AGENDA

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 TO RECONVENE

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

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))

STAFF RECOMMENDATION SHOWN IN CAPS

3) Minutes for Kern County Hospital Authority Board of Governors regular meeting on March 16, 2016 –
APPROVE

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 –
APPROVE; ADOPT RESOLUTION; AUTHORIZE CHAIRMAN TO SIGN SUBJECT TO APPROVAL AS TO FORM BY COUNSEL

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 –
APPROVE; ADOPT RESOLUTION

6) Proposed administrative policy on the development of policies and procedures –
APPROVE POLICY

7) Proposed Memorandum of Understanding (MOU) with CSAC Excess Insurance Authority for participation in the CSAC excess workers' compensation program –
APPROVE; AUTHORIZE CHAIRMAN TO SIGN

8) Proposed presentation on Kern Medical Center Foundation –
HEAR PRESENTATION; RECEIVE AND FILE

9) Miscellaneous Documents –
RECEIVE AND FILE

   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

ADJOURN TO WEDNESDAY, APRIL 20, 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.

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 16, 2016

11:30 A.M.

BOARD CONVENED by Interim Chair Karen S. Barnes, Chief Deputy County Counsel

Directors present: Berjis, Bigler, Bynum, 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.

BOARD ACTION SHOWN IN CAPS

1) Administer Oath of Office – THE OATH OF OFFICE WAS ADMINISTERED TO THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK) BY KATHLEEN KRAUSE, CLERK OF THE KERN COUNTY BOARD OF SUPERVISORS

2) Introductions of Board members and staff – BOARD MEMBERS AND STAFF WERE INTRODUCED

3) Election of Board Chair – MS. BARNES CALLED FOR NOMINATIONS FOR BOARD CHAIR; MOTION BY DIRECTOR MCLAUGHLIN, SECOND BY DIRECTOR MCGAULEY NOMINATING DIRECTOR BIGLER AS BOARD CHAIR; THERE BEING NO FURTHER NOMINATIONS, AND BY UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK), DIRECTOR BIGLER WAS ELECTED CHAIR OF THE KERN COUNTY HOSPITAL AUTHORITY BOARD OF GOVERNORS

NOTE: DIRECTOR BIGLER ASSUMED THE POSITION OF BOARD CHAIR

4) Election of Board Vice Chair and Secretary/Treasurer –

CHAIRMAN BIGLER CALLED FOR NOMINATIONS FOR BOARD VICE CHAIR; MOTION BY DIRECTOR BYNUM, SECOND BY DIRECTOR NILON NOMINATING DIRECTOR MCLAUGHLIN AS BOARD VICE CHAIR; THERE BEING NO FURTHER NOMINATIONS, AND BY UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK), DIRECTOR MCLAUGHLIN WAS ELECTED VICE CHAIR OF THE KERN COUNTY HOSPITAL AUTHORITY BOARD OF GOVERNORS

CHAIRMAN BIGLER CALLED FOR NOMINATIONS FOR BOARD SECRETARY/ TREASURER; MOTION BY DIRECTOR NILON NOMINATING DIRECTOR MCGAULEY AS BOARD SECRETARY/TREASURER; DIRECTOR MCGAULEY DECLINED; CHAIRMAN BIGLER CALLED FOR FURTHER NOMINATIONS; MOTION BY DIRECTOR BERJIS, SECOND BY VICE CHAIRMAN MCLAUGHLIN NOMINATING DIRECTOR BYNUM AS BOARD SECRETARY/TREASURER; THERE BEING NO FURTHER NOMINATIONS, AND BY UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK), DIRECTOR BYNUM WAS ELECTED SECRETARY/TREASURER OF THE KERN COUNTY HOSPITAL AUTHORITY BOARD OF GOVERNORS

5) Hospital Authority Overview/Background – HEARD PRESENTATION; RECEIVED AND FILED
Nilon-McLaughlin: 6 Ayes; 1 Absent - Sistrunk

6) Proposed Kern County Hospital Authority Bylaws for Governance – BYLAWS IMPLEMENTED
Bynum-McGauley: 6 Ayes; 1 Absent - Sistrunk

7) Proposed Resolution establishing the regular meeting dates of the Kern County Hospital Authority Board of Governors for calendar year 2016 – APPROVED; ADOPTED RESOLUTION
Nilon-McGauley: 6 Ayes; 1 Absent - Sistrunk

8) Proposed presentation regarding the Brown Act – HEARD PRESENTATION; RECEIVED AND FILED
Nilon-McLaughlin: 6 Ayes; 1 Absent - Sistrunk

9) Proposed change of ownership plan – APPROVED; AUTHORIZED CHAIRMAN TO SIGN LETTERS; AUTHORIZED RUSSELL V. JUDD TO SIGN ALL CHANGE OF OWNERSHIP DOCUMENTS
McGauley-Nilon: 6 Ayes; 1 Absent - Sistrunk

10) Proposed Resolution recognizing employee organizations – APPROVED; ADOPTED RESOLUTION
Bynum-Nilon: 6 Ayes; 1 Absent - Sistrunk

ADJOURNED TO CLOSED SESSION
Nilon

CLOSED SESSION

11) PUBLIC EMPLOYEE APPOINTMENT/RECRUITMENT - Title: Kern Medical Center Chief Executive Officer (Government Code Section 54957) – SEE RESULTS BELOW

12) PUBLIC EMPLOYEE APPOINTMENT/RECRUITMENT - Title: Kern Medical Center Chief Financial Officer (Government Code Section 54957) – SEE RESULTS BELOW

13) PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern Medical Center Chief Executive Officer (Government Code Section 54957) – SEE RESULTS BELOW

RECONVENED FROM CLOSED SESSION
McLaughlin-Bynum

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item 11 concerning PUBLIC EMPLOYEE APPOINTMENT/RECRUITMENT - Title: Kern Medical Center Chief Executive Officer (Government Code Section 54957) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK), THE BOARD RECOMMENDED RUSSELL V. JUDD BE APPOINTED THE CHIEF EXECUTIVE OFFICE OF KERN COUNTY HOSPITAL AUTHORITY; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS FOR APPROVAL

Item 12 concerning PUBLIC EMPLOYEE APPOINTMENT/RECRUITMENT - Title: Kern Medical Center Chief Financial Officer (Government Code Section 54957) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT (1 ABSENT - SISTRUNK), THE BOARD APPROVED THE RECOMMENDATION OF RUSSELL V. JUDD TO APPOINT ANDREW CANTU AS CHIEF FINANCIAL OFFICER OF KERN COUNTY HOSPITAL AUTHORITY

Item 13 concerning PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Kern Medical Center Chief Executive Officer (Government Code Section 54957) – HEARD; NO REPORTABLE ACTION TAKEN

PUBLIC PRESENTATIONS

14) 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

15) 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 PRAISED RUSSELL V. JUDD FOR HIS EFFORTS TO TURN AROUND KERN MEDICAL AND THE FORMATION OF THE KERN COUNTY HOSPITAL AUTHORITY

ADJOURNED TO WEDNESDAY, MARCH 30, 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

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING
Agenda Item 4

March 30, 2016

SUBJECT: Application for Membership of the Kern County Employees' Retirement Association

Requested Action: Adopt Resolution; Approve; Authorize Chief Executive Officer to sign.

The Kern County Employees' Retirement Association (KCERA) is a multi-employer, defined benefit pension plan, governed by the County Employees' Retirement Law of 1937 (CERL) and subject to the requirements of the Public Employees' Pension Reform Act of 2013 (PEPRA). KCERA is considered a "governmental plan," as defined in Section 414(d) of the Internal Revenue Code. The Kern County Hospital Authority (Authority) is a "district" within the meaning set forth in the CERL and thereby eligible to participate in KCERA.

Prior to becoming employees of the Authority, employees of Kern Medical Center ("the Medical Center") were County employees and enrolled as members of KCERA. Employees transferred from the county to the Authority, shall continue to be a member of KCERA, retaining service credit earned to the date of transfer.

Pursuant to the Kern County Hospital Authority Act, the Authority must provide that county employees who retired from the Medical Center prior to the effective date of the transfer to the Authority, county employees initially transferred to the Authority, and employees directly hired by or retired from the Authority during the first 24 months following the effective date of the transfer to the Authority (Legacy Employees) shall continue be members of KCERA, to the extent provided for in the applicable memorandum of understanding, enabling ordinance or the personnel transition plan.

Therefore in order for the Authority to secure the retirement of Legacy Employees, the Authority must apply as a new employer for KCERA. The KCERA Board of Retirement is the governing body of the retirement association and will ultimately decide whether the Authority may participate in KCERA. This matter will be presented to the KCERA Board of Retirement on April 13, 2016.

The following documents must be included in the KCERA Employer Participation Application Packet:

- Resolution approved by governing board

- Employer Participation Agreement
- New Employer Information Sheet and Application, including:
    - Enabling legislation
    - Local ordinance creating employer
    - Employees information entering Plan
    - Last two years of audited financial statements
    - Personnel Transition Plan
    - Most recent Memoranda of Understanding with union(s)
    - Private Letter Ruling Regarding Tax Status
    - Authority Signature List
    - Primary Contacts Form

Today, we request your Board adopt the KCERA Resolution and approve the Employer Participation Agreement to prepare for our KCERA membership application submission.

BEFORE THE BOARD OF GOVERNORS
OF THE KERN COUNTY HOSPITAL AUTHORITY

In the matter of: Resolution No. _____

INCLUSION OF THE KERN COUNTY HOSPITAL AUTHORITY IN THE KERN COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

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 Transitional Governing Board of the Kern County Hospital Authority at an official meeting thereof on the 30th day of March, 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) Chapter 5.5 commencing with Section 101852 of Part 4 of Division 101 of the Health and Safety Code established the Kern County Hospital Authority ("Authority") as a new political subdivision; and

(b) The Authority is a "District" as provided in Government Code section 31468(m); and

(c) The County of Kern ("County") has heretofore adopted a retirement plan for the eligible officers and employees of the County and other Districts within the County known as the Kern County Employees' Retirement Association ("KCERA"), a defined benefit plan created under the County Employees Retirement Law of 1937 ("CERL") (Gov. Code, § 31450 et seq.); and

(d) Prior to becoming employees of the Authority, employees of the Kern Medical Center were County employees and enrolled as members of the KCERA when qualified; and

(e) For the purpose of continuing to provide retirement, disability and death benefits to eligible employees of the Authority through the KCERA, it is the desire of Authority to include eligible employees of the Authority as members of the KCERA, without interruption of service credit; and

(f) Health and Safety Code Section 101853.1(d)(2) requires the Authority to provide the same level of employee benefits to its employees as does the County for a period of 24 months after the effective date of the transfer of control of the Kern Medical Center to the Authority, which is currently expected to be July 1, 2016 (the "Effective Date").

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 adopts this Resolution for inclusion of the Authority in the KCERA as a "District" under the CERL, on the terms and conditions set forth in the Employer Participation Agreement, attached hereto and incorporated herein by this reference as Exhibit "A."

3. This Board hereby elects to adopt all of the optional provisions of the CERL currently in effect for the County and its general employees, which provisions are listed in Exhibit "A."

4. This Board hereby authorizes and directs the Chairman to execute the Employer Participation Agreement on behalf of the Authority for the inclusion of its eligible employees in the KCERA under the same terms and conditions applicable to the eligible general employees of the County.

5. All eligible officers and employees of the Authority on the Effective Date shall continue their membership in the KCERA; and thereafter, for a period of 24 months after the Effective Date, each person entering into eligible employment for the Authority shall become a member of the KCERA on the first day of the calendar month following his or her entrance into service for the Authority, pursuant to Government Code Section

31557(b), or as otherwise provided by regulation, pursuant to Government Code Section 31527(h), but subject to the eligibility limitations set forth in Government Code Section 31552.5.

6. The Authority shall enter the KCERA effective on the Effective Date, subject to the prior execution of the Employer Participation Agreement and the adoption of a consenting resolution by the Board of Retirement of the KCERA.

7. The Authority shall be responsible for the District contributions and appropriations required of it by the KCERA from time to time, as provided by the CERL.

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

Office of County Counsel
Kern Medical Center
County Administrative Office
Kern County Employees' Retirement Association

[The Employer Participation Agreement

will be sent under separate cover

and made available to the public at the meeting]

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING
Agenda Item 5

March 30, 2016

SUBJECT: 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

Recommended Action: Approve; Adopt Resolution

Applicable Authority:

1. **Kern County Hospital Authority Act**

The Kern County Hospital Authority Act (Health & Saf. Code, § 101852 et seq.) (the "Act") states the Kern County Hospital Authority ("Hospital Authority") shall have the power *"to enter into one or more contracts or agreements, including, but not limited to, contracting with any public or private entity or person for management or other services and personnel, and to authorize the chief executive officer to enter into contracts, execute all instruments, and do all things necessary or convenient in the exercise of the powers granted in [the Act]."* (Health & Saf. Code, § 101855(a)(9).)

2. **Hospital Authority Bylaws for Governance**

The Hospital Authority Bylaws for Governance ("Bylaws") provide that *"the Chief Executive Officer shall be the general manager of the Hospital Authority, and shall have the authority to exercise executive supervision over the general business and affairs of the Hospital Authority in accordance with the statement of duties and responsibilities adopted by the Board of Governors, including, but not limited, to the following: (h) such duties assigned by the Board of Governors and required by these Bylaws or applicable law."* (Bylaws, section 5.02.)

3. **Discussion**

The attached proposed resolution if adopted by your Board will delegate authority to the Chief Executive Officer of the Hospital Authority to enter into contracts and to secure and pay for certain professional and special services, to facilitate timely operations of the hospital. County Counsel will continue to review all agreement for approval as to legal form. Kern Medical will provide periodic reports on the expenditures paid pursuant to this authorization, as directed by your Board.

BEFORE THE BOARD OF GOVERNORS
OF THE KERN COUNTY HOSPITAL AUTHORITY

In the matter of: Resolution No. _____

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

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 Transitional Governing Board of the Kern County Hospital Authority at an official meeting thereof on the 30th day of March, 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 Kern County Hospital Authority Act (Health & Saf. Code, § 101852 et seq.) (the "Act") states the Kern County Hospital Authority ("Hospital Authority") shall have the power *"to enter into one or more contracts or agreements, including, but not limited to, contracting with any public or private entity or person for management or other*

services and personnel, and to authorize the chief executive officer to enter into contracts, execute all instruments, and do all things necessary or convenient in the exercise of the powers granted in [the Act].” (Health & Saf. Code, § 101855(a)(9).); and

(b) The Hospital Authority Bylaws for Governance (“Bylaws”) provide that *“the Chief Executive Officer shall be the general manager of the Hospital Authority, and shall have the authority to exercise executive supervision over the general business and affairs of the Hospital Authority in accordance with the statement of duties and responsibilities adopted by the Board of Governors, including, but not limited, to the following: (h) such duties assigned by the Board of Governors and required by these Bylaws or applicable law.”* (Bylaws, section 5.02.)

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 delegates authority to the Chief Executive Officer of the Kern County Hospital Authority to enter into the contracts and to secure and pay for those certain professional and special services set forth in Exhibit “A,” attached hereto and incorporated herein by this reference.

3. County Counsel shall review all agreements for approval as to legal form.

4. Kern Medical Center shall provide periodic reports on the expenditures paid pursuant to this authorization, as directed by this Board.

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

Office of County Counsel
Kern Medical Center

EXHIBIT "A"

1. **Professional and specialized services (that do not exceed the specified amounts set forth herein), including without limitation, the following:**

    A. Services that are beyond the capability of employed staff to provide
    B. Services of a very specialized nature which are not available at Kern Medical
    C. Services that require special equipment or facilities that are not available at Kern Medical
    D. Services that are infrequent in occurrence, are unpredictable in volume and costs, and therefore may not be identified specifically in the Hospital Authority budget
    E. Services that do not carry any associated fiduciary or liability responsibilities
    F. Services that are necessary to provide patient care or services to patients in an emergent situation
    G. Discretion to utilize Board-approved strategic initiatives that require immediate action
    H. Patient specific letters of agreement
    I. Letters of agreement for services not provided at Kern Medical
    J. Locum tenens agreements
    K. Education/teaching services (e.g., visiting lecturers)
    L. Physician recruiting expenses
    M. Prepayments to vendors who do not accept purchase orders
    N. Health fair/public health promotions
    O. Temporary physician staffing agreements
    P. Administrative penalties (any administrative penalty that does not exceed $50,000; County Counsel shall review any notice of administrative penalty to determine whether a hearing to dispute the penalty is warranted and approve all settlement agreements, if any, negotiated between the Hospital Authority and the relevant agency, prior to payment of the penalty)

2. **Routine agreements that require the expenditure of funds, including without limitation, the following:**

    A. Payer/provider agreements
    B. Any agreement with a not to exceed amount that is less than $250,000 per year that is not specifically budgeted, including multi-year agreements with a maximum payable greater than $250,000 over the term of the agreement
    C. Any physician agreement with a not to exceed amount of $500,000 per year, including multi-year agreements that do not exceed a term of three years, with a maximum payable greater than $500,000 over the term of the agreement

3. **Routine agreements that typically do not require the expenditure of funds, including without limitation, the following:**

    A. Affiliation agreements

B. Indemnification agreements
C. Provider transfer agreements
D. Organ/tissue and blood services agreements
E. Accreditation contracts with The Joint Commission
F. Business Associate Agreements (BAA)
G. Provider participation agreements
H. Quality collaborative agreements
I. Peer review sharing agreements
J. Waivers and Inter-governmental Transfer (IGT) documents and agreements

4. Adding/deleting new positions required to provide patient care and services

5. Contracts previously approved by the Kern County Board of Supervisors that are being assigned by the County of Kern to the Hospital Authority

6. Accept and receive any donations or grants on behalf of Kern Medical and on behalf of its physicians

7. Write advocacy letters on behalf of Kern Medical

8. Approval of policies and procedures that are department specific and operational in nature

9. All meet and confer proceedings unless it involves matters related to fact finding, impasse or MOU negotiation/approval.

10. Designate and authorize the Chief Executive Officer to make necessary adjustments within the approved budget during the budget year if the overall EBIDA of the Hospital Authority is not decreased and any adjustments to be reported to the Board of Governors quarterly as part of the financial report

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING
Agenda Item 6

March 30, 2016

SUBJECT: Policy on Policies

Required Action: Approve.

Healthcare is a highly governed industry. Regulatory bodies provide guidelines/mandates to hospitals in an effort to ensure patient safety and that standard healthcare practices are maintained. Kern Medical has developed a Policy on Policies that provides guidance on how to develop a policy, the process for obtaining approval from the content experts, the process for obtaining approval from additional committees, boards or legal counsel and the process for distribution of the policies/procedures.

The Board of Governors has certain specified powers and authorities with respect to the review and approval of policies and procedures that are regulatory in Nature. Departmental policies may be reviewed and approved by Kern Medical Administration.

The Board of Governors will be provided with all mandated regulatory reports on an annual basis (or more frequently if indicated or requested).

KERN MEDICAL

Standard Policy/Procedure	Department: Administration			
KernMedical	Policy No.	Effective Date:	Review Date:	Page
	ADM-LD-114	March 2010	March 2016	1 of 16 (including addendums)
Title of Procedure:	**Policy and Procedure Development**			

I. PURPOSE:

To provide a process for identifying subjects that require up-to-date written policies and/or procedures to effectively express the will of the hospital; assist in meeting the hospital's mission, goals, objectives, and legal requirements; define the types of policies and procedures in use; a common format; outline the approval process prior to implementation; and ensure regular periodic review, revision, cancellation, and appropriate approval of all types of policies and procedures.

II. DEFINITIONS:

A. **Policy** - an agreed upon course of action selected to guide decisions.

B. **Procedure *** - a series of steps used to implement a policy.

Note: When appropriate, policies and procedures are included in one document.

* Approved procedure publications (i.e., Clinical Skills Manual, Manual of Nursing Pediatric Procedures, etc.) will be used as a guide for routine patient care procedures, guidelines such as IV therapy, catheter insertion, and assisting with procedures. A Table of Contents listing procedures and the appropriate reference manual will be included in the Nursing Standards Manual.

III. POLICY:

A. All policies and procedures at Kern Medical will be maintained in specific manuals. A common format and approval process will be used for all policies developed. Each policy will be scheduled for periodic review.

B. Two (2) Standardized "Table of Contents" will be maintained in each manual. These will include:
   1. Numerical Table of Contents - Organized by The Joint Commission standards
   2. Alphabetical Table of Contents

C. The following is a list of policy and procedure manuals at Kern Medical:

1. **Administrative:** Policies and procedures required by statute or regulation or determined by Administration to pertain to the entire hospital.

2. **Patient Care Services:** Patient care policies and procedures that govern practice or provide directions for patient care across multiple disciplines to include nursing and other ancillary departments.

3. **Nursing Administration:** Nursing care policies and procedures that govern practice or provide directions for patient care within the Nursing department and do not address practice in other departments.

4. **Infection Control:** Policies and procedures pertaining to the infection control program.

5. **Employee Health:** Policies and procedures for all hospital employees required by regulations and determined to comply with practice standards.

6. **Environment of Care:** Contains safety, security and fire policies and procedures for the hospital.

7. **Disaster Manual:** Policies and procedures related to the hospital's responsibilities in external and internal disasters.

8. **Human Resources:** Personnel policies and procedures regulated by regulations and determined by Human Resources to pertain to the entire hospital.

9. **Department Specific:** Department specific policies and procedures related to practices that are limited to one department/discipline. For patient care areas, or department policies, this information may be maintained in a separate section of the Patient Care Services Manual, or as a separate manual.

IV. EQUIPMENT: Does not apply

V. PROCEDURE:

A. **Approval Process:**

1. New Policy Development
   a. The need for policy development may come from Department Manager, Committee chair or Administration.

   b. Once the policy has been developed, a draft copy must be routed to committee(s) and department(s) that are directly involved for input and approval. Typical approval routings for various types of policies/procedures are contained in Addendum A.

      1) A watermark of the word “DRAFT” should appear on every page.

2. Evidence of each Committee/Department approval can be found as follows:
   a. Historical Authorization at the end of each policy/procedure as to the approving body(s) and date of approval(s).
   b. Minutes of the approval body.
   c. Signature cover page after routine and periodic review of entire manual has been accomplished.
   d. The following signatures verify that the policy has been approved by administration and appropriate committees:
      1) Administrative Policies - The Chief Executive Officer;
      2) Patient Care Services Policies - The Chief Nursing Officer and the Chief Medical Officer;
      3) Nursing Administration - The Chief Nursing Officer;
      4) Department/Unit Specific Polices – Director/Manager/Supervisor (if Director/Manager not available) of Department/Unit.

3. The computerized version of all revised, superseded, and/or deleted policies and procedures will be retained for 12 years from the last date of action for historical reference and tracking.

4. A list of policies approved and deleted during the previous year will be submitted to The Joint Conference Committee on an annual basis. Conditions of this process will be documented on the approved/transmittal page of each manual.

B. The following approved format will be used when writing new policies and procedures or revising existing policies and procedures:

1. **Header**

Standard Policy/Procedure	**Department:** ***(i.e. Administrative)***			
KernMedical	Policy No. XXX-XX-XXX	Effective Date: XX-XX-XX	Review Date: XX-XX-XX	Page __ of __
Title of Procedure: ***(Policy/Procedure Title Goes Here)***				

a. **Policy Number**

1) Policies will be numbered with three (3) segments (each segment of the numbering being separated by a "-") using:

a) A three-digit alpha designation identifying the organizational area (i.e., HRM). Addendum "B" provides the hospital approved alpha designations for the organizational areas of the hospital; followed by

b) The alpha of the Joint Commission designated chapter specific to the content of the policy (i.e., PC, IM, RI, MM, etc.); followed by

c) The standard's numeric policy number using a three-digit primary number such as 100, 101, 102, etc. In specific cases (e.g., Nursing), a four-digit number may be used where the first number would represent a specific Nursing Unit (e.g., 2100, 3100, 4100, etc.)

d) For standardization, all manuals will be alphabetically organized by The Joint Commission standards:

EC ..... Environment of Care
EM ..... Emergency Management
HR .....Human Resources
IC ..... Infection Prevention and Control
IM .....Information Management
LD .....Leadership
LS ..... Life Safety
MM ..... Medication Management
MS.....Medical Staff
NPSG .....National Patient Safety Goals
NR.....Nursing
PC.....Provision of Care, Treatment, and Services
PI .....Performance Improvement
RC ..... Record of Care, Treatment and Services
RI ..... Patient Rights and Organization Ethics
TS ..... Transplant Safety

2) An example of the numbering system using Human Resources policy manual numbers:
   a) HRM-HR-100.00
      (1) HRM is the three-alpha indicator for Human Resource Manual;
      (2) HR is the two-alpha indicator for the Joint Commission chapter “Management of Human Resources”;
      (3) 100.00 is the number assigned this specific Human Resource policy.

3) **Effective Date -** The date the policy becomes effective. Generally one (1) month following final approval date in order to allow for distribution and education.

4) **Review Date -** Refers to the date the policy/procedure is due for regularly required review.

5) **Page ___ of ___ -** The specific page number and total number of pages (including Addendums) in the policy/procedure.

b. **Body**

1) The body will contain each of the following sections. If a section does not apply, the heading with Roman Numerals should be included with notation “does not apply”.

2) **Purpose** - reason for the existence of the policy and procedure, or what is to be accomplished by the policy and procedure.

3) **Definitions** - describes specific terms/words pertinent to policy, if applicable.

4) **Policy Statement** - a specific authoritative statement of what is or is not to be done. Keep this simple and concise.

5) **Equipment** (if applicable).

6) **Procedure** (if needed and not covered in reference manuals).

7) **Special Considerations** - specific population or exceptions to procedure or policy.

8) **Education**

a) Patient/Family - identify the expected standard education which will be given to the patient/family related to the procedure(s)_and/or process.

b) Staff - identify the competency required to deliver the procedure(s) and/or process (i.e., how it's to be accomplished, e.g., verbal demonstration or written competency, with time frames to be completed).

9) **Documentation** - identify content and location of required documentation.

10) **Addendums -** list of all attachments.

11) **References** - (if applicable) list reference by author, title, date and page (i.e., textbooks, articles, internet searches).

12) **Key Words** - for policy search (limit to three (3) words).

c. **History of Authorization**

1) Refers to the serial activities, dates and persons or groups of persons used to give a policy/procedure official sanction; provides the legitimacy, credibility, and authority needed to successfully implement a policy. The History will be placed at the bottom of the policy/procedures as follows ("Ownership" defines who is responsible for review of the policy):

Ownership (Committee/Dept/Team) .....*(date)* Original Approval .....*(date)* Reviewed, No Revisions.....*(date - when applicable)* Revised.....*(date - when applicable)* Approved by *(committee/dept name(s) and .. date of approval)* Approved by Legal Counsel (if applicable)…….*(date*) Distribution..... *??? Manuals* Requires Review.....*(date)*	
Administrative Signature of Approval Date *(if applicable)*	Dept Manager Signature of Approval Date *(if applicable)*

a) **Ownership**: Committee/department that is responsible for updates, review and revision of policy.

b) **Original**: Refers to the date the document was originally created.

c) **Reviewed, No Revisions**: Refers to the date a standard was reviewed for currency and appropriateness without any content changes. If a policy has minimal revisions [i.e., change titles of staff or department names, etc.] but the intent of the policy is not changed, the policy does not have to be sent through the approval process.)

d) **Revised**: Refers to the date a standard was reviewed for currency and appropriateness and changes were made.

e) **Approved by**: Refers to the specific Committee(s)/Department(s), if appropriate, that is directly involved with the implementation of the standard and the date the Committee that grants final approval for that department's process (i.e., Medical Executive Committee for policies that effect Medical Staff practice or Clinical Practice Committee for policies that effect Nursing practice).

f) **Approval by the Board of Governors (see Addendum B)**: If the policy needs approval by the Kern County Hospital Authority Board of Governors the CEO or respective department Vice President will present the policy or procedure to the Board of Governors for review and approval. The Guidelines for policies and procedures that must be approved by the Board of Governors are provided in Exhibit 1. The schedule of regulatory reports to be approved by the Board of Governors is provided in Exhibit 2.

g) **Distribution**: Refers to the Manual in which the policy resides.

h) **Requires Review**: Refers to the date the standard is due for regularly required review.

d. Footer: Document Path

1) To determine the location of the computer-version of each policy, the specific document path, including departmental identification *(i.e. NrsQM/NSG210/draft/01-06-00),* should immediately follow below the "History of Authorization".

a) 1st element: the department where the computerized version of the policy is maintained.

b) 2nd element: the 3-digit alpha designation for the manual followed by the policy number.

c) 3rd element: designates if the policy is draft or final form.

d) 4th element: working date if draft/effective dates if final.

C. Preparation Process

1. At the time of initial preparation and/or revision of a policy, the preparer should provide the typist with the appropriate Joint Commission chapter. The typist should then number/re-number the policy based on the Kern Medical policy and procedure numbering system.

2. All standards shall be saved using the standard number (e.g., HRM-HR-100.00).

3. To ensure uniformity within the hospital, a computerized template of the standardized format (see section V. B above), along with a new standardized Table of Contents will be made available to all departments.

   a. The template will include a watermark of the word “DRAFT”, which shall not be removed until final approval has been obtained, and the standard is ready for distribution.

4. All pages of a standard, including attachments, must show both the standard number and the page number.

D. Policy/ Procedure Review Process

1. Policies and procedures will be reviewed and then revised as appropriate, at a minimum, every three (3) years.

2. Infant security policies will be reviewed and then revised as appropriate, at a minimum, every two (2) years as required by state regulations.

E. Policy Manual Maintenance

1. Hard Copies (Paper) of Manuals

   a. A master copy along with signature sheets will be maintained in Nursing Administration for the following manuals: Administrative, Patient Care Services, Nursing Department, and Infection Control.
   b. A current hard copy for back-up during any computer access disruptions will be maintained in Nursing Office for the following manuals: Administrative, Patient Care Services, Nursing Department, and Infection Control.
   c. Each of the departments/units will maintain a hard copy of their department’s specific policy and procedure manuals along with

signature sheets for back-up during any computer access disruptions.

1) It will be the responsibility of each department Director/Manager to assure that a current Table of Contents is maintained.

2. Computer Record of Manuals

a. The Department of Nursing is responsible for the maintenance/oversight of the Administrative, Patient Care Services, and Nursing Department manuals.
b. All other departments/managers are responsible for the maintenance/oversight of their respective manuals.
c. All policy manuals will be maintained on the Hospital's intranet for access to Kern Medical employees.

F. Distribution of Policies

1. Departmental Policies

a. When policies and procedures are approved by all appropriate committees, it is the responsibility of each department director/manager to provide a final electronic document to The Department of Nursing for placement on the intranet.

b. The director/manager will be responsible to provide education on the policy with documentation submitted Staff Development Department.

G. Record of Revisions/Changes of Manuals

1. Owners of hospital-wide and departmental manuals will be responsible for tracking revised, changed and deleted policies.

VI. SPECIAL CIRCUMSTANCES: Does not apply

VII. EDUCATION:

A. Patient/Family – Applies on an as-needed basis.

B. Kern Medical Staff: Directors/Managers/Supervisors will be responsible for the education of their respective staff to both organizational and department policies and procedures through orientation and departmental processes for updates and implementation of new procedures. Medical Staff Chairs and Medical Education will be responsible for the education of their respective Medical and House Staff through orientation and departmental processes for updates and implementation of new procedures.

DOCUMENTATION:

A. Documentation of all education of Kern Medical employees and Medical and House Staff will be through the Staff Education Department process.

IX. ADDENDUMS:

A. Committee Routing
B. Kern County Hospital Authority Board of Governors Policy and Procedure Review and Approval Guidelines

X. REFERENCES: Does not apply

XI. KEY WORDS:

POLICY & PROCEDURE COMMITTEE APPROVAL ..... Oct 14, 1999 OWNERSHIP (Committee/Department/Team) ..... Policy & Procedure Committee ORIGINAL ..... Jan 4, 2000 REVIEWED, NO REVISIONS ..... REVISED ..... Jan 2002, Jan 2007, July 2010, March 2016 APPROVED BY MED EXEC COMMITTEE ..... Jan 4, 2000, 2007, August 3, 2013 APPROVED BY CLINICAL PRACTICE COMMITTEE ..... Jan 2002, Feb 2007, July 19, 2010 APPROVED BY LEGAL COUNSEL (if applicable) ..... March 2016 DISTRIBUTION ..... Administrative Manuals REQUIRES REVIEW ..... March 2019	
_____ Administrative Signature of Approval Date	

Addendum A

Committee Routing Alpha Designations

Administrative Policies ..... **ADM**
Hospital Administrator
As appropriate, Medical Staff or hospital committees

Patient Care Services Policies ..... **PCS**
Inpatient: Director of Inpatient Care – Chief Nursing Officer
Outpatient: Director of Outpatient Care
Medical Staff or hospital committees, as appropriate

Nursing Administration
Inpatient: Director of Inpatient Care – Chief Nursing Officer
Medical Staff or hospital committees, as appropriate

Human Resources ..... **HRM**
Director
Administration
Central California Public Employees Association, as appropriate
Governing Board, as appropriate

Department Specific Policies and Procedures ..... **"As Applicable"**
Department: Director/Manager/Supervisor
Inpatient: Director of Inpatient Care – Chief Nursing Officer
Chief Medical Officer, as appropriate
Medical Staff or other committees, as appropriate

Infection Control Policies and Procedures (includes Employee Health Program)ICM
Infection Control Nurse
Infection Control Committee
Inpatient: Director of Inpatient Care – Chief Nursing Officer
Medical Staff as appropriate
Department Directors

Employee Health (included in Infection Control Manual) ..... **EHM**
Director Human Resources
Administration
Inpatient: Director of Inpatient Care – Chief Nursing Officer
Chief Medical Officer
Governing Board, as appropriate

Environment of Care ..... **EOC**
Safety Officer
Safety Committee
Governing Board

Disaster ..... **DIS**
Safety Officer
Safety Committee

Addendum B

Kern County Hospital Authority Board of Governors
Policy and Procedure Review and Approval Guidelines

Philosophy
The Kern County Hospital Authority Board of Governors is responsible for overseeing the affairs of the Hospital Authority, which includes Kern Medical and has certain specified powers and authorities with respect to review and approval of policies and procedures that are regulatory in nature (see Exhibit A). Departmental policies may be reviewed and approved by Kern Medical Administration.

Regulatory Bodies

- **The Joint Commission** is an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. The Joint Commission's accreditation and certification is recognized nationwide as a symbol of quality that reflects the organizations commitment to meeting certain performance standards.
- **The California Department of Public Health, following the mandates of the California Code of Regulations, title 22,** inspects and licenses general acute care hospitals at least every two years to ensure that quality care is being provided. For hospitals with over 100 licensed bed capacity, the inspection team at minimum includes a physician, registered nurse and persons experienced in hospital administration and sanitary inspections.
- **The Centers for Medicare and Medicaid Services (CMS)** is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicare, Medicaid (known as Medi-Cal in California), the Children's Health Insurance Program and the Health Insurance Marketplace.

Board of Governors Policy Review and Approval
All policies will be reviewed and revised as appropriate a minimum of every three (3) years (unless a specific policy has a more aggressive mandated time frame). Policies are reviewed by appropriate Kern Medical content experts, departmental staff and by clinical practice committees for input and revision prior to submission to the Board of Governors. The CEO and Vice-Presidents will bring their respective department regulatory policies to the Board of Governors for review and approval.

Board of Governors Review of Hospital Reports
The Board of Governors will be provided with all mandated regulatory reports on an annual basis (or more frequently if indicated or requested). The schedule of reports is attached as Exhibit B.

Kern Medical's Policy and Procedure Development
Policy ADM-LD-114 "Policy and Procedure Development" is referenced for specific information regarding the definition of a policy and procedure. Policy ADM-LD-114 offers logistical information regarding policy development, how to ensure that the policy or procedure has been reviewed by the proper committee/department and provides the mandated time frames. Kern

Medical's policies and procedures are located on the intranet for review. Members of the Board of Governors may request to review any policy and procedure from Administration.

Exhibit 1
Policies for the Kern County Hospital Authority
Board of Governors Approval

Regulatory Reference Key:
The Joint Commission (TJC) **Title 22** **CMS**

Function	Regulatory Reference
Leadership (LD)	
Leadership Structure (e.g. org chart)	LD.01.01.01 EP2-3
Hospitals Written Scope of Services	LD.01.03.01 EP3
Mission, Vision, Goals	LD.01.03.01 EP6
Policy for Conflicts of Interests Involving Leaders	LD.02.02.01 EP1
Policy for Conflict of Interest for LIP's and staff	LD.04.02.01 EP2
Code of Conduct	LD.03.01.01 EP4
Policy for Management of Disruptive and Inappropriate Behaviors	LD.03.01.01 EP5
Policy and Procedures that Guide and Support Patient Care, Treatment, Services	LD.04.01.07 EP1
Policy for Sentinel Events	LD.04.04.05 EP7
Patient Care (PC)	
Medical Services general requirements policies	§70203(2)
Nursing Services policies and procedures	§70213(4)
Surgical Services general requirements policies	§70223(2)
Anesthesia Services general requirements policies	§70233(a)
Clinical Laboratory Service general requirements policies	§70243(d)
Radiological Services general requirements policies	§70253(b)
Pharmaceutical Services general requirements policies	§70263(1)
Dietetic Services general requirements policies	§70273(b)
Acute Respiratory Care Services general requirements policies	§70403(a)
Basic Emergency Medical Services, Physician on Duty, general requirements policies	§70413 (a)
Cardiovascular Surgery Services general requirements policies	§70433(a)
Chronic Dialysis Services general requirements policies	§70443(a)
Comprehensive Emergency Medical Services general requirements policies	§70453(a)
Coronary Care Services general requirements policies	§70463(a)
Intensive Care Services general requirements policies	§70493(a)
Nuclear Medicine Services general requirements policies	§70507(a)
Occupational Therapy Services general requirements policies	§70517(a)
Outpatient Services general requirements policies	§70527(a)
Pediatric Services general requirements policies	§70537(a)
Perinatal Unit general requirements policies	§70547(b)
Physical Therapy Services general requirements policies	§70557(a)
Podiatric Services general requirements policies	§70567(a)
Psychiatric Unit general requirements policies	§70577(a)
Radiation Therapy Services general requirements policies	§70587(a)
Respiratory Care Services general requirements policies	§70617(a)
Social Services general requirements policies	§70631(c)
Speech Pathology and/or Audiology Services general requirements	§70641(a)

policies	
Standby Emergency Medical Service, Physician on Call general requirements policies	**§70651(a)**
Patient Rights (RI)	
Complaint and/or grievance process policy	**RI.01.07.01 EP1** **§482.13(a)(2)**
Delegate to the UR committee the authority and responsibility to carry out the UR function(s)	**§482.30(b)**
Medical Staff (MS)	
Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures	**MS.01.01.01 EP3** **§482.12(a)(3) & (a)(4)** **7 - §70701(a)(8) 7 – §70703(2)(b)**

Exhibit 2

Regulatory Report Schedule for the Kern County Hospital Authority Board of Governors

Month	Report
January	Environment of Care Plan Emergency Operations Plan
February	Annual Quality and Patient Safety Report
March	Patient Experience/Satisfaction Report (semi-annual)
April	Medical Staff Bylaws and Functions Report
May	Medical Staff Quality and Performance Improvement Report (semi-annual)
June	Accreditation and Licensure Report (semi-annual) Operating Budget Report
July	Infection Prevention and Control Plan
August	Graduate Medical Education Committee Performance Report
September	Patient Experience/Satisfaction Report (semi-annual)
October	Risk/Compliance Report
November	Medical Staff Quality and Performance Improvement Report
December	Accreditation and Licensure Report (semi-annual)

Note: All reports are annual except those indicated as semi-annual.

KernMedical

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING
Agenda Item 7

March 30, 2016

SUBJECT: California State Association of Counties Excess Insurance Authority Memorandum of Understanding

Required Action: Approve; Authorize Chairman to sign.

The California State Association of Counties Excess Insurance Authority is a risk sharing pool of California public agencies. The County of Kern has been a member of the California State Association of Counties Excess Insurance Authority since 1989.

The California State Association of Counties Excess Insurance Authority Excess Workers Compensation program provides pool purchasing power of members in order to achieve the broadest possible coverage and limits at the lowest rates available. Coverage under the program includes bodily injury coverage for employees when they are injured on the job and compensation for loss of earnings. Self-Insured retentions range from $125,000 to $5 million per occurrence. The Kern County Hospital Authority intends to become a member of this program beginning July 1, 2016.

Adopted: March 5, 1993
Amended: October 4, 1996
Amended: October 6, 2006
Amended: March 6, 2009

MEMORANDUM OF UNDERSTANDING
EXCESS WORKERS' COMPENSATION PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC Excess Insurance Authority (hereinafter referred to as the "Authority") and the participating members who are signatories to this Memorandum.

1. **Joint Powers Agreement.** Except as otherwise provided herein, all terms used herein shall be as defined in Article 1 of the Joint Powers Agreement Creating the CSAC Excess Insurance Authority (hereinafter referred to as "Agreement"), and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **Annual Premium.** The participating members, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Excess Workers' Compensation Program (hereinafter referred to as the "Program"). Annual premiums shall include expected losses for the policy period, including incurred but not reported losses (IBNR), as well as a margin for contingencies based upon a confidence level as determined by the Board of Directors of the Authority (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus the Authority's general expense allocated to the Program by the Board for the next policy period.

3. **Cost Allocation.** Each participating member's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the members participating in the Program.

4. **Dividends and Assessments.** The Program shall be funded in accordance with paragraph 2 above. In general, the annual premium, as determined by the Board, will be established at a level which will provide adequate overall funding without the need for adjustments to past policy period(s) in the form of dividends and assessments. However, should the Program for any reason not be adequately funded, except as otherwise provided herein, pro-rata assessments to the participating members may be utilized to ensure the approved funding level for those policy periods individually or for a block of policy periods, in accordance with the provisions of Article 14(b)(3) of the Agreement. Pro-

rata dividends will be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **Closure of Policy Periods.** Notwithstanding any other provision of this Memorandum, the following provisions are applicable:

(a) Upon reaching ten (10) years of maturity after the end of a program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods except as set forth in paragraph 6(a), below;

(b) Notwithstanding sub-paragraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments (other than as outlined in paragraph 6(a), below) shall be administered to the participating members based upon the proportion of premiums paid to the Program in "open" periods only. For purposes of administering dividends and assessments pursuant to this sub-paragraph, all "open" policy periods shall be considered as one block. New members to the Program shall become eligible for dividends and assessments upon participating in the Program for three consecutive policy periods (not less than 24 months). Participating members who withdraw from the Program prior to the three year policy period restriction are still eligible for any assessments that arose out of the policy years they participated in the Program.

6. **Declaration of Dividends.** Dividends shall be payable from the Program to a participating member in accordance with its proportionate funding to the Program during all "open" policy periods except as follows:

(a) A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level. This dividend shall be distributed based upon each member's proportionate share of assessment paid and accrued to the policy period being closed.

7. **Memorandum of Coverage.** A Memorandum of Coverage will be issued by the Authority evidencing membership in the Program and setting forth terms and conditions of coverage.

8. **Claims Administration.** Each participating member is required to comply with the Authority's Underwriting and Claims Administration Standards (including Addendum A - W.C. Claims Administration Guidelines) as amended from time to time, and which are attached hereto as Exhibit B and incorporated herein.

9. **Late Payments.** Notwithstanding any other provision to the contrary regarding late payment of invoices or cancellation from a Program, at the discretion of the Executive Committee, any member that fails to pay an invoice when due may be given a ten (10) day written notice of cancellation.

10. **Disputes.** Any question or dispute with respect to the rights and obligations of the parties to this Memorandum regarding coverage shall be determined in accordance with the Joint Powers Agreement Article 31, Dispute Resolution.

11. **Amendment.** This Memorandum may be amended by two-thirds of the CSAC Excess Insurance Authority's Board of Directors and signature on the Memorandum by the member's designated representative who shall have authority to execute this Memorandum. Should a member of the Program fail to execute any amendment to this Memorandum within the time provided by the Board, the member will be deemed to have withdrawn as of the end of the policy period.

12. **Complete Agreement.** Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

13. **Severability.** Should any provision of this Memorandum be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

14. **Effective Date.** This Memorandum shall become effective on the effective date of coverage for the member and upon approval by the Board of any amendment, whichever is later.

15. **Execution in Counterparts.** This Memorandum may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Memorandum as of the date set forth below.

Dated: 3/6/2009

CSAC Excess Insurance Authority

Dated: _____

_____

Member Entity: _____

EXHIBIT A

EXCESS WORKERS' COMPENSATION PROGRAM
COST ALLOCATION PLAN

As delegated by the Board of Directors, the Executive Committee will determine the specific allocation of all costs among the members subject to the following parameters:

Actuarial Analysis

An annual actuarial analysis will be performed using loss data and payroll collected from the members. The analysis will determine the necessary funding rates at various confidence levels and using various discount assumptions. Different rates may be developed for different groups or classes of business as is deemed necessary or appropriate by the Executive Committee. At the March Board meeting, the Board of Directors will select the funding level rates and discount factors to be used based upon the actuarial analysis and recommendations from the actuary, the Underwriting Committee and the Executive Committee.

Pool Contributions

The total needed deposit pool contribution will be determined by multiplying the rates described above by the payroll for all of the members participating in the pool. Estimated payroll for the year being funded will be used. The Executive Committee may break the pool into different layers for allocation purposes, and may apply a different loss experience modification for each layer as is deemed appropriate based on loss frequency. In general, the lower layers will be subject to greater experience modification and the higher layers will be subject to lower experience modification or no experience modification. Within the layers, the larger members will be subject to greater experience modification than the smaller members. After the experience modification has been applied for each layer, there will be a pro-rata adjustment back to the total needed deposit pool contribution. This amount will be collected from the members at the beginning of the policy period. The actual payroll for the period will be determined after the completion of the policy period and an adjustment to each member's pool contribution will be made to account for the difference between the estimated and actual payroll. Additional contributions will be collected or return contributions will be refunded as appropriate.

Reinsurance Premiums

The reinsurance premium will be determined through negotiations with the reinsurer(s) and approved by the Board upon recommendation of the

Underwriting and Executive Committees. This premium will then be allocated among the members based upon their estimated payroll. Adjustments will be made based on the actual payroll upon completion of the policy period in the same manner as described in the Pool Contribution section above.

EIA Administration Fees

The total EIA Administration Fees will be determined through the annual budgeting process with an appropriate amount allocated to the Excess Workers' Compensation Program. These fees will be allocated among the members as determined by the Executive Committee. In general, the basis for this allocation will be each member's percentage of the total pool contributions and reinsurance premium.

Deviation From the Standard

The Executive Committee may establish policies to deviate from the standard allocation methodology selected for each year on a case-by-case basis, if necessary. They may also elect to further delegate some or all of the decision-making authority described herein to the Underwriting Committee.

Exhibit B

Adopted:	December 6, 1985
Amended:	January 23, 1987
Amended:	October 6, 1995
Amended:	October 1, 1999
Amended:	October 3, 2003
Amended:	October 1, 2004
Amended:	March 6, 2009

CSAC EXCESS INSURANCE AUTHORITY
UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS

I. GENERAL

A. Each Member shall appoint an official or employee of the Member to be responsible for the risk management function and to serve as a liaison between the Member and the Authority for all matters relating to risk management.

B. Each Member shall maintain a loss prevention program and shall consider and act upon all recommendations of the Authority concerning the reduction of unsafe conditions.

II. EXCESS WORKERS' COMPENSATION PROGRAM

A. Members of the Excess Workers' Compensation Program, except those members of the Primary Workers' Compensation Program whose responsibilities are outlined in Section IV below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its workers' compensation claims. At least one person in the claims office (whether in-house or outside administrator) shall be certified by the State of California as a qualified administrator of self-insured workers' compensation plans.

2. Qualified defense counsel experienced in workers' compensation law and practice shall handle litigated claims. Members are encouraged to utilize attorneys who have the designation "Certified Workers' Compensation Specialist, the State Bar of California, Board of Legal Specialization".

3. The Member shall use the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) and shall advise its claims administrator that these guidelines are utilized in the Authority's workers' compensation claims audits.

B. The Member shall provide the Authority written notice of any potential excess workers' compensation claims in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of the Authority's Workers'

Compensation Claims Administration Guidelines (Addendum A) or as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) shall be performed once every two (2) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claim experience or number of large claims, or

2. There is a change of workers' compensation claims administration firms, or

3. The Member is a new member of the Excess Workers' Compensation Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. indemnity, medical, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors, Claims Review Committee, Underwriting Committee, or Executive Committee. Such records shall include both open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

III. GENERAL LIABILITY PROGRAMS

A. Members of the General Liability I or General Liability II Programs, except those members of the Primary General Liability Program whose responsibilities are outlined in Section V below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its liability claims.

2. Qualified defense counsel experienced in tort liability law shall handle litigated claims. Members are encouraged to utilize defense counsel experienced in the subject at issue in the litigation.

3. The Member shall use the Liability Claims Administration Guidelines (Addendum B) and shall advise its claims administrator that these guidelines are utilized in the Authority's liability claims audits.

B. The Member shall provide the Authority written notice of any potential excess liability claim in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of the Authority's Liability Claims Administration Guidelines (Addendum B) or as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

2. There is a change of liability claims administration firms, or

3. The Member is a new member of the General Liability I or General Liability II Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

IV. PRIMARY WORKERS' COMPENSATION PROGRAM

A. Members of the Primary Workers' Compensation Program shall provide the third party administrator written notice of any claim in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary Workers' Compensation Program and that claims are administered in accordance with the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A).

C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) is performed once every two (2) years.

D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

V. PRIMARY GENERAL LIABILITY PROGRAM

A. Members of the Primary General Liability Program shall provide the third party administrator written notice of any claim or incident in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary General Liability Program and that claims are administered in accordance with the Authority's Liability Claims Administration Guidelines (Addendum B).

C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) is performed once every two (2) years.

D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

VI. PROPERTY PROGRAM

A. Members of the Property Program shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Such records shall be provided to the Authority or its brokers as requested by the Executive or Property Committees.

B. Each Member shall perform a real property replacement valuation for all locations over $250,000. Valuations shall be equivalent to the Marshall Swift system and shall be performed at least once every five (5) years. New members shall have an appraisal or valuation performed within one year from entry into the Program.

VII. MEDICAL MALPRACTICE PROGRAM

A. Program I

1. Members of Medical Malpractice Program I (hereinafter Program I) shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

    a. Members of Program I shall use only qualified personnel to administer its health facility claims.

    b. Qualified defense counsel experienced in health facility law shall handle litigated claims.

    c. Members of Program I shall use the "Claims Reporting and Handling Guidelines" in the CSAC Excess Insurance Authority Medical Malpractice Program Operating and Guidelines Manual (hereinafter Operating and Guidelines Manual), and shall advise its claims administrator that these claims handling guidelines are utilized in the Authority's medical malpractice claims audits.

2. Members of Program I shall provide the Authority written notice of any potential excess claim or "major incident" in accordance with the requirements of the Authority and of the excess carrier as stated in the Operating and Guidelines Manual. Updates on such claims or major incidents shall be provided as requested by the Authority.

3. A claims administration audit utilizing the Authority's Claims Reporting and Handling Guidelines in the Operating and Guidelines Manual shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

    a. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

    b. There is a change of health facility claims administration firms, or

    c. The Member is a new member of the Medical Malpractice Program, or

d. The Medical Malpractice Committee requests an audit. The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

4. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

5. Members of Program I shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

B. Program II

1. For Medical Malpractice Program II (hereinafter Program II) Members, the Authority shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member. The Authority may contract with a third party administrator for handling of such claims.

2. The Authority shall be responsible for ensuring the third party administrator uses qualified personnel to administer Program II claims.

3. The Authority shall be responsible for ensuring qualified defense counsel experienced in health facility law shall handle litigated claims.

4. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Claims Reporting and Handing Guidelines in the Operating and Guidelines Manual shall be performed once every two (2) years.

The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be

addressed by the third party administrator and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

5. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

VIII. SANCTIONS

A. The Authority shall provide the Member written notification of the Member's failure to meet any of the above-mentioned standards or of other concerns, which affect or could affect the Authority.

B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of the Authority's notification.

C. After approval by the Executive or applicable Program Committee of the Member's corrective program, the Member shall implement the approved program within ninety (90) days. The Member may request an additional sixty (60) days from the Executive or applicable Program Committee. Further requests for extensions shall be referred to the Board of Directors.

D. Failure to comply with subsections B or C may result in cancellation of the Member from the affected Authority Program in accordance with the provisions in the Joint Powers Agreement.

E. Notwithstanding any other provision herein, any Member may be canceled pursuant to the provision of the Joint Powers Agreement.

ADDENDUM TO EXHIBIT B

Adopted:	December 6, 1985
Amended:	March 4, 1988
Amended:	October 7, 1988
Amended:	October 6, 1995
Amended:	October 1, 1999
Amended:	June 6, 2003
Amended:	March 2, 2007
Amended:	July 1, 2009

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority (hereinafter The Authority or the EIA) in accordance with Article 18(b) of the CSAC Excess Insurance Authority Joint Powers Agreement. It is the intent of these Guidelines to comply with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Guidelines, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIM HANDLING - ADMINISTRATIVE

A. Case Load

1. On or after July 1, 2007, the claims examiner assigned to the Member shall handle a targeted caseload of 150 but not to exceed 175 indemnity claims. This caseload shall include future medical cases with every 2 future medical cases counted as 1 indemnity case.

2. Supervisory personnel should not handle a caseload, although they may handle specific issues.

B. Case Review and Documentation

1. Documentation should reflect any significant developments in the file and include a plan of action. The examiner should review the file at intervals not to exceed 45 calendar days. Future medical files should be reviewed at intervals not to exceed 90 calendar days. The supervisor shall monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days. An accomplishment level of 95% shall be considered acceptable.

2. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. An accomplishment level of 95% shall be considered acceptable.

3. All medical-only cases shall be reviewed for potential closure or transfer to an indemnity examiner within 90 calendar days following claim file creation. An accomplishment level of 95% shall be considered acceptable.

C. Communication

1. Telephone Inquiries

Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts. An accomplishment level of 95% shall be considered acceptable.

2. Incoming Correspondence

All correspondence received shall be clearly stamped with the date of receipt. An accomplishment level of 95% shall be considered acceptable.

3. Return Correspondence

All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt. An accomplishment level of 95% shall be considered acceptable.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid appropriately. Balancing is defined as, "an accounting of the periods and amounts due in comparison with what was actually paid". An accomplishment level of 95% shall be considered acceptable.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file.

II. CLAIM CREATION

A. Three Point Contact

Three point contact shall be conducted with the injured worker, employer representative and treating physician within 3 working days of receipt of the claim by the third party administrator or self administered entity. If a nurse case manager is assigned to the claim, initial physician contact may be conducted by either the claims examiner or the nurse case manager. In the event a party is non-responsive, there should be evidence of at least three documented attempts to reach the individual. Medical-only claims shall have this three point contact requirement as well. An accomplishment level of 95% shall be considered acceptable.

B. Compensability

1. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination shall be made and documented in the file within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received by the third party administrator or self administered entity within 14 calendar days of the filing of the claim with the employer, the third party administrator or self administered entity shall make the initial compensability determination within 7 calendar days of receipt of the claim. An accomplishment level of 100% shall be considered acceptable.

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self administered entity timely to comply with DWC guidelines, the third party administrator or self administered entity shall mail the benefit letters within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form. An accomplishment level of 100% shall be considered acceptable.

C. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established at the most probable case value. An accomplishment level of 95% shall be considered acceptable.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim. An accomplishment level of 95% shall be considered acceptable.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self administered entity is not notified of the injury and disability within 14 calendar days of the employer's knowledge, the third party administrator or self administered entity shall make payment within 7 calendar days of notification. Initial permanent disability payments shall be issued within 14 calendar days after the date of last payment of temporary disability. This shall not apply with salary continuation. An accomplishment level of 100% shall be considered acceptable.

b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

c. Self imposed penalty shall be paid on late payments in accordance with Section III. A. 7 of this document. An accomplishment level of 100% shall be considered acceptable.

d. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self administered entity shall request reimbursement of overpaid

funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim. An accomplishment level of 95% shall be considered acceptable.

2. Subsequent Temporary and Permanent Disability Payments

   a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability. An accomplishment level of 100% shall be considered acceptable.

   b. Self imposed penalty shall be paid on late payments in accordance with Section III.A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

3. Final Temporary and Permanent Disability Payments

   a. All final indemnity payments shall be issued timely and the appropriate DWC benefit notices sent. An accomplishment level of 100% shall be considered acceptable.

   b. Self imposed penalty shall be paid on late payments in accordance with Section III.A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

4. Award Payments

   a. Payments on undisputed Awards, Commutations, or Compromise and Releases shall be issued within 10 calendar days following receipt of the appropriate document. An accomplishment level of 95% shall be considered acceptable.

   b. For all excess reportable claims, copies of all Awards shall be provided to the Authority at time of payment. An accomplishment level of 95% shall be considered acceptable.

5. Medical Payments

   a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness,

approved for payment and paid within 60 working days of receipt. An accomplishment level of 100% shall be considered acceptable.

b. The medical provider must be notified in writing within 30 working days of receipt of an itemized bill if a medical bill is contested, denied or incomplete. An accomplishment level of 100% shall be considered acceptable.

c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement. An accomplishment level of 95% shall be considered acceptable.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel. An accomplishment level of 95% shall be considered acceptable.

7. Penalties

a. Penalties shall be coded so as to be identified as a penalty payment. An accomplishment level of 100% shall be considered acceptable

b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis. An accomplishment level of 95% shall be considered acceptable.

c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process. An accomplishment level of 100% shall be considered acceptable.

2. Disputes regarding spine surgery shall be resolved using the process set forth in Labor Code Section 4062(b). An accomplishment level of 100% shall be considered acceptable.

3. Nurse case managers shall be utilized where appropriate. An accomplishment level of 95% shall be considered acceptable.

4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented. An accomplishment level of 100% shall be considered acceptable.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued. An accomplishment level of 100% shall be considered acceptable.

D. Disability Management

1. The third party administrator or self administered entity shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The TPA or self-administered entity shall notify a designated Member representative immediately upon receipt of temporary work restrictions or a release to full duty, and work closely with the Member to establish a return to work as soon as possible. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work. An accomplishment level of 100% shall be considered acceptable.

3. If there is no response within20 calendar days, the third party administrator or self administered entity shall follow up with the

designated Member representative. An accomplishment level of 100% shall be considered acceptable.

4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1 which requires an interactive process with the injured worker when addressing a return to work with permanent work restrictions.

5. Third party administrators or self administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Vocational Rehabilitation/Supplemental Job Displacement Benefits

1. Vocational Rehabilitation – Dates of injury prior to 1/1/04: Benefits pursuant to Labor Code Section 139.5 shall be timely provided. An accomplishment level of 100% shall be considered acceptable.

2. Supplemental Job Displacement Benefits – Dates of injury 1/1/04 and after: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. An accomplishment level of 100% shall be considered acceptable.

3. The third party administrator or self administered entity shall secure the prompt conclusion of vocational rehabilitation/SJDB and settle where appropriate. An accomplishment level of 95% shall be considered acceptable.

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g., surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. An accomplishment level of 95% shall be considered acceptable.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately. An accomplishment level of 100% shall be considered acceptable.

3. Permanent disability indemnity exposure shall include life pension reserve if appropriate. An accomplishment level of 100% shall be considered acceptable.

4. Future medical claims shall be reserved in compliance with SIP regulation 15300 allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy. An accomplishment level of 100% shall be considered acceptable.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall take appropriate action to finalize the claim. An accomplishment level of 95% shall be considered acceptable.

2. Settlement value shall be documented appropriately utilizing all relevant information. An accomplishment level of 95% shall be considered acceptable.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of the Authority without the advance written consent of the Authority. An accomplishment level of 100% shall be considered acceptable.

2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual contract between the Member and the claims administrator. An accomplishment level of 100% shall be considered acceptable.

IV. LITIGATED CASES

The third party administrator or self administered entity shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the guidelines".

A. Defense of Litigated Claims

1. The third party administrator or self administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. (Note: If a Member is a County, to comply with Government Code Section 25203, the Member's list should be approved by a two-thirds vote of the governing board.) An accomplishment level of 95% shall be considered acceptable.

3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal. An accomplishment level of 95% shall be considered acceptable.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense. An accomplishment level of 95% shall be considered acceptable.

5. The third party administrator or self administered entity shall comply with any reporting requirement of the Member. An accomplishment level of 95% shall be considered acceptable.

B. Subrogation

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board

(or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. An accomplishment level of 95% shall be considered acceptable.

2. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled. An accomplishment level of 95% shall be considered acceptable.

3. The file shall be monitored to determine the need to file a complaint in civil court in order to preserve the statute of limitations. An accomplishment level of 95% shall be considered acceptable.

4. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action. An accomplishment level of 95% shall be considered acceptable.

5. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments. An accomplishment level of 95% shall be considered acceptable.

V. EXCESS COVERAGE

A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to the Authority within 5 working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through the EIA website. An accomplishment level of 100% shall be considered acceptable.

B. Subsequent reports shall be transmitted to the Authority on a quarterly basis on indemnity claims and on a semi-annual basis on future medical claims sooner if claim activity warrants, or at such other intervals as requested by the Authority, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form available through the EIA website, or a comparable form to be approved by the Authority. An accomplishment level of 95% shall be considered acceptable.

C. Reimbursement requests should be submitted in accordance with the Authority's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement Procedures available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to the Authority. An accomplishment level of 95% shall be considered acceptable.

BOARD OF GOVERNORS
KERN COUNTY HOSPITAL AUTHORITY REGULAR MEETING
Agenda Item 8

March 30, 2016

SUBJECT: Kern Medical Foundation

Recommended Action: Hear Presentation; Receive and File.

Erica Easton, Executive Director, will provide the Board will a brief overview and background of the Kern Medical Foundation. The presentation will include highlights of the projects that have been funded over the past year, as well as future plans for the Foundation.

KernMedical

April 5, 2016

Members, Board of Supervisors
County Administrative Center
1115 Truxtun Avenue
Bakersfield, CA 93301

Re: Approve Initial Appointment of Russell V. Judd as Chief Executive Officer of Kern County Hospital Authority

Dear Honorable Chairman and Members:

The Kern County Hospital Authority Board of Governors respectfully requests that your Board approve the initial appointment of Russell V. Judd as Chief Executive Officer of the Kern County Hospital Authority, which includes Kern Medical Center. On March 16, 2016, the Board of Governors convened to discuss and recommend appointment of a Chief Executive Officer of the Hospital Authority. By unanimous vote of those Directors present, Mr. Judd was recommended for appointment. The applicable legal authority for your Board's approval is set forth below.

1. **Kern County Hospital Authority Act**

Pursuant to the Kern County Hospital Authority Act (Health & Saf. Code, § 101852 et seq.), the California Legislature authorized the County of Kern to establish the Kern County Hospital Authority ("Hospital Authority") and to transfer the ownership, control, management, and operation of Kern Medical Center to the Hospital Authority. Health and Safety Code section 101855(a)(6) provides that the Hospital Authority may *"appoint and employ or otherwise engage a chief executive officer...."*

2. **County Ordinance**

A. Background: On October 6, 2015, your Board enacted Ordinance No. A-356 that adds Chapter 2.170 to Title 2 of the Ordinance Code of the County of Kern ("Ordinance") concerning the creation of the Hospital Authority. The Ordinance was effective on November 6, 2015.
B. Section 2.170.070: Section 2.170.070 of the Ordinance titled *Powers of Hospital Authority* provides that, upon the creation of the Hospital Authority, prior to and subsequent to the transfer of the Kern Medical Center, the Hospital Authority shall have the power to "*appoint and employ or otherwise engage a chief executive officer....*"
C. Section 2.170.080: Section 2.170.080 of the Ordinance titled *Board of Supervisors: Role, Approvals* provides that the *"Board of Supervisors shall approve the initial and any successive Chief Executive Officer of the Hospital Authority prior to his or her appointment by the Hospital Authority."*

3. **Hospital Authority Bylaws for Governance**

The Hospital Authority Bylaws for Governance ("Bylaws") provide that the Board of Governors *"shall appoint a competent and experienced Chief Executive Officer, subject to the prior approval by the Board of Supervisors, to have responsibility for the general management of the Hospital Authority."* (Bylaws, section 5.01(a).) *"The Board of Supervisors shall approve the initial and any successive chief executive officer of the Hospital Authority…."* (Bylaws, section 2.13(3).)

Therefore, it is recommended that your Board approve the initial appointment of Russell V. Judd as Chief Executive Officer of the Kern County Hospital Authority, effective immediately.

Sincerely,

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

cc: Members, Board of Governors
Russell V. Judd
Office of County Counsel
County Administrative Office
Clerk of the Board of Supervisors