Interest Code and Conflict of Interest policy for Kern County Hospital Authority –
APPROVED; REFERRED CONFLICT OF INTEREST CODE TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
6) Proposed Resolution approving the "pick-up" treatment of physician contributions to the Kern County Hospital Authority Pension Plan for Physician Employees as authorized under Internal Revenue Code Section 414(h)(2) –
APPROVED; ADOPTED RESOLUTION 2016-016
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
7) Proposed Resolution revising the Kern County Hospital Authority Pension Plan for Physician Employees' Pension Committee membership –
APPROVED; ADOPTED RESOLUTION 2016-017
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
8) Proposed retroactive Resolution revising the extension of excess medical professional liability coverage for Kern Medical employed and independent contractor physicians, effective July 1, 2016 –
APPROVED; ADOPTED RESOLUTION 2016-018
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
9) Proposed Agreement with Bhani K. Chawla-Kondal, M.D., a contract employee, for professional medical services in the Department of Surgery from October 3, 2016 through October 2, 2018, in an amount not to exceed $1,130,000, plus applicable benefits –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-067
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
10) Proposed Agreement for a triple net lease of a single story office building located at 2011 19th Street, Bakersfield, California 93301 for a term of two years, in an amount not to exceed $61,715, plus utilities, taxes, and operating expenses –
MADE FINDING PROJECT EXEMPT FROM FURTHER CEQA REVIEW PER SECTIONS 15320 AND 15061(b)(3) OF STATE CEQA GUIDELINES; APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-068
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
11) Proposed Agreement with Aslan Ghandforoush, D.O., a contract employee, for professional medical services in the Department of Medicine, Division of Cardiology from October 1, 2016 through September 30, 2019, in an amount not to exceed $3,000,000, plus applicable benefits –
APPROVED; AUTHORIZED CHAIRMAN TO SIGN AGREEMENT 2016-069
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

12) Report from County of Kern Administrative Office, Human Resources Division on county health benefits programs –
HEARD PRESENTATION; RECEIVED AND FILED
Pelz-Sistrunk: 5 Ayes; 2 Absent - McGauley, Nilon

13) Report on Hospital Compare patient satisfaction for the period October 1, 2014 through September 30, 2015 –
RECEIVED AND FILED
Berjis-McLaughlin: 5 Ayes; 2 Absent - McGauley, Nilon

14) Kern County Hospital Authority Chief Executive Officer report -
RECEIVED AND FILED
Pelz-Sistrunk: 5 Ayes; 2 Absent - McGauley, Nilon

15) Kern County Hospital Authority Chief Financial Officer report -
RECEIVED AND FILED
McLaughlin-Berjis: 5 Ayes; 2 Absent - McGauley, Nilon

CA
16) Miscellaneous Documents –
RECEIVED AND FILED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

CA
17) Claims and Lawsuits Filed as of August 31, 2016 –
RECEIVED AND FILED
McLaughlin-Pelz: 5 Ayes; 2 Absent - McGauley, Nilon

ADJOURNED TO CLOSED SESSION
Pelz-Berjis

CLOSED SESSION

18) Request for Closed Session regarding peer review of health practitioners
(Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

19) Request for Closed Session regarding peer review of health facilities
(Health and Safety Code Section 101855(j)(2)) – SEE RESULTS BELOW

20) CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION
(Government Code Section 54956.9(d)(1)) Name of case: Jasmin Delila Hernandez, et al. v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-277124 DRL – SEE RESULTS BELOW

21) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION
(Government Code Section 54956.9(d)(4).) Number of cases: One (1) Based on existing facts and circumstances, the Board of Governors has decided to initiate or is deciding whether to initiate litigation – SEE RESULTS BELOW

22) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION
(Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – SEE RESULTS BELOW

23) CONFERENCE WITH LABOR NEGOTIATORS – Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff – Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – SEE RESULTS BELOW

24) CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – SEE RESULTS BELOW

25) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 DRL – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
Sistrunk-McLaughlin

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 18 concerning a Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (2 ABSENT - MCGAULEY, NILON), THE BOARD APPROVED ALL PRACTITIONERS RECOMMENDED FOR INITIAL APPOINTMENT, REAPPOINTMENT, RELEASE FROM PROCTORING, ADVANCE IN STAFF STATUS, AND VOLUNTARY RESIGNATION OF PRIVILEGES

Item No. 19 concerning a Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 20 concerning CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Jasmin Delila Hernandez, et al. v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-277124 DRL – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 21 concerning CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(4).) Number of cases: One (1) Based on existing facts and circumstances, the Board of Governors has decided to initiate or is deciding whether to initiate litigation – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 22 concerning CONFERENCE WITH LEGAL COUNEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 23 concerning CONFERENCE WITH LABOR NEGOTIATORS – Agency designated representatives: Chief Executive Officer Russell V. Judd, and designated staff – Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6) – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 24 concerning CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2), (e)(3).) Number of cases: One (1) Significant exposure to litigation in the opinion of the Board of Governors on the advice of legal counsel, based on: The receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 25 concerning CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Government Code Section 54956.9(d)(1)) Name of case: Bravo v. County of Kern, et al., Kern County Superior Court Case No. S-1500-CV-280293 DRL – HEARD; NO REPORTABLE ACTION TAKEN

ADJOURNED TO WEDNESDAY, OCTOBER 19, 2016 AT 11:30 A.M.
Pelz

/s/ Raquel D. Fore
Authority Board Coordinator

/s/ Russell E. Bigler
Chairman, Board of Governors
Kern County Hospital Authority

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS
PUBLIC STATEMENT REGARDING CLOSED SESSION

Health and Safety Code Section 101855(j)(2)

On the recommendation of the Chief Executive Officer, the Board of Governors will hold a closed session on October 19, 2016, to discharge its responsibility to evaluate and improve the quality of care rendered by health facilities and health practitioners. The closed session involves:

__X__ Request for Closed Session regarding peer review of health facilities (Health and Safety Code Section 101855(j)(2)) –

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS
PUBLIC STATEMENT REGARDING CLOSED SESSION

Health and Safety Code Section 101855(j)(2)

On the recommendation of the Chief Executive Officer, the Board of Governors will hold a closed session on October 19, 2016, to discharge its responsibility to evaluate and improve the quality of care rendered by health facilities and health practitioners. The closed session involves:

__X__ Request for Closed Session regarding peer review of health practitioners (Health and Safety Code Section 101855(j)(2)) –

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS
PUBLIC STATEMENT REGARDING CLOSED SESSION

On the recommendation of the Chief Executive Officer, the Board of Governors will hold a closed session on October 19, 2016, to consider:

_X_ CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd and designated staff – Unrepresented Employee: Kern County Hospital Authority Chief Executive Officer (Government Code Section 54957.6)

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS
PUBLIC STATEMENT REGARDING CLOSED SESSION

On the recommendation of the Chief Executive Officer, the Board of Governors will hold a closed session on October 19, 2016, to consider:

__X__ PUBLIC EMPLOYEE PERFORMANCE EVALUATION – Title: Chief Executive Officer (Government Code Section 54957)

KERN COUNTY HOSPITAL AUTHORITY
BOARD OF GOVERNORS
PUBLIC STATEMENT REGARDING CLOSED SESSION

On the recommendation of the Chief Executive Officer, the Board of Governors will hold a closed session on October 19, 2016, to consider:

_X_ CONFERENCE WITH LABOR NEGOTIATORS - Agency designated representatives: Chief Executive Officer Russell V. Judd and designated staff – Employee organization: Service Employees International Union, Local 521 (Government Code Section 54957.6)