TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 23, 2017 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: CNA		
	b. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) (3 Matters)		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. Reports Involving Trade Secrets: New Facilities; Conference with Real Property Negotiators (Authority: Health and Safety Code, Section 32106, Gov. Code Section 54956.8) Property: 4002 Vista Way, Oceanside, CA 92056 Agency Negotiator: Steve Dietlin Negotiating Parties: Tri-City Healthcare District and United States Under Negotiation: Development program Date of disclosure: February 28, 2017		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	e. Approval of prior Closed Session Minutes		
	f. Public Employee Evaluation: General Counsel (Authority: Government Code, Section 54957)		
	g. Public Employee Evaluation: Chief Compliance Officer (Authority: Government Code, Section 54957)		
	h. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (2) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523 (3) Larry Anderson Employment Claims (4) SEIU-UHW v. Tri-City Healthcare District PERB Case Number LA-CE-1079-M		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Community Update – 1) Accountable Care Organization (ACO) Report – Wayne Knight, Chief Strategy Officer	10 min.	CSO
13	Report from TCHD Foundation– Glen Newhart, Chief Development Officer	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Acting Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Consideration to approve a Physician Recruitment Agreement with Dr. Geehan D'Souza – Wayne Knight, Chief Strategy Officer	5 min.	CSO
	b. Consideration to engage Moss Adams to conduct the Fiscal Year 2017 Financial Statement Audit	10 min.	ACE Comm.

	Agenda Item	Time Allotted	Requestor
	c. Consideration of North County Back Pack Program for North County Schools	15 min.	Chair
	d. Consideration to appoint Director Leigh Anne Grass to the Employee Fiduciary Subcommittee	3 min.	HR Comm.
	e. Consideration to appoint Ms. Robin Iveson to a two-year term on the Governance & Legislative Committee	3 min.	Gov. & Leg. Comm.
	f. Consideration to appoint Ms. Faith Devine to a two-year term on the Audit, Compliance & Ethics Committee	3 min.	ACE Comm.
17	Old Business a. Report from Ad Hoc Committee on electronic Board Portal	10 min.	Ad Hoc. Comm.
18	Chief of Staff a. Consideration of February 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals b. Privilege Cards: 1) Neonatology 2) Orthopedic Tech	5 min.	Standard
19	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *(Committee minutes* distributed *at Dias due to meeting date)* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *(Committee minutes distributed at Dias due to meeting date)* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 3 *(Committee minutes included in Board Agenda packets for informational purposes)* **D. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* a. Review of Board Policy 15-013 - Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	and Equipment, Procurement of Professional Services and Bidding for Public Works Contracts b. Approval of an agreement with Dr. Alexander Khalessi to join the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning February 1, 2017 through January 31, 2018 c. Approval of an agreement with Dr. Kalyani Korbathina to join the currently existing ED On Call Coverage Panel for Neurology for a term of 12 months, beginning February 1, 2017 through January 31, 2018. d. Approval of the publicly bid agreement with McCoy Design & Construction for $76,197 and the purchase of equipment to replace the lights in operating room 2, for a total expected project cost of $365,828. e. Approval of an agreement with Key Healthcare Consulting, LLC for Charge Entry for a term of 36 months beginning March15, 2017 through March 14, 2020 for an expected annual cost of $285,492 and an expected total cost for the term of $856,476. f. Approval of an agreement with Dr. Sharon Slowik as the Coverage Physician for a term of 24 months, beginning July 1, 2017 through June 30, 2019, not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404.40 and a total cost for the term of $133,808.80 g. Approval of an agreement with Dr. Neil Richtand as the Medical Director of the BHU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of 75,600 and a term cost of $81,900. h. Approval of an agreement with Dr. Neil Richtand as the Medical Director for the CSU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of $75,600 and a term cost of $81,900. i. Approval of the addition of responsibilities to the current Medical Director of Rehabilitation Services contract, with no additional cost.		
E.	**Professional Affairs Committee** Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **1) <u>Patient Care Services</u>** a) Child Passenger Restraint System Education Policy b) Diabetes Education Procedure c) In Custody Patients' Policy d) Knee Immobilizer Application and Range of Motion		PAC

	Agenda Item	Time Allotted	Requestor
	(ROM) Brace Procedure e) Swallow Screening in the Adult Patient Procedure **2) <u>Unit Specific</u>** **A. <u>Infection Control</u>** 1) Transmissible Spongiform Encephalopathies (TSE) **B. <u>Surgical Services</u>** 1) Block Time Policy 2) Bumping Surgery Procedures Policy 3) Disaster and Emergency Preparedness Policy 4) OR Committee Policy 5) Pre-Operative Requirements Policy 6) Safe Medical Device Act – Tracking and Reporting Policy 7) Scheduling Surgical Procedures Policy 8) Scope of Service for Surgical Services Policy **C. <u>Telemetry</u>** 1) Assignments **D. <u>Women and Newborn Services</u>** 1) Hydralazine Hydrochloride 2) Neonatal Team Attendance at a Delivery 3) Standards of Care: Newborn 4) Standards of Care: Postpartum		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 2 *(Committee minutes included in Board Agenda packets for informational purposes)* 1. Medical Staff Rules & Regulations: a) Division of Podiatric Surgery b) Department of Medicine c) Division of Neonatology d) Department of Emergency Medicine 2. Approval of Committee Charter: a) Governance & Legislative Committee 3. Approval of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings		Gov. & Leg. Comm.
	G. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **<u>Approval of Administrative Compliance Policies & Procedures</u>**:		Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	a) 8750-537 - Hiring and Employment: Definitions (DELETED) b) 8750-539 – Screening Covered Contractors c) 8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors d) 8750-541 – Conviction/Exclusion/License Revocation of Current Covered Contractors(DELETED) e)8750-542 – Covered Contractor Requirements to Report Changes in Certification (DELETED) f) 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and/or Policies (2) Minutes – Approval of: a) Regular Board of Directors Meeting – January 26, 2017 b) Special Board of Directors Meeting – February 7, 2017 (3) Meetings and Conferences – a) AHA Annual Meeting – Washington, D.C. – May 7-10, 2017 (4) Dues and Memberships - NONE		Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (January, 2017) (d) Reimbursement Disclosure Report – (January, 2017) (e) Seminar/Conference Reports: 1) Director Nygaard – ACHD 2) Director Grass - ACHD	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2.5 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
Physician Recruitment Proposal – Geehan D'Souza, M.D.

Type of Agreement		Medical Directors		Panel	X	Other: Recruitment Agreement
Status of Agreement	X	New Agreement		Renewal		

Physician Name: Geehan D'Souza, M.D.
Areas of Service: Plastic Surgery
Key Terms of Agreement:

Effective Date:	August 1, 2017 or the date Dr. D'Souza becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
Community Need:	TCHD Physician Needs Assessment shows significant community need for Plastic Surgery
Income Guarantee:	Not to exceed a two-year income guarantee with loan to be forgiven over a three-year forgiveness period provided physician continues to practice within service area
Service Area:	Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
Income Guarantee:	$390,000 (year 1) + $195,000 (Year 2) = $585,000 Total
Incremental Start-Up:	$ 50,000 (with receipts)
Total Loan Amount:	$635,000 (Not To Exceed)
Relocation Expense:	$ 2,500 (with receipts – not part of loan)
Total Expenditure:	$637,500 (Not To Exceed)

Unique Features: Geehan D'Souza M.D. is currently looking for suitable Medical Office space to practice his unique skill in plastic surgery having recently completed his Fellowship training at Cleveland Clinic.

Requirements:

Business Pro Forma: Must submit a two-year business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental expenses and income. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

Expenses: The agreement specifies categories of allowable professional expenses (expenses associated with the operation of physician's practice and approved at the sole discretion of TCHD) such as billing, rent, medical and office supplies, etc. If the incremental monthly expenses exceed the maximum, the excess amount will not be included.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Wayne Knight, Chief Strategy Officer

Motion:

Move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $637,500 in order to facilitate this plastic surgeon practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee) with Geehan D'Souza, M.D.

Gehaan D'Souza, MD

PERSONAL INFORMATION

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Anaheim, CA 92808
Phone: 7145956589
Email gehaan@gmail.com

DATE OF BIRTH: June 20, 1982

PLACE OF BIRTH: Bombay, India

CITIZENSHIP: United States of America

MEDICAL LISCENSE: California: A111406
Nebraska: 6215
Ohio: 127776

EDUCATION

HIGH SCHOOL EDUCATION

6/1996-6/2000 **Canyon High School,** Anaheim, CA
- Valedictorian

UNDERGRADUATE EDUCATION

6/2000-6/2004 **Johns Hopkins University**, Baltimore, MD
- B.S. Molecular Biology
- High Honors

POST GRADUATE TRAINING

6/2016 – 6/2017 **Cleveland Clinic, Division of Plastic Surgery**, Cleveland, OH
- Plastic Surgery –Aesthetic Fellowship Chief: James Zins

6/2013 – 6/2016 **University of California, San Diego, Division of Plastic Surgery**, San Diego, CA
- Plastic Surgery PGY 6-8
- Chief: Marek Dobke
- Program Director: Amanda Gosman
-

6/2010 – 6/2013 **University of Nebraska, Department of Surgery**, Omaha, Nebraska
- General Surgery PGY 3 - 5
- Chairman: David Mercer
- Program Director: Chandrakanth Are

6/2008-6/2010 **University of California, Irvine, Department of Surgery**, Irvine, CA
- General Surgery PGY 1 & 2 Years Completed
- Chairman: David Hoyt/Michael Stamos
- Program Director: Matthew Dolich

6/2004-6/2008 **University of California, Irvine, School of Medicine**, Irvine, CA
- Degree – M.D. - Distinction/Honors - Research

PUBLICATIONS:

REFEREED ORIGINAL ARTICLES

Brown J, **D'Souza GF**. 100 Case Reviews in Neurosurgery. Median Nerve Injury. Accepted for Publication.

Brown J, **D'Souza GF**. 100 Case Reviews in Neurosurgery. Radial Nerve Injury. Accepted for Publication.

DSouza GF, Gosman A. Evaluation of an Academic Resident Aesthetic Clinic from Perspective of Patient and Resident. Plastic Reconstructive Surg. 2015 Oct; 136 (4 Suppl):122-3.

D'Souza GF, Qiu F, Ly Q. Tumor Characteristics Influence the Reconstructive Surgical Decision Making of Breast Carcinoma Patients. Journal of Surgical Oncology. Submitted for Publication.

Tenenhaus M, **D'Souza GF**. Wound Healing Biomaterials: Therapies and Regeneration. Journal Lower Extremity Wounds. 2014 Dec; 13 (4):335-46

D'Souza GF, Abdessalam S. Volvulus of the Appendix: A Case Report. Journal of Pediatric Surgery. 46:8 e63, 2011.

D'Souza GF, Evans GR. *Mexoryl:* A Review of an Ultraviolet A Filter. Plastic and Reconstructive Surgery. Plastic Reconstructive Surg. 2007 Sep 15; 120(4):1071-5.

D'Souza GF, Milliken JC. Patent Ductus Arteriorus. E-medicine. Cardiology, Website Publication. (2007, February 17).

D'Souza GF, Milliken JC. Ventricular Septal Defect. E-medicine. Cardiology, Website Publication. (2007, February 17).

WenLian X, Dunn CA, Jones CR, **D'Souza GF**, Bessman MJ. The 26 Nudix Hydrolases of Bacillus Cereus: A Close Relative of Bacillus Anthracis. Journal of Biological Chemistry. 2004 Jun 4; 279(23):24861-5

ABSTRACTS

D'Souza GF, Reid C, Gosman A. The Process for Rhinoplasty in a Resident Aesthetic Clinic: Optimizing Outcomes and Satisfacation. California Society Plastic Surgery Meeting. Publication. 2016.

D'Souza GF, Gosman A. Evaluation of an Academic Resident Aesthetic Clinic from Perspective of Patient and Resident. UCSD Department of Surgery Research Symposium Publication. 2015.

D'Souza GF, Baker J, Mailey M, Hosseini A, Wallace A. Acellular Dermal Matrix Increases Complications in Breast Reconstructive Patients. Annals of Plastic Surgery. 2014.

D'Souza GF, Qiu F, Ly Q. Tumor Characteristics Influence the Reconstructive Surgical Decision Making of Breast Carcinoma Patients. Journal of Surgical Research. 41:138-139. 2011.

D'Souza GF, Qiu F, Ly Q. Influence of Tumor Characteristics in the Surgical Decision Making of Breast Cancer Patients. Journal of Women's Health. 42:310. 2011.

D'Souza GF, Evans GR, Dhar S. Gankyrin in Breast Cancer Biology. Journal of Investigative Medicine. Volume 55:52, 2007.

D'Souza GF, Evans GR, Dhar S. Significance of Gankyrin in Breast Cancer Biology. Transactions of the Plastic Surgery Research Council. 51(1): 183, 2006.

PRESENTATIONS/POSTER SESSIONS

D'Souza GF (2016 June). The History of the Rhytidectomy.

D'Souza GF, Reid C, Gosman A. The Process for Rhinoplasty in a Resident Aesthetic Clinic: Optimizing Outcomes and Satisfacation. California Society Plastic Surgery Meeting. Publication. 2016.

D'Souza GF, Qiu F, Ly Q (2016 May). Tumor Characteristics Influence the Reconstructive Surgical Decision Making of Breast Carcinoma Patients. Academic Surgical Congress. Oral Presentation: Academic Surgical Congress. Jacksonville, FL.

D'Souza GF, Gosman A (2015 October). Evaluation of an Academic Resident Aesthetic Clinic from Perspective of Patient and Resident. UCSD Department of Surgery Research Symposium.
Oral Presentation: American Society of Plastic Surgery. Boston, MA.

D'Souza GF (2015 June). Orthognathic Surgery of the Mandible.

Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza, GF (2015 March) Facial Aesthetic Analysis.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza, GF (2014 July) Facial Reconstruction.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 July) Flaps and Grafts.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 August) Microsurgery.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 August) Flaps of the Lower Extremity.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 July) Non-Surgical Facial Rejuvenation.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 September) Breast Cancer – New Frontiers.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF (2014 April) Lower Extremity Reconstruction.
Oral Presentation: University of California, San Diego, Plastic Surgery, Grand Rounds. San Diego, CA.

D'Souza GF, Baker, J, Mailey, M, Hosseini, A, Wallace A (2014 May) Acellular Dermal Matrix Increases Complications in Breast Reconstructive Patients.
Oral Presentation: California Society of Plastic Surgery. Newport Beach, CA.

D'Souza GF, Qiu F, Ly Q. (2011, April) Influence of Tumor Characteristics in the Surgical Decision Making of Breast Cancer Patients.
Oral Presentation: Women's Health Congress. Washington, DC.

D'Souza GF (2012, October). Breast Cancer Trends,
Oral Presentation: University of Nebraska, General Surgery Grand Rounds; Omaha, NE.

D'Souza GF (2012, November). Vascular Surgery Case Presentation,
Oral Presentation: University of Nebraska, General Surgery Grand Rounds; Omaha, NE.

D'Souza GF (2007, October). The Jejunal Flap.
Oral Presentation: University of California, Irvine, Plastic Surgery, Grand Rounds. Irvine, CA.

D'Souza GF, Evans GR, Dhar S (2006 May). Significance of Gankyrin in Breast Cancer Biology.
Oral presentation: Plastic Surgery Research Council. Dana Point, CA.

D'Souza G, Evans GR, Dhar S. (2005 September). Tumor Suppressor Gene KLK10 in Breast Cancer Tissue Progression.
Poster Presentation: California Tissue Engineering Meeting, Irvine, CA.

D'Souza G, Evans GR, Dhar S. (2005, November). Significance of Gankyrin in Breast Cancer Biology.
Poster Presentation: American Medical Association; Dallas, TX.

D'Souza G. (2002, November). Mutant Parathyroid Receptor (Jensens Chronodoplaysia & Muscular Oleurism). Oral Presentation: Johns Hopkins University, School of Medicine, Department of Pediatric Endocrinology, Grand Rounds, Baltimore, MD.

PAST GRANT SUPPORT

9/2016	Allergan Resident Aesthetics Meeting Travel Award (ASAPS) $2000
8/2015	Allergan Resident Aesthetics Meeting Travel Award (ASAPS) $2000
6/2004 – 6/2005	University of California, Irvine, Deans Research Fellowship Award: Significance of Gankyrin in Breast Cancer Biology - **University of California, Irvine, School of Medicine** - $6000

AWARDS/HONORS/POSITIONS

7/2010	Top ABSITE Score in General Surgery (97 percentile), **University of California, Irvine, School of Medicine**
8/2005	Organized Research Conference with Dr. Gregory Evans & Staff **California Tissue Engineering Meeting**, Annual Meeting 2005, Irvine, California

2/2005	Tumor Suppressor Gene KLK10 in Breast Cancer Tissue Progression. **California Tissue Engineering Meeting**, Annual Meeting 2005, Irvine, California: **Poster Award**
6/2004 – 6/2005	Medical School Treasurer (American Medical Students Graduate Association), **University of California, Irvine, School of Medicine**
9/2004	Summer Research Fellowship Award, **University of California, Irvine, School of Medicine**
7/2004	Graduated with Departmental High Honors, Department of Biology, **Johns Hopkins University**, Baltimore, MD B.S. Molecular Biology
6/2004	Graduated with University High Honors, **Johns Hopkins University**, Baltimore, MD B.S. Molecular Biology
6/2003	Louis E. Goodman Award for Community Service, **Johns Hopkins University**
7/2003	Deans Academic Award, **Johns Hopkins University**
7/2003	Presidential Student Service Award, **Johns Hopkins University**
7/2000	International Baccalaureate Diploma, **Canyon High School**
7/2000	National Merit Scholar, **Canyon High School**
6/2000	Valedictorian, **Canyon High School**

REFERENCES

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February 10, 2017

Ray Rivas, Chief Financial Officer
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Re: Audit and Nonattest Services

Dear Mr. Rivas:

Thank you for the opportunity to provide services to Tri-City Healthcare District. This engagement letter ("Engagement Letter") and the attached Professional Services Agreement, which is incorporated by this reference, confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Moss Adams LLP ("Moss Adams," "we," "us," and "our") will provide to Tri-City Healthcare District ("you," "your," and "Company").

Scope of Services – Audit

You have requested that we audit the Company's consolidated financial statements, which comprise the consolidated statements of net position as of June 30, 2017, and the related consolidated statements of revenues, expenses, and changes in net position, and consolidated statements of cash flows for the year then ended, and the related notes to the consolidated financial statements. We will also report on whether the consolidating statement of net position and consolidating statement of revenues, expenses and change in net position, presented as supplementary information, is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Scope of Services and Limitations – Nonattest

We will provide the Company with the following nonattest services:

1. Assist you in drafting the consolidated financial statements and related footnotes as of and for the year ended June 30, 2017.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, Company management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.

MOSS-ADAMS LLP

- Oversee the service by designating an individual, preferably within senior management, who possesses skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.
- Accept responsibility for the results of the nonattest services performed.

It is our understanding that you have been designated by the Company to oversee the nonattest services and that in the opinion of the Company are qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

Timing

John Blakey is responsible for supervising the engagement and authorizing the signing of the report. We expect to perform our interim work during the week of May 22, 2017 and begin final audit fieldwork on approximately August 7, 2017, complete final fieldwork on approximately August 25, 2017, and issue our report no later than September 30, 2017. As we reach the conclusion of the audit, we will coordinate with you the date the audited consolidated financial statements will be available for issuance. You understand that (1) you will be required to consider subsequent events through the date the consolidated financial statements are available for issuance, (2) you will disclose in the notes to the consolidated financial statements the date through which subsequent events have been considered, and (3) the subsequent event date disclosed in the footnotes will not be earlier than the date of the management representation letter and the date of the report of independent auditors.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Fees

We estimate that our fees for the services will be $152,000. You will also be billed for expenses at our cost as they are incurred and word processing charges of $1,000.

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the Company's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the

MOSS-ADAMS LLP

engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments and/or untimely assistance will result in an increase of our fees.

Reporting

We will issue a written report upon completion of our audit of the Company's consolidated financial statements. Our report will be addressed to the Board of Directors of the Company. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your consolidated financial statements for the year ended June 30, 2017.

Additional Services

You may request that we perform additional services not contemplated by this Engagement Letter. If this occurs, we will communicate with you regarding the scope of the additional services and the estimated fees. It is our practice to issue a separate agreement covering additional services. However, absent such a separate agreement, all services we provide you shall be subject to the terms and conditions in the Professional Services Agreement.

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in the Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

John Blakey, Partner, for
Moss Adams LLP

Enclosures

MOSS-ADAMS LLP

ACCEPTED AND AGREED:

This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Tri-City Healthcare District with respect to this engagement and the services to be provided by Moss Adams LLP:

Signature: _____

Print Name: _____

Title: _____

Date: _____

Client: # 617641
v. 10/28/2016

PROFESSIONAL SERVICES AGREEMENT

Audit and Nonattest Services

This Professional Services Agreement (the "PSA") together with the Engagement Letter, which is hereby incorporated by reference, represents the entire agreement (the "Agreement") relating to services that Moss Adams will provide to the Company. Any undefined terms in this PSA shall have the same meaning as set forth in the Engagement Letter.

Objective of the Audit

The objective of our audit is the expression of an opinion on the financial statements and supplementary information. We will conduct our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). It will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

Procedures and Limitations

Our procedures may include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of certain receivables and certain other assets, liabilities and transaction details by correspondence with selected customers, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. The supplementary information will be subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves. At the conclusion of our audit, we will require certain written representations from management about the financial statements and supplementary information and related matters. Management's failure to provide representations to our satisfaction will preclude us from issuing our report.

An audit includes examining evidence, on a test basis, supporting the amounts and disclosures in the financial statements. Therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Also, we will plan and perform the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. Such material misstatements may include errors, fraudulent financial reporting, misappropriation of assets, or noncompliance with the provisions of laws or regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity that may have a direct financial statement impact. Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements and noncompliance may not be detected, even though the audit is properly planned and performed in accordance with U.S. GAAS. An audit is not designed to detect immaterial misstatements or noncompliance with the provisions of laws or regulations that do not have a direct and material effect on the financial statements. However, we will inform you of any material errors, fraudulent financial reporting, misappropriation of assets, and noncompliance with the provisions of laws or regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any time period for which we are not engaged as auditors.

Our audit will include obtaining an understanding of the Company and its environment, including its internal control sufficient to assess the risks of material misstatements of the financial statements whether due to error or fraud and to design the nature, timing, and extent of further audit procedures to be performed. An audit is not designed to provide assurance on internal control or to identify deficiencies in the design or operation of internal control. However, if, during the audit, we become aware of any matters involving internal control or its operation that we consider to be significant deficiencies under standards established by the American Institute of Certified Public Accountants, we will communicate them in writing to management and those charged with governance. We will also identify if we consider any significant deficiency, or combination of significant deficiencies, to be a material weakness.

We may assist management in the preparation of the Company's financial statements and supplementary information. Regardless of any assistance we may render, all information included in the financial statements and supplementary information remains the representation of management. We may issue a preliminary draft of the financial statements and supplementary information to you for your review. Any preliminary draft financial statements and supplementary information should not be relied upon, reproduced, or otherwise distributed without the written permission of Moss Adams.

Management's Responsibility for Financial Statements

As a condition of our engagement, management acknowledges and understands that management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America. We may advise management about appropriate accounting principles and their application and may assist in the preparation of your financial statements, but management remains responsible for the financial statements. Management also acknowledges and understands that management is responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud. This responsibility includes the maintenance of adequate records, the selection and application of accounting principles, and the safeguarding of assets. You are responsible for informing us about all known or suspected fraud affecting the Company involving: (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. You are responsible for informing us of your knowledge of any allegations of fraud or suspected fraud affecting the Company received in communications from employees, former employees, regulators or others. Management is responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole. Management is also responsible for identifying and ensuring that the Company complies with applicable laws and regulations.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. Management agrees that as a condition of our engagement management will provide us with:

- access to all information of which management is aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters;
- additional information that we may request from management for the purpose of the audit; and
- unrestricted access to persons within the Company from whom we determine it necessary to obtain audit evidence.

Management's Responsibility for Supplementary Information

Management is responsible for the preparation of the supplementary information in accordance with the applicable criteria. Management agrees to include the auditor's report on the supplementary information in any document that contains the supplementary information and that indicates that we have reported on such supplementary information. Management is responsible to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance by the entity of the supplementary information and the auditor's report thereon. For purposes of this Agreement, audited financial statements are deemed to be readily available if a third party user can obtain the audited financial statements without any further action by management. For example, financial statements on your Web site may be considered readily available, but being available upon request is not considered readily available.

Dissemination of Financial Statements

Our report on the financial statements must be associated only with the financial statements that were the subject of our engagement. You may make copies of our report, but only if the entire financial statements (including related footnotes and supplementary information, as appropriate) are reproduced and distributed with our report. You agree not to reproduce or associate our report with any other financial statements, or portions thereof, that are not the subject of this engagement.

Offering of Securities

This Agreement does not contemplate Moss Adams providing any services in connection with the offering of securities, whether registered or exempt from registration, and Moss Adams will charge additional fees to provide any such services. You agree not to incorporate or reference our report in a private placement or other offering of your equity or debt securities without our express written permission. You further agree we are under no obligation to reissue our report or provide written permission for the use of our report at a later date in connection with an offering of securities, the issuance of debt instruments, or for any other circumstance. We will determine, at our sole discretion, whether we will reissue our report or provide written permission for the use of our report only after we have conducted any procedures we deem necessary in the circumstances. You agree to provide us with adequate time to review documents where (a) our report is requested to be reissued, (b) our report is included in the offering document or referred to therein, or (c) reference to our firm is expected to be made. If we decide to reissue our report or provide written permission to the use of our report, you agree that Moss Adams will be included on each distribution of draft offering materials and we will receive a complete set of final documents. If we decide not to reissue our report or withhold our written permission to use our report, you may be required to engage another firm to audit periods covered by our audit reports, and that firm will likely bill you for its services. While the successor auditor may request access to our engagement documentation for those periods, we are under no obligation to permit such access.

Changes in Professional or Accounting Standards

To the extent that future federal, state, or professional rule-making activities require modification of our audit approach, procedures, scope of work, etc., we will advise you of such changes and the impact on our fee estimate. If we are unable to agree on the additional fees, if any, that may be required to implement any new accounting and auditing standards that are required to be adopted and applied as part of our engagement, we may terminate this Agreement as provided herein, regardless of the stage of completion.

Representations of Management

During the course of our engagement, we may request information and explanations from management regarding, among other matters, the Company's operations, internal control, future plans, specific transactions, and accounting systems and procedures. At the conclusion of our engagement, we will require, as a precondition to the issuance of our report, that management provide us with a written representation letter confirming some or all of the representations made during the engagement. The procedures that we will perform in our engagement will be heavily influenced by the representations that we receive from management. Accordingly, false representations could cause us to expend unnecessary efforts or could cause a material error or fraud to go undetected by our procedures. In view of the foregoing, you agree that we will not be responsible for any misstatements in the Company's financial statements and supplementary information that we fail to detect as a result of false or misleading representations, whether oral or written, that are made to us by the Company's management. While we may assist management in the preparation of the representation letter, it is management's responsibility to carefully review and understand the representations made therein.

In addition, because our failure to detect material misstatements could cause others relying upon our audit report to incur damages, the Company further agrees to indemnify and hold us harmless from any liability and all costs (including legal fees) that we may incur in connection with claims based upon our failure to detect material misstatements in the Company's financial statements and supplementary information resulting in whole or in part from knowingly false or misleading representations made to us by any member of the Company's management.

Fees and Expenses

The Company acknowledges that the following circumstances will result in an increase of our fees:

- Failure to prepare for the audit as evidenced by accounts and records that have not been subject to normal year-end closing and reconciliation procedures;
- Failure to complete the audit preparation work by the applicable due dates;

- Significant unanticipated transactions, audit issues, or other such circumstances;
- Delays causing scheduling changes or disruption of fieldwork;
- After audit or post fieldwork circumstances requiring revisions to work previously completed or delays in resolution of issues that extend the period of time necessary to complete the audit;
- Issues with the prior audit firm, prior year account balances or report disclosures that impact the current year engagement; and
- An excessive number of audit adjustments.

We will endeavor to advise you in the event these circumstances occur, however we may be unable to determine the impact on the estimated fee until the conclusion of the engagement. We will bill any additional amounts based on the experience of the individuals involved and the amount of work performed.

Billings are due upon presentation and become delinquent if not paid within 30 days of the invoice date. Any past due fee under this Agreement shall bear interest at the highest rate allowed by law on any unpaid balance. In addition to fees, you may be billed for expenses and any applicable sales and gross receipts tax. Direct expenses may be charged based on out-of-pocket expenditures, per diem allotments, and mileage reimbursements, depending on the nature of the expense. Indirect expenses, such as processing and copying, are passed through at our estimated clerical and equipment cost and may be charged as a flat fee. If we elect to suspend our engagement for nonpayment, we may not resume our work until the account is paid in full. If we elect to terminate our services for nonpayment, or as otherwise provided in this Agreement, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our work. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for expenses. You acknowledge and agree that in the event we stop work or terminate this Agreement as a result of your failure to pay on a timely basis for services rendered by Moss Adams as provided in this Agreement, or if we terminate this Agreement for any other reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

Limitation on Liability

IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT.

Subpoena or Other Release of Documents

As a result of our services to you, we may be required or requested to provide information or documents to you or a third-party in connection with governmental regulations or activities, or a legal, arbitration or administrative proceeding (including a grand jury investigation), in which we are not a party. You may, within the time permitted for our firm to respond to any request, initiate such legal action as you deem appropriate to protect information from discovery. If you take no action within the time permitted for us to respond or if your action does not result in a judicial order protecting us from supplying requested information, we will construe your inaction or failure as consent to comply with the request. Our efforts in complying with such requests or demands will be deemed a part of this engagement and we shall be entitled to additional compensation for our time and reimbursement for our out-of-pocket expenditures (including legal fees) in complying with such request or demand.

Document Retention Policy

At the conclusion of this engagement, we will return to you all original records you supplied to us. Your Company records are the primary records for your operations and comprise the backup and support for the results of this engagement. Our records and files, including our engagement documentation whether kept on paper or electronic media, are our property and are not a substitute for your own records. Our firm policy calls for us to destroy our engagement files and all pertinent engagement documentation after a retention period of seven years (or longer, if required by law or regulation), after which time these items will no longer be available. We are under no obligation to notify you regarding the destruction of our records. We reserve the right to modify the retention period without

notifying you. Catastrophic events or physical deterioration may result in our firm's records being unavailable before the expiration of the above retention period.

Except as set forth above, you agree that Moss Adams may destroy paper originals and copies of any documents, including, without limitation, correspondence, agreements, and representation letters, and retain only digital images thereof.

Use of Electronic Communication

In the interest of facilitating our services to you, we may communicate by facsimile transmission or send electronic mail over the Internet. Such communications may include information that is confidential. We employ measures in the use of electronic communications designed to provide reasonable assurance that data security is maintained. While we will use our best efforts to keep such communications secure in accordance with our obligations under applicable laws and professional standards, you recognize and accept we have no control over the unauthorized interception of these communications once they have been sent. Unless you issue specific instructions to do otherwise, we will assume you consent to our use of electronic communications to your representatives and other use of these electronic devices during the term of this Agreement as we deem appropriate.

Enforceability

In the event that any portion of this Agreement is deemed invalid or unenforceable, said finding shall not operate to invalidate the remainder of this Agreement.

Entire Agreement

This Professional Services Agreement and Engagement Letter constitute the entire agreement and understanding between Moss Adams and the Company. The Company agrees that in entering into this Agreement it is not relying and has not relied upon any oral or other representations, promise or statement made by anyone which is not set forth herein.

In the event the parties fail to enter into a new Agreement for each subsequent calendar year in which Moss Adams provides services to the Company, the terms and conditions of this PSA shall continue in force until such time as the parties execute a new written Agreement or terminate their relationship, whichever occurs first.

Use of Moss Adams' Name

The Company may not use any of Moss Adams' name, trademarks, service marks or logo in connection with the services contemplated by this Agreement or otherwise without the prior written permission of Moss Adams, which permission may be withheld for any or no reason and may be subject to certain conditions.

Use of Third-Party Service Providers

We may use third party service providers in serving you, including software and data storage providers. You understand that Moss Adams does not control the providers' networks, security or availability of services.

Use of Nonlicensed Personnel

Certain engagement personnel who are not licensed as certified public accountants may provide services during this engagement.

Dispute Resolution Procedure and Venue

This Agreement shall be governed by the laws of the state of Washington, without giving effect to any conflicts of laws principles. If a dispute arises out of or relates to the engagement described herein, and if the dispute cannot be settled through negotiations, the parties agree first to try in good faith to settle the dispute by mediation using an agreed upon

mediator. If the parties are unable to agree on a mediator, the parties shall petition the state court that would have jurisdiction over this matter if litigation were to ensue and request the appointment of a mediator, and such appointment shall be binding on the parties. Each party shall be responsible for its own mediation expenses, and shall share equally in the mediator's fees and expenses.

If the claim or dispute cannot be settled through mediation, each party hereby irrevocably (a) consents to the exclusive jurisdiction and venue of the appropriate state or federal court located in King County, state of Washington, in connection with any dispute hereunder or the enforcement of any right or obligation hereunder, and (b) WAIVES ITS RIGHT TO A JURY TRIAL. EACH PARTY FURTHER AGREES THAT ANY SUIT ARISING OUT OF OR RELATED TO THIS AGREEMENT MUST BE FILED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ARISES.

Termination

This Agreement may be terminated by either party, with or without cause, upon ten (10) days' written notice. In such event, we will stop providing services hereunder except on work, mutually agreed upon in writing, necessary to carry out such termination. In the event of termination: (a) you shall pay us for services provided and expenses incurred through the effective date of termination, (b) we will provide you with all finished reports that we have prepared pursuant to this Agreement, (c) neither party shall be liable to the other for any damages that occur as a result of our ceasing to render services, and (d) we will require any new accounting firm that you may retain to execute access letters satisfactory to Moss Adams prior to reviewing our files.

Regulatory Access to Documentation

The documents created or incorporated into our documentation for this engagement are the property of Moss Adams and constitute confidential information. However, we may be requested to make certain engagement related documents available to regulatory agencies pursuant to authority given to them by law or regulation. If requested and in our opinion a response is required by law, access to such engagement related documents will be provided under the supervision of Moss Adams personnel. Furthermore, upon request, we may provide photocopies of selected engagement related documents to regulatory agencies. The regulatory agencies may intend, or decide, to distribute the photocopies or information contained therein to others, including other government agencies.

Proposal Food Bank

This proposal is to guarantee that all District elementary school aged children have adequate access to food through a coordinated process orchestrated by Tri City Healthcare District(TCHD). TCHD will implement The Food 4 Kids Backpack Program by coordinating through the school districts of Vista, Carlsbad and Oceanside. If approved by the TCHD Board , the CHAC will be the coordinating entity to guarantee funding through a partnership between TCHD, School Districts, and local businesses.

Rationale

In a most recent "White Paper"[1] published by the Governance Institute, The Affordable Care Act is calling into question whether hospitals are doing enough community service to protect their tax exempt status. Most of the institutions rationalize that charity care is a demonstration of their service to the community. However the White Paper notes that many institutions have created board level community health committees that have made more wide range community health policies. The White Paper begins with recommending that all boards create community health committees. It also recommends a concrete monetary commitment towards these programs be implemented and that the committees take a more active role in implementing such programs. The following institutions were singled out as stars.

Sonoma County Hospitals	Boston Children's Hospital	Providence Health & Services
Dignity Health	St Vincent's Healthcare	Pro Medica
Bon Secours	Trinity Health	Presbyterian Intercommunity Hospital

TCHD is a rising star by Governance Institute standards. We have had a active CHAC which over the past few years has devoted most of its efforts to bring to this hospital concepts that improve the health and wellness of this community. Our grant program is a shining star and we are just beginning to look into ways to coordinate with the existing community programs to improve our communities health and wellness.

The backpack program is a program that has consistently delivered on its promise to provide healthy food to children who do not have a guaranteed food source over the weekends. The Food Bank of North County under the direction of Jim Flores, has guaranteed that backpacks filled with food will be delivered to all students who are in need on Friday when they are dismissed from school. The backpacks are returned on Monday and North County Food Bank repeats this process throughout the school year. The North County Food Bank has demonstrated that they have a consistent and abundant supply of food ,both perishables and items with good shelf life. Through their warehouse system they can guarantee delivery to our district schools and has demonstrated the consistency necessary to feed those who are in need.

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[1] Improving Community Health- Leading Governance Practice to Catalyze Change, A Governance Institute White Paper, Fall 2016

Plan

In discussion with Mr. Flores, he has the capacity to implement the backpack program in all elementary schools in our district. On a weekly basis backpacks will be delivered and picked up at each of the elementary schools. The food will meet all of the appropriate federal standards for such programs. Flores will work with the school districts to guarantee that they qualify for such a program and to determine which students are eligible. School districts in turn will need to identify the students, to guarantee that they qualify for this program, and work with the food bank to make sure that this system is uninterrupted.

TCHD should be the coordinator of this program. The healthcare district covers the cities of Vista, Carlsbad, and Oceanside and through the CHAC; TCHD is best positioned to cross school district lines.

In discussion with Mr. Flores, it seems for a school district to receive backpacks, there would need to be a guarantee of $10,000 per year per school. Mr. Flores would like a five-year commitment per school so that he may commit to the manpower and resources needed to service these contracts.

TCHD could also be counted on for providing the initial seed money. Through the CHAC, TCHD could coordinate with businesses in the community to provide additional funding. The committee members are in a perfect position to solicit that monetary support.

January 21, 2017
James Dagostino, Chairman
Governance & Legislative Committee

Mr. Dagostino,

It is my understanding a community vacancy has occurred on the Governance and Legislative Committee of the TCHD Board of Directors.

My previous terms on the Governance and Legislative committee has provided the opportunity to once again serve as a volunteer on this legislative body. My education in healthcare and public administration coalesces with my professional experience in the field including two+ years on the Community Healthcare Alliance Committee (CHAC).

The recent opening on this committee is well timed as I now bring to the committee my specific knowledge in healthcare and governance. I share the goals and objectives of the committee. I believe I can make a significant contribution utilizing my educational, volunteer and professional experience.

I shall look forward to hearing from you.

Sincerely,

Robin Iveson

Robin Iveson

Robin Iveson
825 Cypress Drive
Vista, CA. 92084
(760) 806-9928

B.A. Health Administration 1987
St. Mary's College, Moraga, CA.

Masters in Public Administration, 1991
College of Notre Dame, Belmont, CA.

NARRATIVE RESUME

Prior to moving to Vista for retirement, I lived and studied in the Bay Area, where I was employed in both the entrepreneurial and Not-For-Profit sectors of the healthcare field. With a Masters Degree, I had the opportunity to make a difference as a Program Director at the Lions Blind Center in San Jose.

An integral component of my job was interfacing with the Department of Health and Human Services in Sacramento. This aspect provided critical knowledge into blind seniors aging healthcare issues.

In seeking opportunities to utilize my educational and non-profit experience, I became a volunteer at Tri-City Medical Center. My first volunteer experience was on Mission Community Outreach (presently Community Healthcare Alliance (CHAC). I believed my professional and grant writing skills would be of value to this committee.

My volunteer work with Aging and Independent Services (AIS) provided cognizance of healthcare governance for seniors living in retirement communities. As an Ombudsmen I was able to carry forward that knowledge to G&L on senior issues. At two G&L meetings as a community member, I provided salient information on a patient. At a subsequent meeting I was able to assist the discussion on a patient living in a retirement community.

I have been fortunate to reconcile my educational, professional and 15+ years of volunteer activities with Tri-City Medical Center. If presented with the opportunity to have a seat at the table, I would be pleased to accept. The time commitment is not a factor.

FAITH A. DEVINE
2722 Loker Avenue West, Ste. H
Carlsbad, CA 92010

January 12, 2017

Teri Donnellan, Executive Assistant
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

Re: Audit/Compliance/Ethics Committee Opening

Dear Ms. Donnellan:

I am writing in reference to the community member opening on the Audit/Compliance/Ethics Committee advertised in the The Coast News, and am enclosing my resume for consideration. As described in my resume, I was a federal prosecutor for over 23 years specializing in complex financial fraud, waste and abuse. I have worked with several Offices of Inspector General. I presently serve as a consultant for private clients in the area of fraud prevention and recovery.

I believe my experience matches the criteria outlined in the advertisement. I have extensive experience in finance and accounting issues, and have summarized thousands of pages of financial records. I have also prosecuted a number of health care fraud cases and am familiar will billing codes, certifications, and cost reporting. I am a resident of Carlsbad and am interested in using my experience to serve the local community.

Please feel free to contact me if you would like to discuss my qualifications further or need additional information. I can be reached at 760-842-7095 or by e-mail at faithdevine@att.net.

Very truly yours,

Faith A. Devine

Enc.

FAITH A. DEVINE
2722 Loker Avenue West, Suite H
Carlsbad, California 92010
TEL (760) 842-7095 FAX 760-400-8361
E-mail: faithdevine@att.net

PROFESSIONAL EXPERIENCE

July 2015 to present Attorney/Consultant

Specializing in compliance and fraud prevention.

2001- July 2015 **Assistant U.S. Attorney**
U.S. Attorney's Office, San Diego, CA

- Investigated and prosecuted criminal and civil cases for federal agencies involving fraud, waste, and abuse in the areas of health care fraud, defense contractor fraud, and other government procurement fraud.

1991-2001 **Assistant U.S. Attorney**
U.S. Attorney's Office, Los Angeles, CA

- Investigated and litigated civil violations of the False Claims Act including health care fraud, defense contractor fraud, and other government procurement fraud.

1989-1991 **Associate Attorney**
Graham & James, Los Angeles, CA

Litigated complex commercial, class action, and securities cases for financial institutions, corporations and government agencies.

1988-1991 **Associate Attorney**
Cameron, Hornbostel & Butterman, New York, NY

Represented foreign corporations, financial institutions, and governments in connection with business transactions, regulatory issues involving international trade, and immigration.

EDUCATION

J.D., Hofstra University School of Law, New York, Top 10%, 1989
BBA, International Finance and Marketing, University of Miami, *cum laude*, 1986

BAR ADMISSIONS

California, 1990

PROFESSIONAL ORGANIZATIONS

- Member, Carlsbad Chamber of Commerce, Government Affairs Committee.
- Member, North County Bar
- Member, Association of Certified Fraud Examiners.

COMMUNITY

- 1995-2001 – Judge Pro Tem (Los Angeles Small Claims Court)
- 1989-2001 – Director, Barnsdall Art Park Board of Overseers
- 2001-2015 – San Pacifico Homeowners Association

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
February 08, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/24/2017-1/31/2019)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 2/24/2017 through 1/31/2019:

- **KUSHNARYOV, Anton M.D./Otolaryngology (No.Co. Ear, Nose & Throat Head & Neck Surgery)**
- **LAI, Jasmine M.D. /Maternal & Fetal Medicine(San Diego Perinatal Center)**
- **PIETILA, Michael M.D. / Family Medicine (Tri-City Primary Care Medical)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
February 8, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 2/24/17, unless otherwise specified)

- BEN-HAIM, Sharona M.D. — Neurosurgery
- GROVE, Jay M.D. — General/Vascular Surgery
- MOSTOFIAN, Elimaneh M.D. — OB/GYN
- PERKINS, Rachel M.D. — Pediatrics

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
February 8, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 3/01/2017 –2/28/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 3/01/2017 through 2/28/19, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **ASSELIN, Lynette DO/Pediatrics/Active**
- **BARAGER, Richard MD/Internal Medicine/Active**
- **BARCO, Eric MD/Internal Medicine /Active**
- **BURZYNSKI, Margaret MD/Anesthesiology/Active**
- **EBRAHIMI ADIB, Tannaz MD/Obstetrics & Gynecology/Provisional**
- **FLORES-DAHMS, Kathleen MD/Radiology /Active**
- **IBRAHIM, Nagi MD/Internal Medicine /Affiliate**
- **KALOOGIAN, Harold MD/Podiatric Surgery/Active**
- **KURIYAMA, Steve MD/Internal Medicine/Consulting**
- **LEAN, Eva MD/Radiation Oncology /Active**
- **LUSCHWITZ, Brian MD/Pediatrics/Active**
- **MELLS, Cary MD/Emergency Medicine/Active**
- **NGUYEN, Christine MD/Internal Medicine/Affiliate**

RESIGNATIONS: (Effective date 2/24/2017 unless otherwise noted)

Voluntary:

- **ANTHONY, Julian MD/Urology**
- **GUY, Moltu MD/Anesthesiology**
- **IPSON, Jason T. MD/Anesthesiology**

Attachment B

- KOLLENGODE, Vijay S. MD/Anesthesiology
- KRUETH, Stacy B. MD/Anesthesiology
- MITCHELL, W. B., JR. MD/Emergency Medicine
- MUSINSKI, Scott MD/Obstetrics & Gynecology
- NARLA, Vinod V. MD/Anesthesiology
- SLIWA, Jan P./Anesthesiology
- SMITH, Christina R/Anesthesiology
- TYAGI, Avishkar MD/Radiology
- VAYSER, Dean, DPM/Podiatric Surgery
- WROTSLAVSKY, Philip, DPM/Podiatric Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
February 8, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES
The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 2/28/2017.

- FENTON, Douglas M.D. — OB/GYN
- GABRIEL, Steve M. MD — Emergency Medicine
- NGUYEN, Vu H., MD — Dermatology
- WADWA, Ashish K, M.D. — Otolaryngology

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT
The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by August 31, 2017 would result in these privileges automatically relinquishing.

- GABRIEL, Steve M. MD — Emergency Medicine

ADDITIONAL PRIVILEGE REQUEST (Effective 2/24/2016, unless otherwise specified)
The following practitioners requested the following privileges

- FIERER, Adam M.D. — General/Vascular Surgery

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 2/24/2017, unless otherwise specified)

The following practitioners are voluntarily relinquishing the following privileges.

- GROVE, Jay R., MD — General/Vascular Surgery
- KARANIKKIS, Christos A., DO — OB/GYN

Tri-City Medical Center
MEDICAL STAFF

INTERDISCIPLINARY PRACTICE - CREDENTIALS REPORT
December 2016

ANNUAL EVALUATIONS: The following providers have received annual evaluations and have been recommended for continued AHP membership.

- Ahumada, Alejandro G., AuD
- Allen, Danielle M., AuD
- Allen, Matthew G., PAC,
- Amaral, Polly E., AuD
- Bayudan Inocelda, Andrew G., PAC
- Brockman, Joe B., PAC
- Brownsberger, Richard N., PAC
- Carlton, Vivian W., PAC
- Chandler, Brie A., PAC
- Chase, Nicole J., PAC
- Deatrick, Veronica, NP
- Folkerth, Jean M., RNFA
- Garbaczewski, Stephanie H., PAC
- Hamilton Jr., James N., PAC
- Hermann, Linda, PAC
- Hermanson, Kathleen H., PAC
- Huang, Stephanie K., PAC
- Hueftle, Rachael L., NP
- Kaur, Manpreet, PAC
- Lam, Christina, NP
- Lewis, Chris E., PAC
- Martinez, Melinda W., PAC
- McNally, Paul D., NP
- McQueen, Paula S., CNM
- Olson, Lindsey D., PAC
- Pregerson, Heather A., PAC
- Preiser, Kristin M., NP
- Rice, William M., PAC
- Shuford, Scott A., NP
- Son, Alicia G., PA
- Spencer, Matthew J., PAC
- Spruel, Candyce E., MFT
- Strowd, Megan V., PAC
- Taylor, Phyllis J., NP

ANNUAL EVALUATIONS: The following providers have failed to provide appropriate documentation for their annual evaluations and have been recommended expiration of their AHP membership, effective December 31, 2016

- Heldt, Emily W., AuD
- Nunez, Blanca E., PAC
- Pidding, Apryl D., NP
- Woelke, Dianne M., CNM

Tri-City Medical Center

Delineation of Privileges

Neonatology – 8/16

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Division of Neonatology consists of physicians who are board certified in Neonatal-Perinatal Medicine by the American Board of Pediatrics or are progressing toward certification. Applicants who are progressing toward board certification must complete formal training prior to applying for medical staff membership in the Division of Neonatology and must become board-certified within four (4) years of the initial granting of medical staff membership, unless extended for good cause by the Pediatrics Department.

Neonatologists (Pediatric Cardiologists have separate criteria as outlined in the Pediatric Cardiology Procedures section)
Initial: Training and evidence of current NRP certification
Proctoring: Six (6) admissions or consultations
Reappointment: Evidence of current NRP certification

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform medical history & physical examinations, including via telemedicine (F) ___

___ Attendance at C-Sections and vaginal deliveries, including newborn resuscitation ___

___ Newborn care, Level 2 and Level 3 ___

___ **INVASIVE PROCEDURES** - By selecting this privilege, you are requesting the Invasive Procedures privileges listed immediately below. Strikethrough and intial any privilege(s) you do not want. ___

Invasive Procedures Category Criteria:
Initial Criteria: Evidence of current NRP Certification
Proctoring: Five (5) cases from Invasive Procedures Category
Reappointment: Five (5) Cases from a blend of the privielges listed below and maintain a current NRP Certificate

Arterial puncture
~~Reappointment: One (1) case per two-year reappointment cycle~~

~~Bone marrow aspiration or biopsy~~

Central vessel catheterization
~~Reappointment: One (1) case per two-year reappointment cycle~~

~~Endoscopic Procedures~~

Intubation/Thoracentesis/Thoracostomy, Infant
~~Reappointment: Two (2) cases per two-year reappointment cycle~~

Exchange transfusion of neonates

Interosseous needle insertion

Lumbar puncture
~~Reappointment: One (1) case per two-year reappointment cycle~~

~~Manometrics-Esophageal and Colonic~~

Provider Name:

Request	Privilege	Action MSO Use Only

Peripheral arterial catheterization and umbilical catheterization - artery
~~Reappointment: Two (2) case per two-year reappointment cycle~~

Peripheral I.V. cutdown

~~Percutaneous liver biopsy~~

Suprapubic aspiration
~~Reappointment: One (1) case per two-year reappointment cycle~~

Umbilical catheterization - vein
~~Reappointment: Four (4) cases per two-year reappointment cycle~~

___ **NON-INVASIVE PROCEDURES** - By selecting this privilege, you are requesting the Non-Invasive Procedures privileges listed immediately below. Strikethrough and intial any privilege(s) you do not want. ___

Non-Invasive Procedures Criteria:
Initial Criteria: Evidence of current Neonatal Resuscitation Program (NRP) certification
Proctoring Criteria: Three (3) cases from Non-Invasive Procedures category
Reappointment Criteria: Five (5) cases from a blend of the privileges listed below and maintain a currnet NRP certificate

Care of ventilated patients

Cardiac defibrillation

Delivery Room newborn resuscitation

Echocardiography

Elective cardioversion

Electrocardiography (EKG/ECG)

Parenteral hyperalimentation
~~Reappointment: Ten (10) cases per two-year reappointment cycle~~

~~Pneumogram interpretation~~
~~Reappointment: Three (3) cases per two-year reappointment cycle~~

Pericardiocentesis

___ **Pediatric Cardiology Procedures** ___

By selecting this privilege, you are requesting the Pediatric Cardiology Procedures privileges listed immediately below. Strikethrough and intial any privilege(s) you do not want.

Initial: Successful completion of a fellowship training program in Neonatology or Pediatric Cardiology
Proctoring: Two (2) cases from this category
Reappointment: Ten (10) cases from this category

Cardiac defibrilation

Consultation, Pediatric Cardiology

Echocardiography

Elective cardioversion

Tri-City Medical Center

Delineation of Privileges

Neonatology – 8/16

Provider Name:

Request	Privilege	Action MSO Use Only
	Electrocardiography (EKG/ECG)	
	Pericardiocentesis	
	OTHER:	
___	Moderate Sedation (special credentialing required - Refer to Medical Staff policy 8710-517 and evidence of current NRP certification)	___

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Orthopedic Technician - 9/13

Provider Name:

Request	Privilege	Action MSO Use Only

CRITERIA:

Initial and Reappointment:
1. Certified by the National Board for Certification of Orthopedic Technologists
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS

Proctoring: Six (6) cases

INTRAOPERATIVE RETRACTIONS:

___ Retract Tissue or organs by use of hand ___

___ Place or hold surgical retractors ___

___ ~~Pack sponges into body cavity to hold tissues or organs out of the operative field~~ ___

___ Manage all instruments in the operative field ___

INTRAOPERATIVE HOMEOSTASIS

___ Aspiration of blood and other fluids from the operative site ___

___ Sponge wounds or other areas of dissection ___

___ ~~Clamp bleeding tissues or vessels~~ ___

___ ~~Cauterize and approximate tissue~~ ___

___ ~~Place hemoclip or ligating sutures on vessels or tissue~~ ___

INTRAOPERATIVE WOUND CLOSURE:

___ Apply surgical dressing ___

___ ~~Care and removal of drains~~ ___

OTHER:

___ ~~Connects Drainage~~ ___

___ Assist with applying casts, braces, or plaster splints ___

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Orthopedic Technician - 9/13

Provider Name:

Request	Privilege	Action MSO Use Only

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.

Approval:

_____
Division/Department Signature

_____
Date

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
February 16, 2017

MEMBERS PRESENT: CHAC Chair Julie Nygaard, BOD Chair Jim Dagostino, Director Larry Schallock; Dr. Victor Souza, MD; Bret Schanzenbach, Carol Herrera, Gigi Gleason, Linda Ledesma, Marge Coon, Mary Donovan, Mary Lou Clift, Roma Ferriter, Sandy Tucker, Scott Ashton, Ted Owen, Xiomara Arroyo

MEMBERS ABSENT: Barbara Perez, Danielle Pearson, Dung M. Ngo, Guy Roney, Jack Nelson, Marilou de la Rosa Hruby, Mary Murphy, Rosemary Eshelman

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; David Bennett, Chief Marketing Officer; Cheryle Bernard-Shaw, CCO

NON-VOTING MEMBERS ABSENT: Audrey Lopez, Kapua Conley, COO

OTHERS PRESENT: Director Laura Mitchell, Brian Greenwald, Celia Garcia, CHAC Coordinator; Susan McDowell, CHAC Coordinator

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The February 16, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:32 pm by Director and CHAC Chair Julie Nygaard.		
Approval Of Meeting Agenda	Ted Owen motioned to approve the February 16, 2017 meeting agenda. The motion was seconded by Gigi Gleason and unanimously approved.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 16, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Director Dagostino motioned to approve the January 19, 2017 CHAC meeting minutes. The motion was seconded by Carol Herrera and unanimously approved. Director Larry Schallock abstained.		
Presentation: Dr. Karim El-Sherief, MD, FACC, FASE, Interventional Cardiologist	Dr. Karim El-Sherief, MD, FACC, FASE, Interventional Cardiologist, discussed Heart Health with the group noting the following: • The AHA recognized this hospital for achieving 85% or higher composite adherence to all Mission: Lifeline® STEMI Receiving Center Performance Achievement indicators. • The success of the Cardiac Rehab Program is very good, with over 200 people in various phases of the program. TCMC is one of very few hospitals offering such a successful rehab program. • Members were urged to take advantage of the 2 for 1 Heart Health screenings offered by the Cardiovascular Health Institute, at a lower rate for the month of February – Heart Health Month. • TCMC's exclusive North County affiliation with AHA (American Heart Association), noting that the first walk is planned for September 30, 2017 at the Oceanside Pier. It is hoped that this affiliation will begin the process to assist laws and policies to improve heart health and prevent stroke.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Dr. Karim El-Sherief, MD, FACC, FASE, Interventional Cardiologist (CON'T	Dr. El-Sherief also provided examples of actual patient stories. The group thanked Dr. El-Sherief for the great information regarding heart health care.		
CEO Update Steve Dietlin	CEO Steve Dietlin updated the group as follows: • Steve reiterated Dr. El-Sherief's sentiments that Tri-City is blessed with World Class Physicians and the commitment to increase community awareness in a variety of health related areas. • TCMC recently discontinued broadcasting the Board of Director meetings on KOCT due to a lack of viewership. KOCT will now be contracted to provide multiple health related topics for the community. • Steve addressed the uncertainty expressed by some about future changes in the ACA (Affordable Care Act). Steve noted that it is too early to be sure of related outcomes and changes; however TCMC is involved with the issue to be able to assist the community once the changes are in place. • Steve noted that the campus redevelopment plan is still underway. TCMC recently secured a loan rate lock of under 5% which will help roll outstanding debt, including the Wellness Center, into a 25 year debt program which will allow the hospital to move forward into Phase 1 of the campus redevelopment plan.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Kapua Conley	N/A		
Chief Marketing Officer Update David Bennett	Chief Marketing Officer David Bennett reported as follows: • David reiterated how happy TCMC is with their recent association with the AHA and the upcoming walk is expected to have over 10,000 in attendance. • TCMC is a finalist at the upcoming Vista Heroes Event. David thanked Vista Chamber CEO, Bret Schanzenbach, for the consideration. • David noted TCMC's involvement with the Oceanside Promise Program and our combined hope to make a positive impact in the lives and health of our community's youth. • Director Dagostino, David Bennett, Rosemary Eshelman (Carlsbad Unified School District), Carol Herrera (Vista Unified School District) and James Floros, CEO of the San Diego Food Bank, met recently to discuss youth hunger within the District and the need to coordinate efforts to ensure greater success. Director Dagostino addressed the CHAC members to see if the Committee would be willing to assist in the success of this program, and to see if there was a consensus to bring the idea to the Board of Directors for further development. The CHAC Committee members agreed with no objections.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
LexisNexis Socioeconomic Health Solutions	Director Larry Schallock provided a handout to the group showing the impact societal, economic and stress issues have on health outcomes, noting that social factors account for over 1 in 3 total deaths in the US annually.		
Public Comments	Director Laura Mitchell thanked the group for being so conscientious of the communities they serve.		
Committee Communications	Gigi Gleason highlighted the Grant Forum held on January 25th noting that it was a full room and great event for those considering submitting grants in the 2017 cycle. Director Nygaard expressed her appreciation to Gigi for all her work and effort to make the meeting successful. Fernando Sanudo noted that the VCC and CSUSM have utilized the grant provided in 2016 for the Medical Assistant training program, and the 1st graduating class is at the end of February. The program is successful and growing. Mary Donovan noted that the recent Operation Hope Forum on domestic violence was very successful with over 100 attendees.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Communications (con't)	Bret Schanzenbach noted that the "Meet the Leaders" event is planned for March 24th. The event will host Representative Darrell Issa, Senator Patricia Bates and Assemblywoman Diane Harkey. Scott Ashton relayed information regarding the Oceanside Promise workshop held on February 15th, noting that it was a successful event. Director Dagostino thanked the Committee for working together so well and creating so much good for the community.		
Next Meeting	The next CHAC meeting is scheduled for Thursday, March 16, 2017.		
Adjournment	The February 16th, 2017 CHAC Committee meeting was adjourned at 1:48pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
February 14, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter, Tim Keane
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO Wayne Knight, Chief Strategy Officer
Others	Director Jim Dagostino, David Bennett, Tom Moore, Glen Newhart, Charlene Carty, Joni Penix, Jeremy Raimo, Sharon Schultz, Chris Miechowski, Sherry Miller, Priya Joshi, Jane Dunmeyer, Eva England, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Dr. John Kroener, Dr. Frank Corona, Kathleen Mendez

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:32 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved to accept the agenda of February 14, 2017.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of January 17, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of January 17, 2017, are to be approved without any requested modifications.**	
5. Old Business			

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
6. New Business			
a. Review & Discuss Board Policy #15-013 • Policies & Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts		**MOTION** **It was moved by Mr. Harrington, Mr. Keane seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve Board policy # 15-13, as it is currently written, with no recommended changes or modifications.**	Chair / Chris Miechowski
b. Physician Agreement for ED On-Call Coverage - Neurosurgery • Alexander A. Khalessi, M.D.	Sherry Miller stated that this write-up is to add Dr. Alexander A. Khalessi, as new physician to the existing panel for ED On-Call coverage for Neurosurgery, with no increase in expense.	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Alexander Khalessi M.D. to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning February 1, 2017 and ending January 31, 2018.**	Sherry Miller
c. Physician Agreement for ED On-Call Coverage – Neurology • Kalyani Korabathina, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Kalyani Korabathina as new physician to the existing panel for ED On-Call coverage for Neurology, with no increase in expense.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Kalyani Korabathina M.D. to the currently existing ED On-Call Coverage Panel for Neurology for a term of 12 months, beginning February 1, 2017 and ending January 31, 2018.**	Sherry Miller

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d. Surgical Light Replacement and Video Integration Proposal, O.R. # 2	In Mary Diamond's absence, Chris Miechowski conveyed that this proposal was to update the lighting in operating room #2, as well as install a state of the art digital routing system. He further explained that this was the second of 10 rooms that would eventually be renovated.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the publicly bid agreement with McCoy Design & Construction for $76,197, and the purchase of equipment to replace the lights in operating room 2, for a total expected project cost of $365,828.**	Mary Diamond / Chris Miechowski
e. Key Healthcare Consulting, LLC Proposal	Joni Penix explained this write-up was a renewal of the agreement for this vendor, who renders charge entry services for the Emergency Room, Crisis Stabilization Unit and Observation. Minor discussion ensued.	**MOTION** **It was moved by Mr. Lingenfelter, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Key Healthcare Consulting, LLC for Charge Entry for a term of 36 months beginning, March 15, 2017 and ending, March 14, 2020 for an expected annual cost of $285,492, and an expected total cost for the term of $856,476.**	Joni Penix
f. Physician Agreement for Cardiac Rehabilitation Physician Supervision • Sharon M. Slowik, M.D.	Eva England conveyed that this was a renewal of the agreement with Dr. Slowik to continue as an on-site supervising physician for the Cardiac Rehabilitation program at the Wellness Center, for an additional 24 months.	**MOTION** **It was moved by Director Kellett, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Sharon M. Slowik as the Coverage Physician for a term of 24 months beginning July 1, 2017 and ending**	Eva England

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		June 30, 2019. Not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404.40, and a total cost for the term of $138,808.80.	
g. Physician Agreement for Medical Director for Behavioral Health Services – Behavioral Health Unit (BHU) • Neil Richtand, M.D., Ph.D.	Sharon Schultz reported that this agreement was for Dr. Richtand to act as the Medical Director for the Behavioral Health Unit. He will provide professional guidance, oversight for this area, as well as customary medical director duties as outlined in the agreement.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Neil Richtand as the Medical Director of the BHU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of $75,600, and a term cost of $81,900.**	Sharon Schultz
h. Physician Agreement for Medical Director for Behavioral Health Services – Crisis Stabilization Unit (CSU) • Neil Richtand, M.D., Ph.D.	Sharon Schultz reported that this agreement was for Dr. Richtand to act as the Medical Director for the Crisis Stabilization Unit. He will provide professional guidance, oversight for this area, as well as customary medical director duties as outlined in the agreement.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Neil Richtand as the Medical Director of the CSU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of $75,600, and a term cost of $81,900.**	Sharon Schultz
i. Physician Agreement for Rehabilitation Services • Mark Sadoff, M.D.	Priya Joshi explained that this agreement would add telemedicine consultation duties to Dr. Sadoff's	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was**	Priya Joshi

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	current responsibilities, under his present contract. Priya explained that this request was for a two week trial for the telemedicine services to determine the feasibility and success of these services. After some discussion, it was requested that Priya return after the trial period to advise the committee of the overall results.	**unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the addition of Telemedicine responsibilities to the current Medical Director of Rehabilitation Services contract, with no additional cost.**	
j. Recruitment Agreement Proposal • Geehan D'Souza, M.D.	Jeremy Raimo and Wayne Knight each emphasized that according to an independent needs assessment, a physician with Dr. D'Souza's unique reconstructive plastic surgery skills would be of great benefit to the Tri-City area. Historically, plastic surgery has been an underserved specialty within the District.	**MOTION** **It was moved by Dr. Contardo, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $637,500 in order to facilitate this plastic surgeon practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee) with Geehan D'Souza, M.D.**	Wayne Knight
k. Financials	Ray Rivas presented the financials ending January 31, 2017 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 195,285 Operating Expense $ 196,359 EBITDA $ 11,735		Ray Rivas

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EROE $ 2,869 **TCMC – Key Indicators – FYTD** Avg. Daily Census 183 Adjusted Patient Days 66,495 Surgery Cases 3,690 Deliveries 1,580 ED Visits 37,155 **TCHD-Financial Summary – Current Month** Operating Revenue $ 28,711 Operating Expense $ 29,565 EBITDA $ 1,010 EROE $ (226) **TCMC – Key Indicators – Current Month** Avg. Daily Census 188 Adjusted Patient Days 9,377 Surgery Cases 549 Deliveries 217 ED Visits 5,166 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 43.0 Days in Net A/R Avg. 50.0 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital – Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay		
I. Work Plan – Information Only	Director Nygaard reported that these agenda items were for		Chair

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	review only, but Committee members were welcome to ask questions.		
• Wellness Center	Ray Rivas gave a one page PowerPoint presentation of the Wellness Center P & L financials. Some discussion ensued.		Ray Rivas
• Tri-City Real Estate Holding and Management LLC	Ray Rivas conveyed that there is now only one property remaining in the LLC, which is the former bank building site located off of Vista Way, near the medical office building.		Ray Rivas
• Accountable Care Organization (ACO)	Wayne Knight conveyed that due to changes within some of the affiliated medical groups, the criterion for an active ACO is currently not being met.	**After some discussion, it was recommended and agreed by consensus that the nominal fees should continue to be paid, in order for the ACO to remain active and viable.**	Wayne Knight
• Dashboard	No discussion.		Ray Rivas
7. Comments by Committee Members		None	Chair
8. Date of next meeting	March 21, 2017		Chair
9. Community Openings (none)			
10. Adjournment	Meeting adjourned 1:53 pm		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-013 (FOP)

POLICY TITLE: Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts

Government Code section 54202 requires the District to adopt policies and procedures, including bidding regulations, governing purchases of supplies and equipment by the District. In addition, with limited exceptions, Health & Safety Code section 32132 requires the District to competitively bid contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for materials and supplies to be furnished, sold, or leased to the District, as well as contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for work to be done. Finally, Government Code section 4525 et seq. requires the District to select firms to provide certain professional services on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required.

The following policies and procedures governing purchases of supplies and equipment, procurement and bidding for public works contracts, and procurement of professional services are hereby adopted.

I. FORMAL BIDDING REQUIREMENTS

A. Contracts Requiring Formal Bids – Materials, Supplies, and Work to be Done Involving Expenditure of More Than $25,000.

Unless exempted by this Policy or applicable law (including, for example, bidding exemptions for medical or surgical equipment or supplies and professional services), any contract for work to be done or for materials and supplies to be furnished, sold, or leased to the District shall be awarded through the "formal" bidding procedures specified in this Section "I" (Formal Bidding Requirements) if they involve an expenditure of more than Twenty Five Thousand Dollars ($25,000). (H&S Code § 32132(a).) Unless otherwise provided by law or this policy, such contracts involving an expenditure of Twenty Five Thousand Dollars ($25,000) or less may be made through the procedures specified in Section "II" or "III" of this policy. As used herein, "work to be done" includes, among other things, general maintenance work and public works contracts. Statutes requiring bidding, and exceptions from competitive procurement requirements for certain types of contracts are summarized in the table attached hereto and incorporated herein as Exhibit A for easy reference.

B. Bid Procedures.

1. Preparation of Bid Package.

Before entering into any contract which requires formal bidding, the District shall prepare or cause to be prepared a bid package. Unless exempted by the President/CEO or his/her designee pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, the bid package shall include a notice inviting bids, instructions to bidders, bid form, which shall include a provision as to the method for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," contractors qualification statement contract form, conditions of the contract, required bonds and other forms, drawings, and full, complete, and accurate plans and specifications, giving such directions as will enable any competent supplier or contractor to ascertain and carry out the contract requirements. The bid package shall also contain a statement that no gratuities of any kind will be accepted, including meals, gifts or trips, and violation of this condition may constitute immediate disqualification.

The President/CEO or his/her designee shall endeavor to include all required contract documents in the bid package. To the extent that the President/CEO or his/her designee determines, pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, that any required contract document cannot be incorporated into the bid package, its terms shall be negotiated with the lowest responsible bidder prior to the award of the contract.

To the extent possible, the plans and specifications shall also be reviewed and approved by the District's authorized representative prior to their insertion in the bid package.

2. Notice Inviting Bids – Contents.

All bid packages shall include a notice inviting bids. The notice inviting bids shall include, among other things determined necessary for a particular contract by the President/CEO or his/her designee, information as to the type, quality and quantity of materials, supplies or work to be provided, the contract performance schedule, the project location, the basis for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," a contact person, and other bid requirements and information regarding how to obtain a bid package, the place where bids are to be received, and the time by which they are to be received. For contracts involving public works projects, the notice inviting bids shall also contain any other information required by state law or

Section "IV" (Provisions Applicable to Public Works Contracts) of this Policy.

3. Notice Inviting Bids - Distribution by Mail, Posting or Other Means.

The District shall distribute the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. The President/CEO, or his/her designee may require that, except in cases of emergency or where not practicable, all suppliers and contractors who have notified the District in writing that they desire to bid on contracts, and all suppliers and contractors which the District would like to bid on contracts, shall be furnished with the notice inviting bids by postal or electronic mail.

The President/CEO, or his/her designee, may also require that in addition to notifying all such persons by mail or electronic mail, the District shall post the notice inviting bids in one or more public places typically used by the District. It shall be posted in sufficient time in advance of the bid opening to allow bidders to bid, as determined by the President/CEO or his/her designee. The notice shall remain posted until an award has been made. Notice may also be made by internet, telephone, facsimile, telegram, personal contact, letter, or other informal means.

4. Notice Inviting Bids - Advertising/Publication.

The District shall advertise/publish the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. For example, the President/CEO or his/her designee may require that, except in cases of emergency or where circumstances require that less notice be given, the notice inviting bids shall be published on the District's website and, in the case of a public works project also furnished to one or more contractor plan rooms or services.

For cost efficiency purposes, the published notice inviting bids need not be as detailed as that provided by other means, including by mail, posting or inclusion in the bid package, but should contain the legally and practically required essential contents of the notice, including but not limited to, where and how to obtain the complete bid package, Labor Code notice provisions, and bonding requirements.

5. Bid Form.

As part of the bid package, the District shall furnish to each bidder an appropriate bid form prepared by the District for the type of contract being let. Bids not presented on forms so furnished, or exact copies thereof,

shall be rejected as non-responsive. Bidders shall be required to execute and submit the contract in the form provided in the bid package as part of their bid.

6. Presentation of Bids.

All bids shall be presented under sealed cover. Upon receipt, the bid shall be date and time stamped.

7. Withdrawal of Bids.

Bids may be withdrawn at any time prior to the time fixed in the public notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of a bid does not prejudice the right of the bidder to timely file a new bid. Except as authorized by law for public works contracts (Pub. Contract Code § 5100 et seq.), no bidder may withdraw its bid after opening for the period of time indicated in the bid package.

C. Award of Contracts.

1. Opening of Bids.

On the day named in the public notice, the District shall publicly open the sealed bids.

The Board of Directors is under no obligation to accept the lowest responsive and responsible bid received, since the District has absolute discretion in the acceptance of bids and reserves the right to reject all bids if it is desires. The Board of Directors also reserves the right to determine the conditions of responsibility including matters such as delivery date, product quality, and the service and reliability of the supplier.

2. Responsible Bidder.

The District's determination of whether a bidder is responsible shall be based on an analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest bidder is to be rejected because of an adverse determination of the bidder's responsibility based on the District's staff review, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility. In such event, the District shall give the rejected bidder and the bidder to be awarded the contract at least five (5) working days' notice of a public board meeting at which the responsibility issue shall be considered by the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be required. The Board may, in its discretion, continue its

consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be conclusive.

3. Bid Challenges.

If any bidder wishes to challenge a potential bid award, he shall file a written objection within five (5) calendar days following bid opening. The written objection shall include specific reasons why the District should reject the bid questioned by the bidder. The District may, in its discretion, consider the protest during the public meeting at which the contract award is to be considered, or it may consider it at a prior meeting. The District shall give the challenging bidder and the bidder to be awarded the contract at least five (5) working days' notice of the board meeting at which the challenge shall be considered by the Board or the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be required. The Board may, in its discretion, continue its consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be final.

D. Emergencies.

The Board of Directors has adopted a resolution pursuant to Public Contract Code section 22050 authorizing the Chief Executive Officer (or the Chief Operating Officer if the Chief Executive Officer is unavailable, or a non-elected officer or employee of the District upon delegation of such authority by the Chief Executive Officer or Chief Operating Officer) to take immediate action and award certain emergency contracts not exceeding $250,000 (Two Hundred Fifty Thousand Dollars) without seeking competitive bids ("Emergency Contract Resolution"). The scope of such delegation and authority, including the process for such award and subsequent review by the Board of Directors, is set forth in the Emergency Contract Resolution. In the event that the Emergency Contract Resolution is rescinded, revoked, modified, amended, replaced, or superseded, this policy shall be read and interpreted consistent with the most recent action by the Board of Directors regarding authority to award emergency contracts even if this policy has not yet been amended to conform to such Board action. This is in addition to the District's authority under Health & Safety Code section 32136 as it may be amended from time to time.

II. GROUP PURCHASING ORGANIZATIONS ("GPO").

The District may participate as a member of any organization described in Section 23704 of the Revenue and Taxation Code ("GPO"). Any purchases made, or services rendered, by the GPO on behalf of the District are not subject to the bidding requirements pursuant to Section 32123 of the Health and Safety Code and are not subject to the formal bidding

requirements or informal competitive purchasing procedures established by this policy. (H&S Code § 32132(e).)

III. INFORMAL COMPETITIVE PURCHASING PROCEDURES

A. Contracts Requiring Informal Competitive Procurement Procedures.

All contracts subject to this Policy and not subject to Sections I or II shall be awarded in accordance with this Section III (Informal Competitive Purchasing Procedures).

B. Requirements for Specific Types of Contracts.

1. Certain Professional Services (Professional Architecture, Landscape Architectural, Engineering, Environmental, Land Surveying, Construction Management).

Contracts for professional services, as defined in Government Code section 4526, as it may be amended from time to time, may be awarded without following the "formal" bidding procedures, but shall meet the "informal" competitive purchasing procedures specified in Section III" (Informal Competitive Purchasing Procedures) of this Policy or comply with Board Policy No. 14-023. (Gov. Code § 4525 et seq.) In no event shall a contract for professional services be awarded based solely upon the lowest cost to the District.

a. Proposals Submitted for Construction Project Management Services

Any individual or firm proposing to provide construction project management services shall provide evidence that the individual or firm and its personnel carrying out onsite responsibilities have expertise and experience in construction project design review and evaluation, construction mobilization and supervision, bid evaluation, project scheduling, cost-benefit analysis, claims review and negotiation, and general management and administration of a construction project. (Gov. Code § 4529.5.)

b. Maximum Participation of Small Business Firms

In selecting professional services of private architectural, landscape architectural, engineering, environmental, land surveying, or construction management firms, the selection procedures shall assure maximum participation of small business firms, as defined by the Director of General Services pursuant to Section 14837. (Gov. Code § 4526.)

2. Electronic Data Processing and Telecommunications Goods and Services.

Contracts for electronic data processing and telecommunications goods and services shall be awarded through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures of this Policy); provided, that such contracts may be made without soliciting or securing bids when they involve an expenditure of $25,000 or less or when the Board determines either that: (1) the goods and services proposed for acquisition are the only goods and services which can meet the District's need; or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.

3. Professional Financial, Economic, Accounting, Legal or Administrative Services.

Contracts for the professional services set forth in Government Code section 53060, which include but are not limited to special services and advice in financial, economic, accounting, legal or administrative professional services may be procured through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures) of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the Board, or the President/CEO.

4. Clinical Services Agreements.

All clinical services agreements (e.g., anesthesiology, pathology, radiology, emergency, hospitalists) shall be subject to competitive selection procedures based on recommendations from General Counsel and/or outside special healthcare counsel. Such contracts may be procured through the Informal Competitive Purchasing Procedures of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the President/CEO.

C. Informal Competitive Purchasing Procedures.

1. Contracts Exceeding $1,000,000.

a. The President/CEO or his/her designee will issue a formal Request for Proposal for any individual contract award (not required to be bid by statute) exceeding One Million Dollars ($1,000,000) unless a written sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

b. Preparation of Request for Proposals.

The President/CEO or his/her designee shall prepare or cause to be prepared a written request for proposals ("RFP"). Unless exempted by the President/CEO or his/her designee pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, the RFP shall include at least the following information: (1) the specific nature or scope of the goods and/or services being sought; (2) the type of project contemplated, if applicable; (3) the estimated term of the contract; (4) the specific experience expected of the consultant or supplier; (5) the time, date and place for submission of the RFP; (6) a contact person who can answer questions of the consultants or supplier during the bidding process; (7) a contract form; and (8) the evaluation criteria to be utilized in the selection of the consultant or supplier.

The President/CEO or his/her designee shall endeavor to include all required information in the RFP. To the extent that the President/CEO or his/her designee determines, pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, that any required information cannot be incorporated into the RFP, its terms shall be negotiated with the successful consultant or supplier prior to the award of the contract.

c. Circulation of Request for Proposals.

The District shall attempt to obtain and consider completed RFP's from at least three (3) qualified sources.

2. Contracts Greater than or Equal to $250,000 and Less Than or Equal to $1,000,000.

The President/CEO or his/her designee shall obtain at least three (3) quotes from vendors for any proposed individual contract award (not otherwise required by statute to be bid) between Two Hundred Fifty Thousand Dollars ($250,000) and One Million Dollars ($1,000,000), unless a written sole source justification is provided to and approved by the President/CEO. The approved sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

3. Contracts Less Than $250,000.

a. Unless otherwise required by applicable law or this Policy, contracts less than Two Hundred Fifty Thousand Dollars ($250,000) may be awarded without soliciting bids or proposals from multiple vendors. Agreements for legal services shall be

approved by the Board or its designee pursuant to Board Policy No. 14-023.

b. Contracts for electronic data processing and telecommunications goods and services with a cost to the District of more than Twenty-Five Thousand Dollars ($25,000) and less than Two Hundred Fifty Thousand Dollars ($250,000) shall be awarded after obtaining quotes from a minimum of three (3) vendors. Contracts with a cost of Two Hundred Fifty Thousand Dollars ($250,000) or more shall be subject to the procedures stated in Section III.C. (Informal Competitive Purchasing Procedures), subsections 2 and 3, as applicable.

D. Award of Contracts.

1. Electronic Data Processing and Telecommunications Goods or Services Exceeding $25,000.

When the District awards a contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures) for electronic data processing and telecommunications goods or services with a cost to the District of more than Twenty Five Thousand Dollars ($25,000), the contract award shall be based on the proposal which provides the most cost effective solution to the District's requirements, as determined by the specified evaluation criteria. The evaluation criteria may provide for the selection of a consultant or supplier on an objective basis other than cost alone (H&S Code § 32138(c).)

2. Other Contracts.

When the District awards any other contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures), the contract award shall be based on the proposal which is in the best interests of the District. In addition, unless exempted pursuant to Government Code section 4529, contracts for professional architectural, landscape architectural, engineering, environmental, land surveying, construction management and any other services specified in Government Code section 4526, as it may be amended from time to time, shall be awarded on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. In no event shall a contract for such professional services be awarded on the basis of cost alone. (Gov. Code § 4525 et seq.)

IV. PROVISIONS APPLICABLE TO PUBLIC WORKS CONTRACTS

A. Prequalification May Be Required Prior to Bidding on Public Works Contracts.

On a case-by-case basis based on the complexity and estimated cost of a contract, as determined by the President/CEO or his designee, the District may require all prospective bidders, including not only contractors also subcontractors, to prequalify by fully completing a pre-qualification questionnaire available from the District, providing a current Dunn & Bradstreet report and bond rating, and providing all materials requested by the District's Notice of Prequalification of Bidders, and be approved by the District to be on the final Bidders list. A financial statement shall not be required from a prospective bidder who has qualified as a Small Business Administration entity pursuant to paragraph (1) of subdivision (d) of Section 14837 of the Government Code, when the bid is no more than twenty-five percent (25%) of the qualifying amount provided in paragraph (1) of subdivision (d) of Section 14837 of the Government Code.

If prequalification is required by the District, no bid will be accepted from a bidder that has failed to comply with these requirements. If two or more business entities submit a bid on a project as a Joint Venture, or expect to submit a bid as part of a Joint Venture, each entity within the Joint Venture must be separately qualified to bid.

The President/CEO, or his designee, shall adopt and apply, on behalf of the District, a uniform system of rating bidders on the basis of the completed questionnaires and financial statements, in order to determine both the minimum requirements permitted for qualification to bid, and the type and size of the contracts upon which each prospective bidder shall be deemed qualified to bid. The uniform system of rating prospective bidders shall be based on objective criteria.

The District will use the information and documents submitted by prospective bidders as the basis of rating prospective bidders in respect to the size and scope of contracts upon which each prospective bidder is qualified to bid. The District reserves the right to check other sources available.

The prospective bidder's inclusion on the final Bidder's list does not preclude the District from a post-bid consideration and determination on a specific project of whether a bidder has the quality, fitness, capacity and experience to satisfactorily perform the proposed work, and has demonstrated the requisite trustworthiness.

The pre-qualification packages should be submitted under seal and marked "CONFIDENTIAL" to Tri-City Healthcare District Facilities Department by the date and time specified in the quarterly Notice of Prequalification issued by the District.

The pre-qualification packages submitted by prospective bidders are not public records and are not open to public inspection. All information provided will be

kept confidential to the extent permitted by law, although the contents may be disclosed to third parties for the purpose of verification, investigation of substantial allegations, and in the process of an appeal hearing. State law requires that the names of contractors applying for pre-qualification status shall be public records subject to disclosure, and the first page of the questionnaire will be used for that purpose.

Each questionnaire must be signed under penalty of perjury in the manner designated at the end of the form, by an individual who has the legal authority to bind the prospective bidder on whose behalf that person is signing. If any information provided by a prospective bidder becomes inaccurate, the prospective bidder must immediately notify the District and provide updated accurate information in writing, under penalty of perjury.

The District reserves the right to waive minor irregularities and omissions in the information contained in the pre-qualification application submitted, to make all final determinations, and to determine at any time that the pre-qualification procedures will not be applied to a future public works project. The District shall notify each prospective bidder submitting an application for prequalification in writing by first-class mail or email within ten (10) days after the District's decision as to prequalification. Upon request of the prospective bidder, the District shall provide notification to the prospective bidder in writing of the basis for the prospective bidder's disqualification and any supporting evidence that has been received from others or adduced as a result of an investigation by the District.

After receiving notice of the basis for disqualification, the prospective bidder (except where disqualified for failure to submit required information) may file a written protest to the disqualification within seventy-two (72) hours of its receipt of notice of disqualification. Receipt shall be deemed to be two (2) days after mailing of the notice. The written objection shall include specific reasons, facts, supporting documentation and legal authorities explaining why the prospective bidder should be found qualified.. The written objection must be filed with:

Tri-City Healthcare District
Facilities Department
4002 Vista Way
Oceanside, CA 92056

Unless a prospective bidder files a timely appeal, the prospective bidder waives any and all rights to challenge the prequalification decision of the District, whether by administrative process, judicial process or any other legal process or proceeding.

If the prospective bidder gives the required notice of appeal and requests a hearing, the hearing shall be conducted no later than ten (10) business days after the District's receipt of its Notice of Appeal. The hearing so provided shall be conducted by a panel to which the District's Board of Directors has delegated

responsibility to hear such appeals (the "Appeals Panel"). At the hearing, the prospective bidder will be given the opportunity to present information and present reasons in opposition to the pre-qualification determination. At the conclusion of the hearing or no later than three (3) business days after completion of the hearing, the Appeals Panel will render its decision.

Prospective bidders shall be allowed to dispute their proposed prequalification rating prior to the closing time for receipt of bids. In the event that the District circulates bid packages before the completion of a pending appeal, the District will provide the prospective bidder with a bid package only after the prospective bidder has made payment therefore in an amount equal to the District's cost of printing and reproduction of the bid package, if any. The District will reimburse the prospective bidder for such amount if the prospective bidder successfully appeals the disqualification determination and is found to be qualified to submit a bid. The Appeals Panel shall render its decision on the pending appeal prior the closing time for receipt of bids.

B. Bid Security.

All bids shall be accompanied by bid security in an amount equal to at least ten percent (10%) of the total bid price. The security shall be in a form as follows:

1. Cashier's or Certified Check in the required amount; or

2. Bidder's Bond executed by an admitted surety insurer and made payable to the District.

Any bid not accompanied by one of the foregoing forms of bidder's security shall be rejected as non-responsive.

C. License and Registration Requirement.

The notice inviting bids and plans shall identify the required contractor's license classification. (Pub. Cont. Code § 3300.) In every completed bid, and in all construction contracts and subcontracts, shall be included the license number of the contractor and all subcontractors working under him. No project may be awarded to a contractor which is not licensed pursuant to state law or which utilizes subcontractors not so licensed.

Additionally, all contractors and subcontractors listed on a bid proposal for a public works project must be registered with the California Department of Industrial Relations ("DIR") pursuant to Labor Code section 1725.5 (with limited exceptions from this requirement for bid purposes only under Labor Code section 1771.1(a)). No contractor or subcontractor may be awarded a contract for public work on a public works project unless registered with the DIR.

D. Insurance.

All contracts shall require insurance of the type, in amounts and with provisions approved by District Legal Counsel. All contractors awarded contracts shall furnish the District with original certificates of insurance and endorsements effecting coverage required by the contract. The certificates and endorsements for each insurance policy shall be signed by a person authorized by that insurer to bind coverage on its behalf, and shall be on forms supplied or approved by the District. All certificates and endorsements must be received and approved by the District before work commences, or sooner if indicated by the contract documents. The District shall reserve the right to require complete, certified copies of all required insurance policies, at any time.

At a minimum, all general liability and automobile insurance policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (1) the District, its directors, officers, employees and agents shall be covered as additional insureds with respect to the work or operations performed by or on behalf of the contractor, including materials, parts or equipment furnished in connection with such work; and (2) the insurance coverage shall be primary insurance as respects the District, its directors, officers, employees and agents, or if excess, shall stand in an unbroken chain of coverage excess of the contractor's scheduled underlying coverage. Any insurance or self-insurance maintained by the District, its directors, officers, employees and agents shall be excess of the contractor's insurance and shall not be called upon to contribute with it in any way.

At a minimum, all workers' compensation and employers' liability policies shall contain the following provision, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provision to the insurance policies: (1) the insurer shall agree to waive all rights of subrogation against the District, its directors, officers, employees and agents for losses paid under the terms of the insurance policy which arise from work performed by the contractor.

At a minimum, all policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (l) coverage shall not be canceled except after thirty (30) days prior written notice by mail has been given to the District; and (2) any failure to comply with reporting or other provisions of the policies, including breaches of warranties, shall not affect coverage provided to the District, its directors, officials, officers, employees and agents. Insurance carriers shall be qualified to do business in California and maintain an agent for process within the state. Such insurance carrier shall have not less than an "A" policyholder's rating and a financial rating of not less than "Class VII" according to the latest Best Key Rating Guide.

All insurance required by the contract shall contain standard separation of insureds provisions. In addition, such insurance shall not contain any special limitations on the scope of protection afforded to the District, its directors, officers, employees or agents.

All builders'/all risk insurance policies shall provide that the District be named as loss payee. In addition, the insurer shall waive all rights of subrogation against the District. The making of progress payments to the contractor shall not be construed as creating and insurable interest by or for the District, or as relieving the contractor or its subcontractors of any responsibility for loss from any direct physical loss, damage or destruction covered by the builders'/all risk policy occurring prior to final acceptance of the work by the District.

The District shall not be liable for loss or damage to any tools, machinery, equipment, materials or supplies of the contractor. The contractor shall supply to the District an endorsement waiving the insurance carrier's right of subrogation against the District for all policies insuring such tools, machinery, equipment, materials or supplies.

E. Contract Terms.

All contract terms, including, but not limited to, the contract form, general conditions and special conditions, shall include any applicable mandatory public works provisions and shall be approved by District Legal Counsel.

F. Changes in Plans and Specifications.

Every contract shall provide that the District may make changes in the plans and specifications for the project after execution of the contract. Bid procedures as set forth in this Policy need not be secured for change orders which do not materially change the scope of the project, as set forth in the original contract, if the contract was made after compliance with bidding requirements, and if each individual's change order does not total more than five percent (5%) of the original contract. (H&S Code § 32132(c).)

All changes or amendments to the original contract must be in writing and signed by both the contractor and a duly authorized representative of the District.

V. AUTHORITY TO AWARD CONTRACTS

The President/CEO may award contracts within his/her signatory authority as provided in the Approval and Authorization Matrix, and consistent with Board Policy No. 14-023 and this Policy, unless Board of Directors approval is required by law. All contracts exceeding the President/CEO's signature authority shall be awarded by the Board of Directors only.

VI. FLEXIBILITY AND WAIVER OF POLICY REQUIREMENTS

In recognition of the fact that the contracting and procurement needs of the District may from time to time render certain procedures or requirements herein impracticable, the President/CEO or his/her designee is authorized to permit or waive deviations from this Policy, to the extent permitted by law, upon making a written finding that such deviations are in the District's best interests in consultation with District Legal Counsel as to legal issues involved.

Additionally, provisions required by Section "IV" (Provisions Applicable to Public Works Contracts) to be included in public contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts, if appropriate.

VII. CONFLICTS OF INTEREST

As to all contracts covered by this policy, any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration, are prohibited. No employee may participate in the selection process when the employee has a relationship with a person or business entity seeking a contract when disqualified under the provisions of Section 87100 of the Government Code or other provisions of law. (See, Gov. Code § 4526.) Additionally, all employees must comply with the District's Code of Conduct, including restrictions on accepting gifts and entertainment.

Reviewed by the FO&P Committee: 11/21/06
Approved by the Board of Directors: 12/14/06
Reviewed by the FO&P Committee: 11/27/07
Approved by the Board of Directors: 12/13/07
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Approved by the Board of Directors: 12/16/10
Approved by the FO&P Committee: 6/18/14
Approved by the Board of Directors: 6/26/14
Reviewed by the FO&P Committee: 8/18/15
Approved by the Board of Directors: 8/27/15

EXHIBIT A

BIDDING AND COMPETITIVE PROCUREMENT REQUIREMENTS

Category	Bidding or Competitive Procurement Requirement
Materials and supplies to be furnished sold or leased to the district involving an expenditure of more than $25,000	Bidding required. (See Health & Safety Code § 32132, subd. (a).) This is the general rule, some specific exceptions apply as listed below. Emergency Exception: Bidding not required if board of directors first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property. (See Health & Safety Code § 32136.)
Work involving an expenditure of more than $25,000 (including public works)	Bidding required. (See Health & Safety Code § 32132, subd. (a).) Emergency Exception: Bidding not required if board of directors first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property. (See Health & Safety Code §32136.) Change Orders - Bids are not necessary for change orders that do not materially change the scope of the work if the contract was awarded through bidding and each individual change order does not total more than 5 percent of the contract. (See Health & Safety Code § 32132, subd. (c).)
Medical or surgical equipment or supplies	Bidding does not apply. (See Health & Safety Code § 32132, subd. (b).) This includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital. (See Health & Safety Code § 32132, subd. (d).)
Electronic data processing and telecommunications goods and services	If the cost is less than or equal to $25,000, no bidding requirements. (See Health & Safety Code § 32132, subd (b).) If the cost is more than $25,000, must be procured

Category	Bidding or Competitive Procurement Requirement
	through competitive means as described by statute. (See Health & Safety Code § 32138.) Exception: Competitive means not required if the board determines either that (1) the goods and services proposed for acquisition are the only goods and services which can meet the district's need, or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety. (See Health & Safety Code § 32138, subd. (a).)
Professional services	Competitive bidding does not apply. (See Health & Safety Code § 32132, subd. (b); see also Gov. Code § 53060.) Architectural, landscape architectural, engineering, environmental, land surveying and construction management services must be selected on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. (See Gov. Code § 4525 et seq.) Exception: These provisions do not apply where the District head determines that the services needed are more of a technical nature and involve little professional judgment and the requiring bids would be in the public interest. (See Gov. Code § 4529.)
Energy conservation contracts	District may enter into such contracts after a public hearing and findings required by statute. (See Gov. Code § 4217.10 et seq.)

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - NEUROSURGERY

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Alexander A. Khalessi, M.D.

Area of Service: Emergency Department On-Call: Neurosurgery

Term of Agreement: 12 months, Beginning, Feb 1, 2017 – Ending, January 31, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Neurosurgery
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$800	365	$292,000
	Total:	$292,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurosurgery specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Alexander Khalessi M.D. to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning February 1, 2017 and ending January 31, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Neurology

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Kalyani Korabathina, M.D.

Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 12 months, Beginning, February 1, 2017 – Ending, January 31, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Neurology
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$740	365	$270,100
	Total:	**$270,100**

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurology specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Kalyani Korabathina M.D. to the currently existing ED On-Call Coverage Panel for Neurology for a term of 12 months, beginning February 1, 2017 and ending January 31, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
SURGICAL LIGHT REPLACMENT AND VIDEO INTEGRATION PROPOSAL, O.R. #2

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Stryker (Berchtold Lights and Stryker Video Integration)
Sun Structural Engineering (Design)
McCoy Construction (Construction/Installation)

Area of Service: Surgery

Term of Agreement: One-Time Purchase

Maximum Totals:

Item:	**Amount:**
• Purchase of Berchtold F-Generation Surgical Lights and ChromoVision Camera System Full HD for E	$75,639
• Purchase of SwitchPoint Infinity All-in-One HD Digital Routing System, ProCare Service Plan for Three (3) Years and Misc. Accessories	$111,252
• Purchase of SDC 3 Base w/SDP 1000 printer kit and wireless transmitter	$28,850
• Construction (publicly bid agreement with McCoy Design & Construction)	$76,197
• Design Services, Inspection Services, Permit Fees, Contingency	$52,170
• 8% Tax, Shipping & Handling	$21,720
Total Expected Cost:	**$365,828**

Description of Services/Supplies:

- Replacement of Surgical Lights in OR 2 , along with installation of an integration system to allow for better image availability during minimally invasive surgery and storage of images:

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Mary Diamond, Sr. Director-Nursing, Surgical Services / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the publicly bid agreement with McCoy Design & Construction for $76,197, and the purchase of equipment to replace the lights in operating room 2, for a total expected project cost of $365,828.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
KEY HEALTHCARE CONSULTING, LLC PROPOSAL

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Vendor's Name: Key Healthcare Consulting, LLC

Area of Service: Charge Entry Services for Hospital Emergency Room, Crisis Stabilization Unit and Observation

Term of Agreement: 36 months, Beginning, March 15, 2017 – Ending, March 14, 2020

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$23,791	$285,492	$856,476

Description of Services/Supplies:

- KHC will provide charge entry services for Hospital Emergency Department, Observation accounts and Crisis Stabilization Unit within 3 days from the date of service. This is a per visit charge of $2.92 per visit for ED and $18.00 per visit for Observation and the Crisis Stabilization Unit. The monthly cost is based on number of visits. We do not expect to go over the maximum total.
- Procedures for which the consultant will enter charges include injection, infusion and vaccine administration charges defined by CPT Guidelines
- KHC determines ED level of care and number of observation and CSU hours charged
- KHC provides quarterly audit reports which include, duplicate charges, injection, E/M, modifiers, missing charges, meds and audit procedure errors. Additional training is provided as needed.
- KHC provides education to staff to correctly capture additional procedure charges

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Joni Penix, Director, Patient Financial Services / Sharon Shultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Key Healthcare Consulting, LLC for Charge Entry for a term of 36 months beginning, March 15, 2017 and ending, March 14, 2020 for an expected annual cost of $285,492, and an expected total cost for the term of $856,476.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
PHYSICIAN AGREEMENT for Cardiac Rehabilitation Physician Supervision

Type of Agreement		Medical Directors		Panel		Other: Supervising Physician
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Sharon M. Slowik, M.D.

Area of Service: Cardiac Rehabilitation Services, On-Site and Wellness Center

Term of Agreement: 24 months, Beginning, July 1, 2017 – Ending, June 30, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$148.30	39	468	$5,783.70	$69,404.40	$138,808.80

Position Responsibilities:

- Cardiac rehabilitation Wellness Center Supervising Physician in accordance with CMS 42 CFR 410.49 (Direct supervision of the Cardiac Rehabilitation program by a physician is a requirement).
- Maintain cardiac rehabilitation program as a physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.
- Attend meetings with Hospital administration, Hospital's medical staff as required by Hospital and/or Dept.
- Participate in and otherwise cooperate with continuing education and in-service training of Department Personnel and others working in Department.
- Assure that adequate medical coverage is provided for Cardiac Rehabilitation clinical services activities performed within Department during hours of operation.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Eva England, CV Service Line Administrator/ Kapua Conley, Chief Operating Officer

Motion:

Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon M. Slowik as the Coverage Physician for a term of 24 months beginning July 1, 2017 and ending June 30, 2019. Not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404.40, and a total cost for the term of $138,808.80.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
Physician Agreement for Medical Director for Behavioral Health Services – BHU

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Neil Richtand, M.D., Ph.D.
Area of Service: Behavioral Health Unit (BHU)
Term of Agreement: Beginning, March 11, 2017- Ending, March 31, 2018
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Annual Cost	Term Cost
$150	42	504	$75,600	$81,900

Position Responsibilities:

- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital's and medical staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	No*
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Neil Richtand as the Medical Director of the BHU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of $75,600, and a term cost of $81,900.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
Physician Agreement for Medical Director for the Crisis Stabilization Unit – CSU

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Neil Richtand, M.D., Ph.D.
Area of Service: Crisis Stabilization Unit (CSU)
Term of Agreement: Beginning, March 11, 2017 - Ending, March 31, 2018
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Annual Cost	Term Cost
$150	42	504	$75,600	$81,900

Position Responsibilities:

- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital's and medical staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	No*
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Neil Richtand as the Medical Director of the CSU, beginning March 11, 2017 through March 31, 2018, not to exceed an average of 42 hours per month, at an hourly rate of $150 for an annual cost of $75,600, and a term cost of $81,900.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 14, 2017
PHYSICIAN AGREEMENT for Dr. Mark Sadoff – Rehabilitation Services

Type of Agreement	X	Medical Directors		Panel	X	Other: Add Responsibilities
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Mark Sadoff, M.D.

Area of Service: Add Telemedicine to Current Responsibilities
Term of Agreement: 16 months, Beginning, March 1, 2017 – Ending, June, 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	16 month (Term) Cost
$165	80	960	$13,200	$158,400	$211,200

Position Responsibilities:

- Physician has an active /current contract. Agreement would add Telemedicine consultation services within the scope of Dr. Sadoff's current duties, permitting greater time sensitive accessibility to physician, for the benefit of the unit.
- Total hours per month will include Telemedicine and will not exceed the current maximum of 80 hours a month. No change in hourly rate for current contract term.
- Provide Medical oversight for patients admitted to the Acute Rehabilitation Unit at TCMC
- Provide services as Medical Director of Rehabilitation services and specifically for the Acute Rehab Unit
- ***Add on*** Include Telemedicine Services within the current scope of duties up to a maximum of 10 hours per month

Document Submitted to Legal:		Yes	X	No*
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Priya Joshi, Director, Rehab Services / Kapua Conley, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the addition of responsibilities to the current Medical Director of Rehabilitation Services contract, with no additional cost.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
February 9, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. Ma, Dr. Johnson, Dr. Contardo and Dr. Worman.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Kathy Topp, Kevin McQueen, Lori Roach, Michelle Musich, Priscilla Reynolds, Mary Diamond, Sharon Davies, Carol Reeling, Patricia Guerra and Karren Hertz.

Members Absent: Jami Piearson, Director of Regulatory Compliance.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:01 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of January 2017.	Director Mitchell called for a motion to approve the minutes from January 12, 2017 meeting. There were a couple of corrections regarding the Interpretation and Translations Services policy and also in the follow-up section where Director Schallock's name was erroneously written.	The minutes were ratified following the amendments made. Dr. Ma moved and Director Dagostino seconded the motion to approve the minutes from January 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Child Passenger Restraint System Education Policy 2. Consent for Operative or Other Procedures 3. Diabetes Education Procedure	There was no discussion on this policy. There was question regarding the consent for surrogates; the issue is there always need to be two physicians present for consent but the policy states only one is needed. Marcia clarified that there are two physicians needed for interdisciplinary conference only but not for the procedural part. There seems to be a continuous challenge with the diabetes education. The challenge is in monitoring the patient's diet to keep their blood sugar at a stable rate. It was also noted that patients with gestational	**ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	diabetes are being currently referred to the Sweet Success program.		
4. In Custody Patients' Policy	A clarification made by Diretor Mitchell indicated the difference between an inmate on physical arrest and patients that are in custody. Director Dagostino also noted of the new term "justice involved" for the description of forensic patients.		
5. Knee Immobilizer Application and Range of Motion (ROM) Brace	This policy is being amended and will be approved with the amendments made. Priya Joshi made some modifications to this policy.		
6. Swallow Screening in the Adult Patient Procedure	There was no discussion on this policy.		
Administrative Policies and Procedures:			
1. Administrator On-Call 281	It was noted that there are two separate administrator on-call—one is for clinical since most of the emergent issues are patient-related and other one is administrative which calls out the C-suite involved when there is a house-wide issue after hours.	**ACTION:** The Administrative policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Lost and Found Articles-202	Director Dagostino clarified to the group that tthe hospital has a safe for lost and found articles.		
Unit Specific			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Infection Control			
1. Transmissible Spongiform Encephalopathies (TSE)	Dr. Contardo mentioned that new regulations just came out regarding some issues mentioned in this policy.	**ACTION:** This policy will move forward for approval after putting in some updated information provided by Dr. Contardo.	Patricia Guerra
Surgical Services			
1. Block Time Policy	It was discussed that Dr. Lee, the Medical Director of OR and Mary Diamond, in coordination with the OR Committee regularly reviews the surgery schedule to avoid unnecessary block of time that the OR is not being used.	**ACTION:** This Surgery policies were approved. Dr. Ma moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Bumping Surgery Procedures Policy	In cases of emergent situation, the communication between physicians is very vital to avoid bumping surgery cases.		
3. Disaster and Emergency Preparedness Policy	This policy encompasses the emergency preparedness of the OR.		
4. OR Committee Policy	Dr. Dandy Lee is doing a good job of addressing all the issues in the OR as he heads the OR Committee as well.		
5. Pre-Operative Requirements Policy	There was no discussion on this policy.		
6. Safe Medical Device Act-Tracking and reporting Policy	There was no discussion on this policy.		
7. Scheduling Surgical Services Policy	Mary Diamond emphasized that sometimes there needs to be clarity in the time		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	specified. If a patient was told that he/she is having surgery at 7:30AM; that means he/she needs to be inside the OR area being prepped up and not in the waiting area.		Patricia Guerra
8. Scope of Services for Surgical Services Policy	It was noted that there needs to be a parameter for the scope of services intended for adults and then for pediatrics.		
Telemetry			
1. Assignments	Sharon mentioned that RNs in Telemetry unit have ACLS assignment too.	**ACTION:** The Telemetry policy and procedure was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Women's and Newborn Services			
1. Hydralazine Hydrochloride	This policy is being deleted since the policy pertaining to hypertension includes this policy already.		
2. Neonatal Team Attendance at a Delivery	Sharon Davies reported that a neonatologist is always present in the OB department for either in emergent or elective deliveries. It was also noted that only a neonantologist or NP can intubate a baby.	**ACTION:** Upon Dr. Johnson's recommendation, it was agreed that Sharon D. will ask the people to introduce themselves on deliveries so the staff and patient is aware of who is present in the room.	Sharon Davies
3. Standards of Care: Newborn	The checking of vitals signs is always a part of the standards of care for a newborn.		
4. Standards of Care:	There was no discussion on this policy	**ACTION:** The Women's and Newborn Services policies were	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Postpartum		approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Ma seconded and it was unanimously approved to go into closed session at 1:00 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:11 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
February 9th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Child Passenger Restraint System Education Policy	practice change	Forward to BOD for approval
2. Consent for Operative or Other Procedures	practice change	Pulled for further review
3. Diabetes Education Procedure	3 year review, practice change	Forward to BOD for approval
4. In Custody Patients Policy	3 year review, practice change	Forward to BOD for approval with revisions
5. Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure	3 year review, practice change	Forward to BOD for approval with revisions
6. Swallow Screening in the Adult Patient Procedure	3 year review, practice change	Forward to BOD for approval
Administrative Policies & Procedures		
1. Administrator On Call - 281	3 year review, practice change	Forward to BOD for approval
2. Lost and Found Articles - 202	3 year review, practice change	Forward to BOD for approval
Department Specific		
Infection Control		
1. Transmissible Spongiform Encephalopathies (TSE)	3 year review, practice change	Forward to BOD for approval
Surgical Services		
1. Block Time Policy	3 year review, practice change	Forward to BOD for approval
2. Bumping Surgery Procedures Policy	3 year review, practice change	Forward to BOD for approval
3. Disaster and Emergency Preparedness Policy	3 year review, practice change	Forward to BOD for approval
4. OR Committee Policy	3 year review, practice change	Forward to BOD for approval
5. Pre-Operative Requirements Policy	DELETE	Forward to BOD for approval
6. Safe Medical Device Act - Tracking and Reporting Policy	DELETE	Forward to BOD for approval
7. Scheduling Surgical Procedures Policy	3 year review, practice change	Forward to BOD for approval
8. Scope of Service for Surgical Services Policy	3 year review, practice change	Forward to BOD for approval with revisions
Telemetry		
1. Assignments	3 year review, practice change	Forward to BOD for approval
Women & Newborn Services		
1. Hydralazine Hydrochloride	DELETE	Forward to BOD for approval
2. Neonatal Team Attendance at a Delivery	3 year review, practice change	Forward to BOD for approval
3. Standards of Care: Newborn	3 year review, practice change	Forward to BOD for approval
4. Standards of Care: Postpartum	3 year review, practice change	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/2012	**SUBJECT:** Child Passenger Restraint System Education
REVISION DATE:	**POLICY NUMBER:** V.E

Department Approval:	08/16
Clinical Policies & Procedures Committee Approval:	~~05/15~~09/16
Nurse Executive Council Approval:	~~05/15~~09/16
Department of Pediatrics Approval	~~02/16~~11/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/16~~01/17
Professional Affairs Committee Approval:	~~04/16~~01/17
Board of Directors Approval:	04/16

A. **PURPOSE:**

1. The purpose is to provide a method for disseminating information to parents/authorized caregivers of infants and young children regarding child passenger safety seats.
2. Prior to the discharge of any child under age 8, regardless of weight, or less than 4 feet 9 inches (regardless of age), the parents or authorized caregiver to whom the child is being released, will be given information regarding current child passenger restraint system. Included are the risks associated with their non-use or misuse. A list of programs offering rental and no or low-cost purchase will be available.

B. **POLICY:**

1. Before an infant or young child is discharged, the parents or authorized caregiver to whom the child is being released, will be verbally informed of the need to have an age-appropriate child passenger safety seat, about Car Seat Safety and the importance that all children under 13 years of age ride in the back seat and be properly buckled when being transported.
   a. This information shall be provided to all parents of children receiving care in the Emergency Department and in Women and Newborn Services.
      i. Infants must be properly buckled in a rear-facing car seat in the back until they are at least ~~1 year old AND 20 pounds.~~ **2 years old (except for those that are 40 inches tall or 40 pounds or more).**
         ~~1) The American Academy of Pediatrics (AAP) recommends rear facing until the age of 2 or the maximum weight of the car seat for rear facing.~~
      ii. If a child is too large for a safety seat, the AAP recommends children who are 4 feet 9 inches tall or shorter ride in a belt positioning booster seat, regardless of age.
      iii. Children **age 8 or older, or** who are over 4 feet 9 inches **or taller may**~~can~~ use a lap~~/~~-shoulder belt if:
         1) The child can sit all the way back/ hips against the seat.
         2) The child's knees bend comfortably at the edge of the seat.
         3) The shoulder strap should cross **the center of the chest**~~over the shoulder between the neck and the arm~~.
         4) The belt fits low and flat on the hips.
         ~~4)~~**5) Child remains seated.**
         ~~5)~~**6)** If the answer is no to any of the following, then a booster is still required according to the California Law.

b. It is illegal for a person to smoke a pipe, cigar or cigarette in a motor vehicle in which there is a minor [Health and Safety Code Section 118948].

c. A parent, legal guardian, or other person responsible for a child who is 6 years of age or younger may not leave that child inside a motor vehicle without being subject to the supervision of a person who is 12 years of age or older, under either of the following circumstances.
   i. Where there are conditions that present a significant risk to the child's health or safety.
   ii. When the vehicle's engine is running or the keys are in the ignition, or both.

b. Other regulatory recommendations:
   i. Toddlers should remain rear-facing until they reach 2 years of age ~~or until they reach the upper weight and height limit of the car seat~~ **except if they are 40 inches tall or weigh 40 pounds or more**. Always follow the manufacturer's instructions for proper use and fit.
   ii. Do not buy a used car seat if you do not know if it has been in a crash.
   iii. Do not buy a car seat that is older than 6 years or has been in a crash.
   iv. Children should ride in the back seat until they are 13 years old.
   v. Never allow your child to place the shoulder belt behind his/her back or under the arm.
   vi. Never seat a child in front of an airbag.
   vii. Never leave your child alone in or around cars.

2. Literature available in both English and Spanish will be provided outlining current state laws regarding ~~this issue,~~ proper use of safety seats, and risk of death/injury associated with non-use or misuse, including air-bag issues.

3. Prior to the discharge of the child, parent/conservator or guardian shall provide a signature that this information was reviewed and discussed.
   a. Person receiving information outlining current law requiring child passenger restraint system, will sign the "release of a child under 8 years of age" form. The original will be kept in the medical record and a copy will be given to the person to whom the child is released.

4. Hospitals are required only to provide and discuss information concerning child passenger restraint system laws.
   a. Hospitals are not required to, and should not attempt to prevent a parent (or other authorized person) from transporting a child in a vehicle which does not have a child passenger system.
   b. Hospitals also should not instruct parents regarding how to install a car seat or help parents install a car seat, for liability reasons. A parent with questions about appropriate car seat installation should be referred to a local police or fire station, a local CHP office or loan program. Parents may also call (866) SEAT-CHECK or visit www.seatcheck.org to locate free car seat inspection facilities.

5. Facilities that provide the required information to the person to whom the child is released cannot be held legally responsible for the failure of that person to use a child passenger restraint system.

C. **REFERENCES:**

1. California Highway Patrol www.chp.ca.gov, retrieved January 2017
2. Following California Laws Will Keep You Child Safe in the Car, https://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/ParentBrochure-English.pdf, retrieved January 2017
3. www.Kohlscarsafety.org.
4. National Highway Traffic Safety Administration www.safercar.gov/Air+Bags, retrieved January 2017
~~**1.**~~**5.** Pacific Safety Council, 9880 Via Pasar, Suite F, San Diego, CA 92126, Phone: 858-621-2313 or http://www.safetycouncilonline.com/full/url/

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DIABETES EDUCATION AND DISCHARGE PLANNING**
Purpose:	To outline Nursing's responsibility for providing survival skill diabetes self-management education
Supportive Data:	American Diabetes Association (ADA), American Association of Diabetes Educators (AADE) guidelines and The Joint Commission Certification Compliance/Standards.
Supplies	Diabetes Patient Education Booklets, selected medication education leaflets, blood glucose meters with test strips.

A. **DIABETES EDUCATION**:

1. It is not necessary to obtain an order for Diabetes Education from the physician.
2. All patients **with diabetes** should be assessed for diabetes self-management deficits deemed to be survival skills by the Joint Commission's education compliance standards.
3. This includes patients who are newly diagnosed or patients who have a history of diabetes whether it is Type 1, Type 2, Gestational Diabetes, or pre-diabetes.
4. The required elements of education are all included in the Diabetes Patient Education Booklets.
5. The Tri-City Medical Center (TCMC) Type 1 Diabetes Booklet should be used for patients newly and previously diagnosed. Patients admitted with **diabetic ketoacidosis (**DKA**)** will most likely, though not always, fall into this category.
6. The TCMC Type 2 Diabetes Booklet should be used for patients newly and previously diagnosed with Type 2 Diabetes, pre-diabetes, and Gestational Diabetes.
7. Every patient admitted to TCMC as an inpatient is assessed by a Registered Dietitian (RD). Education on meal planning ~~is~~**may be** provided by the RD, **depending on the circumstances of admission to the hospital, e.g. DKA** ~~at a minimum, according to.~~ **T**~~t~~he content in the Patient Diabetes Education Booklets **serves as the basis for meal planning education by the RDs**. This **same** content ~~can also be~~ **is used** ~~reinforced~~ by the Registered Nurse.
8. Each diabetic patient or at risk patient should have an A1c done on admission. **If the A1c is not done, obtain order from physician.**
   ~~a. The result should be written in the patient's booklet and documentation that the result was shared with the patient should be included on the Diabetes portion of the Education All Topics Ad Hoc form.~~
   ~~b.~~**a.** An A1c greater than 8% warrants a change in medication and/or better self-management.
9. The Interdisciplinary Plan of Care (IPOC) should include "Adult Diabetes Endocrine" from which all education elements can be accessed for documentation.

~~9.~~**10. All education is documented on the Education All Topics Ad Hoc Form or in IView.**

~~10. The Family Risk Assessment can be completed by using the Diabetes Risk Test written by the ADA and found in the education booklets.~~

B. **TEACHING SUPPLIES:**

1. Supplies should be obtained as soon after admission as possible so that there is enough time for learning
2. The Diabetes Education Booklets contain all of the topics required for teaching in an inpatient setting.
3. The Inpatient Diabetes Educator is available to all nursing staff for complex patient education and management. Examples include:
   a. Repeated hypoglycemic episodes
   b. Persistent hyperglycemia
   c. Patients with insulin pumps
   d. Patients with frequent readmissions
   e. Patients with learning difficulties

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Diabetes Task Force	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/06; 1/10; 2/13	1/06; 3/09; 2/10; 3/13, **10/16**	2/06; 5/09; 2/10;3/13, 10/16	12/16	**n/a**	2/06; 5/09;3/10; 1/14, **01/17**	3/06; 6/09; 4/10; 2/14, **02/17**	3/06; 6/09; 4/10;2/14

4. The Diabetes Task Force is a multidisciplinary committee that generally meets every other month. Diabetes care issues may be brought to this committee for discussion and resolution.

~~4.~~**C. DIABETES DISCHARGE PLANNING:**

1. **Prior to discharge, a diabetes care follow-up appointment is made with the provider who cares for the patient's diabetes.**
   a. **The appointment is documented in the electronic health record (EHR) including the provider, date and time.**
      i. **If unable to schedule an appointment document reason in EHR.**
2. **Outpatient Diabetes Self-Management Education classes are encouraged. Registration information is found in the Diabetes Education Booklets.**
3. **The A1c is shared with the patient and documented in EHR.**
4. **The Family Risk Assessment (found on the back cover of the Diabetes Education Booklets) is provided to the patient with an explanation that siblings and children of the patient assess their risk for diabetes.**
5. **Prescriptions for diabetes supplies should be written for patients as needed, especially patients who are newly diagnosed with diabetes. These include:**
   a. **Glucose meter, lancets, and strips**
   b. **Glucagon emergency kit if patient is prone to severe hypoglycemia**
   c. **Ketone test strips for patients admitted for dka**
   d. **Syringes and/or pen needles**

~~C. DIABETES EDUCATIONAL TOPICS:~~

~~1. Document any education provided to the patient/caregiver and/or family member regarding the patient's diabetes in the Diabetes section of the Education All Topics Powerform.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 4/97	**SUBJECT:** ~~In-Custody Patients~~**Justice Involved Patients**
REVISION DATE: 10/99, 6/03, 8/05, 8/07, 4/12	**POLICY NUMBER:** VI.B.2

Department Approval:	**11/16**
Clinical Policies & Procedures Committee Approval:	**~~04/12~~12/16**
Nurse Executive Council Approval:	**~~10/12~~01/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/13~~01/17**
Professional Affairs Committee Approval:	**~~02/13~~02/17**
Board of Directors Approval:	**02/13**

A. **PURPOSE**

1. To establish guidelines for the responsibility of patients who are **justice involved individuals**~~in-custody, prisoners~~ receiving medical care, and/or are admitted to Tri-City **Healthcare District**~~Medical Center~~ **(TCHD) facility**.

. **DEFINITIONS**

1. **Law Enforcement Personnel**~~Custody Officer~~: Any Federal, State, or Local Peace Officer or **Correctional** ~~ustody~~ Officer or their contract agencies **that has the responsibility for the custody of justice involved individual**.
2. **Justice Involved Individual:** ~~Prisoner: a~~ **A**ny individual who is under lawful physical arrest~~/ and~~ in the custody of a **Law Enforcement Officer** ~~Custody Officer~~ and brought to ~~Tri-City Medical Center~~**TCHD** to receive medical care, evaluation, treatment, or admission.

C. **POLICY**

1. Law Enforcement personnel, in consultation with ~~Tri-City Medical Center~~**TCHD** personnel, are responsible for considering issues related to the use of restraint for non-clinical purposes; imposition of disciplinary restrictions and the restriction of rights.
2. Law Enforcement shall be responsible for maintaining the security and the detention of any **justice involved individual** ~~prisoner~~ seen or admitted for medical care of the duration of the admission. The ~~Tri-City Medical Center~~**TCHD** Security Department shall be the contact liaison between the custodi**al**~~y~~ agency and the Medical Center. ~~Tri-City Medical Center~~**TCHD** Security Department personnel shall not assume any custodial duties as they relate to **justice involved individual**~~the prisoner~~.
3. The Admitting Physician is responsible for determining the **justice involved individuals**~~prisoner's~~ plan of care while in the Medical Center, including the length of stay for medical treatment, the discharge plan, and consulting with the **law enforcement** ~~custodial~~ agency in the continuing care and discharge plan.
4. Patient care shall be delivered to the **justice involved individual** ~~prisoner~~ as determined by the Clinical Staff, following the admitting Physician's orders and hospital or departmental standards of care, that also meets and respects security concerns and restrictions
5. ~~Tri-City Medical Center~~**TCHD** recognizes the American Civil Liberties Union and will ensure that **justice involved individuals**~~prisoners~~ receive adequate medical care while **admitted to** ~~TCMC~~**TCHD**.~~in custody.~~

6. Registration Department Responsibilities:
   a. The Registration Department shall notify Security (via **Private Branch Exchange (PROGRESSIVE CARE**PBX) when a~~n~~ **justice involved individual** ~~in-custody prisoner~~ is admitted to either the Emergency Department or the Medical Center with the following information:
      i. Patient Name
      ii. Location of ~~Prisoner~~ **justice involved individual**
      iii. **Law Enforcement** ~~Custodial~~ Agency responsible for patient
7. Security Department Personnel Responsibility:
   a. Security personnel shall:
      i. Contact the **Law Enforcement Officer**~~Custodial Officer~~ responsible for guarding the **justice involved individual**~~prisoner~~.
      ii. Establish communications.
      iii. Orient the **Law Enforcement** ~~Custodial~~ Officer using the "~~Forensic~~**Progressive Care** Service Training" form (attachment 1).
      iv. Obtain Custodial Officer's signature indicating they have read the "Forensic Services Training" form.
   b. Security shall liaison with the Assistant Nurse Manager (ANM) or designee and the Administrative Supervisor **(AS)** to verify that the proper measures are being used by the agency responsible for the **justice involved individual** ~~prisoner~~ as it relates to the safety, security, and welfare of all patients, visitors, and staff members.
   c. Any situation that puts the safety, security, and welfare of any patient, visitor, or staff member at risk shall be immediately reported to the Lead Security Officer on duty. The Lead Security Officer shall inform the Security Supervisor and Risk/Legal Services.
8. **Law Enforcement Officer** ~~Custodial Officer~~ Responsibilities:
   a. **Law Enforcement** ~~Custodial~~ Officers shall **maintain custodial**~~use forensic~~ restraints on the **justice involved individual** ~~prisoner~~ at all times, unless the medical condition or prescribed treatment indicates otherwise.
   b. Should **medical** restraints or seclusion of a **justice involved individual** ~~custody patient~~ for behavioral or medical issues become necessary, ~~Tri-City Medical Center~~**TCHD** policies shall be followed.
9. Security Supervisor Responsibilities:
   a. If the Lead Security Officer informs the Security Supervisor of a safety issue, the Security Supervisor shall contact the **law enforcement agency** ~~custodial agency~~ involved in the incident to resolve the issue.
   b. The Security Supervisor shall contact the **Administrator of the Law Enforcement agency** ~~custodial agency~~ responsible for the **Law Enforcement Officer**~~Custodial Officer~~ regarding any violation of this policy.
   c. The Security Supervisor shall maintain a file regarding the **involved Law Enforcement Officer** ~~Custodial Officer~~ and incident.

D. RELATED DOCUMENTS:

~~c.~~**1. Progressive Care Services Training**

~~Attachment 1~~

1. **Medical Evaluation and Treatment:**
The primary concern for ~~Tri-City Medical Center~~**TCHD**'s Clinical Staff is the proper treatment and care of the **justice involved individual** ~~prisoner~~ and the safety, security, and welfare of all ~~P~~**p**atients, ~~V~~visitors, and **s**~~S~~taff **m**~~M~~embers.

2. **Custodial ~~Forensic~~ Restraints:**
Law Enforcement ~~Custody~~ Officers are required to remain with the **justice involved patient** ~~prisoner~~ at all times while in the Medical Center. The **justice involved patients** ~~prisoner~~ must remain in **custodial** ~~forensic~~ restraints at all times and the **Law Enforcement** ~~Custody~~ Officer must have a key in his/her possession.

3. **Evacuation:**
Medical Center personnel are familiar with the evacuation routes. In the event an evacuation becomes necessary, the **Law Enforcement** ~~Custody~~ Officer must remain with the **justice involved patients** ~~prisoner~~ at all times. ~~**TCMC**~~**TCHD**~~Medical Center~~ personnel shall direct you and the **justice involved patients** ~~prisoner~~ out of the Medical Center.

4. **Facility Orientation:**
The Security Officer conducting this orientation shall show you where the restrooms, phones, and exits are located. Smoking is not permitted inside the Medical Center and only permitted in designated areas on the campus.

5. **Cell Phones:**
The use of personal cell phones shall follow ~~TCMC~~TCHD policy as well as the Law Enforcement Agency
Policy regarding use while on duty. Cell phones may not be used to photograph patients or any Individual including self without permission from ~~TCMC~~TCHD admistration.

~~5.~~ **Security Codes:**
Internal and external disasters or security codes are communicated to Medical Center personnel by overhead paging using the below listed codes. -It is not necessary for the Custody Officer **Law Enforcement Officer** to respond in any way to a code unless directed by a ANM or designee, Security, or the Administrative Supervisor.

Code Blue:	Adult Arrest/Medical Emergency	Code Adam:	Infant Abduction
Code Pink:	Infant Arrest/Medical Emergency	Code Gray:	Hostage Situation
Code Yellow:	Radiation Disaster	Code Orange:	Internal/External Disaster
Code Green:	Oxygen Emergency	Code Red:	Fire
Dr. Strong:	Violent Person	Code Caleb:	Severely ill infant
Code OB	STAT Team Mobilization	Code Silver:	Active shooter situation

~~76.~~ **Phones:**
To contact the operator in case of an emergency dial "66." Dial "80" and then "911" to contact the local police department in case of an emergency. Dial "80" for an outside line for non-emergency calls. Personal calls are not allowed. The **custodial Law Enforcment Officer** ~~Custody Officer~~ is required to call Security and notify them if the **justice involved patient**~~prisoner~~ is ~~moved~~ **transferred** within the Medical Center. To contact the operator, Administrative Supervisor, or Security, dial "0."

~~87.~~ **Relief:**
The **custodial Law Enforcement** ~~Custody~~ Officer's agency is responsible for providing relief for the on-duty Officer. Medical Center staff, including Medical Center Security Officers, may not take custody of any prisoner. The on-duty **custodial Law Enforcement** ~~Custody~~ Officer must call the Security Department and have an Officer dispatched to your location to orientate the relief **custodial Law Enforcement** ~~Custody~~ Officer. Each **custodial Law Enforcement** ~~Custody~~ Officer shall be required to sign a copy of the "~~Forensic~~**Progressive Care** Services Training" form.

~~8.~~ **Patient Confidentiality:**
In the course of medical treatment for the prisoner, the **custodial Law Enforcement** ~~Custody~~ Officer may become aware of the **justice involved patient's** ~~prisoner's~~ personal history, medical history, diagnosis, and treatment plan. This information is confidential and may not be shared with anyone

including the **Law Enforcement** ~~Custody~~ Officer's agency. Violations of the justice involved individual's confidential information could result in legal action.

I certify that I have read and understand the above requirements and that I have received a copy of this document for my records.

Signature	Print Name	Date
Agency Name	Patient Name	Room Number

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**KNEE IMMOBILIZER APPLICATION AND RANGE OF MOTION (ROM) BRACE**
Purpose:	To outline the nursing responsibilities in the application of knee immobilizer.
Supportive Data:	Knee immobilizers provide support to prevent knee flexion. Requires a physician order.
Equipment:	Knee immobilizer/universal knee splint; ROM brace.

A. **KNEE IMMOBLIZER:**

1. Assess neurovascular status and skin integrity of patient pre and post application of splint and ongoing~~.~~ (**ie. ~~M~~minimum** every 4 hours or per physician orders~~.~~). **Include proper placement of the splint while splint is on.**
2. Place leg inside immobilizer with posterior fossa resting in posterior panel so that when the immobilizer is secured, **it is in~~the~~ alignment with** patella **if~~is~~** visible **(if not compare with contra-lateral patella). It is not necessary for the patella strap to ~~may not~~ fasten.**
3. ~~Close anterior panel over medial panel.~~
4. ~~4.~~**3.** ~~Run~~ **Apply** Velcro straps through metal loops ~~and then secure~~**snugly,** ~~Velcro straps should not be so tight as to~~ **but not** restrict**ing** venous flow.
5. ~~5.~~**4.** Record neurovascular assessment, application of immobilizer/splint, and patient's tolerance in the medical record.

B. **RANGE OF MOTION (ROM) BRACE:**

1. Assess neurovascular status and skin integrity of patient pre and post application of brace. (**ie.** ~~Minimum~~ **minimum** every 4 hours or per physician orders.)
2. Set dial for extension and flexion per physician order.
3. Open brace and place under leg. Line padding up for lower and upper sections of leg and making sure that circular padding lines up with knee joint, using popliteal fossa as a point of reference.
4. Close ~~up~~ padding with Velcro**, starting at the bottom and working upwards**.
5. Apply Velcro straps snugly, but not restricting venous flow.
6. Record neurovascular assessment, application of brace, and patient's tolerance in the medical record.

C. **REFERENCES:**

1. ~~W.B. Saunders Co. (2004). Orthopedic nursing, 4th ed.~~**National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**
2. **NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/93, 01/11	02/11, **11/15**	03/11, **12/15**	**05/16**	04/11, **10/16**	05/11, **02/17**	12/93, 5/00, 6/00, 7/03, 1/06, 6/08, 05/11

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**SWALLOW SCREENING IN THE ADULT PATIENT**
Purpose:	To screen for appropriateness of oral intake.
Supportive Data:	The swallow screen is performed on any **medically stable** patient who is at risk for aspiration secondary to the inability to swallow safely. This includes the nursing assessment of patient alertness, respiratory status, secretion management, voice quality and an effective cough. Oral intake is contraindicated if any of the above are compromised. This would constitute failure of the swallow screen.

A. **PROCEDURE:**

1. **Prior to 3 Ounce Water Protocol check patient's ability to swallow by giving the patient a teaspoon of water and assess for laryngeal movement, clear vocal quality, coughing, choking, or throat clearing during swallowing up to one minute. If able to swallow without difficulty proceed to 3 Ounce Water Protocol.**

~~A.~~**2. 3 Ounce Water Protocol:**

- **a. Observe patient.**
  - **i. If patient is not alert then make patient NPO until alert and then screen the patient.**
  - **~~i.~~ii. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed with swallow screen.**
    - **1) Sit patient upright.**
    - **2) Ask patient to drink entire 3 ounces (90 mL) of water from a cup or through a straw in sequential swallows without stopping.**
    - **3) Assess patient for coughing, choking, or throat clearing during swallowing and up to one minute after drinking.**
- b. **Results**
  - **i. Pass: Able to drink 3-ounces of water sequentially without overt signs or symptoms of aspiration.**
  - **ii. Fail: Inability to drink the entire amount sequentially or demonstration of coughing or choking during trial.**

3. **If patient passes protocol, diet per physician/Allied Health Professional's order**
4. **If patient fails protocol:**
   - **i. Keep NPO, notify the physician as needed**
   - **ii. Obtain order for Swallow Evaluation by Speech Pathologist as needed**

~~2.~~**5. Document results in electronic health record under Swallow Screen**

B. **REFERENCES:**

1. **Suiter DM, Leder SB, Karas DE. The 3 ounce (90 cc) water swallow challenge: A screening test for children with suspected oropharyngeal dysphagia. Otolarygology Head & Neck Surgery 2009;140:187-190.**
2. **Suiter DB, Leder SB. Clinical utility of the 3 ounce water swallow test. Dysphagia 2008; 23:244-250**
3. **Suitor, D. S., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A Prospective Double-Blinded Videofluoroscopic Study. *Dysphagia*, 199-203.**

~~**LOOK** Observe patient. If patient is not alert then make patient NPO until alert and then screen patient. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed to **LISTEN**. If patient fails **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.~~

~~**LISTEN** Have the patient say "ahhh" and hold the sound for a count of three. If patient's voice sounds clear, proceed to **FEEL**. If patient coughs, sounds wet or gurgly **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.~~

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 7/09, 1/12, 10/16	09/11, 4/15, 11/16	10/11; 4/15, **01/17**	n/a	n/a	11/11; 05/15, **01/17**	1/12; 06/15, **02/17**	6/15

FEEL — Feel for movement of the larynx by placing the tips of the fingers vertically on the front of the throat. If you feel a strong and timely vertical movement of the larynx, then proceed to Safe Section of the Swallowing Screening Results Table. If patient fails, **STOP** assessment and proceed to Swallowing Screening Results Table.

SWALLOWING SCREENING RESULTS TABLE	
AT RISK – Screening Failed	**SAFE – Screening Passed**
If the patient is unable to pass any of the above steps:	If the patient is able to perform **all** of the above steps:
• **DO NOT** give any oral intake, including oral medication. Make patient NPO for 24 hours or until Swallow Evaluation is ordered and performed by Speech Pathologist. • Document **FAIL** in Cerner under Swallow Screen.	• Give patient sips of water without a straw. • Look, Listen and Feel as above. • If patient coughs, sounds gurgly or wet in response to water then document as **FAIL** in Cerner under Swallow Screen. • If patient passes, document **PASS** in Cerner under Swallow Screen, then resume diet per physician's orders. • Proceed with oral medications. • Supervise the patient's initial attempts of eating and drinking.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/01 **SUBJECT: ADMINISTRATOR ON CALL**

REVISION DATE: 11/02, 8/03, 3/06; 02/09; 03/11; 11/13 **POLICY NUMBER:** 8610-281

Department Approval:	**01/17**
Administrative Policies & Procedures Committee Approval:	**~~11/13~~01/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~04/14~~02/17**
Board of Directors Approval:	**04/14**

A. **PURPOSE:**

1. To provide a process of administrative oversight and direction to ensure effectiveness of service continues during off hours (after business hours, weekends and holidays).

B. **DEFINITIONS:**

1. Administrator on Call: The Chief Operating Officer (COO), Chief Nurse Executive (CNE) and Chief Financial Officer (CFO) and Senior **Leaders**~~Directors of Clinical Areas~~ are assigned on a rotational basis to provide administrative oversight and direction.
2. Administrative Supervisor: The Administrative Supervisor on duty is responsible to the Directors **and Managers** for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the Chief Nurse Executive, Directors, and Nurse Managers.

C. **POLICY:**

1. The Administrator on Call (AOC) rotates weekly amongst the Senior Team.
2. The Administrative Supervisor will report any Level IV (Sentinel) occurrence/incident or significant patient care, risk management or operational issues to the Administrator on Call. Types of occurrences/incidents that are reportable to the Administrator on Call are:
   a. Any occurrence requiring reporting to the California Department of Public Health per Administrative Policy **Mandatory Reporting Requirements** #236
   b. Significant risk management issues
   c. Significant physician, staff or operational issues
   d. Implementation of Hospital Incident Command System (HICS)
   e. Media contacts or potential media reportable events
   f. Non-availability of inpatient beds
3. All reported occurrences will include the following information in the Administrative Supervisor report:
   a. Brief description of event
   b. Individuals involved
   c. Action Plan (current and proposed)
   d. Impact on Organization or Outcome (current and potential)
   e. Communication Status
   f. Requested Assistance
      i. None Necessary
      ii. Approval
      iii. Plan Modification

D. **RELATED DOCUMENTS:**

1. **Administrative Policy: Policy Mandatory Reporting Requirements #236**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 7/76

SUBJECT: Lost and Found Articles

REVISION DATE: 4/89; 6/94; 10/99; 9/00; 9/02; 6/03; 2/06; 01/09; 02/11

POLICY NUMBER: 8610-202

Department Approval:	01/17
Administrative Policies & Procedures Committee Approval:	~~01/14~~01/17
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~02/14~~02/17
Board of Directors Approval:	02/14

A. **PURPOSE:**

1. The Lost and Found service provided by Security and the Patient Representative Office provides a method for returning lost or misplaced articles to their proper owners and/or reimbursement, if applicable.

B. **DEFINITIONS:**

1. Items of Value: Money, Credit Cards (to be destroyed after 90 days), jewelry, and watches.

C. **POLICY:**

1. Lost or misplaced items shall be promptly returned to their rightful owners.

D. **PROCESS:**

1. When an article is found, a reasonable effort is made to determine its ownership immediately, and, whenever possible, to return the article to its rightful owner. If this is not possible, the person who found the article must attach a Tri-City Healthcare District (TCHD) "Found Property Slip" and take directly to the Lost and Found or Security. Call Security and someone will meet you to receive the item. "Found Property Slips" may be obtained from Security. NOTE: The loss of hearing aids, dentures and glasses will be reported directly to the Patients' Representative.
2. If the owner is a patient who has been discharged, a representative from the Nursing Unit where the article was found will contact the patient or his/her family and ask him/her to claim the article in the Lost and Found section of Security. The time and date of the contact, the name of the person contacted, and the person making the call, is to be recorded and provided to Security. The article may not be held on the unit, but forwarded immediately to Security.
3. The article is to be forwarded by placing it in a container labeled with the name of the person who found the article, the patient's name, address, room number, contents of container, and recorded notes of contact with patient or family on the TCHD "Found Property Slip." A notation should also be made on the patient's medical record in Clinical Notes.
4. Items found in areas other than patient rooms, which cannot be returned to the owners (or ownership cannot be determined), are to be placed in a container and labeled with a TCHD "Found Property Slip", indicating where the item was found, the time and date of discovery, the name of the person who found the article, and the contents of the container and sent to Lost and Found.
5. Upon receipt of lost items Security will:
   a. Place all items deemed to be of value in the ~~Patient Business Services~~ **Security** Office safe until claimed. If unclaimed after 90 days, the item is to be donated to an approved charitable organization.
   b. Give all other items an identification number and properly log into the Lost and Found Control Binder.
   c. Attempt to identify ownership, then contact owner.

~~d.~~**6.** **The Patient Representative will** ~~M~~**m**ail identified articles to owners who are unable to come to the hospital. Mail certified, return receipt. ~~When receipt is returned to TCHD, it is to be scanned to patient's electronic record.~~

~~e.~~**a.** After a period of 90 days all unclaimed items will be donated to a charity as determined by Administration and allowed by law.

~~6.~~**7.** Anyone who has lost articles may contact Security **through**~~by calling~~ **the** PBX operator.~~ and have operator connect you to Lost and Found~~.

~~7.~~**8.** Reports of lost articles that cannot be found are to be referred to the Patient Representative's Office via phone, with follow-up in writing for investigational purposes and information with description and contact information placed in the Lost and Found Inquiry book.

~~8.~~**9.** If an investigation concludes a hospital representative is responsible for a lost/damaged article, and reimbursement by the Organization is appropriate, a check request and a copy of the investigation **General Release of All Claims Form (from the patient)** will be submitted by the Patient Representative Office to the Director of Risk Management.

~~9.~~**10.** The Director of Risk Management will obtain the signature of the proper administrator~~. if needed; otherwise, he/she will sign the check request.~~ The Patient Representative will obtain the cost center location for charging purposes. **The check request will be forwarded to AP in Accounting.**

~~10.~~**11.** ~~The Director of Risk Management will forward the check request to the Patient Representative, who will send it to the Accounting Department.~~**When the check is issued Accounting emails the Patient Representative the date, the check number and the amount. Accounting sends out the check to the patient/family member or the professional who is preparing the replacement articles (for example: new dentures or hearing aid).**

~~11.~~**12.** ~~Accounting will approve and return to Patient Representative for distribution.~~**The original forms will be filed along with the check information to the Patient Relations Specialist and into the Complaint Resolution file.**

13. ~~The original forms will be filed in the Patient Representative office.~~

E. RELATED DOCUMENT(S):

~~12.~~**1. General Release of All Claims Form Sample**

General Release of All Claims Form Sample

The undersigned, being over the age of eighteen, for the sole consideration for waiving events that occurred on or about date:_____ with a value in the amount of _____($00.00) by TRI-CITY HEALTHCARE DISTRICT (hereinafter referred to as the "RELEASEE") do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge the RELEASEE, their agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and/or property damage or loss and the consequences thereof resulting.

It is understood and agreed that this settlement is the compromise of doubtful and disputed claims, and that the payment made is not to be construed as an admission of liability on the part of the RELEASEE. The RELEASEE specifically denies liability therefor and intends merely to avoid litigation and buy its peace. It is further understood and agreed that this Release in Full of All Claims and the write off herein acknowledged shall be held in confidence and that the undersigned and his/her attorneys will not publicize, publish, disclose, talk about, or promote the publication or disclosure of the facts or terms of this Release in Full of All Claims or the payment/write off here acknowledged to any person not a party to this Release of All Claims.

It is further understood and agreed that all rights under Section 1542 of the *Civil Code of California* and any similar law of any state or territory of the United States are hereby expressly waived. Section 1542 reads as follows:

> **"Section 1542. [Certain claims not affected by general RELEASE.]** ***A general release does not extend to a claim which the creditor does not know or suspect to exist in its favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."***

The Undersigned hereby declares and agrees that they rely only upon their own judgment, belief and knowledge of the nature, extent, effect and duration of said damages and liability. This RELEASE is made without reliance upon any statement or representation of the RELEASEE or its/their representatives or by any party or person employed by it/them.

The Undersigned further declares and represents that no promise, inducement or agreement not herein expressed has been made to the Undersigned, and that this RELEASE contains the entire agreement between the parties hereto and that the terms of this RELEASE are contractual and not a mere recital.

The Undersigned has been advised by the RELEASEE of the right to have this RELEASE reviewed by counsel and has either voluntarily chosen not to seek counsel or the Undersigned have been represented by counsel of their own choosing and have relied only upon the advice and counsel of their attorney.

The Undersigned has read the foregoing RELEASE and fully understands it.

CAUTION: READ BEFORE SIGNING BELOW

I declare under penalty of perjury according to the laws of the state of California that the forgoing is true and correct.

Signed this _____date. Print or Type Name: _____:

Signature:_____

FOR YOUR PROTECTION CALIFORNIA LAW
REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

SUBJECT: **Prion Diseases: Transmissible Spongiform Encephalopathies (TSE) such as: Creutzfeldt-Jakob disease (CJD) and Variant (vCJD), Gerstmann-Sträussler-Scheinker Syndrome (GSS), Kuru, Fatal Insomnia, or Bovine Spongiform Encephalopathy (BSE or Mad Cow disease)**

ISSUE DATE: 01/03
REVISION DATE: 01/09 ~~**POLICY NUMBER: IC.6.5**~~

Department Approval:	**03/16**
Infection Control Committee Approval:	~~**1/12**~~**03/16**
Medical Executive Committee Approval:	~~**2/12**~~**01/17**
Professional Affairs Committee Approval:	**02/17**
Board of Directors Approval:	~~**2/12**~~

A. **INTRODUCTION:**

1. **Prion diseases, or transmissible spongiform encephalopathies (TSE's) are a family of rare progressive neurodegenerative disorders that affect both humans and animals. They are distinguished by long incubation periods, characteristic spongiform changes associated with neuronal loss, and a failure to induce inflammatory response. The causative agents of TSE's are believed to be prions. The term "prions" refers to abnormal, pathogenic agents that are transmissible and are able to induce abnormal folding of specific normal cellular proteins called prion proteins that are found most abundantly in the brain. This abnormal folding of the prion proteins leads to progressive degenerative brain and nervous system damage. Prion diseases are usually rapid progressive and always fatal. Examples of Human Prion Diseases: Creutzfeldt-Jacob Disease (CJD), Variant Creutzfeldt-Jakob Disease (vCJD), Gerstmann-Straussler-Scheinher Syndrome, Fatal Familial Insomnia, and Kuru. Examples of Animal Prion Diseases: Bovine Spongiform Encephalopathy (BSE or Mad Cow Disease), Chronic Wasting Disease, and Scrapie.** ~~Transmissible spongiform encephalopathies (TSEs), also known as prion diseases, are degenerative brain diseases. They are invariably fatal and there is no proven treatment or prophylaxis. TSEs are characterized by microscopic vacuoles and the deposition of amyloid (prion) protein in the grey matter of the brain. Examples include: Kuru, Gerstemenn-Straussler-Scheinder (GSS), Fatal familial insomnia, and Creutzfeldt-Jakob (CJD, the most common prion disease).~~
2. **Prion diseases** ~~TSEs~~ are not known to spread **by contact from** ~~by contact from~~ person to person. **In the healthcare setting, risk of transmission to patients has been associated with direct contact with infectious tissues (See B.76. Tissue Infectivity). Contaminated surgical equipment or implantation of electrodes deep in the brain can also transmit infectious prions from one patient to another.** ~~I~~Transmission has occurred during invasive medical interventions (two confirmed and four unconfirmed cases) after contaminated medical equipment was not properly cleaned before use on another person.
3. **The prions that cause TSE's exhibit an unusual resistance to conventional chemical and physical decontamination methods. The infectious agents that transmit prion diseases are resistant to inactivation by heat and chemicals, and therefore require special biosafety precautions. Incineration is the preferred method for all instruments exposed to high infectivity tissues.** ~~The disease has been transmitted by depth electrodes (inserted in the brain) used for another patient; injected pooled pituitary hormones (growth hormone and gonadotropin); and transplanted infected corneal, dura mater, and pericardium tissues.~~

4. **Prion diseases are transmissible by inoculation or ingestion of infected tissues.** A new variant CJD has been linked to eating contaminated beef, elk or deer meat.
5. Symptoms include an insidious onset of confusion, progressive dementia, variable ataxia**, seizures, visual or sensory deficits, and rapid mental deterioration**~~.~~ in patients' aged 16+, most frequently between 40 and 70 years old. Incubation period ranges from 15 months to more than 30 years**, usually fatal within 1 year after diagnosis.**~~.~~
6. The most common form, sporadic Creutzfeldt-Jakob disease (CJD), has a worldwide death rate of about 1 case per million people each year.

B. **PATIENT CARE:**

1. Normal social and patient contact, and non-invasive procedures with TSE patients do not present a risk to healthcare workers, relatives, other patients or visitors.
2. **Standard precautions should be used for all known or suspected cases.**~~Apply Standard Precautions.~~
~~2.~~**3.** **It is very important that patients who are known or suspected to have prion disease be identified before any surgical procedure involving tissues that may be infectious.**
~~3.~~**4.** Patients with TSEs must not donate organs**, tissues, or blood components.**~~.~~
~~4.~~**5.** TSE is not known to be transmitted from mother to child during pregnancy or childbirth.
~~5.~~**6.** To prevent the transmission, it is important to consider: (1) the probability that an individual has or will develop TSE, (2) the level of infectivity in tissues or fluids, and (3) the nature or route of the exposure. **Risk assessment and prevention of exposure through the use of personal protective equipment and disposable equipment are the best means to reduce any risk of transmission in the healthcare setting** [Assignment of different organs and tissues to categories of high and low infectivity is chiefly based upon the frequency with which infectivity has been detectable, rather than upon quantitative assays of the level of infectivity, for which data are incomplete.]
~~6.~~**7.** Tissue infectivity.

a.	Highly infective tissues	~~Highest concentration in~~ **B**~~b~~rain, spinal cord & eye
b.	Low infective tissues	**Cerebral spinal fluid, l**~~L~~ung, liver, kidney, spleen/lymph nodes, and placenta
c.	Not infective	Heart, skeletal muscle, peripheral nerve, adipose tissue, gingival tissue, intestine, adrenal gland, thyroid, prostate, testis) or in blood, bodily secretions or excretions (urine, feces, saliva, mucous, semen, milk, tears, sweat, serous exudates).

~~7.~~**8.** Route of exposure

a.	Very serious risk	CNS exposures (i.e. inoculation of the eye or CNS)
b.	Greater potential risk	Transcutaneous exposures: cut or puncture by a contaminated sharp instrument or contact with the mucus membrane of the eye
c.	Negligible risk	Cutaneous exposure of intact skin or mucous membranes, except those of the eye

C. **DIAGNOSTIC AND SURGICAL PROCEDURES**

1. All non-emergent brain biopsy procedures and neurosurgical and neuroophthalmology procedures are screened by the schedulers in Surgery Services or Interventional Radiology (See Appendix A). If **the brain biopsy is for any reason OTHER than tumor, or if** TSE is suspected, notify the departments listed on the screening tool so that planning can be made for instrument handling, storage, cleaning and decontamination or disposal.
   a. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7~~, and~~ 8**, and 9** for details. Clinical Laboratory stores 1 Molar sodium hydroxide.
   b. All known cases and cases that meet the case definition of suspect Transmissible Spongiform Encephalopathies will be performed with disposable instruments whenever

possible.

c. Procedures that are normally carried out at the bedside (e.g. lumbar puncture) may be performed at the bedside. Use a chux at the site to contain a potential spill of infective material.

d. Alert the laboratory and clearly label all specimens. Place specimens in formalin as usual.

2. Dental Procedures: general infection control practices recommended by national dental associations are sufficient when treating TSE patients during procedures not involving neurovascular tissue. The following are precautions for major dental work:
   a. Use single-use items and equipment e.g. needles and anesthetic cartridges.
   b. Re-usable dental broaches and burrs that may have become contaminated with neurovascular tissue should be destroyed after use by incineration or decontaminated by a method listed on Controlling TSE Agent Transmission Table on pages 6, 7, ~~and~~ 8, **and 9** for details.
   c. Schedule procedures involving neurovascular tissue at end of day to permit more extensive cleaning and decontamination.
3. If reusable instrumentation must be used keep instruments and other devices moist between the time of exposure to infectious materials and subsequent decontamination and cleaning. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7, ~~and~~ 8, **and 9** for details.
   a. Remove bio-burden from reusable instruments while wearing a face shield or goggles and surgical mask and double glove. Instruments are then placed in a flash pan for processing as close as possible to the room where the procedure was performed. Autoclave for 18 minutes at 134° C.
   b. If the procedure was performed in another department (for example a brain biopsy in the CT Scan) call **Sterile Processing Department** ~~the OR charge nurse~~ for assistance with autoclaving.
   c. After autoclaving place instruments in a robust, leak-proof container labeled "Incinerate Only". This box will be placed and remain in ~~the SPD Manager's Office~~**a designated locked area**.
      i. If the laboratory result is negative, all items can be returned to the decontamination area and reprocesses as normal.
      ii. If the laboratory result confirms a Transmissible Spongiform Encephalopathy, the instruments ~~are incinerated~~**will be sent out for incineration**.
4. See unit specific policies for safety in the Clinical Laboratory.
5. Occupational exposure
   a. There have been no confirmed cases of occupational transmission of TSE to humans. Report any occupational exposure to blood, body fluids, or other potentially infectious materials to your supervisor and go to Emergency Room for assistance.

~~6.~~**b.**

D. RELATED DOCUMENTS:

1. **Infection Control Manual: Bloodborne Exposure Control Plan**
2. **Infection Control Manual Standard and Transmission Based Precautions**
3. **Employee Health Services Policies: AP&P #401 Injury Prevention Program**
4. **Tri-City Medical Center Laboratory Procedure: The Handling of Tissues of Patients with Transmissble Spongiform Encephalopathies (TSE) including Creutzfeld-Jakob Disease**

~~D.~~E. REFERENCES:

1. www.who.int/emc WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies. (1999)

2. ~~Macmillan, S~~**Kavanagh, B.** (**2014**~~2000~~) Creutzfeldt-Jakob disease and other **Prion Diseases**~~prions~~. **In P. Grota (Ed.),** *APIC Text of Infection Control and Epidemiology* ***4th Ed.***, ~~10~~**73**:1-1~~40~~**.**

~~3. Olmsted, R, ed. (1996) APIC Infection Control and Applied Epidemiology: principles and practice. St. Louis: Mosby.~~

3. Karasin, M. (2014, October). Special Needs Populations: Perioperative Care of the Patient with Creutzfeldt-Jakob Disease. Vol 100, No 4.

4. Steelman, V.M. (1994) Creutzfeld-Jakob Disease: recommendations for infection control. American Journal of Infection Control, 22(5): 312-318.

5. Brown, P., Wolff, A., Gajdusek, D.C. (1990) A simple and effective method for inactivating virus infectivity in formalin-fixed tissue samples from patients with CJD. Neurology, 40: 887-890

~~5.~~**6. Rutula, W., and Weber, D. (2010, February). SHEA Guideline: Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments.** ***Infection Control and Hospital Epidemiology*****, Vol 31, No.2, 107-117.**

~~6. Bloodborne Exposure Control Plan IC. 11~~

~~7. Standard and Transmission Based Precautions IC.5~~

~~8. Employee Health Services Policies~~

~~9. AP&P #401 Injury Prevention Program~~

Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

This information is required when scheduling any patient for non-emergent craniotomy or brain biopsy to identify potential Creutzfeldt-Jakob Disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstemenn-Straussler-Scheinder Syndrome (GSS), Kuru, or Fatal Insomnia

	Circle One	
1. Does the patient present with symptoms of TSE (rapidly progressive dementia, cerebella symptoms, spasticity or hyper-reflexia, EEG with periodic sharp-wave complexes, rapid cerebral atrophy on CT scan)?	Yes	No
2. Does the patient have a family history of CJD or CJD-like fatal illness?	Yes	No
3. Is the patient being scheduled for craniotomy or brain biopsy when diagnosis is unknown or uncertain (no specific lesion identified by imaging procedures)?	Yes	No
4. Is the biopsy for the diagnosis of dementia or encephalitis?	**Yes**	**No**

Patient Name_____ Today's Date_____

Surgeon providing the screening information_____

Office personnel providing the screening information_____

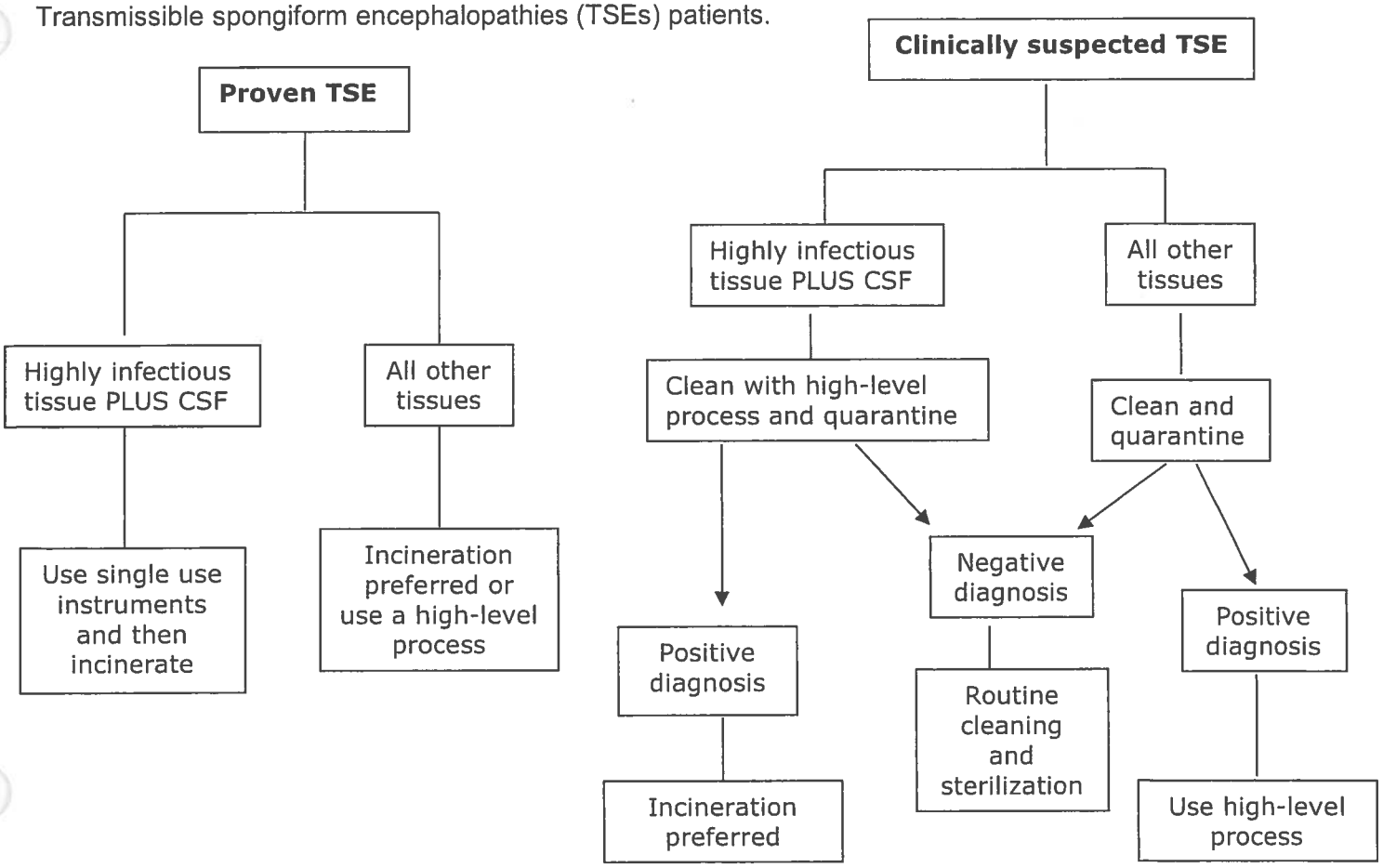
Print name of scheduler taking the Information_____

A "No" answer may be scheduled as usual. ~~File this form in the scheduling department for at least 7 years.~~

A "Yes" answer to one of these questions means the patient meets the case definition of suspect Transmissible Spongiform Encephalopathies. Call the following services below to report and reference the policy in the Infection Control Manual, ~~IC 6.4~~ Transmissible Spongiform Encephalopathies. ~~When complete, file this form in the scheduling department for at least 7 years.~~

Service	Phone Number	Message left	Spoke with (name of person) and Comments
Neuro-Speciality Coordinator	5400		
Environmental Services	7295		
SPD Ops Manager	7338		
Histology Supervisor	7914		
Infection Control	~~3007~~**7410 or 5696**		
Pharmacy	3012		

Decontamination and disposition of instruments and equipment used with confirmed or suspected Transmissible spongiform encephalopathies (TSEs) patients.



Diagnosis	Procedures	Method and product/devices	Comments
Sporadic CJD; suspected TSE; at risk for CJD asymptomatic; (hormone recipient, dura mater transplant, familial CJD in a first degree relative).	1. Noninvasive procedures 2. Care after death, no postmortem performed 3. Employee sharps injury	1. Use standard cleaning, regular laundering, and routine waste handling. 2. Embalming is acceptable. 3. Gently encourage site to bleed, wash with warm soapy water, rinse, and cover with a waterproof bandage.	1. There is no epidemiological evidence that normal contact presents a risk to health care providers. Procedures involving high-risk tissue or fluid, e.g., brain, spinal cord, pituitary, dura mater, retina, and cornea, require use of disposal aprons/gowns, gloves and single-use instruments/equipment. See next section. 2. Refer to special handling of tissue and special handling of the body after pathology procedures and postmortem. 3. Document all incidents. Maintain all files in the Employee Health dept.

Controlling TSE Agent Transmission in the Hospital

Diagnosis	Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)	Other nondisposable equipment		
Known TSE	• Where possible, avoid performing OR procedure. • If procedure must take place, book case at the end of the day. • The surgeon is to alert Surgery or Interventional Radiology when scheduling procedures. Schedulers are to notify the departments listed on the Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool. • Use dedicated sterile equipment or equipment nearing "end-of-life use" where possible. • Use disposable OR packs, gowns, drapes. • Use nonelectrical (mechanical) hand saws/drills. • Incinerate disposable supplies when procedure is complete. Suction wastewater and treat container with Premicide prior to placing in "Incinerate Only" box. 1. During procedure, use a damp cloth OR sponge-superficial wiping method to keep items clear of debris. Avoid excess handling of instruments. 2. At the end of the procedure, place all disposables in an "Incinerate Only" box and call the waste management vendor for disposal. Do not put any instruments from this case in contact with reusable containers.	• Cover nondisposable power equipment that must be used with plastic drapes. • Avoid touching surfaces with gloves, which have been in contact with brain, spinal cord and adjacent tissue. If in doubt, change gloves. • Keep the least amount of equipment in the room. • Completely isolate/drape anesthetic/respiratory equipment near the patient's head to prevent accidental splatter or contamination of the equipment.	Steps, OR Room: 1. Use damp cloth/sponge, superficial cleaning method ~~(1 molar sodium hydroxide (NaOH) per gal. water)~~**2 N NaOH undiluted** for surfaces in the OR. 2. At end of case, place cleaning cloths in an "Incinerate Only" box. 3. Chemical disinfection - **2 N NaOH undiluted**~~1 Molar NaOH per gal. water~~, disassembled equipment, completely submerged, or continuously wet for 60 min. Rinse in water and wipe dry. 4. Confine and contain all effluent for incineration. Treat with Premicide to solidify waste for ease of handling 5. Manual clean instruments in OR area while wearing full face shield or mask and goggles. 6. Steam autoclave reusable items for 18 min. at 134 C; use an open container in a prevaccum sterilizer. 6. Place in an "Incinerate Only" box and transport to SPD for quarantine in the ~~Manager's Office~~**in a designated locked area**.	• Consult with Sterile Processing Department (SPD) for supply and use of equipment nearing end-of-life use. (NaOH is highly corrosive). • Cases booked at the end of the day allow for surface decontamination of "touch surfaces" at end of the case with noxious agents (~~1 Molar NaOH for 60 min continuous wetting~~ **2 N NaOH undiluted for one hour and rinsed with water, non-critical patient care items and surfaces**). • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent. • Tissue dried on instruments, which have not been inactivated first by NaOH, may have a protective effect on the TSE agent and render the autoclave process ineffective. Keep instruments moist until decontamination occurs.

Controlling TSE Agent Transmission in the Hospital

Diagnosis	Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)	Other procedures, equipment, potential risk	Comments
Suspected TSE	Follow steps as above. SPD 1. Quarantine autoclaved reusable equipment until the diagnosis is finalized. • If confirmed positive, incinerate equipment. • If negative, follow regular cleaning in a washer disinfector, then routine sterilization.	Follow steps as above.	See comments above.
At risk for TSE asymptomatic (hormone recipient, dura mater, corneal transplant, familial CJD in a first-degree relative.	• Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period). Use disposable instruments wherever possible and follow steps as above.	Follow standard cleaning and sterilization.	• Regular cleaning and disinfection procedures with a hospital grade disinfectant in a basin (contact time according to label recommendation). • the incubation period for TSE is long. • Asmptomatic patients have very low infectivity. • Upgraded neurosurgical procedure equipment sterilization cycles will provide a margin of safety in the very rare event a TSE diagnosed case is found.

Diagnosis	Lumbar puncture/biopsies	Specimen handling	Comments
Known TSE **Suspected TSE** **At risk for TSE asymptomatic**	• Notify Infection Control • Only trained staff aware of TSE hazards should perform these procedures. • Perform procedures in an OR environment whenever possible. • Use disposable, single-use equipment where possible. • Incinerate packs, gowns, barrier drapes after use. • Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period) use disposable instruments wherever possible or use the NaOH decontamination process (see above procedure for suspected TSE). • Regular cleaning and sterilization	• It is prudent to refer to a specialist neuropathology lab center for brain and tissue biopsy material. • Containment is level 3 for central nervous system (CNS) samples. See department specific P&P. • Other clinical specimens are handled as per standard routine infection control precautions. • Tissue may still be infective if fixed in formaldehyde and then c steam sterilized. • Other clinical specimens are handled as per standard routine infection control precautions. Other clinical specimens are handled as per standard routine infection control precautions.	• Routine disinfection for all non-contaminated surfaces. • Cases booked at the end of the day allow for decontamination of brain tissue contaminated surfaces with a solution of ~~1 Molar NaOH for 60 min of continuous wetting~~**2 N NaOH undiluted for one hour and rinsed with water, non critical patient care items and surfaces**. Pay close attention to technique to avoid contamination and decrease the need for additional use of NaOH. • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: BLOCK TIME

ISSUE DATE: 3/08
REVISION DATE(S): 6/09, 11/09, 4/15, 11/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To outline the granting, review, use~~,~~ and revocation ~~use~~ of block time. Block time scheduling will be provided in the operating room to regulate and ensure continuity of scheduling and to optimize the utilization of the operating room.

B. **DEFINITIONS:**

1. **Block Time:** Surgical time consistently reserved for a surgeon, surgeon group or specialty.
2. **Full Block:** Eight (8) hours of time.
3. **Half Block:** Four (4) hours of time.
4. **Release Time:** Specified lead time prior to the day of **the** block which is a cutoff date or time.
   a. If the block is not booked by this time, the time will become available for open booking.
   b. If the surgeon voluntarily releases the block prior to the specified release date, the time will not be included when the adjusted utilization is calculated.
   c. If the block is not released prior to the specified lead time, the unused time is included in the adjusted utilization.
5. **Utilization:** The amount of time used for surgical cases.
~~5.~~**6.** **Utilization calculation: The amount of time used for surgical cases** divided by the amount of time allocated to the block.
~~6.~~**7.** **Adjusted Utilization:** Utilization calculated with released time subtracted from the allocated time.
~~7.~~**8.** **Unadjusted Utilization: Utilization calculated with all released and unused time included in the allocated time.**

C. **POLICY:**

1. Requested/Approval of Block Time:
   a. Surgeon, service~~,~~ or group may request time.
   b. Hospital administration may request time on behalf of a new surgeon or service.
   c. Block time will be granted based on actual/anticipated case volume.
   ~~c.~~**d.** **Requests will be approved by the OR Committee.**
2. Release Time: Release time may vary among individual block and percentage released, depending upon utilization and type of service.
   ~~a. Release time may vary among individual block and percentage released, depending upon utilization and type of service.~~
   ~~b.~~**a.** For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).
   ~~c.~~**b.** For utilization of 70-84%: 72 hour release.

~~d. For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).~~

~~e.~~**c.** For utilization ~~of 70-84%~~**at or below 69%**: ~~72 hour~~**7 day** release.

~~f.~~**d.** Release block time cannot be reclaimed once released and other cases are scheduled.

~~g.~~**e.** Released block time can be reclaimed if no cases are scheduled in the time.

~~h.~~**f.** If the block time is voluntarily released before the assigned release time, the released time does not count in the adjusted utilization ~~and~~ calculation.

~~i.~~**g.** If the block time is not voluntarily released before the automatic release time, then unused time will be included in the adjusted utilization.

~~j.~~**h.** Adjustments to release times will be made quarterly (January, April, July, October) based on the prior quarter's utilization.

3. Maintenance of Block Time:
   a. Monthly block time utilization reports will be distributed to individual surgeons.
   b. Monthly block time utilization reports will be reviewed at OR Committee.
   c. Quarterly (January, April, July, October) block utilization will be reviewed **and the block time may be increased, reduced or revoked** based on the prior six-month average.
   d. Block utilization must be at ~~65~~**60**% adjusted or 50% unadjusted to ~~be~~ retain~~ed~~ block time.
   e. If utilization for the previous quarter falls below requirements, the surgeon-/-surgeon group-/-service will be notified of the deficiency. ~~They will then be given the next quarter to improve the average utilization to minimum requirements.~~

~~f. Inability to utilize block time at 65% adjusted will result in loss of time.~~

~~g.~~**f.** Periodic reviews of block time and surgeon on time arrival by the OR Committee may result in further adjustments to or reinstatement of block time.

~~h.~~**g.** Generally, action is taken based on a rolling six-month average, NOT by per month average.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: BUMPING SURGERY PROCEDURES

ISSUE DATE: 6/09
REVISION DATE(S): 11/10, 09/12, 4/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To provide guidelines for "bumping" of a surgical procedure

B. **DEFINITIONS:**
1. **Bumping:** The process of superceding a scheduled case with an emergency/emergent/urgent procedure
2. **Emergency Surgical Procedure:** Any procedure requiring surgical intervention immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room, or may require staffing an additional operating room (OR) immediately to care for the patient (i.e., trauma).
3. **Emergent Surgical Procedure:** Any procedure requiring surgical intervention within approximately one hour of presentation. Emergent procedures are performed in the first available time in the OR schedule.
4. **Urgent Surgical Procedure:** Any procedure which requires surgical intervention within approximately 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.

C. **POLICY:**
~~D.~~**1.** ~~Any ee~~**E**mergency~~-~~/~~-~~emergent~~-~~/ urgent surgical procedures will~~ **procedures will** take priority and will be performed before a scheduled procedure that is not in progress. The OR charge nurse-/-Anesthesiologist running the schedule will advise the bumping surgeon of the affected surgeon to be contacted, based on the criteria listed below.

~~1.~~**2.** **When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent**.

~~2.~~**3.** The surgical case to be bumped will be determined ~~by the bumping surgeon~~**by the OR Charge Nurse and Anesthesiologist** -based on the following criteria:
   a. Time of case
   b. Length of case
   c. Condition of patient
   d. Availability of equipment
   e. Least disruptive to entire schedule
   f. Date/time the case was scheduled (last scheduled may be bumped first)
   g. Choosing of surgeons within the same group will not be a determining factor

~~3.~~**4.** Urgent procedures may require surgical intervention within a specific time period and may require a scheduled procedure to be bumped.

~~4.~~**5.** Every effort will be made to accommodate the bumped procedure in a timely manner, and the bumped procedure will take first priority for any open time.

~~6. When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent.~~

~~5.~~**6.** When a surgeon elects to bump his**/her** own elective scheduled case, the bumped case will be placed in the order to be rescheduled based on availability of rooms and staff to accommodate the case.

7. Disagreement between surgeons in the above process will be arbitrated by the **OR Medical Director,** Chief of Surgery **or Chief of Staff.**

~~6.~~**8. Requests for bumping may be referred to the** ~~and the~~ **appropriate surgical Division for review** ~~Surgery Supervisory Committee~~.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: DISASTER AND EMERGENCY PREPAREDNESS

ISSUE DATE: 4/94
REVISION DATE(S): 2/05, 6/09, 11/10, 9/12, 5/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. To provide guidelines for Perioperative Services **(Pre-op Education, Pre-op Hold/SPRA, OR and PACU)** personnel in the event of a disaster.
2. **To maintain adequate availability of personnel and supplies during a disaster.**
1. ~~Patients coming to this service will be triaged as immediate life saving emergency surgery or delayed emergency surgery.~~

~~B.~~ ~~**PERSONNEL:**~~

~~1. Director of Surgical Services~~
~~2. Clinical Managers~~
~~3. Registered Nurses~~
~~4. Operating Room Technicians~~
~~5. Anesthesia Technicians~~
~~6. Perioperative Aides~~
~~7. Scheduling Secretaries~~
~~8. Clinical Educator~~
~~9. Anesthesiologists/Surgeons~~
~~10. Instrument Aide~~
~~11. SPD Manager~~
~~12. SPD Technicians~~

~~C.~~**B. PROCEDURE:**

~~1. LEVEL I – Internal Disaster~~

1. **Due to the varying types and magnitudes of emergency events, Tri-City Healthcare District (TCHD) has adopted the command structure of Hospital Incident Command System (HICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the TCHD Disaster Plan Manual located in each department.**
2. **French Rooms 1 and 2 are designated as the Incident Command Center (ICC).**

C. **NOTIFICATION:**

1. **In the event of a disaster (Code Orange or Code Yellow), departments will be notified via the overhead paging system.**
2. **Management staff is to be notified by their respective area lead staff via pager/phone 24 hours per day, 7 days per week.**

3. Manager/Supervisor/designee responsibilities following the activation plan for a disaster or drill:
   a. The Surgical Services Clinical Manager(s)/designee from their respective areas will:
      i. Review the HICS form, located in the disaster manual
      ii. Assess number of patients currently in department(s)
      iii. Assess anticipated time of discharge from departments
      iv. Assess number of available staff
      v. Complete HICS form and submit to the Incident Command Center.
   b. Dependent upon the type and severity of the disaster, the Incident Command Center may direct the departments to:
      i. Delay or cancel elective surgeries/procedures
      ii. Discharge patients
      iii. Call in on-call staff
      iv. Initiate the disaster recall list
      v. Post Anesthesia Care Unit may be directed to discharge all patients capable of returning to the nursing units, and clearing this department for holding area of disaster victims if necessary.
      vi. OR staff will obtain emergency case carts and pick extra supplies for emergency procedures:
         1) Extra Lap, Chest, and Extremity custom packs
         2) Six (6) extra cases of Laps and 4x4 sponges
         3) IV solutions and tubing
         4) Blood administration sets
         5) Irrigation: water and saline
         6) Antibiotics
         7) Morgue packs
4. Employee's Responsibilities:
   a. Employees at work but away from the department are to return immediately to their home department.
   b. In the event that the department is in the location of the disaster, employees will report to the Labor Pool.
   c. Personnel will take direction from the OR/PACU Clinical Managers/designee in each area.
      i. Operating Room:
         1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.
         2) Anesthesia technician will assist anesthesiologist with line placement and intubations as directed.
         3) OR Technicians will scrub surgical cases or assist with instrument processing and running errands.
         4) Endoscopy Suite personnel will assist with minor surgical care and in Pre-Op holding area.
         5) Perioperative Aides will assist with transporting patients from the ER and discharging cancelled elective surgical patients, as well as routine duties of cleaning.
         6) OR Secretaries will answer the telephones, take messages, and run errands as needed.
      ii. Post Anesthesia Care Unit:
         1) Registered Nurses will assist with the delayed surgery patients. Some of these patients may require resuscitation or monitoring. They will also assist in ICU nursing units if patients are sent directly back, bypassing PACU if staffing allows.

2) **Acute Care Technicians (ACTs) will assist with transporting patients and patient care as directed.**

D. **EVACUATION OF THE OPERATING ROOM:**

1. **In the event the Surgical Services is directed to evacuate:**
   a. **Evacuation routes are posted in each specific department**
   b. **Hallways are to be cleared, moving any carts/equipment to the closest storage areas.**
      i. **Storage Room 1 and 2**
      ii. **Dirty Utility Room**
      iii. **Case Cart Room**
      iv. **Back hallway by the windows**
      v. **Any open Operating Room**
      vi. **Forensic Pre-Op Hold**
      vii. **PACU cubicles**

~~2. On duty Monday through Friday 0700 to 2300 hours:~~
   ~~i. The OR Clinical Managers (OCM) / designee will assess the OR rooms in progress and bump scheduled cases for immediate life saving emergencies.~~
   ~~ii. It may be necessary to cancel some elective cases.~~
~~b. 2300 to 0700 hours shift, Saturdays, Sundays, and Holidays:~~
   ~~i. The OR Clinical Manager/designee on Saturday or Sunday 0700 to 1700 hours will call in all call crews (including open heart team).~~
   ~~ii. Staff on duty after 1700 hours on Saturday or Sunday will call in call crews as necessary.~~
   ~~iii. Extra staff may be called in as necessary.~~
~~3. LEVEL II – External Minor~~
~~a. On duty Monday through Friday 0700 to 2300 hours:~~
   ~~i. The OR Manager/designee will assess elective surgeries in progress for possible cancellations.~~
   ~~ii. The OR Manager/designee will assess surgical caseload for possibility of calling in off-duty nurses.~~
~~b. 2300 to 0700 hours shift, Saturdays, Sundays, and Holidays:~~
   ~~i. Saturday, Sunday 0700 to 1700 hours OR Clinical Manager/designee will assess number of patients needing life saving emergency surgeries and call in all three call crews (OR and PACU).~~
   ~~ii. PACU Nurse on duty will call in extra nurses as necessary. ACCU patients may go directly back to unit when beds are available.~~
   ~~iii. 2300 to 0700 hours and Holidays, the personnel on duty will call in all nurses, techs, OR aides, and anesthesia technicians on call. Extra nurses will be called in if necessary.~~
~~4. LEVELS III & IV – External Major~~
~~a. On duty 0700 to 2300 hours:~~
   ~~i. **The Director of Surgical Services, in conjunction with the OR/PACU Clinical Manager/designee, will review the disaster plan.**~~
   ~~ii. Employees away from the department will return immediately to the department.~~
   ~~iii. In the event that the department is in the location of the disaster, employees will report to the Personnel Pool.~~
   ~~iv. The Chief of the Department of Surgery/designee will be notified and will assume medical command of the Surgery, in conjunction with the Chief of the Department of Anesthesia.~~
   ~~v. The Director of Surgical Services/OR/PACU Clinical Manager/designee will be notified as to which level disaster is underway. The direction of the entire area will be under her/his supervision, in conjunction with the Anesthesiologist in~~

charge that day. He/she will assist with communication between the OR and the triage area of the Emergency Department.

vi. All elective surgeries will be cancelled and patients discharged.

vii. The OR will immediately be assessed for availability of open rooms and length of surgeries in progress.

viii. The OR Secretary will call in any available personnel who may be off-duty that day, from the OR or PACU, in addition to all available Anesthesiologists.

ix. Post Anesthesia Care Unit will discharge all patients capable of returning to the nursing units, clearing this department for holding area of disaster victims. Unstable surgery patients needing resuscitation or monitoring may go to this area (maximum of 10 patients).

x. OP-PACU will dress all patients. Those patients who are recovered will be discharged. All others will be placed in the OP-PACU, clearing the main recovery area for holding disaster victims.

xi. The Operating Room will take those patients triaged as urgent (maximum of eleven patients at one time).

xii. Post Anesthesia Care Unit and Pre-Op Holding areas will take those patients needing surgery but have been triaged as delayed surgeries.

xiii. OP-PACU will hold patients needing surgery but triaged as delayed surgery (maximum of six patients), holding one area for post anesthesia patients.

b. Patients coming out of surgery will go directly to ACCU post-op, bypassing PACU if agreed upon by the anesthesiologist and surgeon.

c. Endoscopy Suite personnel will assist with minor surgical care and in holding area.

d. Personnel will take direction from the OR/PACU Clinical Managers/designee in each area.

i. Operating Room:

1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.

2) OR Technicians will scrub surgical cases or assist with instrument processing and running errands.

3) Perioperative Aides will assist in transporting patients from the ER and discharging cancelled elective surgical patients, as well as routine duties of cleaning.

4) OR Secretaries will man the telephones, take messages, and run errands as needed.

ii. Post Anesthesia Care Unit:

1) Registered Nurses will assist with the delayed surgery patients. Some of these patients may require resuscitation or monitoring. They will also assist in ACCU nursing units if patients are sent directly back, bypassing PACU if staffing allows.

2) Perioperative Aides will assist in transporting patients from the ER, and discharging cancelled elective surgical patients.

e. Weekends, Holidays, and 1700 to 0700 hours, Monday through Friday:

i. The OR/PACU Clinical Manager /designee or Call Nurse will activate the Emergency / Disaster Recall list. In the event of a disaster, all employees contacted will be expected to report to duty. In the event of a major disaster, and telephone services are out, personnel will report automatically to their departments for direction.

ii. The OR is always staffed with at least one RN or Technician. Personnel on duty will immediately pick and set-up each Operating Room. The room will be opened as directed by the Physician (i.e., abdominal, chest, or head case) in charge of the disaster triage.

iii. Each area will be staffed and used in the same way outlined in regularly staffed hours.

f. ~~LEVELS III & IV: SUPPLIES~~
   i. ~~Extra Lap, Chest, and Extremity custom packs~~
   ii. ~~Six (6) extra cases of Laps and 4 x 4 sponges~~
   iii. ~~IV solutions and tubing~~
   iv. ~~Blood administration sets~~
   v. ~~Irrigation: water and saline~~
   vi. ~~Narcotics and Antibiotics~~
   vii. ~~Glutaraldehyde to sterilize instruments if water supply is lost~~
   viii. ~~Morgue packs~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: OPERATING ROOM (OR) COMMITTEE

ISSUE DATE: 4/94
REVISION DATE(S): 1/05, 6/09, 10/12, 5/15; 11/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **OPERATING ROOM COMMITTEE:**

1. Existence
   a. The chairperson of the Operating Room Committee will be either the chief of surgery or chief of anesthesia, alternating each fiscal year.
   b. Members shall consist of ~~P~~**physicians representation from- A**~~a~~**nesthesia, S**~~s~~**urgical S**~~s~~**ub-specialities, P**~~p~~**erioperative N**~~n~~**ursing L**~~l~~**eadership and Aadministration.** ~~a general surgeon, orthopedic surgeon, gynecologist, other sub-specialty surgeons, one anesthesiologist, the Director of Surgical Services, PACU Manager and OR Manager.~~
   c. The committee shall function as a liaison between ~~operating room~~**Perioperative Services** and **the M**~~m~~**edical Staff**~~staff~~ and shall:
      i. Conduct periodic review of operation**al** policies (i.e., scheduling of elective and emergency cases)
      ii. Review incidents and adverse events
      iii. Review problems with the daily management of the Operating Room schedule
      iv. Review~~s~~ block time utilization
      v. Review late surgeons for appropriate sanctions
   d. The committee shall meet monthly in addition to any meetings called by the committee chair.
   e. The chair of the committee with input from the Director of Surgical Services**/designee and OR Medical Director** ~~, OR , surgeons, and anesthesia department~~ develop**s the meeting** agenda ~~formation.~~
   f. Documentation of the minutes is ~~done by the~~**forwarded to the** ~~m~~**M**edical ~~s~~**S**taff ~~o~~**O**ffice and ~~must be~~ approved by the Medical Executive Committee and Board of Directors.
2. Responsibility
   a. All surgical and anesthesia services are coordinated by the Operating Room Committee through the development of policies and protocols relating to the functioning of the Operating Room, **Post-Anesthesia Care Unit** (PACU), and Anesthesia Department. These are coordinated in conjunction with administration and are reviewed ~~annually~~**at least every three years**.
   b. The Committee ~~has~~**determines** ~~input into the~~ **OR** ~~room~~ availability requirements to meet the needs of the community.

~~The quality assurance summary report is done on a monthly basis and reported to Patient Care Review monthly with a quarterly summary to the Committee.~~

B. **EXTERNAL COMMITTEES:**

1. ~~The Operating Room~~**Perioperative Services**- is represented on select hospital level committees in order to link surgical/anesthesia activities with other hospital-wide critical

situations. The following lists these external committees and addresses the Operating Room/external group interactions.

~~a. ENVIRONMENT OF CARE~~

~~The Perioperative Services Educator is an active member of the Environment of Care Committee and report to the Director of Surgical Services.~~

~~b.~~**a.** Clinical Value Analysis Team (CVAT)

i. The OR Materials Manager**, OR Manager** -and the **Sterile Processing Department** (SPD) Operations Manager are members of this committee, which reviews products for the entire facility for compatibility, cost effectiveness, etc.

~~i. The SPD Operations Manager reports to the Director of Surgical Services.~~

~~c.~~**b.** Infection Control

i. The Director for Surgical Services **and SPD Manager are** ~~is a~~ members of the Infection Control committee, which reviews hospital-wide infection control issues.

~~.IPC~~

~~i.The Director of Surgical Services is a member of this committee, which reviews ancillary licensed and unlicensed assistive personnel applying for privileges.~~

c. Quality Assurance (QA)/Performance Improvement (PI) Committee

i. The Director of Surgical Services attends this committee, which reviews Quality Initiatives and Outcomes.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE - Content added to "Admission/Discharge Criteria" or covered in other policies

SUBJECT: PRE-OPERATIVE REQUIREMENTS

ISSUE DATE: 6/09
REVISION DATE(S): 10/12; 4/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

~~A. PURPOSE:~~
~~To provide guidelines for the pre-operative patient.~~

~~B. POLICY:~~
~~1. Except in cases of emergency, all patients scheduled for surgery should be admitted no later **less** than 1.5 hours prior to the scheduled surgery start time.~~
~~2. Except in the cases of emergency, Physical Examination and Medical History (H&P) shall be **available** in the **in the** medical record prior to the patient being taken into the Operating Room.~~
~~a. The H&P shall be shall be dictated or electronically generated within the first twenty-four (24) hours of admission and before surgery or anesthesia.~~
~~If the history & physical has been completed within thirty (30) days prior to the patient's admission or readmission, an update to the patient's condition shall be dictated or written upon admission.~~
~~b. **If the history and physical was completed more than 30 days prior to the patient's admission, the H&P must be redone; anupdate alone is not sufficient**~~
~~c. In cases of emergency, the physician shall document in the medical record the medical determination that an emergency exists.~~
~~3. Except in cases of emergency, all patients scheduled for surgery shall have an "Authorization For and Consent To Surgery or Special Diagnostic or Therapeutic Procedures" completed (**and** or other consent forms as required) and contained in the medical record prior to the patient being taken into the surgical suite.~~
~~a. The procedure listed on the consent must match the physicians order.~~
~~b. In cases of emergency, the physician shall document in the medical record the medical determination that an emergency exists.~~
~~c. The Consent form is valid only through the patient's specific admission.~~
~~d. If it is necessary to repeat the same surgery/procedure during this admission, a new consent must be obtained. This does not include follow-up studies that are an expected part of the original procedure.~~
~~e. A Consent for Sterilization is required ONLY when sterilization is the primary reason for the surgical procedure.~~
~~4. NPO Requirements:~~
~~a. Adult patients:~~
~~i. Adult p**P**atients must be NPO for at least 2 hours for clear liquids (examples of clear liquids include, but are not limited to, water, fruit~~

juices without pulp, carbonated beverages, clear tea and black coffee; these liquids do not include alcohol).

ii. Allow 2 hours NPO for hard candy (i.e., life savers, mints), chewing gum and communion wafers.

iii. Allow 8 hours NPO for all other solid foods and non-clear liquids prior to surgery.

b. Pediatric patients:

i. Infants 0-1 year of age:

1) No solids the day of procedure
2) Formula or breast milk until 4 hours before procedure
3) Clear liquids until 2 hours prior to procedure
4) NPO thereafter until the procedure

ii. Ages 1 to 2 years:

1) No solids the day of procedure
2) Full liquids until 6 hours prior to procedure
3) Clear liquids until 3 hours prior to procedure
4) NPO thereafter until the procedure

iii. Ages 3 to 10 years:

1) No solids the day of procedure
2) Clear liquids until 4 hours prior to procedure
3) NPO thereafter until the procedure

c. Note: The volume of liquid ingested is less important that the type of liquid ingested.

5. Appropriate laboratory screening tests based on the needs of the patient, as determined by the surgeon and anesthesiologist, must be accomplished and recorded within 72 hours prior to surgery [22 CCR §70223(d)(2)].

6. A Blood Type, RH, and appropriate antibody titer(s) should be determined or available in the patient's record for all patients undergoing therapeutic abortion or D&C for incomplete abortion. Pregnancy termination for dead fetus, which is either hydropic or ≥ 20 weeks gestational age and ≥ 30 days duration, shall include a fibrinogen.

7. Patients undergoing voluntary sterilization:

a. Medi-Cal patients must wait 30 days from the date the consent form is signed.

b. Private patients may voluntarily waive the 30-day waiting period to no less than 72 hours. This waiver must be in writing. (22 CCR §70707.1 through §70707.6

c. EXCEPTION: Sterilization may be performed at the time of premature delivery if the physician certifies that:

i. The written informed consent was signed at least 30 days before the expected date of delivery. The physician shall state the expected date of delivery on the MediCal/Medicare Consent Form.

ii. At least 72 hours have passed after written informed consent to be sterilized was given and the sterilization consent form was signed.

8. Sterilization may be performed at the time of emergency abdominal surgery if the following requirements are met:

a. The written informed consent was signed at least 30 days before the expected date of delivery. The physician shall state the expected date of delivery on the Medi-Cal/Medicare Consent Form.

b. At least 72 hours have passed after written informed consent to be sterilized was given and the sterilization consent form was signed.

c. Describe the emergency on the Medi-Cal/Medicare Consent Form.

9. Documentation of any other preoperative studies or procedures ordered by the attending physician, consultant, or Anesthesiologist.

10. **ALL** patients must have an interval History and Physical examination on the chart performed within the previous 24 hours [22 CCR §70223(d)(1)].

a. Excluding emergencies, a completed "Physician Procedural Verification" form must be on the chart before the patient is brought to the operating room.

11. The requirements above do not preclude rendering emergency medical or surgical care to a patient in dire circumstances [22 CCR §70223(e)].

12. Documentation by a nurse that preoperative medications (including antibiotics) were given as ordered, and that the Pre-Operative Check List was completed.

13. Check chart for any Advance Directives.

C. REFERENCES:

1. California Code of Regulations Title XXII, §70223 & §70707.1 through §70707.6

2. California Physicians Legal Handbook, Chapter 6

3. Jones, D., Weintraub, P. (2000). Surgical patients benefit from less strict `nothing after midnight' rule. http://www.asahq.org/Media/NPOrelease.html.

4.1. American Society of Anesthesiologists. (1998, October). Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: Application to healthy patients.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE - Content covered in Patient Care Services Policy: Safe Medical Device Act Tracking and Reporting

SUBJECT: SAFE MEDICAL DEVICE ACT: TRACKING & REPORTING

ISSUE DATE: 4/94
REVISION DATE(S): 2/05; 6/09

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **POLICY:**
1. In compliance with the "Safe Medical Devices Act" of 1990 (effective 8/29/93), all implants and explants will be recorded into the patient's surgical record.

B. **DEFINITIONS:**
1. **Permanently implantable device**: A device that is intended to be placed into a surgically or naturally formed cavity to continuously assist, restore, or replace the function of an organ system or structure throughout the useful life of the device. (Does not include devices intended and used for temporary purposes or that are intended for explanation.)
2. **Life-supporting or life-sustaining device used outside a device user facility**: A device that is essential, or yields information that is essential, to the restoration or continuation of a bodily function important to the continuation of human life that is intended for use outside a hospital, nursing home, ambulatory surgical facility, or diagnostic or outpatient treatment facility.

C. **PROCEDURE:**
1. Examples of devices subject to tracking, including but not limited to:
   a. Permanently implantable devices:
      i. Vascular graft prosthesis
      ii. Ventricular graft prosthesis
      iii. Implantable pacemaker generator
      iv. Cardiovascular permanent pacemaker electrode
      v. Annuloplasty ring
      vi. Replacement heart valve
      vii. Automatic implantable cardioverter/defibrillator
      viii. Tracheal prosthesis
      ix. Implanted cerebellar stimulator
      x. Implanted diaphragmatic/phrenic nerve stimulator
      xi. Implantable infusion pumps
      xii. TMJ prosthesis
      xiii. Glenoid fossa prosthesis
      xiv. Mandibular condyle prosthesis
      xv. Interarticular disk prosthesis
   b. Life-sustaining or life-supporting devices used outside device user facilities:
      i. Apnea monitor
      ii. Continuous ventilator
      iii. DC defibrillator and paddles
   c. FDA designated devices:
      i. Silicone inflatable breast prosthesis
      ii. Silicone gel filled breast prosthesis
      iii. Silicone gel filled testicular prosthesis
      iv. Silicone gel filled chin prosthesis
      v. Silicone gel filled Angelchik reflux valve
      vi. Inflatable penile implant

~~vii. Infusion pumps (electromechanical only)~~
~~viii. Urinary sphincter prosthesis~~

~~2. Documentation of Implants (on Implant Record) must include:~~
~~a. Name/type of implant, size if applicable~~
~~b. Site of implantation~~
~~c. Manufacturer of implant~~
~~d. Catalog number of implant if available~~
~~e. Serial or lot number of implant~~
~~f. Expiration date if noted on packaging~~
~~g. Date of implantation~~
~~h. Name of surgeon implanting the device~~

~~3. If an implantable device has patient user information included in the packaging, this must be labeled with the patient's name and sent with the patient.~~

~~4. If the packaging includes a manufacturer tracking device form this must be completed and mailed back to the company for their records.~~

~~5. EXPLANTS:~~
~~a. Documentation of Explanted items must include:~~
~~i. The date the device was explanted~~
~~ii. Name, mailing address, and telephone number of the explanting physician~~
~~iii. The date of the patient's death (if applicable)~~
~~iv.~~**i.** ~~The date the device was returned to the manufacturer or distributor, permanently retired from use, or otherwise permanently disposed of.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: SCHEDULING SURGICAL PROCEDURES ~~**POLICY NUMBER: 7420-109**~~

ISSUE DATE: 04/94
REVISION DATE(S): 09/99; 04/01; 01/02; 06/03; 02/05; 02/08; 06/09; 11/10; 10/12; 12/12; 04/13; 08/13; 5/15
REVIEW DATE (S): 12/05; 12/07

Department Approval Date(s):	**08/16**
Department of Anesthesiology Approval Date(s):	**n/a**
Operating Room Committee Approval Date(s):	**08/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	**01/13**

A. **PURPOSE:**
1. To provide scheduling guidelines for surgery, ~~and~~ endoscopy**, and elective cesarean sections (in OB-OR).**

B. **DEFINITIONS:**
1. **Add-On Cases:** Additions to the surgery schedule after the "final schedule" has been published. The "final schedule" is published by 4 PM for the next day.
2. **Elective Case:** Surgery can be scheduled at the time best suited for the surgeon and the patient.
3. **Urgent Case**: Surgical intervention is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.
4. **Emergent Case:** Surgical intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. **Emergency**: Surgical intervention is needed immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room and may require that another scheduled or add-on case is bumped.

C. **SCHEDULING ~~WEEKDAY~~ ELECTIVE CASES:**
1. All **elective** surgical and endoscopic procedures **and elective cesarean sections in OB-OR** will be scheduled through the ~~OR~~**Surgery** ~~-~~scheduling office ~~or OR main desk~~.
2. There are 12 rooms in the TCMC OR suite which are utilized as follows:
   a. Ten (10) operating rooms (OR 1-10) can accommodate any type **of** case.
   b. OR 5 and 6 are set up and primarily are used for cardiac cases.
      i. OR 5 is released for non-cardiac cases at 24 hours
      ii. OR 6 is held for cardiac cases
   c. OR 11 is the Cystoscopy Room and is considered a wound class II room. Only certain procedures may be performed in this room due to the open drain:
      i. Circumcision
      ~~i.~~**ii.** Endourology procedures
      ~~ii.~~**iii.** Percutaneous Subprapubic Cystotomy
      iv. Vasectomy
      ~~iii.~~**v.** Orchiectomy
   d. OR 12 is the GI/~~Pulmonary~~ Endoscopy Room

3. **Expected** ~~A~~available surgery rooms Monday-~~Friday~~**Thursday (may fluctuate based on staffing, surgical volume and surgical acuity)**:
   a. 0730-1500 hours: 8 rooms
   b. 1500-1900 hours: 5 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms
4. **Expected available surgery rooms on Friday (may fluctuate based on staffing, surgical volume and surgical acuity):**
   a. 0730-1500 hours: 7 rooms
   b. 1500-1900 hours: 4 rooms
   c. 1900-2100 hours: 3 rooms
   d. 2100-2300 hours: 2 rooms

~~4.~~**5.** **Elective** ~~C~~cases shall be scheduled by the surgery scheduling office between the hours of ~~8:35AM~~**0835** and ~~4:30PM~~**1630**, Monday through Friday, at 760-940-7382.
   a. Elective cases are performed Monday through Friday from 07**15**~~30~~ (08**15**~~30~~ on Thursday) to 2300 hours. Elective cases should not extend beyond 2300.

6. **Start Times:**
   a. The Start time of a procedure (time on the OR schedule) is the time the patient is expected to be in the OR. Start time of first cases are tracked and report to the OR committee monthly.
   b. The start time of elective or add-on case requested for 1600 or later cannot be guaranteed. In those instances, the surgeon's preferred start time will be noted, and the surgeon will be given one hour's notice of expected start time. If the surgeon cannot start at the expected time, the next surgeon to start will be offered the time.

7. **Delays:**
   a. Surgeons who notify the OR they will be late for their scheduled start time must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another surgeon's schedule will cause the first surgeon to be bumped back to the next available start time.
   b. Surgeons who are not in house 30 minutes past the scheduled time of surgery and are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the OR.

~~6. Urgent, Emergent, and Emergency cases may be performed at any time.~~

~~5.~~**8.** Cases are scheduled on a consecutive, first-come first-served basis, or in a surgeon's block time.

~~6.~~**9.** Procedures may be scheduled by the surgeon or the surgeon's office staff only.

~~7.~~**10.** The **process for scheduling an elective case**~~information required at the time of scheduling~~ is as follows:
   a. The surgeon's office ~~shalls~~ calls the TCMC Surgery Scheduling department to reserve a case time.
   b. The surgeon's office ~~shall~~ completes a written "TCMC Surgery Scheduling Patient Information" booking form and faxes to the TCMC Surgery department fax server (Fax # 760-940-7138) within 48 hours of the telephone reservation.
      i. Upon receiving the written booking form, the TCMC Surgery Scheduler will schedule the case, obtain a FIN# and book a Pre-Operative Education appointment.
      ii. The TCMC Surgery Scheduler will write the FIN# and the date and time of the Pre-Operative Education appointment on the "TCMC Surgery Scheduling Patient Information" booking form, and will fax the form back to the surgeon's office as confirmation.
   c. The surgeon's office enters electronic orders or ~~shall~~ faxes written orders to the TCMC Surgery Scheduling department fax server *at least one week prior to surgery date*. Electronic orders will also be accepted.

i. If the case is scheduled less than one week prior to the date of surgery, written or electronic orders are required by the next business day.

~~Patient name and second approved identifier~~
~~b. Surgeon and Assistant, if required~~
~~c. Name of monitor, if required~~
~~d. Procedure~~
~~e. Approximate amount of time including preparation time~~
~~f. Pre-op diagnosis~~
~~g. Patient's phone number, date of birth, Social Security number, insurance company, address~~
~~h. Patient status (i.e., inpatient, outpatient, AM admit, admit day before, etc.)~~
~~i. Permission to contact patient by hospital personnel~~
~~j. Special equipment, supplies, any special instructions~~
~~k. Special requests (i.e., Anesthesiologist)~~
~~7. Infants & Children:~~
~~8. The order of cases will be revised so that the youngest is first and then up to the oldest.~~
~~a. Pre-Op Teaching will notify the parents when to arrive with the child at the hospital.~~
~~b. Pediatric Cases:~~
~~i. Outpatient surgery may be performed on patients of any age~~
~~ii. Inpatient pediatric surgery patients should be:~~
~~1) At least 80 lbs~~
~~2) At least 124 years of age~~
~~3) ASA class I or II~~

11. Age/Weight/ASA Requirements:

a. Surgery patients must be at least 14 years of age at the time of surgery
b. Adolescent patients (ages 14-18) must be:
i. At least 80 lbs
ii. ASA class I or II
c. Adult Patients (over age 18) must be at least 80 lbs.
d. Any requested Adolescent or Adult patient who does not meet criteria must be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.

~~8. d. Any requested pediatric inpatients who do not meet these criteria must be approved by the chief of anesthesia/designee.~~

12. The surgeon must have the appropriate privileges granted to be allowed to schedule a procedure.

a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
~~c.~~**b.** If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification.

~~9. After the patient has been scheduled for surgery, during the same phone contact, the OR Scheduler will schedule the patient with the office staff for a pre-operative education visit.~~
~~a. Patients may be scheduled for a telephone vs. in-person pre-operative education appointment.~~
~~b. Those patients who do not need to be scheduled for regular teaching include:~~
~~i. Debilitated patients~~
~~ii. Nursing home patients~~
~~iii. Requests from physician's office if HMO is doing blood work and the patient has a transportation problem~~
~~iv. Patients who are rescheduled for surgery and have already attended a Pre-operative Education appointment~~

D. <u>PRE-OPERATIVE EDUCATION APPOINTMENT SCHEDULING GUIDELINES</u>:

1. Patients may be scheduled for a telephone vs. in-person Pre-Operative Education appointment.

2. **Those patients who do not need to be scheduled for regular teaching include:**
   a. **Debilitated patients**
   b. **Nursing home patients**
   c. **Requests from physician's office if HMO is doing blood work and the patient has a transportation problem**
   d. **Patients who are rescheduled for surgery and have already attended a Pre-Operative Education appointment**

E. **SCHEDULING ADD-ON URGENT, EMERGENT, OR EMERGENCY PROCEDURES:**
1. **Urgent, Emergent, and Emergency cases may be performed at any time.**
2. **Urgent, Emergent, and Emergency cases shall be scheduled through the Main OR desk in person or via telephone (760-940-5400).**
3. **Required information when scheduling an add-on case includes:**
   a. **Patient name, date of birth, age, and medical record number**
   b. **Patient phone number, Social Security number, and insurance information (excludes in-house patients)**
   c. **Patient current location in the hospital**
   d. **NPO status**
   e. **Pre-Op diagnosis and Procedure to be performed**
   f. **Surgeon and assistant (if applicable)**
   g. **Equipment/X-ray needed**
   h. **Relevant cardiac/medical history**
   i. **Time of surgeon availability**

F. **WEEKEND/HOLIDAY CASES:**
1. Saturday, Sunday and three recognized Monday Holidays (President's Day, Memorial Day and Labor Day) have two rooms available for Add-on and Urgent cases **0730-1530. After 4 PM only one room is available.** ~~A third room is available for emergency cases only.~~**In addition, one room is available for emergency cases only.**
   ~~b.~~**a. The heart room counts as one of the available rooms.**
~~9.~~**2.** The remaining holidays (July 4, Thanksgiving, Christmas, New Year's Day) have one urgent room and one emergent room only. **No elective surgeries are scheduled on these holidays.**
~~10.~~**3.** Weekend/holiday cases are scheduled no more than 24 hours prior to the day of surgery.
~~11.~~**4.** Add-on cases are started in order of scheduling, providing the surgeon is available and the patient is ready for surgery.
5. If the first scheduled add-on case cannot be performed in the first available time, the next case's surgeon will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the surgeon for the first case will again be contacted and offered the time.
   a. **The first available time is 071530. If a physician requests a specific time, eg, 0900 to start a case, then another physician is available to start at 071530, the physician requesting the 0900 start time will be contacted to move up to 071530, or will start after the preceding case is finished.**
~~12.~~**6. For 0715 cases, the patient must be ready for transfer to the Operating Suite by 0645, otherwise, the next scheduled case may replace the delayed case**
7. When the first Saturday/Sunday room is booked for three hours or more, the second room is opened. The surgeon following the 071530 slot in the first room will be offered the **0715**~~0730~~ slot in the newly available room.
8. **Surgeons are allowed to schedule no more than ONE elective procedure, no greater than three hours, per weekend.**
   a. **Scheduling questions for weekend electives are decided by the 1st call Anesthesiologist.**
   b. **Robotic Cases (Mazor or daVinci) are not scheduled for weekends or holidays**

~~D.~~**G. ENDOSCOPY:**

1. Endoscopy services are available 24/7.
2. Endoscopy procedures are scheduled in the same manner as surgical procedures.
~~2.~~**3. Endoscopic procedures requiring general anesthesia are scheduled in an open time on the OR schedule.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: SCOPE OF SERVICE FOR SURGICAL SERVICES

ISSUE DATE: 10/11
REVISION DATE(S): 12/11; 10/12; 5/15

Department Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy & Therapeutics Committee Approval Dates(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To describe the Scope of Service for the department of Surgical Services at Tri-City Medical Center, including Pre-operative Education, Pre-operative Hold (POH), Surgery and Endoscopy.

B. **POLICY:**

1. Goals
   a. To improve the general health and well-being of patients who require surgical care.
   b. To improve patients' health knowledge related to pre-operative preparation, the scheduled surgical procedure, and post-operative plan for patients requiring surgical care.
   c. To reduce and manage complications and unexpected outcomes.
   d. To continuously evaluate and improve the services provided.
2. Description of Service & Assessing Department Services
   a. The department of surgical services provides diagnostic, therapeutic and operative interventions for patients requiring a variety of surgical procedures 24 hours a day, 7 days a week.
   b. Assessment activities include pre-operative, intra-operative and post-operative patient care for persons requiring elective, urgent or emergent surgery.
   c. The Pre-operative Education department provides instructions to patients **electively scheduled for procedures** ~~s~~regarding preparation for surgery, surgical procedures and post-operative care, facilitates ordered laboratory and diagnostic procedures as part of the pre-operative patient preparation, and gathers patient health history information. Pre-operative Education appointments are conducted in-person or via telephone, Monday-Friday 8:00am-5:00pm.
   d. The Pre-operative Hold department is responsible for assessing patients prior to surgery and carrying out pre-operative orders. POH is staffed with RN's Monday-Friday 5:30am-5:00pm. After hours, the surgical RN is responsible for assessing patients pre-operatively and completing pre-operative orders.
3. Methods Used To Assess Patient Needs
   a. Patient health history and educational needs related to the surgical procedure and post-operative care are assessed by a Pre-operative Education Registered Nurse (RN) during the Pre-operative Education appointment **(as applicable)**~~-~~.
   b. Patients are assessed and prepared for surgery by a ~~POH~~ **perioperative** RN **on** ~~in the pre-operative area on~~ the day of surgery. ~~Pre-operative orders are carried out in this area prior to going to the Operating Room.~~

c. Patient assessment is performed by a surgical Registered Nurse (RN) and anesthesia care provider (if applicable) ~~in the Pre-operative area~~ prior to going to surgery/Endoscopy suite.

d. Ongoing patient assessment and care is performed by the circulating RN and anesthesia care provider in the surgical suite throughout the procedure. RN's may monitor patients and administer moderate sedation for appropriate procedures (including Endoscopy procedures).

4. Scope of Services

a. Service specialties include orthopedic, thoracic, vascular, neurosurgical, urologic, gynecological, anesthesia, plastics, otolaryngolic, ophthalmologic, oral surgery, endoscopic, cardiac, robotic and general surgery.

b. There are 12 rooms in the OR suite, including 10 operating rooms (1-10) that can accommodate any type of case, **a cystoscopy** ~~a cystoscopy~~ suite (OR #11) and an Endoscopy suite (OR #12).

c. Patients are discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure, and admitted to the appropriate postoperative level of care.

d. The Pre-operative Hold department, located in the surgical pavilion, contains **patient** ~~8~~6 bays, with additional access to two private cubicles located in the Post-Anesthesia Care Unit (PACU). **A Preoperative Hold area with six bays is available for elective admission of** ~~Forensic~~**Progressive Care Unit patients.** POH services inpatients, outpatients and AM admissions for all surgical specialties and Endoscopy.

e. The Pre-operative Education department services **electively scheduled** outpatients and AM admissions for all surgical specialties~~, including patients undergoing Cesarean sections.~~

5. Staffing and Availability of Staff

a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the OR. Standby and call-back will be utilized to additionally staff those shifts that have minimal staffing in-house.

b. Each patient is assigned at least two surgical team members, one of which is the RN circulator.

c. The Assistant Nurse Manager (ANM) or charge nurse will make staff assignments according to individual staff competencies and patient needs.

d. Procedures requiring additional resources, due to severity of illness of the patient or complexity of the procedure, shall be staffed with additional personnel as appropriate.

e. For complete staffing and on-call guidelines see Surgical Services Polic**ies**~~y~~ ~~#7420-203:~~ Staffing, ~~#7420-101:~~ Admission/Discharge Criteria and ~~#7420-201:~~ On-call.

f. Pre-operative Education appointments are conducted by RN's. Appointments are scheduled in advance by the surgery schedulers. ~~Pre-operative Education also has a Unit Secretary and Pre-operative Education Liaison staffed during normal business hours.~~

g. Pre-operative Hold department**s** ~~is~~**are** staffed with RN's during normal business hours. After hours, the surgical RN conducts the pre-operative patient assessment and preparation.

6. Patient Population

a. ~~Pediatric~~**Adolescent**, adult, and geriatric patients requiring surgical management. ~~Outpatient surgery may be performed on patients of any age~~**Patients between the ages of 14-18 must meet defined criteria set forth in Surgical Services Policy ~~#7420-109:~~ Scheduling Surgical Procedures.**

~~b. Limitations apply to inpatient pediatric patient selection. For complete pediatric patient guidelines see Surgical Services Policy #7420-109: Scheduling Surgical Procedures.~~

7. Extent to Which The Department's Level of Care/Service Meet Patient Needs

a. The services provided by surgical services meet the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population.

8. Performance Improvement (PI)
   a. In order to improve patient care, several indicators are monitored ~~to reported quarterly to Quality Control Council.~~**and reported to the OR Committee, Infection Control Committee, Quality Committee or other committees as requested.**
   b. PI data is posted in the department.
   c. ~~Surgical Services PI Committee meet every other month, with minutes maintained in the binder in the staff lounge. See Surgical Services Policy #7420-202: Staff Based Committees/Meetings for complete details of PI committee composition and function.~~
9. Standards of Practice
   a. Surgical Services follows practice recommendations as outlined in the Association of PeriOperative Registered Nurses (AORN) ~~Perioperative Standards and Recommended Practices.~~**Guidelines for Perioperative Practice**
   b. The nursing service abides by regulations of California Title XXII, Joint Commission guidelines, CMS and the Board of Registered Nursing.
   c. See Surgical Services Policy ~~#7420-506:~~ Perioperative Standards of Practice.
10. Medication Administration Standards Related to Care of The Patient
   a. Medications, general and narcotics, are dispensed via the Pyxis system. Emergency cardiac medications are stored in Cardiac OR Suites in locked cabinets and refrigerator. Medications requiring refrigeration are stored at the appropriate temperature.
   b. Anesthesia Pyxis machines are maintained in each OR suite.
   c. Preoperative antibiotics and medications **dispensed to and/or** administered on the surgical field during the surgical procedure are documented in the surgical **nursing** record.
   d. Anesthesi**ologists**~~a providers~~ are responsible for documenting all meds they administer on the Anesthesia record.
   e. Medications administered in POH are documented in the electronic Medication. Administration Record (MAR~~) for inpatients and AM admissions, and on the paper chart for outpatients.~~
   f. See Surgical Services Policy ~~#7420-408:~~ Medications in Surgery.

C. **RELATED DOCUMENTS:**

1. **Surgical Services Policy: Admission/Discharge Criteria**
2. ~~1.~~**Surgical Services Policy: On-call**
3. **Surgical Services Policy: Scheduling Surgical Procedures**
4. **Surgical Services Policy: Staffing**

SUBJECT: Assignments for~~:~~ Telemetry Core Staff & Acute Care Services (ACS) ~~and Resource Staff~~ Floating to Telemetry

~~POLICY NUMBER: 6150-102~~

ISSUE DATE: 10/96
REVISION DATE(S): 10-12, 4-13.4/15

Department Approval Date(s):	**01/17**
Division of Cardiology Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**02/17**
Board of Directors Approval:	**02/11**

A. **PURPOSE:**

1. To outline the Registered Nurse (RN) and Advanced Care Technician (ACT) patient assignments and responsibilities on the Telemetry Unit.
2. To outline the patient assignments and responsibilities of TCMC staff floating to the Telemetry Unit.

DEFINITIONS:

1. Core Telemetry Staff: RNs or ACTs hired as staff for the Telemetry Unit and/or resource staff identified by the Telemetry Assistant Nurse Manager (ANM).
2. **Acute Care Staff (ACS):** ~~CS staff: One North, 2P, 3P, 4P, Forensics, and Rehab services RNs and ACTs~~**: staff hired on an ACS unit**.

C. **POLICY**

1. Assignments
   a. Each unit will be assigned the appropriate RN staff based on TCMC's staffing guidelines.
   b. An ACTs shall be assigned based on unit staffing guidelines.
      i. ACTs duties shall be assigned by the RN. Refer to the ACT Shift Routines
   c. Each nurse shall be assigned a maximum of 4 (four) patients.
   d. Each unit shall have an assigned Resource Nurse. The Resource Nurse shall be a core Telemetry RN or RN assigned by the ANM/Relief Charge Nurse ~~(RCN).~~
   e. The Resource Nurse shall ensure appropriate assignments are made based on the Synergy Model.
      i. Assignments may be changed throughout the shift based upon the Synergy Model and patient acuity.
      ii. The Telemetry Admission and Discharge Criteria shall serve as a reference.
   f. The ANM/**Relief Charge Nurse**~~CN~~ may make changes to the assignment as necessary to ensure the assigned nurse competencies meet the patient's characteristics and needs.
   g. The following patients shall be assigned to Telemetry core RNs and core Intensive Care Unit (ICU) RN floating to Telemetry:
      i. Pre and post cardiovascular surgery
      ii. Immediate post Percutaneous Coronary Intervention (PCI) patients with femoral arterial and/or venous sheaths post coronary cardiac catheterization 12 hours or less
      iii. Immediate post PCI without femoral and/or venous sheaths 12 hours or less

iv. Patient requiring invasive line monitoring; femoral or radial arterial sheath monitoring, and/or central venous pressure (CVP) monitoring
v. Patients requiring application of a FemoStop after losing hemostasis
vi. Patients requiring removal of a FemoStop
vii. Patients requiring transcutaneous pacing
viii. Patients with dysrhythmias requiring the initiation, loading, or maintenance of IV antiarrhythmic drugs, IV calcium channel blockers and/or IV beta-blockers to decrease a tachycardia, or patients requiring vasoactive drips.
ix. Immediate post conscious sedation for bedside procedures
x. Carotid Endarterectomy
xi. Ventilated endotracheal tube or tracheostomy patients
xii. Ventilator dependent
xiii. Patients requiring Bi-PAP

~~2. Resource Staff~~
~~a. TCMC resource nurses successfully completing one or all of the following may be assigned patients listed in number 7 per the ANM/relief charge nurse.~~
~~i. Telemetry or ICU RN Skills Checklist~~
~~i. Telemetry or ICU RN Advanced Nursing Skills Checklist~~
~~ii. Demonstration of skill during an annual skills lab~~
~~b. 2. TCMC resource ACTs successfully completing one of all of the following may be assigned care responsibilities and task for all telemetry patient populations:~~
~~i. Telemetry Advanced Care Technician Skills Checklist~~
~~ii. Telemetry Advanced Care Technician Skills Checklist Addendum~~

~~3.~~**2.** Acute Care Services (ACS)
a. RNs floating to Telemetry from Acute Care Services (ACS) ~~and resource nurses~~ who have not completed the Telemetry or ICU Skills Checklist and/or the Telemetry or ICU skills lab cannot be assigned total responsibility for patient care including duties and responsibilities for planning and implementing patient care, and ~~providing clinical supervision and coordination of care given by LVNs and~~ unlicensed nursing personnel" (Board of Registered Nursing (BRN), 1998).
b. RNs floating to Telemetry from ACS~~, resources RNs~~ whose primary floating pod is not Telemetry and registry medical surgical nurses patient assignments and responsibilities may include but are not limited to the following:
i. RNs shall receive patient assignments based on their clinical competency on ACS.
ii. Assignments will be modified throughout a shift based on patient acuity and Telemetry unit specific criteria for assigning patients to ACS and registry nurses.
iii. ~~RNs "~~**RNs** "may accept a limited assignment of nursing care duties, which utilizes his/her currently existing clinical competence" (BRN, 1998).
c. RNs shall perform "duties and responsibilities for which their competency has been validated" (BRN, 1998) by the following:
i. ACS per their unit specific skills checklist
ii. Registry per their agency skills checklist
d. RNs shall implement interventions within their scope of practice on ACS
e. RNs may not institute care, administer IV medications, or accept orders from physician that are not within their ACS scope of practice and/or orders that may not be received or implemented on ACS.
f. RNs may not implement Standardized Procedures, policies or procedures, which are specific to the Telemetry unit.
g. RNs shall consult with a core Telemetry RN~~, Resource RN~~, **or** ANM/RCN when the following occurs:
i. Receive report on a new admission or transfer to unit
ii. Changes in patient status from initial assessment or information obtained during hand-off.
iii. Cardiac rhythm, rate, or vital sign changes

iv. New orders to initiate procedures i.e., BiPAP, cardioversions, bronchoscopy, insertion of chest tube, pre-operative teaching for cardiovascular surgery, cardiac catheterization, insertion of pacemaker or implanted cardioverter defibrillator.

~~4.~~**3.** Orders to implement, initiate, or maintain IV a RNs floating to Telemetry from Acute Care Services (ACS) ~~and resource nurses~~ who have not completed the Telemetry or ICU Skills Checklist and/or the Telemetry or ICU skills lab "cannot be assigned total responsibility for patient care including duties and responsibilities for planning and implementing patient care, ~~and providing clinical supervision and coordination of care given by LVNs~~ and unlicensed nursing personnel" (Board of Registered Nursing (BRN), 1998).

~~5.~~**4.** RNs floating to Telemetry from ACS~~, resources RNs~~ whose primary floating pod is not telemetry and registry medical surgical nurses patient assignments and responsibilities may include but are not limited to the following:

a. RNs shall receive patient assignments based on their clinical competency on ACS.
b. Assignments will be modified throughout a shift based on patient acuity and Telemetry unit specific criteria for assigning patients to ACS and registry nurses.
c. RNs "may accept a limited assignment of nursing care duties, which utilizes his/her currently existing clinical competence" (BRN, 1998).
d. RNs shall perform "duties and responsibilities for which their competency has been validated" (BRN, 1998) by the following:
    i. ACS per their unit specific skills checklist
    ii. Registry per their agency skills checklist
e. RNs shall implement interventions within their scope of practice on ACS
f. RNs may not institute care, administer IV medications, or accept orders from physician that are not within their ACS scope of practice and/or orders that may not be received or implemented on ACS.
g. RNs may not implement Standardized Procedures, policies or procedures, which are specific to the Telemetry unit.
h. RNs shall consult with a core Telemetry RN~~, Resource RN,~~ **or** ANM/relief charge nurse when the following occurs:
    i. Receive report on a new admission or transfer to unit
    ii. Changes in patient status from initial assessment or information obtained during hand-off.
    iii. Cardiac rhythm, rate, or vital sign changes
    iv. New orders to initiate procedures i.e., BiPAP, cardioversions, bronchosocpy, insertion of chest tube, pre-operative teaching for cardiovascular surgery, cardiac catheterization, insertion of pacemaker or implanted cardioverter defibrillator.
    v. Orders to implement, initiate, or maintain IV antidysrhythmics or IV vasoactive medications, or any medications that cannot be administered on ACS.
    vi. Discharge of patient's with the following admitting diagnoses without consulting a core Telemetry nurse or ANM/RCN:
        1) Heart failure
        2) Acute Myocardial Infarction (MI)
        3) Post PCI
        4) Post CVS
    vii. Antidysrhythmics or IV vasoactive medications or any medications that cannot be administered on ACS.
    viii. Discharge of patient's with the following admitting diagnoses without consulting a core Telemetry nurse or ANM/Charge Nurse:
        1) Heart failure
        2) Acute MI
        3) Post PCI
        4) Post CVS

~~6.~~**5.** Registry Nurses

a. It is the responsibility of the registry RN to notify the **Telemetry**~~resource~~ RN, ANM and/or the relief charge nurse of their skills prior to accepting an assignment or implementing interventions.
b. Registry staff shall receive patient assignments as outlined for ACS.
c. Registry staff may not be assigned the following patients post cardiovascular surgery, post cardiac catheterization, ventilator assisted, or patients as identified by an ANM.
d. Registry staff may not be assigned total responsibility to provide interventions outside of their agency's skills checklist.
e. Registry Certified Nursing Assistant will be assigned task within their skill set for all Telemetry patients.

D. **EXTERNAL LINKS:**

1. **California** Board of Registered Nursing **(BRN). Retrieved from http://www.rn.ca.gov/regulations/rn.shtml**
   a. California Nursing Practice Act: Scope of Regulation. Business and Professional Code Division 2, Chapter 6. Article 2
   b. RN Responsibility when Floating to New Patient Care Unit or Assigned to New Population
   c. Standards of Competent Performance
   d. Unlicensed Assistive Personnel
   e. Abandonment of Patients

DELETE – no longer required

Tri-City Medical Center

Distribution: Women and Newborn Services

PROCEDURE: **HYDRALAZINE HYDROCHLORIDE ADMINISTRATION**

Purpose: To outline the nursing management of the obstetric patient receiving hydralazine hydrochloride.

Supportive Data: Hydralazine is a direct vasodilator; reducing vascular resistance via direct relaxation of arteriolar smooth muscle. Initially, pulse rate, cardiac output and renal blood flow will increase. Vasodilatation with Hydralazine results in a reflex increase in cardiac output (increased uterine blood flow); this increase in cardiac output blunts the hypotensive effect and makes it difficult to overdose the patient (Roberts.J.M.; Creasy et Resnick, 2004). The rennin-angiotensin-aldosterone system influences expansion of plasma and extra cellular fluid volumes, sodium and water retention and edema formation. Clinically, diastolic **Blood Pressure (BP)** is usually decreased more than systolic BP.
Administration Intervention is usually recommended when the BP is consistently > **or equal to** 160/110 mm/Hg. (BP point at which hypertensive end organ failure can occur). A satisfactory antepartum , and intrapartum **and/or** (or postpartum) response has been defined as a decrease in diastolic blood pressure to 90-100 mm/Hg. without decreasing utero-placental perfusion. Apresoline is used to prevent cerebral vascular accidents (CVA) and to reduce diastolic BP to levels of 90-100 mm/Hg or 15-20% (ACOG Perinatal guidelines, 2007).

Half Life	2 to 4 hours
Maximum Effect	10 to 80 minutes
Duration	2 to 6 hours

Equipment:
1. Syringe
2. Hydralazine (20 mg per mL)

PROCEDURE:

1. Position **blood pressure cuff on a superior arm.**
2. Obtain two BPs ten minutes apart with the patient in the lateral recumbent position.
3. Obtain order for hydralazine (Apresoline) **administration from OB provider for persistent BP greater than or equal to 160/110.(List,** route, dose, and frequency)for persistent B/P > 160/110.
4. Identify the patient and check for medication allergies.

Maintain continuous electronic fetal monitoring (antepartum and intrapartum)

5. **Notify the provider for non-reassuring fetal heart rate tracing.**
6. Assess patient's level of understanding regarding the need for the medication and her condition**ion**. Obtain the medication, syringe, and automatic blood pressure equipment.Apply blood pressure cuff on a superior arm.
7. Initially give hydralazine 5 mg **via iIntravenous push (**IVP) over 1-2 minutes for severe **BP findings per provider order.** e pregnancy induced hypertension.
   a. **A**May give additional doses of hydralazine 5-10 mg IVP **can be given** every 20 minutes **per provider order until a**for desired diastolic BP range of not lower that 90-100 mmHg **is obtained**.
   b. Decreasing the diastolic blood pressure suddenly from ≥ 110 mm Hg to ranges below 90 to 100 mm Hg, can cause decreasing utero-placental perfusion resulting in fetal compromise
   c. **If no effect after 20 mg, provider shall consider switching to another agent**
   d. **Do NOT** Recommendation of total bolus amount not to exceed 40 mg per hypertensive episodeConfirm order if different from recommended guidelines for administration with

Review/Revision Date	Clinical Policies & Procedures	Patient Care Quality Committee	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
8/96; 2/99; 4/00; 3/03; 8/09, 05/16	n/a	n/a	8/09, 08/16	11/16	01/17	02/17	7/03, 9/09

attending obstetrician If no effect after 20 mg, physician will consider switching to another ag

- Assess BP after each IVP dose.Q2 minutes x 10 minutes, then Q5 minutes x 15 minutes, thenQ15 minutes x 1 hour, thenQ1 hour if stable.
- Monitor the fetus via electronic fetal monitoring while the mother is receiving IV Hydralazine.Notify obstetrician immediately for non-reassuring FHR tracing. Maintain strict Intake & Output, assess every 1 to 2 hours or as ordered by the **provider.**hysician.
  - Notify **provider** hysician for urine output of ≤ 30 mL per hour or ≤120 mL per 4 hour**s.**
- rs Notify **provider** hysician if diastolic blood pressure is not decreased to ≤100 mm/Hg within 20 minutes after last IV push administration**n.** Refer to AGoal is to reduce maternal diastolic blood pressure to levels not lower than a range of 90-100 mm Hg For continued physician evaluation for patient's blood pressure not responding to Hydralazine treatment

e. **Make sure** Assure that the pre-eclamptic emergency supplies and the crash cart are immediately available.

B. **DOCUMENTATION:**

1. Record abnormal BP findings in OB TraceVue/Cerner, as well as other abnormal findings in the clinical notes.
2. Document maternal-fetal response in the patient '**s electronic medical record.** care record.

C. **CONTRAINDICATIONS:**

1. Relative contraindications to the use of hydralazine **includes**are:
   a. Drug sensitivity
   b. Severe dehydration
   c. Coronary artery disease
   d. Pre-existing angina
   e. Mitral vascular rheumatic heart disease

D. **ADVERSE EFFECTS MAY INCLUDE:**

1. Maternal
   a. Tachycardia
   b. Palpitations
   c. Flushing
   d. Headache* -may be confused with worsening preeclampsia
   e. Epigastric discomfort* -may be confused with worsening preeclampsia
      i. Nausea
      ii. Diarrhea
   f. Hypotension
   g. Sodium retention
   h. Angina
   i. Dizziness
   j. Dyspnea
   k. Hydralazine induced SLE syndrome
2. Fetal
   a. Tachycardia
   b. Late decelerations (a sharp decrease in the maternal diastolic BP will decrease utero-placental blood flow and O_2 delivery to the fetus)
   c. Thrombocytopenia, leukopenia in newborns

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ISSUE DATE: 10/94

SUBJECT: NEONATAL TEAM ATTENDANCE AT DELIVERIES

REVISION DATE: 1/00, 6/03, 3/06, 9/09, 4/10

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Medical Executive Committee Approval:	~~05/13~~01/17
Professional Affairs Committee Approval:	~~06/13~~02/17
Board of Directors Approval:	06/13

A. **POLICY:**

1. The goals of neonatal resuscitation include rapid assessment and stabilization of the newborn's airway, breathing and circulation (~~the~~ ABC's) as well as the stabilization of the thermal environment.
2. To the degree that all resuscitations can be anticipated, the guidelines for neonatal resuscitation as put forth by the **Neonatal Resuscitation Program** (NRP) ~~program~~ developed by the American Academy of Pediatrics and the American Heart Association will apply to all impending deliveries in the Women **and Newborn Services (WNS)** ~~'s and Children's Center~~ of Tri-City Medical Center.
3. Compliance with this policy is the responsibility of all health care providers in **WNS** ~~Women's and Children's Services~~ and the **Neonatal Intensive Care Unit (NICU)**.
4. ~~Refer to California Children's Services Manual of Procedures/ Community NICU /Provider Standards Chapter 3.25.2; Community NICU General Policies and Procedures #2 f page 27,1999.~~

B. **PURPOSE :**

1. To provide guidelines for NICU team attendance at deliveries **for the resuscitation and stabilization of the high risk newborn.**
2. ~~For the resuscitation and stabilization of the high-risk neonate.~~

C. **EQUIPMENT**:

1. Infant warmer
2. Resuscitation equipment
1. ~~Neonatal medications~~
3. Warmed Blankets **and towels**
~~3.~~**4.** **Warming Mattress if 35 weeks gestation and less**~~,~~
2. ~~Towels~~
~~4.~~**5.** Neowrap (if ~~less than 28~~ **32** weeks **gestation and less**)
~~5.~~**6.** Stethoscope
~~6.~~**7.** Thermometer
~~7.~~**8.** Neonatal Crash Cart
~~8.~~**9.** Neonatal Transport Warmer

D. ~~**NEONATAL INTENSIVE CARE UNIT (NICU)**~~ **RESUSCITATION TEAM ATTENDANCE AT DELIVERIES:**

1. The NICU resuscitation team will be present at the delivery of **newborns**~~infants~~ with the following **risk factors**~~problems~~:

a. Anticipated delivery of 35 completed weeks (35 weeks 6 days) or less or more than 42 completed weeks gestation
b. Known or suspected congenital defects or chromosomal anomalies
c. Multiple gestations
d. Cesarean sections – ~~**Unscheduled,**~~ **Emergent, and/or with high risk indications not limited to:**
i. Fetal Heart Rate Category III strip tracing
ii. Prolapsed Cord suspicion
iii. Placental Abruption
~~a.~~**iv. Uterine Rupture** ~~high risk as defined in D.1.~~
~~d.~~**e.** Signs of fetal distress at the discretion of the **Obstetrical (OB) provider**~~obstetrician~~
f. Macrosomic fetus and**/ or** potential for shoulder dystocia
~~e.~~**g.** At the request of the labor and delivery (L&D) Assistant Nurse Manger (ANM)/or designee~~*~~ in collaboration with the **OB provider**~~obstetrician~~.

2. The NICU resuscitation team shall consist of:
a. Neonatal Attending Physician (MD) **or Neonatal Nurse Practitioner/ Allied Healthcare Provider (AHP)**
b. NICU nurse
c. Respiratory Care Practitioner
3. The composition of the NICU resuscitation team may vary according to special circumstances.
4. One member of the team must be skilled in neonatal intubation.
5. All team members must be currently trained in NRP ~~(Neonatal Resuscitation Program).~~

E. **RESPONSIBILITIES OF L&D AND NICU TEAM MEMBERS:**

1. The NICU resuscitation team shall be identified at the start of each shift.
2. The L&D ANM **or designee**~~*~~ shall provide the NICU ANM **or designee**~~*~~ with updated information regarding the status of high-risk patients that will require the presence of the NICU resuscitation team at a delivery **as indicated**.
3. The **OB provider** ~~Obstetrician (OB) and~~ or the L&D nurse (in collaboration with the OB **provider**) may request the presence of the NICU resuscitation team at birth.
4. When the request for the NICU resuscitation team is made the following information shall be communicated**, as available**:
a. Whether the infant is yet delivered
b. The type of problem and estimated gestational age (if known)
c. The location
5. The L&D or Nursery nurse shall be responsible for having the resuscitation supplies available in the room.
6. The L&D or Nursery nurse shall provide sufficient time for the NICU team to arrive and check equipment **as possible**.
7. Management of the NICU resuscitation team shall belong to the neonatologist**/AHP**, and includes coordination, performance, and delegation of activities.
8. For delivery of multiple gestations, the neonatologist shall determine the staffing and supplies needed to ensure adequate neonatal care.
9. Upon arrival for the delivery the NICU resuscitation team shall identify themselves to the patient/family and to the L&D team.
10. The neonatologist**/AHP** will ensure that there is communication with the parents and the L&D team about the infant's condition after delivery.
~~10.~~**11.** The assessment, care and evaluation of the infant shall be provided by the NICU resuscitation team following the guidelines put forth in the NRP program.
~~11.~~**12.** The NICU nurse shall receive the ID bands from the L&D or Nursery nurse and place them on the baby.
~~12.~~**13.** The NICU nurse will report off to the L&D or Nursery nurse prior to leaving the birthing area.
14. At no time will a newborn be left without the presence of a nurse designated to provide care for him/her.

F. **DOCUMENTATION:**

1. Documentation of all assessments and interventions shall be completed by the NICU nurse and/or licensed professional performing the interventions~~/ and~~ assessments prior to leaving the birthing area **on the newborn admission record and in the patient's electronic medical record, as appropriate**.
2. The documentation shall include:
   a. The time the NICU team arrived **and** ~~The timed interventions and~~ who on the team performed the interventions
   b. The condition of the infant and response to interventions
   ~~a.~~**c. Use of the Neonatal Resuscitation Record, if indicated**
   ~~b. The name and discipline of each member of the NICU resuscitation team~~

G. **REFERENCES**:

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Tri-City Medical Center
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WOMEN'S AND NEWBORN SERVICES (WNS)

SUBJECT: STANDARDS OF CARE — NEWBORN'S

ISSUE DATE: 06/14
REVISION DATE(S):

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Division of Neonatology Approval Dates(s)	**08/16**
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Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**~~06/14~~02/17**
Board of Directors Approval Date(s):	**06/14**

A. PREAMBLE:

1. Nursing practice in the care of Women's and Newborn's **Services (WNS)** is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women and Newborn nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN). Couplet care is based on a philosophy that embraces the family-s spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices.

~~A.~~B. DEFINITIONS:

1. **Standards of Professional Nursing Practice ~~Care~~:** "Authoritative statements **of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p.2).** ~~by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p. 77)." "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p.78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.~~

1. Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010)".

2. Standards: "Authoritative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2010, p. 67).
   a. "Standards of care are Standards of Professional Nursing Practice."

~~2.~~3. Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA 2016 includes the following: ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment, and~~

~~patient health care promotion and the planning for continuity of care. The nursing process includes the following:~~

a. **Assessment:** A systematic, dynamic **way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.**~~process by which the registered nurse through interaction with the patient, significant others, and health care providers collect comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance, and restoration.~~

~~i. Registered Nurses (RN) performs assessments.~~

~~ii. Obstetrical Technician (OB Techs), OB Advanced Care Technicians (ACTs) collect patient data.~~

~~iii. Only RNs perform admission, transfer, and/or discharge assessments.~~

i. Subjective-what the patient says

ii. Objective-observation based on assessment findings

iii. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to : sleep/alert status, cry reflexes, tone, movement, respiratory symptoms, respirations, respiratory pattern, room air/oxygen, abdominal description, skin color, skin temperature and neonatal skin integrity.

b. **Diagnosis:** A **nurses'** clinical judgment about the client's response to actual or potential health conditions or needs.

c. **Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short and long-range goals".** ~~Measurable, expected, client-focused goals.~~

~~d.~~**i. Planning:** (**Care Plan i.e.,** Plan of Care): A comprehensive outline of care to be delivered to attain expected outcomes.

~~e.~~**d. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care" from the patient during hospitalization and in preparation for discharge needs".** ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

i. ~~TCMC's Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

~~f.~~**e. Evaluation:** The process of determining both **"The patient's status and the** ~~the client's progress toward the attainment of expected outcomes~~ and the effectiveness of nursing care. **It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".**

~~3.~~**4. Patient:** Recipient of nursing care.

~~4.~~**5. Health Care Providers:** Individuals with special expertise who provide healthcare services or assistance to clients.

~~5.~~**6. Significant Others:** Family members and/or those significant to the client.

~~6.~~**7. Reasonable and a Timely Manner:** Defined as within 4 hours after completion of assessments or care provided.

B. **REGISTERED NURSES:**

1. Use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)."

C. **WNS NEWBORN STANDARDS OF PRACTICE:**

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic database shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.
4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the healthcare team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interview, patient medical records, and from other members of the healthcare team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according to the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **GENERAL NEWBORN NURSING ASSESSMENT:**

1. **Standards of Care: Vital Signs**
   a. Vital sings with the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age, upon transfer of care, then every 4 hours until 12 hours post-birth, then if stable, every 6 hours until discharge with vital signs, prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients, or per provider's orders.
2. Vitals shall include:
   a. Axillary temperature documented in Celsius.
   b. Apical Heart Rate (AHR).Respiratory Rate (RR).
   c. SpO_2, prn spot check when clinically indicated.
   d. Pain level.

~~3. **If mother and infant are stable v**Vital signs **while the mother has time for skin to skin and breastfeeding** will be assessed within the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age.~~

~~4.~~**3.** If mother and infant stable, vital signs will be assessed while infant is skin-to-skin **or breastfeeding** within the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age.
   a. After two hours of age, the vitals will be taken every 4 hours until 12 hours post birth, then if stable after the 12 hours, every 6 hours until discharge (unless condition warrants more frequent vital signs or per provider order) and prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients.
   b. Any deviation of temperature, pulse**, respirations** and/or normal limits should warrant reassessment within 30-60 minutes.
   c. Notify provider if reassessment outside of normal limits.
   d. Any deviation from normal limits warrants further assessments, documentation, appropriate intervention and provider notification as needed.
   e. Oximetry spot checks may be considered based on vital signs and clinical assessments.
   f. Normal ranges for newborns after transition (a few hours after birth).
   g. Temperature range: 97.5°F – 99.5°F (36.5°C - 37°5C).
   h. Pulse range: 110-160 bpm **(may be lower due to sleep status).**
   i. Respirations: 30-60 per minute **(may be lower due to sleep status).**

E. **STANDARDS OF CARE: NEWBORN PAIN ASSESSMENT:**

1. **Assessment: Pain per Pain Management Policy**
   a. The Neonatal Infant Pain Scale (NIPS) is used for pain assessment of the neonate. The infant shall be assess on a scoring system based on 5 parameters, (Behavioral and one physiologic parameter):
      i. Facial expression
      ii. Cry
      iii. Breathing patterns
      iv. Arms
      v. Legs
      vi. State of arousal

2. Pain assessment will be done on admission at the initial shift assessment with vital signs, and as needed.

~~2.~~**3. Patient may have fussiness due to delivery or handling versus pain. Reassessment does not need to occur in these instances.**

~~3.~~**4.** Pain will be assessed and assigned a score as follows:

a.

Assessment of Pain	Intervention
No pain	NIPS 0
Mild pain	NIPS less than 2~~, may be managed with non-pharmacologic measures~~
Mild to moderate pain	NIPS 2-4~~, may be managed with non-pharmacologic measures~~
Moderate to severe pain	NIPS greater than 4-7 ~~may need pharmacologic intervention in addition to comfort measures~~

~~4. Pain assessment will be performed before and after procedures that may induce pain.~~
~~5. Pain assessment will be performed after an intervention as follows:~~
~~a. Within one hour of the intervention or as soon as the nurse deems it to be necessary.~~
~~i. Reassess within minutes if infant experiencing acute pain.~~
~~ii. Within two hours or at the next overall nursing assessment, whichever is first.~~

F. **STANDARDS OF CARE: INTAKE AND OUTPUT:**

1. Intake and output shall be monitored as ordered and as follows:
   a. Intake:
      i. Encourage breastfeeding of the baby at least 8 to 12 times in a 24-hour period.
         1) In the first 24-hours, infant may be sleepy and requirements and demands may be less than the 8-12 feedings.
         2) Evaluate and document LATCH assessment every shift until discharge.
         3) A lactation consult is a separate evaluation and shall be assessed and documented as needed and/or for infants in the NICU.
      ii. ~~If formula is requested for any infant: feeding every 3-4 hours ad lib per Lactation Services Policy.~~ **Formula should only be given per mother request or~~f physician recommendation.** Refer to Infant Feeding policy.
   b. Output:
      i. Urine – the baby should have:
         1) 1 wet diaper in the first 24 hours.
         2) 2 wet diapers on the second day of life.
         3) 3-5 wet~~d~~ diapers on the third-fifth day of life.
         ~~4) 4-6 wet diapers per day by 5-7 days of life.~~
      ii. Stooling:
         ~~1)~~ Ensure the infant is passing meconium a minimum of 1 stool per day ~~(3-4) during the first 1-3 days of life.~~
         ~~2) The baby should have 3-4 stool eliminations by 3-5 days of life.~~
         ~~3)~~**1)** ~~The baby should have 3-6 stool eliminations by 5-7 days of life.~~

iii. Stools will change color, consistency, and texture after meconium passed on day 1-3 (green to yellow).
1) Breastfed infants may appear to have stool that is runny and seedy once milk supply is in.
iv. Document number of wet and/or stooled diapers per shift.
v. Document color and consistency of stooled diapers per shift.
c. Notify provider:
i. Infant has not urinated in the first 24 hours.
ii. Infant has not stooled or passed meconium plug in first 24 hours.
1) Terminal meconium may have occurred after delivery. Ensure that this was reported and documented.

G. **STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS:**

1. Weight and length will be measured and documented after birth. Daily weight will be measured and documented until discharge.
a. Weights shall be documented in grams and length in cm.
2. Occipital frontal circumference (OFC) will be measured at birth and/or when ordered by a provider.
3. Abdominal (ABD) and chest circumference will be measured at birth.
a. ABD, chest, and OFC measurements shall be documented in centimeters (cm).
b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.
c. Ballard assessment for gestational age shall be performed on all newborns within 12 hours post-delivery.

H. **STANDARDS OF CARE: ASPIRATION ASSESSMENT:**

1. Maintain aspiration precautions for newborns in transition.
a. Keep bulb syringe in clean dry area close to newborn's head for use PRN.
i. Do not use bulb suctioning for oropharyngeal and nasal malformations
b. Some newborn infants may have increased or thick secretions and may require deep suctioning.
c. Chest physiotherapy requires a provider order and is contraindicated for newborns with history of meconium fluids.
i. Chest physiotherapy when ordered shall be performed by a respiratory clinical practitioner (RCP).

I. **STANDARDS OF CARE: PATIENT SAFETY:**

1. The healthcare team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet.
2. Patient safety shall be assessed per the following:
a. The RN shall observe the patient's physical condition on admission at transfer to their unit, prior to and after procedures and as needed.
b. All newborns shall have identification bands placed at birth and be identified per WCS procedure: "Identification/Banding of Newborns."
i. Newborns admitted to TCMC following delivery outside the labor and delivery unit shall be banded with mother present prior to separation for evaluation of current condition per procedure as referenced above.
c. **Newborn a**Allergies will be monitored and documented upon admission **as No Known Allergies (NKA)**.
i. Any known medication or fool allergy shall be documented as follows:
1) The patient allergy band.
2) Allergy sticker placed on the front of the chart.
3) Medication Administration Record.
d. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders policy.

e. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
f. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
g. Electronic or medical equipment brought to TCMC shall be evaluated, used, and store per PCS: Medical Equipment brought into the Facility, policy.
h. Hand-off communication shall be provided per PCS: Hand-off Communication policy and unit specific hand-off policies.
i. Medication shall be reconciled per PCS: Medication Reconciliation policy.
j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

J. **SYSTEM REVIEW:**

1. All newborn patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

K. **STANDARD OF CARE NEWBORN: ASSESSMENT:**

1. All patients admitted to WNS nursing units shall be assessed by a registered nurse per the following:
   a. Admission and/or Transfer: Assessment.
      ~~i. All patients admitted or transferred to a higher level of care shall have a biophysical assessment initiated within the following time frames:~~
      ~~ii.~~**i.** **Infant should first have skin to skin contact with mother and time to breastfeed for as long as possible according to infant stability.** Complete physical exam by 2 hours of age.
      ~~iii.~~**ii.** Upon admission to couplet care
      ~~iv. The biophysical assessment shall be completed in a timely manner.~~
2. Admission Assessment – Patient History (post-delivery):
   a. All inpatients shall have the Admission Assessment – Patient History completed ~~and documented~~ within 2 hours of delivery.
   b. After delivery: Vitals will be done q30 minutes times four with one assessment being a complete head to toe.
3. Initial Shift Assessment
   a. An RN shall perform an ongoing head to toe assessment as follows:
      i. **Transition RN**~~Nursery~~: within 2 hours of the start of the shift.
      ii. Newborn couplet: within 3 hours of the start of the shift.
   b. Reassessment (Focused assessment)
      i. After completion of an admission or an initial shift assessment, all patients shall have ~~a head to toe~~ focused reassessment performed and documented ~~on the ongoing assessment during the shift~~ **as assessment completed and no changes since last assessment. See definition section.**
      ii. Guidelines for reassessment are as follows:
         1) **Transition RN**~~Nursery~~: every 6 ~~4~~ hours until stable newborn returned to couplet care (if applicable) or more frequently if treatment or condition warrants.
         2) Newborn couplet: after transitional assessments are complete, every 4 hours until 12 hours post birth, then if stable, every 6 hours until discharge or more frequent if treatment or condition warrants.
      iii. If the patient's guardian refuses a reassessment, document their refusal in the medical record.

L. **STANDARDS OF CARE 1.1: ADMISSION ASSESSMENT NEUROLOGICAL SYSTEM REVIEW:**

1. Neurological: System Review.
2. Assess for the following:

a. Periods of alertness.
b. Symmetric features and movements
c. Posture
d. Tone
e. Tremors or jitteriness

3. Seizure activity.
   a. Facial nerve paralysis.
   b. Newborn reflexes (Moro/startle, reflex, rooting, grasp, plantar, and Babinski reflexes).
   c. Assess if reflexes are symmetrical.
      i. Birth trauma of the head, assess for risk factors.
      ii. Operative assist during delivery process.
   d. Molding or bruising of head, presence of.
      i. Abrasions.
      ii. Caput succedaneum.
      iii. Cephalohematoma.
   e. Eyes:
      i. Sclera – clear, redness, hemorrhage.
      ii. Drainage.
4. Abstinence scoring needs continuous monitoring by RN to assess for signs and symptoms of withdrawal. See Neonatal Abstinence Scoring policy.

M. **STANDARDS OF CARE 1.2: ADMISSION ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW:**

1. Cardiovascular System Review.
   a. Assess heart sounds in all auscultatory areas; note regular or irregular apex or point of maximal impulse (PMI) at left third or four intercostal space.
      i. Murmurs should be reported to MD with notification of birth.
      ii. Murmurs that are present after 12 hours of life should be reported and evaluated to rule out underlying structural abnormalities.
         1) Notify provider immediately if infant is symptomatic.
         2) Notification of the stable infant during provider rounds the next morning is appropriate **or notification via the well baby line**.
   b. Check capillary refill.
   c. Check edema location and grade.
   d. Palpate bilateral brachial and femoral pulses of the newborn.
   e. Assess peripheral perfusion; skin warm and dry.
   f. Assess newborn's fontanels – anterior and posterior.
      i. Flat, depressed, bulging.
      ii. Soft, tense.

N. **STANDARDS OF CARE 1.3: ADMISSION ASSESSMENT PULMONARY SYSTEM REVIEW:**

1. Pulmonary: System Review.
   a. Check oxygen delivery devices if applicable.
   b. Check amount oxygen flow/FiO_2 if applicable.
   c. Assess respiratory effort.
   d. Auscultate breath sounds all lobes.
   e. Assess sputum amount, color, and consistency.
   f. Assess for presence of cough.
   g. Assess for presence of artificial airway, tubes, and drains.
   h. Assess chest expansion for symmetry.
2. In addition to above:
   a. Expected findings for chest/lungs:
      i. Patency of airway.
      ii. Patency of nares.
         1) Presence of congestion or drainage.
         2) Symmetric, barrel shaped, with equal anteroposterior and lateral diameters.

3) Slight subcostal and intercostals retractions are common **during transition**~~.~~
4) Bilateral bronchial breath sounds. Fine crackles and transient hoarseness are normal **during transition.**
5) Respiratory rate and effort.

b. Document all findings, notify provider for abnormals. Assess for:
i. Tachypnea – persistent respiratory rate greater than 60 per minute.
ii. Grunting.
iii. Significant retraction.
iv. Questionable color.
v. Lack of breath sounds in one or more lobes.
vi. Oximetry spot checks based on vital signs and clinical assessments.

O. **STANDARDS OF CARE 1.4: ADMISSION ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW:**

1. GI: System Review
a. Assess contour/tone of abdomen.
~~i. Round, concave, scaphoid, distention.~~
~~ii. Soft, firm.~~
b. Assess for ~~nausea and/or~~ vomiting.
c. Auscultate for presence of bowel sounds in all four quadrants.
d. Assess bowel function including ~~passing flatus~~ or last stool.
~~e. Assess for the presence of tubes and drains, if present assess type and location.~~
~~i. Confirmation of placement, and drainage description.~~
~~ii. Check tube placement for drainage and insertion site integrity.~~
~~iii. Assess type of formula, rate, and residual amounts.~~

2. In addition to above assess for:
a. Maternal risk factors:
i. Polyhydraminios.
ii. Cesarean delivery.
iii. Maternal intrapartum bleeding.
iv. Meconium stained fluid.
b. Warning signs:
i. Green bilious emesis.
ii. Presence of blood in emesis or stools.
iii. Tense or tender abdomen.
iv. Abnormal distention.
v. Notify provider immediately for presence of warning signs.

P. **STANDARDS OF CARE 1.5: ADMISSION ASSESSMENT GENITOUTINARY SYSTEM REVIEW**

1. Genitourinary (GU) System Review
a. Assess urine color and frequency.
b. Assess for bladder distension if no urination in 24 hours.
c. Assess external anatomy as applicable.

2. In addition to above, assess for:
a. Females:
i. Presence of labial skin tags and/or edema.
ii. Presence of discharge.
iii. Presence of ambiguous genitalia.
b. Males:
i. Location of meatus (hypospadias, epispadias).
ii. Condition of foreskin.
iii. Presence of descended testes.
iv. Condition of scrotum (hydrocele, hernia, etc.).
v. Presence of ambiguous genitalia.

vi. Assess circumcision site when applicable.

Q. **STANDARDS OF CARE 1.6: ADMISSION ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW:**

1. Musculoskeletal System Review.
   a. Presence of joint or musculoskeletal abnormalities.
   b. Full range of motion against gravity, some to full resistance of all extremities.
   c. ~~Mobility~~ Movement appropriate for age.
2. In addition to above, assess for presence of:
   a. Symmetry of extremities.
   b. Head/neck:
      i. Full range of motion of neck without torticollis.
         ~~1) Tonic neck reflex present.~~
      ii. Sutures.
         ~~1) Overriding, widened, fused.~~
      iii. Mouth, lips, and palate (patent, fused, cleft, intact, precocious teeth).
      iv. Nares
   c. Muscle tone.
   d. Intact clavicles with no tenderness, swelling, or crepitation.
   e. All ten fingers and toes present without webbing, extra digits.
   f. Spine intact without openings, masses, curves, dimples, or hairy tufts.
   g. Gluteal folds/creases, palmar creases, or hip click.

R. **STANDARDS OF CARE 1.7: ADMISSION ASSESSMENT INTEGUMENTARY SYSTEM REVIEW:**

1. Skin Assessment.
   a. Admission ~~and/or shift assessment~~ exams.
      i. Temperature.
      ii. Color ~~– pink, cyanosis, acrocyanosis, pallor, jaundice, plethoric.~~
      iii. Warmth.
      iv. Turgor.
      v. Moisture.
      vi. Edema.
      vii. Transient mottling.
      viii. Vernix
      ix. Lanugo.
      x. Milia.
      xi. Port wine stain.
      xii. Capillary hemangiomas: "stork bite," "angel kiss."
      xiii. Mongolian spots.
      xiv. Skin tags.
   ~~b. Ongoing assessments shall also include presence of:~~
      ~~i.~~**xv. Newborn Rash(e**~~E~~rythema toxicum**)**: pink popular rash with vesicles on chest, arms, **back**, or abdomen.
      xvi. Petechiae.
      ~~ii.~~**xvii. Ecchymosis**
2. The infant should be dried per Neonatal Resuscitation Guidelines without wiping all the vernix from the skin. Visible blood should be cleaned from the infant. After 24 hours of life, the stable infant may receive an initial bath upon parent's request. ~~For term infants (greater than or equal to 37 weeks and 0 days), recommended only after newborn's temperature and vital signs have been stabilized. Postpone bath until thermal stability is ensured, unless indicated by maternal infection risk factors (i.e., HIV, Hep B, etc.).~~
   a. If the infant is bathed during the hospital stay, familial participation should be encouraged.
   b. A sponge bath may be given to the infant in the crib and then the infant should be placed skin to skin with mother.

c. Earlier bathing may be considered per specific parental request, meconium stained infant, or malodorous fluid.

d. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after delivery.

3. Cord Care/Assessment.
   a. Assessment to include:
      i. Number of vessels.
      ii. Condition – moist, drying.
      iii. Drainage.
      iv. Clamp.
   b. Initial: clean the cord and surrounding skin surface during the initial bath with cleansing solution, rinse thoroughly and then allow to air dry folding the diaper away from the umbilical cord.
   c. Ongoing: every shift and as needed, inspect cord for degree of moisture or dryness, drainage and odor. Keep the cord dry and clean if cord becomes soiled with urine or stool, cleanse with water.

S. **STANDARDS OF CARE 1.8: ASSESSMENT PSYCHOLOSOCIAL SYSTEM REVIEW:**

1. Psychosocial assessment will be done with the mother and social service consultation ordered as needed.

T. **OTHER PROCEDURES:**

1. Newborn will have blood glucose performed per **Blood Glucose Newborn Monitoring**~~Newborn Hypoglycemia during Transition to Extrauterine Life~~ Standardized Procedure.
2. Toxicology urine specimen will be obtained if the mother has a positive toxicology screen, a positive history of substance abuse, is suspected of substance abuse or with diagnosis, has had less than or equal to three prenatal visits or suspicion of placental abruption and on all babies assigned to Neonatology.
3. Prophylactic eye ointment and Vitamin K will be given per PCS Standardized Procedure: Administration of Aquamephyton Injection and Erythromycin Ophthalmic Ointment to the Newborn.
4. Hepatitis B vaccination or Hep B vaccine and HBIG immunuglobin injection will be given per PCS Standardized Procedure: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns.
5. Newborn Hearing Screen prior to discharge, but at least 12 hours post-delivery per hospital procedure: Hearing Screening Newborn and Infant.
6. **Serum** ~~Transcutaneous~~ bilirubin screening for assessment of jaundice will be done around 24 hours, prior to discharge or if baby visually jaundiced.
7. Newborn metabolic screen will be done prior to discharge per PCS Procedure: Newborn Screen, Collection of Specimen.
8. Universal Screening for Critical Congenital Heart Disease will be done after 24 hours of life or prior to discharge per Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).
9. Car seat challenge will be performed on infants meeting criteria per WNS/NICU Procedure: Care Seat Challenge Test.
10. Neonatal Abstinence Scoring will be performed on all infants meeting criteria per WNS/NICU Procedure: Neonatal Abstinence Scoring.

U. **NURSING PROCESS:**

1. Standards of Care: Assessment.
   a. An RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. Standards of Care: Diagnosis.

a. An RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift, and PRN.

3. Standards of Care: Outcome Identification.
   a. An RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. Standards of Care: Planning.
   a. An RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions which may be implemented to attain expected outcomes.
5. Standards of Care: Implementation.
   a. An RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task appropriately.
6. Standards of Care: Evaluation.
   a. An RN shall evaluate the patient's progress forward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.
7. Standards of Care: Documentation.
   a. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.
   b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.

   c. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

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SUBJECT: STANDARDS OF CARE - POSTPARTUM

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval Date(s):	**07/16**
Department of OB/GYN Approval Date(s):	**~~04/13~~12/16**
Division of Neonatology Approval Date(s):	**n/a**
Department of Pediatrics Approval Date(s):	**n/a**
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Medical Executive Committee Approval Date(s):	**01/17**
Professional Affairs Committee Approval Date(s):	**~~06/14~~02/17**
Board of Directors Approval Date(s):	**06/14**

A. **PREAMBLE:**

1. Nursing practice in the care of Women and Newborns is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women's and ~~Children's~~**Newborn's Services (WNS)** nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN).Couplet-care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices

B. **DEFINITIONS:**

1. **Standards of ~~Care~~Professional Nursing Practice: "**Authoritative statements **of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p. 2.**~~by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p.78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.~~
2. **Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010 p. 67).**
   a. **"Standards of care are Standards of Professional Nursing Practice."**
~~2.~~3. **Nursing Process: The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision-making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care. The nursing process includes the following:~~
   a. **Assessment:** A systematic, dynamic **way to collect and analyze data about a ~~client~~patient i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.** ~~process by which the registered~~

~~nurse, through interaction with the patient, significant others, and health care providers, collects comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance and restoration.~~

~~a. Registered Nurses (RN) performs assessments.~~

~~b. Obstetrical Care Technicians (OB Techs) and OB Advanced Care Technicians (ACTs) collect patient data.~~

~~c. Only RNs perform admission, transfer, and and/ or discharge assessments.~~

i. Subjective-what the patient says

ii. Objective-observation based on assessment findings

b. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to: orientation, assessment, level of consciousness, affect/behavior, respiratory symptoms, respirations, respiratory pattern, skin color, skin temperature, fundal/lochia/cesarean section/tubal ligation assessment.

~~b.~~**c. Diagnosis:** A **nurses'** clinical judgment about the ~~client's~~ **patient's** response to actual or potential health conditions or needs.

~~c.~~**d. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measureable and achieved short and long-range goals".** ~~Measurable, expected, client-focused goals~~

~~2.~~**i. Planning**: ~~(~~**Care Plan i.e.** Plan of Care~~)~~: A comprehensive outline of care to be delivered to attain expected outcomes.

~~d.~~**e. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".** ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

i. ~~TCMC's, Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

~~e.~~**f. Evaluation:** The process of determining both the **"Patient;s status** ~~client's progress toward the attainment of expected outcomes~~ and the effectiveness of nursing care. **It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care."**

~~3.~~**4. Patient:** Recipient of nursing care.

~~4.~~**5. Health Care Providers:** Individuals with special expertise who provide health care services or assistance to ~~clients~~**patients**.

~~5.~~**6. Significant Others:** Family members and/or those significant to the ~~client~~**patient**.

~~6.~~**7. Reasonable and a timely manner:** Defined as within 4 hours after completion of assessments or care provided.

~~7.~~**8. Registered nurses** use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

C. **~~WCS~~WNS STANDARDS OF PRACTICE:**

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic data-base shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.

4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according **to** the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **NURSING PROCESS:**

1. **STANDARDS OF CARE: ASSESSMENT**
   a. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. **STANDARDS OF CARE: DIAGNOSIS**
   a. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
3. **STANDARDS OF CARE: OUTCOME IDENTIFICATION**
   a. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. **STANDARDS OF CARE: PLANNING**
   a. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.
5. **STANDARDS OF CARE: IMPLEMENTATION**
   a. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task**s** appropriately.
6. **STANDARDS OF CARE: EVALUATION**
   a. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.

E. **STANDARDS OF CARE: DOCUMENTATION:**

1. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.
2. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.

3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

GENERAL OB NURSING ASSESSMENT

A. **STANDARDS OF CARE: VITAL SIGNS:**

1. Maternal vital signs shall include:
   a. Temperature, documented in Celsius (preferred)
   b. Blood Pressure (BP)
   c. Heart Rate (HR)
   d. Respiratory Rate (RR)
   e. SpO2
   f. Pain Level
2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge per Patient Care Services (PCS) procedure Discharge of Patients, per provider's orders and as follows:
   a. **Postpartum, Vaginal Delivery**:
      i. **In Labor and delivery v~~V~~**ital signs **are obtained** every 15 minutes x4, at 2 hours, upon admission to couplet care, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients and prn as clinically indicated or ordered by provider. Patient's temperature is taken x 1 following delivery.
      ii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12
   b. **Post-Operative, Cesarean Delivery**:
      i. PACU vital signs as ordered by anesthesiologist/provider
      ii. Vital signs, including temperature, upon admission to couplet care, then every 6 hours for first 48 hours post-delivery, then every shift and prn as clinically indicated or ordered by provider and prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients
         1) See anesthesia Power Plan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).
      iii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12

B. **STANDARDS OF CARE: PAIN ASSESSMENT:**

1. Assessment: Pain per Pain Management Policy
   a. A general pain assessment shall consist of the following:
   b. Acceptable pain
   c. Pain scale
   d. Current pain intensity
   e. If patient complains of pain, assess the following:
      i. Location, intensity, and duration/onset
      ii. Quality/type

iii. Aggravating factors
iv. Alleviating factors

f. Assess for presence of pain/discomfort with vital signs and PRN
g. Perform a pain assessment with each patient report of new or different pain.
h. Perform a pain reassessment as follows:
i. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention
ii. One (1) hour after PO intervention

C. **STANDARDS OF CARE: INTAKE AND OUTPUT:**

1. Intake and output shall be monitored as ordered and as follows:
a. Postpartum, Vaginal Delivery:
i. Check if patient voiding without difficulty x 2 post-delivery.RN or designee to offer assistance as needed.
ii. After delivery or after catheter removal goal is for patient to void spontaneously within 6 hours
1) If patient on I/O or has an IV ordered, notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
iii. Maintain IV access for 24 hrs. post epidural anesthesia unless ordered by provider.
iv. Post-partum hemorrhage
1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
2) Monitor lochia color, odor, amount, consistency, clots, steady stream or trickle
a) Assess pads and saturation
b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
d) Refer to ~~WCS~~**WNS** Obstetrical Hemorrhage procedure.

b. Postoperative, Cesarean Delivery:
i. OB PACU: upon arrival from the OR and prior to transfer to couplet care:
1) Assess and document the number of the IV fluid bag
2) Assess and document patency of the Foley catheter with urine collection bag for amount, color and clarity of urine
ii. I&O totals every shift with 24 hour totals for day of delivery, and post-op day.
1) Notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
2) IV converted to saline lock or discontinued on post-op day 1, or as ordered by provider
3) Foley catheter discontinued on post-op day 1 or as ordered by provider
a) Assess bladder/voiding difficulties prn
b) Check voiding x2 post-removal of catheter. RN or designee to offer assistance as needed. After catheter removal goal is for patient to void spontaneously within 6 hours.
iii. Post-operative cesarean hemorrhage:
1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
2) Monitor lochia color, odor, amount, consistency, clots, steady stream or trickle
a) Assess pads and saturation

b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
d) Refer to ~~WCS~~**WNS** Obstetrical Hemorrhage procedure.

iv. Assess for the presence of tubes and drains, if present, assess type and location
1) Confirmation of placement, and drainage description
2) Check tube placement for drainage and insertion site integrity

D. **STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENT:**

1. Height and weight will be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation permits, it is preferred that the patient be weighed upon admission to Labor and Delivery.
   a. Weights shall be documented in kilograms (kg) and height in centimeters (cm)
   b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.

E. **STANDARDS OF CARE: ASPIRATION ASSESSMENT:**

1. Maintain aspiration precautions for maternal patients identified at risk.
   a. Maintain head of bead (HOB) at 30 degrees at all times
      i. If eclamptic seizure, lower head of bed, open airway, roll patient to side and suction secretions as necessary
      ii. Avoid attempts to insert suctioning device when patient's teeth are clenched
   b. Maintain suction equipment at bedside at all times.

F. **STANDARDS OF CARE: PATIENT SAFETY:**

1. The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes the bed in the lowest position, wheels locked, and room free of clutter.
2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures and as needed.
   b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
   c. Allergies will be monitored and documented upon admission
      i. Any known medication or food allergy shall be documented as follows:
         1) The patient allergy band
         2) Allergy sticker placed on the front of the chart
         3) Medication Administration Record
      ii. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders Policy.
   d. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
   e. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
   f. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
   g. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
   h. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.
   i. Medication shall be reconciled per PCS: Medication Reconciliation Policy.

j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

SYSTEM REVIEW

A. All maternal patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

B. **STANDARD OF CARE 1: ASSESSMENT:**

1. All patients admitted to ~~WCS~~**WNS** nursing units shall be assessed by a Registered Nurse per the following:
2. Admission and/or Transfer: Assessment
   ~~1. All patients admitted or transferred to a higher level of care shall have a head to toe assessment initiated within 30 minutes of arrival to unit. A detailed or disease specific assessment shall be document as needed.~~
3. Admission Assessment- Patient History:
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
      i. This assessment-patient history shall include an assessment for obstetric hemorrhage
4. Medication Patient History Form
   a. All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.
5. Initial Shift Assessment
   a. RN shall initiate an ongoing head to toe assessment as follows: within 3 hours of the start of the shift
6. Reassessment**/focused assessment may be documented as no change since last assessment**
   a. After completion of an Admission or an Initial shift Assessment, all patients shall have a:
      i. Focused reassessment (to usually include fundus, lochia, bladder~~,~~ **incision if applicable** ~~breasts and nipples~~) performed and documented in the EMR.
      ~~a. Ongoing Assessment during the shift every 6 hours until discharge or transferred to another level of care.~~
      ~~i.~~**ii.** **A**~~a~~ more detailed assessment may be completed dependent on clinical condition or per PCS Magnesium Sulfate procedure.
      ~~ii.~~**iii.** If the patient refuses a reassessment, document their refusal in the medical record.
      ~~2.~~**iv.** System Specific Assessment (Focus assessment/postpartum assessment) shall ~~be also~~**also be** completed as follows:
         ~~a.~~**1)** Change in patient's condition from the initial shift assessment or reassessment.
         ~~b.~~**2)** Response to treatment provided to a patient
   b. Postpartum assessment **and frequency**:
      i. Uterine assessment (to include lochia assessment):
         1) Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)
         2) Location (midline (ML), right of ML, left of ML, displaced – bladder assessment)
         3) Consistency (firm, boggy - firms with massage, boggy)
         4) Time intervals, beginning post-delivery:
            a) Birth – 2 hrs.: every 15 minutes x4, then at 2hours
            b) 2hrs-6hrs: upon admission to MBU, then every 6 hrs. post-delivery

c) **Vaginal Delivery:** 6- 24 Hrs. every 6 hrs. or sooner if clinically indicated times 24 hours, then q shift until discharge
d) **Cesarean Section:** 6-48 hours: every 6 hours or sooner if clinical indicated times 24 hours then q shift until discharge.

ii. Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment
1) Slight, Scant, Moderate, Heavy (with or without clots)
2) Rubra, serosa or other
3) Note presence of foul odor
4) Risk assessment for obstetric hemorrhage
a) Refer to ~~WCS~~**WNS** Obstetrical hemorrhage procedure.

iii. Perineal/hemorrhoid assessment as applicable.
1) Approximated
2) Color (presence or absence of ecchymosis)
3) Edema
4) Presence or absence of Hemorrhoids

C. **STANDARDS OF CARE 1.1: ASSESSMENT NEUROLOGICAL SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Neurological: System Review
a. Assess the following:
i. Level of consciousness
ii. Orientation
iii. Presence of Headache
iv. Visual disturbances, e.g. blurred vision or scotoma
v. Deep Tendon Reflexes
vi. Patellar or brachial
vii. Clonus
b. Effects of epidural/regional anesthesia on lower extremities
i. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
ii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: ~~WCS~~**WNS** procedure: "Epidural Medication Administration")

D. **STANDARDS OF CARE 1.2: ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Cardiovascular System Review
a. Assess heart sounds in all auscultatory areas; note regular or irregular
b. Check capillary refill
c. Check edema location and grade
d. Palpate bilateral peripheral pulses: radial and dorsalis pedis
~~3. Palpate bilateral brachial~~
e. Assess peripheral perfusion; skin warm and dry
f. Assess Homan's sign for presence of thrombophlebitis

E. **STANDARDS OF CARE 1.3: ASSESSMENT PULMONARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Pulmonary: System Review
a. Check oxygen delivery devices if applicable
b. Check amount oxygen flow if applicable
c. Assess pulse oximetry
i. For Magnesium Sulfate administration for preeclampsia/preterm labor see Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"

d. Assess respiratory effort
e. Auscultate breath sounds all lobes
f. Assess sputum amount, color, and consistency if applicable
g. Assess for presence of cough
h. Assess for presence of artificial airway, tubes, and drains if applicable
i. Assess chest expansion for symmetry

F. **STANDARDS OF CARE1.4: ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. GI: System Review
   a. Assess abdomen
      i. Round, distention
      ii. Soft, firm, distended, non-distended
   b. Assess for nausea and/or vomiting
   c. Auscultate for presence of bowel sounds in all four quadrants
   d. Assess bowel function including passing flatus or last stool

G. **STANDARDS OF CARE 1.5: ASSESSMENT GENITOUTINARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Genitourinary (GU) System Review
   a. Assess urine color and clarity, frequency and voiding difficulties/dysuria
   b. Assess for bladder distension

H. **STANDARDS OF CARE 1.6: ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Musculoskeletal System Review
   a. Presence of assistive devices
   b. Presence of joint or musculoskeletal abnormalities
   c. Full range of motion against gravity, some to full resistance of all extremities
   d. Mobility appropriate for age

I. **STANDARDS OF CARE 1.7: ASSESSMENT INTEGUMENTARY SYSTEM REVIEW ADMISSION ASSESSMENT:**

1. Integumentary System Review:
   a. Assess mucous membranes
   ~~a.~~**b.** ~~and S~~skin color; consistent with person's ethnicity
   ~~b.~~**c.** Palpate skin for temperature and moisture
   ~~c.~~**d.** Assess skin turgor
   ~~d.~~**e.** Assess skin integrity, temperature, and condition of any dressings
   ~~e.~~**f.** Complete Braden Scale
   ~~f.~~**g.** Assess for presence of specialty mattress/bed or overlay
   ~~g.~~**h.** Assess for the presence of skin abnormalities
   ~~h.~~**i.** Assess for the presence of pressure ulcers

J. **STANDARDS OF CARE 1.8: ASSESSMENT PSYCHO/SOCIAL ADMISSION ASSESSMENT:**

1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior
   c. Social Service (SS) Referral Reason
   d. Distress
   e. Stressors
   f. Support/Coping Interventions
2. Psycho/Social: Nursing Interventions **will be documented on initial admission assessment and prn if change occurs**

a. In ordered to promote family centered care, the nurse shall:
   i. Introduce bedside health care providers to the patient/family.
   ii. Review visitation and unit policies to patient/family on admission and as needed.
   iii. Assess and then verify with patient/family age appropriate needs.
   iv. Assess and then verify patient/family's ability to understand and participate in the plan of care.
   v. Encourage the family to have periods of uninterrupted sleep/bonding when appropriate.
   vi. Promote patient/family centered care
      1) Discuss expectations and collaborate with patient/family
      2) Encourage patient/family to ask questions
   vii. Promote patient independence in Activities of Daily Living (ADL)
   viii. Promote comfort measures (if ordered or request order) by:
      1) Music therapy
      2) Therapeutic recreation
      3) Spiritual comfort
      4) Guided imagery
      5) Reminiscence therapy
      6) Encourage family/friend to visit
      7) Arrange for a child's visitation
      8) Arrange for pet therapy
      9) Arrange for physical and/or occupational therapy.
   ix. Patients shall be informed of their responsibilities upon admission and as necessary thereafter.
      1) These responsibilities include:
         a) Providing information
         b) Asking questions
         c) Following instructions
         ~~1) Accepting consequences~~
         d) Following rules and regulations
         e) Showing respect and consideration
         f) Meeting financial commitments.
            i) See TCMC Patient Handbook.
   x. Encourage patient and/or their family to participate in their plan of care.
   xi. Observe bonding behaviors when applicable:
      1) Eye contact
      2) Holding infant
      3) Talking to infant
      4) Participating in care of infant – feeding, diaper changes, comforting
   xii. Request social services as appropriate.
      1) Initiate social services referrals for the following (including, but not limited to:
         a) Adoptions; surrogates
         b) Infants going to foster care
         c) Patients with no prenatal care
         d) Teen moms
         e) Positive toxicology results
         f) Mothers of infants in Neonatal Intensive Care or in another facility
         g) All mothers and families experiencing Perinatal loss
         h) Assistance with post-partum home care~~.~~

K. **STANDARDS OF CARE: INFUSION THERAPY:**
1. Central venous lines shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed on admission, ongoing and transfer from other nursing unit.

a. The following shall be assessed:
   i. IV insertion date
   ii. IV access type
   iii. IV site and condition
   iv. Patency
   v. Dressing type and condition
   vi. Date infusion changed
   vii. Date central venous dressing changed

3. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN.
4. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
5. Infusion Therapy: Nursing Interventions
   a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
   b. Document initials and date IV started directly on the dressing.
   c. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
   d. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site
   e. IV solutions and tubing shall be changed as follows:
      i. Change every 4 days
         1) All IV tubing
         2) Add-on devices (neutral displacement connector MicroClave), antireflux, extension set, etc.) and with tubing change
         3) Rotate IV insertion sites
         4) Commercially prepared solutions, if the bag is spiked once with initial start
         5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback
      ii. Change every 24 hours
         1) All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours
         2) Lipids or lipid containing products
         3) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc.) and with tubing change
   f. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
   g. Label IV solutions with date and time IV solution hung **and document in the EMR**
   h. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site
   i. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
   j. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
   k. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
   l. Swab Cap
      i. When a Central Venous line injection port is not in use, place an ~~orange~~ Swab Cap on the unused port(s).
      ii. Apply a new Swab Cap
         1) Every time the cap is removed
         2) Every 8 hours with routine IV flushing
      iii. PRN IV flushing

L. **STANDARDS OF CARE: IMMUNIZATIONS/OTHER:**

1. Rhogam will be administered if indicated
2. Rubella will be administered if needed

3. During the flu season: patients will be screened for influenza and vaccination will be administered if indicated per Standardized Procedure Pneumococcal and Influenza Vaccine Screening and Administration
4. All patients will be screened for Tetanus, Diphtheria, Pertussis (Tdap) and vaccination will be administered if indicated per Standardized Procedure Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine Administration for Postpartum Patients.

M. **REFERENCES:**

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2. American Nurses Association (ANA). (201~~0~~04). *Nursing scope and standards of practice*. Silver Spring, MD: Nursesbooks.org.
3. **American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org**
4. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.
~~3.~~5. **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (2014). 4th edition.**
~~4.~~6. California Board of Registered Nursing. (2010). Nursing practice act business and professions code. Chapter 6 Nursing: Section 2725. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml
~~5.~~7. California Board of Registered Nursing. (2010). Standards of competent performance, California code of regulations, title 16, section 1443.5. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml
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~~7.~~9. Mattson, S., & Smith, J.E. (Eds.) (2011) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia, PA: Saunders

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
February 7, 2017

Members Present:	James J. Dagostino, DPT, PT, Chairperson; Director Laura E. Mitchell, Director RoseMarie V. Reno; Dr. Paul Slowik, Community Member; Dr. Cary Mells, Physician Member; Dr. Gene Ma, Chief of Staff ; Dr. Marcus Contardo, Physician Member; Sherry Miller, Manager, Medical Staff Office
Non-Voting Members:	Steve Dietlin, CEO; Kapua Conley, COO; Cheryle Bernard-Shaw, Chief Compliance Officer
Others Present:	David Bennett, CMO; Wayne Knight, CSO; Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Robin Iveson, Community Member; Greg Moser, General Counsel
Absent:	

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino. Chairman Dagostino reported Mr. Eric Burch has resigned from the committee due to a potential relocation.		
2. Approval of Agenda	**It was moved by Director Reno to approve the agenda as presented. Dr. Ma seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Dagostino read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Director Mitchell to ratify the minutes of the January 3, 2017 Governance & Legislative Committee. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan
5. Old Business a. Review and discussion of Committee Charter	Chairman Dagostino stated the Board referred the Committee's Charter back to the Committee upon a recommendation and advice of the Medical Executive		

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1) Governance & Legislative Committee	Committee to strike Privilege Cards from the committee's purview. The rationale is that the Privilege Cards are debated through the Medical Staff committees and ultimately brought to the Board. In addition, due to the apparent lack of community member interest on the committee it was recommended the number of community members be changed to a minimum of two and a maximum of three. Discussion was held regarding the advertisement for community members. Chairman Dagostino explained an ad is placed in the Coast News and on our internet. He confirmed that we no longer place ads in the Union Tribune. Director Reno stated community members do not understand what the committee does and therefore feel useless. Discussion was held regarding broadening the search to other areas such as college newspapers and senior centers. Director Reno stated in her opinion it is time for a Board Educational Workshop to discuss items of this nature with a Board Facilitator. Chairman Dagostino noted our last Board Facilitator indicated the Board has too many meetings and suggested the possibility of consolidating committees. **It was moved by Director Reno to recommend approval of the amended Governance & Legislative Committee Charter as presented. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Governance & Legislative Committee Charter as presented; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations: 1) Division of Podiatric Surgery 2) Department of Medicine	Dr. Ma reported the Division of Podiatric Surgery Rules & Regulations were placed on today's agenda following a question at last month's meeting related to Podiatric Surgery. Ms. Sherry Miller explained the core privileges for all of the Rules & Regulations presented today are being removed from the Rules& Regulations and will be a		

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3) Division of Neonatology 4) Department of Emergency Medicine	separate document known as the Privilege Card. Dr. Slowik questioned who has oversight of the Privilege Cards. Dr. Ma stated there is a collaborative process where the needs of the organization are considered. There were no suggested revisions to the Rules & Regulations presented for consideration. **It was moved by Dr. Slowik to recommend approval of the Division of Podiatric Surgery, Department of Medicine, Division of Neonatology and Department of Emergency Medicine Rules & Regulations as presented. Dr. Contardo seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Division of Podiatric Surgery, Department of Medicine, Division of Neonatology and Department of Emergency Medicine Rules & Regulations; items to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
b. Review and discussion of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings	Chairman Dagostino reported Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings was referred by the Board to the Committee. He explained the policy as written allows an individual Board member to request items be placed directly on the Board agenda. Per discussion at the Board meeting it was suggested that action items be referred to the appropriate Board committee for consideration prior to the full Board. Chairman Dagostino stated when a Board agenda item is requested by a Board member the item will be considered at the agenda conference by the Board Chair, CEO and General Counsel and action items will routinely be referred to the appropriate committee. **It was moved by Director Mitchell to recommend approval of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings. Dr. Mells seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings as written; item to be placed on Board Agenda and appear in agenda packet.	Ms. Donnellan
c. Consider development of a new	Chairman Dagostino explained this agenda item was		

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Board Policy related to the Board's contract approval process	requested by Director Reno and referred by the Board to this committee. Chairman Dagostino stated that although there is not a Board Policy related to the contract approval process there is an Administrative Policy 8610-278 entitled Contract Review. Director Reno expressed concern that it is an Administrative Policy rather than a Board Policy yet the Board is held accountable. Mr. Moser stated there is no distinction between a Board and an Administrative Policy and both are enforceable. Ms. Bernard-Shaw stated the Contract Review Administrative Policy is "tied" into Board Policy 013 – Policies and Procedures Including Bidding Regulations Governing Purchase of Supplies and Equipment, Procurement of Professional Services and Bidding for Public Water Contracts. Mr. Conley stated Policy 8610-278 is a procedural document that was recently revised to adjust the process based on feedback during a CMS visit. Mr. Conley further explained that the policy gives us the flexibility to adjust the process as needed based on CDPH regulations. Mr. Knight recommended Exhibit A be amended to strike Clinical Trial Agreements (device and drug) from the first sentence and move to letter s. Mr. Dietlin suggested the addition of the word "oversight" to Section C. 2. a. to read "The Governing Body is responsible for **oversight** of all services covered under contracts at Tri-City Healthcare District (TCHD)". Ms. Bernard-Shaw recommended the policy be sent back to the AP&P Committee with revisions as described. Mr. Moser noted upon review by AP&P the policy should go through the Audit, Compliance & Ethics Committee as noted on the Department Approval Dates. The committee directed administration to revise the	Administrative Policy 8610-278 will be	Ms. Donnellan

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	policy as described and send through the appropriate committees for approval.	revised as described and sent through the appropriate approval process.	
d. Interviews of community candidates for open community seat on Governance & Legislative Committee (1) Robin Iveson	Chairman Dagostino introduced candidate Ms. Robin Iveson to committee members. Ms. Iveson provided a brief summary of her background and experience. She stated that she has served on several hospital committees over the years, most recently the Community Healthcare & Alliance Committee. Ms. Iveson stated she had some concern over the recent resignation of several of the community committee members who expressed they did not feel their input was of much value to the committee. Ms. Iveson stated she believes the community member's input and role is very important and she would be honored to serve on the committee. Committee members commented on Ms. Iveson's commitment to the District and her diligence in attending not only committee meetings but also the regular monthly board meetings. *Ms. Iveson left the meeting at 1:28 p.m. to allow discussion by committee members.* Committee members unanimously agreed that Ms. Iveson has the passion, credentials, experience and dedication to serve on the committee. **It was moved by Director Mitchell to recommend that Ms. Robin Iveson be appointed to a two year term on the Governance & Legislative Committee. Dr. Mells seconded the motion. The motion passed unanimously.** *Ms. Iveson returned to the meeting at 1:35 p.m.* Chairman Dagostino reported the committee unanimously recommended Ms. Robin Iveson be recommended for appointment to the Governance & Legislative Committee.	Recommendation to be sent to the Board of Directors to recommend Robin Iveson be appointed to a two-year term on the committee; item to be placed under New Business on Board agenda and included in agenda packet.	Ms. Donnellan

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7. Discussion regarding Current Legislation	The committee had extensive discussion regarding Key State Issues, including the following: ➢ AB 1774 – Would have repealed the laws requiring a clinical laboratory to be licensed and inspected by CDPH including the licensing fee. (Held on Suspense in Assembly Appropriations Committee May 27th and supported by CHA). ➢ SB 1076 – Creates the regulatory structure for hospitals wishing to provide observation services in a dedicated unit. The bill states that observation patients may also be cared for in an inpatient unit or in the ED. (Signed by the Governor September 27. CHA's position is neutral). *It was suggested Mr. Dietlin and Mr. Conley delve deeper into the bill to determine what is different from current procedure.* ➢ AB 533 – Attempted to address "surprise billing" by out-of-network providers. Bill was amended April 15 and would have applied only to non-contracting individual health professionals, not to hospitals. (Placed on Assembly Inactive File August 31. CHA's position is neutral). *Dr. Ma expressed frustration with AB 533 and stated as a healthcare provider you have no leverage and is concerned that CHA has taken a neutral position on this bill.* ➢ AB 1568 - Along with SB 815, implements California's section 1115(a) demonstration waiver, titled "California's Medi-Cal 2020 Demonstration." The waiver renewal effective December 30, 2016 through December 31, 2020 included $6.2 billion of initial federal funding to support the state's Medi-Cal program. (Signed by the Governor July 1 and supported by CHA). *Mr. Dietlin noted both AB 1568 and SP 815 relate to PRIME.* ➢ AB 2024 – Authorizes a critical access hospital to employ physicians, surgeons and doctors of podiatric medicine and charge for professional		

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	services rendered by those medical professionals if the Medical Staff concurs, by an affirmative vote, that which employment is in the best interest of the communities the hospital serves. (Signed by the Governor September 23 and supported by CHA).*Mr. Moser noted the bill will largely affect the rural areas.* ➢ AB 1300 – Would have specified that trained emergency room physicians and psychiatric professionals in non-designated hospitals, when probable cause exists, have the authority to write/initiate an up to 72-hour involuntary hold. (Referred to Senate Rules Committee and sponsored by CHA.) *Dr. Ma clarified this bill is for non-designated hospitals such as those that do not have an LPS.* ➢ AB 1306 – Would have removed the physician supervision requirement on certified nurse midwives, allowing them greater independence in meeting the health care needs of the millions of individuals added to California's health are system by the Affordable Care act and facilitating timely access to quality care. (Failed passage by full Assembly August 31 and supported by CHA.) ➢ SB 323 – Would have allowed nurse practitioners to practice to the full extent of their education and training to ensure access to healthcare delivery systems for millions of Californian's who now have access to coverage under the Affordable Care Act. (Held in the Assembly Business Professions Committee June 28 and supported by CHA). In addition, Mr. Moser reported on AB 1978 which will require janitors to be trained on sexual harassment by their employers starting July 1, 2018. It was recommended the Key State Issues be included in the Board agenda packet for Chairman Dagostino to lead a discussion with the full Board	Key State Issues to be placed on the Board agenda and included in agenda packet.	Ms. Donnellan

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	Dr. Ma stated if discussion of the Legislative Issues will be a component of this committee, it would be helpful to know the key positions and what is of concern to the physicians. It was suggested the March agenda include ACHD's proposed bills as well as CMA and CHA. Discussion was held as to whether the Committee should look at federal legislation. Chairman Dagostino stated he, Director Schallock and perhaps other Board members will be attending AHA's Annual Meeting in May in Washington, D.C. which will focus on federal legislation and will share that info with the Committee. Ms. Bernard-Shaw stated President Trump has alluded that the Affordable Care Act will stay in play through 2017 and into 2018. Discussion was held regarding the fact that the District does not have a dedicated Government Relations individual. Chairman Dagostino stated Board members have done a good job of keeping the District abreast and informed of legislative issues affecting the District. Director Reno requested that Mr. Wayne Knight provide the Board with an Affordable Care Act update. Mr. Knight, attending as a community member stated there is no public direction as to where the ACA is going at this point and the new phrase is "amend and repair".	The committee's March agenda will include information on ACHD's key legislative issues as well as CMA and CHA key legislature issues.	Ms. Donnellan
8. Review of FY2017 Board Work Plan	Chairman Dagostino reported a draft Work Plan has been developed based on the Committee's Charter. It was suggested an X be placed for each item in all months to reflect these items may be placed on the agenda whenever the need arises. Director Mitchell suggested Legislative Oversight be discussed every other month or quarterly due to time it takes bills to work its way through the Legislature. Director Reno suggested a Board Educational Session be added to the Work Plan. It was suggested a Board Educational	Revisions will be made to the Work Plan as described. A Board Educational Session will be added to the Board's Work Plan.	Ms. Donnellan Ms. Donnellan

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	Session be added to the Board's Work Plan rather than the Governance Committee's Work Plan.		
9. Committee Communications	Committee members welcomed Ms. Robin Iveson to the Committee.		
10. Committee Openings – Two	There are currently two openings on the committee		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, March 7, 2017 at 12:30 p.m.	The next meeting of the Committee is March 7, 2017.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 2:09 p.m.		

I. MEMBERSHIP

The Division of Podiatric Surgery consists of physicians who are board certified or board qualified and actively pursuing certification by the American Board of Podiatric Surgery. For those members who were granted such privileges on or before June 1, 1991 must demonstrate comparable ability, training and experience.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Podiatric Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the ~~QA/PI/PS~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Department of Surgery, Medical Executive Committee, and Board of Directors.

III. DIVISION MEETINGS

The Division of Podiatric Surgery shall meet ~~at least annually~~ quarterly or at the discretion of the Chair. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrated ability in the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division.
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~	~~Training~~	~~N/A~~	~~N/A~~
~~Perform history and physical examination, including via telemedicine (F)~~	~~Training~~	~~Six (6) cases~~	~~N/A~~
~~Surgical Assistant - Surgical assist for DPM in any podiatric procedures (if licensed prior to 1984), and do not hold special ankle license, may assist DPM or any other surgeon as a surgical assist per Medical~~	~~Per Medical Staff Policy #8710-536~~	~~Per Medical Staff Policy #8710-536~~	~~Per Medical Staff Policy #8710-536~~

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Staff Policy #8710-536			
Minor Procedures Category			
Capsulotomy, synovectomy, fasciotomy	Documentation of representative blend of fifty (50) Minor Procedure Category cases within the previous 2 years or list from residency.	Six (6) cases from Minor or Major categories	Six (6) cases from Minor Procedures Category
Casting and taping			
Debridement of wounds and wounds/wound grafts			
Excision of foreign bodies			
Excision of neuroma/soft tissue neoplasms			
Excision of skin lesions with biopsy/skin plasty			
Extracorporeal shock wave therapy			
I & D/debridement of soft tissue infection			
Nerve decompression			
Tenotomy, tenoplasty, tendon transfer			
Treatment of Toenails (F)			
Major Procedures Category			
Arthroplasty	Documentation of representative blend of twenty (20) Major Procedure Category cases within the previous two (2) years **or** list from residency. Partial amputation at/or distal to Chopart's Joint only - In addition to initial requirements. Must also be either licensed prior to1984 or hold special ankle license.	Six (6) cases from the Major Procedures Category	Ten (10) cases from the Major Procedures Category
Bunion/Hallux Valgus Corrections			
Debridement of osteomyelitis			
Excision of bone cyst or tumor			
Excision of sesamoid bones			
Fusions			
Osteotomy			
Partial amputation at/or distal to Chopart's Joint (licensed prior to1984 or holding special ankle license)			
Partial or complete resection of metatarsal or phalanges			
Reduction of fractures/dislocation			
Use of bone grafts, implants &			

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~internal/external fixation~~			
~~**Minor Procedures Forensic Outpatient Clinic**~~			
~~Treatment of Toenails~~ ~~Skin/Callous Debridement~~ ~~Superficial Wound Debridement~~ ~~Injections~~	~~Six (6) from prior two years or activity list from residency.~~	~~New appointees - five (5) cases of any combination of the Minor Procedures for the Forensic Outpatient Clinic.~~ ~~Current Division members who hold unrestricted podiatric surgery privileges are considered to have satisfied Forensic Outpatient Clinic proctoring requirements.~~	~~N/A~~

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

A. Procedural privileges may be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

B. Any member of the Division who was Board Qualified when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification by the American Board of Podiatric Surgery. Failure to obtain timely certification shall be considered in making Division recommendations regarding applications for reappointment and renewal of clinical privileges. All privileges are accessible on the Tri-City Medical Center intranet and a paper copy is maintained in the Medical Staff Office.

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credentials Committee and to the Medical Executive Committee with final approval by the Board of Directors. This is to include extensive surgical procedures treated in the Emergency Department.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the *Division Chief* to inform the monitored

member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

C. Supervision of the new member by the proctor will include concurrent or retrospective chart review and direct observation of procedural techniques. The new member shall select an appropriate member from the Division of Podiatric Surgery to proctor his/her operative case. The new member shall contact the monitor and inform him/her of his/her plans for the case. **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE~~, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE~~.** If the proctor is not available, the applicant must notify another physician with the same privileges to proctor. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure.

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

IX. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.

APPROVALS:

Division of Podiatric Surgery:	06/17/2015
Department of Surgery:	06/18/2015
Medical Executive Committee:	07/22/2015
Governance Committee:	08/04/2015
Board of Directors:	08/27/2015

I. MEMBERSHIP

A. The Department of Medicine consists of physicians in the Divisions of:

~~1. Allergy and Dermatology~~

~~1.~~ Cardiology

~~2.~~ Gastroenterology

~~3.~~ Internal Medicine

a. ~~a.~~ Allergy and Dermatology

b. Endocrinology

c. Hospice & Palliative Medicine

d. Infectious Disease

b. ~~b.~~ Internal Medicine

c. Nephrology

c. Physiatry (Physical Medicine and Rehabilitation)

d. Rheumatology

~~4.~~ ~~Hematology /~~ Oncology

~~5~~ Neurology

~~6~~ Psychiatry

~~7~~ Pulmonary Medicine

II. FUNCTIONS

The general functions of the Department of Medicine, carried out through the functions of the Division shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients within the division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;

C. Conduct, participate in and make recommendations regarding continuing Medical education programs in clinical practice;

D. Review and evaluate departmental adherence to:

1. Medical Staff Policies and procedures;
2. Sound principles of clinical practice.

E. Submit minutes to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. Department's review and evaluation of activities, actions taken thereon, and the results of such action;
2. Recommendations for maintaining and improving the quality of patient care and patient safety provided in the department and the hospital;
3. Recommend / Request Focused Professional Practice Evaluation as indicated for Medical Staff members (pursuant Medical Staff Policy 509);
4. Approval of On-Going Professional Practice Evaluation Indicators.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care and clinical performance, patient safety or opportunities to improve patient care are identified;
H. Formulate recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DEPARTMENT MEETINGS

A. The Department of Medicine shall meet quarterly or at the discretion of the chairman. The functions of the Department are carried out through the Divisions; including the monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Regular reports shall be transmitted to the Medical Executive Committee;
B. Twenty-five percent (25%) of the Active Department members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

A. The Department shall have a Chairman and a Vice-Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrate ability in at least one of the clinical areas covered by the Department;
B. The Department Chairman shall serve a ~~one~~two-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in that Department. Department officers shall be eligible to succeed themselves). Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department.

V. DUTIES OF THE DEPARTMENT CHAIRMAN

A. The Department Chairman shall assume the following responsibilities of the Department:
   1. Be accountable for all professional administrative activities of the Department;
   2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
B. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
C. Recommend clinical privileges for each member of the Department; and
D. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
E. Assure that the quality, safety and appropriateness of patient care provided within the Department are monitored and evaluated through Ongoing Professional Practice Evaluation;
F. Continuously assess and improve the quality and safety of care provided in the Department;
G. Other duties may be assigned, in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests for privileges in the Department of Medicine shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring; Practitioner's practice only within the scope of their privileges as defined within the respective Division's Rules and Regulations. Recommendations for privileges are made to the Credentials and Medical Executive Committees;
B. The Department of Medicine has established the following classifications of medical privileges:
   1. Physicians are expected to have training and/or experience and competence on a

level commensurate with that provided by specialty training, such as in the broad field of Internal Medicine although not necessarily at the level of sub specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultations when:

a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
b. Unexpected complications arise which are outside this level of competence;
c. Specialized treatment or procedures are contemplated in which they are not familiar;

2. Allied Health Professionals – *See Allied Health Professional Rules & Regulations* Physician Assistants may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant;

a. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients;

b. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition;

c. A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures to be delegated to the physician assistant until assured competency;

d. A physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care;

e. The supervising physician must see patient cared for by the physician assistant at least once during the hospital stay or as delineated by the Division Rules and Regulations;

f. A physician assistant may not admit or discharge patients.

g. Refer to the AHP rules and regulations for further delineation of sponsoring physicians supervision requirements;

h. Medical / Surgical Units: Documentation of an examination of the patient by the sponsoring physician(s) every third day if care is given by the Allied Health Professional(s);

i. Non Scheduled Admission(s): Examination of the patient by the sponsoring physician(s) the same day as care is given by the AHP;

j. The Department of Medicine requires a physician co-signature as delineated in the AHP's Rules and Regulations:

k. Order(s)and telephone Order(s) may be immediately implemented and physician co signature required within 24 hours of AHP's order;

l. Any medical record of any patient cared for by a physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within 24 hours;

j. The sponsoring physician must review and authenticate any progress note within the medical record of any patient(s) documented by a physician assistant within 24 hours;

l. Non Scheduled admissions: the sponsoring physician(s) must dictate the H&P within 24 hours;

m. ACCU/AMC Units: Examination of the patient by the sponsoring physician(s) the same day as care is given by the Allied Health Professional(s).

3. Nurse Practitioners: Nurse practitioner means a registered nurse who posses' additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a

~~Member of the Department of Medicine will develop the standardized procedure or the protocols and be approved by the Department of Medicine;~~

~~a. Proctoring and privileges requested are delineated for Allied Health Professionals/Mid Level Practitioner within the Allied Health Rules and Regulations and each retrospective Division (s) specified criteria.~~

VII. REQUIREMENTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

A. Active certification by the appropriate certifying board or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center;

B. Privileges requested are granted based on Division specified criteria;

C. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

III. SPECIAL PROCEDURES / PRIVILEGES

A. The applicant will be responsible for checking all procedures he/she wishes to perform and for listing his/her qualifications, training, and experience concerning the requested procedures in accordance with criteria established by various Divisions of the Department of Medicine, copies of which are available in the Medical Staff ~~Office~~Department.;

1. The medical privileges granted each physician will be recorded and a copy of which will be forwarded to the applicant with his medical staff appointment;
2. Pain Management Privileges are delineated per Medical Staff Policy # 541 *Credentialing Criteria for Pain Management Privileges*;
3. Surgical Assist Privileges as delineated per Medical Staff Policy #536 *Physician Surgical Assistant*;
4. Each practitioner's privileges will be assessable on Tri-City's Intra-net (MD-Staff) which is located in each patient care area. A paper copy is maintained within the Medical Staff Department ~~Nursing Administration Office and the Main Operating Room~~.

IX. PROCTORING

A. The new medical staff member granted initial privileges, or medical staff member requesting ~~Each new applicant granted initial or~~ additional privileges shall be evaluated by a proctor from his/her Division with like privileges until his or her privilege status is established by a recommendation from the Division Chief and subsequently to the Credentials Committee to the Medical Executive Committee with final approval by the Board of Directors~~as delineated by the Divisions of the Department of Medicine~~. If enough cases have not been admitted, or evaluation of the ~~applicant's~~ new Medical Staff member's performance cannot be completed in the first year, then an additional year of provisional staff will be recommended;

B. At the discretion of the retrospective Division Chair(s) the decision to assign further proctoring of cases is based on current clinical competence, practice behavior, and the ability to perform the requested privilege(s);

C. Supervision of the applicant by the proctor will emphasize concurrent or retrospective chart

review of cognitive processes and include direct observation of invasive procedural techniques. The ~~applicant~~ new Medical Staff member must notify his / her proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another physician in the appropriate subspecialty area. Proctors are obligated to be available within seven (7) days after a proctor request has been made to proctor the member concurrently for invasive procedures, or to thoroughly evaluate the practitioner's performance through concurrent or retrospective chart review of cognitive processes. If the procedure must be done emergently without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

D. All active staff members of the Department of Medicine will act as proctors as delineated by the Divisions of the Department of Medicine to monitor performance of medical care and compliance with assigned privileges~~;~~. Associate(s) of the new Medical Staff member may monitor up to 50% of the required proctoring;

E. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports. It is the responsibility of the Division Chief to inform the monitored member when their proctoring is being continued for noted deficiencies;

G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Department;

~~E.~~ H. Specific proctoring requirements are outlined in each respective Division's privilege cards ~~Rules and Regulations~~.

X. EMERGENCY DEPARTMENT CALL

A. Medical Staff department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Refer to Medical Staff Policy and Procedure #520 *Emergency Room Call Duties of the On-Call Physician*;

B. While serving on the Emergency Department Call Roster, each member shall respond to requests from the Emergency Department by examining and treating patients in the Emergency Department, unless the member and Emergency Department physician agree that such care may be provided in the member's office. Any member who elects to provide care in his office must do so without regard to the patient's ability to pay, and must provide a minimum level of care sufficient to respond to the patient's immediate needs;

C. It is the policy of the Emergency Department that when it is discovered that a patient has been previously treated by a staff member, that member will be given the opportunity to provide further care;

D. The member of the Department of Medicine will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care;

E. If a physician has discharged a patient from his practice and the patient comes to the Emergency Department when the physician is on call, the physician is responsible for the disposition of the patient.

F. A physician on-call, who provides care for a patient in the Emergency Department, is responsible for the disposition of that patient for forty-eight (48) hours and must accept responsibility if said patient is readmitted to the Emergency Department within forty-eight (48) hours. The care provided by an on-call physician will not create an obligation to provide further care.

G. Provisional or courtesy member(s) are able to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

APPROVALS:

Department of Medicine:	~~07/01/2015~~ 01/16/2017
Medical Executive Committee:	07/22/2015
Governance Committee	08/04/2015
Board of Directors:	08/27/2015

I. **MEMBERSHIP**

A. The Division of Neonatology consists of physicians who are board certified in Neonatal-Perinatal Medicine by the American Board of Pediatrics or are progressing toward certification.

B. Applicants who are progressing toward board certification must complete formal training prior to applying for medical staff membership in the Division of Neonatology and must become board certified within four (4) years of the initial granting of medical staff membership, unless extended for good cause by the Pediatrics Department.

C. Board certified members who were issued certificates in Neonatology after 1989 are required to become re-certified prior to their expiration date to keep their certification current.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Neonatology are:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendation regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve of On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

A. The Division of Neonatology shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee. .

B. Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be board certified in Neonatal-Perinatal Medicine.

B. The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election.
C. The Chief shall be elected by a simple majority of the members of the Division.
D. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continue surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Pediatrics and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Assume other duties as recommended from the Department of Pediatrics or the Medical Executive Committee.

VI. MEDICAL DIRECTOR DUTIES

A. Participate in the development, review, and assurance of the implementation of NICU policies;
B. Supervise NICU quality control and quality assessment activities, including morbidity and mortality reviews as demonstrated by participating in the bi-monthly M&M conferences for NICU and the quarterly Quality Review Committee for Pediatrics.
C. Assure NICU staff competency in resuscitation techniques and proficiency in needle aspiration for pneumothorax per Needle Aspiration of Chest for Pneumothorax Standardized Procedure.
D. Assure ongoing NICU staff education as evidenced by attending, skills labs, monthly education for NICU, attendance at the National NICU Conferences, and attending the Pediatric Ground Rounds on a quarterly basis.
E. Participate in the NICU budget process.
F. Provide oversight of neonatal/infant transport to and from NICU and;
G. Assure maintenance of the NICU database and vital statistics.

VII. ALLIED HEALTH PROFESSIONALS

A. Nurse Practitioners: A registered nurse who has specialized advanced skills in diagnosis, assessment, and patient management and is permitted to prescribe certain medications. The nurse practitioner shall function according to standardized procedures developed in collaboration with the supervising physician, who shall be a member of the Department of Pediatrics, and approved by the Department of Pediatrics, Interdisciplinary Practice Committee, Medical Executive Committee and Board of Directors.

VIII. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

D. Requests for privileges in the Division of Neonatology are evaluated based on the physician's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on Division specified criteria. Practitioner's practice only within the scope of their privileges as defined within these Rules and Regulations.

E. Classification of Newborns:

1. Level 3: Newborns needing intensive care and other infants who have potentially life-threatening illnesses, are otherwise unstable, including those needing ventilator support. Admission criteria per the NICU unit-specific "Admission and Discharge Criteria for the NICU" policy.
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   - i Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   - ii Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   - iii Hypoglycemia (without other risk factors, such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   - iv Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
   - v Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

~~Neonatology Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~	~~Training and evidence of current Neonatal Resuscitation Program (NRP) certification~~	~~Six (6) admissions and/or consultations~~	~~Evidence of current NRP certification~~
~~Consultation, including via telemedicine (F)~~			
~~Perform medical history and physical examination, including via telemedicine (F)~~			
~~Attendance at C-sections and vaginal deliveries, including newborn resuscitation~~			
~~Newborn care, Level 2 and Level 3~~			
~~Invasive Procedures~~			
~~Arterial puncture~~	~~Training and evidence of current Neonatal Resuscitation Program (NRP) certification~~	~~Five (5) cases from Invasive Procedures category~~	~~One (1) case and evidence of current NRP certification~~
~~Bone marrow aspiration or biopsy~~			~~Evidence of current NRP certification~~
~~Central vessel catheterization~~			~~One (1) case and evidence of current~~

Neonatology Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
			NRP certification
Endoscopic procedures			Evidence of current NRP certification
Exchange transfusion of neonates			
Interosseous needle insertion			
Intubation/Thoracentesis/Thoracostomy, Infant			Two (2) cases and evidence of current NRP certification
Lumbar puncture			One (1) case and evidence of current NRP certification
Manometrics – esophageal and colonic			Current NRP evidence of certification
Peripheral arterial catheterization, and umbilical catheterization – artery			Four (4) cases and evidence of current NRP certification
Peripheral IV cutdown			Current NRP evidence of certification
Percutaneous liver biopsy			
Suprapubic aspriation			One (1) case and evidence of current NRP certification
Umbilical catheterization – vein			Four (4) cases and evidence of current NRP certification
Non-Invasive Procedures			
Care of ventilated patients	Evidence of current Neonatal Resuscitation Program (NRP) certification	Three (3) cases from Non-Invasive Procedures category	Evidence of current NRP certification
Cardiac defibrillation			
Delivery room newborn resuscitation			
Echocardiography			
Elective cardioversion			
Electrocardiography (EKG/ECG)			
Pneumogram interpretation			Three (3) cases and evidence of current NRP certification
Parenteral hyperalimentation			Ten (10) cases and evidence of current NRP certification
Pericardiocentesis			Evidence of current NRP certification
Pediatric Cardiology Procedures			
Cardiac defibrilation	Successful completion of a fellowship training	Two (2) cases from this category	Ten (10) cases from this category
Consultation, Pediatric Cardiology			
Echocardiography			

~~Neonatology Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Elective cardioversion~~ ~~Electrocardiography (EKG/ECG)~~ ~~Pericardiocentesis~~	~~program in Neonatology or Pediatric Cardiology~~		
~~Other~~			
~~Moderate sedation~~	~~See Policy 8710-517 and evidence of current NRP certification~~	~~See Policy 8710-517~~	~~See Policy 8710-517 and evidence of current NRP certification~~

IX. **REAPPOINTMENT**

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

X. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may proctor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the proctored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s).

~~C. THE PROCTOR MUST BE PRESENT FOR THE PROCEDURE FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.~~ For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

~~D.~~C. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

~~E.~~D. The member shall have free choice of suitable consultants and assistants.

~~F.~~E. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

~~G.~~F. A form shall be completed by the proctor, and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e. qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

~~H.~~G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~I.~~H. Responsibility of New Medical Staff Member:

1. The applicant must notify the Division Chief (or his designee) at the time a procedure is scheduled. If the Division Chief is not available to observe the procedure, he/she should appoint a designee to observe the procedure.
2. If the procedure must be done as an emergency without proctoring the Division Chief must be informed at the earliest appropriate time following the procedure.

~~XI. UNASSIGNED NEWBORN CALL~~

~~A. Medical Staff members of the Neonatal Division will participate in the Unassigned Newborn call roster.~~

~~B. To participate in the Unassigned Call Roster, the Division members must consistently exhibit timely response. Once notified by Obstetrics Department, the Division member is expected to respond in person to an emergent situation within thirty (30) minutes.~~

~~C. Provisional or Courtesy Staff can be on the unassigned call panel at the discretion of the Division Chair.~~

~~D. When it is discovered that a patient has been previously treated by a Neonatology Division staff member, that member should be given the opportunity to provide further care unless the patient or primary care physician request otherwise.~~

~~E. The physician on call or his designee, who provides care for an unassigned patient is responsible for the disposition of that patient until discharge.~~

APPROVALS:

Division of Neonatology:	8/19/14
Department of Pediatrics:	8/19/14
Interdisciplinary Practice Committee:	9/29/14
Medical Executive Committee:	10/27/14
Governance Committee:	11/4/14
Board of Directors:	11/6/14

I. **MEMBERSHIP:**

The Department of Emergency Medicine consists of physicians who are Board Certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine or have completed an approved residency in Emergency Medicine, and/or are board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and actively pursuing Board Certification in Emergency Medicine through ~~that Board~~either of those Boards. Board certification is required within two (2) years of joining the Department of Emergency Medicine. If Board certification lapses, the physician will have two (2) years to provide proof of recertification; if after the two (2) years proof of recertification has not been received, the physician will be placed on automatic suspension. If proof of recertification is not received within 90 days following the next available testing date, the physician will be automatically terminated.

The department, at its sole discretion, may also admit Physicians Assistants (PA) upon a majority vote of physician members. These PAs must be certified by the National Commission on Certification of Physician Assistants (NCCPA) or be board eligible and actively pursuing Board Certification as Physician Assistants through the NCCPA. Board certification is required within two (2) years of appointment and must be maintained at all times. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the State of California. If the California PA license has lapsed, the PA will be placed on automatic suspension until proof of license renewal is received. If the NCCPA certification has lapsed, the PA will have two-hundred (200) days from notification by the Medical Staff Office to provide proof of recertification; if after the two-hundred (200) days proof of recertification has not been received, the PA will be placed on automatic suspension until proof of recertification is received.

Each Physician who wishes to supervise PAs must sign a Delegation of Services Agreement with the PA. Each physician may supervise only two (2) PAs at a time/day (i.e., per clinical shift). Each PA may have more than one supervisory physician.

II. **FUNCTIONS OF THE DEPARTMENT:**

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for granting clinical privileges and evaluating the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the QA/PI/PS Committee and Medical Executive Committee concerning:
   1. Department review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring.

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified.

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy #8710-509.)
I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Supervise the physician assistants' quality of Emergency Department care.
K. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee and Board of Directors.

III. **DEPARTMENT MEETINGS**

The Department shall meet ten (10) times per year or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/PS Committee, and then to the Medical Executive Committee.

Twenty five percent (25%) of the Active physician members of the Department, but not less than five (5) members, shall constitute a quorum at any department meeting.

Physician Assistants may attend department meetings. They may participate in a non-voting capacity in peer review and performance improvement or other activities as directed by the Chair. They shall have no vote on Departmental affairs.

IV. **DEPARTMENT OFFICERS**

The Department shall have a Chair and a Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the Department.

The Department Chair and Vice-Chair shall be elected every year by the Active staff members of the Department who are eligible to vote. If there is a vacancy for any reason, the position shall be filled for the unexpired term through a special election. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair and Vice-Chair shall serve a one-year term, which coincides with the Medical Staff year unless they resign, are removed from office, or lose their Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

Emergency Department officers may serve a maximum of two (2) consecutive years.

V. **DUTIES OF THE DEPARTMENT CHAIRMAN**

A. The Department Chair, and the Vice-Chair in the absence of the Chair, shall assume the following responsibilities:
B. Be accountable for all professional and administrative activities of the Department.
C. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
D. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
E. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department.
F. Recommend clinical privileges for each member of the Department.
G. Assure that the quality, safety, and appropriateness of patient care provided by members of the

Department are monitored and evaluated; and

H. Other duties as recommended from the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. **Initial Criteria - Physicians:**

1. Requests for General Patient Care privileges in the Department of Emergency Medicine shall be evaluated on the basis of the requesting physician's education, training, competence, judgment, character, experience (as demonstrated by treatment of at least one-hundred (100) typical Emergency Department patients within the past six (6) months – excluding physicians who have completed an ACGME American Board of Emergency Medicine Residency Program within the past twelve (12) months), ability to perform in Tri-City Emergency Department, the needs of the department, and the ability to function as a member of the Emergency Department team. Formal documentation of procedure experience may be requested at the discretion of the Department Chair.

C. All new physicians in the Department of Emergency Medicine shall be required to work up to eight (8) night shifts per month (or half of their total shifts if working part time) for at least six (6) years. Physicians shall practice only within the scope of the privileges as defined within the Department's rules and regulations and stated on the privilege form. However, in any emergency situation, an Emergency Medicine Physician may perform any procedure(s) for which he/she has proper training and/or experience, even if not delineated on his/her privilege card. The performance of such procedures may be reviewed by the Department Chair or by the QA/QI/PI Committee, at the Chair's discretion.

~~Physician Privilege Table~~			
~~General Patient Care Privileges~~	~~Initial – see statement above~~	~~Proctoring~~	~~Reappointment every two years~~
~~As part of General Patient Care Privileges, all physicians are authorized to 1) perform occult blood testing and 2) order diagnostic and therapeutic tests (and other associated testing within their scope of practice, or for any emergency procedure, which, in the physician's judgment, is deemed indicated), services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~			

Physician Privilege Table			
General Patient Care Privileges	**Initial - *see statement above***	**Proctoring**	**Reappointment every two years**
Anesthesia: • Regional anesthesia • Nerve blocks	Training/experience as demonstrated by treatment of at least one-hundred (100) typical Emergency Department patients within the past six (6) months – excluding physicians who have completed an ACGME American Board of Emergency Medicine Residency Program) within the past twelve (12) months	Twenty-five (25) cases of General Patient Care	Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
Cardiac Procedures • CPR/ACLS • Cardioversion/Defibrillation • Transthoracic and transcutaneous pacing • Pericardicentesis • Emergency thoracotomy • Thrombolytic administration • EKG interpretation • Pericardiocentesis			
Dermatology: • I&D of abscess • Digital nail removal • Subungual hematoma drainage • Soft tissue aspiration • Laceration repair			
Gastroenterology: • Nasogastric tube insertion • Anoscopy • Thrombosed external hemorrhoids • Paracentesis • Hernia reduction • Digital rectal exam			
General Surgery: • Wound & laceration management • Soft tissue foreign body removal			
Neurology/Neurosurgery • Emergency burr hole • Lumbar puncture • Spinal immobilization • Neurologic exam			
Orthopedics: • Splinting/Casting			

Physician Privilege Table			
General Patient Care Privileges	**Initial – *see statement above***	**Proctoring**	**Reappointment every two years**
• Dislocation management • Emergency fracture management • Extensor tendon repair • Arthrocentesis • Measurement of compartment pressures			
OB/GYN: • Emergency childbirth • Culdocentesis • GYN exam • I & D Bartholin abscess			
Ophthalmology: • Slit lamp examination • Ocular foreign body removal • Ocular irrigation • Tonometry • Fundoscopic exam			
Otolaryngology: • Direct laryngoscopy • Foreign body removal: ear, nose, throat • Peritonsillar abscess drainage • Nasal packing • Nasal cautery • Cerumen removal • Dental nerve block			
Pediatrics: • Advanced airway management of infants/children • Advanced life support for infants/children • Intraosseous line placement for infants/children • Lumbar puncture • Suprapubic bladder aspiration • Management of lacerations • Emergency fracture/ dislocation management			
Respiratory Procedures: • Advanced airway management/techniques			

Physician Privilege Table			
General Patient Care Privileges	Initial - *see statement above*	Proctoring	Reappointment every two years
• Surgical airway placement • Mechanical ventilation • Thoracentesis • Tube/Needle thoracostomy • ABG interpretation • BVM ventilation • Bronchodilator treatment			
Urology: • Suprapubic bladder aspiration • Suprapubic cystostomy placement • Foley catheter placement • Management of urinary retention • U/A interpretation			
Vascular Access: • Venous cutdown • Central line placement • Midline catheter placement • Intraosseous line placement • Arterial line placement • Peripheral IV placement			
OTHER			
Base station supervision	Training	N/A	N/A
Sedation: • Moderate • Deep	Per policy Medical Staff #8710-517	Per policy Medical Staff #8710-517	Per policy Medical Staff #8710-517
Emergency ultrasound: • Ultrasound guidance of approved procedures • Limited obstetrical ultrasonography • Limited abdominal ultrasonography	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522

A. **Initial Criteria- Physician Assistants:**

1. Requests for physician assistant privileges in the Department of Emergency Medicine shall be evaluated on the basis of the needs of the Emergency Department, the requesting PA's education, training, experience, competence, judgment, character, and ability to perform in the Tri-City Emergency Department, and the PA's satisfaction of qualifications as outlined in the "Membership" section above.
2. Physician assistants shall also adhere to the Rules and Regulations for Allied Health Professionals. The Department of Emergency Medicine will review the performance of the physician assistants in order to ensure on-going competency in their field as part of

their on-going professional practice evaluation process.

3. A Physician Assistant may provide those Emergency Department services which are consistent with the physician assistant's education, training, experience and "PA Regulations" which are delegated by a supervising physician who is responsible for the patients cared for by that physician assistant. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols, which allow for some or all of the tasks performed by a PA ~~(see PA Privilege Table below).~~ The supervising physician shall review, countersign, and date within seven (7) days the Emergency Department record of any patient for whom the physician assistant issues or carries out a Schedule II drug order.

Physician Assistant Privilege Table			
General Patient Care Privileges	Initial	Proctoring	Reappointment every two years
As part of General Patient Care Privileges, all physician assistants are authorized to 1) Perform occult blood testing and 2) order x-ray, other studies, therapeutic diets, physical/rehab, occupational/speech, and respiratory therapies, and nursing services unless otherwise indicated.			
Evaluation, emergency management and triage of neonatal, infants, pediatric, adolescents, adults, and geriatric patients	PA may be authorized to perform these privileges when competency is established by the Department of Emergency Medicine, taking into account training and experience.	Twenty-five (25) cases of General Patient Care Privileges	Two hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
Ordering and/or administration of medicine by all routes (orally, IM, IV, PR, aerosolized, inhaler, other) in the Department, and by prescription			
Take a focused or complete medical history, which will include the Medical Screening Exam, including past medical, family, social history, review of systems, and performing focused or complete physical exam			
Anesthesia: • Subcutaneous local anesthetics • Nerve blocks • Dental nerve block			
Cardiovascular: • Taking of EKG and recognition of gross abnormalities			
Dermatology: • Digital nail removal • Subungual hematoma drainage • Treatment of minor 1st and 2nd degree burns			
Gastroenterology: • Nasogastric intubation and gastric lavage • Performance of anoscopy • Thrombosed external hemorrhoids • Collection of specimens: stool • Removal of foreign bodies from rectum, and other • Hernia reduction • Digital rectal exam			
General Surgery:			

Physician Assistant Privilege Table			
General Patient Care Privileges	Initial	Proctoring	Reappointment every two years
• Incision and drainage of superficial skin infections, abscess • Debridement, suture, and care of superficial wounds/lacerations (including facial lacerations) • Arrest of hemorrhage • Soft tissue aspiration • Removal of foreign bodies from skin and soft tissue, and other • Removal of sutures			
Imaging: • Preliminary interpretation of X-rays			
Neurology/Neurosurgery • Spinal immobilization • Neurologic exam			
Orthopedics: • Strapping and immobilizing of sprains/fractures • Splinting/Casting • Dislocation management • Emergency fracture management • Measurement of compartment pressures			
OB/GYN: • GYN Exam • Incision and drainage of Bartholin's abscess • Performance of pelvic exam and pap smear • Removal of foreign bodies from vagina, and other			
Ophthalmology: • Slit lamp examination • Ocular irrigation • Removal of foreign bodies from eyes, and other • Measure intraocular pressure • Ophthalmic, visualization of fundus			
Otolaryngology:			

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial**	**Proctoring**	**Reappointment every two years**
• Collection of specimens: nasopharyngeal and throat • Anterior nasal packing for epistaxis • Nasal cautery • Removal of impacted cerumen • Performance of otoscopy and nasoscopy • Peritonsillar abscess drainage • Removal of foreign bodies from ear, nose, throat, and other			
Respiratory Procedures: • Drawing ABGs and interpretation • BVM Ventilation • Bronchodilator treatment			
Urology: • Suprapubic Cystostomy Placement • Catheterization and routine urinalysis • Management of urinary retention			
Vascular Access: • Arterial puncture • Drawing of venous blood from peripheral site and peripheral IV placement			
ASSIST ONLY PROCEDURES	**Initial**	**Proctoring**	**Reappointment every two years**
• Performing CPR, assist • Cardioversion/Defibrillation, assist • Transthoracic and transcutaneous pacing, assist • Emergency childbirth, assist • Blood transfusion, assist • Starting thrombolytic medication, assist • Pericardiocentesis, assist • Surgical airway placement, assist • Open thoracotomy, assist • Emergency C-Section, assist	Training/experience	Twenty-five (25) cases of General Patient Care Privileges (includes cases from non-assist only privileges/procedures)	Included in the above required Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)

Physician Assistant Privilege Table			
PROCTORED PROCEDURES	Initial	Proctoring	Reappointment every two years
• Lumbar puncture	PA may be authorized to perform these procedures when competency is established by the Department of Emergency Medicine, taking into account training and experience. Emergency Ultrasound privileges must be held by the PA in order to be eligible for Central IV access, Thoracentesis, or Paracentesis privileges in a non-"assist only" role.	3	Included in the above required Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
• Reduction of major joints		3	
• Repair complex lacerations		3	
• Central IV access		3	
• Arterial Line Access		3	
• Endotracheal intubations		3	
• Thoracentesis and Paracentesis		3 combination of paracentesis & thoracentesis cases	
• Arthrocentesis		3	
• Intraosseous line placement, adult/infants/children		3	
• Tube/Needle thoracostomy		3	
Emergency Ultrasound: • Ultrasound guidance of approved procedures • Limited obstetrical ultrasonography • Limited abdominal ultrasonography	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. A minimum of 200 Emergency Room cases are required (100 cases must be from TCMC). For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other Emergency Rooms (up to 100 cases) may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING REQUIRMENTS**

A. Each Medical Staff member or Physician Assistant granted initial privileges, or Medical Staff member or Physician Assistant requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department shall act as proctors. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued where deficiencies are noted.

C. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

D. A form shall be completed by the proctor, and should include comments on the overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be made available from either the Medical Staff Office or the Emergency Department.

E. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

IX. HOSPITAL ADMITTING ORDERS

A. No members of the department shall write admitting orders.

X. TELEPHONE ADVICE

A. Members of the Department shall not give telephone advice, except in the following situations:

1. A departmental professional relationship has previously been established with a patient, involving recent treatment of the patient for the problem about which they are seeking advice.
2. To provide advice unrelated to their capacity as a member of the department (and without representation of same) including non-departmental professional relationships.

XI. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

A. The Department will have a Quality Review Committee (QRC). The committee Chairman is the Department's representative on the Medical Staff QA/PI/PS Committee. The QRC shall meet at least four (4) times per year, or at the discretion of the QRC Chair.

B. General Function

1. The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members for the patients seen in the Emergency Department.

C. Specific Functions

1. The QRC is established to:
   a) Identify important elements of Emergency Department patients' care in all areas in which it is provided.
   b) Select and approve the Department's performance monitoring indicators;
   c) Identify relevant information for these indicators which will be integrated and reviewed quarterly by the Emergency Department QRC Committee;
   d) Formulate thresholds for evaluation related to these performance monitoring indicators;
   e) Review and evaluate physician practice if specific thresholds are triggered;
   f) Identify areas of concern and opportunities to improve care, safety and educate Department members based on these reviews;
   g) Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member, in accordance with Medical Staff Bylaws;
   h) Request Focused Professional Practice Evaluation if/when questions arise regarding a physician's practice;
   i) Monitor and review the effectiveness of any intervention and document any change;

D. Other functions
   1. Assist in the reappointment process through retrospective review of charts;
   2. Review any issues related to Emergency Department care that are forwarded for review by other Departments/Divisions;
   3. Assist in the collection, organization, review, and presentation of data related to Emergency Department patient care and safety;
   4. Review all cases involving unanticipated death(s) in the Emergency Department;

E. Reports
   1. Minutes will be transmitted to the QA/PI/PS Committee and the Medical Executive Committee. The QRC will provide minutes and, as needed, verbal, or written communication to the Department members and to QA/PI/PS Committee regarding any general educational information gleaned through chart review or the quality review process.

XII. **RESIDENT SUPERVISION**

A. Department members shall supervise Emergency Department care provided by residents in Tri-City Emergency Department, and shall examine and document an Emergency Department patient record for all patients seen by a resident. Department members shall countersign/authenticate all charts and orders by residents according to Medical Staff Policy #8710-518 (Medical Records Documentation Requirements).

APPROVALS:

Emergency Medicine Department:	05/27/2015
Medical Executive Committee:	07/27/2015
Governance Committee	08/04/2015
Board of Directors:	08/27/2015

TRI-CITY HEALTHCARE DISTRICT

GOVERNANCE AND LEGISLATIVE

COMMITTEE CHARTER

The Governance and Legislative Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to monitor developments in governance best practices, make recommendations to the District's Board of Directors ("Board") on governance matters referred to it, and monitor, report upon, and make recommendations to the Board regarding state and federal legislative developments related to District and hospital governance, legislative affairs and advocacy.

1. **Governance Policies and Procedures**: The Committee shall respond to Board requests, monitor developments in, report upon and make recommendations to the Board regarding:

    a. Changes in best practices and legal requirements relating to healthcare district governance and healthcare reform initiatives;

    b. The District's governing documents, including Bylaws, Policies, Committee charters, and other governance or policy matters as requested by the Board;

    c. Proposed amendments to the Medical Staff Rules and Regulations. ~~and Privilege Cards.~~ Amendments to Medical Staff Bylaws will be pursuant to the attached Pathway for Medical Staff Bylaw Amendments;

    d. Review its Charter every three years or as necessary;

    e. Develop and maintain an annual work plan, as may be amended from time-to-time by the Committee Chair;

2. **Legislative Affairs Oversight:** The Committee shall monitor, report upon and make recommendations to the Board regarding:

    a. Significant changes to state and federal laws, rules and regulations and accreditation standards applicable to the District, with special attention to the legislative and policy agendas of associations of which the District is a member (e.g., Association of California Healthcare Districts and California Hospital Association);

    b. Actions to be taken to address or implement legislative or regulatory changes proposed, pending or enacted, including advocacy efforts.

II. Membership

The Committee shall consist of three Directors, a minimum of ~~three (3)~~ two (2) but no more than ~~four (4)~~ three (3) community members, and three (3) physicians. In addition, The CEO, COO, Manager, Medical Staff Services, and Chief Compliance Officer shall support the Committee without vote, but may be counted toward a quorum as alternatives in the event absences result in the Committee lacking a quorum.

Each Committee member shall have a basic understanding of governance and legislative affairs of public hospitals, and should have experience and familiarity with the specialized issues relating to governance of complex healthcare organizations, healthcare laws and legislative affairs.

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for review and approval of recommendations at its meetings. The Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas, and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all recommendations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved October 27, 2011 by Board of Directors
Approved August 30, 2012 by Board of Directors
Approved March 28, 2013 by Board of Directors
Approved May 29, 2014 by Board of Directors

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #176-010

POLICY TITLE: Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson

I. BOARD MEETING AGENDA DEVELOPMENT

The Board of Directors Agenda shall be developed by the Chairperson, with the assistance of the President/CEO and General Counsel. Individual Board members may place items on the Agenda through the Board Chairperson. The procedure will be:

A. A Board member shall submit a written description of the Agenda item to the Chairperson or the CEO or the Board Secretary, prior to the time of the Agenda Conference. Recognizing that the Agenda Conference meeting date and time may on occasion change, it is the responsibility of the requestor to confirm the Agenda Conference meeting date to ensure timely submittal of the requestor's Agenda item. Discussion items may~~will~~ be placed on the Board Agenda at the request of any Board member; proposed action items shall normally be referred to the appropriate Board committee for consideration prior to full Board consideration. At the beginning of each calendar year, the Chairperson of the Board of Directors shall set the date and time of the Agenda Conference.

B. A member of the public may submit a written request to the President/CEO, Chairperson or a member of the Board of Directors. The written request shall contain a description of the Agenda item. The member of the public shall be informed if and when the item will appear on the Board Agenda.

C. General Counsel, at the Chairperson's or President/CEO's request, shall contact the Board member, or the public member, to confirm the intent of their request, and will then formulate the Agenda item in a format that conforms with legal requirements.

D. Copies of the Agenda shall be posted on the TCHD website and at other public locations as required by law.

II. EFFICIENCY OF BOARD MEETINGS

The Board of Directors and management shall work cooperatively to prepare for and manage Board meetings in a manner that produces efficient and effective meetings (See Policy #10-39). To achieve that end, the following process will be followed:

A. The Board of Directors shall receive their Board Agenda packet with appropriate written information and materials at least five (5) days prior to a regularly scheduled Board of Directors meeting.

B. Board members who require further information or clarification on Board Agenda packet materials are welcome to contact the President/CEO or General Counsel with questions prior to the meeting. Responses shall be presented to all Board members at the Board meeting.

C. To facilitate deliberation and action on items at Tri-City Healthcare District Board of Directors meetings, suggested written motions may be developed in advance by members of the Board of Directors or Executive Management. Such suggested written motions shall be included in the Board of Directors Agenda packet with supporting materials for the action item.

III. TIME LIMITS FOR BOARD OF DIRECTOR MEETINGS

A. Regular meetings of the Board of Directors shall be a maximum of three and one half (3½) hours for any open session and a maximum of four hours (4) for any closed session. Agenda items not addressed during those time periods will be carried forward to a subsequent date, which shall be agreed upon by a majority vote of the Board before adjourning the meeting.

B. The time limits under Section A may be waived by a majority of the Board. The waiver shall be effective only for the meeting in which the waiver is approved. A motion for waiver may specify that the limit will be waived entirely for the balance of the session, will be extended for a specified amount of time of at least one-half (1/2) hour, or will be extended only for so long as the Board requires to address one or more specified items on the Agenda for that session.

IV. ROLE AND POWERS OF CHAIRPERSON

The Chairperson of the Board of Directors shall have the authority to act on behalf of the Board of Directors, as provided in the District Bylaws and these policies.

The Board Chairperson shall report any such actions to the Board of Directors at their next regularly scheduled meeting.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Received by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Revised by the Gov/Leg Committee: 8/4/15
Approved by the Board of Directors: 8/27/15
Reviewed by the Gov/Leg Committee: 8/02/16

Approved by the Board of Directors: 8/25/16

Tri-City M cal Center
Audit, Compliance & Ethics Committee
February 16, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino, DPT, PT; Director Leigh Anne Grass; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant
Absent:	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Schallock.		
2. Approval of Agenda	**It was moved by Mr. Cumming and seconded by Director Dagostino to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – January 19, 2017	**It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan
5. Old Business a. A) Fiscal Year 2017 – Financial Statement Audit Proposal	Pursuant to the recommendation by the committee last month, Mr. Rivas reported a proposal was requested from Moss Adams to perform the FY2017 Financial Statement Audit.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Mr. Rivas distributed the proposed Engagement Letter and Professional Services Agreement from Moss Adams which outlined the Scope of Services, Timing, Fees and Reporting. Mr. Rivas stated Mr. Blakey would once again be the Engagement Reviewer and Mary Nguyen, Engagement Senior Manager. He explained Moss Adams has requested a 2% increase in fees for this year from prior year to adjust for inflation which amounts to approximately $3,000. Mr. Rivas stated there was no increase in fees for FY2015 or FY2016 and he believes this is a modest increase. Discussion was held regarding additional fees that may be incurred. Mr. Dietlin explained there could be additional fees based on audit findings however we are prohibited from limiting the scope of the audit. Mr. Rivas stated historically Moss Adams has been conservative in their fees and he recommends the committee recommend the proposal to the Board. **It was moved by Mr. Cumming to recommend the Board engage Moss Adams to perform the FY2017 Financial Statement Audit with the terms and fees presented. Mr. Schwartz seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to engage Moss Adams to perform the FY2017 Financial Statement Audit with the terms and fees described; item to be placed on Board Agenda and included in agenda packet.**	Ms. Donnellan
6. New Business			
A) Interviews of community candidates for open community seat on the Audit, Compliance & Ethics Committee 1) Faith Devine	Chairman Schallock reported four (4) individuals have applied for the open seat on the committee, Ms. Faith Divine, Mr. Bryan Gonzales, John Harper and Robert Knezek. Chairman Schallock explained the interview process to the candidates in which they would be interviewed one at a time in alphabetical order.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	The first candidate interviewed was Faith Devine. Ms. Devine provided a brief summary of her background and experience. Ms. Devine stated she was a federal prosecutor with the U.S. Department of Justice specializing in financial fraud, waste and abuse. Committee members asked questions of Ms. Devine related to her educational background and any potential conflicts that might prevent her from serving on the committee. In closing, Ms. Devine stated she is an average private citizen interested in utilizing her knowledge and background and believes she could provide insight on many issues.		
2) Bryan Gonzales, JD, MBA	The second candidate, Mr. Bryan Gonzales presented a brief summary of his background and experience. Mr. Gonzales stated he is the Chief Executive Officer and Corporate Counsel for Pacific Medical Care, Inc. & Pacific Recovery, Inc. Committee members asked questions of Mr. Gonzales related to his educational background and any potential conflicts that might present him from serving on the committee. In closing, Mr. Gonzales stated he has been a member of the Tri-City community for approximately 18 months and feels that he can bring a real life hands on experience to the committee.		
3) John Harper, R.T.	Mr. John Harper provided a brief summary of his background and experience. He stated he worked at Tri-City previously as a MRI Technologist and has been a member of the Tri-City community since 1983. Committee members asked questions of Mr. Harper related to educational background. Mr. Harper also described his experience in neogitating with union personnel.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
4) Robert Knezek	In closing, Mr. Harper stated he is familiar with compliance regulations related to government acquisition processes and understands healthcare and the processes involved in healthcare. He is recently retired and has the time to devote to the committee. Mr. Robert Knezek provided a brief summary of his background and experience. He stated he has served previously on the Audit, Compliance & Ethics Committee as well as the Finance, Operations & Planning Committee. Committee members asked questions of Mr. Knezek related to his educational background. In closing, Mr. Knezek stated he is very familiar with the hospital and committee structure and would bring an analytical mind to the committee. At the conclusion of the interviews, committee members had discussion and reviewed the qualifications of each candidate. Committee members concurred it was an impressive group of candidates and all individuals presented outstanding credentials. **It was moved by Mr. Cumming to recommend Ms. Faith Devine be appointed to the Audit, Compliance & Ethics Committee. Director Dagostino seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to appoint Ms. Faith Devine to the Audit, Compliance & Ethics Committee; item to be placed on Board agenda and included in agenda packet.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
B) Administrative Policies & Procedures: 1) 8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease	Ms. Kathy Topp, Director of Education and Clinical Informatics joined the meeting at 9:40 a.m. Ms. Kathy Topp explained Policy #8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease was designed to protect our personnel from infectious communicable diseases on preadmission. She stated by law we are required to report exposures of pre-hospital emergency medical personnel to certain infectious diseases. Director Grass noted this policy applies to police officers, firefighters, volunteers and others who might provide emergency care or rescue services as well. Dr. Mells expressed concern with the process and questioned if there is a mechanism in place to "close the loop" by providing notification back to staff if it is discovered a patient presented with an infectious disease. Mr. Schwartz questioned what the "Act" refers to in E. 3. and 4. Director Dagostino questioned if the policy applies to other TCHD entities such as the Wellness Center. Due to the number of unanswered questions and ambiguity of the policy, it was recommended the policy be pulled for further review and clarification.	**Policy 8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease will be sent back to the appropriate committees for further review and clarification.**	Ms. Topp
2) 8750-537 – Hiring and Employment : Definitions (Deleted)	Ms. Topp explained the deleted policies on today's agenda were incorporated into existing policies to avoid redundancy.	**Policy deleted as recommended.**	
3) 8750-539 – Screening Covered Contractors	Policy #8750-539 – Screening Covered Contractors was reviewed by the Committee. Minor formatting and typographical changes were suggested.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
4) 8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors	The committee reviewed Policy #8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors. It was suggested Definitions 1. and 2. be reversed for consistency with Policy #8750-539. There was extensive discussion regarding sections C. 2. a. and b. It was suggested Ms. Topp and Ms. Bernard-Shaw work with General Counsel on acceptable language and move forward to the Board for approval.		
5) 8750-541- Conviction/Exclusion/License Revocation of Current Covered Contractors (Deleted)	Policy 8750-541 - Conviction/Exclusion/License Revocation of Current Covered Contractors has been deleted.	**Policy deleted as recommended.**	
6) 8750-542 – Covered Contractor Requirements to Report Changes in Certification (Deleted)	Policy 8750-542 – Covered Contractor Requirements to Report Changes in Certification has been deleted.	**Policy deleted as recommended.**	
7) 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and/or Policies	The committee reviewed Policy 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and/or Policies. Ms. Topp recommended the Addendums be amended to reflect that the employee has read the Code of Conduct and will adhere to the Tri-City Healthcare Districts Policies. It was also suggested that the abbreviation for Tri-City Healthcare District be used in lieu of the full name when it appears more than once in the document. Discussion was held regarding the location that the contracts are housed. After extensive discussion it was suggested the language "in each employee's personnel file" be struck from D. 2. **It was moved by Ms. Kathryn Fitzwilliam to recommend approval of Policies 8750-539 – Screening Covered Contractors, 8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors, deletion of Policies 8750-537 – Hiring and**	**Recommendation to be sent to the Board of Directors to approve the Policies described and delete policies as**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Employment: Definitions, 8750-541 – Conviction/Exclusion/License Revocation of Current Covered Contractors and 8750-542 - Covered Contractor Requirements to Report Changes in Certification with amendments as described. Director Grass seconded the motion. The motion passed unanimously.	**recommended; items to appear on the Board agenda and included in agenda packet.**	
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Schallock made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and one matter of Potential Litigation.		
8. Motion to go Into closed session	**It was moved by Director Dagostino and seconded by Mr. Cumming to go into closed session at 10:30 a.m.**		
9. Open Session	The committee returned to open session at a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
11. Comments from Committee Members	None.		
12. Date of Next Meeting	Chairperson Schallock stated the Committee's next meeting will be held on March 16, 2017.	**The committee's next meeting is scheduled for March 16, 2017.**	
13. Adjournment	Chairperson Schallock adjourned the meeting at 10:44 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
February 16th, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Emergency Response Employees, Notification of	530	3 year review, practice change	Pulled for further review
2. Hiring and Employment; Definitions	537	DELETE	Forward to BOD for approval
3. Hiring & Employment Screening Current Employees - Covered Contractors	539	3 year review, practice change	Forward to BOD for approval with revisions
4. Hiring and Employment; Pending Charges against Current Employees & Covered Contractors	540	3 year review, practice change	Forward to BOD for approval with revisions
5. Hiring and Employment; Conviction Exclusion License Revocation of Current Employees & Covered Contractors	541	DELETE	Forward to BOD for approval
6. Hiring and Employment; Employee & Covered Contractor Requirement to Report Changes in Certification	542	DELETE	Forward to BOD for approval
7. Education and Training; Distribution Certification of Code of Conduct and Policies	546	3 year review, practice change	Forward to BOD for approval with revisions

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – This is being incorporated into Administrative Policies 8750-539 and 8750-541 and Human Resources Policies 485 and 487.

ISSUE DATE: 5/12

SUBJECT: Hiring and Employment: Definitions

REVISION DATE: 12/12

POLICY NUMBER: 8750-537

Human Resources Department Approval Date(s):	**05/16**
Administrative Policies and Procedures Approval Date(s):	**09/16**
Organizational Compliance Committee:	**09/16**
Medical Executive Committee Approval Date(s):	**n/a**
Audit, Compliance and Ethics Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	**12/12**

A. PURPOSE:

This Policy sets forth hiring and employment definitions relating specifically to Tri-City Healthcare District's (TCHD) Compliance Program. These Polices supplement TCHD's existing hiring and employment practices, as developed and maintained by its Human Resources Department.

B. DEFINITIONS:

As used herein, the following phrases shall have the following meanings:

1. **Adverse Action**. Adverse action means, with respect to a professional license, registration, or certification, any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.

2. **Covered Contractor**. A Covered Contractor is an individual or entity that has a contractual relationship with the District (other than employment), including:

   a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and physician extenders such as physician assistants and nurse practitioners;

   b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state heath care program.

3. **Federal health care program**. The phrase "Federal health care program" shall have the same meaning as set forth at 42 U.S.C. 1320a-7b(f) and includes, by way of example, Medicare and Medicaid.

4. **GSA EPLS**. The General Services Administration's ("GSA") Excluded Parties List System.

5. **OIG LEIE**. The U.S. Department of Health & Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities.

C. QUESTIONS RELATED TO THE POLICIES:

Any questions concerning the Hiring and Employment Policies, or questions that are not specifically addressed by the Hiring and Employment Policies, should be directed to the District's Compliance Officer.

AUDIT AND DOCUMENTATION:

The District shall audit and document compliance with the Hiring and Employment Policies. Such audit shall be conducted pursuant to 8750-553. Relevant documentation shall be maintained in the District's Compliance Program files consistent with the District's document retention practices.

Tri-City Medical Center
Oceanside, California

This policy is being split into a Compliance policy 539 and a new Human Resources policy 485.

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: ~~Hiring and Employment;~~ Screening ~~Current Employees/~~Covered Contractors

REVISION DATE(S):

POLICY NUMBER: 8750-539

Department Approval:	**09/16**
~~**Human Resources Department Approval Date(s):**~~	~~**05/16**~~
Administrative Policies and Procedures Approval Date(s):	**09/16**
Organizational Compliance Committee:	**09/16**
Medical Executive Committee Approval Date(s):	**01/17**
Audit, Compliance and Ethics Committee Approval Date(s):	**02/17**
Board of Directors Approval Date(s):	**05/12**

A. **PURPOSE:**

1. ~~Policy 8750-539 provides (1)~~**To provide** ~~a statement~~**guidance** of the **Tri-City Healthcare** District's **(TCHD'S)** policy regarding screening ~~current employees and~~ Covered Contractors.

B. **DEFINITIONS:**

1. **Covered Contractor – an individual or entity that has a contractual relationship with TCHD (other than employment), including, but not limited to:**
   a. **Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;**
   b. **Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state health care program.**
2. **Adverse Action – Adverse action means with respect to a professional license registration, or certification, any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed** ~~**a final event or status that could impair the Contractor's ability to perform the**~~.

~~**Services being contracted for or for services that are in the process of being provided. Such Event (s) can prevent TCHD from billing for a service or providing a service.**~~

~~b. **already contracted for** .~~

~~2. **GSA EPLS – The General Services Administration's (GSA) Excluded Parties List System.**~~

~~3. **OIG LEIE – The U.S. Department of Health & Human Services, Office of Inspector General's (OIG) List of Excluded Individuals/Entities.**~~

3. **OIG List of Excluded Individuals/Entities is located at https://.exlusions.OIG.hhs.gov.**

~~4. **Excluded Parties List System (EPLS) is located at http://www.epls.gov**~~

~~5.~~4. **System for Award Management (SAM) is located at https://www.sam.**

~~6.~~5. **Medi-Cal Suspended and Ineligible Provider List at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.**

~~7. **Excluded Parties List System (EPLS) is located at http://www.epls.gov**~~

~~**System for Award Management (SAM) is located at https://www.sam.gov**~~

C. **SCREENING ~~CURRENT EMPLOYEES~~/COVERED CONTRACTORS:**

1. Periodically, but at least on **an annual** ~~a an annual~~**a quarterlyequarterlymonthly** basis **and prior to contracts being considered for approval by the Board of Directors**, ~~the District~~**TCHD** shall screen ~~current employees~~/Covered Contractors against the**:**
   a. Office of Inspector General**'s** List of Excluded Individuals/Entities (OIG LEIE), and
   ~~United States General Services Administration Excluded Parties List System (~~**~~U.S.~~**~~GSA EPLS); and.~~
   b. System for Award Management (SAM), and
   ~~b.~~**c. Medi-Cal Suspended and Ineligible Provider List.**
2. Periodically, but at least on an annual basis, the District shall require each **Contractor**~~employee~~ to certify in writing that the **Covered Contractor**~~employee~~:
   a. Has not been charged with or convicted of committing any criminal offense;
   b. Does not have any charges pending for violating any criminal law;
   c. Has not been debarred, excluded or otherwise deemed ineligible for participation in Federal health care programs;
   d. Is not the subject of or otherwise part of any ongoing federal or state investigation; and
   e. Possesses a current professional license, registration, or certification, as applicable, and is in good standing with, and has had no Adverse Action taken by, any and all authorities granting such license, registration or certification, as applicable.

~~e.~~**3. ~~May also provide a certification in writing.~~All Contracts are to be evaluated and assessed on an annual basis per CMS (Center for Medicare and Medicaid Service) regulations and provide a certificate in writing.~~~~may also provide a certification in writing W when the Contract is evaluated and assessed on an annual basis per CMS (Center for Medicare and Medicaid Service regulations and provide certificate in~~**

~~3.~~**4.** In the event that the **Covered Contractor**~~employee~~ cannot provide the certification set forth in Section ~~II.B~~**C.1** above, the **Covered Contractor** ~~employee~~ shall provide complete and accurate information with respect to the matters at issue.

~~4.~~**5.** In addition, as specified in 8750-**540**~~542~~, ~~employees and~~ Covered Contractors are required to report **any criminal convictions under state or federal law,** in writing to the ~~District~~ **Compliance~~Human Resources~~ Department within five (5) working days of such convictions** ~~any changes relevant to the certification set forth in Section II.B above and/or Section II.F of Policy 8750-538 immediately upon becoming aware of any such change(s)~~.

D. **RETENTION:**

1. ~~Subject to legal constraints, the District~~**TCHD** shall not knowingly retain any ~~employee or~~ Covered Contractor if the ~~employee~~/Covered Contractor:
   a. Has been convicted of a criminal offense that has a bearing on the (a) trustworthiness of the ~~employee~~/Covered Contractor, or (b) ability of the ~~employee~~/Covered Contractor to perform relevant job responsibilities; or
   b. Has been convicted of committing a health care fraud-related criminal offense; or
   c. Is currently debarred, excluded or otherwise ineligible for participation in Federal health care programs; or
   d. Does not have a current professional license, registration or certification as applicable, and/or is not in good standing with, and/or has had **an** Adverse Action taken by, the relevant state authorities that grant such license, registration or certification, as applicable.
   e. **When the Covered Contractor is a member of the TCHD Medical Staff, there shall be coordination between the Medical Staff Office and the Chief Compliance Officer in order to ensure appropriate action and follow-up is conducted.**
   f. **When a Covered Contractor is identified as being impacted by this policy, or as soon as possible thereafter, TCHD employees, Medical Staff and Board of Directors shall consult with the Chief Compliance Officer and/or Legal Counsel to determine the appropriate action to be taken.**

E. **DOCUMENTATION:**

1. ~~Tri City Healthcare District~~**TCHD** ~~shall document compliance with 8750-539.~~ For **Covered Contractors** ~~employees,~~ such documentation shall be maintained in the ~~employee's personnel~~ **Covered Contractors's** file consistent with the ~~District's~~ **TCHD's** document retention policies. ~~For Covered Contractors, such documentation shall be maintained in the relevant Covered Contractor file consistent with the District's~~ **TCHD's** ~~document retention policies~~.

F. **RELATED DOCUMENT(S):**

1. **Administrative Policy 8750-540 Pending Debarment, Criminal Charges or Adverse Action Against Current Covered Contractors**
2. **TCHC Board Policy #14-008 – Board Document Retention Policy**

G. **REFERENCE(S):**

~~3.~~**1. Medi-Cal law, Welfare and Institutions Code (W&I Code) sections 14043.6 and 14123** ~~**mandates that providers be suspended convicted of a felony, misdemeanor or breach of contractual agreements.**~~

Tri-City Health Care District
Oceanside, California

This policy is being split into a Compliance policy 540 and a new Human Resources policy 486.

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: ~~Hiring and Employment; Pending~~ Debarment, Criminal Charges or Adverse Action ~~Charges~~ against Current ~~Employees~~ /Covered Contractors

REVISION DATE:

POLICY NUMBER: 8750-540

Department Approval:

~~Human Resources Department Approval Date(s):~~	~~05/16~~
Administrative Policies and Procedures Approval Date(s):	09/16
Organizational Compliance Committee:	11/16
Medical Executive Committee Approval Date(s):	01/17
Audit, Compliance and Ethics Committee Approval Date(s):	02/17
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

~~1. Policy 8750-540 provides (1)~~**To provide** ~~a statement~~**guidance regarding** ~~of the~~ **action** ~~(s)~~ **of** ~~the~~ ~~the~~ **Tri-City Healthcare** District's~~s~~ **(TCHD's) will take when a Covered Contractor has a pending suspension, debarment, exclusion action, criminal conviction or Adverse Action.** ~~policy regarding pending charges against a its employees or Covered Contractor (s)~~rs.

B. **DEFINITIONS:**

1. **Covered Contractor – A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including but not limited to:**
   a. **Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;**
   b. **Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.**
2. **Adverse Action – Adverse action means with respect to a professional license, registration, or certification, any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.**
3. **Federal Health Care Program – The phrase "Federal health care program" shall have the same meaning as set forth at 42 U.S.C. 1320a-7b(f) and includes, by way of example, Medicare and Medicaid.**

~~A.~~C. **ACTION PENDING RESOLUTION OF CHARGES:**

1. If ~~the District~~**TCHD** learns that:
   a. A current ~~employee or~~ Covered Contractor has been charged with a criminal offense bearing on trustworthiness, or the ability of the ~~employee/~~Covered Contractor to perform relevant **contractual** ~~job~~ responsibilities; **and/or**~~,~~

b. A current ~~employee or~~ Covered Contractor has been charged with a criminal offense related to health care fraud,

c. A federal agency has issued a notice proposing to debar, exclude, or otherwise deem the current ~~employee or~~ Covered Contractor ineligible to participate in any Federal health care program, or;

d. A state agency or authority has proposed to take an Adverse Action ~~(as defined in 8750-537)~~ against a professional license, certification or registration of a current ~~employee or~~ Covered Contractor~~,~~

2. Then, pending resolution of the charges:

a. The Chief Compliance Officer (CCO) in consultation with Legal Counsel as necessary and appropriate, shall review whether the Covered Contractor's contract should be terminated based on the circumstances (and/or Covered Contractor's employee should be removed from his or her position related to services furnished at TCHD).

~~If the employee /Covered Contractor is in a position that involves direct responsibility for, or involvement in, patient care or billing any federal, state or private payer, then the employee shall be placed on Administrative Leave and the Covered Contractor shall be removed from that position **or the contract will be terminated subject to review by the CCO and/or Legal.**.~~

~~If the employee/Covered Contractor is not in a position that involves direct responsibility for or involvement in, patient care or billing any federal, state or private payer, then the employee /Covered Contractor shall not be appointed to such a position.~~

~~a.~~**b. If the Covered Contractor is a credentialed Medical Staff member, the matter shall be resolved through the coordination of the Medical Staff Office and the Chief Compliance Officer.**

~~b.~~**3. TCHD shall make reports to the CCO and Contracts department regarding compliance with the reporting requirements of this policy.**

~~3.~~**4. At the discretion of TCHD, reports will be made to the appropriate licensing authority.**

~~B.~~D. DOCUMENTATION:

1. ~~Tri-City~~**TCHD** ~~shall document compliance with 8750-540~~. For ~~employees~~ **Covered Contractors**, such documentation shall be maintained in the ~~employee's~~ **Covered Contractor's** ~~personnel~~ file consistent with the ~~District's~~ **TCHD's** document retention policies. ~~For Covered Contractors, such documentation shall be maintained in the relevant Covered Contractor file consistent with the District's **TCHD's** document retention policies~~.

~~C.~~E. REFERENCES:~~ED RELATED DOCUMENTS~~:

1. **42 U.S. Code § 1320a–7b ~~– Criminal penalties for acts involving Federal health care programs.~~**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE - It is being incorporated into a Compliance policy 540 and a new Human Resources policy 487.

ISSUE DATE: 05/12

SUBJECT: ~~Hiring and Employment;~~ Conviction/Exclusion/License Revocation of Current ~~Employees of~~ /Covered Contractors

REVISION DATE(S):

POLICY NUMBER: 8750-541

~~Human Resources Department Approval Date(s):~~	~~05/16~~
Administrative Policies and Procedures Approval Date(s):	09/16
Organizational Compliance Committee:	11/16
Medical Executive Committee Approval Date(s):	01/17
Audit, Compliance and Ethics Committee Approval Date(s):	02/17
Board of Directors Approval Date(s):	05/12

~~A. PURPOSE:~~

~~1. Policy 8750-541 provides (1)~~**~~To provide~~** ~~a statement~~**~~guidance~~** ~~of the District's~~ **~~TCHD's~~** ~~policy regarding the criminal conviction, debarment or exclusion of employees or Covered Contractors, or the revocation of the professional license, certification or registration of an employee or Covered Contractor.~~

~~B. DEFINITION(S):~~

~~Covered Contractor – A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including:~~

~~Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;~~

~~Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.~~

~~C. ACTION FOLLOWING CONVICTION/PROHIBITION/LICENSE REVOCATION:~~

~~1. If a District~~ **~~TCHD~~** ~~employee or Covered Contractor:~~

~~a. Has been convicted of a criminal offense that bears on trustworthiness, or the ability to perform relevant job functions or is related to health care fraud, or~~

~~b. Has been debarred, excluded or otherwise deemed ineligible to participate in Federal health care programs, then, subject to legal constraints, the District~~**~~TCHD~~** ~~shall terminate the employee or the Covered Contractor.~~

~~2. If a District~~ **~~TCHD~~** ~~employee or Covered Contractor has had his or her professional license, registration, or certification revoked, cancelled or otherwise removed or nullified, then (assuming that such license, registration or certification is needed to fulfill the duties and obligations of the employee or Covered Contractor), subject to legal constraints, the District~~**~~TCHD~~** ~~shall terminate the employee or Covered Contractor or suspend such person pending the reinstitution of his/her license, registration or certification.~~

~~D. DOCUMENTATION:~~

~~1. The District~~**~~TCHD~~** ~~shall document compliance with 8750-541. For employees~~ **~~Covered Contractors~~**~~, such documentation shall be maintained in the employee's~~ **~~Covered Contractor's~~** ~~personnel file consistent with the District's~~ **~~TCHD's~~** ~~document retention policies. For Covered~~

~~Contractors, such documentation shall be maintained in relevant Covered Contractor file consistent with the District's~~**TCHD's** ~~document retention policies.~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE - split into a Compliance policy 540 and a new Human Resources policy 488.

ISSUE DATE: 5/12

SUBJECT: ~~Hiring and Employment;~~ ~~Employee~~/Covered Contractor Requirements to Report Changes in Certification

REVISION DATE(S):

POLICY NUMBER: 8750-542

Department Approval Date(s):	05/16
Administrative Policies and Procedures Approval Date(s):	09/16
Organizational Compliance Committee:	11/16
Medical Executive Committee Approval Date(s):	01/17
Audit, Compliance and Ethics Committee Approval Date(s):	02/17
Board of Directors Approval Date(s):	05/12

~~A. **PURPOSE:**~~

~~1. Policy 8750-542 provides (1)~~**~~To provide~~** ~~a statement~~**~~guidance~~** ~~of the District's~~ **~~Tri-City Healthcare District's (TCHD)~~** ~~policy regarding the requirement that employees/Covered Contractors report changes to their last certification regarding criminal acts, Adverse Action, and other events, to the District~~**~~TCHD.~~**

~~B. **GENERAL POLICY:**~~

~~1. District~~ **~~TCHD~~** ~~employees and Covered Contractors are required to report any changes to their most recent certification made per~~ **~~Administrative Policy~~** ~~8750-538 and/or 8750-539 to the District~~ **~~TCHD~~** ~~immediately.~~

~~C. **SPECIFIC POLICY:**~~

~~1. As provided in~~ **~~Administrative Policies~~** ~~8750-537~~ **~~538~~** ~~through 8750-541, the District~~**~~TCHD~~** ~~screens prospective employees and Covered Contractors and requires current employees and Covered Contractors to certify to the absence of criminal activity, exclusion, or Adverse Action, etc.~~

~~2. In addition, each District~~ **~~TCHD~~** ~~employee/Covered Contractor~~ **~~must report any criminal convictions under state or federal law, in writing to the Compliance Department within five (5) working days of such conviction.~~** ~~is required to notify the District, through a written communication to his or her supervisor and the Chief Compliance Officer, immediately — but no later than two days — following a change in the information obtained by the District during the most recent screening, and/or the information provided by the employee/Covered Contractor on the most recent certification.~~

~~D. **RELATED DOCUMENT(S):**~~

~~1. **Administrative Policy 8750-538 – Hiring and Employment; Screening for Eligibility of Prospective Employees/Covered Contractors**~~

~~2. **Administrative Policy 8750-539 – Hiring and Employment; Screening Current Employees/Covered Contractors**~~

~~3. **Administrative Policy 8750-540 – Hiring and Employment; Pending Charges Against Current Employees/Covered Contractors**~~

~~4. **Administrative Policy 8750-541 – Hiring and Employment; Conviction/Exclusion/License Revocation of Current Employees/Covered Contractors**~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: Education and Training; Distribution/Certification of Code of Conduct and/or Policies

REVISION DATE(S): 12/12

POLICY NUMBER: 8750-546

Department Approval Date(s):	~~10/15~~01/17
Administrative Policies and Procedures Approval Date(s):	01/17
Organizational Compliance Committee:	01/17
Medical Executive Committee Approval:	n/a
Audit and Compliance Committee Approval Date(s):	02/17
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. ~~Policy 8750-546~~**To** provides a statement of ~~the~~ **Tri-City Healthcare** District's **(TCHD)** ~~District's~~ policies regarding the distribution of the **TCHD** Compliance Program Code of Conduct and Policies.

B. **DISTRIBUTION TO EMPLOYEES/DIRECTORS:**

1. The ~~District~~**TCHD**'s Compliance Program Code of Conduct and Policies shall be distributed, either electronically or in hard copy.~~, to all:~~.
2. **Compliance Policies will be available electronically on the Policy Management database on the Intranet.**
~~1.~~**3. The above shall be distributed to:**
   a. Current employees, including officers and managers.
   b. New employees (within 30 days of their start date), which may be part of the ~~District~~**TCHD**'s orientation process, as appropriate and
   c. Members of the Board of Directors.

C. **DISTRIBUTION TO COVERED CONTRACTORS:**

1. The ~~District~~**TCHD**'s Compliance Program Code of Conduct shall be distributed, either electronically or in hard copy, to all:
   a. Current Covered Contractors, and
   b. New Covered Contractors (within 30 days of their start date).

D. **CERTIFICATIONS:**

1. On an annual basis, each employee and Director shall certify in writing that he or she has read, understands, and will comply with the ~~District~~**TCHD**'s Compliance Program Code of Conduct and **applicable** Policies.
2. Each new employee and Covered Contractor shall certify in writing that he or she has read, understands and will comply with the ~~District~~**TCHD**'s Compliance Program Code of Conduct and **applicable** Policies. Such certification must be obtained within 30 days of employment or contract.

E. **DOCUMENTATION:**

1. Copies of all certification executed in accordance with 8750-546 shall be maintained ~~in each employee's personnel file,~~ consistent with the ~~District~~**TCHD**'s document retention policies.

F. **RELATED DOCUMENT(S):**

1. **Compliance Certification Form**
2. **New Employee Orientation Compliance Certification Form**

COMPLIANCE CERTIFICATION FORM

"I hereby certify that I have read, understand, and will comply with Tri-City Health**care** District's **(TCHD)** Compliance Program Code of Conduct and **will adhere to** ~~the Tri-City Health District~~**TCHD**'s Policies and Procedures. I understand that my agreement with this certification is a condition of my employment and/or new contract with ~~Tri-City Health District~~**TCHD**. I also acknowledge that my failure to comply with ~~Tri-City Health District~~**TCHD**'s Compliance Program Code of Conduct, and ~~Tri-City Health District~~**TCHD**'s Policies and Procedures could lead to the imposition of the disciplinary process (if an employee) or appropriate sanction (if not an employee)."

_____ Date:_____
Printed Name

_____ Position:_____
Signature

NEW EMPLOYEE ORIENTATION

COMPLIANCE CERTIFICATION

I hereby certify that I have read, understand, and will comply with Tri-City Healthcare District's (TCHD) Compliance Program Code of Conduct and **will adhere to** TCHD's Policies and Procedures.

Print Name

Signature Date

I hereby understand that my agreement with this certification is a condition of my employment with TCHD. I also acknowledge that my failure to comply with TCHD's Compliance Program Code of Conduct, and TCHD's Policies and Procedures could lead to me being subjected to the disciplinary process.

Print Name

Signature Date

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

January 26, 2017 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on January 26, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Ray Rivas, Acting Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairman Dagostino pulled item 17 b. Consideration to approve Resolution No. 781, A Resolution of Tri-City Healthcare District Authorizing Borrowing.

   It was moved by Director Reno to approve the amended agenda. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the January 26, 2017 Regular Board of Directors Meeting Agenda.

4. Oral Announcement of Items to be discussed during Closed Session.

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the January 26, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; one Report Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding three (3) matters of Existing Litigation; three (3) matters of Potential Litigation, Public Employee Evaluation: General Counsel and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Nygaard to go into closed session at 1:35 p.m. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in open session.

10. Director Nygaard led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12. Board Recognition of Outstanding Service – J. Johnson, Director of Marketing and Marketing Team

Mr. David Bennett stated the Tri-City Carlsbad Marathon was incredible with over 8,000 runners that were represented by 14 countries. Otto and Charlotte from the Alaska Frontier show also attended the marathon to cheer on their son who is a fireman in Alaska participating in the marathon. In addition, over 1,500 children participated in the walk/run at Legoland. Mr. Bennett stated Tri-City received great coverage with four major media stations that generated eight (8) clips throughout the day.

Mr. Bennett introduced Ms. Jamie Johnson, Director of Marketing and her team, Jessica Schrader, Event Coordinator, Celia Garcia, Media Specialist, Jodi Berg, Physician Relations Liaison and Brian Greenwald, Social Media and Website Content Specialist. Mr. Bennett stated in his opinion these individuals did an incredible, over the top job and really created the visibility and brand image for Tri-City Medical Center.

Directors expressed their appreciation to Ms. Johnson and her team for their hard work. Director Schallock also complemented David Tweedy, President of the Foundation who ran the half marathon as well as the nurse monitors at the Legoland walk/run.

Chairman Dagostino expressed his appreciation to Dr. Gene Ma and the Emergency Room group who volunteered their time, set up medical tents and helped make the marathon one of the safest national/international's marathon.

13. Community Update -

1) Patient Safety Summit Video – Kevin McQueen

Mr. Kevin McQueen stated Tri-City leadership was approached by the leadership at the Patient Safety Movement to see if we were interested in participating in their upcoming summit by doing a video of TCMC's patient safety activities to showcase some of the fine work that our nurses are doing. Mr. McQueen explained the Patient Safety Movement is an International Organization with the goal of eliminating preventable harm and death in healthcare. He stated the Movement brings in leaders from around the world to get together and discuss best practices in healthcare and how do we make it safer for the patient. Mr. McQueen showed a video that celebrates our nurses on the front line staff and shows how they are helping with patient safety. He stated the video will be showcased at the summit in Orange County that is attended by the experts in the field and it is quite an honor to have been chosen to participate.

2) Flu Update – Sharon Schultz

Ms. Sharon Schultz encouraged everyone to get their flu shots and said it is not too late! She stated it is worrisome 21 people have died from the flu this year and only two out of five Americans receive the flu shot.

14. Report from TCHD Auxiliary, Pat Morocco, President

Mr. Pat Morocco, TCHD Auxiliary President reported in the past year the volunteers comprised of 375 seniors, 91 students and 61 Junior Volunteers have provided 72,670 hours of service to Tri-City Medical Center.

Mr. Morocco reported the Auxiliary awarded 87 Scholarships for a total of $68,500. 77 scholarships were awarded to Palomar College Mira Costa nursing students and 10 were awarded to Junior Volunteers. Mr. Morocco stated our major donor, the Argyros family awarded an additional $1,000 to each of the scholarship recipients for a grand total of $155,000.

Mr. Morocco highlighted the Auxiliary's events from 2016 and stated they are looking forward to another successful year in 2017.

Director Reno stated she is very happy to see that so many scholarships were awarded to the nurses and believes the scholarships give these nurses an incentive to improve their education. Director Reno noted she sat on the Task Force in 1999 that helped bring the Cal State Nursing Program here.

No action was taken.

15. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO expressed his appreciation to Mr. Pat Morocco, President of the Auxiliary and all the volunteers for their service. He stated the Auxilians make Tri-City different than any other hospital. Their passion shows through every day and that translates into the community.

Mr. Dietlin stated the Tri-City Carlsbad Marathon was a great community event with over 100 employee and Foundation volunteers, three medical tents, doctors, nurses, clinical and non-clinical volunteers. He commented on the Lucky 13 and their inspiring stories that remind us of why we are here, to serve the community.

Mr. Dietlin reported we are approximately six (6) months into the fiscal year and continue to move forward with our initiatives to expand healthcare services offered to this community. He stated that he expects value based reimbursement to expand and Tri-City is doing very well with those initiatives.

Mr. Dietlin stated efforts continue to reduce ED Wait times and we continue to see "leave without being seen" numbers decreasing.

Lastly, Mr. Dietlin stated we continue to move forward placing long term capital, continue to work with HUD and have locked in a rate below 5% which is what our goal was. He stated there is no guarantee until an actual funding occurs, however we remain extremely optimistic and hope to bring a resolution for financing to the Board within the next 60 days.

No action was taken.

19. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date as follows (Dollars in Thousands):

- Operating Revenue – $166,573

- Operating Expense – $166,794
- EBITDA- $10,726
- EROE - $3,095

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 182
- Adjusted Patient Days – 57,118
- Surgery Cases – 3,141
- Deliveries – 1,363
- ED Visits – 31,989

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $27,606
- Operating Expense – $28,269
- EBITDA - $1,556
- EROE - $317

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 180
- Adjusted Patient Days – 9,456
- Surgery Cases – 563
- Deliveries – 200
- ED Visits – 5,082

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.1
- Days in Net Accounts Receivable – 50.2

Mr. Rivas presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

Chairman Dagostino questioned where the PRIME revenue is listed in the financials. Mr. Rivas explained PRIME revenue will appear in our operating revenue and is spread out throughout the year. Mr. Rivas stated he will point that out in the future.

In response to a question by Director Schallock, Mr. Rivas stated we are below our projected Net Patient Revenue due to our reduction in volume, however staff is doing a good job of controlling expenses and supplies.

No action was taken.

20. New Business

a. Media Update

Chairman Dagostino stated there is no KOCT coverage today as the contract with KOCT as expired and it was felt this would be a good time to evaluate this expense.

He stated Mr. Dietlin and Mr. Bennett are taking a hard look at streamlining the overall Marketing budget and looking at how we outreach to the community. Chairman Dagostino stated he, along with Mr. Dietlin and Mr. Bennett met with Mr. Tom Reeser and got some eye opening information. Mr. Reeser communicated that viewership has been declining over the past years and he agreed there may be better methods to reach out to the community. Chairman Dagostino stated we are not aware of any other public healthcare district that televises their Board meetings. Additionally, Vista has not televised our meetings in the last two years. Director Kellett confirmed that Carlsbad also does not televise the meetings.

Mr. David Bennett provided a proposed list of topics that we might consider featuring on KOCT that would be of interest to our community and bring visibility to Tri-City. Director Mitchell questioned if we might consider doing our own direct streaming.

Director Kellett stated he would support broadcasting special features for those who don't use the computer and direct streaming as well.

Director Schallock suggested Mr. Bennett and Mr. Dietlin meet with Mr. Reeser and bring back ideas for the Board to consider that would be beneficial to the community not only through KOCT but through other media.

b. Consideration to approve Resolution No. 781, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Borrowing

Pursuant to discussion previously, Resolution 781 has been pulled from the agenda.

c. Consideration of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings

Chairman Dagostino stated Director Reno requested this item be placed on the agenda to discuss how the Consent Agenda is developed. Chairman Dagostino explained the Consent Agenda is developed by the Board Chair, CEO and General Counsel at the agenda conference.

Director Reno stated there has been some feedback from the community that the Consent Agenda may be abused or overused and some of the issues should be isolated and put on the regular agenda for discussion by the Board. She stated additionally, people have stopped coming to the Board meetings because everything is on the Consent Calendar. Director Reno did note that former consultant Mr. Witalis suggested the Board utilize a Consent Calendar for efficiency of running the meetings.

Director Reno stated another issue is that community members have commented that they are not getting enough information from the Audit Committee and our same auditor has been in place for two long.

Director Schallock stated prior to implementation of the Consent Agenda, Board meetings ran 5-6 hours. At the time the Consent Agenda was introduced it was explained that the main work is done at the committee level and when a conclusion is reached it comes forward to the Board through the Consent calendar. However, Board members also have the ability to pull an item from the Consent Calendar for discussion. Director Schallock stated he believes the process has worked quite well.

Director Nygaard stated all the Board Committee meetings are noticed, the agenda is posted on the website and the meetings are open to the public. She suggested that all items go to a Board committee before being placed on the Board agenda. Director Nygaard recommended the policy be sent back to the Governance Committee for clarification.

Director Kellett stated there are limitations as to what the Finance, Operations & Planning committee can approve on its own. Physician Recruitment Contracts must be listed separately and publicly voted on. Also, Administration is allowed to approve a certain dollar amount. Mr. Dietlin stated the maximum amount is $250,000.

The Board directed staff to bring Board Policy 16-010 back to the Governance & Legislative Committee for clarity.

d. Consideration of Board Policy 16-040 – Activities for which Board Compensation is Available

Chairman Dagostino stated the Governance Committee has requested that the Board consider reimbursement for Board members attending the Foundation and Auxiliary monthly Board meetings.

Director Kellett questioned if a Board member can be compensated for attending a meeting that is not a Board Meeting. Mr. Moser stated you can be compensated for attending other meetings if it is considered to be a service to the agency. He stated the District's Bylaws also provide some discretion in this regard. Chairman Dagostino clarified that there is a process in place where only one Board member attends the monthly meeting at a time.

Director Schallock stated state law provides that Board members are entitled to $100/meeting for a maximum of five (5) meetings per month or $500. Director Reno clarified that the meeting must be a minimum of 30 minutes long and compensation is limited to $50 per meeting in the advisory capacity for both Auxiliary and Foundation Board meetings.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve Board Policy 16-040 – Activities for which Board Compensation is Available. Director Mitchell seconded the motion.

Discussion continued. Chairman Dagostino stated debating this issue speaks to the character of this Board.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Kellett, Mitchell, Reno**
NOES:	**Directors:**	**Nygaard, Schallock**
ABSTAIN:	**Directors:**	**Grass**
ABSENT:	**Directors:**	**None**

e. Consideration to direct the Governance & Legislative Committee to develop a policy relative to contract approval process by the Board

Director Reno stated she had several concerns regarding the approval contract process. She expressed the need to have a summary sheet ready at the Board

meeting to aid Board members in their review of the contract outlining important and legal issues.

Secondly, Director Reno stated it is the Board's responsibility to oversee these contracts. She stated consultants have been hired over the past couple of years without Board approval and that concerns her.

Thirdly, she questioned what has happened to the bidding process in which three (3) RFP's would come to the Board and the Board would make the decision on who was selected based on cost efficiency. Director Reno stated she has not seen the Board participate in this process of late.

Director Reno commented on staff members who have brought to her attention that we are hiring consultants to do work in this hospital possibly to outsource. She stated she is not aware of any outsourcing but if so, the Board must be made aware. Director Reno suggested the Board look at the contract process at the Governance level.

Director Schallock agreed that these issues should be addressed at the Governance & Legislative Committee level with management input. Director Schallock asked Mr. Dietlin if we are outsourcing or trying to do outsourcing. Mr. Dietlin stated he is not aware of any outsourcing or any contracts that did not go through the Board that should have. He commented on agency nursing that is used when we are short staffed, however those contracts have come through the proper process. Director Reno stated the comments have nothing to do with Nursing and are more along the lines of Dietary and IT. Director Schallock reiterated Mr. Dietlin' s comments that at this time there is no effort at this point in time to outsource any positions. Mr. Conley stated we are looking at an operational assessment. He explained we have been without a Dietary Director for almost a year and have looked at companies to do an operational assessment, however there is no consultant in Dietary on the grounds. With regard to IT, Mr. Conley explained we do have IT support due to the fact that we have been without an interim leader, however that project did go through the Finance, Operations & Planning Committee. Director Reno stated her concerns are from both the employee and hospital's point of view.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors table both items e. and f. and refer the Board Contract process to the Governance & Legislative Committee for discussion and Board Policy 15-013 to the Finance, Operations & Planning Committee for review. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

f. Consideration of Board Policy 15-013 – Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services and Bidding for Public Works Contracts

Pursuant to previous discussion, Board Policy 15-013 will be referred to the Finance, Operations & Planning Committee for review.

g. Consideration to appoint Ms. Linda Ledesma, Ms. Xiomara Arroyo and Ms. Marilou de la Rosa Hruby to an additional two-year term on the Community Healthcare and Alliance Committee.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors appoint Ms. Linda Ledesma, Ms. Xiomara Arroyo and Ms. Marilou de la Rosa Hruby to an additional two-year term on the Community Healthcare and Alliance Committee. Director Kellett seconded the motion.

Director Nygaard stated these ladies have worked very hard and the committee unanimously supports their reappointment.

Director Reno stated per Board Policy committee members may serve a maximum of four (4) years and she believes Ms. Hruby has been on the committee past that time allotment. Director Nygaard stated if a committee member is serving by appointment they can be on the committee for an extended period of time. Director Nygaard indicated she would check on Ms. Hruby's role on the committee and report back.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

21. Old Business

a. Report from Ad Hoc Committee on Electronic Board Portal

Director Mitchell reported a Special Meeting is scheduled for February 7th to look at demonstrations of the three (3) platforms.

No action was taken.

22. Chief of Staff

a. Consideration of January 2017 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on January 23, 2017.

It was moved by Director Nygaard to approve the January 2017 Credentialing Actions and Reappointments involving the Medical Staff and Allied Health Professionals, as recommended by the Medical Executive Committee at their meeting on January 23, 2017. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Approval of Neurosurgery Privilege Cards.

It was moved by Director Mitchell to approve the Neurosurgery Privilege Card as recommended by the Medical Executive Committee on January 23, 2017. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

23. Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Schallock seconded the motion.

It was moved by Director Mitchell to pull item 20 (1) F. 2. a) Governance & Legislative Committee Charter. Director Schallock seconded the motion.

Director Schallock called for the vote.

The vote on the main motion minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

24. Discussion of items pulled from Consent Agenda

Director Mitchell, who pulled item 20 (1) F. 2. a) Governance & Legislative Committee Charter recommended the Charter be sent back to the Governance

Committee due to a potential change in the committee's purview of Medical Staff Privilege Cards.

It was moved by Director Mitchell to refer the Governance & Legislative Committee Agenda back to the committee. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

25. Reports (Discussion by exception only)

26. Legislative Update

Director Reno questioned what will happen to patients in the Affordable Care Act. Mr. Wayne Knight, Chief Strategy Officer stated there is no public direction as to where the ACA is going at this point and the new phrase is "amend and repair". Chairman Dagostino stated we may have a clearer picture after Legislative Days and the AHA Annual Meeting in May.

27. Comments by members of the Public

There were no comments by members of the public.

28. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

29. Board Communications

Director Schallock reported last Friday Stedman Graham meet with Tri-City leadership to talk about *The Oceanside Promise*, a community-wide commitment, anchored by the Oceanside Unified School District, to work together providing youth (and their families) with our best coordinated and data-driven efforts to ensure young people enter adulthood prepared to become successful leaders. Director Schallock stated a flyer was distributed at the Dais on another program that will be held next Wednesday and Thursday at the Veteran's Administration and El Camino High School, respectively, again focusing on our youth and getting the community involved in developing successful leaders.

Director Reno did not have any comments.

Director Nygaard reported yesterday the Community Healthcare & Alliance Committee held their kick off meeting for our Grants. She stated 40 people attended the event and she anticipates receiving many great grant proposals. She noted Brian Greenwald, Website Content Specialist spent a great deal of time explaining the digital application process to the attendees.

Director Nygaard also reported that ACHD Legislature Day is scheduled for April 3rd.

Director Grass expressed her appreciation to Mr. Bennett and his team for all their hard work in the marathon. She also expressed her appreciation to Dr. Ma and his team and the clinical staff that was there providing hands on care as the runners crossed the finish line.

Director Mitchell did not have any comments.

Director Kellett congratulated all who participated in the Tri-City Carlsbad Marathon.

30. Report from Chairperson

Chairman Dagostino expressed his appreciation to his colleagues for their hard work and service to the Board.

35. There being no further business Chairman Dagostino adjourned the meeting at 5:30 p.m.

_____
James J Dagostino, DPT
Chairman

ATTEST:

_____
Laura E. Mitchell, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

February 7, 2017 – 3:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on February 7, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
David Bennett, Chief Marketing Officer
Wayne Knight, Chief Strategy Officer
Glen Newhart, Chief Development Officer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 3:00 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Mitchell led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Mitchell to approve the agenda as presented. Director Schallock seconded the motion. The motion passed unanimously (7-0).

   Director Mitchell reported Board Max, one of the scheduled presenters, had to cancel unexpectedly and will not be presenting today.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

   New Business

   a) Consideration of alternative proposals for Board Portal electronic data processing and telecommunications goods and services

Presentations were given on two (2) Board Portal platforms, Diligent (Scott Mallery) and Board Effect (John Rooney). Each vendor provided a summary of their background and client base. Presentations focused on ease of use for the end user. Board members asked questions throughout each presentation.

At the conclusion of each presentation, Board Ad Hoc Chair, Director Mitchell requested that each vendor submit a proposal to include cost for 60 users, training and a list of clients in the southern California area.

Director Mitchell provided Board members with a comparison chart for both vendors as well as BoardMax (which will be presented at a later date) which reflected the features of each platform.

Discussion was held regarding the platform used by the Medical Executive Committee which in essence is a protected PDF that includes software for notetaking.

Members of the IT Department were present and answered questions as well.

5. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser, made an oral announcement of item listed on the February 7, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Existing Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed (6-1) with Director Reno voting no.

6. Chairman Dagostino adjourned the meeting to Closed Session at 5:00 p.m.

8. The Board returned to Open Session at 5:17 p.m. with all Board Members present with the exception of Director Reno.

9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in Closed Session.

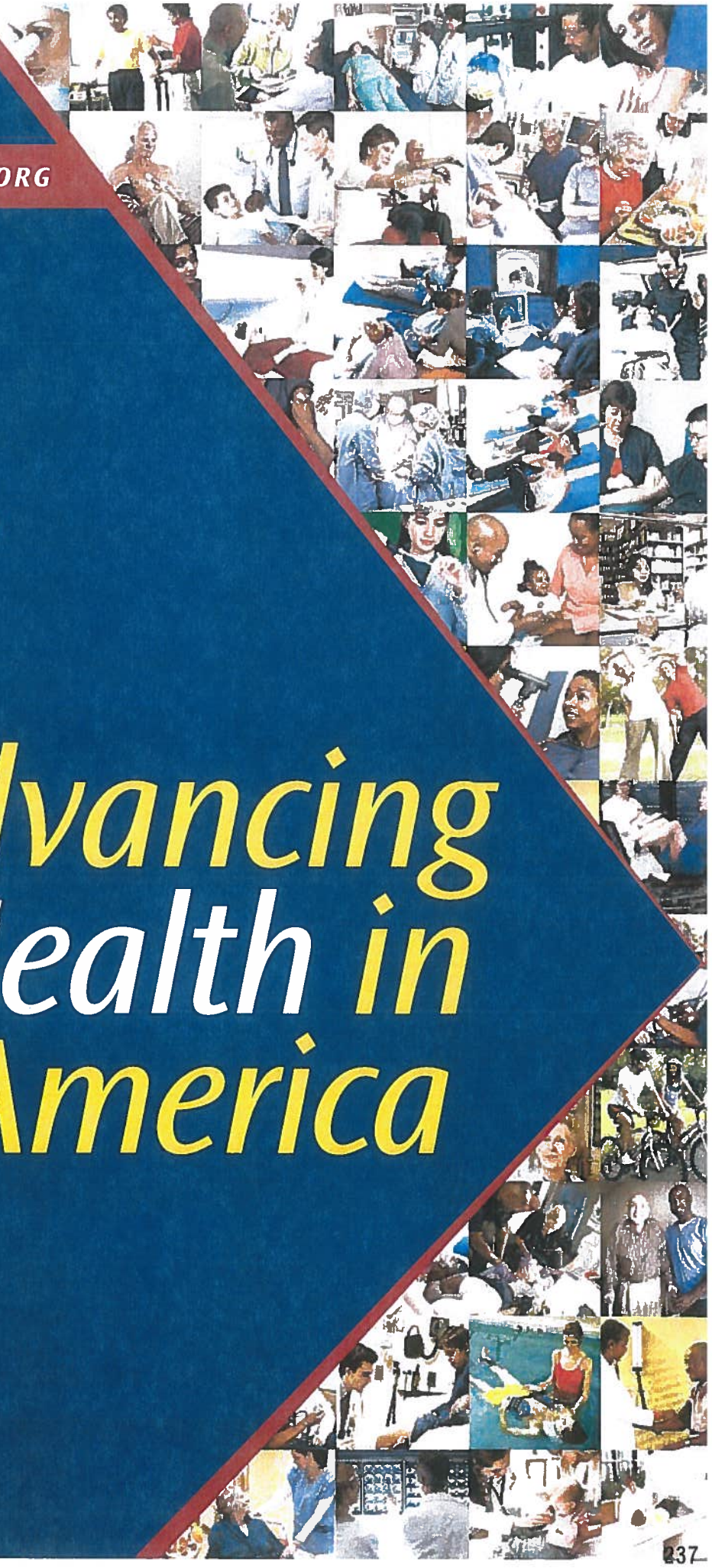
10. There being no further business, Chairman Dagostino adjourned the meeting at 5:18 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

REGISTER NOW AT WWW.AHA.ORG



American Hospital Association®

Advancing Health in America

ANNUAL MEMBERSHIP MEETING

MAY 7–10, 2017

WASHINGTON, D.C.

237

American Hospital Association

Dear Colleague:

Health care is changing and what the future holds depends largely on how we shape it. Political, policy, opinion and health care leaders will come together May 7-10, 2017 in Washington, D.C., at the AHA ANNUAL MEMBERSHIP MEETING. Don't miss this opportunity to be part of the discussion as hospitals and health systems continue to Advance Health in America. See you there!

Rick Pollack
President and CEO
American Hospital Association

SATURDAY MAY 6

3:00 P.M. – 5:00 P.M. **Registration**

5:00 P.M. – 6:30 P.M. **State Auxilian Leaders Welcome Reception**

SUNDAY MAY 7

7:00 A.M. – 5:00 P.M. **Registration**

8:00 A.M. – 9:00 A.M. **Liturgy of the Eucharist**
Sponsored by the Catholic Health Association of the U.S.
(BREAKFAST TO FOLLOW)

9:00 A.M. – 4:30 P.M. **State Auxilian Leaders Meeting**

11:00 A.M. – 12:00 P.M. **AHAPAC's Ben Franklin Club Reception**
Join AHAPAC for this exclusive event honoring Ben Franklin Club members. For more information on AHAPAC, please contact Shari Dexter at (202) 626-2338.

12:00 P.M. – 1:30 P.M. **AHAPAC Appreciation Luncheon**

Second City

Chicago-based **SECOND CITY** brings its improv humor to D.C. for this special AHAPAC appreciation luncheon. For more information on AHAPAC, contact Shari Dexter at (202) 626-2338.

1:45 P.M. – 3:15 P.M. **American College of Healthcare Executives (ACHE) Educational Session**

VALUE-BASED CARE DELIVERY — LOCAL MARKETS STILL RULE THE DAY

Brian J. Silverstein, M.D.

Interested in how organizations overcame challenges and how your organization can find a realistic value-based path forward? **BRIAN J. SILVERSTEIN, M.D.**, managing partner at HC Wisdom, will outline key operations from organizations delivering value-based care and improving outcomes as well as reducing total costs.
Participants will receive 1.5 ACHE Face-to-Face Education credits for this session. See registration form for information on how to register.

1:45 P.M. – 3:15 P.M. **Trustee Educational Session I** R

WHITHER THE SOUL OF TRUSTEESHIP? EFFECTIVE GOVERNANCE IN A TIME OF CHALLENGE AND CHANGE

James E. Orlikoff

Governance expert **JAMES E. ORLIKOFF**, president, Orlikoff & Associates, Inc., will identify the trends impacting boards and address the changing soul of governance, outlining take-home strategies for effective governance in these challenging times.

Special Briefings R

1:45 P.M. – 3:15 P.M. **RURAL ROUNDTABLE**
Learn what federal legislative and regulatory activity will impact rural hospitals, including Medicare extenders, 340B, and direct supervision, and hear what Congress and the administration are planning.

1:45 P.M. – 3:15 P.M. **PROTECTING 340B**
Policy experts weigh in about the latest developments in the 340B Drug Pricing Program.

1:45 P.M. – 3:15 P.M. **POST-ACUTE CARE**
Hear from innovative hospital/post-acute partnerships that bridge the continuum of care through improved referrals, case management, at-risk arrangements and post-acute networks to improve care and lower costs.

1:45 P.M. – 3:15 P.M. **UNDER THE MACRASCOPE – AN UPDATE ON THE PHYSICIAN QUALITY PAYMENT PROGRAM**
The Medicare Access and CHIP Reauthorization Act changes to clinician payment are here to stay and will impact clinicians and hospitals alike. Join us for the latest developments from CMS and how they may impact your MACRA implementation.

3:30 P.M. – 4:45 P.M. **ASSOCIATE MEMBER BRIEFING**
At this special briefing, AHA associate members hear the latest developments in the health care field and how to become involved in AHA's mission and 2017 objectives.
The AHA associate membership is comprised of commercial firms and non-hospital health providers.

3:30 P.M. – 4:30 P.M. **NEW MEMBERS/FIRST-TIME ATTENDEES**
Get the most from AHA membership and maximize your annual meeting experience through this special briefing.

3:30 P.M. – 4:45 P.M. **AHA DIVERSITY ROUNDTABLE**
Be part of the conversation around how best practices and national collaborative efforts are reducing health care disparities and promoting diversity within the health care field.

ATTENDANCE KEY
By invitation only.
Tickets for this event are $43 per person and can be purchased using the registration form.
This is included in your registration fee; please indicate whether you will attend on the registration form.

5:00 P.M. – 6:00 P.M. **Annual Meeting Opening Ceremony and Investiture of Chairman, AHA Board of Trustees**


Gene Woods

Celebrate the investiture of GENE WOODS, president and CEO of Carolinas HealthCare System, as 2017 chairman of the AHA Board of Trustees.

6:00 P.M. – 7:30 P.M. **Reception honoring the Chairman and AHA Board of Trustees**

MONDAY MAY 8

6:30 A.M. – 4:00 P.M. **Registration**

7:00 A.M. – 8:15 A.M. **Hospital Awards for Volunteer Excellence Recognition Breakfast**

AHA leaders, volunteers, auxilians and hospital executives recognize excellence in volunteer programs and the service hospital volunteers and auxilians provide to patients, hospital staff and their communities.

7:00 A.M. – 8:15 A.M. **Sections for Metropolitan and Small/Rural Hospitals Breakfast Meeting**


Nicolle Wallace

NICOLLE WALLACE, political analyst, New York Times best-selling author and former White House director of communications under President George W. Bush, shares her political insights.

$5 from every purchased ticket benefits the AHA Rural Hospital Leadership Award.

8:30 A.M. – 10:30 A.M. **Federal Forum Opening Plenary**


Frank Sesno

RICK POLLACK, AHA president and CEO, kicks off the federal forum and sets the stage for public policy and advocacy discussions. TOM NICKELS, AHA executive vice president of government relations and public policy, with FRANK SESNO, former CNN Washington bureau chief, review the key issues impacting hospitals on Capitol Hill, and within the administration. We will also honor the 2017 AHA Distinguished Service Award winner.

10:45 A.M. – 12:15 P.M. **Executive Briefings**

Attend one of these concurrent briefings on challenges and opportunities facing the hospital field.

HEALTH CARE POLITICS: CONGRESSIONAL CHIEFS OF STAFF PANEL

Congressional chiefs of staff discuss how policy and politics play out in the health and hospital field. Moderated by ERIK RASMUSSEN, AHA vice president legislative affairs.

Connect with colleagues and AHA leadership in the EXECUTIVE NETWORKING LOUNGE open to all attendees.


M. Michelle Hood

ACHIEVING MEANINGFUL REGULATORY RELIEF

This session, moderated by AHA board member M. MICHELLE HOOD, president and CEO of Eastern Maine Healthcare Systems, will focus on AHA's work cataloguing the full sweep of regulatory requirements along with opportunities for reducing the current regulatory burden that hospitals and health systems face.

CONTINUING THE MOVE TO VALUE IN CHANGING TIMES


Rodney F. Hochman, M.D.

Get a timely update on CMS efforts to increase participation in alternative payment and delivery models in the Trump administration. In addition, hospital/health system leaders share their own experiences with the move to value. Moderated by AHA board member RODNEY F. HOCHMAN, M.D., president and CEO of Providence St. Joseph Health.

10:45 A.M. – 12:15 P.M. **Trustee Educational Session II**

LEADING AND ENGAGING BOARDS IN IMPROVING COMMUNITY HEALTH


Philip Newbold

How can governing boards guide traditional business models focused on health care to one of health and well-being? PHILIP NEWBOLD, Beacon Health System president and CEO, explains how boards can better understand community health needs, set priorities and allocate resources for community health initiatives, and guide the organization's work with community partners.

10:45 A.M. – 12:15 P.M. **State Auxilian Leaders Meeting**

12:30 P.M. – 2:15 P.M. **AHA Recognition Luncheon**


Bret Baier

AHA Chairman GENE WOODS is joined by special guest BRET BAIER, FOX News Channel's chief political anchor and host of the *Special Report with Bret Baier*, to honor recipients of AHA's leadership awards.

12:30 P.M. – 2:15 P.M. **Government Relations Officers Network Luncheon**


Ana Navarro

ANA NAVARRO, CNN Political Analyst and GOP Strategist, shares insights on the election, politics and what it means for America.

2:30 P.M. – 4:00 P.M. **Federal Forum Plenary**


Trent Lott


Tom Daschle

Former senators TRENT LOTT and TOM DASCHLE, coauthors of "Crisis Point: Why We Must — and How We Can — Overcome our Broken Politics in Washington and Across America," talk

"The AHA Annual Meeting is the 'go-to' event to learn how health policy decisions are going to affect my hospital. I consider it part of my board responsibilities to attend."

— Anthony C. Stanowski, DHA, Board of Trustees, Bon Secours Baltimore Health System, Baltimore, Maryland


Kelly O'Donnell

to **KELLY O'DONNELL**, NBC News Capitol Hill Correspondent, about how our country must move beyond politics to governing. We'll also honor the 2017 AHAPAC Award Winners.

4:30 P.M. – 5:50 P.M. **Trustee Reception**

TUESDAY MAY 9

6:30 A.M. – 12:00 P.M. **Registration**

7:00 A.M. – 8:15 A.M. **ACHE Breakfast Meeting**


Chuck D. Stokes

Network with fellow ACHE colleagues and get the latest news from ACHE Chair **CHARLES "CHUCK" D. STOKES**, FACHE, executive vice president and COO of Memorial Hermann Health System.

7:00 A.M. – 8:15 A.M. **Trustee Leadership Breakfast: National Political Update**


David Gregory

DAVID GREGORY, journalist and former moderator of NBC's *Meet the Press*, shares insights and political predictions for 2017.

7:00 A.M. – 8:15 A.M. **Equity of Care Breakfast** R

Ensuring the highest quality of care requires a focus on health care disparities and their reduction. Join us as we hear from experts on how equity of care and the promotion of diversity can benefit your organization.
Presented by the AHA's Institute for Diversity.

8:30 A.M. – 9:45 A.M. **Executive Briefings** R

Attend one of these concurrent briefings on challenges and opportunities facing the hospital field.

MAKING HEALTH CARE MORE AFFORDABLE


David Entwistle

Government, private sector and hospital and health system leaders discuss policies, technologies, and other approaches that reduce costs and make health care more affordable. Moderated by AHA board member **DAVID ENTWISTLE**, president and CEO of Stanford Health Care.

THE FUTURE OF HEALTH CARE COVERAGE


Wright L. Lassiter III

With a new administration and Congress, the future of coverage for millions of Americans is uncertain. Get an update on where Congress and the Trump administration stand on "repeal and replace" of the Affordable Care Act and an assessment of potential coverage alternatives as well as implications for hospitals and health systems. Moderated by AHA board member **WRIGHT L. LASSITER III**, president and CEO of Henry Ford Health System.

THE PATH FORWARD TO ENSURING ACCESS TO ESSENTIAL HEALTH CARE SERVICES IN VULNERABLE COMMUNITIES


Randy Oostra

AHA board member **RANDY OOSTRA**, president and CEO of ProMedica Health System, moderates a discussion on public policy initiatives that support integrated, comprehensive strategies to reform health care and delivery in rural and inner city communities as outlined in the AHA Task Force on Ensuring Access in Vulnerable Communities.

8:30 A.M. – 9:45 A.M. **Trustee Educational Session III** R

CREATING A CULTURE OF INNOVATION AND SAFETY: FROM THE BOARDROOM TO THE BEDSIDE


Todd Linden

Learn techniques to engage board members in patient safety goals. **TODD LINDEN**, Grinnell Regional Medical Center president and CEO, explores how generative thinking in the boardroom leads to innovative solutions to foster a culture of safety.

10:00 A.M. – 11:30 A.M. **Federal Forum Closing Plenary**


Hugh Hewitt

HUGH HEWITT, host of *The Hugh Hewitt Show* and NBC News analyst, explores the current political climate. The 2016 Foster G. McGaw Prize winner is honored.

12:30 P.M. – 2:00 P.M. **The Foster G. McGaw Prize Luncheon**

This luncheon, hosted by The Baxter International Foundation, honors the 2016 Foster G. McGaw Prize winner and finalists. The Foster G. McGaw Prize recognizes excellence in community service and is jointly sponsored by The Baxter International Foundation, AHA and Health Research & Educational Trust.

3:30 P.M. – 5:00 P.M. **State Caucuses**

WEDNESDAY MAY 10

9:00 A.M. – 5:00 P.M. **State Delegation Capitol Hill Visits**

Contact your state hospital association for Capitol Hill visit details.

AHA Events

REGISTER NOW AT WWW.AHA.ORG

REGISTRATION INFORMATION

DEADLINES:

By Mail: **APRIL 21**
Online: **MAY 5**
Register by **MARCH 24** and **SAVE!**

HOW TO REGISTER

ONLINE: Register with credit card only at **WWW.AHA.ORG.**

MAIL: Download the registration form from **WWW.AHA.ORG.** Mail your form and check to:

American Hospital Association
2017 AHA Annual Membership Meeting
75 Remittance Drive, Suite 6881
Chicago, IL 60675-6881

For registration, customer service and overnight mail instructions, call **(844) 441-9610** (9 a.m. – 5 p.m. ET).

ON-SITE: Register on-site using a check or credit card at the Washington Hilton, **MAY 6 – MAY 9.**

REGISTRATION FEES

Attend the AHA Annual Membership Meeting

(includes the Federal Forum Plenary Sessions, choice of Trustee Educational Sessions, Executive and Special Briefings, AHA Board Chair Investiture and Reception, AHA Recognition Luncheon, and Equity of Care Breakfast):

- **$850** AHA Member – **EARLY BIRD: $800 BY MARCH 24**
- **$450** State, Regional and Metropolitan Hospital Association Staff
- **$700** Regional Policy Board, Committee on Governance, Governing Council Member
- **$950** AHA Associate Member
- **$1,100** Non-AHA Member

Register your spouse and/or student

- **$125** for Spouse or Student

Add the Sunday ACHE Educational Session to your Annual Membership Meeting Registration

- **$150 EARLY BIRD** for AHA Member by **MARCH 24**
- **$200** for AHA Member and Non-AHA Member

ACHE programming must be added to a full meeting registration.

ACHE EDUCATION CREDITS

Attendees of the **Sunday ACHE Education Session** will receive **1.5 HOURS** of ACHE Face-to-Face Education credits.

For All Annual Meeting Attendees:

AHA is authorized to award **10.5 HOURS** of pre-approved ACHE Qualified Education credit for the **AHA Annual Membership Meeting** toward advancement, or recertification, in the American College of Healthcare Executives. Participants in this program who wish to have the continuing education hours applied toward ACHE Qualified Education credit must self-report their participation. To self-report, participants must log into their MyACHE account and select ACHE Qualified Education Credit.

CANCELLATIONS

Cancellations must be made in writing via email to **aharegistration@expologic.com**. Refunds, less a $150 service fee, will be given for the AHA Annual Membership Meeting registration and special events, if written cancellation is received no later than **APRIL 21**. No refunds will be given after **APRIL 21**. You can send a substitute. Please call registration customer service at **(844) 441-9610.**

HOTEL INFORMATION

The Washington Hilton
1919 Connecticut Ave., NW (at Columbia Road, NW)
Washington, D.C. 20009

(800) 445-8667 or **(202) 483-3000**

You must be registered for the AHA Annual Membership Meeting to reserve a room at the Washington Hilton. Your registration confirmation email will contain a link to a special AHA-Hilton web page, along with an event code. You can use this web page to book your room anytime before the AHA hotel block expires on Friday, April 14. You can also make a reservation by phone by providing the code to a reservation agent. You will only be able to make one room reservation per registrant.

RATES: Single: **$341**
Double: **$351**
Single Executive Level Room: **$361**
Double Executive Level Room: **$371**

Please contact the Hilton directly at **(202) 483-3000** for suite rates and availability. ***Hotel reservations must be made no later than FRIDAY, APRIL 14.***

TRAVEL DISCOUNTS

The following carriers are offering special meeting discounts for all attendees of the the AHA Annual Membership Meeting. Simply call (or have your travel agent call) one of our preferred airlines directly to receive these special fares.

DELTA AIRLINES ticketing, call **1 (800) 328-1111.**
Refer to Meeting Code **NMPDK.**

UNITED AIRLINES ticketing, call **1 (800) 426-1122.**
Refer to Meeting Code **ZXPJ620165.**

HERTZ car rental reservation, call **1 (800) 654-2240.**
Refer to Meeting Code **CV#03AB0013.**

ENTERPRISE & NATIONAL car rental reservation, call **1 (800) 261-7331.**
Refer to Meeting Code **K2C1074.**

"I look forward to this meeting each year."

— Craig E. Aasved, CEO, Shodair Children's Hospital, Helena, Montana

Stakeholder Experience

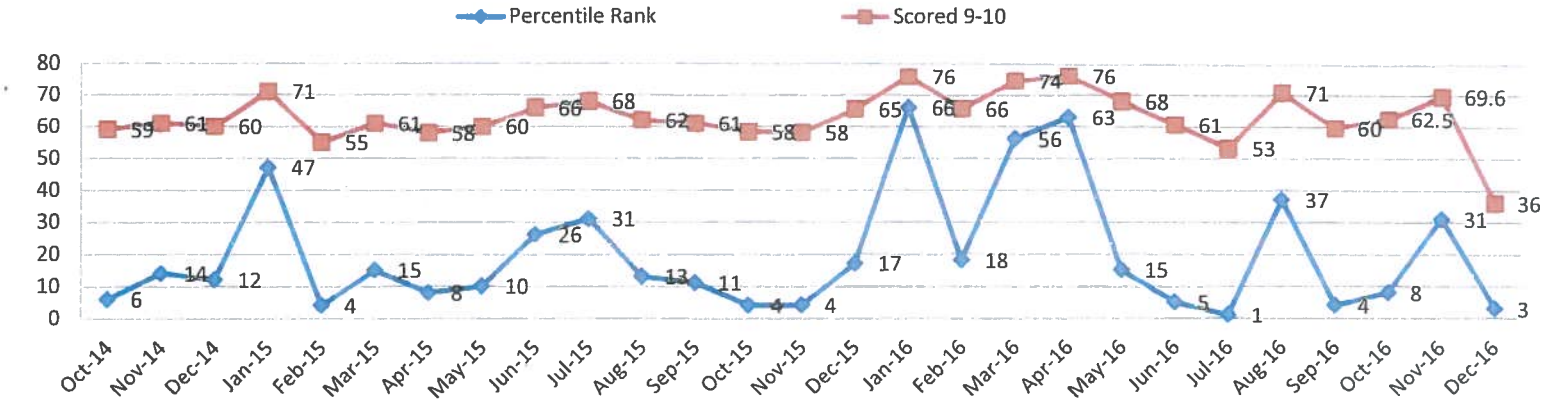
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

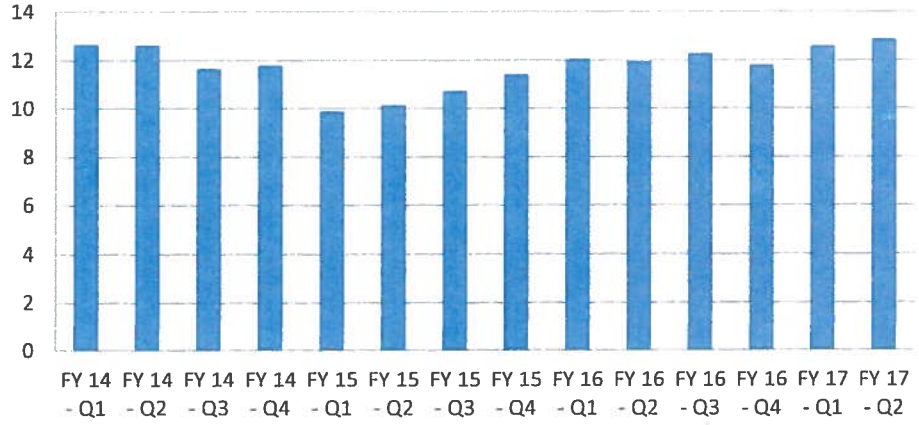
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

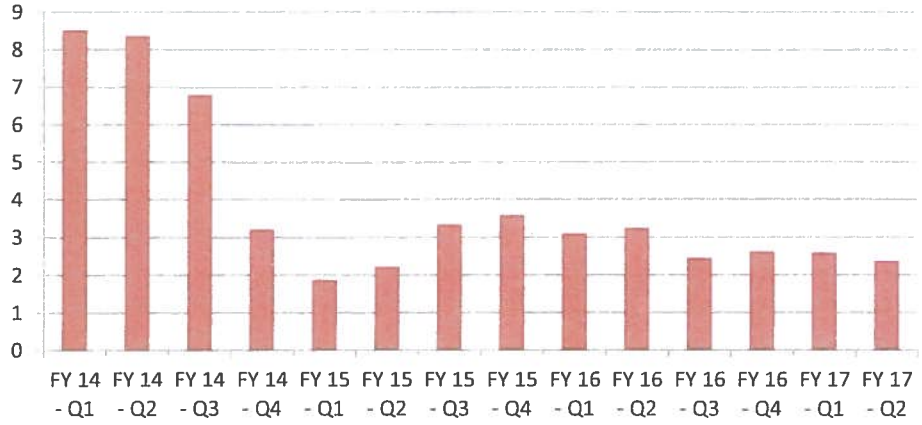
Overall Rating of Hospital (0-10)



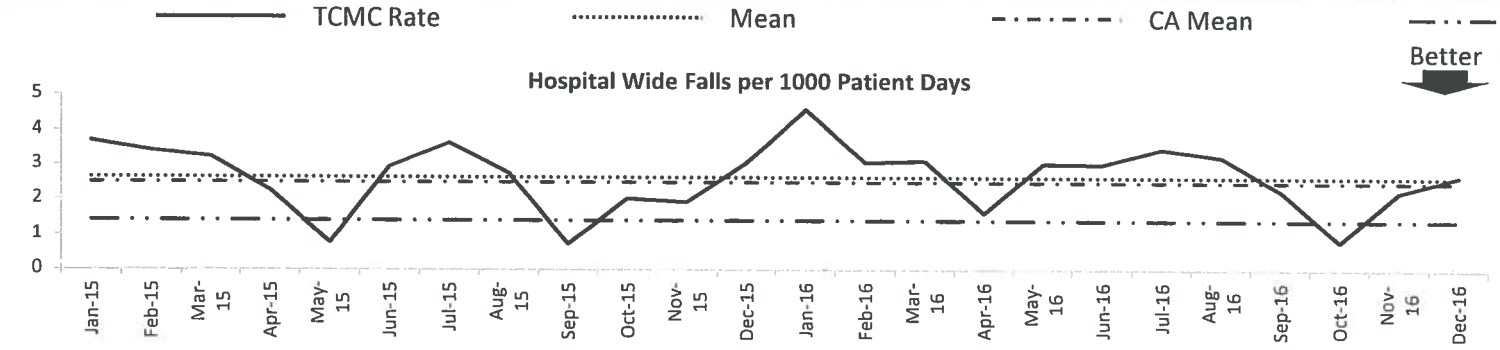
Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

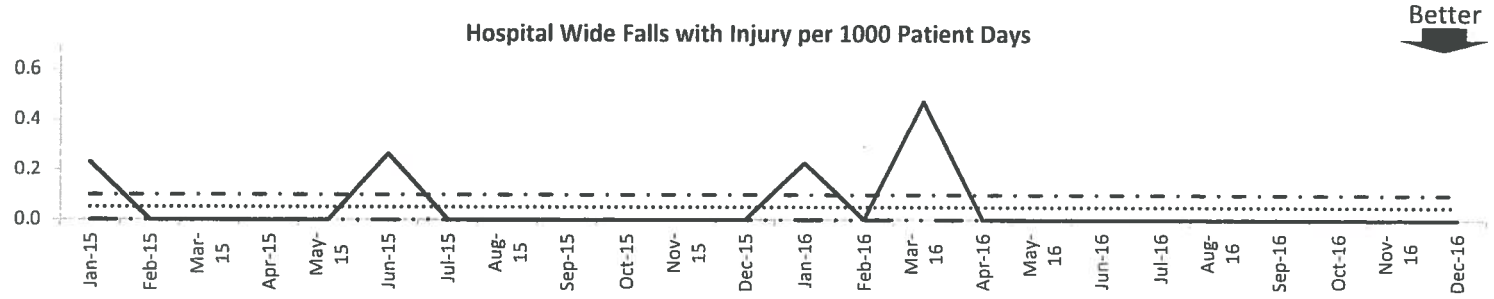


Fall & HAPU's



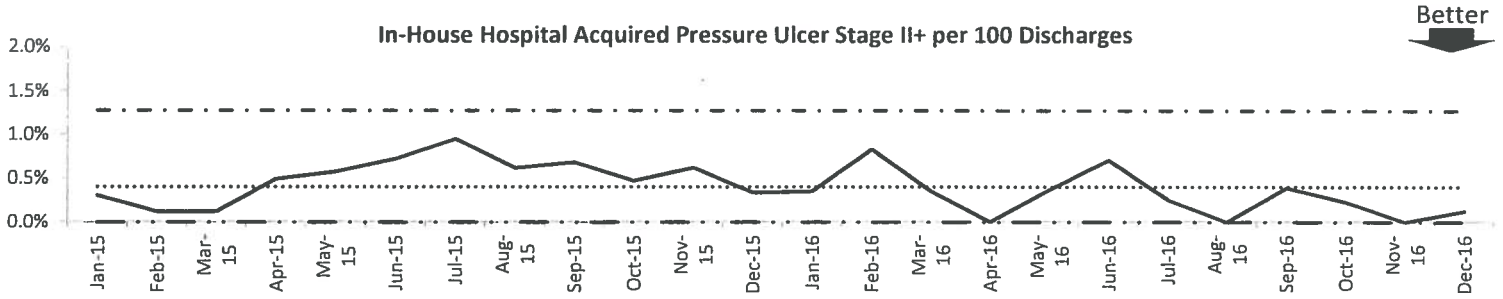
Action Plan

45 CHARMS Mnemonic Poster created by Maria Coy RN, Telemetry ANM (See below) C: Call Lights answered immediately
H: Hand-off of high risk patients
A: Assist woth Toileting and Activities
R: Rounding
M: Magnets and Signs visible
S: Sign Safety Plan for all Patients



Action Plan

(Cont) We appreciate a 16% decrease in FY2016 compared to FY 2015 related to the TST Falls prevention tool.
9 consecutive months without a Fall with Injuries.



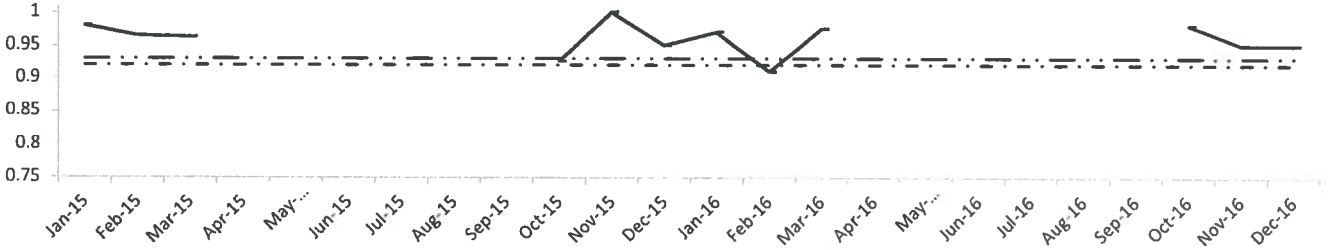
Action Plan

HAPUs are now called Pressure Injuries instead of Ulcers. Unstagable, Stage 3 or 4 Hosp Acquired Press Injuries must have prompt RL and are reported to State.
Excluded injuries include: Diabetic lesions, perineal dermatitis, Stage 1 or 2 injuries, Moisture Associated Skin Damage, or traumatic skin. Staff education on these revised guidelines are in process.

Core Measures

TCMC Rate — Mean — CA Mean — TCMC Target

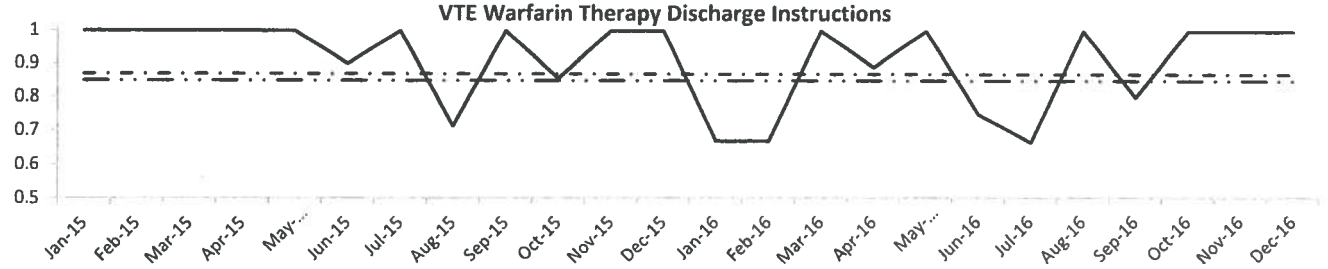
Influenza Immunization



Action Plan

Consistently above our goal.

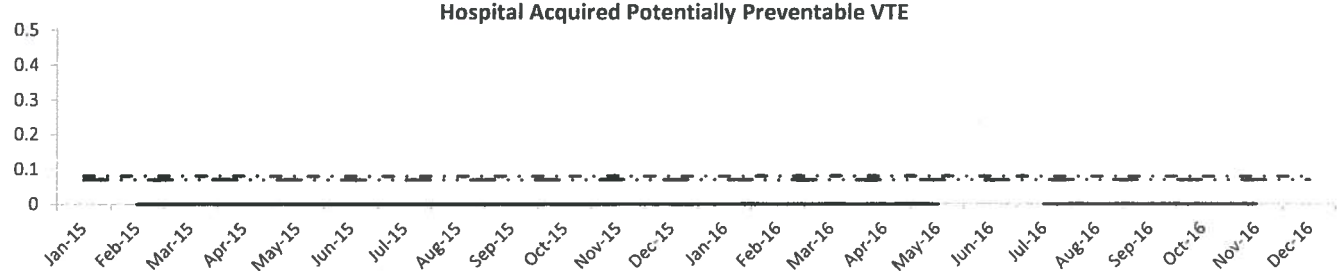
VTE Warfarin Therapy Discharge Instructions



Action Plan

100% for 3 consecutive months.
Redesign and education showing results.
This measure is now retired by CMS & Joint Comm.

Hospital Acquired Potentially Preventable VTE

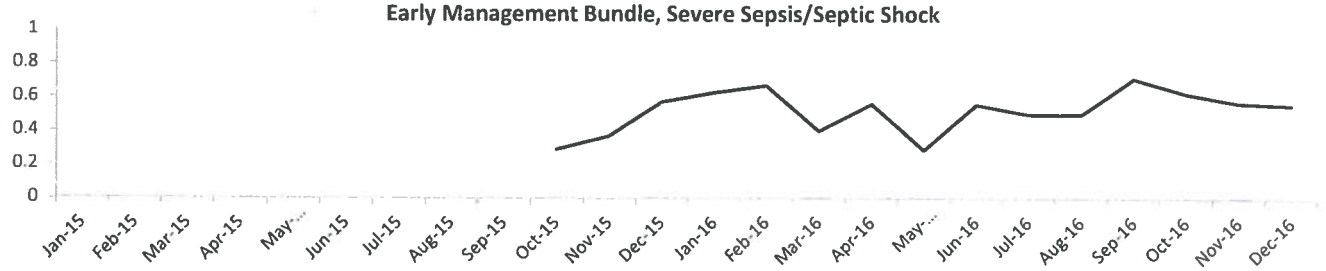


Action Plan

No cases this month. Consistently at 0%.

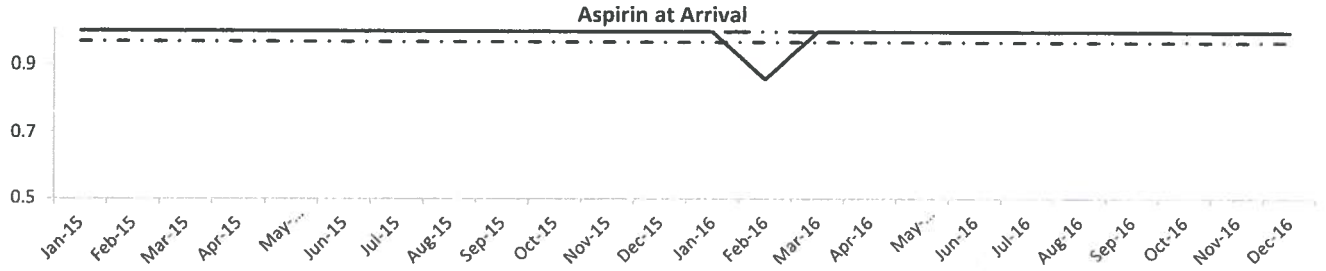
Core Measures

TCMC Rate Mean CA Mean TCMC Target



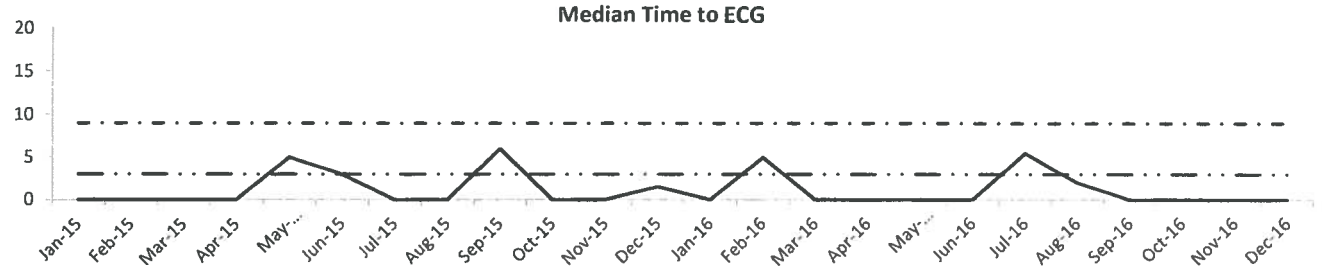
Action Plan

Conitinued challenge with slow trend better. We have fixed several issues only to find new challenges. Current work on Code Sepsis in ED. Our results appear comparable to other hospitals.



Action Plan

Consistantly at 100%.

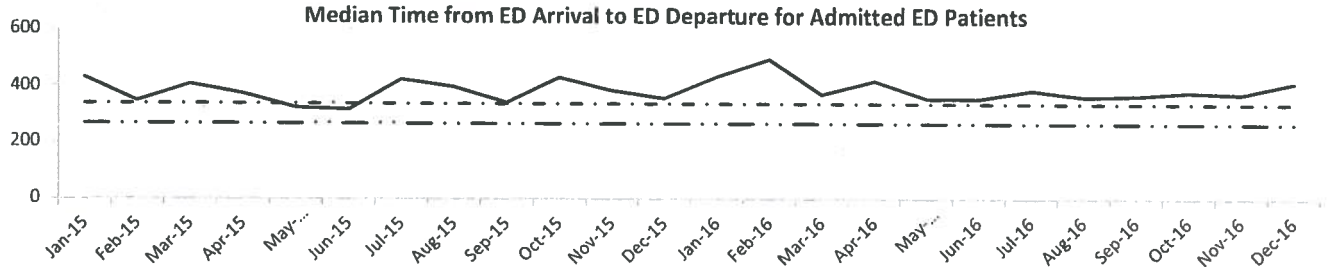


Action Plan

Consistently at "0" minutes arrival to 1st ECG. Below national top 10%.

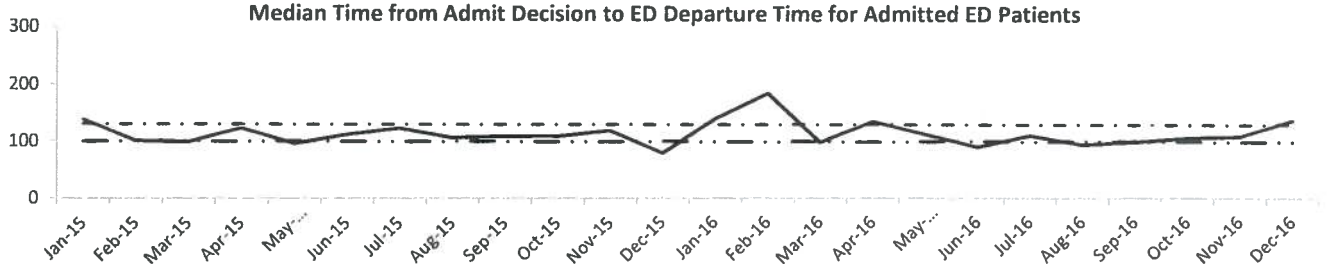
Core Measures

TCMC Rate Mean CA Mean TCMC Target



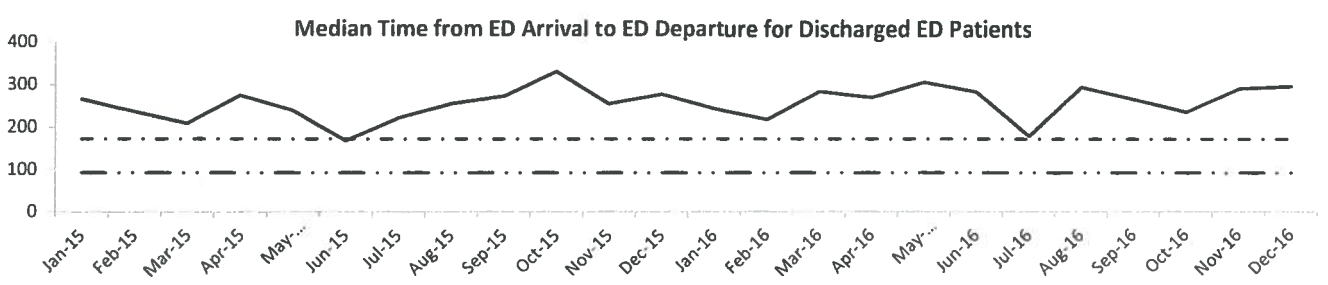
Action Plan

Holding steady the last six months, continue to work on initiatives to further lower this rate.



Action Plan

Rate has been steady for many months, continue to work on improving admission process to floors.

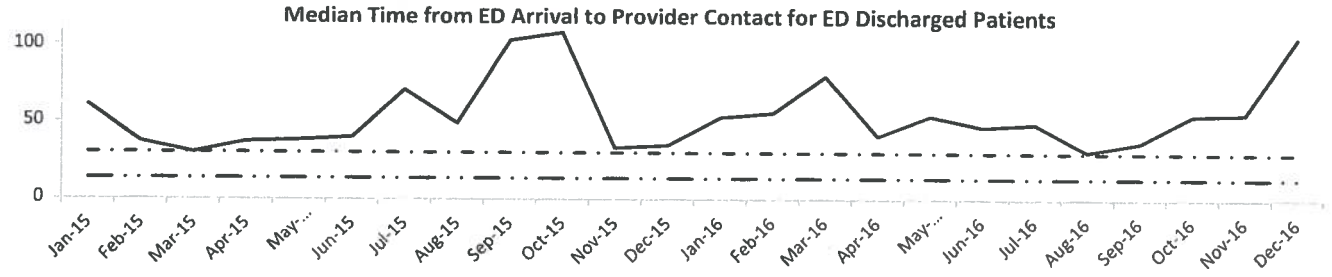


Action Plan

Seeing an increase in time, in part due to backlog of CSU patient throughput as well as ED Staffing issues. Piloting new Zoomer RN to assist with this which looks promising.

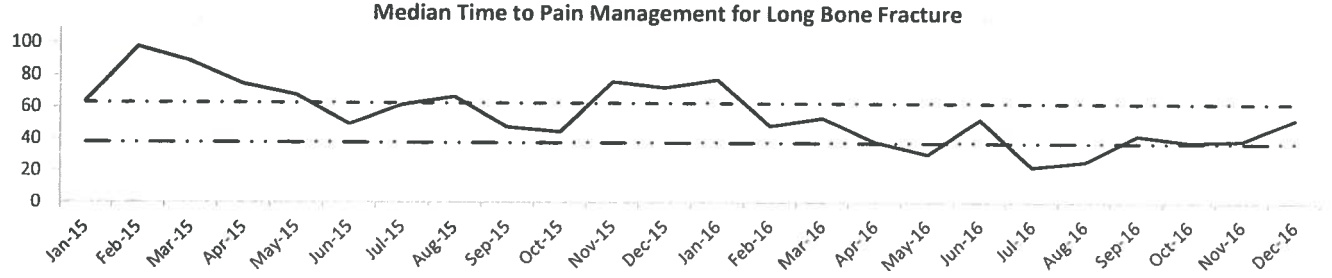
Core Measures

TCMC Rate Mean CA Mean TCMC Target



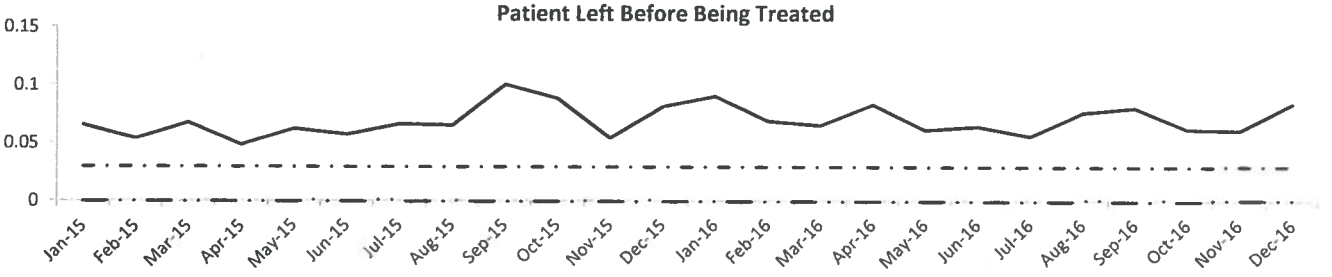
Action Plan

Team Triage has expanded hours, should be seeing a reduction in these times in the months ahead



Action Plan

CMS criteria is pain med administration within 60 min of arrival. Currently below that level. Process redesign and education has met our goal of 40 min median time for 2 months.



Action Plan

This rate increases when satuation hits the ED, have developed algorithm to predict when expect to see LWBS rate increase to be more proactive. Institute Code Surge.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	28	22	13	25	27	23	19					157
FY16	49	29	30	30	23	29	23	28	32	27	27	356

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	9	9	5	13	12	11	10					69
FY16	20	19	15	23	12	13	16	15	15	17	8	188

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	8	11	8	13	12	8	12					72
FY16	9	10	8	8	13	11	9	13	14	8	8	120

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	18	18	17	14	20	22	20					129
FY16	16	19	13	4	7	9	15	20	15	13	17	163

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	31	35	29	42	34	29	31					231
FY16	40	36	37	44	34	33	45	39	38	39	38	473

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4					15.9
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5	15.2	14.5	15.3	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6					6.4
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6	5.0	6.5	5.5	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5					16.3
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3	13.5	16.0	17.1	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0					182.5
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0	186.7	200.7	183.9	191.9

Performance compared to prior year: Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	223	239	274	230	197	200	217					1580
FY16	215	214	252	227	232	220	216	183	209	189	208	2565

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	12	11	12	16	11	14	15					91
FY16	16	9	19	12	16	10	11	15	15	15	18	168

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	4	4	6	6	5	7	2					34
FY16	7	3	7	4	5	7	6	6	6	4	2	64

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	10	9	8	7	6	9	8					57
FY16	7	14	4	6	7	10	2	8	13	12	5	95

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61					1.69
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63	1.65	1.60	1.66	1.62

Performance compared to prior year: Better Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9						49.9	48-52
FY16	46.7	45.7	45.7	45.3	47.0	49.1	51.7	48.9	49.5	50.4	47.4	46.7	47.3	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6						85.6	75-100
FY16	83.6	85.8	92.1	88.7	84.0	82.5	83.6	81.1	81.4	81.1	81.1	80.7	86.1	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$288	$211	$746	$1,118	$414	$317	($226)						$2,869	$1,453
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315	($1,842)	$135	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%						1.47%	0.72%
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%	-0.77%	1.13%	1.09%	-6.82%	0.07%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010						$11,735	$10,591
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598	($558)	$8,436	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%						6.01%	5.24%
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%	3.56%	5.22%	5.55%	-2.07%	4.35%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26						6.04	6.04
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43	6.07	5.86	6.09	5.99	5.99	

TCHD Fixed Charge Coverage Covenant Calculation

	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	TTM Jun	Covenant	
FY17	1.37	1.37	1.37	1.59	1.73	1.50	1.35						1.10	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73	1.70	1.82	1.63	1.47	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7						
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5	$24.8	$28.0	$37.6	$31.7	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending January 31, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm Ending	Services & Location
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.85	(a)	10,102.89	4/1/2016	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.63	(a)	20,106.00	2/1/2015	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,265.25	12/01/15	12/31/20	**PCP Clinic** 2375 Melrose Dr. Vista Vista, CA 92081
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.92	(a)	3,398.15	01/01/13	01/31/17	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	9,998.67	09/01/12	08/31/17	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.37	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.00	(a)	25,580.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$2.11	(a)	5,039.70	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	246,428.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009
Total				**$340,019.67**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending 1/31/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	CERNER CONFERENCE	120816	1,325.62	82875	DEBRA DERUYTER
6185	CERTIFICATE RENEWAL	120816	103.00	80795	MARIA FATIMA MERCADO
6340	CHA BHC SYMPOSIUM	122016	114.64	80707	JOY MELHADO
8390	CHA MEDICATION COURSE	121416	151.68	81328	THERESA VIDALS
8390	ASHP MEETING	121316	262.13	79349	TORI HONG
8390	ASHP MEDYEAR CONFERENCE	10417	505.71	82539	OSKA LAWRENCE
8510	CRYSTAL REPORTS TRAINING	742416	2,571.43	82564	STEVE DAY; ERNIE MIER
8510	COST AND CONTRACTING TRAINING	741040	4,500.00	82564	ERNIE MIER
8618	CRYSTAL REPORTS TRAINING	742416	1,285.71	82564	CONNIE KRESSIN
8620	LEADERSHIP ACADEMY REGISTRATION	123116	150.00	81163	LEIGH ANNE GRASS
8650	WORKPLACE STRATEGIES SEMINAR	120716	795.00	82746	NORMA BRAUN
8740	DISTRESSED COUPLES SEMINAR	10517	120.19	71410	TONY VITRANO
8740	SCANN CONFERENCE	121516	165.00	78458	LESLIE SEMANA
8740	AHA PALS PROGRAM	12617	190.00	82803	CHARA COTE
8740	PCCN PREP COURSE	11217	200.00	80935	FRANK DICINTIO
8740	CEN PROGRAM	122216	200.00	9715	SHIRLEY ARMSTRONG
8740	RN TO BSN	122216	2,500.00	82567	JENNIFER GLEAVES
8740	BSN-RN-CCRN	10517	4,326.66	81414	LORAL J. STANDISH
8740	MBA-HEALTHCARE	122216	5,000.00	37799	PRIYA JOSHI
8756	CRYSTAL REPORTS TRAINING	742416	2,571.43	82564	RICK SANCHEZ; JESS THRIFT
8764	CRYSTAL REPORTS TRAINING	742416	1,285.71	82564	KATIE PRESNALL
8765	CRYSTAL REPORTS TRAINING	742416	1,285.72	82564	JENELLE LOVELADY

**This report shows payments and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

Julie Nygaard
February 5,2017

Seminar Title: 2017 Leadership Academy

Location Sacramento
Dates February 2 and 3rd

This is a good opportunity to provide Newly elected and Returning District Trustees and Executives with relevant public sector resources and governance tools necessary to improve governance, effectiveness, sharpen organizational intelligence and be successful. It is a great opportunity to get to know other directors and network.
This years program was filled with useful up to date information on governing. One of the most interesting sessions for me was the one on LAFCOS Pamela Miller Executive Director for California Association of Local Agency Formation Commission was the speaker. She did a good job giving us clear picture of what LAFCO do and why they were formed. I think it would be useful for us to bring her down to talk to our whole board.
Robert Nelson give a very good discussion on Board Culture and Strategic Governance. He stressed the importance of board having a clear plan and always referring back to it when making decisions for the District. He was very clear about how important it was to carefully listen to each other and diversified points of view when trying to solve problems. He said that finding a shared vision that was clear was very important to moving district forward.
There was a very good session on Strategic Messaging. Amanda Gordan talked about how very important it is to have a clear message that explains the relevance and the value of our district to the community and its leaders. She talked about how very important social media is to getting our story out. She talked about how important it is for our board members to be in the community telling our story. We all have to be singing that same song. It was particularly interesting to me since we are doing an evaluation of how we get our message out right now. We have to make sure that we are covering all the possible ways to let people what an important part of our community we are.
Gary Winuk gave a very good overview of the Brown Act. He was an engaging speaker on a topic can sometime be less than exciting. He was very through is going over all the important issues that could cause a problem for board members.
Finally Dan Heckathorne gave a very good talk about things to look our for when evaluating our financial condition of our district. He gave us practical tips on what to be looking for to keep our district sound.

I thought it was a very good conference covering a wide range of topics to help board members understand their role in the governance of the district.

Key State Issues

Latest News on Key Bills in the State Legislature

CALIFORNIA HOSPITAL ASSOCIATION

October 7, 2016

During the final month of the 2016 legislative session, lawmakers sent 1,051 bills to Governor Brown to sign or veto. In the end, the Governor signed 893 bills and vetoed 158. For an online version of this report that can be filtered by topic and is updated daily, visit www.calhospital.org/key-state-issues.

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Civil Actions					
SB 1065	Monning (D-Carmel)	Requires the court of appeal, in an appeal of an order dismissing or denying a petition to compel arbitration involving a claim under the Elder and Dependent Adult Civil Protection Act in which a party has been granted a court preference, to issue its decision no later than 100 days after the notice of appeal is filed, except as specified. Also requires the Judicial Council to adopt rules implementing this provision and shortening the time within which a party may file a notice of appeal in these cases.	Signed by the Governor Sept. 25 (Chapter 628).	Neutral	Jackie Garman/ Connie Delgado
Disaster Preparedness					
AB 1562	Kim (R-Fullerton)	Would have provided a one-day window to purchase disaster preparedness supplies without paying sales tax, giving hospitals and medical centers the opportunity to purchase a variety of items — such as evacuation equipment, communications equipment and medical supplies — with a tax break. The one-day sales tax would have also assisted businesses in encouraging individual and family preparedness among their employees, which is foundational to organizational preparedness. This measure was amended to add a sunset date of 2018 and would have applied only to state taxes.	Held on Suspense in Assembly Appropriations Committee May 27.	Support	Cheri Hummel/ Kathryn Scott
Emergency Services					
SB 867	Roth (D-Riverside)	Extends the operative date of the Maddy Emergency Services Fund to Jan. 1, 2027, and authorizes each county to establish an emergency services fund for reimbursement of costs related to emergency medical services.	Signed by the Governor Aug. 19 (Chapter 147).	Co-sponsor	BJ Bartleson/ Connie Delgado
Health Facilities					
AB 1774	Bonilla (D-Concord)	Would have repealed the laws requiring a clinical laboratory to be licensed and inspected by CDPH, including the licensing fee. Would have also made other conforming changes.	Held on Suspense in Assembly Appropriations Committee May 27.	Support	Cathy Martin/ Alex Hawthorne
AB 1843	Stone (D-Scotts Valley)	Prohibits all California employers from soliciting or using any information related to an applicant's juvenile criminal history record, from arrests to adjudications. Amendments allow health facilities to obtain juvenile adjudication information related to sex or drug-related crimes, but not all felonies.	Signed by the Governor Sept. 27 (Chapter 686).	Oppose, Unless Amended	Kathryn Scott/ Gail Blanchard-Saiger

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Health Facilities (continued)					
AB 2743	Eggman (D-Stockton)	Would have required the California Department of Public Health to establish and administer a pilot program to create a website-based acute psychiatric bed registry to collect, aggregate and display information about the availability of acute psychiatric beds in psychiatric health facilities in 10 counties.	Held on Suspense in Assembly Appropriations Committee May 27.	Oppose	Sheree Lowe/ Alex Hawthorne
SB 1076	Hernandez (D-Azusa)	Creates the regulatory structure for hospitals wishing to provide observation services in a dedicated unit. The bill states that observation patients may also be cared for in an inpatient unit or in the ED. The observation unit must maintain the same nurse staffing ratios as the ED. The bill clarifies that observation services are triggered by a physician order, rather than potentially applying to all outpatient services. The bill also requires patient notification when the patient is moved to observation status.	Signed by the Governor Sept. 27 (Chapter 723).	Neutral	Debby Rogers/ Connie Delgado
Labor					
AB 1978	Gonzalez (D-San Diego)	Requires Cal/OSHA to develop a standard for workplace violence for janitorial workers as well as four-hour training for any supervisor of janitorial workers. Also creates a registry for janitorial contractors.	Signed by the Governor Sept. 15 (Chapter 373).	Follow, Hot	Gail Blanchard-Saiger/ Kathryn Scott
AB 2272	Thurmond (D-Richmond)	Would have required Cal/OSHA to develop, by June 1, 2018, rules to regulate plume — noxious airborne contaminants generated as byproducts from specific devices used during surgical, diagnostic and therapeutic procedures — and the evacuation of plume when generated in acute care hospitals.	Vetoed by the Governor Sept. 30.	Oppose, Unless Amended	Gail Blanchard-Saiger/ Kathryn Scott
AB 2467	Gomez (D-Los Angeles)	Would have required private nonprofit general acute care hospitals, acute psychiatric hospitals, private for-profit general acute care hospitals, hospital groups and hospital-affiliated medical foundations to annually submit an executive compensation report for every executive employee whose annual compensation exceeds $250,000 per year. As amended in committee, the measure would have required the collection and reporting of ethnicity, race, gender, sexual orientation and gender identity information.	Failed passage on Assembly Floor June 2.	Oppose	Gail Blanchard-Saiger/ Kathryn Scott
SB 878	Leyva (D-Chino)	Would have required employers operating retail establishments or restaurants, including cafeterias, to provide at least seven days' notice of an employee's work schedule and further require additional pay to employees when the employer alters that schedule within the seven-day period.	Held on Suspense in Senate Appropriations Committee May 27.	Follow, Hot	Gail Blanchard-Saiger/ Kathryn Scott

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Managed Health Care					
AB 72	Bonta (D-Alameda)	Addresses surprise billing for covered services at a contracting health facility from a non-contracting individual health professional. AB 72 is similar to AB 533 (Bonta, D-Alameda). This bill requires health plans to reimburse the noncontracting health professional the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. Amendments to the bill have placed obligations on health plans when reporting average contract rates and maintaining network adequacy requirements. AB 72 is the new version of AB 533.	Signed by the Governor Sept. 23 (Chapter 492).	Neutral	Deepa Prasad/ Alex Hawthorne
AB 533	Bonta (D-Alameda)	Attempted to address "surprise billing" by out-of-network providers. The introduced version of the bill contained ambiguities that could have been interpreted to impose obligations on network hospitals to provide information they do not have and/or cannot obtain for noncontracted physicians. Amended April 15 for clarification, the bill would have applied only to noncontracting individual health professionals, not to hospitals.	Placed on Assembly Inactive file Aug. 31.	Neutral	Deepa Prasad/ Alex Hawthorne
SB 932	Hernandez (D-Azusa)	Would have prohibited numerous provisions in contracts between hospitals and health plans, as well as expanded the authority of the Department of Managed Health Care to approve any merger, consolidation, acquisition or purchase of control, directly or indirectly, between any entity and any health care service plan.	Held on Suspense in Senate Appropriations Committee May 27.	Oppose	Deepa Prasad/ Alex Hawthorne
Medi-Cal					
AB 1568	Bonta (D-Alameda)	Along with SB 815 (Hernandez, D-Azusa), implements California's section 1115(a) demonstration waiver, titled "California's Medi-Cal 2020 Demonstration." The waiver renewal — effective Dec. 30, 2015, through Dec. 31, 2020 — includes $6.2 billion of initial federal funding to support the state's Medi-Cal program. The waiver implements the following programs: Public Hospital Redesign and Incentives in Medi-Cal, Global Payment Program, Dental Transformation Initiative and Whole Person Care Pilots. The waiver also contains several independent analyses of the Medi-Cal program and evaluations of the waiver programs, including an assessment of access in the Medi-Cal managed care program and studies of uncompensated care in California hospitals.	Signed by the Governor July 1 (Chapter 42).	Support	Anne McLeod/ Barbara Glaser
AB 1607	Assembly Budget Committee	Extends the hospital quality assurance fee by one year, to Jan. 1, 2018.	Signed by the Governor June 27 (Chapter 27).	Support	Anne McLeod/ Barbara Glaser
SB 586	Hernandez (D-Azusa)	Authorizes the Department of Health Care Services to establish a Whole Child Model for children enrolled in both Medi-Cal and the California Children's Services (CCS) Program in the 21 counties served by the four county organized health systems. It continues the CCS carve-out in the remaining 37 counties until Jan. 1, 2022.	Signed by the Governor Sept. 25 (Chapter 625).	Follow, Hot	Amber Kemp/ Barbara Glaser

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Medi-Cal (continued)					
SB 815	Hernandez (D-Azusa)	Along with AB 1568 (Bonta, D-Alameda), implements California's section 1115(a) demonstration waiver, titled "California's Medi-Cal 2020 Demonstration." The waiver renewal — effective Dec. 30, 2015, through Dec. 31, 2020 — includes $6.2 billion of initial federal funding to support the state's Medi-Cal program. The waiver implements the following programs: Public Hospital Redesign and Incentives in Medi-Cal, Global Payment Program, Dental Transformation Initiative and Whole Person Care Pilots. The waiver also contains several independent analyses of the Medi-Cal program and evaluations of the waiver programs, including an assessment of access in the Medi-Cal managed care program and studies of uncompensated care in California hospitals.	Signed by the Governor July 25 (Chapter 111).	Support	Anne McLeod/ Barbara Glaser
Medical Staff					
AB 2024	Wood (D-Healdsburg)	Authorizes a critical access hospital to employ physicians, surgeons and doctors of podiatric medicine and charge for professional services rendered by those medical professionals if the medical staff concurs, by an affirmative vote, that such employment is in the best interest of the communities the hospital serves. It prohibits the critical access hospital from directing or interfering with the professional judgment of a physician or surgeon.	Signed by the Governor Sept. 23 (Chapter 496).	Support	Peggy Wheeler/ David Perrott/ Barbara Glaser
SB 1177	Galgiani (D-Stockton)	Authorizes the healing arts board of the Department of Consumer Affairs' Substance Abuse Coordination Committee to establish a physician and surgeon health and wellness program for early identification and appropriate interventions to support a physician or surgeon in his or her rehabilitation from substance abuse.	Signed by the Governor Sept. 24 (Chapter 591).	Support	David Perrott/ Connie Delgado
Mental Health					
AB 38	Eggman (D-Stockton)	Establishes a state fund to reimburse the Regents of the University of California for providing early intervention, assessment, diagnosis and treatment to individuals with severe mental illness and children with severe emotional disturbance. The Early Diagnosis and Preventive Treatment (EDAPT) Program Fund will accept moneys from federal or private funds; when the total amount reaches $1,200,000, the state Controller will give it to the Regents. The Regents will study the current EDAPT program operated by UC Davis and report to the Legislature by Jan. 1, 2023, on its outcomes and cost effectiveness.	Signed by the Governor September 24 (Chapter 547).	Support	Sheree Lowe/ Alex Hawthorne
AB 1300	Ridley-Thomas (D-Los Angeles)	Would have specified that trained emergency room physicians and psychiatric professionals in non-designated hospitals, when probable cause exists, have the authority to write/initiate an up to 72-hour involuntary hold. It would have also codified that the 5150 application form is valid in all counties regardless of whether it is an original or a copy; clarified that all designated facilities are required to accept, within their clinical capability and capacity, all individuals for whom it is designated; and authorized improved sharing of patient information when emergency services are provided.	Referred to Senate Rules Committee.	Sponsor	Sheree Lowe/ Barbara Glaser

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Mental Health (continued)					
AB 2279	Cooley (D-Rancho Cordova)	Would have required the Department of Health Care Services (DHCS) to develop and administer instructions for the compilation of revenue and expenditure information related to the Mental Health Services Act (MHSA) by counties, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California. Would have also permitted DHCS to withhold MHSA funds from counties that do not submit their annual MHSA report until the report is submitted.	Vetoed by the Governor Sept. 14.	Support	Sheree Lowe/ Alex Hawthorne
SB 938	Jackson (D-Santa Barbara)	Would have required a patient with a major neurocognitive disorder who has a conservator to ask a court for judicial approval each time a physician orders a new or different antidepressant, sleeping pill, anti-anxiety medication, antipsychotic or other psychotherapeutic drug. While well intentioned, this bill would have jeopardized patients' access to timely and appropriate medical care, clogged the court system and resulted in higher medical and legal costs for these patients and their families.	Placed on Assembly Inactive file Aug. 29.	Oppose	Sheree Lowe/ Alex Hawthorne
SB 1273	Moorlach (R-Costa Mesa)	Would have clarified that California's counties may use funds from the Mental Health Services Act to provide outpatient stabilization services to individuals voluntarily receiving those services, even when those who are receiving services involuntarily are treated at the same facility.	Placed on Assembly Inactive file Aug. 29.	Support	Sheree Lowe/ Alex Hawthorne
Nursing Services					
AB 1306	Burke (D-Inglewood)	Would have removed the physician supervision requirement on certified nurse midwives, allowing them greater independence in meeting the health care needs of the millions of individuals added to California's health care system by the Affordable Care Act and facilitating timely access to quality care.	Failed passage by full Assembly Aug. 31.	Support	Jackie Garman/ BJ Bartleson/ David Perrott/ Connie Delgado
SB 323	Hernandez (D-Azusa)	Would have allowed nurse practitioners to practice to the full extent of their education and training to ensure access to health care delivery systems for millions of Californians who now have access to coverage under the Affordable Care Act.	Held in the Assembly Business and Professions Committee June 28.	Support	BJ Bartleson/ Connie Delgado
SB 1195	Hill (D-San Mateo)	Would have provided requirements and procedures for the Director of Consumer Affairs to review a decision or other action by a board under the Department about a restraint of trade. Among other things, would have prohibited the Board of Nursing executive director from being a licensee of the board.	Placed on Senate Inactive File June 2.	Follow, Hot	BJ Bartleson/ Connie Delgado

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Professional Workforce Education					
SB 66	Leyva (D-Chino)/ McGuire (D-Healdsburg)	Requires the Department of Consumer Affairs to make available, upon request by the Office of the Chancellor of the California Community Colleges, information on every licensee so that the Office of the Chancellor can better measure employment outcomes of students who participate in career technical education programs and make recommendations as to how these programs may be improved. The bill also urges the Chancellor to align these measures with the performance accountability measures of the federal Workforce Innovation and Opportunity Act.	Signed by the Governor Sept. 28 (Chapter 770).	Support	Cathy Martin/ Alex Hawthorne
Public Health					
AB 508	Garcia (D-Bell Gardens)	Would have established the California Maternal Quality Care Collaborative (CMQCC) within CDPH. The bill has been amended to require CDPH to prepare and submit to the Legislature an annual report on maternal mortality and morbidity in California, including an analysis of maternal deaths and severe maternal morbidity. The bill also would have required CDPH to consider existing resources, including opportunities for partnerships with other entities and the use of physician volunteers.	Held in Senate Judiciary Committee.	Follow, Hot	David Perrott/ Alex Hawthorne
AB 2424	Gomez (D-Los Angeles)	Would have created the Community-based Health Improvement and Innovation Fund within the state treasury. A target level of annual statewide investment from the fund would have been established as a set dollar amount per capita, to be allocated to the CDPH to support community-based prevention of priority chronic health conditions throughout the state, including in the form of competitive grants.	Held on Suspense in the Senate Appropriations Committee Aug. 11.	Follow	Amber Kemp/ Kathryn Scott
AB 2439	Nazarian (D-Sherman Oaks)	Creates a CDPH pilot program to select four or fewer hospital emergency departments to offer HIV tests to patients. CHA originally opposed the bill as an unfunded mandate and inappropriate setting to conduct HIV tests, but removed opposition with amendments that made hospital participation in the pilot program voluntary.	Signed by the Governor Sept. 26 (Chapter 668).	Follow, Hot	David Perrott/ Debby Rogers/ Alex Hawthorne
AB 2640	Gipson (D-Carson)	Requires every medical provider who orders an HIV test to provide information to specified patients about methods that prevent or reduce the risk of contracting HIV, including pre-exposure prophylaxis and post-exposure prophylaxis, consistent with guidance of the federal Centers for Disease Control and Prevention. CHA opposed this bill on the grounds that it codifies the practice of medicine into law; however, an agreement was reached with the author to ensure physician discretion is preserved. Amendments addressed CHA's concerns.	Signed by the Governor Sept. 26 (Chapter 670).	Neutral, as Amended	David Perrott/ Debby Rogers/ Alex Hawthorne

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Reimbursement					
SB 1365	Hernandez (D-Azusa)	Requires a hospital that offers a service in a hospital-based outpatient clinic to provide a notice to each patient when that service is available in a non-hospital-based location.	Signed by the Governor Sept. 23 (Chapter 501).	Neutral	Amber Ott/ Barbara Glaser
Skilled-Nursing Facilities					
AB 1518	(Committee on Aging and Long-Term Care)	Would have increased access to the home and community-based Medi-Cal Nursing Facility/Acute Hospital Waiver by increasing the number of authorized waiver slots and requiring an expedited authorization process for patients in acute care hospitals who are awaiting discharge to a skilled-nursing facility.	Placed on Senate Inactive File.	Support	Pat Blaisdell/ Jackie Garman/ Barbara Glaser
SB 503	Hernandez (D-Azusa)	Would have addressed deficiencies in current law identified by a judge in a recent court decision for the treatment of unrepresented patients who lack capacity to make medical decisions. The bill would have allowed skilled nursing facilities (SNFs) to continue to obtain consent for the care of a patient by using an interdisciplinary team process, if the SNF provides a specified written notice to the patient. The bill also would have required that, prior to administering an antipsychotic drug to a SNF patient, the SNF convene a hearing with the patient, the ordering physician, an independent physician, a patient advocate and an interpreter (if necessary) to review the medication order. The independent physician and advocate would have had to meet a list of qualifications; the physician had to also issue a written decision. The patient could not have been billed for the services of the independent physician, advocate or interpreter. CDPH, the bill sponsor, decided not to move the bill forward this year.	Held in Assembly Health Committee.	Oppose, Unless Amended	Lois Richardson/ Alex Hawthorne