**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**March 30, 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<br>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<br>(Authority: Government Code, Section 54957.7) | | |
| 5 | Motion to go into Closed Session | | |
| 6 | Closed Session | **2 Hours** | |
| | a. Conference with Labor Negotiators:<br>(Authority: Government Code, Section 54957.6)<br>Agency Negotiator: Steve Dietlin<br>Employee organization: CNA | | |
| | b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees<br>(Authority: Health & Safety Code, Section 32155) | | |
| | c. Reports Involving Trade Secrets<br>(Authority: Health and Safety Code, Section 32106)<br>Discussion Will Concern: Proposed new service or program<br>Date of Disclosure: March 30, 2017 | | |
| | d. Reports Involving Trade Secrets<br>(Authority: Health and Safety Code, Section 32106)<br>Discussion Will Concern: Proposed new service or program<br>Date of Disclosure: December 31, 2017 | | |
| | e. Conference with Legal Counsel – Potential Litigation<br>(Authority: Government Code, Section 54956.9(d) (7 Matters) | | |

*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 |
|---|---|---|---|
| | f. Conference with Real Estate Negotiators: APN: 165-362-36<br>(Gov. Code Section 54956.8)<br>Negotiating Parties: Tri-City Healthcare District and OPS Enterprises<br>Agency Negotiator: Steve Dietlin<br>Under Negotiations: Transfer of Shares | | |
| | g. Approval of prior Closed Session Minutes | | |
| | h. Conference with Legal Counsel – Existing Litigation<br>(Authority: Government Code, Section 54956.9(d)1, (d)4<br><br>(1) Medical Acquisitions Company vs. TCHD<br>Case No: 2014-00009108<br><br>(2) TCHD vs. Medical Acquisitions Company<br>Case No: 2014-00022523<br><br>(3) Larry Anderson Employment Claims<br><br>(4) SEIU-UHW v. Tri-City Healthcare District<br>PERB Case Number LA-CE 1079-M | | |
| | i. Public Employee Evaluation: General Counsel<br>(Authority: Government Code, Section 54957) | | |
| | j. Public Employee Evaluation: Chief Compliance Officer<br>(Authority: Government Code, Section 54957) | | |
| 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<br>(Authority: Government Code, Section 54957.1) | | |
| 10 | Roll Call / Pledge of Allegiance | 3 min. | Standard |
| 11 | Public Comments – Announcement<br>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.<br>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 | Special Presentation<br>1) Recognition of Vista Unified School District for use of kitchen/dish machine during piping issue<br><br>2) Recognition of hospital leadership during our recent kitchen closure caused by basement pipe break | 5 min.<br><br>5 min. | COO/Chair<br><br>Chair |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 13 | Introductions:<br><br>a) Himani Singh, M.D.<br>b) Aaron Boonjindasup, M.D. | 10 min. | CSO |
| 14 | Community Update –<br>a) Media | 10 min. | CMO |
| 15 | Report from TCHD Auxiliary– Pat Morocco – Auxiliary President | 5 min. | Standard |
| 16 | Report from Chief Executive Officer | 10 min. | Standard |
| 17 | Report from Acting Chief Financial Officer | 10 min. | Standard |
| 18 | New Business | | |
| | a. Consideration to appoint Dr. Gene Ma, Interim Medical Director, Employee Health | 5 min. | CHRO |
| | b. Consideration to approve 60 day extension to the Employee Leasing Agreement with Venus Medical Group. | 5 min. | CSO/CCO |
| | c. Consideration to match community donations for the Back Pack Program for North County schools not to exceed $100,000 | 10 min. | Chair/Director Schallock |
| 19 | Old Business | | |
| | a. Consideration to direct staff to implement plans related to an internal Board Portal as described in the Report of the Ad Hoc Technology Committee dated March 30, 2017 | 10 min. | Director Mitchell |
| 20 | Chief of Staff<br>a. Consideration of March 2017 Credentialing Actions and Reappointments Involving the Medical Staff<br><br>b. Privilege Cards:<br>1) Anesthesiology | 5 min. | Standard |
| 21 | Consideration of Consent Calendar<br><br>(1) Board Committees<br>***(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.***<br>***(2) All items listed were recommended by the Committee.***<br>***(3) Requested items to be pulled require a second.***<br><br>**A. Human Resources Committee**<br>Director Kellett, Committee Chair<br>Open Community Seats – 0<br>(No meeting held in March, 2017) | 5 min. | Standard<br><br>HR Comm. |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | **B. Employee Fiduciary Retirement Subcommittee**<br>Director Kellett, Subcommittee Chair<br>Open Community Seats – 0<br>(No meeting held in March, 2017) | | Emp. Fid. Subcomm. |
| | **C. Community Healthcare Alliance Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 3<br>*(Committee minutes included in Board Agenda packets for informational purposes)* | | CHAC Comm. |
| | **D. Finance, Operations & Planning Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 0<br>*(Committee minutes included in Board Agenda packets for informational purposes)*<br><br>a. Approval of an agreement with Cerner for the required Meaningful Use project, beginning May/June for a one time fixed fee, total cost of $297,000.<br><br>b. Approval of an agreement with In Motion, Inc. for three (3) events scheduled in January of 2018, 2019 and 2020, for an annual cost of $150,000 and a total cost for the term of $450,000.<br><br>c. Approval of an agreement with Dr. Henry Showah, as the Inpatient Wound Care Physician for a term of 12 months beginning March 1, 2017 through February 28, 2018, not to exceed an average of two (2) hours a month, at an hourly rate of $150 for a total cost for the term of $3,600.<br><br>d. Approval of an agreement with Dr. Henry Showah as the Wound Care/HBO – Carlsbad Coverage Physician for a term of 12 months from March 1, 2017 through February 28, 2018, not to exceed an average of six (6) hours a month, at an hourly rate of $150 for a total cost for the term of $10,800.<br><br>e. Approval of a lease agreement with Achieve TMS for a term of 60 months, beginning April 1, 2017 through March 31, 2022 for an annual rent received of $9,600 (plus % annual increase) for a total amount for the term of $50,968.<br><br>f. Approval to add Dr. Anton Kushnaryov to the currently existing ED On Call Coverage Panel for ENT for a term of 15 months, beginning April 1, 2017 through June 30, 2018.<br><br>g. Approval to add Drs. Rahele Esfandiari, Eimaneh Mostofian and Marlene Poutney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 15 months, beginning April 1, 2017 through June 30, 2018.<br><br>h. Approval to authorize Neurology Physicians, Drs.Andrew Blumenfeld, Bilal Choudry, Laura Desadier, Benjamin Frishberg, Gary Gualberto, Any Nielsen, Irene Oh, Remia Paduga, Ray Rosenber, Mark Sadoff, Gregory Sahagian, Jack Schim, Anchi | | FO&P Comm. |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | Wang, Chunyang Tracy Wang, and Michael Zupancic to the Neurology ED-Call Coverage for a term of 12 months, beginning July 1 2017 through June 30, 2018 at a daily rate of $740, for an annual cost of $270,100 and a total cost for the term of $270,100.<br><br>i. Approval of an agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 through March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565.<br><br>j. Approval of an agreement with Immucor, Inc. for Echo Blood Type and Screen Instrument and Consumables for a term of five (5) years beginning March 1, 2017 through February 28, 2022, for an annual cost of $114,936 and a total cost for the term of $574,680.<br><br>k. Approval of an agreement with the University of California San Diego Health System for Medical Directorship and management of the Behavioral Health Unit and Crisis Stabilization Units for a term of 36 months, beginning April 1, 2017 through March 31, 2020, for an annual cost of $1,238,215 and a total cost for the term of $3,715,740.<br><br>**E. Professional Affairs Committee**<br>Director Mitchell, Committee Chair<br>*(Committee minutes included in Board Agenda packets for informational purposes)*<br><br>1) **Patient Care Services**<br>a. ALARIS System Data Set Approval and CQI Activities Procedure<br>b. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure<br>c. Care of the Newborn Standardized Procedure<br>d. Deceased Newborn Stillborn, Care of Procedure<br>e. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy<br>f. Food Brought in From Outside the Hospital Policy<br>g. Food Expiration Dates Policy<br>h. Needle Aspiration Neonates Standardized Procedure<br>i. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure<br>j. Physicians Orders for Life Sustaining Treatment (POLST) 393<br>k. Rapid Response Team and Condition Help Policy<br>l. Stroke Code, Emergency Department Procedure<br>m. Telephone Service for Patient Rooms Policy<br>n. Therapeutic Hypothermia After Cardiac Arrest Procedure<br>o. Visiting Guidelines<br><br>2) **Administrative Policies and Procedures**<br>a. Administrator On Call 281<br>b) Code Gray- Hostage Response Plan 283<br>b. Control for Locks and Keys 243<br>c. Helicopters on District Policy 207<br>d. Lost and Found Articles 202 | | PAC |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|

3) **Unit Specific**

**A. Education**

1. AHA & AWHONN Course Card Acceptance Policy
2. AHA Care and decontamination of AHA Equipment Policy
3. AHA Continuing Education Statement Policy
4 AHA Mission Statement and Goals Policy
5. AHA Quality Assurance Program Policy
6. AHA TC Course Card Management Policy (DELETE)
7. Copyright Policy

**B. Infection Control**

1. Meningococcal Exposure IC 6.2
2. Risk Assessment and Surveillance Plan IC 2
3.Toy Cleaning IC 9.1

**C. NICU**

1. Blood product Aliquot Syringes, Emergent Preparation of
2. Cardio-Respiratory Monitoring in the NICU
3. Neonatal Abstinence Syndrome, Management of Scoring

**D. Women and Newborn Services**

1. Infant Safety and Security

4) Approval of the Risk Management/Patient Safety Plan for FYs 2017-2018

F. Governance & Legislative Committee
Director Dagostino, Committee Chair
Open Community Seats - 1
(Committee minutes included in Board Agenda packets for informational purposes)

1. Medical Staff Rules & Regulations:

a) Division of General & Vascular Surgery
b) Division of Urology
c) Division of Orthopedic Surgery
d) Department of Obstetrics & Gynecology
e) Allied Health Professionals

2. Review of Board Policy 16-037 – Chief Executive Officer and Chief Compliance Officer Succession Planning Policy

3. Review of Board Policy 15-039 – Comprehensive Code of Conduct

4. Recommend the Board discuss scheduling a potential Board Educational Workshop at the April 25, 2017 Strategic Planning Workshop

5. Recommend presentation to the Board on Midwives

6. Approve submittal of the ACHD Certified District Designation

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | application<br><br>**G. Audit, Compliance & Ethics Committee**<br>Director Schallock, Committee Chair<br>Open Community Seats – 1<br>(Committee minutes included in Board Agenda packets for informational purposes.)<br><br>1) **Approval of Administrative Compliance Policies & Procedures**:<br><br>a) Policy 8610-292 – Internal Charge Audit<br>b) Policy 8610-530 – Emergency Response Employees, Notification of<br>c) Policy 8610-562 – Responding to Compliance Issues; Remedial Action<br>d) Policy 8750-574 – Tracking, Remuneration & Use of Items & Services to and from Referral Source and Tracking; use of TCHC Resources by Referral Sources<br><br>2) Approval of Non-Clinical Contract Spreadsheet<br><br>(2) Minutes – Approval of:<br><br>a) Regular Board of Directors Meeting – February 23, 2017<br>b) Special Board of Directors Meeting – March 2, 2017<br>c) Special Board of Directors Meeting – March 10, 2017<br>d) Special Board of Directors Meeting – March 16, 2017<br><br>(3) Meetings and Conferences – NONE<br><br>(4) Dues and Memberships - NONE | | Audit, Comp. & Ethics Comm.<br><br>Standard |
| 22 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 23 | Reports (Discussion by exception only)<br>(a) Dashboard<br>(b) Construction Report – None<br>(c) Lease Report – (February, 2017)<br>(d) Reimbursement Disclosure Report – (February, 2017)<br>(e) Seminar/Conference Reports:<br>1) Director Dagostino – CHA Leg Days<br>2) Director Schallock – CHA Leg Days (hand-out) | 0-5 min. | Standard |
| 24 | Legislative Update | 5 min. | Standard |
| 25 | Comments by Members of the Public<br>NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board | 5-10 minutes | Standard |
| 26 | Additional Comments by Chief Executive Officer | 5 min. | Standard |
| 27 | Board Communications (three minutes per Board member) | 18 min. | Standard |
| 28 | Report from Chairperson | 3 min. | Standard |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | Total Time Budgeted for Open Session | 2.5 hours | |
| 29 | Oral Announcement of Items to be Discussed During Closed Session | | |
| 30 | Motion to Return to Closed Session (if needed) | | |
| 31 | Open Session | | |
| 32 | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed) | | |
| 33 | Adjournment | | |

# Himani Singh, M.D.

Phone: 347-683-1425
Email: sinhim@gmail.com


## Profile

### HEMATOLOGY & ONCOLOGY

**"Providing compassionate, quality cancer care and giving patients the knowledge to make the most empowered decisions about their cancer diagnoses."**

**Board Certified, with experience delivering care to underserved populations and working effectively with multidisciplinary teams of all sizes. Background encompasses solid oncology, hematologic malignancies, benign hematologic disorders and cancer survivorship. Seeking to be a partner to patients in the midst of embarking on treatment plans, always keeping their interests at the forefront. Hindi and Punjabi fluent, Intermediate in French.**

Interests: **Patient Advocacy, Patient Safety, Public Health, Preventative Care, Genetic Counseling, Medical Ethics, Quality Improvement, Medical Education, Services Expansion**

## Education

- Fellowship in Hematology-Oncology- Thomas Jefferson University Hospital, PA (7/08-6/11)
- Residency in Internal Medicine (Associate Chief Resident between 2007-2008)- Norwalk Hospital, CT, affiliated with Yale University (7/05-6/08)
- Doctor of Medicine (M.D.)- St. George's University School of Medicine, West Indies (8/01-5/05)
- Bachelor of Science with Distinction (Biochemistry Major, Humanistic Studies Minor)- McGill University, Canada (9/97-6/01)
- Academic Honors: Dean's List at St. George's University (2001-2003), Member of Iota Epsilon Alpha (IEA) International Honor Medical Society (2002), Recipient of McGill University Entrance Award (1997), Ontario Scholar (1997)

## Licensure & Certification

- ABIM Certified in Internal Medicine
- ABIM Certified in Medical Oncology
- ABIM Certified in Hematology
- Active Medical License for the State of NY, Medical Licensure in Progress for State of CA

## Professional Appointments

**CLAXTON HEPBURN MEDICAL CENTER**
**Ogdensburg, NY** **8/11-Present**

Staff Hematologist/Medical Oncologist

- Played integral role in services expansion to satellite clinics, as well as in development of Breast Cancer Program, providing much-needed medical assistance to an underserved region.
- Collaborated with multidisciplinary team in delivering quality care to a diverse, largely Medicare and Medicaid patient population. 2 Medical Oncologists, Radiation Oncologist, and NP.
- Addressed diverse range of cases including lung, colorectal, breast, genitourinary, gynecologic, Non-Hodgkin's Lymphoma, multiple myeloma and Langerhans Cell Histiocytosis. Displayed a keen interest in cancer survivorship.
- Gained significant experience with genetic counseling.

## Postdoctoral Training

**THOMAS JEFFERSON UNIVERSITY HOSPITAL**
**Philadelphia, PA** **7/08-6/11**

**Hematology/Medical Oncology Fellowship**

- Executed rotations at Hemophilia/Thrombosis Center, Heritable Anemias Program including adult Sickle Cell Center, and Coagulation Laboratory, treating patients with a wide range of non-malignant hematological conditions including myeloproliferative and platelet disorders.
- Gained experience across Hematology, Hematologic Malignancy/Blood and Marrow Transplant and Solid Tumor Oncology.

## Research Experience

- Case Report, Eliminating the Need for Chronic Immunosuppression in a Kidney Transplant Recipient After Bone Marrow Transplantation from the Same Donor, Thomas Jefferson University, Margie Kasner, M.D. (4/10).
- Cohort Study to Determine the Impact of Tailored Navigation on Colorectal Cancer Screening Utilization among African Americans in Primary Care Practices, Thomas Jefferson University Hospital, Ronald E. Myers Ph.D. (1/10-6/11).
- Prospective Study Establishing the Effect of Blood Transfusion on Diagnosing the Underlying Cause of Anemia, Brown University and Norwalk Hospital, David Berz M.D. and Eric Mazur M.D. (1/06-5/08).

## Posters & Presentations

- Singh H, Brandy K, Gebert J, Gharagozloo A. Panel Discussion on Breast Cancer Therapy Using a Multidisciplinary Approach, St. Lawrence University, Canton, NY. (10/12).
- Singh H, Ronald M. The Use of Decision Aids in Medical Oncology, Oncology Grand Rounds, Thomas Jefferson University Hospital, Philadelphia, PA (6/11).
- Singh H, Kulaga E. The Treatment of Lichen Planus with Low Molecular Weight Heparin. Poster Presentation, Annual American College of Physicians Meeting, Southington, CT (9/07).
- Singh H, Mazur E. Variant Sickle Cell Syndromes. Oral Presentation, Chief's Conference, Norwalk Hospital, Norwalk, CT (8/07)..
  Singh H, Peretz D, Seeberger F. Research at Norwalk Hospital. Oral Presentation, Medical Grand Rounds, Norwalk Hospital, Norwalk, CT (12/06).
- Berz D, Singh H, Mazur E. The Effect of Blood Transfusion on Establishing the Underlying Cause of Anemia. Abstract Accepted to the American Society of Hematology Annual Meeting for Poster Presentation, Orlando, FL (12/06).
- Singh H, Berz D, Mazur E. The Effect of Blood Transfusion on Establishing the Underlying Cause of Anemia. Oral Presentation, Annual ACP Meeting, Southington, CT (10/06).
- Singh H, Hryniewicz K, Ruskin A. The Development of Secondary Hematological Malignancy Following Radiation & Chemotherapy for Primary Breast Carcinoma. Poster Presentation, Annual ACP Meeting, Southington, CT (10/05).
- Hryniewicz K, Singh H, Story D. A Case Series of Rapid Responses to Intravenous Recombinant Tissue Plasminogen Activator in Acute Stroke. Poster Presentation, Annual ACP Meeting, Southington, CT (10/05).

## Languages

- Fluent in English, Hindi and Punjabi, Intermediate in French (Written and Spoken)

**Aaron Boonjindasup MD, MPH, MS**
2711 Joseph St. New Orleans, LA 70115
(949) 293-7680 · Email: aboonjin@tulane.edu

***Training:***

**Tulane University School of Medicine** **New Orleans, LA**
Urology Residency
July 2012 – Present (Completion date: June 2016)

- Interests include Urologic oncology, Urologic trauma, upper tract reconstructive techniques, including robotic approaches.

**Tulane University Hospital and Clinics** **New Orleans, LA**
General Surgery Internship
July 2011 – June 2012

***Education:***

**Tulane University School of Medicine** **New Orleans, LA**
M.D.
August 2007 – May 2011

**Tulane University School of Public Health and Tropical Medicine** **New Orleans, LA**
Masters in Public Health (M.P.H.)
Concentration: Epidemiology
Thesis: "*Laparoscopic and Robotic Partial Nephrectomy: Cost Analysis of Peri-operative and Post-operative Outcomes at a Single Institution*"
Aug 2007 – May 2011

**Tulane University School of Medicine** **New Orleans, LA**
M.S. Pharmacology
Thesis: "*Serum-Deprived Mesenchymal Stem Cells Undergo Autophagy and Secrete Growth Factors Favorable to Tumor Growth*"
Aug 2006 – May 2007

**University of California-Irvine** **Irvine, CA**
B.S. Biological Sciences
B.A. Cognitive Sciences
Sept 2001 – May 2005

***Fellowships:***

**Summer Research Internship – Tulane Gene Therapy**
Louisiana Cancer Research Consortium (LCRC)
June 2007- August 2007
Worked with mesenchymal stem cells (MSCs) to understand their role in the tumor milieu as well as heartiness in nutrient-deprived situations. My projects necessitated the use of cell culture techniques along with mice models to determine how MSCs affect tumor growth and angiogenesis in a solid breast cancer tumor model. Several assays were learned including RT-PCR, Western Blot, and ELISA techniques.

**Summer Researcher – Tulane Hypertension and Renal Center of Excellence (THRCE)**
Macronutrient and Heart Disease Risk Study (MACRO)
June 2008 – October 2008
This study analyzed the effect of diet modification to evidence-based proportions of carbohydrates, protein, and fat content on blood pressure, serum cholesterol, blood sugar, and BMI. The arm of the study that I participated in focused on changes in

bone mineral density as per DEXA scan data. My role was to aid in participant recruitment, DEXA scheduling, data procurement and maintenance, and patient debriefing.

***Awards:***

2015 Tulane Department of Urology Annual Research Award

2013 Montague Boyd Essay Contest 1st place - *Prostate cancer cell-derived microvesicles confers androgen production by adult stem cells: Implications for tumor growth and metastasis* Southeast Section of the American Urologic Association (SESAUA) Annual Meeting 2013; Williamsburg, VA

2011 Joseph Hume Award for Excellence in Urological Research – Tulane School of Medicine Ivy Day Awards 2011, New Orleans, LA

***Accepted abstracts:***

**Boonjindasup A,** Smith A, Colli J, Killackey M, Buell J, Thomas R, Paramesh A. (2014) *Boari Flap Reconstruction Offers Superior Treatment for Late Transplant Ureter Strictures.* Southeastern Section of the American Urologic Association Annual Meeting; Hollywood, FL

**Boonjindasup A,** Maddox M, Rittenberg D, Shaw E, Dorsey P, Thomas R. (2014) *Urologic Reconstructive Surgery of the Upper Tract: Impact of the Robot*. Southeastern Section of the American Urologic Association Annual Meeting; Hollywood, FL

**Boonjindasup A,** Pinsky M, Wang J, Maddox M, Feibus A, Paramesh A, Thomas R, Silberstein J (2014) *Etiologies of Renal Transplant Graft Failure: A UNOS Database Review*. Southeastern Section of the American Urologic Association Annual Meeting; Hollywood, FL

Pinsky M, **Boonjindasup A**, Wang J, Feibus A, Maddox M, Thomas R, Sartor O, Silberstein J (2014) *Genitourinary Malignancy Before, During and After Renal Transplantation in the United States*. Southeastern Section of the American Urologic Association Annual Meeting; Hollywood, FL

Oommen M, Colli J, **Boonjindasup A**, Keel C, Dorsey P, Thomas R (2013) *Long-Term follow up of robotic pyeloplasty in the pediatric population.* World Congress of Endourology 2013; New Orleans, LA

**Boonjindasup A**, Mandava S, Woodson B, Thomas R, Lee BR (2013) *Laaroscopic and robotic partial nephrectomy: Cost analysis of perioperative and postoperative outcomes at a single institution.* World Congress of Endourology 2013; New Orleans, LA

**Boonjindasup A**, Rittenberg D, Shaw E, Dorsey P, Thomas R (2013) *Urologic reconstructive surgery of the upper tract: impact of the robot*. World Congress of Endourology 2013; New Orleans, LA

**Boonjindasup A**, Colli J, Patel K, Caire A, Paramesh A, Thomas R (2013) *Treatment outcomes of ureteral strictures after renal transplantation*. Southeastern Section of the American Urologic Association Annual Meeting 2013; Williamsburg, VA

**Boonjindasup A**, Pinsky M, Abdel-Mageed Z, Yang Y, Moparty K, Thomas R, Colli J, Abdel-Mageed AB (2013) *Prostate cancer cell-derived microvesicles confers androgen production by adult stem cells: Implications for tumor growth and metastasis.* Southeastern Section of the American Urologic Association (SESAUA) Annual Meeting 2013; Williamsburg, VA

Caire A, **Boonjindasup A**, Richardson B, Hellstrom WJ (2011) *Does the need for a replacement inflatable penile prosthesis lead to decreased patient satisfaction*. American Urologic Association (AUA) Annual Meeting 2011; Washington D.C.

Caire A, **Boonjindasup A**, Bernie A, Mitchell G, Thomas R, Lee BR. (2011) *Is preoperative imaging in prostate cancer overused? An analysis of the 2010 National Comprehensive Cancer Network guidelines.* American Urologic Association (AUA) Annual Meeting 2011; Washington D.C.

Caire A. Bayne C, Bernie A, **Boonjindasup A**, Lee BR. *Is Robot-Assisted partial nephrectomy an effective technique on T1B (4-7cm) renal lesions?* Southeastern Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

Caire A. Bernie A. Armstrong W, **Boonjindasup A**, Lee BR. (2011) *Robotic partial nephrectomy demonstrates favorable ischemia times compared to laparoscopic partial nephrectomy*. Southeastern Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

Caire A, **Boonjindasup A,** Bernie A, Fifer L, Thomas R. (2011) *Stage II Percutaneous Nephrolithotomy: A Novel Technique for residual stone disease*. Southeastern Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

Caire A, **Boonjindasup A**, Johnsen N, Bernie A, Thomas R, Lee BR. (2011) *Is preoperative imaging in prostate cancer overused? An analysis of the 2010 National Comprehensive Cancer Network guidelines.* Southeastern Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

Caire A, Bowen A, Bernie A, **Boonjindasup A**, Sikka S, Hellstrom WJ. (2010) *Intralesional injections in combination with penile traction is an effective treatment in Vitamin E refractory Peyronie's Disease* Sexual Medicine Society of North America (SMSNA) 2010; Miami, FL

Caire AA., **Boonjindasup A**., Bernie AM., Mikkilineni L., Bailey K., Richardson B., Conley SP., Thomas R., Lee BR. (2010) *Is preoperative imaging in prostate cancer overused? An analysis of the 2010 National Comprehensive Cancer Network guidelines.* World Congress of Endourology (WCE) 2010; Chicago, IL

Bernie A.M., Caire A.A., **Boonjindasup A**., Fifer GL, Thomas R. (2010) *Stage II Percutaneous Nephrolithotomy: a novel technique for residual stone disease.* World Congress of Endourology (WCE) 2010; Chicago, IL

**Boonjindasup A.**, Caire AA., Bernie AM., Sartor EA., Conley SP., Lee BR.; (2010) *Is robot-assisted partial nephrectomy an effective technique on T1b (4-7cm) renal lesions?* World Congress of Endourology (WCE) 2010; Chicago, IL

**Boonjindasup A.**, Caire A.A., Bernie A.M., Bailey K., Mikkilineni L., Conley S.P., Thomas R., Lee B.R. (2010) *Should outside institution prostate biopsies be reviewed prior to radical prostatectomy?* World Congress of Endourology (WCE) 2010; Chicago, IL

Bernie A.M., Caire A.A., Conley S.P., **Boonjindasup A.**, Hopkins M., Sartor E.A., Lee B.R. (2010) *Robot-assisted partial nephrectomy demonstrates favorable ischemia times compared to laparoscopic partial nephrectomy*. World Congress of Endourology (WCE) 2010; Chicago, IL

Dorsey, P.J., **Boonjindasup, A**., Thomas, R. (2010) *Pre-operative decision making: Predictors of extra-prostatic capsular extension in a contemporary cohort and criteria for selective nerve-sparing prostatectomy*. World Congress of Endourology (WCE) 2010; Chicago, IL.

**Boonjindasup, A.G.,** Bernie, A.M., Conley, S.P., Thomas, R., and Lee B.R.(2010) *Gleason Score Upgrading from Biopsy to Final Pathology Specimen in Robotic Assisted Radical Prostatectomy.* Tulane Research Days 2010; New Orleans, LA

Bernie AM, **Boonjindasup, AG,** Conley SP., Sartor O, Thomas R, Lee BR. (2010)
*Robotic Assisted Radical Prostatectomy In High Risk Patients: Biochemical Outcome and Recurrence*. Tulane Research Days 2010; New Orleans, LA

Hopkins M., Boylu, U., Conley, S.P., **Boonjindasup, A.G**., Sartor E.A., Pinsky M.R., Lee B.R. (2010)
*Difference in Tumor Size Measured On Contemporary Imaging Compared to Final Pathology Following Radical Nephrectomy.* Tulane Research Days 2010; New Orleans, LA

Sartor E.A, **Boonjindasup A.G.,** Hopkins, M., Pinsky M.R., Boylu, U., Lee B.R. (2010) *Contemporary Analysis of Change in Creatine in the First Month and Longterm Following Laparoscopic vs. Open Radical Nephrectomy*. Tulane Research Days 2010; New Orleans, LA

Sanchez, C., Penfornis, P., Oskowitz, A.Z., **Boonjindasup A.G**., Cai D.Z., Rowan B.G., Kelekar A., Krause D.S., Pochampally R.R. (2010) *Stromal Support by Mesenchymal Stem Cells in Breast Cancers.* Tulane Research Days 2010; New Orleans, LA

**Boonjindasup A.G.,** Penfornis P., Sanchez C., Pochampally R.R. (2007) *Serum-Deprived Mesenchymal Stem Cells Can Survive Serum Starvation Through Autophagy and Promote Tumor Initiation by Secreted Factors* Louisiana Cancer Research Consortium Summer Fellowship Presentation; New Orleans, LA

Sanchez, C., **Boonjindasup, A.G.,** Penfornis P., Prockop D.J., Pochampally R.R. (2007) *Global epigenetics changes in human multipotential stromal cells (hMSCs) during culture*. MSC 2007

***Podium Presentations:***

**Boonjindasup A**, Pinsky M, Abdel-Mageed Z, Yang Y, Moparty K, Thomas R, Colli J, Abdel-Mageed AB (2013) *Prostate cancer cell-derived microvesicles confers androgen production by adult stem cells: Implications for tumor growth and metastasis.* Southeast Section of the American Urologic Association (SESAUA) Annual Meeting 2013; Williamsburg, VA – 1st Place Montague Boyd Essay Contest 2013

**Boonjindasup A**, Pinsky M, Smith B, Trost L, Chaffin A, Jansen D, Hellstrom W (2013) *Management of concealed penis using meshed split-thickness skin grafting in an adult population* (2013) Southeast Section of the American Urologic Association (SESAUA) Annual Meeting 2013; Williamsburg, VA

**Boonjindasup A**, Caire A, Bernie A, Mikkillineni L, Bailey K, Conley S, Thomas R, Lee B. *Should outside institution prostate biopsies be reviewed prior to radical prostatectomy*. (2011) Southeast Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

Caire A, **Boonjindasup A**, Richardson B, Hellstrom W. *Does the need for a replacement inflatable penile prosthesis lead to decreased patient satisfaction?* (2011) Southeast Section of the American Urologic Association (SESAUA) Annual Meeting 2011; New Orleans, LA

***Peer-Reviewed Journal Publications***

Trost, L., **Boonjindasup A.** Hellstrom W.J.G. *Comparison of infrapubic versus transcrotal approaches for inflatable penile prosthesis placement: a multi-institution report.* (2015) Int J Impot Res 27(3): 86-9. PMID 25339138

Maddox M., Mandava S., Liu J., **Boonjindasup A,** Lee BR. *Robotic Partial Nephrectomy for Clinical Stage T1b Tumors: Intermediate Oncologic and Functional Outcomes.* (2015) Clin Genitourin Cancer 13(1):94-9. PMID 25176501

Sanchez, C., Penfornis, P., Oskowitz, A.Z., **Boonjindasup A.G.**, Cai, D.Z., Rowan, B.G., Kelekar, A., Krause, D.S., Pochampally, R.R. *Nutrient Deprived Stromal Cells Support Solid Tumor Growth by Activating Autophagy and Secreting Antiapoptotic Factors.* (2011) Carcinogenesis 32(7): 964-72. PMID 21317300

Caire, A.A., **Boonjindasup A.G**., Hellstrom W.J.G. *Does the need for a replacement inflatable penile prosthesis lead to decreased patient satisfaction?* (2011) Int J Impot Res 23(2): 39-42. PMID 21307871

***Book Chapters:***

**Boonjindasup A.,** Serefoglu E.C., Hellstrom W.J.G (2013) *Risk Factors in Premature Ejaculation: The Urologic Risk Factor.* Premature Ejaculation: From Etiology to Diagnosis and Treatment**.** Springer-Link Publishing. Editors: Jannini E.A., McMahon C.G., Waldinger M.D. ISBN: 978-88-470-2645-2 (Print) 978-88-470-2646-9 (Online)

***Courses Attended:***

Principles of Laser Physics. Safety Precautions: Surgical Laser Education Certification – July 2012, New Orleans, LA

American Medical Systems Greenlight XPS Laser Simulation Training Course – July 2013, New Orleans, LA

Society of Urodynamics, Female Pelvic Medicine, & Urogenital Reconstruction (SUFU) Research Foundation Resident Preceptorship 2013 – August 2013, Chicago, IL

8th Annual National Urology Resident Preceptorship (NURP) in Adult and Pediatric Reconstructive and Prosthetic Urologic Surgery - September 2013, Cleveland Clinic, OH

Society of Urologic Prosthetic Surgeons (SUPS) Resident Surgical Lab – November 2013 - New Orleans, LA

Southeast Section of the American Urological Association Robotics Course – January 2015, Celebration, FL

***Meetings Attended:***

American Urological Association Annual Meeting - New Orleans, LA, May 2015

Southeastern Section of the American Urological Association (SESAUA), 78th Annual Meeting - Hollywood, FL, March 2014

Sexual Medicine Society of North America, Annual Fall Scientific Meeting - New Orleans, LA, November 2013

World Congress of Endourology, 31st Annual - New Orleans, LA, October 2013

American Urological Association Annual Meeting – San Diego, CA, May 2013

Southeastern Section of the American Urological Association (SESAUA), 77th Annual Meeting – Williamsburg, VA, March 2013

Southeastern Section of the American Urological Association (SESAUA), 75th Annual Meeting - New Orleans, LA, March 2011

**Current Projects**

- Quality Improvement Project – Improvement in timely surgical care within the Veterans Adminstration of New Orleans (VANO)
- Improving treatments of renal transplant surgical complications
- Characterizing surgical training improvements in regards to laparoscopic and robotic training

# Tri-City Healthcare District
# Board of Directors

# Report of the
# Ad Hoc Technology Committee

# March 30, 2017

## Situation

The delivery of health care is more complex and complicated today than it was when the Tri-City Healthcare District (TCHD) was founded in 1961. In addition to changes in care delivery such as evidence-based practice, acute care hospitals are discharging patients sooner than in days past to skilled nursing facilities, rehabilitation facilities and home (i.e. "sicker and quicker"). This coupled with the current regulatory requirements and an ever-changing reimbursement landscape has necessitated an evaluation of the current processes and practices of the TCHD Board of Directors.

## Background

Each TCHD Director devotes approximately 50 hours per month to the work of the District while TCHD staff spend approximately 90 hours per month on Board activities (e.g. Board committees). The work of the Board of Directors occurs on paper. Approximately 34 reams (at 500 sheets per ream) of paper are used each month. Distribution of Board materials is via United States Postal Service, Federal Express and courier. The TCHD Medical Executive Committee currently utilizes an electronic format for the dissemination of information. With this in mind, the TCHD Board of Directors has created an Ad Hoc technology committee.

## Assessment

**Technology Survey.*** A technology assessment tool was developed by the Ad Hoc committee and distributed to Directors, TCHD staff and community and physician committee members. The information was used to determine the what devices were being used and individual comfort levels with technology including desktop computers and handheld devices.†

### Devices

**Computers.** The majority of respondents used either/or a desktop computer (47%) or a laptop computer (45%), with 8% familiar with netbooks. Windows was

---

* Many respondents are familiar with and utilize multiple devices and operating systems

† Charts in Appendix One

the predominate operating system (OS) on desktop, laptop, and netbook computers with a few respondents utilizing Mac OS on desktop and/or laptop computers.

**Phones.** The majority of respondents (93%) have smart phones versus 7% who use flip (clamshell) phones. The majority of respondents (64%) have iPhones while 28% have Android and 8% have another or unknown OS.

**Tablets.** The majority of respondents utilize iPads (57%) with 13% each using Android and Windows OS and 17% using Amazon Kindle.

## Applications and Device Use

The majority of respondents rated themselves as proficient in Microsoft Word, Excel, PowerPoint and Outlook. Phones and tablets were used for: phone calls, text/instant messaging/Skype, email, calendar, camera, eReader (e.g. Kindle), media (e.g. YouTube), social media such as Facebook, and web surfing.

## Platforms

The committee evaluated 3 platforms: Board Effect (both from the Vendor and via the Governance Institute), Diligent, and BoardMax.

| | BOARD EFFECT | | | |
|---|---|---|---|---|
| **VENDOR** | **BOARD EFFECT** | **GOVERNANCE INSTITUTE*** | **DILIGENT** | **BoardMax** |
| **WEB SITE** | http://www.boardeffect.com/ | ----- | diligent.com | Boardvantage.com |
| **ANNUAL COST** | ***$8750.00‡*** Up to 80 users Unlimited storage Can have trial with 30 day opt-out | ***$13,900.00*** Unlimited users Unlimited conference passes Access to online education | ***$33,600*** | ***$4000.00*** Unlimited users |
| **ACCESS** | Web-based portal | | Web-based portal | Web-based portal |
| **APPS** | iOS, Android | | iOS, Android | iOS, Android, Surface |
| **CYBERSECURITY** | Data encrypted at rest and in transit. Three levels of data protection Data Recovery | | Data encrypted at rest and in | Data encrypted at rest and in transit. Three levels of data |

* The District's current membership is $21,275. The additional $13,900 upgrades our membership to enhanced membership.

‡ On-site training is $2000/day

| | | | |
|---|---|---|---|
| | Role based permissions | transit.<br>Three levels of data protection<br>Data Recovery<br>Role based permissions | protection<br>Data Recovery<br>Role based permissions |
| **REGULATORY COMPLIANCE** | HIPAA compliant<br>HITECH compliant | HIPAA compliant<br>HITECH compliant | HIPAA compliant<br>HITECH compliant |
| **TECH SUPPORT** | Board Effect[9]** | Diligent | BoardMax |
| **COMPONENTS/FEATURES (standard across platforms)** | **Meeting Cycle:** Online board books (workbooks and workrooms); Scheduling; Approvals; Tasks; Archives.<br>**Annual Cycle:** Surveys; Board Policy Handbooks; New Member Orientation Tools.<br>**Development Cycle:** Ad hoc groups; collaboration tools; board education; profiles | Same as Board Effect | Same as Board Effect |

** The Governance Institute forwards tech support requests to Board Effect

# Devices (prices are Manufacturer's Suggested Retail Price for off the shelf devices)

| SPECS | iPad Pro | Samsung Galaxy Tab A | HP ElitePad 1000G2 Tablet |
|---|---|---|---|
| Cost | From $599.00 | $299.99 | $1009.00 |
| Operating System | iOS 9 | Android | Windows 10 Pro 64 |
| Main Display Size | 9.7"/12.9" | 9.7" | 10.1" |
| Weight | 0.96 pounds | 0.99 pounds | Starting at 1.5 pounds |
| Battery | 27.5 watt/hour lithium polymer | 6000mAh Li-Ion | 2-cell, long life 20 WHr Li-Ion polymer |
| RAM | 2 GB/4GB | 1.5 GB | 4 GB |
| ROM | 32 GB, 128 GB, 256 GB | 16 GB | 128 GB eMMMC SSD |
| External Memory | No | Up to 128 GB | 1 microSDXC |
| Wi-Fi | Yes | Yes | Yes |
| Bluetooth | Yes | Yes | Yes |
| Processor | A9X chip with 64 bit architecture, M9 coprocessor | 1.2 GHz Quad Core, Qualcomm APQ 8016 | Intel Atom Z3795 (1.6 GHz, up to 2.39 Hz using Intel Burst Technology, 2 MB caches, 4 cores) |
| Camera | Yes | Yes | Yes |
| Audio | Yes | Yes | Yes |
| Video | Yes | Yes | Yes |
| Applications/Software, Installed | Siri, Photos, Messages, Face Time, Mail, Music, Safari, Maps, Calendar, iTunes Store, App Store, Notes, Contacts, iBooks, Game Center, Reminders, Clock, Videos, Photo Booth, Podcasts, News, Find my iPhone, Find My Friends, iCloud Drive. MS Word, Excel, and Powerpoint are free at the Apple App Store. | Google: Chrome, Drive, Gmail, Google, Settings, Google+, Hangouts, Maps, Photos, Play Books, Play Games, Play Movies & TV, Play Music, Play Newstand, Play Store, Voice Search, YouTube; MS Office: Word, Excel, PowerPoint, One Note, Cloud Drive, Skype; Hancom Office Viewer, Milk, Netflix, ScreenSaver, SideSync 3.0, Smart Manager | Buy Office; PDF Complete Corporate Edition; HP Mobile Connect; HP Wireless Hotspot (models with WLAN); HP ePrint; HP Manageability; HP PageLift; HP Support Assistant; HP SoftPaq Download Manager, Kindle; Box |
| Free Apps | Pages, Numbers, Keynote, iMovie, GarageBand, iTunes U, Apple Store, Trailers, Remote, Music Memos | MS Office with One Drive (free for 2 years) | |
| Computer Sync, Windows | Windows 7 or later | | |
| Computer Sync, Mac | OS X v10.8.5 or later | | |

## Recommendations

The committee has reviewed the three portals, with BoardEffect and Diligent being presented to the entire board and C-Suite. The committee has the following recommendations:

These portals were developed to bring together boards that are geographically separated. Per state law, Directors of a Healthcare District Board are required to reside within the boundaries of the District. Teleconferencing is permissible for meetings that are within the subject matter jurisdiction of the District (Calif. Gov. Code 54953(b)(2) and has been used when a board member has been outside the district during a meeting.

These portals have many features, one of which is the ability to annotate documents within the portal. This could be problematic for a government entity, such as a healthcare district, in that the portal copy is the copy of record.

These portals also require an annual subscription fee, ranging from approximately $4000 annually (Board Max) to over $30,000 annually (Diligent), with additional one-time and/or enhanced feature costs.

With these aspects in mind, the committee looked at the capabilities of the Tri-City Healthcare District (TCHD) website. After discussions with the Director of IT, the Board Executive Assistant and others, the Committee recommends that a *Board Only* portal be developed for the web site. This portal would contain documents the Board currently receives on paper in a format that cannot be annotated. If a Director wishes to make notes, the document can be downloaded onto a device of the Director's choosing or printed by the Director. Community members of board committees would receive their materials electronically via email. However, because not everyone is familiar or comfortable with technology, Directors and community committee members may elect to receive their materials on paper. The committee recommends that closed session items remain on paper.

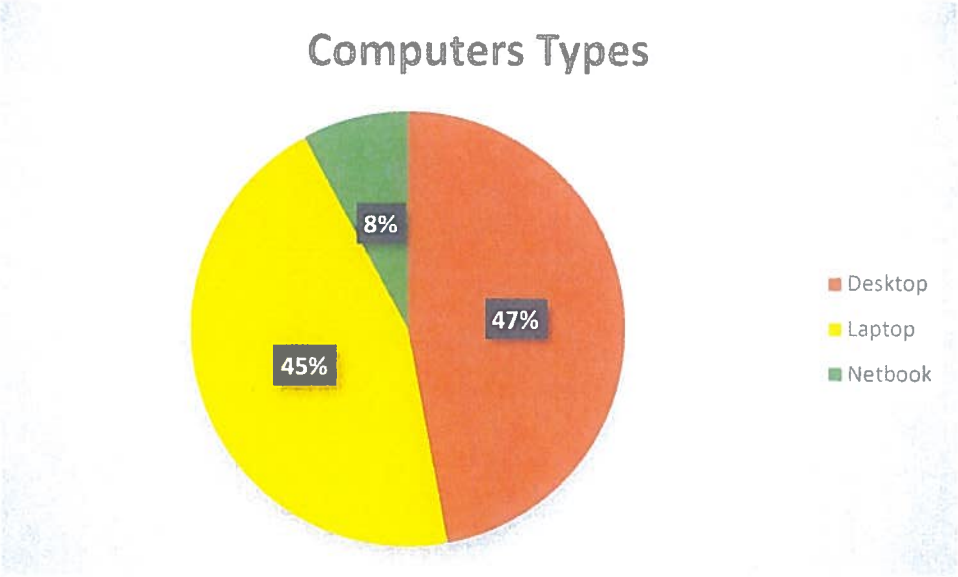
With regard to devices, the committee recommends that the Board *only* be offered a District issued iPad Pro, with Microsoft Word, Excel, PowerPoint as well as Apple's GoodReader app installed (which will allow annotation of PDF documents). Other committee members (e.g. community members) can use a smartphone or tablet to access relevant material. TCHD staff should use the method that is most effective for them.

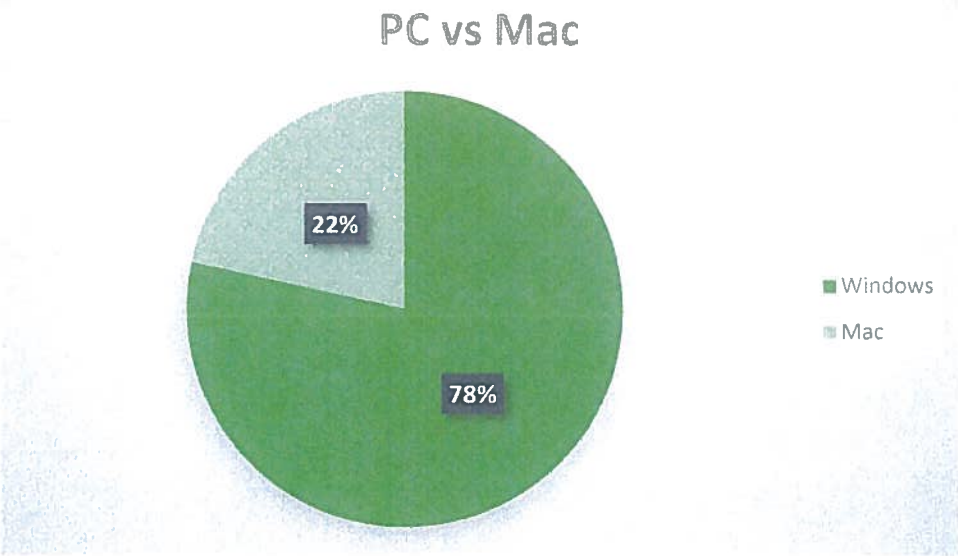
The committee also recommends that this ad hoc committee remain an ad hoc committee that meets at least once a year and more often on an as needed basis. The committee also recommends that the chair of this committee (or designee), the Board Executive Assistant and the Director of Information Technology be designated as System Administrators. The system administrators will develop/adapt from existing policies and procedures for use of both the portal and District issued devices.

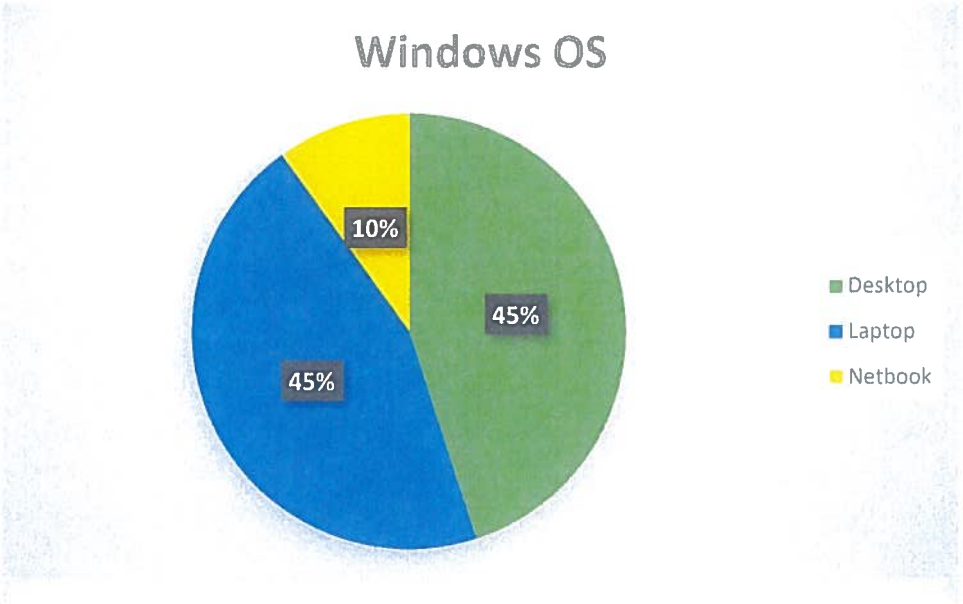
# APPENDIX ONE

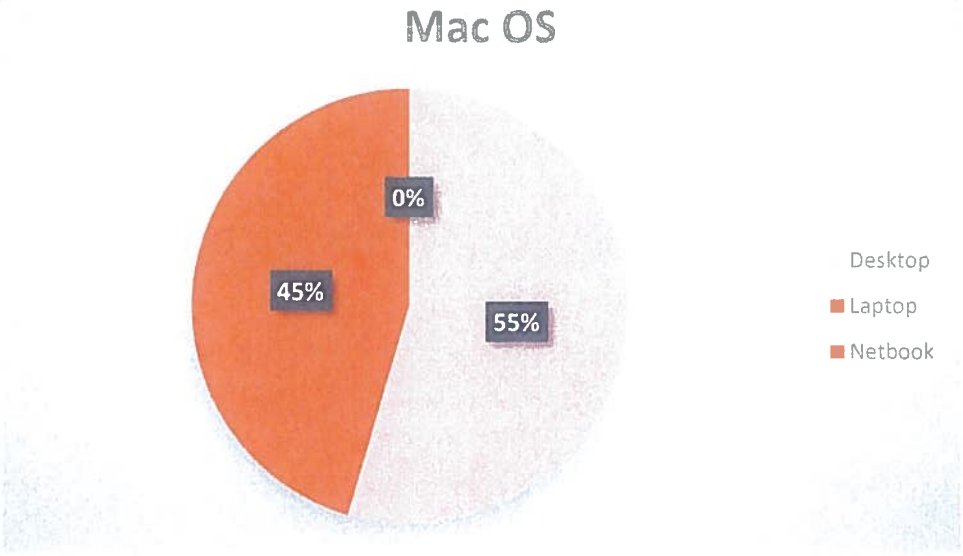
## *Computer Survey Results*

## COMPUTERS

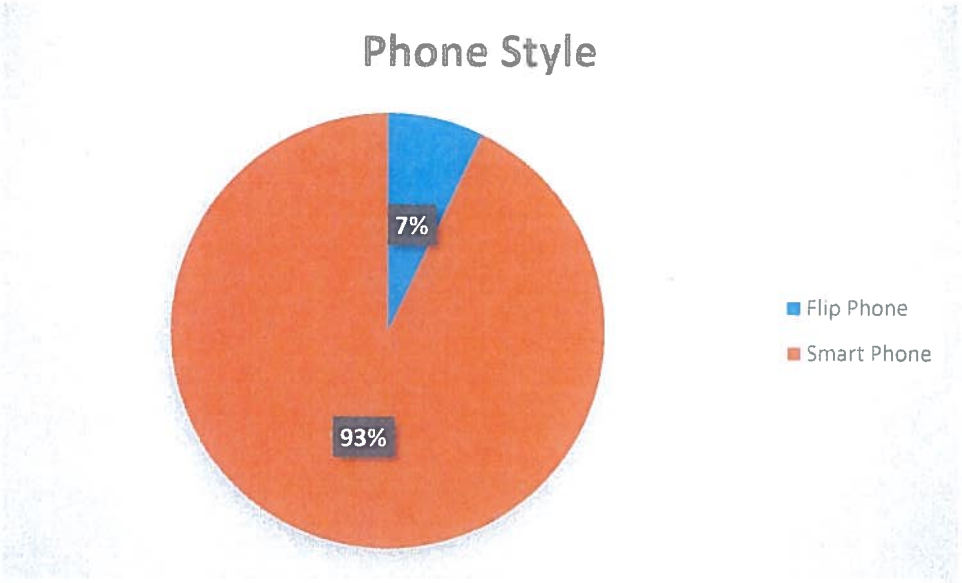


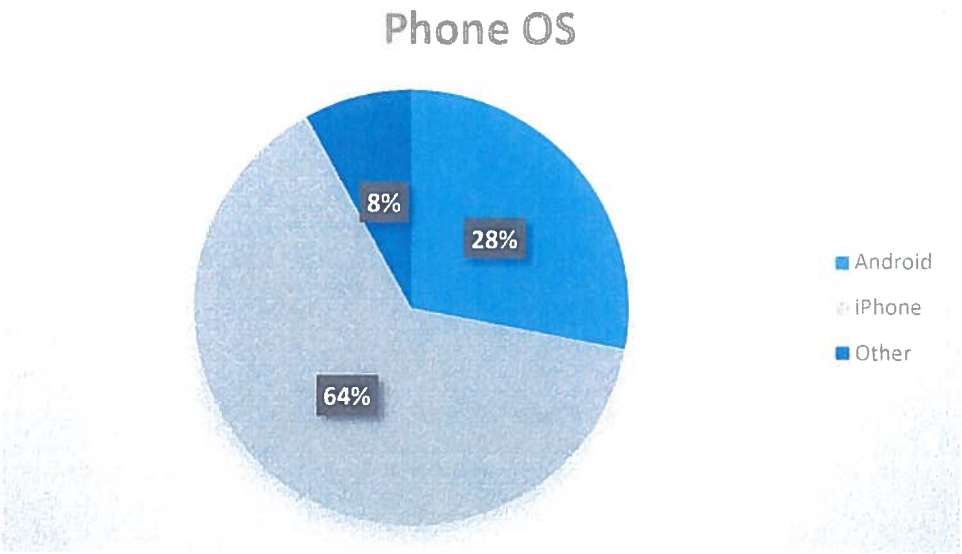



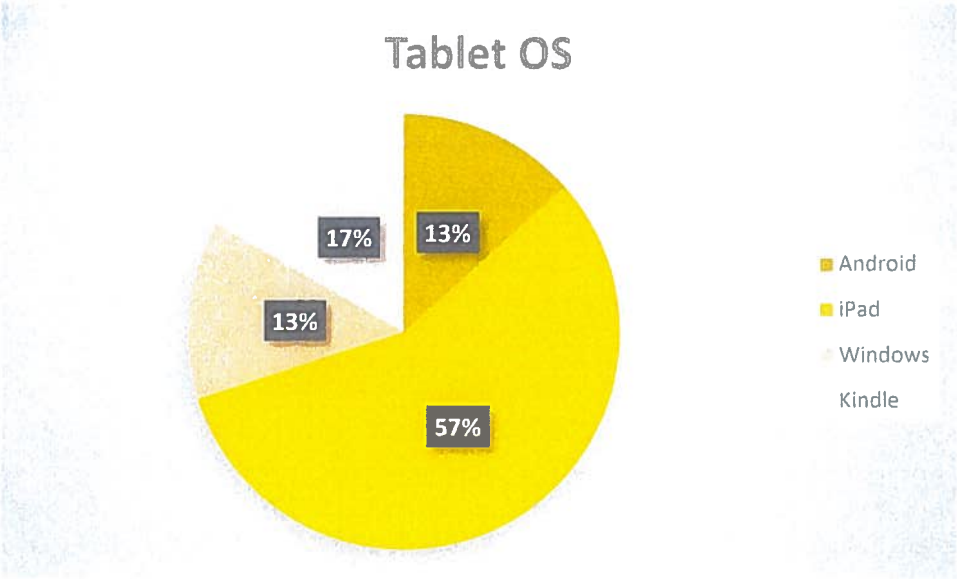

Windows OS
10%
45%
45%
Desktop
Laptop
Netbook


Mac OS
0%
45%
55%
Desktop
Laptop
Netbook

## PHONES AND TABLETS




Tablet OS
17%
13%
13%
57%
Android
iPad
Windows
Kindle

Tri-City Medical Center
MEDICAL STAFF

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

*Attachment A*

## INITIAL APPOINTMENTS (Effective Dates: 3/31/2017-2/28/2019)

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 3/31/2017 through 2/28/2019:

- **BLAKE, Patrick M.D./Dermatology (MedDerm Associates)**
- **JACOBS, Karl M.D. / Psychiatry (UCSD)**
- **ONAITIS, Mark M.D./Cardiothoracic Surgery (UCSD)**
- **QUAN, Maria M.D./OB/GYN (Vista Community Clinic)**
- **ROCHELLE, Michelle M.D./Radiology (San Diego Imaging)**

Tri-City Medical Center
MEDICAL STAFF

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

*Attachment B*

## BIENNIAL REAPPOINTMENTS: (Effective Dates 4/01/2017 –3/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 4/01/2017 through 3/31/2019, 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:

- **ANDRADE, Kristine, MD/Teleradiology/Provisional**
- **FREDERIKSEN, Ryan, MD/Teleradiology/Provisional**
- **FURUBAYASHI, Jill, MD/Teleradiology/Provisional**
- **GOELITZ, Brian, MD/Interventional Radiology/Active**
- **GREIDER, Bradley, MD/Ophthalmology/Active**
- **HELMY, Marwah, MD/Teleradiology/Associate**
- **HELTON, Derek, MD/Oncology/Active**
- **MUHTASEB, Talal, MD/Obstetrics & Gynecology/Active**
- **NEWMAN, Jeffrey, MD/Family Medicine/Active**
- **PARDO, Patricia, MD/Anesthesiology/Courtesy**
- **POUNTNEY LEVESQUE, Marlene, MD/Obstetrics & Gynecology/Active**
- **SAHAGIAN, Gregory, MD/Neurology/Active**
- **SERDAREVIC, Hanna, MD/Anesthesiology/Provisional**
- **SHAFQAT, Jon, DDS/Oral & Maxillofacial Surgery/Associate**
- **SMITH, Mark, MD/Ophthalmology/Active**
- **SMITH, Richard, MD/Infection Disease /Active**
- **SMITH, Ryan, DO/Emergency Medicine/Active**

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

*Attachment B*

## RESIGNATIONS: (Effective date 3/31/2017 unless otherwise noted)

**Automatic:**

- **BIELAWSKI, Anthony MD/Emergency Medicine**

**Voluntary:**

- **BLUMENFELD, Andrew MD/Neurology**

## CORRECTIONS:

## BIENNIAL REAPPOINTMENTS: (Effective Dates 02/01/2017 –01/31/2019)

The following application was recommended for reappointment to the medical staff office effective 02/01/2017 through 1/31/19:

- **SHIMIZU, Kenneth, MD/Radiation Oncology/Active**

## BIENNIAL REAPPOINTMENTS: (Effective Dates 03/01/2017 –02/28/2019)

The following application was recommended for reappointment to the medical staff office effective 03/01/2017 through 02/28/19:

- **BARAGER, Richard MD/Nephrology/Active**
- **KURIYAMA, Steve MD/Infectious Diseases/Consulting**

Tri-City Medical Center
MEDICAL STAFF

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

*Attachment C*

## PROCTORING RECOMMENDATIONS (Effective 3/31/17, unless otherwise specified)

- ELLINI, Ahmed M.D. — Pediatrics
- GUPTA, Anshu M.D. — Plastic Surgery
- GUTHRIE, Carlie M.D. — Anesthesiology
- JUREWITZ, William M.D. — OB/GYN
- MAYBERRY, Jennifer M.D. — Radiology
- MITCHELL, Charles M.D. — Radiology
- PENRY, Jackson M.D. — Radiology
- SHOWAH, Henry M.D. — Family Medicine

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
# March 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 3/31/2017.**

- **PERRIZO, Nathan DO/Active** — **Pain Medicine**
- **ZUPANCIC, Michael MD/Active** — **Neurology**

**ADDITIONAL PRIVILEGE REQUEST (Effective 3/31/2017, unless otherwise specified)**

**The following practitioners requested the following privileges**

- **BEN-HAIM, M.D.** — **Surgery/Neurosurgery**
- **RAYAN, Sunil MD/Consulting** — **General/Vascular Surgery**
- **SHOWAH, Henry M.D.** — **Emergency Medicine**
- **WHITNEY, Janet D.O.** — **Family Practice**

**VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 3/31/2017, unless otherwise specified)**

**None**

**STAFF STATUS CHANGES**

- **CHABALA, James V. MD**
- **GOODING, Isaac MD**

Tri-City Medical Center

# Delineation of Privileges

Anesthesiology 6/14

Provider Name:

| Request | Privilege | Action<br>MSO Use Only |
|---|---|---|

**Anesthesiology**

CRITERIA FOR OBTAINING PRIVILEGES: As part of the Department's goal to ensure that its physicians meet high standards of clinical quality, the Department has determined that Board Certification is an important indicator of quality. Therefore, the Department of Anesthesiology consists of physicians who are at all times and remain Board Certified by the American Board of Anesthesiology (ABA), or are a candidate in the ABA examination system,Board Eligible as determined by the American Board of Anesthesiology. Physicians who make an initial application to join the Department after January 1, 2013, must become Board certified within five (5) years of joining the Department. Department members with time-limited certificates must participate in the ABA's Maintenance of Certification in Anesthesiology (MOCA) program in order to maintain their certification. For those members who have non-time limited certificates, the Department recommends participation in the MOCA program.

**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.

**COGNITIVE PRIVILEGES**

___ Consultation including via telemedicine (F) ___

___ Evaluate and treat patients with anesthesia related problems ___

___ Perform history and physical examination, including via telemedicine (F) ___

**CORE PROCEDURAL PRIVILEGES**

___ General Anesthesia ___
Initial: Training
Proctoring: Three (3) cases need to be proctored
Reappointment: Twenty (20) cases required per two year reappointment cycle

___ Regional Anesthesia (Epidural, Spinal) ___
Initial: Training
Proctoring: Two (2) cases need to be proctored
Reappointment: Five (5) cases required per two year reappointment cycle

___ Invasive Monitoring (Includes: Arterial line, Central line, Midline, and Pulmonary Artery catheters) ___
Initial: Training
Reappointment: Five (5) cases required per two year reappointment cycle.

~~___ Pediatric Anesthesia (Children 5 years and under)~~ ___
~~Initial: Training~~
~~Reappointment: Two (2) cases required per two year reappointment cycle~~

**SPECIAL PROCEDURES**

___ Cardiac Anesthesia ___
Initial: Cardiac anesthesia privileges are considered for applicants who fall under one of the following two categories:
Category 1:
Successful completion of cardiac anesthesia fellowship OR completion of six-months of focused cardiac anesthesia training during third year of residency OR documentation of current activity managing cardiopulmonary bypass cases.
Category 2:
Completion of approved anesthesia residency training program that included three (3) months of cardiac anesthesia with additional proctoring: 1) Five (5) cases will be proctored via direct observation; and 2)



Printed on Monday, February 27, 2017~~Thursday, February 23, 2017~~

Tri-City Medical Center
**Delineation of Privileges**
Anesthesiology 6/14

Provider Name:

| Request | Privilege | Action<br>MSO Use Only |
|---|---|---|

Twenty-five (25) prospectively reviewed cases where the plan for anesthesia is discussed with an eligible proctor and the proctor reviews the case retrospectively.

___ Transesophageal Echocardiography (TEE) ___
Initial:
1. Cardiac fellowship training, or
2. Documentation of recent training program where TEE was part of training, or
3. Six (6) months Cardiac Anesthesia during residency

Proctoring: Three (3) cases
Reappointment: Ten (10) cases required per two year reappointment cycle

___ Coronary sinus catheter placement ___
Initial: Successful completion of all privileging criteria for Cardiac Anesthesia (Category 1 or 2) and Transesophageal Echocardiography
Proctoring: Two (2) cases

___ **PAIN MANAGEMENT CORE PRIVILEGES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541 ___
By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

Admit Patients

Chemo-Denervation (i.e. Stellate Ganglion block, peripheral nerve block, Botox injections, Intra-muscular phenol injections)

Epidural procedures (i.e. Translaminar and transforaminal epidural injections (cervical, thoracic, lumbar), and epidural blood patch)

Joint Injections (i.e. Facets, SI joint)

Sympathetic Blocks

**PAIN MANAGEMENT SPECIAL PROCEDURES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541

___ Discograms ___

___ Radiofrequency Thermocoagulation Lesion Ablation (RFTC) ___

___ Intradiscal Electrothermal Annuloplasty ___

___ Implantables (i.e. intrathecal or epidural infusion pumps with tunneled catheter, spinal cord stimulator) ___

___ Cranial nerve blocks - All types ___

**OTHER PRIVILEGES**

___ Fluoroscopy in accordance with hospital policy ___

(Refer to Medical Staff Policy #528 and 528A)

_____
Print Applicant Name

_____



Printed on Monday, February 27, 2017~~Thursday, February 23, 2017~~

Tri-City Medical Center

# Delineation of Privileges

Anesthesiology 6/14

Provider Name:

| Request | Privilege | Action<br>MSO Use Only |
|---|---|---|
| | | |

Applicant Signature

_____

Date

_____

Division/Department Signature

_____

Date

# Human Resources Committee
# (No meeting held in March, 2017)

# Employee Fiduciary Subcommittee
# (No meeting held in March, 2017)

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

**MEMBERS PRESENT:** CHAC Chair Julie Nygaard, BOD Chair Jim Dagostino, Director Larry Schallock; Dr. Victor Souza, MD; , Carol Herrera, Gigi Gleason, Linda Ledesma, Marge Coon, Mary Donovan, Dung M. Ngo, Guy Roney, Jack Nelson, Mary Lou Clift, Rosemary Eshelman, Scott Ashton, Xiomara Arroyo

**MEMBERS ABSENT:** Bret Schanzenbach, Barbara Perez, Danielle Pearson, Marilou de la Rosa Hruby, Mary Murphy, Roma Ferriter, Sandy Tucker, Ted Owen

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

**NON-VOTING MEMBERS ABSENT:** Audrey Lopez, Fernando Sanudo

**OTHERS PRESENT:** Brian Greenwald, Celia Garcia, CHAC Coordinator; Gwen Sanders

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Call To Order** | The March 16, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:30 pm by Director and CHAC Chair Julie Nygaard. | | |
| **Approval Of Meeting Agenda** | Director Dagostino motioned to approve the March 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

March 16, 2017

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Public Comments & Announcements** | No public comments or announcements were made. | | |
| **Ratification Of Minutes** | Gigi Gleason motioned to approve the February 16, 2017 CHAC meeting minutes. The motion was seconded by Director Dagostino and approved. | | |
| **Presentation: Wayne Knight, Chief Strategy Officer** | Wayne Knight, Chief Strategy Officer, discussed the North Coast Accountable Care Organization(ACO) with the group noting the following:<br>• The hospital's ACO was started July 2012 as a shared savings plan with no downside risk. Savings were accrued as long as quality criteria were met.<br>• The program was successful for 3 years, although due to increasing standards on a yearly basis, providers received a physician distribution amount in the first year only. The ACO ended December 2016 because it fell below member threshold.<br>• Tri-City is looking to re-implement the ACO in 2017 and beyond due to potential upcoming changes in MACRA/Medicare reimbursement and the Bundled Payment Structure.<br>• Bundled Payment Structure as explained by Mr. Knight is a CMS initiative which is similar to capitation. This will potentially take effect in 2018. | | |

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

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **CEO Update**<br>**Steve Dietlin** | CEO Steve Dietlin updated the group as follows:<br>• There was no food at the meeting because of a pipe break near the cafeteria. The patients are having their dietary needs met and the cafeteria is schedule to reopen March 17.<br>• Steve reiterated Wayne Knight's information that pressure for high quality care with lower reimbursement is on the horizon and stated that Tri-City has a unique advantage because of excellent safety ratings and low cost compared to competitors.<br>• HUD financing closed under the 242 Refinancing Program and Tri-City is the first district hospital that HUD has worked with on the West Coast. We secured a 3.22% fixed interest rate for 25 years.<br>• Steve stated that the goals for the $51 Million that is now usable are to ensure seismic compliance of Central/South Towers, build a new parking structure and Emergency Department, create private patient rooms, and retrofit other areas.<br>• Steve stated that the next step in the hospital's plan for campus redevelopment is to attain via RFP a master plan which breaks construction down into phases.<br>• Steve thanked the community for their help in attaining the financing & mentioned HUD's comment that they were impressed by the community representation on our behalf. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| | • Marge Coon proposed the question as to how proactive the hospital was in reviewing current infrastructure, with the example of the cafeteria. Kapua Conley responded that we are reviewed by the Joint Commission in addition to having regular consultants come in & review for preventative maintenance. Steve added that we do have routine campus care and are rigorously reviewed. Steve also added that we are making sure to repair the entirety of the damage that has been done in the cafeteria due to the pipe bursting. | | |
| **COO Update Kapua Conley** | Chief Operating Officer Kapua Conley reported as follows:<br>• The Patient Discharge Lounge has been opened and there have been positive results. There is a partnership with Uber & Lyft to avoid patients waiting for taxi transportation. The patient discharge lounge will continue to expand as physicians are informed of its existence and benefits.<br>• As part of the community outreach with the police department a documentation station at the hospital has been proposed. This would cut down on response times for incidences occurring at the hospital. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Chief Marketing Officer Update David Bennett** | Chief Marketing Officer David Bennett reported as follows:<br>• Marketing to the public about the HUD financing will begin, and a press release will be released shortly. After the press release there will be media segments on TV and articles in local community papers. He stated that the committee can let him know if they have any additional ideas for marketing.<br>• David noted that Senator Bates came to Tri-City and was very impressed with our robotics & other technology.<br>• A program schedule with KOCT will be announced shortly which will take the place of the board meeting programming. David stated that this will allow the community to have more information about what is happening at Tri-City than before. | | |
| **Old Business, CHAC Grant Update, Gigi Gleason** | Gigi Gleason extended a thank you to Brian and all of marketing for a successful close of the grant application process. The result was 30 grants with a total ask of under $800K. The total amount available for distribution is $300K. Gigi will report back about the grant selection process during the May CHAC meeting. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Committee Communications** | Rosemary Eschelman shared information on a Community Forum April 27th which focuses on several topics including transportation, entertainment, & lower income housing. She will send additional information to distribution to the entire committee.<br><br>Xiomara Arroyo stated that the American Banking Association launched a "Teach Kids to Save" program recently. The program is available to schools and anyone can contact her for more information.<br><br>Mary Donovan noted that financial classes are also available to those being sheltered once per week in addition to parenting classes. The finance classes are done by Wells Fargo.<br><br>Scott Ashton shared information about the upcoming Latino Business Showcase in 2 weeks. Also the Oceanside Community Guide was distributed to all members of the committee and Scott expressed his thanks to Tri-City for being an advertiser. | | |
| | Rosemary Eschelman commented that there is a 5 week course for students with parents encouraged to attend thru the school district. Topics include careful driving and coping with stress.<br><br>Carol Herrera shared that there is a report on homelessness in children and there are currently 35 homeless children in the school district. The parent liaisons, fire & police departments share who those students are and non-profit organizations step in to help as the schools are prohibited from using their funds for this purpose. Carol expressed her support for the previously | | |

| | | | |
|---|---|---|---|
| **Committee Communications (con't)** | proposed backpack program. Carol stated that the school districts can attend a CHAC meeting and present on homelessness in children in the 3 communities.<br><br>Director Dagostino commented that the HUD funding will guarantee that Tri-City will continue to be around and that it's a promise to use the funds responsibly and for citizenry. He also stated that Tri-City will preserve what's good and build only when necessary.<br><br>Director Schallock noted that he saw the Homeless Outreach team in Oceanside and would like to have them come in to present to CHAC.<br><br>Linda Ledesma suggested that we notify agencies to apply for grants to give more awareness to what's occurring in our community to which Director Nygaard responded that we can suggest to the board what we would like to grant to focus on, at which point the CHAC committee could vote on the issue.<br><br>Director Dagostino thanked the Committee for their input and commented that Palomar questioned him about the CHAC committee community representatives and stated that Palomar would like to add more community representatives.<br><br>Dung Ngo presented the question to Steve Dietlin of whether there was a clause in the HUD financing which included a pre-payment lock-out period. Steve responded that there was a pre-payment lockout period of 7 years, with years 8, 9, and 10 having lock-out penalties of 3%, 2%, and 1% respectively. Following that there are no penalties. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

March 16, 2017

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Next Meeting** | The next CHAC meeting is scheduled for Thursday, April 27, 2017. | | |
| **Adjournment** | The March 16th, 2017 CHAC meeting was adjourned at 1:31pm. | | |

**Tri-City Medical Center**
**Finance, Operations and Planning Committee Minutes**
**March 21, 2017**

| | |
|---|---|
| **Members Present** | Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Steve Harrington |
| **Non-Voting Members Present:** | Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO Wayne Knight, Chief Strategy Officer |
| **Others** | Glen Newhart, Sharon Schultz, Kevin McQueen, David Bennett, Jami Piearson, Charlene Carty, Kathy Topp, Ernie Rosales, Sarah Jayyousi, Norma Braun, Jane Dunmeyer, Steve Young Candice Parras, Sherry Miller, Jody Root (Procopio), Barbara Hainsworth |
| **Members Absent**: | Dr. John Kroener, Dr. Frank Corona, Kathleen Mendez, Carlo Marcuzzi, Wayne Lingenfelter, Tim Keane |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to order | Director Nygaard called the meeting to order at 12:32 p.m. | | |
| 2. Approval of Agenda | | **MOTION**<br>**It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved to accept the agenda of March 21, 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 February 14, 2017 | Minutes were ratified. | Minutes were ratified.<br>**MOTION**<br>**It was moved by Director Kellett, Director Mitchell seconded, that the minutes of February 14, 2017, are to be approved without any requested modifications.** | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 5. Old Business | | | |
| 6. New Business | | | |
| a. Cerner Meaningful Use (MU3) Proposal | Kathy Topp conveyed the importance of purchasing the 3rd phase of the Meaningful Use software upgrade from Cerner. This software will allow TCMC to report regulatory compliance that ties to direct patient care. It also supports other requirements and data reporting. Without the upgrade, TCMC risks penalties and reduced reimbursement. | **MOTION**<br>**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 authorize the agreement with Cerner for the required Meaningful Use project, beginning, May/June, 2017 for a one-time fixed fee, total cost of $297,000.** | Kathy Topp<br>(for Terry Moede) |
| b. In Motion, Inc. Proposal | David Bennett emphasized that this proposal with In Motion, Inc. would permit TCMC to be featured as the Title Sponsor of the annual Carlsbad Marathon and Half Marathon for years 2018, 2019 and 2020. Brief discussion ensued.<br><br>An amended write-up was distributed at the meeting to reflect that this agreement had not been submitted for legal review, as was noted on the document originally distributed to the Committee. Per the Chief Compliance Officer, this write-up is a renewal of the initial agreement, which had received legal review, and did not require a secondary review. | **MOTION**<br>**It was moved by Director Mitchell, 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 In Motion, Inc. for 3 events, one each to be held in January of 2018, 2019 and 2020, for an annual cost of $150,000, and a total cost for the term of $450,000.** | David Bennett |

| Topic | Discussions, Conclusions & Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| c. Physician Agreement for Covering Physician for Inpatient Wound Care<br>• Henry Showah, M.D. | Sharon Schultz conveyed that this proposal was for Dr. Showah to act as a covering physician for wound care inpatients. | **MOTION**<br>**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 authorize Dr. Henry Showah as the Coverage Physician for Inpatient Wound Care from March 1, 2017 for a term of 12 months, ending February 28, 2018. Not to exceed an average of 2 hours a month, at an hourly rate of $150 for a total cost for the term of $3,600.** | Sharon Schultz |
| d. Physician Agreement for Covering Physician at the Carlsbad Wound Care / HBO Center<br>• Henry Showah, M.D. | Sharon Schultz conveyed that this proposal was for Dr. Showah to act as a covering physician at the Carlsbad Wound Care / HBO Center. | **MOTION**<br>**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 authorize Dr. Henry Showah as the Coverage Physician at the Carlsbad Wound Care / HBO Center from March 1, 2017 for a term of 12 months, ending February 28, 2018. Not to exceed an average of 6 hours a month, at an hourly rate of $150 for a total cost for the term of $10,800.** | Sharon Schultz |
| e. Proposal for Sub-Lease of the 501 W. Vista Way Suite<br>• Achieve Transcranial Magnetic Stimulation (TMS) | Sarah Jayyousi explained that this proposal was to sub-lease space to Achieve Transcranial Magnetic Stimulation (TMC). This sub-lease is expected to generate approximately $50,968 in rent, as well as offer an expanded treatment option for Behavioral | **MOTION**<br>**It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the lease agreement with Achieve TMS for a** | Sarah Jayyousi |

| Topic | Discussions, Conclusions, Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | Health patients. | **term of 60 months, beginning, April 1, 2017 and ending, March 31, 2022 for an annual rent received of $9,600 (plus 3% annual increase), for a total amount for the term of $50,968.** | |
| f. Physician Agreement for ED On-Call Coverage - ENT Physician Supervision<br>• Anton Kushnaryov, M.D. | Sherry Miller conveyed that this write-up is to add Dr. Anton Kushnaryov as new physician to the existing panel for ED On-Call coverage for ENT, with no increase in expense. | **MOTION**<br>**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 add Dr. Anton Kushnaryov to the currently existing ED On-Call Coverage Panel for ENT for a term of 15 months, beginning April 1, 2017 and ending June 30, 2018.** | Sherry Miller |
| g. Physician Agreement for Covering Physician – OB<br>• Raheleh Esfandiari, M.D.<br>• Eimaneh Mostofian, M.D.<br>• Marlene Poutney-Levesque, M.D. | Sherry Miller conveyed that this write-up is to add Drs. Raheleh Esfandiari, Eimaneh Mostofian and Marlene Pountney-Levesque as new physicians to the existing panel for ED On-Call coverage for OB, with no increase in expense. | **MOTION**<br>**It was moved by, Director Mitchell Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Drs. Raheleh Esfandiari, Eimaneh Mostofian and Marlene Pountney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 15 months, beginning April 1, 2017 and ending June 30, 2018.** | Sherry Miller |
| h. Physician Agreement for ED On-Call Coverage – Neurology<br>• Andrew Blumenfeld, M.D.<br>• Bilal Choudry, M.D.<br>• Laura Desadier, M.D.<br>• Benjamin Frishberg, M.D. | Sherry Miller conveyed that this write-up is a renewal of the physician panel agreement for ED On-Call coverage for Neurology, at the same rate. | **MOTION**<br>**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 authorize the** | Sherry Miller |

| Topic | Discussions, Conclusions, Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| • Gary Gualberto, M.D.<br>• Amy Nielsen,D.O.<br>• Irene Oh, M.D.<br>• Remia Paduga, M.D.<br>• Jay Rosenberg, M.D.<br>• Mark Sadoff, M.D.<br>• Gregory Sahagian, M.D.<br>• Jack Schim, M.D.<br>• Anchi Wang, M.D.<br>• Chunyang Tracy Wang, M.D.<br>• Michael Zupancic, M.D. | | **above Neurology physicians as the Neurology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at daily rate of $740, for an annual cost of $270,100, for a total cost for the term of $270,100.** | |
| i. Pulse Oximetry Equipment and Disposables Agreement<br>• Masimo Americas, Inc. | Kevin McQueen reported that this agreement is for pulse oximetry equipment and disposables. He conveyed that with the agreement commitment, TCMC will receive $778,699 in new and upgraded ICU bedside / nurses station monitoring equipment, hand held pulse oximetry equipment, as well as installation and training.<br><br>An amended write-up was distributed at the meeting to reflect that this agreement had not been submitted for legal review, as was noted on the document originally distributed to the Committee. Per the Chief Compliance Officer, the write-up document has now been provided to Procopio for legal review, but had not been completed in advance of this meeting. | **MOTION**<br>**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 authorize the agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 and ending March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565.** | Kevin McQueen (for Tom Moore) |

| Topic | Discussions, Conclusions & Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| j. Renewal of Blood Type and Screen Instruments, Consumables and Cerner Interface Proposal<br>• Immucor, Inc. | Steve Young detailed that this agreement was for the Immucor Echo, an instrument that performs antibody type (ABO/Rh D) antibody screening and blood unit cross match, as well as for the requisite consumables. He further emphasized that this agreement equates to a total savings of $150,000 over the life of the 5-year agreement. | **MOTION**<br>**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 authorize the agreement with Immucor, Inc. for Echo Blood Type and Screen Instrument and Consumables for a term of 5 years, beginning, March 1, 2017 and ending, February 28, 2022 for an annual cost of $114,936 and a total cost for the term of $574,680.** | Steve Young (for Tara Eagle) |
| k. BHU/CSU Coverage Proposal<br>• Regents of University of California (UCSD) | Wayne Knight conveyed that this proposal was with the Regents of University of California (UCSD) for psychiatric medical services for inpatients in the Behavioral Health and Crisis Stabilization Units. He further explained that UCSD is the sole community provider willing to perform these services.<br>In addition, this write-up reflects that final approval by the Chief Compliance Officer was pending receipt of additional fair market value documentation, which had not been finalized in advance of this meeting. | **MOTION**<br>**It was moved by Dr. 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 agreement with the University of California San Diego Health System for medical directorship and management of the Behavioral Health Unit and Crisis Stabilization Units for a term of 36 months, beginning April 1, 2017 and ending March 31, 2020, for an annual cost of $1,238,215 and a total cost for the term of $3,715,740.** | |
| l. Financials | Ray Rivas presented the financials ending February 28, 2017 (dollars in thousands)<br>**TCHD – Financial Summary**<br>**Fiscal Year to Date**<br>Operating Revenue $ 222,308 | | Ray Rivas |

| Topic | Discussions, Conclusions & Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | Operating Expense $ 223,708<br>EBITDA $ 13,163<br>EROE $ 3,050<br>**TCMC – Key Indicators – FYTD**<br>Avg. Daily Census 182<br>Adjusted Patient Days 75,115<br>Surgery Cases 4,169<br>Deliveries 1,777<br>ED Visits 41,828<br>**TCHD-Financial Summary – Current Month**<br>Operating Revenue $ 27,023<br>Operating Expense $ 27,350<br>EBITDA $ 1,428<br>EROE $ 181<br>**TCMC – Key Indicators – Current Month**<br>Avg. Daily Census 178<br>Adjusted Patient Days 8,620<br>Surgery Cases 479<br>Deliveries 197<br>ED Visits 4,673<br>**TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year**<br>Net Patient A/R Avg. (in millions) $ 43.0<br>Days in Net A/R Avg. 49.9<br>**Graphs:**<br>• TCMC-Net Days in Patient Accounts Receivable<br>• TCMC-Average Daily Census, Total Hospital – Excluding Newborns<br>• TCMC-Acute Average Length of Stay<br>• TCMC-Emergency Department Visits | | |

| Topic | Discussions, Conclusions & Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| m. Work Plan – Information Only | Director Nygaard reported that these agenda items were for review only, but Committee members were welcome to ask questions. | | Chair |
| • ED Throughput | Sharon Schultz gave a brief PowerPoint presentation reflecting ED Throughput metrics. Candice Parras noted areas of improvement in the flow of the Emergency Department. | | Candice Parras / Sharon Schultz |
| • Dashboard | No discussion | | Ray Rivas |
| • Meaningful Use | Kapua Conley gave a short PowerPoint presentation detailing the definition of Meaningful Use, the respective phases of same, as well as the risks / penalties TCMC could incur for lack of Meaningful Use attestation. | | Kapua Conley / Ray Rivas |
| 7. Comments by Committee Members | | None | Chair |
| 8. Date of next meeting | April 18, 2017 | | Chair |
| 9. Community Openings (none) | | | |
| 10. Adjournment | Meeting adjourned 1:20 pm | | |

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**Cerner Meaningful Use (MU3) Proposal**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Service |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Cerner

**Area of Service:** Compliance / Quality / IT

**Term of Agreement:** Fixed Fee: The total professional services will be a one-time fee
Project kickoff: May/June; July 2017 payment.

**Maximum Totals:**

| Total Cost |
|---|
| $297,000 |

**Description of Services/Supplies:**

- **Value:** Supports Quality Patient Care. Regulatory Compliance related. Meaningful Use/MU is a requirement of the ACA for all hospitals. This allows us to report regulatory compliance that ties to direct patient care. MU supports other requirements, data reporting for Stroke Certification and Diabetic Certification.
- **What is MU Stage 3?**: EHR Incentive Program/Measurements that requires the reporting of key Objective metrics. Such as Clinical Decision Support, Protect electronic protected health information, patient care related computerized provider order entry to list a few. The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology.
  - **History:** MU has already included Stage 1 and Stage 2 completion. MU3 addresses functional reporting for key Objectives such as ePrescribe, Electronic Access to health info, Secure Messaging, HIE/Data Exchange, and Base EHR data elements, and ensures that we will meet 2018 compliance requirements.
  - **Technical:** Software upgrade for Cerner for MU3; three month upgrade and 4 month implementation in order to report regulatory required data.
- TCMC risks penalties and reduced reimbursement and reduced competitive market edge, if compliance is not met.

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

**Person responsible for oversight of agreement:** Terry Moede, Project Lead, IT / Kapua Conley, Chief Operating Officer

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Cerner for the required Meaningful Use project, beginning, May/June, 2017 for a one-time fixed fee, total cost of $297,000.

**AMENDED**

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**IN MOTION, INC. PROPOSAL**

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

**Vendor's Name:** In Motion, Inc.

**Area of Service:** Marketing, Communications and Public Affairs

**Term of Agreement:** 3 events, one each to be held in January of 2018, 2019 and 2020
*(Actual dates of event undetermined, but will be in January of each year)*

**Maximum Totals:**

| Annual Cost | Total Term Cost |
|---|---|
| $150,000 | $450,000 |

**Description of Services/Supplies:**

- TCMC will be featured as the Title Sponsor of the 2018, 2019, 2020 Carlsbad Marathon and Half Marathon in Carlsbad, CA.

| | | | | |
|---|---|---|---|---|
| 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 |

**Person responsible for oversight of agreement:** David Bennett, Chief Marketing Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with In Motion, Inc. for 3 events, one each to be held in January of 2018, 2019 and 2020, for an annual cost of $150,000, and a total cost for the term of $450,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PHYSICIAN AGREEMENT for Covering Physician for Inpatient Wound Care**

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

**Physician's Name:** Henry Showah, M.D.

**Area of Service:** Inpatient Wound Care

**Term of Agreement:** 12 months, Beginning, March 1, 2017- Ending February 28, 2018

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
No increase in expense

| Rate/Hour | Hours per Month | Hours per Year | Cost for this Contract | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $150 | 2 hours | 24 hours | $3,600 | $3,600 | $3,600 |

**Position Responsibilities:**

- Provide supervision for inpatient wound care
- 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
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians
- 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 hospital and Medical Staff's utilization review, quality, performance improvement and risk programs

| | | | | |
|---|---|---|---|---|
| Board Approved Physician Contract Template: | X | Yes | | No |
| Approved by Chief Compliance Officer: | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | X | Yes | | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Sharon Schultz R.N., Chief Nurse Executive / Sr. VP

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician from March 1, 2017 for a term of 12 months, ending February 28, 2018. Not to exceed an average of 2 hours a month, at an hourly rate of $150 for a total cost for the term of $3,600.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PHYSICIAN AGREEMENT for Covering Physician at the Carlsbad Wound Care/HBO Center**

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

**Physician's Name:** Henry Showah, M.D.

**Area of Service:** Wound Care / HBO – Carlsbad

**Term of Agreement:** 12 months, Beginning, March 1, 2017- Ending February 28, 2018

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
No increase in expense

| Rate/Hour | Hours per Month | Hours per Year | Cost for this Contract | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $150 | 6 hours | 72 hours | $10,800 | $10,800 | $10,800 |

**Position Responsibilities:**

- Provide supervision for the clinical operation of the Wound Care and HBO Programs in Carlsbad.
- 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 hospital and Medical Staff utilization review, quality, performance improvement and risk programs.

| | | | | |
|---|---|---|---|---|
| Board Approved Physician Contract Template: | X | Yes | | No |
| Approved by Chief Compliance Officer: | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | X | Yes | | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Sharon Schultz, R.N., Chief Nurse Executive / Sr. VP

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician from March 1, 2017 for a term of 12 months, ending February 28, 2018. Not to exceed an average of 6 hours a month, at an hourly rate of $150 for a total cost for the term of $10,800.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**Proposal for Sub-Lease of the 501 W. Vista Way Suite**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Lease Agreement |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Achieve Transcranial Magnetic Stimulation (TMS)

**Area of Service:** Outpatient Behavioral Health

**Term of Agreement:** 60 months, Beginning, April 1, 2017 – Ending, March 31, 2022

**Maximum Totals:**

| Monthly Charge to Achieve TMS | Annual Amount | Total Term Amount |
|---|---|---|
| $800 (With 3% annual increase) | $9,600 | $50,968 |

**Description of Services/Supplies:**

- Currently leasing the 501 W. Vista Way suite, for Outpatient Behavioral Health staff offices. No patient care conducted in the 501 suite.
- Approached by Dr. Manish Sheth, Achieve TMS, regarding sharing our space and using common areas plus two offices in the 501 suite.
- Proposal allows us to cover half the 501 suite rent by sharing half our space (562 sq. ft.) and charging the same amount charged by our landlord. Agreement permits cancellation of lease with 30 day notice.
- Positives associated with this move are the close provision of Transcranial Magnetic Stimulation (TMS) Treatment, expanding treatment options for our Behavioral Health patients. TMS is currently provided by many hospitals and many patients ask for this treatment modality.

| | | | | |
|---|---|---|---|---|
| Board Approved Contract Template: | X | Yes | | No |
| Approved by Chief Compliance Officer: | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | | Yes | X | No |
| Budgeted Item: | N/A | Yes | N/A | No |

**Person responsible for oversight of agreement:** Sarah Jayyousi, Operations Manager, Outpatient Behavioral Health Services / Sharon Schultz, Chief Nurse Executive

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the lease agreement with Achieve TMS for a term of 60 months, beginning, April 1, 2017 and ending, March 31, 2022 for an annual rent received of $9,600 (plus 3% annual increase), for a total amount for the term of $50,968.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT**

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

**Physician's Name:** Anton Kushnaryov, M.D.

**Area of Service:** Emergency Department On-Call: ENT

**Term of Agreement:** 15 months, Beginning, April 1, 2017 – Ending, June 30, 2018

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $450/Monday - Thursday | 260 | $117,000 |
| $550/Friday - Sunday | 196 | $107,800 |
| | **Total Term Cost:** | **$224,800** |

**Position Responsibilities:**

- Provide 24/7 patient coverage for all ENT 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 Dr. Anton Kushnaryov to the currently existing ED On-Call Coverage Panel for ENT for a term of 15 months, beginning April 1, 2017 and ending June 30, 2018.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN**

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

**Physician's Name:** Raheleh Esfandiari M.D., Eimaneh Mostofian M.D. and Marlene Pountney-Levesque M.D.

**Area of Service:** Emergency Department On-Call: OB/GYN

**Term of Agreement:** 15 months, Beginning, April 1, 2017 – Ending, June 30, 2018

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

**Maximum Totals:** For entire Current ED On-Call Area of Service Coverage: OB/GYN
New physicians to existing panel, no increase in expense

| Rate/Day | Current Panel Days per Year | Current Panel Annual Cost |
|---|---|---|
| Weekday $800 | 317 | $253,600 |
| Weekend/holiday $1000 | 139 | $139,000 |
| | **Total Term Cost:** | **$392,600** |

**Position Responsibilities:**

- Provide 24/7 patient coverage for all OB/GYN 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 Drs. Raheleh Esfandiari, Eimaneh Mostofian and Marlene Pountney-Levesque to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 15 months, beginning April 1, 2017 and ending June 30, 2018.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - NEUROLOGY**

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

**Physician's Name:** Andrew Blumenfeld, M.D.; Bilal Choudry, M.D.; Laura Desadier, M.D.; Benjamin Frishberg, M.D.; Gary Gualberto, M.D.; Amy Nielsen, D.O.; Irene Oh, M.D.; Remia Paduga, M.D.; Jay Rosenberg, M.D.; Mark Sadoff, M.D.; Gregory Sahagian, M.D.; Jack Schim, M.D.; Anchi Wang, M.D.; Chunyang Tracy Wang, M.D.; Michael Zupancic, M.D.

**Area of Service:** Emergency Department On-Call: Neurology

**Term of Agreement:** 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage:

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $740 | 365 | $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 authorize the above Neurology physicians as the Neurology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at daily rate of $740, for an annual cost of $270,100, for a total cost for the term of $270,100.

AMENDED

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**PULSE OXIMETRY EQUIPMENT AND DISPOSABLES AGREEMENT**

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

**Vendor's Name:** Masimo Americas, Inc.

**Area of Service:** Nursing Services

**Term of Agreement:** 60 months, Beginning, April 1, 2017 – Ending, March 31, 2022

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $32,059 | $384,713 | $1,923,565 |

**Description of Services/Supplies:**

- Disposable pulse oximetry probe pricing agreement with minimum purchase commitment of $384,713 annually. Previous agreement was $500,000 per year
- Current annual spend in this category with this vendor is almost $600K, so there are no new or additional costs to the District with this agreement
- With this commitment, we will receive $778,699 in new and upgraded ICU bedside/nurses station monitoring equipment, hand held pulse oximeter equipment, as well as installation and training
- The current ICU monitors are due for replacement
- Pricing of Masimo disposables will remain at our current GPO price schedule

| | | | | |
|---|---|---|---|---|
| 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 |

**Person responsible for oversight of agreement:** Tom Moore, Director, Purchasing / Ray Rivas, Acting Chief Financial Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 and ending March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**Renewal of Blood Type and Screen Instruments, Consumables and Cerner Interface Proposal**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Equipment & Peripherals |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Immucor, Inc.

**Area of Service:** Laboratory

**Term of Agreement:** 5 years, Beginning, March 1, 2017 – Ending, February 28, 2022

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $9,578 | $114,936 | $574,680 |

**Description of Services/Supplies:**

- The Immucor Echo is an instrument that performs antibody type (ABO/Rh D), antibody screen, and blood unit cross match on patient samples in our Laboratory Transfusion Medicine Department. It is our instrument of choice for blood unit transfusion services.
- This proposal includes the renewal of a 5 year instrument lease with 5 years of service on the instrument, 5 years of consumables, and Cerner interface and necessary hardware. Among the consumables are reagents, quality control and calibration material.
- The agreement delivers two significant financial benefits and allows us to continue to use this tried and proven technology. It reduces our current annual expenditure by $30,000 and holds the line on this reduced pricing for the contract term of five years. ****This equates to a savings total of $150,000 over the life of the agreement.**

| | | | | |
|---|---|---|---|---|
| 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:** Tara Eagle, Operations Manager, Lab / Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Immucor, Inc. for Echo Blood Type and Screen Instrument and Consumables for a term of 5 years, beginning, March 1, 2017 and ending, February 28, 2022 for an annual cost of $114,936 and a total cost for the term of $574,680.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: March 21, 2017**
**BHU/CSU COVERAGE PROPOSAL**

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

**Vendor's Name:** Regents of the University of California (UCSD)

**Area of Service:** IP Behavioral Health and Crisis Stabilization Units

**Term of Agreement:** 36 months, Beginning, April 1, 2017 – Ending, March 31, 2020

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $103,215 | $1,238,580 | $3,715,740 |

**Description of Services/Supplies:**

- Manage psychiatric medical services on inpatient Behavioral Health Unit and Crisis Stabilization Unit 24 hours a day, 7 days a week, 365 days a year.
- Provide Medical Director and 4 FTE positions
- UCSD is the sole community provider who is willing to provide these services.

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

**Pending review of FMV documentation*

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

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the University of California San Diego Health System for medical directorship and management of the Behavioral Health Unit and Crisis Stabilization Units for a term of 36 months, beginning April 1, 2017 and ending March 31, 2020, for an annual cost of $1,238,215 and a total cost for the term of $3,715,740.

DRAFT

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

**Members Present**: Director Laura Mitchell (Chair), Director Jim Dagostino, 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, Jami Piearson, Director of Regulatory Compliance, Kathy Topp, Kevin McQueen, Sherry Miller, Aimee Hardt, Nancy Myers, Sharon Davies, Jenessa French, Oska Lawrence, Natalie Mills, Zechariah Smith, Lisa Mattia, Priya Joshi, Patricia Guerra and Karren Hertz.

**Members Absent:** Director Leigh Anne Grass.

| 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. The Administrative Policy #4 on mandatory reporting requirements was pulled out of the agenda for further review. | Motion to approve the agenda was made by Dr. Contardo and seconded by Dr. Johnson. | 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 February 2017. | Director Mitchell called for a motion to approve the minutes from February 9, 2017 meeting. There was a clarification made on the statement that "only a neonatologist is allowed to intubate a baby". There was a short discussion and it was identified that this policy specifically deals with the presence of neonatologist in the OR for deliveries and not talking about the whole hospital. | The minutes were ratified following the amendments made. Director Dagostino moved and Dr. Ma seconded the motion to approve the minutes from February 2017. | Karren Hertz |
| 5. New Business<br>a. Consideration and Possible Approval of Policies and Procedures<br><br>**Patient Care Policies and Procedures:**<br>1. ALARIS System Data Set Approval and CQI Activities Procedure<br><br>2. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure<br><br>3. Care of the Newborn Standardized Procedure | There was no discussion on this policy.<br><br>This policy further clarified that BLS response now includes AED.<br><br>There was a duplication in the section where the mother initiates breastfeeding when mother and infant are separated for longer than 3 hours. This will be corrected in the policy. | **ACTION:** The Patient Care Services policies and procedures were approved. Dr. Ma moved and Director Contardo 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 |
|---|---|---|---|
| 4. Deceased Newborn Stillborn, Care of Procedure | There was no discussion on this policy. | | |
| 5. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy | There was no discussion on this policy. | | |
| 6. Food Brought in From Outside the Hospital Policy | There was no discussion on this policy. | | |
| 7. Food Expiration Dates Policy | There was no discussion on this policy. | | |
| 8. Needle Aspiration Neonates Standardized Procedure | It was noted that all NICU babies are required to use the cardio respiratory monitoring which is the standard of care for this procedure. | | |
| 9. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure | There was no discussion on this policy. | | |
| 10. Physicians Orders fro Life Sustaining Treatment (POLST) 393 | There was no discussion on this policy. | | |
| 11. Rapid Response Team and Condition Help Policy | There was a clarification if staff in the unit knows how to initiate a Rapid Response call for condition H. | | |
| 12. Stroke Code, | The finger stick blood glucose is still being | | |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| Emergency Department Procedure | done in the ED for stroke code patients. This is being done on other areas as well. | | |
| 13. Telephone Service for Patient Rooms Policy | There is no discussion on this policy. | | |
| 14. Therapeutic Hypothermia After Cardiac Arrest Procedure | The therapeutic hypothermia is usually done for arrests that happened inside and outside the hospital . It was agreed that policy should be kept as it is. | | |
| 15. Visiting Guidelines | There was no discussion on this policy. | | |
| **Administrative Policies and Procedures:** | | | |
| 1. Code Gray- Hostage Response Plan 283 | Director Dagostino asked how will the BOD be informed in case there is a Code Gray situation. The group had a consensus to add:<br>• The CEO will notify the Board of Directors<br>• The CEO will notify the Chief of Staff | **ACTION:** The Administrative policies and procedures were approved. Director Dagostino moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |
| 2. Control for Locks and keys 243 | There was no discussion on this policy. | | |
| 3. Helicopters on District Policy | There was a brief discussion on the weight of the helicopter ; it was noted that for the helicopters they factor in everything for compliance purposes—weight of the crew and equipment. | | |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 4. Mandatory Reporting Requirements | This policy was pulled out as it needs further review. | | |
| **Unit Specific Education**<br>1. AHA and AWHONN Course Card Acceptance Policy<br>2. AHA Care and Decontamination of AHA Equipment Policy<br>3. AHA Continuing Education Statement Policy<br>4. AHA Mission Statement and Goals Policy<br>5. AHA Quality Assurance Program Policy<br>6. AHA TC Course Card Management Policy<br>7. Copyright Policy | Dr. Ma had an inquiry on why are we reviewing these policies for AHA. It was noted that sinceTri-City is an acredited AHA training center, the hospital needs to have these policies revisited, reviewed and approved. | **ACTION:** The Education policies were approved. Director Dagostino moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |
| **Infection Control**<br>1. Meninoccocal Exposure IC 6.2<br>2. Risk Assessment and Surveillance Plan IC.2<br>3. Toy Cleaning IC 9.1 | All sections that still have Tri-City Medical Center should be changed to Tri-City Healthcare Ditrict.<br>The part that mentions significant deviations should be discussed in medical staff committees should be changed to only be on an as-needed basis. | **ACTION:** The Infection Control 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 |
| **NICU** | | | |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 1. Blood Product Aliquot Syringes, Emergent preparation Of<br>2. Cardio-Respiratory Monitoring in the NICU<br>3. Neonatal Anstinence Syndrome, Management of Scoring<br><br>**Women's and Newborn Services**<br>1. Infant Safety and Security | There was no discussion on these NICU policies.<br><br>There is no discussion on this policy. | **ACTION:** The NICU policies and procedures were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.<br><br>**ACTION:** The Women's and Newborn Services policy approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra<br><br>Patricia Guerra |
| 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 | No comments. | | Director Mitchell |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| the Committee | | | |
| 11. Adjournment | Meeting adjourned at 2:11 PM. | | Director Mitchell |

# PROFESSIONAL AFFAIRS COMMITTEE
## March 9th, 2017

CONTACT: Sharon Schultz, CNE

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Patient Care Services Policies & Procedures** | | |
| 1. Alaris System Data Set Approval and CQI Activities Procedure | 3 year review, practice change | Forward to BOD for approval |
| 2. Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure | 2 year review, practice change | Forward to BOD for approval |
| 3. Care of the Newborn Standardized Procedure | 2 year review, practice change | Forward to BOD for approval with revisions |
| 4. Deceased Newborn Stillborn, Care of Procedure | 3 year review, practice change | Forward to BOD for approval with revisions |
| 5. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy | 3 year review, practice change | Forward to BOD for approval |
| 6. Food Brought in from Outside the Hospital Policy | 3 year review, practice change | Forward to BOD for approval |
| 7. Food Expiration Dates Policy | 3 year review, practice change | Forward to BOD for approval |
| 8. Needle Aspiration Neonates Standardized Procedure | 2 year review, practice change | Forward to BOD for approval |
| 9. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure | 3 year review, practice change | Forward to BOD for approval |
| 10. Physicians Orders for Life Sustaining Treatment (POLST) 393 | 3 year review, practice change | Forward to BOD for approval |
| 11. Rapid Response Team and Condition Help Policy | 3 year review, practice change | Forward to BOD for approval |
| 12. Stroke Code, Emergency Department Procedure | 3 year review, practice change | Forward to BOD for approval with revisions |
| 13. Telephone Service for Patient Rooms Policy | 3 year review, practice change | Forward to BOD for approval |
| 14. Therapeutic Hypothermia after Cardiac Arrest Procedure | 3 year review, practice change | Forward to BOD for approval |
| 15. Visiting Guidelines 301 | 3 year review | Forward to BOD for approval |
| | | |
| **Administrative Policies & Procedures** | | |
| 1. Administrator On Call - 281 | 3 year review, practice change | Forward to BOD for approval |
| 2. Code Gray - Hostage Response Plan 283 | 3 year review, practice change | Forward to BOD for approval with revisions |
| 3. Control for Locks and Keys 243 | 3 year review, practice change | Forward to BOD for approval |
| 4. Helicopters on District Policy 207 | 3 year review, practice change | Forward to BOD for approval |
| 5. Lost and Found Articles - 202 | 3 year review, practice change | Forward to BOD for approval |
| 6. Mandatory Reporting Requirements 236 | practice change | Pulled for further review |

# PROFESSIONAL AFFAIRS COMMITTEE
## March 9th, 2017

CONTACT: Sharon Schultz, CNE

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Unit Specific** | | |
| **Education** | | |
| 1. AHA & AWHONN Course Card Acceptance Policy | 3 year review, practice change | Forward to BOD for approval |
| 2. AHA Care and Decontamination of AHA Equipment Policy | 3 year review, practice change | Forward to BOD for approval |
| 3. AHA Continuing Education Statement Policy | 3 year review, practice change | Forward to BOD for approval |
| 4. AHA Mission Statement & Goals Policy | 3 year review, practice change | Forward to BOD for approval |
| 5. AHA Quality Assurance Program Policy | 3 year review, practice change | Forward to BOD for approval |
| 6. AHA TC Course Card Management Policy | DELETE | Forward to BOD for approval |
| 7. Copyright Policy | 3 year review, practice change | Forward to BOD for approval |
| | | |
| **Infection Control** | | |
| 1. Meningococcal Exposure IC 6.2 | 3 year review, practice change | Forward to BOD for approval |
| 2. Surveillance Program IC 2 | 1 year review, practice change | Forward to BOD for approval with revisions |
| 3. Toy Cleaning IC 9.1 | 3 year review, practice change | Forward to BOD for approval |
| | | |
| **NICU** | | |
| 1. Blood Product Aliquot Syringes, Emergent Preparation of | 2 year review, practice change | Forward to BOD for approval |
| 2. Cardio-Respiratory Monitoring in the NICU | 3 year review, practice change | Forward to BOD for approval |
| **3.** Neonatal Abstinence Scoring | 3 year review, practice change | Forward to BOD for approval with revisions |
| | | |
| **WNS** | | |
| 1. Infant Safety and Security | 3 year review, practice change | Forward to BOD for approval |
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| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **ALARIS SYSTEM DATA SET APPROVAL AND CQI ACTIVITIES** |
| Purpose: | To outline the process for modification/approval of the Guardrails data set on infusion pumps and evaluation of CQI reports and data. |

A. **PROCEDURE**

1. **Modification of existing Data Set**
   a. Requests for data set revision by Registered Nurses (RNs):
      i. Requests for data set revision may be submitted by any RN to the Clinical Educator for their unit.
      ii. The Clinical Educator shall determine if the change has merit and if a consensus from the staff utilizing that data set profile approve of the change.
      iii. If the change is still recommended, then the Clinical Educator shall forward the request to the Alaris CQI Task Force.
      iv. Changes shall be submitted to the Pharmacy & Therapeutics (P&T) Committee and forwarded to Medical Executive Committee (MEC) for Medical Staff approval.
      v. Upon Medical Staff approval, changes shall be submitted to the Board of Directors (BOD) for final approval.
   b. Requests for data set revision by the Medical Staff: Requests for data set revision may be submitted by any medical staff member to the Pharmacy Clinical ~~Specialist~~**Manager**. These requests shall be submitted to P&T Committee, MEC, and BOD for approval.
2. **Fast-track Approval of Data Sets**
   a. Fast-track approval of data set changes/edits may be granted by the Pharmacy Clinical ~~Specialist~~ **Manager** if deemed necessary and in the best interest of patient safety. These changes may be put into effect without delay, but must be submitted through the standard approval process after fast-track approval.
3. **CQI Data Review**
   a. CQI Data and Reports – Medical Staff: CQI data and reports shall be submitted to the P&T Committee on a quarterly basis. Pertinent information, trends identified, and recommended CQI initiatives shall be summarized and reported to MEC.
   b. CQI Data and Reports – Hospital Staff: A multi-disciplinary task force (Nursing, Pharmacy, Process Improvement) shall have access to the CQI data and reports via the Alaris CQI data software. Profile specific CQI initiatives shall be identified and improvement tracked and trended. Reports to Nursing Professional Practice Council (NPPC) shall occur on an ongoing basis (at least quarterly).
   c. Practitioners for Each Profile shall be identified as *CQI Champions* to facilitate the dissemination of progress made to the unit staff and the communication between the NPPC and the end-users of the Alaris pump system.

| 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 |
|---|---|---|---|---|---|---|---|
| 10/05; 12/00; 06/08, **11/16** | 04/11, **12/16** | 04/11, **01/17** | **n/a** | **02/17** | 05/11, **n/a** | 06/11, 03/17 | 06/11 |

**STANDARDIZED PROCEDURE: CARDIAC WELLNESS CENTER (ON CAMPUS) EMERGENCY TREATMENT**

I. **POLICY:**

A. Function: Safe and standardized management of unexpected cardiovascular events or exercise related changes in cardiovascular status including, but not limited to, acute angina or change in anginal pattern, stable angina, chest wall/incisional/musculoskeletal pain, cardiac dysrhythmias, hypotensive/syncopal episodes, and acute dyspnea.

B. Circumstances:
1. Setting: Cardiac Rehabilitation service area (on campus), Tri-City Medical Center
2. Supervision: RN; upon arrival of a physician, nursing staff shall follow physician orders instead of standardized procedure.
3. Patient contraindications – Patients with written orders to the contrary of the Standardized Procedure. Patients with Special Considerations:
   i. No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate".

C. Definitions:
1. Acute angina: Pain, pressure, heaviness, burning sensation, indigestion. May be felt in center of chest, arms, neck, jaw, and shoulders. Other symptoms may include weakness, shortness of breath, diaphoresis, nausea vomiting (1 or more symptoms may be present.)
2. Change in Anginal pattern: Change in frequency, duration, and pattern of angina.
3. Stable Angina: Angina symptoms are relieved with rest or nitroglycerin.
4. Chest wall/incisional/musculoskeletal pain: Atypical pain associated with movement, stretching, straining, coughing, and palpable tenderness.
5. Cardiac Dysrythmias: Any rhythm other than sinus rhythm that requires immediate intervention due to life threatening potential or that results in the patient becoming symptomatic (compromised).
6. Hypotensive/syncopal episodes: Any decrease in blood pressure of 30 - 40 mmHg or more from pre-exercise levels or less than 80 mmHg systolic associated with symptoms.

D. Data Base:
1. Subjective: Patient complaints including, but not limited to, pain, pressure heaviness, burning sensation, indigestion felt in center of chest, arms, neck, jaw, shoulders. Other symptoms may include weakness, shortness of breath, nausea, dizziness, light-headedness, and confusion.
2. Objective: Cardiac rate and rhythm disturbances, decreased level of responsiveness, hypotension, labored respiration, oxygen saturation less than 92%, diaphoresis, vomiting.
3. Assessment: Unexpected cardiovascular events/exercise related changes in cardiovascular status.
4. Plan:
   i. Initiate standardized procedure as appropriate and notify cardiologist or primary physician (if no cardiologist) as soon as possible.
   ii. Call CODE BLUE by dialing 66 to respond to Cardiac Wellness Center as appropriate.

| Department Review | Clinical Policies & Procedures | Nurse Executive Council | Division of Cardiology | Pharmacy & Therapeutics Committee | Interdisciplinary Practice Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 9/02; 3/10;12/12, 6/16 | 3/10;2/13, 08/16 | 12/10;2/13, 09/16 | 10/16 | 1/11;5/13, 11/16 | 1/11;9/13, 01/17 | 2/11;10/13, 02/17 | 03/17 | 8/03, 1/05, 6/06, 8/08, 2/11;10/13 |

iii. Assist with transportation of patient to Emergency Department (ED) via wheelchair or gurney as appropriate. Provide protection of umbrella to protect patient from rain or inclement weather during transportation.

II. **PROCEDURE:**

A. **ACUTE ANGINA OR CHANGE IN ANGINAL PATTERN:**

1. Stop exercise
2. Assess patient's blood pressure, $SpO_2$, heart rate and rhythm, lung sounds, respirations, color and mentation. Assess chest pain (location, severity, character).
3. Administer oxygen to maintain $SpO_2$ greater than 95%.
4. Administer nitroglycerin (NTG) spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays for symptoms of angina unrelieved by rest.
   i. If chest pain is unrelieved after 3 NTG sprays, transport to ED for further evaluation.

B. **STABLE ANGINA:**

1. Administer prophylactic nitroglycerin as indicated and per physician order.
2. Assess and document patient's response to nitroglycerin and exercise.
3. Assess patient's blood pressure, heart rate and rhythm, respirations, color and mentation.
4. Stop activity if angina is unrelieved and proceed as for acute angina.

C. **CHEST WALL/INCISIONAL/MUSCULOSKELETAL PAIN:**

1. Evaluate cause of pain.
2. Assess blood pressure, heart rate and rhythm, respirations, color, and mentation.
3. Discontinue modalities that aggravate symptoms, or decrease workloads.
4. Notify physician if symptoms persist.
5. Document assessment and treatment on patient's chart.
6. Re-evaluate at next exercise session.

D. **TREATMENT FOR DYSRHYTHMIAS THAT MAY RESULT IN CARDIOPULMONARY ARREST:**

1. Assessment
   i. Establish baseline if time allows and patient is stable (Historical Data)
      a) Review baseline ECG
      b) Review medications
      c) Inquire regarding the use of stimulants (i.e. caffeine, smoking, cold remedies)
   ii. Evaluation of new arrhythmias
      a) Evaluate hemodynamic status, i.e., blood pressure, heart rate, skin color and temperature, lightheadedness, dizziness, shortness of breath.
2. Treatment
   i. Ventricular fibrillation and pulseless ventricular tachycardia, asystole, PEA
      a) **Call Code Blue**~~Begin BLS~~
      b) **Begin BLS**~~Call CODE BLUE~~
      ~~c) Administer oxygen to maintain $SPO_2$ greater than 95%~~
      ~~d)~~**c)** Place on a cardiac monitor
   ii. Symptomatic Cardiac Rhythm: Complete heart block, symptomatic bradyarrhythmia or tachyarrhythmia
      a) Administer oxygen to maintain $SPO_2$ greater than 95%
      b) Place on a cardiac monitor
      c) Alert Lift Team/Rapid Response Team **(RRT)** to assist with immediate transport to ED
   iii. New changes in cardiac rhythm: stable bradyarrhythmia or tachyarrhythmia, new onset atrial fibrillation, increase in premature ventricular contractions (PVC), or runs of stable ventricular tachycardia
      a) Stop exercise

b) Assess patient's blood pressure, respiratory rate, $SPO_2$ percentage, skin color, temperature, mentation, and other symptoms
c) Administer oxygen to maintain $SPO_2$ greater than 95%
d) Contact physician for further orders
e) Transport to ED with assistance of Lift Team if necessary

E. **HYPOTENSIVE EPISODES:**
1. Assist patient to supine position.
2. Assess blood pressure, heart rate, rhythm, respiration, oxygen saturation, skin color, temperature, mentation, and presence of other symptoms.
3. Administer oxygen to maintain $SPO_2$ saturation greater than 95%
4. Notify physician
5. If no improvement, transport to the ED

F. **ACUTE DYSPNEA:**
1. Stop exercise.
2. Assess oxygen saturation by pulse oximetry
   i. If oxygen saturation is less than 92%, place patient on oxygen and titrate to oxygen saturations greater than 95%.
3. Assess breath sounds
4. Assess patient for use of rescue drug inhalers and encourage patient to use inhaler if available.
5. Notify physician if symptoms do not improve and transport to the Emergency Department **(ED)** via wheelchair or gurney.

G. **LEFT VENTRICULAR ASSIST DEVICE (LVAD):**
**1.** Check to see if pump is still working**:**
   **i. Look to see if all lights are green**
   ~~i.~~**ii.** ~~(~~Listen for quiet whirling sound with stethoscope or feel by placing hand over abdomen~~).~~
2. Check that all connections to power source and fix if loose or disconnected.
3. Replace current batteries with a new, fully charged pair.
4. Contact LVAD coordinator
**5.** If patient unstable, **call RRT to assist with immediate transport to ED**~~start ACLS protocol~~
   **i. No**~~WITHOUT~~ compressions~~.~~
   **ii.** Keep all connections together if defibrillation is necessary,
      a) DO NOT stop pump prior to delivering shock.

H. **DOCUMENTATION:**
1. Document event, intervention, and response in the medical record and notify the physician.
2. Record subjective data
3. Record rhythm strip, blood pressure, heart rate, oxygen saturation
4. Send information to primary physician/cardiologist

III. **<u>REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:</u>**
A. Current California RN license.
B. Education: Successful completion of ACLS course (with current course completion card), performance of annual mock code.
C. Experience: Initial job requirements.
D. Initial Evaluation: During Orientation period.
E. Ongoing Evaluation: Annually

IV. **<u>DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:</u>**
A. Method: This standardized procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

/. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All ACLS-certified Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure.

Tri-City Medical Center
Oceanside, California

## PATIENT CARE SERVICES

## STANDARDIZED PROCEDURE: CARE OF THE NEWBORN

I. **POLICY:**

A. Function: To define the care and immediate treatment post-delivery for the newborn weighing greater than or equal to 2000 grams that is equal to and are greater than 35 6/7 weeks gestational age.

B. Circumstances:

1. Setting: Labor and Delivery **(L&D)**, Newborn Nursery, and Mother-Baby
2. Supervision: None required. Physician's office/answering service will be notified of delivery time and date.
3. Requires that a **Registered Nurse (**RN**)** provide immediate care to administer medications, provide nutrition and/or nutritional support, and to perform procedures, laboratory and diagnostic tests that are considered to be routine care to the well born term or near term newborn infant.
4. The Women and Newborn Services (WNS) RN must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**

A. Newborns greater than or equal to 2000 grams and who are greater than 35 6/7 weeks gestational age shall receive:

1. Prophylactic treatment of eyes (Erythromycin ophthalmic ointment) and medication to normalize coagulation (Vitamin K) within 2 hours of delivery time.
   a. Refer to Patient Care Services (PCS) ~~s~~**S**tandardized ~~p~~**P**rocedure (SP)**:** Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to the Newborns.
   b. Exception: Parents who refuse verbal consent**.**
2. The newborn shall receive Hep**atitis** B vaccine or Hep**atitis** B vaccine/HBIG immunoglobulin injection if indicated according to the mother's HBsAg status and within 12 hours of delivery time.
   a. Refer to PCS SP: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (H**BIG**~~big~~) (Hyper B Sd®) to Newborns.
   b. Exception: Parents who refuse verbal consent.

B. Infant nutrition:

1. Breastfeeding
   a. Initiate feedings as soon as possible but no longer than 2 hours following delivery.
      i. If cesarean delivery, as soon as possible (ASAP) when mother and infant are reunited.
      ii. If mother and infant are separated for longer than 3 hours, initiate breast-pumping (even if mother going to NICU to breastfeed).
         1) Refer to WNS Procedure: Breast Milk, Pumping, Handling and Storage of.
      iii. Assess and attempt to feed 8 or more times within a 24 hour period-approximately every 2-3 hours and on demand.
      iv. No supplementation of formula unless ordered by provider, requested by mother or as per other procedures where supplementation is required.

| Department Review | Clinical Policies & Procedures | Nursing Executive Council | Division of Neonatology | Department of Pediatrics | Pharmacy & Therapeutics Committee | Interdis-ciplinary Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|---|
| 04/15 | 8/12, 11/13, 4/15, 6/16 | 8/12,11/13 , 4/15, 7/16 | 08/16 | 05/15, 11/16 | 9/12,11/13, 05/15, 11/16 | 11/12, 2/14, 09/15, 01/17 | 4/13, 2/14, 09/15, 02/17 | 10/15, 03/17 | 4/13;2/14; 10/15 |

v. Obtain lactation consult as clinically indicated
1) Refer to WNS ~~p~~**P**olicy: Infant Feeding.

2. Bottle-feeding
a. Offer bottle with formula of mother's choice, ~~20 Kcal/ounce,~~ by 3 hours of age
i. Assess feeding status every 3-4 hours, offer formula PRN and on demand.
ii. Refer to WNS ~~p~~**P**rocedure: ~~Bottle~~**Formula** Feeding.

C. Procedures:
1. Newborn hearing screen
a. Ensure hearing screen is ordered per WNS ~~p~~**P**olicy: Hearing Screening **Program:** Newborn and Infant**s**.
2. Obtain Total Serum Bilirubin at approximately 24 hours of age or sooner if baby visually appears to have jaundice.
a. If greater than or equal to 95$^{th}$ percentile (high risk zone) on Bhutani's curve (per hours of age**)** notify provider.
b. Notify provider of Total Serum Bilirubin prior to discharge if he/she is not already aware of the result and the baby will not be rounded on/seen again by a pediatrician prior to discharge.
3. If infant Coombs positive, order CBC with manual differential, retic count, and total serum bilirubin STAT and call provider with results.
a. Contact physician immediately upon return of test results.
4. All infants meeting criteria will have a car seat challenge performed prior to discharge as per WNS/Neonatal Intensive Care Unit (NICU) ~~p~~**P**rocedure: Car Seat Challenge Test.
5. All infants meeting criteria will have neonatal abstinence scoring performed as per WNS/NICU ~~p~~**P**rocedure: Neonatal Abstinence Scoring.
6. All infants will have pulse oximetry done after 24 hours of life or prior to discharge per PCS SP**:** Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).

D. Laboratory tests:
1. Point of care glucose testing
a. Perform per PCS **SP:** Blood Glucose Newborn Monitoring ~~Standardized Procedure~~.
2. Toxicology
a. Obtain a urine specimen if mother has a positive toxicology screen, a positive history of substance use, is suspected of substance use or with diagnosis, has had less than or equal to three prenatal visits, or suspicion of placental abruption.
i. If positive for cocaine, amphetamines and or opiates, lab will perform a confirmation.
b. Obtain a urine specimen on all babies assigned to Neonatology.
3. Cord blood screen (Direct Coombs and blood typing) ASAP
4. Newborn metabolic screen prior to discharge but at least 24 hours following delivery.
a. Refer to PCS ~~p~~**P**rocedure: Newborn Screen**ing**, Collection of Specimen.
**5. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age if:**
**a.** If Mother is GBS positive**,** ~~and~~ received no treatment or **received a dose** ~~1 dose only~~ of antibiotics less than 4 hours prior to delivery
**i. Infant is either less than 37 weeks estimated gestational age (EGA)**
~~5.~~**ii. Infant is greater than 37 weeks EGA , but mother had a rupture of membranes greater than 18 hours:**
~~a. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age~~
~~i.~~**6.** Notify provider of CBC with manual differential results if abnormal
~~1)~~**a.** Abnormal CBC for infant, at least one of the following:
~~a)~~**i.** WBC greater than 35,000 or less than 9,000
~~b)~~**ii.** ANC less than 1500
~~c)~~**iii.** Platelet Count less than 120,000

E. Call provider immediately for maternal/infant signs of chorioamnionitis/infection or the following symptoms~~:prior to delivery~~
   1. Maternal temperature greater than or equal to 100.4 degrees Fahrenheit plus two or more of the following:
      a. Maternal tachycardia (greater than 100bpm)
      b. Fetal tachycardia (greater than 160bpm)
      c. Uterine tenderness
      d. Foul smelling amniotic fluid
      e. Maternal leukocytosis (greater than 15,000 WBC)

III. **DOCUMENTATION:**

A. Document assessment, actions and provider notification/response in electronic health record (EHR) as appropriate.

B. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the **(EHR)**~~electronic health record~~ as Standardized Procedure.
   1. Not required if a screening process triggers the order.
   2. Utilizing **Computerized Physician Order Entry** (CPOE), select the Standardized Procedure (SP) power plan **PCS** SP**:** Newborn Admit.
   3. Type in provider's name and select "Standardized Procedure" as the order communication type.

C. Initiate, sign and refresh Newborn Medications power plan prior to birth in order to readily access medications in Pyxis.

D. Prior to administration of vaccines **see PCS Policy: Vaccination Administration**~~provide a copy of the Center for Disease Control (CDC) Vaccine Information Statements (VIS) to the newborn's mother/legal guardian and document in Cerner. Document the name and edition date of the VIS in the "comments" section of the e-mar and in care plan~~.

~~E. Document administration and injection sites of medications on the Cerner electronic Medication Administration Record (eMAR). Including: manufacturer, lot number and expiration date for all vaccines administered.~~

~~F. Document administration of vaccine on the yellow California Immunization Record card. Give this record to the mother/legal guardian with instructions to take the card with her/him to all infant healthcare provider visits at discharge.~~

~~G.~~**E.** Document patient (mother/legal guardian) teaching in the education section of the EHR.

~~H.~~**F.** Total serum bilirubin will be documented in the EHR.

~~I. Document newborn screen specimen collection in EHR.~~

~~J. Document newborn hearing screen in EHR.~~

~~K. Document car seat challenge, if appropriate, in EHR.~~

~~L. Document neonatal abstinence score, if appropriate in EHR~~

~~M. Document the universal blood saturation screening in the EHR.~~

IV. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license working in Women's and Children's Services
B. Education: Register Nurse
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform "Care of the Newborn" Standardized Procedure.

VII. **RELATED DOCUMENTS:**

**A. PCS Policy: Vaccination Administration**
~~A.~~**B.** PCS Procedure: Newborn Screen**ing**, Collection of Specimen
~~B.~~**C.** PCS Standardized Procedure: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns
~~C.~~**D.** PCS Standardized Procedure: Administration of **Pediatric** Hepatitis B Vaccine and **Hepatitis B** Immunoglobulin (HBIG) **(Hyper B Sd®)** to Newborns
~~D. PCS Standardized Procedure - Erythromycin Ophthalmic Ointment to the Newborns~~
~~E. PCS Standardized Procedure - Hepatitis B Immunoglobulin (Hbig) (Hyper B Sd®) to Newborns~~
~~F.~~**E.** PCS Standardized Procedure: Blood Glucose Newborn Monitoring
~~G.~~**F.** PCS Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)
**G.** WNS Policy: Infant Feeding
H. **WNS Policy: Hearing Screening Program: Newborn and Infants**
I. WNS Procedure: ~~Bottle-Feeding~~**Formula Feeding**
J. WNS Procedure: Breast **Milk,** Pumping**, Handling** and ~~Milk~~ Storage **of**
K. WNS/NICU Procedure: Car Seat Challenge Test
L. WNS/NICU Procedure: Neonatal Abstinence Scoring

VIII. **REFERENCES:**

~~A. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.~~
~~B.~~**A.** AWHONN Core curriculum for Maternal-Newborn Nursing 4th edition. St Louis, Missouri: Elsevier Saunders 2007. pp 427- 429.
**B.** Gilstrap, L.C. ed., et al. Guidelines for Perinatal Care, 7th Edition. AAP & ACOG 2012.
**C. Schrage, S. et al: Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CBC. MMWR, 2010; 59 (no. RR 10): November 19, 2010.**
~~C.~~**D. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.**

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **PERINATAL DEATH~~DECEASED NEWBORN/~~ (MISCARRIAGE, STILLBIRTH~~BORN,~~ AND NEONATAL DEATH CARE ~~OF~~ AND DISPOSITION** |
| Purpose: | To assist the family in cope~~ing~~**ing** with **a perinatal death via miscarriage, stillbirth or neonatal** ~~the~~ death**, obtain mementos, if applicable** ~~of their newborn~~ and provide postmortem care. Families experiencing a Perinatal death ~~or miscarriage~~ shall be provided ~~a~~ support~~ive atmosphere~~ for grieving. |
| Supportive Data: | ~~To facilitate bonding, separation, and loss of their newborn and provide time for expression of feelings, asking of questions in preparation for the grief process.~~**Data shows that assisting families ~~to make~~in making memories during a perinatal death helps ~~to~~ validate the lost life and can help facilitate an effective grieving process. Use of multidisciplinary resource support during this time also has a vital role in helping these grieving families~~families who are grieving~~.** |
| Equipment: | 1. Personal protective equipment<br>2. Infant scale<br>3. Disposable measuring tape<br>4. ID bracelets**, if applicable**<br>5. **Disposition preparation items for transfer to the morgue** ~~Shroud —~~ (Chux, baby blanket, **instrument packing**~~disposable~~ drape, ~~and~~ tape **and 3x 5 card)**<br>6. Authority for Release of Deceased/ **Miscarriage** Form — triplicate**, if applicable**<br>7. Authorization for Autopsy form, if applicable<br>8. Camera<br>9. Grief packet, including:<br>• Checklist for assisting parent experiencing neonatal death/stillborn<br>• Mementos **folder**~~booklet~~<br>• Care Plan – Perinatal Loss<br>• Discharge Instruction Form |

A. **POLICY:**

1. **Families who experience ~~the~~a perinatal death during pregnancy or shortly after birth may grieve for their baby and the loss of an entire lifetime with that child. Caring, supportive people can help families move through the initial crisis toward re-establishing their lives without their babies.**
2. **It is important to meet the needs of bereaved parents and their family during the initial crisis of their perinatal loss by offering comprehensive care that includes compassion and an interdisciplinary perspective.**

~~1. Inform the necessary personnel, when a patient with a known perinatal loss is admitted.~~
~~2. The attending physician shall be notified of the perinatal loss.~~
~~3. If the patient has not been previously informed of the loss, the attending physician shall inform patient of miscarriage/perinatal death.~~
~~4. The attending physician shall diagnose/confirm fetal death with ultrasound.~~
~~5. The patient's response shall be documented in the medical record.~~
~~6. Contact the Women's & Children's Services Social Worker to provide support and supplies.~~
~~a. Psychological support and privacy shall be provided; Social Services to assist.~~
~~7. The plan of care shall be discussed with the patient. Encourage the mother to conduct labor as she originally planned.~~
~~8. The patient and her family shall be encouraged to express their thoughts and feelings.~~
~~a. Social Services shall be notified for consult.~~
~~9. The nurse shall verify the patient's blood type and notify physician if RhoGam is indicated.~~
~~10. The patient shall be recovered in an area away from other delivered patients, if possible.~~

| Revision Date | Clinical Policies & Procedures | Nursing Executive Council | Department of OB/GYN | Division of Neonatology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 12/08; 6/11 | 04/11, 10/16 | 04/11, **10/16** | **12/16** | **01/17** | n/a | 05/11, **02/17** | 06/11, **03/17** | 06/11 |

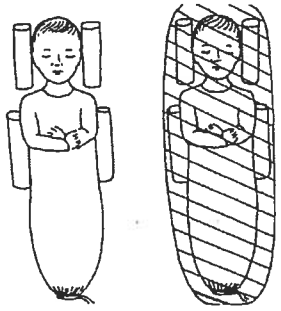
**PROCEDURE:**

1. **Miscarriage**
   a. **Assign patient to a room away from other patients and unit activity to promote a private and quite atmosphere free from chaos, laboring patients and crying babies if possible.**
      i. **If miscarriage greater than 16 weeks estimated gestational age (EGA), occurs in the ED and the ED provider initiates an Obstetrical consult, arrangements may be made to transfer the patient to the labor and delivery (L&D) unit for admission and care coordination as available.**
      ii. **Efforts shall be made to ensure the patient has necessary supports to assist her through this difficult time if not already present.**
2. **Newborn or stillbirth**
   a. **Complete the same patient admission requirements to the unit per standards of care for the patient and for the newborn if born alive. See Standards of Care for Intrapartum, Postpartum and Newborn Care.**
      i. **If the delivery is a stillbirth, there will NOT be a medical record created for baby. All of the delivery information is charted in the mother's chart.**
         1) **Identification band information shall be entered on the bands manually and include:**
            a) **Last name and baby's sex, if known**
            b) **Patient's first and last name**
            c) **Patient's medical record number**
         2) **Attach one band to the stillbirth's arm for identification for remains disposition.**
         3) **The other baby band/parent bands can be saved and included as a part of the memory making process.**
      ii. **If the delivery is a LIVE birth, but then later dies, the banding process for the baby is followed per unit routine and is usually computer generated.**
         1) **One band shall remain on the baby's arm for identification for remains disposition.**
         2) **The other baby band/parent bands can be saved and included as part of the memory making process.**
      iii. **The patient shall be included in the decision of where she would like to remain post delivery and for the remainder of her stay. Transfer off the unit may be coordinated with a providers order, once the patient is stable, and as indicated.**
3. **Staffing considerations should include recognition that this situation may require more intense psychosocial and emotional support and assignments adjusted, as indicated.**
4. **Post a special bereavement card outside the entrance to the patient to notify staff entering the space that a loss/ death has occurred to ensure sensitivity.**
5. **Inform Social Services and/or pastoral care of the perinatal death to ensure alternate support measures are offered to the family.**
   a. **Social Services can evaluate any psychosocial needs, provide bereavement support and discuss disposition options with the family if desired.**
      i. **For miscarriage see Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process ~~is usually disposed of by hospital regulations, but the family does have options if they would like the remains to be taken to a funeral home for processing instead~~.**
      ii. **A "Comfort Cub" may be given to the family to assist with bereavement support and shall be determined by the social worker.**

b. Pastoral care provides both spiritual comfort and support to families and can provide blessings, naming ceremony, baptism and/or a memorial service as indicated.

6. Discuss the anticipated plan of care with the patient including these options as appropriate: ~~Offer options to the parents, which can include these items:~~
   a. To see and hold their pregnancy tissue~~,~~ /baby.
      i. The family may wish to hold the newborn/fetus immediately after delivery.
      ii. Care should be taken to treat anything that comes from the mother's body with respect.
      iii. It is helpful to prepare them for what they will see: color, shiny skin, fused eyes, translucency, tiny hands and feet, any defects, skin sluffage, ~~deformaties~~deformities, coloring, etc.
      iv. When handling the remains it is important to use gloves and complete good hand hygiene
      v. Ask the family if they have an outfit they want the baby to wear, a special blanket to wrap him/her, when appropriate
         1) If no outfit, staff can offer donated outfit layettes from the angel room. Have the family select one.
   b. Weigh and measure the length of the remains, if able.
   c. Obtain footprints, if able Or, if loss is small, can trace around the baby's hands, feet and/or body on paper background to represent size.
      i. The application of acetone to the surface of the foot and then use of a black marker (rather than an ink pad) will make prints clearer in this small gestation
   d. Complete newborn identification certificate/card with parent's name and birth information.
   e. Discuss naming the baby
   f. Cut locks of the baby's hair if available.
   g. Obtain photos upon verbal consent ~~Arrange for photos to be taken~~
      i. The parents may take their own photos on personal camera
      ii. A hospital camera may be used for non-medical photography after verbal consent is obtained from the parents.
      iii. When appropriate, attempt to capture candids with the baby and family interactions as well as posed positions to highlight some of the physical attributes of the newborn/stillbirth.
   h. Ask family if they want to bathe the baby and facilitate as indicated.
7. Collect all of the mementos and place them in the memory box including any photos, memento booklet, the outfit the baby was wearing, the blanket and hat and any other mementos.
   a. The Labor and Delivery unit has a dedicated room where the memento box and other memory making supplies are stored.
   b. If parents refuse mementos, they remain in a locked file in Women's & Newborn Services Department.
8. If the family desires to make arrangements for the miscarriage disposition, ensure the Authority for Miscarriage Remains Release form is completed.
   a. Staff should move the remains to an appropriate and private room to prepare for transport.
   b. It is important that placement of the remains for transport not be done in the parent's presence to ensure dignity is maintained.
   c. Send remains to the Laboratory using the corresponding tissue requisition and per PCS Procedure: Miscarriage and Stillbirth Identification and Disposition Process.

9. When the family is ready for the stillbirth/newborn remains (baby) to be brought to the morgue, it is important that the preparation and positioning of the baby be performed in a way that combats the combined effects of rigor mortis, algormortis (cooling of the body), and permanent discoloration in case the parents wish to view the baby at another time.
   a. The baby should be unclothed except for a diaper in place, if desired and have an identification band located on its arm.
   b. Place on a chucks pad first, the body supine.
      i. Care should be taken to not place any textured blankets or towels on exposed skin because it may leave permanent impressions.
   c. Support the head in position, by having two rolled towels/chux pads positioned at each side of the head to keep it upright.
      i. If the head is left unsupported, it may fall to one side and blood may collect in the soft facial tissues, leaving permanent discolorations.



   d. Fold the arms with a towel roll inserted under the arms at the side of the body to support the position.
      i. Place the hands crossed or next to each other on the chest.
   e. Wrap the body in the chux and baby blanket mummy-fashion to secure positioning, followed by an instrument packing drape which shall be taped in place.
   f. Complete an index card with the following information and tape it to the outside of the baby's wrap:
      i. Baby's last name and gender (baby girl/baby boy)
      ii. Mother's name and medical record number
         1) May use an admission sticker
         2) Newborn's medical record number if a newborn death
      iii. Date and time of delivery
      iv. Weight (gms) and length (cm)
      v. Attending provider
   g. Coordinate transfer to the morgue per PCS: Release of the Deceased Procedure.
      i. Ensure the morgue log book is completed when bringing baby to and from the morgue for family viewing.
10. Give the family bereavement support material to review as indicated and discharge instructions for follow-up:
   a. Provide information about medical care options available to them by their provider depending on their perinatal loss diagnosis
   b. Include in the plan of care regarding post procedure and/or post delivery options, and disposition options.
   c. For a miscarriage please review the "Authority for Miscarriage Remains Release form" with the family, per Patient Care Services (PCS) procedure: Miscarriage and Stillbirth identification and disposition process.
   d. For a stillbirth or neonatal death, please review the "Release of the Deceased form" with the family per PCS procedure: Miscarriage and Stillbirth identification and disposition process.
11. A grief checklist should be completed to provide information on what has been done.

~~2. Perform hand hygiene and don gloves.~~
~~3. Offer viewing of newborn/fetus to parents before removing infant. The family may wish to hold the newborn/fetus immediately after delivery.~~

~~4. Baptize "conditionally" (refer to Patient Care Services, *Infant Baptism* procedure).~~
~~5. Weigh and measure newborn (refer to Patient Care Services, *Differentiating Intrauterine Fetal Demises from Miscarriages* procedure).~~
~~6. Complete Newborn identification certificate with parent's name and birth information.~~
~~a. Apply footprints of the newborn/fetus.~~
~~b. Save as a memento for the family.~~
~~7. Complete the identification bracelets as follows:~~
~~a. Last name and sex of newborn~~
~~b. Mother's first and last name~~
~~c. Mother's medical record number~~
~~d. Newborn's medical record number~~
~~i. Only newborns born alive will have medical record numbers. Stillborns are not assigned a medical record number.~~
~~8. Attach identification bracelet to arm of newborn. This allows correct identification for mortuary or correct disposition of fetal remains.~~
~~9. Prepare the newborn for viewing as follows:~~
~~a. Groom and clean newborn~~
~~b. Wrap in receiving blankets (place on Chux as a fluid barrier)~~
~~10. Provide privacy for mourning. Allow parents and family to hold newborn if desired.~~
~~11. Complete the following after the family viewing (preparation for the morgue):~~
~~a. Take photos~~
~~b. Place newborn on Chux and wrap in receiving blanket and disposable drape and secure with tape~~
~~12. Complete an index card with the following information:~~
~~a. Newborn's name and gender~~
~~b. Mother's name and medical record number~~
~~c. Newborn's medical record number, if applicable~~
~~d. Date and time of delivery~~
~~e. Weight and length~~
~~f. Attending physician~~
~~13. Prepare mementos for parents and place in envelope:~~
~~a. Pictures of newborn/fetus~~
~~b. Footprint ID Certificate~~
~~c. ID bracelet~~
~~d. Lock of hair, if applicable~~
~~e. Name band with newborn's statistics~~
~~f. Blanket and hat, if applicable~~
~~14. The parents shall be given grief support material, memento booklet, and other mementos including any photos taken by hospital staff for the parents. If parents refuse mementos, they remain on file in Women's & Children's Services.~~
~~15. Complete grief checklist to provide information for others.~~
~~16. Arrange for body to be taken to the morgue.~~

C. **DOCUMENTATION:**

1. Document the **miscarriage and/or delivery information and other interventions in the Perinatal Death Ad Hoc form, including the disposition ~~of the~~with fetal remains**~~following on the Delivery Summary Sheet:~~**.**
~~a. Date and time of stillbirth/fetal demise~~
~~b. Weight and length of newborn~~
~~c. Disposition of newborn/fetal remains~~
~~2. Document all required birth and physical information on Patient Care Record.~~
~~3.~~**2. If born alive, ~~D~~d**ocument **admission items per standards of care in the Electronic Medical Record**~~on the Newborn Patient Care Record, if the newborn was born alive:~~**, complete Perinatal Death Ad Hoc form, including the disposition of the newborn.**

~~a. Date and time of death~~
~~b. Name of attending physician who pronounced death of newborn~~
~~c. Disposition of newborn~~

~~D. TECHNICAL NOTES:~~
~~1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.~~
~~2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."~~
~~3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."~~

## D. RELATED DOCUMENTS:

1. **Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process**
2. **Women and Newborn Services Standards of Care for Intrapartum**
3. **Women and Newborn Services Standards of Care Postpartum**
4. **Women and Newborn Services Standards of Care Newborn Care**
5. **Authority for Miscarriage Remains Release Form**
~~5.~~6. **Authority for Release of the Deceased Form**

## E. REFERENCES:

1. **Wilke, J. & Limbo, R. (2012) *Bereavement training in perinatal death (8th ed.)*. La Crosse: Gunderson Lutheran Medical Foundation, Inc.**
2. **Simpson, K. & Creehan, P. (2014) *AWHONN Perinatal nursing (4th ed.)*. Philadelphia: Lippincott, Williams & Wilkins.**
3. **Rosenbaum, J., Renaud-Smith, J., & Zollfrank, R. (2011) Neonatal end-of-life spiritual support care. The Journal of Perinatal and Neonatal Nursing 25(1), 61-69.**
~~1. TCMC Pathology Department – Histology Policy and Procedure Manual.~~
~~2.~~4. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.)*. Philadelphia: Saunders.
~~3. Besuner, P. (2007). *AWHONN Templates for Protocols and Procedures for Maternity Services, (2nd Ed.).*~~
~~California Penal Code Section 643~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

**ISSUE DATE:** 2/94

**SUBJECT:** Enteral Feeding Preparation, Storage, Distribution, and Administration

**REVISION DATE:** 4/00; 10/02, 6/03, 7/05, 8/07, 5/10, 3/13

**POLICY NUMBER:** IV.AA.3

| | |
|---|---|
| **Department Approval:** | 01/17 |
| **Clinical Policies & Procedures Committee Approval:** | ~~03/13~~02/17 |
| **Nurse Executive~~Patient Care Quality~~ Committee Approval:** | ~~03/13~~02/17 |
| **Medical Staff Department/Division 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:** | ~~05/13~~03/17 |
| **Board of Directors Approval:** | 05/13 |

A. **PURPOSE:**

1. To assure proper preparation, storage, distribution, and administration of enteral feedings.

B. **POLICY:**

1. Food & Nutrition Services is responsible for preparation, storage and distribution of enteral feedings.
2. Nursing shall administer enteral feedings to patients.
3. Most enteral formulas utilized shall be prepared and packaged by various medical nutritional companies and shall be available in cans or closed system liter bottles.
4. Homemade, blenderized formulas shall not be processed at Tri-City Medical Center.
5. Canned or bottled enteral formulas shall be stored in the nursing pantry areas.
   a. Opened cans of formula shall be labeled with the date and time of expiration, and refrigerated and discarded if not used within 24 hours.
   b. Unopened cans of formula shall be discarded on manufacturer's expiration date.
6. Nursing and Food & Nutrition shall process orders for enteral feedings. Food & Nutrition Service workers shall process and gather product for delivery to nursing station via food carts after the tube feedings are verified for accuracy by the Food & Nutrition supervisor.
7. Closed feeding system hang times shall be according to the labeled manufacturer's recommendation. Document the date and time the container is opened on the container. Attach new tubing with each container.
   a. ~~Closed feeding systems, bags, and tubing are good for forty-eight (48) hours.~~ Label feeding system tubing with *change day sticker* indicating date tubing is to be changed using numerical day and month.
8. Formula used in an open system should be changed every **eight hours for adult patient and every** four hours **for neonates**, the tubing and the bag shall be flushed thoroughly with tap water; any existing formula shall be discarded and new formula should be added.
   **a.** Open system bags and tubing should be changed every 24 hours. Label the open system bag with date and time formula is first placed in the bag. Label feeding system tubing with change day sticker indicating date tubing is to be changed using numerical day and month.

C. **REFERENCES:**

~~a.~~**1. ASPEN Guidelines (2012)**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

| | |
|---|---|
| **ISSUE DATE:** 5/78 | **SUBJECT:** Food Brought in from Outside the Hospital |
| **REVISION DATE:** 4/00, 6/03, 7/05, 4/08, 03/11 | **POLICY NUMBER:** IV.AA.1 |

| | |
|---|---|
| **Department Approval:** | 02/17 |
| **Clinical Policies & Procedures Committee Approval:** | ~~01/11~~05/15~~10/15~~02/17 |
| **Nursing Executive Council Approval:** | ~~01/11~~02/17 |
| **Pharmacy & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~02/11~~ n/a |
| **Professional Affairs Committee Approval:** | ~~03/11~~03/17 |
| **Board of Directors Approval:** | 03/11 |

A. Food brought from outside for patient:

~~1. The use of food prepared or brought in by an individual outside the hospital is discouraged.~~

~~a.~~1. Food shall not be contraindicated on the patient's diet.

2. Food is to be eaten immediately and not stored.

~~b.~~**a. Food prepared outside of the hospital shall not be stored in the patient food refrigerators.**

~~c. Food prepared from milk or eggs are not permitted because of bacterial contamination risks.~~

3. ~~While food brought in from the outside for patients is discouraged, a~~**A**ny such occurrence will be documented in the patient's medical record.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

**ISSUE DATE:** 8/02

**SUBJECT:** Food Storage on Nursing Units~~Expiration Dates~~

**REVISION DATE:** 6/03, 7/05, 03/11

**POLICY NUMBER:** XI.D

| | |
|---|---|
| **Department Approval:** | 02/17 |
| **Clinical Policies & Procedures Committee Approval:** | ~~01/11~~10/15~~02~~/17 |
| **Nursing Executive Council Approval:** | ~~01/11~~10/15~~02~~/17 |
| **Medical Executive Committee Approval:** | ~~02/11~~ n/a |
| **Professional Affairs Committee Approval:** | ~~03/11~~03/17 |
| **Board of Directors Approval:** | 03/11 |

A. **POLICY:**

~~1. Food Storage on the Nursing Units:~~

~~a.~~**1.** Food shall not be stored in a refrigerator used to store medicines, chemicals, or specimens.

~~b.~~**2.** Food items shall not be removed from the patient trays and placed in the patient nutrition refrigerators.

~~c.~~**3.** Refrigerators designated for food are used for food and food products only.

~~i.~~**a.** All foods without manufacturer's expiration dates shall be dated with an expiration date 3 days from date placed in refrigerator.

~~ii.~~**b.** Upon opening any item, it shall be re-dated for 24 hours from opening and discarded on new expiration date.

~~iii.~~**c.** All foods shall be covered or protected during transit.

**STANDARDIZED PROCEDURE: NEEDLE ~~ASPIRATION~~ THORACENTESIS OF CHEST FOR PNEUMOTHORAX IN NEONATES**

I. **POLICY:**

A. Function: To **outline the procedure**~~provide guidelines~~ for the Neonatal Intensive Care Unit (NICU) **registered** nurse **(RN)** to perform thoracentesis on a neonate.

1. The NICU RN must adhere to the policies of the institution and remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

B. Circumstances **under which the NICU RN may perform function**:

**1.** Setting: ~~Labor & Delivery, Newborn Nursery, NICU, and/or Emergency Department.~~

**a. Inpatient neonatal patients**

**~~a.~~b. ~~-~~Neonates being admitted or transferred to and from Tri-City Medical Center (TCMC) NICU.**

**2.** Supervision:

**a.** The necessity of the procedure will be determined by the RN in verbal collaboration with the attending ~~neonatologist~~ **physician**. Ideally the procedure will first be discussed with the **physician**~~attending~~, but if time does not permit for that, then the attending ~~neonatologist~~**physician** is to be notified as soon as possible after the procedure. Direct supervision will not be necessary once competency is determined as provided for in this standardized procedure.

**3. Patient Conditions/Indications (Subjective/Objective):**

**a. Suspicion of a pneumothorax as evidence by:**

**i. Respiratory distress**
**ii. Unstable vital signs**
**iii. Abnormal pulse oximetry**
**iv. Abnormal blood gas**
**v. Cyanosis**
**vi. Shifted cardiac impulse**
**vii. Tracheal shift**
**viii. Asymmetrical/absent breath sounds**

**b. Chest X-ray interpreted as showing**

**i. Mediastinal shift**
**ii. Pneumothorax**
**iii. Pleural fluid collection (effusion, hemothorax, empyema, and/or chylothorax)**

**c. High intensity transillumination is interpreted as showing a pneumothorax**

**~~b.~~i.**

~~2.~~**4.** Contraindications:

a. ~~If there is a s~~**S**uspected diaphragmatic hernia

~~When the air collection is likely to resolve spontaneously without patient compromise.~~

**b. Current thrombolytic therapy**

**~~b.~~c. History of known bleeding disorder**

~~c.~~**d.** When the vital signs are stable enough to allow for the placement of a thoracotomy tube instead.

| Department Review | Clinical Policies & Procedures | Nursing Executive Council | Department of Neonatology | Pharmacy & Therapeutics Committee | Interdisciplinary Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 11/12, **5/16** | 11/12, **6/16** | 12/12, **7/16** | **08/16** | 1/13, **11/16** | 1/13, **01/17** | 3/13, **02/17** | 03/17 | 3/13 |

~~C. Indications: Decompression of tension pneumothorax or fluid accumulation (pleural effusions, chylothorax, empyema) in order to allow adequate lung expansion for ventilation. In an acute emergency, needle aspiration should be performed if the baby's cardiopulmonary status is unstable.~~

~~D.~~**C.** Definitions:

1. Neonate: Any infant **less than 30 days old.**~~in the NICU, delivery room, newborn nursery or emergency department.~~
2. Pneumothorax: The presence of free air or gas in the pleural cavity.
   a. May be produced by the application of positive pressure to the airway and lung tissue. With ventilation pressures greater than 30 cm water, there is significant rise in risk.

~~3. Symptoms: May vary from irritability and restlessness to apneic spells, tachypnea, grunting, retractions, and in severe cases bradycardia, cyanosis, and shock. A tension pneumothorax must be diagnosed and treated promptly. Clinical signs of a tension pneumothorax include:~~

~~a. Abrupt and dramatic worsening of respiratory or circulatory status~~
~~b. Hypotension with narrowed pulse pressure~~
~~c. Bradycardia and severe cyanosis in association with absent or decreased breath sounds on the affected side.~~

~~E. Database:~~

~~1. Subjective – Any of the following: irritability, restlessness, apneic spells, tachypnea, grunting, and retractions.~~
~~2. Objective – Abrupt worsening of respiratory and circulatory status; bradycardia, hypotension, cyanosis.~~
~~3. Diagnosis – Tension pneumothorax~~
~~4. Plan – Evacuate air from pleural space by needle aspiration.~~

~~F. Transillumination of the chest with a fiberoptic light source can help to determine the affected side. Definitive diagnosis should be made by x-ray.~~

## II. PROCEDURE:

A. Equipment:

1. Cardiac monitor, oximeter and/or bedside nurse to monitor apical pulse
2. Transilluminator
3. Needle Aspiration Kit:
   a. **2% chlorhexidine gluconate**~~Povidone-iodine swab sticks~~
   ~~b. Sterile saline pads~~
   ~~c.~~**b.** 2x2 gauze sponges
   ~~d.~~**c.** 23 or 25 gauge butterfly needle**, or 23 or 25-gauge angiocatheter.**
   **d.** Three-way stopcock
   e. **T-connector (if using an angiocatheter)**
   f. Transparent Dressing
   g. ~~10/20~~ **20 or 35** mL syringe

B. Pre-treatment evaluation:

**1. Notify attending physician of sudden onset of symptoms**

~~1.~~**2.** Obtain chest x-ray if possible. If chest x-ray cannot be obtained promptly, transilluminate before placement if pneumothorax is life-threatening, to confirm affected side.

**3. Ensure that the neonate is pre-medicated for the procedure and that a plan for pain control and developmental management is in place.**

~~2. If time permits pre-medicate infant for pain control and or sedation. Assess need for further medication throughout the procedure. Offer oral sucrose with a pacifier.~~

~~a. Morphine~~
~~b. Pacifier~~
~~c. Oral Sucrose~~

~~3.~~**4.** Monitor the patient's cardiorespiratory status and oxygen status throughout the procedure.

~~4.~~**5.** If time permits inform the family of the treatment plan, otherwise notify them after the procedure is complete.

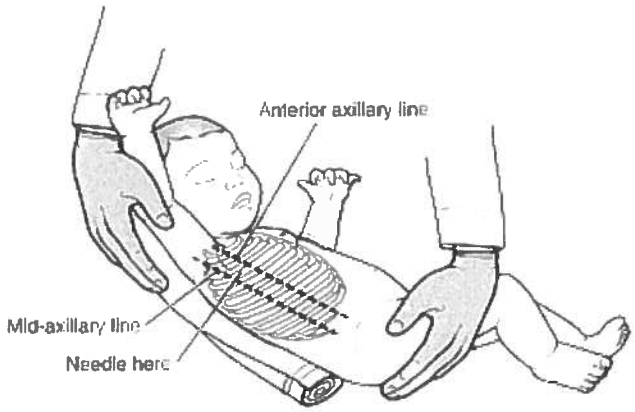
C. Set-up

1. The equipment is assembled as follows:
   a. Connect the 3-way stopcock to the syringe.
   **b. If using a butterfly needle, c**~~C~~onnect the tubing of the butterfly needle to the 3 way stopcock~~. May instead connect the angiocath to a T-connector and connect that to the 3 way stopcock~~.
   ~~b.~~**c. If using an angiocatheter, connect stopcock and syringe assembly to a t-connector.**

~~D. Notify attending/neonatologist of sudden onset of symptoms~~
~~Obtain chest x-ray if possible. If chest x-ray cannot be obtained promptly, transilluminate before placement if pneumothorax is life-threatening, to confirm affected side.~~

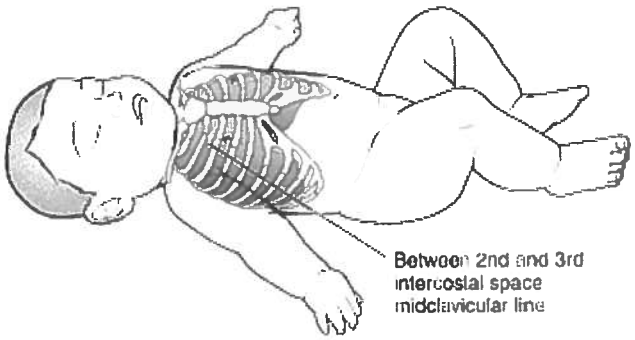
**D. Plan:**

1. Perform a time out ~~with all the appropriate steps~~**per Patient Care Services (PCS): Universal Protocol**.
2. **Positioning of Infant:**
   a. **For the lateral approach position the neonate with a blanket roll behind the back, the affected side slightly above the mattress, and the arm of the affected side restrained above the head. The needle or catheter will be inserted into the 4th intercostals space in the mid-axillary or anterior axillary line.**




Needle aspiration procedure option 1: Lateral approach.

   b. **For the anterior approach position the neonate supine for needle insertion into the second -intercostal space in the midclavicular line.**




Needle aspiration procedure option 2: Anterior approach.

c. ~~Position the infant supine position. Remember that air rises. For lateral approach position neonate with blanket roll behind back, affected (side with pnemothroax) elevated approximately 45° above the mattress, and arm of the affected side restrained about the head..~~

d. ~~The second inter space is used in the midclavicular line (MCL). Confirm site of insertion with another nurse and mark area.~~

~~2.~~**3.** Prep this area with **2% chlorhexidine gluconate,**~~povidone-iodine~~ allowing it to dry a minimum of ~~30 seconds~~**1 minute.**.. ~~Wipe povidone-iodine away with sterile saline pads.~~

~~3.~~**4.** Have assistant hold infant's legs and arms.

~~4.~~**5.** **Puncture the skin at a 45-degree angle, angling over the top of the 3rd rib (5th rib for lateral approach) to avoid the artery and nerve located on the inferior surface of the rib. The distance required for needle insertion varies with the neonate's size but is usually less than 15 mm. Avoid trauma to breast tissue. Insert the needle only once, and do not move it back and forth.**~~Enter the pleural cavity through the second interspace in the MCL just above the third rib. This is to avoid damage to the intercostals vessels which run immediately beneath each rib. Angle the needle at 45° and direct toward the medastium.~~ On entry into the pleural cavity, a slight "pop" is often felt The needle is steadied in this position~~.. Gently aspirate the syringe to see if air is present. If no air is obtained, advance needle slightly and repeat the procedure.~~

a. **If using an over-the-needle catheter, remove the needle from the catheter while sliding the catheter into the pleural space. Attach the catheter hub to the pre-assembled T-connector, stopcock, and syringe setup.**

b. **If using a butterfly needle, have an assistant gently aspirate the syringe as the needle is inserted into the pleural space. Stop advancing the needle when air is obtained.**

6. **Stabilize the catheter or butterfly needle, and slowly aspirate the air or fluid. Continue withdrawing until no fluid is aspirated.**

~~**If the plunger is withdrawn to its fullest extent, turn the stopcock off to the neonate and atmosphere.**~~

~~**Attach a new syringe, turn the stopcock open to the neonate, and continue aspirating air or fluid.**~~

~~5.~~**7.** ~~**If the purpose of the thoracentesis is to remove fluid, and laboratory tests are ordered, have the assistant place the aspirated fluid in specimen collection tubes.**~~ If air is present, there is free withdrawal. Withdrawal continues until resistance is met.

~~6.~~**8.** If plunger is withdrawn to its fullest extent (~~10~~/20/**35**ml), turn the stopcock off to the patient**, then rapidly pushing air out of the syringe from the side port.**~~.~~

~~7.~~**9.** Repeat this process until all of the air is evacuated.

~~8.~~**10.** Observe the infant's ~~heart rate~~**vital signs** and listen for breath sound improvement. ~~Usually eliminating the air from the pleural space will improve the infant's condition immediately.~~

~~9. Transilluminate and obtain an order for a chest x-ray to assess adequacy of air removal and catheter placement.~~

**11. Remove the catheter or butterfly needle when no more air or fluid can be obtained.**

**12. Apply pressure with a folded 2 × 2 sterile gauze until any oozing or bleeding has stopped. Cover the site with a dry, sterile, and occlusive dressing.**

~~10. Follow-up treatment~~

~~11.~~**13. Obtain a** ~~C~~chest X-ray to determine continued presence of air or fluid.

~~12. Termination of Treatment~~

~~a. Needle throacostomy discontinued when:~~

~~i. Chest tube is placed~~

~~ii. Air or fluid is evacuated and does not reaccumulate.~~

~~13.~~**14.** Potential Complication

a. Lung puncture

b. Pneumothorax
c. Bleeding
d. Liver puncture
e. Infection
f. Hypovolemia if draining a large amount of fluid.

~~14.~~**15.** Documentation
a. Document the following:
i. Time procedure started
ii. Reason for thoracentesis
iii. Infant's status before and after procedure including heart rate, respiratory rate, degree of respiratory effort and blood pressure, Fio2, O2 saturations and pain management.
iv. Results of chest x-ray or transillumination
v. Size of needle used, and location of insertion
vi. Amount of air or drainage obtained
vii. Infant's tolerance of procedure
viii. Any complication

## III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Education: The RN shall attend the required TCMC didactic class on Needle Aspiration for Pneumothorax, and pass all written and performance tests. The RN shall demonstrate proper procedure and technique for thoracentesis on a training mannequin or **simulation**~~skills~~ labs.
C. Initial Evaluation: The NICU Clinical Nurse Specialist **or designee** in collaboration with **a Division of** Neonatology **representative** shall validate initial competency. The initial competency shall be completed in a **simulation**~~skills~~ lab.
D. Ongoing Evaluation: The RN shall exhibit knowledge and skills to perform thoracentesis during annual competency testing on the training mannequin or **simulation**~~skills~~ lab.

## IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with an authorized representative from Nursing Administration, Administration and Medical Staff.
~~B. Review: Bi-Annually**Every two years.**~~
~~Nursing Administration~~
~~1. **Division of Neonatology**~~
~~2. Interdisciplinary Practice Committee~~
~~3. Medical Executive Committee~~
~~4. Board of Directors~~

## V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All NICU Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Neonatal Thoracentesis -Standardized Procedure.

## VI. RELATED DOCUMENTS:

A. **PCS: Universal Protocol**

## VII. REFERENCES:

**A. Karlsen, K. (2013). Procedures: Pneumothorax Evacuaiton: Needle Aspiration of the Chest. The S.T.A.B.L.E. Program, 6th edition.**
**B. Mosby's Nursing Skills. (2016). Needle Thoracostomy. Elsevier, Inc.**
**~~A.~~C. National Association of Neonatal Nurses. (2011). Procedure: Chest-tube Management: Placement, Needle Aspiration, and Maintenance. Policies, Procedures, and Competencies for Neonatal Nursing Care.** ~~The S.T.A.B.L.E. Program, 5th edition (2013)~~
~~B. Neonatal Resuscitation Program, 6th edition (2012)~~

C. ~~University of California San Francisco, Standardized Procedure (2008)~~
D. ~~Neonatal Handbook, Neonatal handbook Editorial Board, (2011)~~

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **PERTUSSIS NASOPHARYNGEAL (NP) SWAB, ADULT** |
| Purpose: | To identify the process for obtaining a nasopharyngeal swab for *Bordetella petussis.* |
| Supportive Data: | Proper technique for obtaining a nasopharyngeal specimen for isolation of *Bordetella pertussis* is essential for optimal results. Once a NP swab has been collected it should be placed into a collection container and transported immediately to the lab. |
| Equipment: | Nasopharyngeal Swab with flexible wire handle<br>Transport Container<br>Personal Protective Equipment (i.e. Mask, Gloves, Face Shield)<br>Tissue<br>Nurse Collectable Requisition<br>Patient Label |

A. **ORDERING A PERTUSSIS SWAB**

1. Place patient in droplet isolation until an order is obtained to discontinue isolation.
2. Ensure a physician order is obtained prior to collecting a NP swab
3. Ensure a ~~**STAT**~~ order is **entered**~~placed~~ in Cerner **as Bordetella Pertussis by PCR** ~~for a~~ Nurse Collectable ~~Pertussis Nasal Swab~~ and notify the laboratory.
4. Obtain the following equipment from the Microbiology laboratory department:
   a. Nasopharyngeal swab with flexible wire handle (blue top).
   b. Specimen collection container (blue top).

B. **LABELING**

~~B.~~**1. Refer to Patient Care Services Specimen Labeling Procedure**

C. **OBTAINING SPECIMEN**

1. Perform hand hygiene
2. Don personal protective equipment.
3. Identify patient per TCMC policy.
4. Place supplies on clean surface.
5. Open Culture Swab Collection and Transport package.
6. Remove nasopharyngeal swab with flexible wire handle (blue-top) from package.
7. Remove the collection and transport culture from the package and discharge (white top).
8. Have patient sit up in bed, place pillow behind shoulders to assist in maintaining an upright position.
9. Insert swab into one nostril **straight back** (not upwards) along the floor of the nasal passage for several centimeters until reaching the posterior wall of the nasopharynx (resistance will be met). See diagram below.
   a. The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not force the swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.

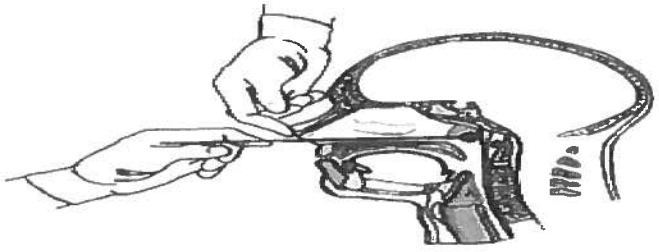


Image: Manual for the Surveillance of Vaccine-Preventable Diseases, 4th ed, 2008

| Department Review | Clinical Policies & Procedures | Nurse Executive Council | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 10/10; 09/14, **11/16** | 12/10;10/14, **01/17** | 12/10;10/14, 02/17 | n/a | 01/11; 10/14 | 02/11;11/14; 03/17 | 02/11;12/14 |

10. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.
11. Remove swab without touching sides of speculum or nose.
12. Remove the cap from blue-capped specimen container and insert wire swab.
13. Break or cut wire swab handle with clean scissors to fit the specimen container and reattach cap securely.
14. Offer patient facial tissue or using a tissue, wipe any residual nasal secretions from patient's nose.
15. Discard used supplies, remove gloves, and perform hand hygiene.
16. **C**~~Label specimen and c~~omplete the **nurse collectable**~~NC~~ requisition.
17. Send specimen to the laboratory immediately.
18. Perform hand hygiene.
19. Document collection of specimen in the medical record.

D. **REFERENCES:**

1. California Department of Public Health. (2010, March). Pertussis: laboratory testing. Retrieved October 26, 2010 from http://www.cdph.ca.gov/programs/immunize/Documents/CDPH_Pertussis
2. Centers for Disease Control and Prevention (CDC). (2009, August 10). Manual for the surveillance of vaccine-prevention disease. (4th e.d.). Chapter 10 pertussis. Retrieved October 26, 2010 from http://www.cdc.gov/vaccines/pubs/surv-manual/chpt10-pertussis.htm
3. Centers for Disease Control and Prevention (CDC). (2010, August 26). Pertussis (whooping cough) diagnostic testing. Retrieved October 26, 2010 from http://www.cdc.gov/pertussis/clinical/diagnostic.html
4. Mosby's Nursing Skills. (2006-2010). Specimen collection: nose throat specimens for culture. Retrieved October 27, 2010 from TCMC intranet.

Tri-City Medical Center
Oceanside, California

~~Administrative Policy Manual~~PATIENT CARE SERVICES

**ISSUE DATE:** 12/09

**SUBJECT:** Physicians Orders for Life Sustaining Treatment (POLST)

**REVISION DATE:** 05/10

~~**POLICY NUMBER: 8610-393**~~

| | |
|---|---|
| **Department Approval:** | **08/16** |
| **Clinical Policies and Procedure Committee Approval:** | **~~09/15~~09/16** |
| ~~**Administrative Policies & Procedures Committee Approval:**~~ | ~~**01/10**~~ |
| **Nurse Executive ~~Operations Team~~ Committee Approval:** | **~~04/10~~09/15~~09~~/16** |
| **Critical Care Committee Approval:** | **10/16** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **02/17** |
| **Professional Affairs Committee Approval:** | **~~05/10~~03/17** |
| **Board of Directors Approval:** | **05/10** |

A. **DEFINITIONS:**

1. Physicians Orders for Life Sustaining Treatment (POLST): A standardized form that complements an advance directive by taking the individual's wishes regarding life-sustaining treatment, and converting them into a physician order.
   a. The POLST document is a statewide mechanism for seriously ill individuals or those in very poor health to communicate his or her wishes about a range of life-sustaining or resuscitative measures. It is portable, authoritative, and immediately actionable physician order consistent with the patient's wishes, which shall be honored across treatment settings.
   b. Pink paper is the recognized and recommended color of the form; however, the form remains valid on any color paper including facsimiles and photocopies.

B. **POLICY:**

1. Tri-City ~~Medical Center~~**Healthcare District (TCHD)** shall honor Physicians Orders for Life Sustaining Treatment (POLST). This policy outlines appropriate actions when a patient enters the hospital with a POLST form.
2. A health care provider is not required to initiate a POLST form, but is required to treat a patient in accordance with the POLST form.
3. A legally recognized health care decision maker may execute, revise, or revoke the POLST form for a patient only if the patient lacks decision making capacity.
4. If the POLST form conflicts with the patient's previously-expressed health care instructions or advance directive, then the most recent expression of the patient's wishes govern.
5. For any conflicts or ethical concerns about the POLST orders, appropriate hospital resources (e.g., ethics committees, care conference, legal, risk management, or other administrative and medical staff resources) may be utilized to resolve the conflict.
6. Patient presents with a completed POLST form:
   a. The RN shall confirm with the patient, or the patient's legally recognized health care decision maker that the POLST form is valid.
   b. The RN shall communicate to the treating physician **or Allied Health Professional** the existence of the POLST form.
   c. A copy of the POLST form shall be placed in the medical record under the Orders tab. The original POLST form shall be returned to the patient.
      i. Enter POLST orders in Cerner.
7. Reviewing/Revising a POLST form:

a. The POLST form may be revised at any time by the patient or the patient's legally recognized healthcare decision maker. Initiate a referral to Social Services for assistance in revising the form.
   i. Discussions about revising or revoking the POLST shall be documented in the medical record, and dated and timed. This documentation shall include the essence of the conversation and the parties involved in the discussion.
   ii. To void the POLST form, draw a line through sections A through D and write "VOID" in large letters. Sign and date this line.
      **1.** If a new POLST form is completed, a copy of the original POLST marked "VOID" shall be kept in the medical record directly behind the current POLST.

~~1.~~

C. **FORMS/RELATED DOCUMENTS~~ATTACHMENT~~:**

**1.** Physicians Orders for Life Sustaining Treatment (POLST) **sample** form

**D. REFERENCES:**

1. **California Hospital Association Consent Manual (2015)**

# California POLST Form

In order to maintain continuity throughout California, please follow these instructions:

****** Copy or print POLST form on 65# Cover Pulsar Pink card stock. ******

Wausau Pulsar Pink card stock is available online and at some office supply stores.

Pulsar pink paper is used to distinguish the form from other forms in the patient's record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.

## Physician Orders for Life-Sustaining Treatment (POLST) Sample

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

### Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

**First follow these orders, then contact physician.** This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

| Last Name | |
|---|---|
| First /Middle Name | |
| Date of Birth | Date Form Prepared |

**A** *Check One*

**CARDIOPULMONARY RESUSCITATION (CPR):** ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
**(Section B: Full Treatment required)**

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

**B** *Check One*

**MEDICAL INTERVENTIONS:** ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes int*

Additiona

**DELETE – old form**

**C** *Check One*

**ARTIFICIALLY ADMINISTERED NUTRITION:** ***Offer food by mouth if feasible and desired.***

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

**Additional Orders:**_____

**D**

**SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**

**Discussed with:**
☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

**Signature of Physician**
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

| Print Physician Name | Physician Phone Number | Date |
|---|---|---|
| Physician Signature (required) | Physician License # | |

**Signature of Patient, Decisionmaker, Parent of Minor or Conservator**
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

| Signature (required) | Name (print) | Relationship (write self if patient) |
|---|---|---|
| Summary of Medical Condition | Office Use Only | |

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

| HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY | | | |
|---|---|---|---|
| Patient Name (last, first, middle) | | Date of Birth | Gender: M F |
| Patient Address | | | |
| **Contact Information** | | | |
| Health Care Decisionmaker | Address | | Phone Number |
| Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared |

## Directions for Health Care Professional

### Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

### Using POLST

- Any incomplete section of POLST implies full treatment for that section.

**Section A:**

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation"

**DELETE – old form**

**Section B:**

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

### Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

### Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit **www.capolst.org**.

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**

# Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

| Patient Last Name: | Date Form Prepared: |
|---|---|
| Patient First Name: | Patient Date of Birth: |
| Patient Middle Name: | Medical Record #: *(optional)* |

## A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

*If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

## B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

**Additional Orders:** _____

_____

## C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

## D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

**Signature of Physician / Nurse Practitioner / Physician Assistant** (Physician/NP/PA)
**My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.**

| Print Physician/NP/PA Name: | Physician/NP/PA Phone #: | Physician/PA License #, NP Cert. #: |
|---|---|---|
| Physician/NP/PA Signature: *(required)* | | Date: |

**Signature of Patient or Legally Recognized Decisionmaker**
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

| Print Name: | | Relationship: *(write self if patient)* |
|---|---|---|
| Signature: *(required)* | Date: | FOR REGISTRY USE ONLY |
| Mailing Address (street/city/state/zip): | Phone Number: | |

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**

**Patient Information**

| Name (last, first, middle): | Date of Birth: | Gender: M F |
|---|---|---|

| **NP/PA's Supervising Physician** | **Preparer Name** (if other than signing Physician/NP/PA) | |
|---|---|---|
| Name: | Name/Title: | Phone #: |

**Additional Contact** ☐ None

| Name: | Relationship to Patient: | Phone #: |
|---|---|---|

## Directions for Health Care Provider

### Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

### Using POLST

- Any incomplete section of POLST implies full treatment for that section.

*Section A:*

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

*Section B:*

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

### Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

| | |
|---|---|
| **ISSUE DATE:** 10/06 | **SUBJECT:** Rapid Response Team Activation and Condition Help (H) |
| **REVISION DATE:** 3/07, 10/07, 9/08, 6/11, 3/12 | **POLICY NUMBER:** IV.L |

| | |
|---|---|
| **Department Approval:** | ~~04/16~~07/16 |
| **Clinical Policies & Procedures Committee Approval:** | ~~03/12~~05/~~16~~09/16 |
| **Nursing Executive Council Approval:** | ~~03/12~~05/~~16~~09/16 |
| **Critical Care Committee Approval:** | 10/16 |
| **Pharmacy & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~05/12~~02/17 |
| **Professional Affairs Committee Approval:** | ~~06/12~~03/17 |
| **Board of Directors Approval:** | 06/12 |

A. **DEFINITIONS:**

1. Bipap (NIPPV): A type of mechanical ventilation which provides inspiratory and/or expiratory positive pressure ventilation via nasal, full face or total face mask in order to improve hypoxemia, reduce ventilatory muscle fatigue, and to support ventilation.
2. Condition Help (H): A program that enables patients and family members to call for immediate help if they feel the patient is not receiving adequate medical attention.
3. Multidisciplinary Medical Team: A team consisting of multiple members with varying medical education backgrounds such as an ICU Nurse, an RCP, Patient's Primary Nurse and the Administrative Supervisor if duties/time permits. For Condition H, a social worker and a chaplain also will respond.
4. Rapid Response Team (RRT): A multidisciplinary team that responds to urgent patient situations throughout the hospital.

B. **PURPOSE:**

1. To provide, within minutes a multidisciplinary medical team approach using a formalized process, to assess and treat a patient, whose condition is deteriorating or when nursing staff on the floors has concerns related to patient's condition.
2. To provide support when a patient/family recognizes a noticeable medical change in condition and feels they are not receiving the appropriate response from the healthcare team.
3. Tri-City Medical Center (TCMC) will plan for, support, and coordinate a systematic approach to complex patients such as the implementation of the Rapid Response Team (RRT) to respond to deterioration in patient status outside the critical care setting.
4. The role of the Rapid Response Team is to:
   a. Assess
   b. Stabilize
   c. Assist with communication
   d. Educate and support
   e. Assist with transfer to a higher level of care if necessary

C. **POLICY:**

1. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
   a. Reduced cardiac and/or respiratory arrests in the hospital;

b. Reduced or more timely transfers to the Intensive Care Unit (ICU) or a higher level of care;
c. Reduced patient intubations; and
d. Reduced number of hospital deaths.

2. The RRT Nurse provides clinical expertise, advanced assessment skills and support for the patient's primary nurse, patient and patient's family, as well as facilitates a more timely transfer to a higher level of care when needed.
3. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the RRT Nurse, and assist in the care of the patient.
4. The Respiratory Care Practitioner (RCP) provides advanced respiratory assessment, immediate oxygen therapy, delivery of aerosolized medications, and assistance in delivering mechanical ventilation, through Non-Invasive Positive Pressure Ventilation (NIPPV) if required.

D. **PROCEDURE:**

1. When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will:
   a. Contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room -----", three times overhead.
      i. Once notified, the RRT members will simultaneously respond to that room/location within 5 minutes.
   b. **Call RRT cell phone.**
2. When a caregiver/family member is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Condition H" and the RRT members will respond.
3. Criteria to call the Rapid Response Team:
   a. Staff member is concerned/worried about the patient
   b. Acute change in:
      i. Heart rate (less than 50 or greater than 130 beats per minute)
      ii. Systolic blood pressure (less than 90 mm/Hg or greater than 180 mm/Hg)
      iii. Respiratory rate (less than 8 or greater than 28 breaths per minute) or threatened airway
      iv. Oxygen saturation, which reflects the percentage of red blood cells, saturated with oxygen (level is less than 92% despite oxygen therapy)
      v. Level of consciousness, sudden unexplained agitation and confusion.
      vi. Urine output (less than 50 mL in 4 hours)
   c. ~~Other neurological changes such as n~~**N**ew onset unilateral motor weakness, sensory loss, and/or aphasia ~~warrant a Code Stroke call~~**or other neurological changes suggestive of stroke**.
   d. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS)
   e. Acute significant bleed
   f. New, repeated, or prolonged seizures
   g. Failure to respond to treatment for an acute problem/symptom
   h. Change in skin tone (pale, dusky, gray or blue)
   i. The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.
4. Criteria to Call a Condition H Rapid Response:
   a. A caregiver or family member is worried about the patient's condition and feels it is not receiving appropriate response from the healthcare team.
   b. Noticeable medical changes:
      i. Shortness of breath or barely breathing
      ii. Severe pain not resolved after treatment
      iii. Feels as though heart is beating too fast
      iv. Difficulty speaking or moving arms or legs

v. Confusion, agitation, or other mental changes
vi. Difficulty waking up when aroused
vii. Using the bathroom less or more frequently

5. RRT Nurse Responsibilities:
   a. Takes emergency cart to room.
   b. Speak with the primary nurse to get the situation, background, assessment and recommend (SBAR) of the patient.
   c. Assist with further assessment of the patient.
   d. Speak with the physician/family/patient about the situation.
   e. Assist with/facilitate transfer to higher level of care if indicated.
   f. **Provides necessary treatment and obtains pertinent diagnostic tests per Rapid Response Standardized Procedure.**
   g. In emergency situations implements current standards of care by following ACLS protocols.
   h. Functions as role model.
   i. Provides education pertinent to event and general clinical education as time allows.
   j. Follows up on patients maintained on the floor within 4 hours of the call.
   k. **Completes a RRT Cart check at least daily and documents the following on the RRT Cart Checklist located inside the RRT Cart:**
      i. **Presence of**:
         1) **RRT cellular telephone and charging cable.**
         2) **Cart keys**
         3) **Manual blood pressure cuff**
         4) **Emergency supplies, including**
            a) **Three sets of gel defibrillation pads**
            b) **Three sets of multifunction defibrillator pads**
            c) **Resuscitation bag (Ambu).**
            d) **Restock any missing supplies**
      ii. **Verifies contents of Respiratory bag and tool box**
         1) **Restock any missing supplies**
      iii. **Expiration dates of all supplies completed on the first day of each month**
         1) **Replace any expired supplies**
      iv. **Proper functioning of defibrillator**
         1) **Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit**
         2) **Ensure the Multi-Function Cable is plugged into the unit**
            a) **The Multi-Cable Function should not be plugged into the test connector**
         3) **Switch unit to *DEFIB* and set energy to 30 joules**
            a) **The messages *CHECK PADS* and *POOR PAD CONTACTS* will alternately display**
         4) **Plug the Multi-Function Cable into its test connector**
            a) **The message *DEFIB PAD SHORT* will display**
         5) **Press the *CHARGE* button on the front panel or on the apex paddle handle**
         6) **Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules**
            a) **The message will read *DEFIB 30J READY***
            b) **The strip chart recorder will print a short strip indicating *TEST OK* energy delivered if the unit delivered energy within specifications**
               i) **During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules**

**c) If *TEST FAILED* appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately**

**7) Defibrillator battery change performed**

~~ii.~~**v. Sign your name in the signature box of the Cart Checklist**

6. Respiratory Care Practitioner Responsibilities:
   a. Assesses and provides treatment.
   b. Assists in managing airway and providing ventilatory support.
   c. Assists with and provides treatment as necessary to facilitate transfer to higher level of care.
   d. Functions as role model.
7. Primary Care Nurse Responsibilities:
   a. Briefs the team on patient history, current assessment, and identified concerns.
   b. Ensures patient's chart, all labs and diagnostic test results are available for the team.
   c. Remains with patient as a vital member of the team, repeats vital signs and other assessments as needed.
   d. Contacts ~~P~~physician if asked by RRT Nurse and give information as needed, using SBAR communication.
   e. ~~Responsible for following~~ **Follows** through with determined plan of action and ongoing patient assessment.
8. Administrative Supervisor Responsibilities:
   a. ~~May r~~Responds and assists as needed if duties/time permits.
   b. Provides necessary resources.
   c. Facilitates efficiency of the team.
   d. Recognizes and utilizes the chain of command to obtain appropriate medical care when necessary to ensure patient's well-being.
   e. Facilitates transfer and bed assignment if a higher level of care is indicated.
   f. Responds to Condition H on nights, weekends, and holidays in place of social worker to address patient/family non-medical concerns.
9. Social Worker Responsibilities:
   a. Responds to Condition H to address patient/family non-medical concerns.
10. Chaplain:
    a. Responds to Condition H to provide spiritual and emotional support to patient/family.
11. **In the event the ICU is unable to provide a RRT RN (such as in times of unanticipated low staffing), the following steps will occur:**
    a. **The ICU Charge Nurse will notify the AS when there is no RRT; the ICU Charge Nurse will notify the AS when the RRT becomes available.**
    b. **The AS will notify each unit's Assistant Nurse Managers (ANMs)/Charge Nurses that the RRT has been pulled to patient care.**
       i. **Each unit's ANM/Charge Nurse will ensure their immediate staff is aware of the lack of RRT coverage.**
       ii. **Each unit's ANM/Charge Nurse will be available to all immediate staff to address patient concerns prior to calling a Rapid Response event.**
    c. **The ICU Charge Nurse (or other designated ICU RN) will be available for telephone consults.**
       i. **Call forwarding from the RRT phone to the Charge Nurse phone *may* be done to avoid carrying more than one cell phone (optional).**
          **1) Dial *72 760 802 1939 and press *CALL* from the RRT phone to forward calls to the charge nurse phone (you will hear 3 beeps when the task is complete).**
          **2) Dial *720 and press *CALL* from the RRT phone to cancel call forwarding (you will hear 3 beeps when the task is complete).**
    d. **The ICU Charge Nurse (or other designated ICU RN) will respond to overhead RRT pages and/or provide bedside support to floor nurses when necessary.**

i. **If a designated ICU RN other than the Charge Nurse will respond to a Rapid Response call, the Charge Nurse will ensure adequate coverage of that RN's patient assignment.**

E. **DOCUMENTATION:**

1. The Emergency Event Record will be used to document the RRT and Condition H activation and interventions performed.
2. An evaluation tool (Form# 6010-1006) ~~will~~**may** be completed by the primary nurse on the floor.

F. **RELATED DOCUMENTS:**

1. **PCS SP: Rapid Response**

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **STROKE CODE, EMERGENCY DEPARTMENT** |
| Purpose: | To outline the procedure for prompt recognition of a patient with signs and symptoms of stroke or worsening stroke and to outline appropriate interventions. |
| Supportive Data: | Rapid response is critical to obtain required data for a prompt diagnosis and appropriate intervention. |
| Equipment: | Stroke Admission Packet |

A. **POLICY:**

1. A Stroke Code shall be initiated if a patient presents to the Emergency Department (ED) experiencing "stroke-like" symptoms of less than eight (8) hours duration.

B. **PROCEDURE:**

1. **Stroke Code Activation:**
   a. Patient with "stroke-like" symptoms who are en route to **Tri-City Medical Center (TCMC)** by **Emergency Medical Service (EMS)** providers will have a Stroke Code activated by the **Mobile Intensive Care Nurse (MICN)** prior to arrival by dialing 66 and notifying the operator.
      i. The MICN will notify the ANM/Charge RN as well as the **ED**~~Emergency Department~~ Physician.
   b. Patients with "stroke-like" symptoms who present through triage should be immediately placed in an emergency department bed and notify the ~~Emergency Department~~ **ED** ANM/Charge RN and ~~Emergency Room~~ **ED** physician.
      i. The Registered Nurse or Unit Secretary will activate a Stroke Code at the direction of the ~~Emergency Department~~ **ED** Physician by dialing 66 and notifying the operator.
   c. The operator will page the Stroke Team consisting of:
      i. **Computed Tomography (CT)** Technologist
      ii. Lab Phlebotomist
      iii. Stroke Coordinator
      iv. Radiology Technologist
      v. Lab Technologist
2. **Notification of Neurologist:**
   ~~a. When a Stroke Code is initiated by the MICN for patients arriving by EMS providers, the operator will notify the Neurologist on call.~~
   ~~b.~~**a.** ~~When a Stroke Code is initiated by the Emergency Department ED Physician, t~~The Neurologist on call will be notified by the ~~Emergency Department~~ **ED** Physician.
3. **Initial Care of the Stroke Patient:**
   a. Initial care of the stroke patient should include immediate stabilization of the airway, breathing, and circulation (ABC's). This is quickly followed an assessment using the NIHSS (National Institute Health Stroke Scale).
   b. The ~~Emergency Department~~ **ED** Physician serves as the Stroke Team Leader and is responsible for initial evaluation and stabilizing treatment, as well as determining eligibility for thrombolytics in collaboration with the Neurologist.
      ~~i. Emergency Medical Technician (EMT) to stay with patient and complete all items on stroke checklist form and hand form to secretary when released by ED physician.~~
   c. Determine time of symptom onset.
      i. This is defined as when the patient was at his or her previous baseline or symptom-free state. For patients unable to provide this information or who awaken

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|---|---|---|---|---|---|---|
| 4/09; 11/1101/17 | 12/11, 4/15, 02/17 | 12/11; 4/15, 02/17 | 02/17 | 1/12, 02/17 | 2/12, 03/17 | 2/12 |

with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom-free or known to be "normal".

d. Obtain finger stick blood sugar.
   i. Notify Emergency Department **ED** Physician of result.
e. Initiate continuous cardiac monitoring
f. Monitor blood pressure ~~Q~~ **every** 15 minutes until thrombolytic eligibility is determined.
g. Obtain vital signs including: heart rate, blood pressure, respiratory rate, oxygen saturation, and actual weight.
h. Obtain 12 lead **Electrocardiogram** (ECG).
i. Obtain **Intravenous** (IV) access.
   i. Place 18 or 20 gauge IV in **antecubital** (AC) or forearm.
j. Initiate supplemental oxygen as ordered.
k. Perform NIHSS assessment and Swallow Screen prior to any oral intake.
   i. Notify ~~Emergency Department~~ **ED** Physician of results.

4. **Time Parameter goal is to maintain the best practice times listed below:**
   a. Draw STAT labs to include **prothrombin time** (PT)**/international normalized ratio** (INR), **partial thromboplastin time** (PTT), Glucose, and Creatinine –complete within 45 minutes of arrival but not to delay ~~rTPA~~**rtPA** administration.
      i. Draw labs prior to CT scan.
   b. Obtain STAT CT scan – completed within 25 minutes of arrival.
      i. The Emergency Department RN accompanies all Stroke Code patients to CT scan.
      ii. CT Technologist will notify Radiologist of the Stroke Code CT for STAT read.
      iii. Radiologist will notify the Emergency Department Physician of CT results within 20 minutes of completion.
   c. Obtain portable chest x-ray and ECG – complete within 45minutes of arrival but not to delay ~~rTPA~~**rtPA** administration.

~~5. **Care of Stroke Patients Not Eligible for Thrombolytics:**~~
   ~~a.~~**d.** ~~Care should be provided according to the Emergency Department Standard of Nursing Care~~.

~~6.~~**5. Care of the Patients Eligible for Thrombolytics:**
   a. Continuous cardiac monitoring
   b. Place second peripheral IV.
   c. Place Foley Catheter prior to ~~rTPA~~**rtPA** administration if ordered by the ~~Emergency Department~~ **ED** Physician.
   d. Monitor blood pressure Q 15 minutes.
      i. Blood pressure obtained prior to administration of ~~rTPA~~**rtPA** is a systolic blood pressure < 185 and diastolic blood pressure of <110.
   e. ~~Consider reconstituting rTPA in patients eligible for thrombolytic intervention early to prevent delays in administration. If rTPA is reconstituted and not used, return to pharmacy~~.
   f. If patient is eligible for ~~rTPA~~**rtPA** treatment informed consent will be obtained by ~~Emergency Department~~ **ED** Physician and/or Neurologist.
      i. Signed consent~~r~~ is not required for administration of ~~rTPA~~**rtPA**.

~~7.~~**6. Administer rtPA per Physician Order:**
   a. Recommended TOTAL dose of ~~rTPA~~**rtPA** is 0.9 mg/kg, not to exceed 90 mg.
   b. Reconstitute and administer ~~rTPA~~**rtPA** as follows:
      i. **Reconstitute**~~10% of the total dose of rTPA~~ **rtPA** with 100 ml of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.
      ii. With a second Registered Nurse, calculate the weight based dose of ~~rTPA~~**rtPA**.
      iii. Remove from the vial any quantity drug in excess of that specified for patient treatment~~. To do this~~, calculate the excess dose and discard 10 ml less than that dose. This will allow for the complete dose of ~~rTPA~~**rtPA** to be infused.

iv. Withdraw the bolus amount **(bolus dose is 10% of total dose)** and administer IVP over 1 minute.
v. Program the infusion pump to deliver the remaining dose over 60 minutes.
vi. ~~rTPA~~**rtPA** must be double checked by two Registered Nurses and documented in the Medication Administration Record.

~~8.~~**7. Monitoring During and Post Thrombolytic Administration:**

a. Continuous cardiac monitoring.
b. Monitor blood pressure **every**~~Q~~ 15 minutes ~~X~~ **times** 2 hours, then ~~Q~~ **every** 30 minutes for 6 hours, then ~~Q~~**every** 1 hour ~~X~~ **times** 16 hours.
   i. Notify Emergency Department Physician immediately for systolic blood pressure > 185 and/or diastolic blood pressure > 110.
c. Monitor neurological status ~~Q~~ **every** 15 minutes ~~X~~ **times** 2 hours, then ~~Q~~ **every** 30 minutes for 6 hours, then ~~Q~~**every** 1 hour ~~X~~ **times** 16 hours.
   i. Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria, and pupillary response.
   ii. If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify Emergency Department Physician immediately.
   iii. Monitor temperature and maintain normothermia.
   iv. Monitor blood sugar and maintain euglycemia.
**d. Continue monitoring patient upon transport and during diagnostic tests. If unable to perform assessment/vital signs during test, document reason and resume assessment/vital signs as soon as test is completed.**
   ~~d.~~**i. Note: most diagnostic areas have vital sign monitoring capability but staff may not be able to perform assessment during test**
e. Disposition of Stroke Patient:
   i. Stroke patients who have received thrombolytics are admitted to the Intensive Care Unit.
   ii. Stroke patients who do not meet the criteria for admission to the Intensive Care Unit should be admitted to 4 Pavilion or Telemetry.

~~Most diagnostic areas have vital sign monitoring capability, but staff may not be able to perform assessment during diagnostic test.~~

C. **RELATED DOCUMENTS/FORMS:**

1. 24 hour rtPA Flow Sheet. Form # 6010-1010

D. **REFERENCES:**

1. Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708
2. **Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 44 pages 870-947 (2013)**
3. ~~The National Institute of Neurological Disorders and Stroke tPA Stroke Study Group. N Engl J Med 1995;333:1581-7.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

**ISSUE DATE:** 3/65

**SUBJECT:** Telephone Service for Patient Rooms

**REVISION DATE:** 5/88, 9/91, 10/96, 3/00, 11/00, 6/03, 8/05, 7/07, 4/10,7/136

**POLICY NUMBER:** II.G

| | |
|---|---|
| **Department Approval:** | 12/16 |
| **Clinical Policies & Procedures Committee Approval:** | ~~04/10~~07/~~13~~01/17 |
| **Nurse Executive ~~Patient Care Quality~~ Council Approval:** | ~~05/10~~07/~~13~~02/17 |
| **Medical Staff Department/Division Approval:** | n/a |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | n/a |
| **Professional Affairs Committee Approval:** | ~~05/10~~03/17 |
| **Board of Directors Approval:** | 05/10 |

A. **POLICY:**

1. Tri-City Medical Center (TCMC) shall allow telephone access to and from patient rooms while providing adequate amounts of rest for both patients in the room.
   ~~1.~~**a. Behavioral Health Services – Public phones are available for patients.**
2. All telephones in patient rooms have the capability for direct dialing. Patients can initiate and receive phone calls on a twenty-four hour basis.
3. Incoming calls to the P.B.X. operator shall not be connected to the patient rooms between the hours of 2200 and 0700 but shall be referred to the Nursing Unit.
4. If telephone communications need to be limited based on nursing assessment or patient behaviors, the process shall be verbally explained to the patient and/or family. Restrictions shall be evaluated by nursing for their effectiveness, so that at the earliest possible time the restriction may be lifted.
5. At the patient's request, phone service may be blocked.
6. Accommodations shall be made for patients requesting a private area for telephone usage. The Assistant Nurse Manager or the Administrative Supervisor may be contacted for assistance.

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | ~~**THERAPEUTIC HYPOTHERMIA**~~ **TARGETED TEMPERATURE MANAGEMENT AFTER CARDIAC ARREST** |
| Purpose: | To manage comatose patients after cardiac arrest using cooling methods to induce hypothermia in order to improve neurological outcomes. |
| Supportive Data: | In studies of cardiac arrest, induced hypothermia protocols have contributed to improved neurological outcomes. This procedure is done in the Emergency Department (ED) and Intensive Care Unit (ICU). |
| Equipment: | ~~Arctic Sun~~ Temperature Management System ~~or alternate system~~<br>Ice packs<br>Core body temperature monitoring system (bladder, rectal, esophageal, or pulmonary artery)<br>Refrigerated (4°C) normal saline |

A. **POLICY:**

1. Patient Indications:
   a. Adults age 14 years and older.
   b. Cardiac arrest followed by return of spontaneous circulation.
   c. Persistent coma after cardiac arrest as evidenced by no eye opening, no speech, no purposeful response to noxious stimuli (Glasgow Coma Scale 8 or lower).
   d. Those able to maintain a systolic blood pressure greater than 90mmHg, with or without vasopressor agents after return of spontaneous circulation.
2. Absolute Contraindications:
   a. Active bleeding
   b. Severe sepsis
3. Relative Contraindications:
   a. Pregnancy (women < 50 years old must have a negative pregnancy test prior to initiating the protocol)
   b. Major head trauma
   c. Other causes of coma, ie. drug overdose, pre-existing coma)
   d. Recent major surgery within 14 days
   e. Greater than 6 hours from return of spontaneous circulation
   f. **Preexisting** DNR status

B. **DEFINITIONS:**

1. Cardiac Arrest – When the heart stops pumping blood effectively due to a lethal arrhythmia such as ventricular fibrillation or asystole, or due to mechanical failure such as in pulseless electrical activity (PEA).
2. Hypothermia – Core body temperature less than 35°C3. Severe hypothermia – Core body temperature less than 30°C

C. **PROCEDURE:**

1. Assessment:
   a. Confirm that patient meets eligibility criteria for ~~therapeutic hypothermia~~**targeted temperature management**.
   b. Obtain physician orders.
   c. Verify that patient will not be going for immediate cardiac catheterization. If immediate cardiac catheterization is planned, ~~therapeutic hypothermia~~**targeted temperature management** may be started after catheterization is complete.

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| 10/12, 08/16 | 10/12, 09/16 | 10/12, 09/16 | 10/16 | n/a | 01/13, 02/17 | 02/13, 03/17 | 02/13 |

d. Perform neurological assessment, including Glasgow Coma Scale, before initiating therapy and at the end of therapy.
e. Assess pupil response every hour if paralytics are used.
f. Assess **and document** vital signs, including core body temperature, every 15 minutes during therapy.
**i.** Assess core body temperature **using** one of the following methods, listed in order of preference:
**1)** ~~(1)~~ Pulmonary artery catheter~~,~~
**2)** ~~(2)~~ Esophageal catheter~~,~~
~~i.~~**3)** ~~(3)~~ Bladder or rectal probe.
~~g. Assess skin condition every two hours during therapy.~~
~~h.~~**g.** Draw labs frequently, as ordered, to monitor patient for electrolyte abnormalities, coagulopathy, and infection.

2. Patient/Family Education:
a. Explain the purpose of ~~therapeutic hypothermia~~**targeted temperature management** and goals of treatment to family.
**b.** Assure family that appropriate comfort measures will be taken (i.e. sedation and analgesia).
~~b.~~**c. Provide hypothermia teaching handout.**

3. Initiation of hypothermia using the ~~Arctic Sun~~ temperature management system:
**a. Artic Sun (topical cooling device)**
**i. Artic Sun Instructions for Use**
**b. Zoll Thermogard Intravascular System (intravascular device)**
**i. Zoll Thermogard XP Instructions for Use**
**c. Gaymar Cooling Blanket (topical device)**
**i. Gaymar Cooling Blanket Instructions for Use**
~~a. Use the sizing chart to determine the appropriate size gel pads for the patient.~~
~~b. Apply gel pads to the patient.~~
~~i. Gel pads must be placed only on intact skin.~~
~~ii. Gel pads may be placed over top of defibrillation pads.~~
~~c. Connect the gel pads and temperature probe to the machine's console.~~
~~d. Set the patient's target temperature to 33°C.~~
~~i. Goal temperature is 32 - 34°C.~~
~~e. Ensure the Arctic Sun is in "automatic mode" (can only be used with attached temperature probe.)~~
~~f. Time to target should be at MAX.~~
~~g. Document time of initiation of patient cooling and 24-hour point of therapy on the order sheet and flow sheet.~~
~~h. Administer cold intravenous saline, per physician's order, if no evidence of pulmonary edema on chest x-ray.~~
~~i. If core temperature is NOT decreasing by at least 1°C per hour, see the Arctic Sun troubleshooting guide.~~
~~j. Notify the physician if unable to reach target temperature within 4 – 6 hours.~~
~~k. Monitor the patient for shivering during cooling using the Bedside Shivering Assessment Scale (BSAS) and notify physician if shivering cannot be controlled with the medications ordered.~~
~~l. Monitor the patient for hypokalemia during cooling.~~
~~m. Avoid severe hypothermia.~~

~~4. Maintenance phase:~~
~~a. Once the target temperature has been achieved, the patient will be maintained at 32 – 34 °C for 24-hours from the initiation of cooling.~~
~~b. Monitor the Arctic Sun water temperature hourly. A decrease in water temperature may indicate increased resistance to cooling, such as with shivering or fever from an infectious source.~~

~~c. If the water temperature remains less than 10°C for more than 8 hours, refer to the Arctic Sun troubleshooting guide.~~

~~5. Rewarming phase:~~

~~a. Begin rewarming the patient 24 hours after the initiation of hypothermia.~~

~~b. Set the patient's target temperature to 37°C.~~

~~c. Set the rate of rewarming to 0.3°C per hour. (Please note that the default setting is to "warm – MAX." The rewarming rate must be changed in order to achieve slow, controlled rewarming over 12 hours.)~~

~~d. Monitor the patient for hypotension related to rewarming, secondary to vasodilation.~~

~~e. Potassium replacement should be conservative 8 hours prior to rewarming and during rewarming.~~

~~f. Monitor for hyperkalemia during rewarming.~~

~~g. After rewarming is complete the Arctic Sun pads may be left in place for a total of 5 days. Monitor for rebound hyperthermia and reinitiate cooling if necessary to maintain the patient's core body temperature less than 37.5°C.~~

~~6. Therapeutic hypothermia with the Gaymar cooling blanket:~~

~~a. Therapeutic hypothermia may be performed without the use of the Arctic Sun temperature management system only if all of the Arctic Sun machines are unavailable.~~

~~b. Apply ice packs to the groin, sides of chest, axillae, neck and limbs to initiate cooling.~~

~~c. Cold IV saline may also be administered, as ordered, to facilitate rapid cooling.~~

~~d. The Gaymar cooling blankets should be placed beneath and on top of the patient, with a sheet between the patient and the blanket to protect the skin.~~

~~e. The water temperature in the Gaymar system is adjusted manually to achieve the desired rate of cooling.~~

~~f. Ice packs can be removed during the maintenance phase.~~

~~g. After 24 hours, the water temperature must again be manually readjusted to achieve slow, controlled rewarming at a rate no faster than 0.5°C per hour.~~

~~7.~~**4.** Communication:

a. Notify the physician of any changes in patient condition, complications of treatment or if unable to reach target temperature within specified time frame.

~~8.~~**5.** Documentation:

a. Time of initiation of hypothermia shall be documented in the medical record.

b. Patient assessments and communication with the physician shall be documented in the medical record.

## D. RELATED DOCUMENTS:

1. **Artic Sun Instructions for Use**
2. **Zoll Thermogard XP Instructions for Use**
3. **Gaymar Cooling Blanket Instructions for Use**

## ~~D.~~E. REFERENCES:

1. Geocadin, R.G., Koenig, M.A., Stevens, R.D., Peberdy, M.A. (2007). Intensive Care for Brain Injury after Cardiac Arrest: Therapeutic Hypothermia and Related Neuroprotective Strategies. Crit Care Clin; 22: 619-636.
2. Bernard, S. (2006). Therapeutic Hypothermia after Cardiac Arrest. Neurol Clin.; 24:61-71.
3. J.P. Nolan, et.al. (2003). Therapeutic hypothermia after Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation. Circulation. 108: 118-121.
4. **Palmer, S. J. (2015). Nursing the Out-of-Hospital Cardiac Arrest Patient: Use of Targeted Temperature Management. British Journal of Cardiac Nursing, 10(7), 335-344 10p.**
5. **Mathiesen, C., McPherson, D., Ordway, C., & Smith, M. (2015). Caring for Patients Treated with Targeted Temperature Management. Critical Care Nurse, 35(5) e-1-e13 13p. doi;10.4037/ccn2015168.**

# Artic Sun Instructions for Use

1. Use the sizing chart to determine the appropriate size gel pads for the patient.
   a. Apply gel pads to the patient.
      i. Gel pads must be placed only on intact skin.
      ii. Gel pads may be placed over top of defibrillation pads.
   b. Connect the gel pads and temperature probe to the machine's console.
   c. Set the patient's target temperature to 33°C.
      i. Goal temperature is 32 - 34°C.
   d. Ensure the Arctic Sun is in "automatic mode" (can only be used with attached temperature probe.)
   e. Time to target should be at MAX.
   f. Document time of initiation of patient cooling in the electronic health record (EHR).
   g. Administer cold intravenous saline as necessary to facilitate patient cooling, per physician's order, if no evidence of pulmonary edema on chest x-ray.
   h. If core temperature is NOT decreasing by at least 1°C per hour, see the Arctic Sun troubleshooting guide.
   i. Notify the physician if unable to reach target temperature within 4 – 6 hours.
   j. Monitor the patient for shivering during cooling using the Bedside Shivering Assessment Scale (BSAS) and notify physician if shivering cannot be controlled with the medications ordered.
   k. Monitor the patient for hypokalemia during cooling.
   l. Avoid severe hypothermia.
   m. Assess and document skin condition every two hours during therapy.
2. Maintenance phase:
   a. Once the target temperature has been achieved, the patient will be maintained at 32 – 34 °C for 24-hours from the initiation of cooling.
   b. Monitor the Arctic Sun water temperature and flow rate hourly in the EHR. A decrease in water temperature may indicate increased resistance to cooling, such as with shivering or fever from an infectious source.
   c. If the water temperature remains less than 10°C for more than 8 hours, refer to the Arctic Sun troubleshooting guide.
3. Rewarming phase:
   a. Begin rewarming the patient 24-hours after the initiation of hypothermia.
   b. Set the patient's target temperature to 37°C.
   c. Set the rate of rewarming to 0.3°C per hour. (Please note that the default setting is to "warm – MAX." The rewarming rate must be changed in order to achieve slow, controlled rewarming over 12 hours.)
   d. Monitor the patient for hypotension related to rewarming, secondary to vasodilation.
   e. Potassium replacement should be conservative 8 hours prior to rewarming and during rewarming.
   f. Monitor for hyperkalemia during rewarming.
   g. After rewarming is complete the Arctic Sun pads may be left in place for a total of 5 days. Monitor for rebound hyperthermia and reinitiate cooling if necessary to maintain the patient's core body temperature less than 37.5°C.

# Zoll Thermogard XP Instructions for Use

**Insertion of Zoll Quattro Catheter (note insertion procedure same as with central venous catheter insertion).**

1. **Assemble Supplies:**
   - a. **Full body sterile drape**
   - b. **Sterile gown for physician**
   - c. **Sterile gloves for assistant and physician**
   - d. **Mask with face shield for physician**
   - e. **Full face shield for physician**
   - f. **Caps for assistant and physician**
   - g. **Gel hand hygiene solution**
   - h. **Zoll Intravascular Temperature Management Catheter**
     - i. **Each catheter insertion kits contain all the necessary line insertion equipment**
     - ii. **The "Quattro" heat exchange catheter is a 4 balloon femoral venous catheter preferred for post cardiac arrest patients who need cooling (orange and white package). This is a 9.3 French 45 cm catheter . Catheter should be positioned so that the distal tip is in the inferior vena cava below its junction with the right atrium and parallel to the vessel wall. All balloons should reside within the vessel.**
   - i. **Zoll Start Up Kit for the Thermogard**
   - j. **500 ml. IV bag of normal saline . Note: takes about 250 ml of normal saline to prime the Thermogard.**
   - k. **Temperature probe connector for "T1" temperature from Foley catheter ; & secondary temperature monitoring source with temperature probe**
2. **Ensure physician/designated healthcare provider (HCP) has performed chlorhexidine skin antisepsis**
3. **Provide maximal barrier precautions for the inserting and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves, and full body sterile drape)**
4. **Ensure "time out" is performed per Patient Care Standards (PCS) Universal Protocol procedure.**
5. **Ensure Central Line Insertion Procedure Checklist is completed in Cerner.**
6. **Confirmation of Line Placement:**
   - a. **After insertion of the line by the physician, confirm placement with KUB or CXR but do not delay initiation of cooling while waiting for this to be done.**
   - b. **Ensure line confirmation is documented in Cerner .**
7. **After femoral insertion keep patient's HOB at a 30 degree angle or less).**
8. **For ongoing maintenance and care of femoral catheter, refer to Central Venous Access Devices, Adults .**
9. **Machine set-up and connection to the patient**
   - a. **The Zoll Thermogard consists of three major components: a recirculating chiller, a sterile fluid roller pump, and a temperature control system.**
   - b. **The Thermogard is connected to a ZOLL catheter (a temperature-controlled central line catheter) by two small-bore plastic tubes (orange luers).**
   - c. **Steps for Machine Set Up:**
     - i. **Check the level of the coolant in the coolant well, add more sterile or distilled water if necessary to ensure fluid is filled to just below the indicated "Max" coolant line (note: clinical engineering will add to the coolant chamber propylene glycol as part of routine machine maintenance). Place a "do not discard" sticker on the round plastic coolant cap and be sure to return it to the top of the coolant chamber.**

ii. Plug in the power cord and turn the power switch on. The machine will go through a self-test.
iii. Make the following selections on the system set-up display screens:
  1) When asked if it is new patient, select "no" for the TCMC Thermogard Trial. This will allow all data to be stored.
  2) Bath Pre-Set: Choose Precool and Enter
  3) Set Target Temperature: Turn the knob and select 33.0 C degrees for Hypothermia post-cardiac arrest with ROSC patients and then push "Enter".
  4) For Normothermia patients select 36.0 C degrees as target temperature.
  5) Set low temperature alarm at 32.5 when using hypothermia.
  6) Max Power, Control Rate or Fever: Turn the knob to select MAX Power and Enter
iv. Install the start-up kit tubing set.
  1) Insert the heat exchange coil into the coolant well.
  2) Insert the air trap into the air trap holder.
  3) Open lid of roller pump. The large section of tubing goes into the roller pump.
  4) Manually rotate the pump to facilitate loading of tubing (see quick reference guide attached to machine).
v. Load the pump tubing into the pump, following the tubing circuit diagram printed on the inside of the machine's top cover. The side of tubing with flange fits into the slot on the right side of the roller pump house.
vi. Firmly close the top cover of the pump.
vii. Hang 500 ml of sterile normal saline on the hook.
viii. Using aseptic technique, connect the tubing to the 500ml normal saline using the spike connector. Ensure that spike is all the way to the hub but be very careful that you do not puncture the bag as the spike is exceptionally long.
ix. Lift out the air trap from its holder and turn it upside down. Press and continuously hold the PRIME switch down until the air trap and tubing are completely flushed with saline (approx. 2 minutes).
x. Turn the filled air trap right side up and place it in the holder.
xi. Slip the insulating jacket over the saline container. Note: When you use this insulating jacket you will not be able to view the amount of fluid in the saline bag. Therefore, when using the insulating bag be sure to regularly check the fluid level in the saline bag. Normally there should be about 250 ml. in the 500 ml bag. If the saline bag level is decreasing in volume assess it for a leak.
xii. Route the tubing out of the machine through notches in the front of the console and through the channel at the rear of the console.
xiii. Close the top cover making sure the tubing is not kinked.

d. Connection to The Patient
i. Position the Thermogard near the patient's bed and lock the casters.
ii. Place the primary and secondary patient temperature probes in the patient.
  1) Plug the cable from the primary temperature probe into T1.
  2) Note: T2 will not display on the Thermogard.
iii. The supply and return connectors of the tubing are connected to each other. Use aseptic technique to disconnect the two catheters.
iv. Connect the male tubing connector to the female connector on the patient's ZOLL catheter.
v. Connect the female tubing connector to the male connector on the patient's ZOLL catheter (orange-to-orange connection).

vi. Position the tubing so that it is not kinked, obstructed, or cannot be dislodged by the patient's movement.
vii. Press the STANDBY/RUN button to place the Thermogard in the Run mode.

10. Disconnection / reconnection procedures:
    a. The Thermogard does not have a battery and will have to be disconnected if a patient needs to be transported.
    b. Temporary Disconnection From The Patient:
        i. Press the STANDBY/RUN button to place the Thermogard in standby mode. Do not turn the machine off.
        ii. Disconnect the temperature probes from their cables. Leave the temperature probes in the patient.
        iii. Using aseptic technique, disconnect Start up Kit tubing from the ZOLL catheter. Do not cap the orange ports, simply connect the two ends of the catheter to each other. Do the same with the start up kit tubing to ensure the ends stay clean. ** The product used for the evaluation has ORANGE luers. This is the updated product that was released in April. The orange luers are custom luers, which provide an additional safety feature and will not be able to connect to a luer lock syringe or IV tubing, thus preventing the possibility of a misconnection.
    c. Reconnection After a Temporary Disconnection:
        i. Using aseptic technique, reconnect the Start up Kit tubing to the ZOLL catheter.
        ii. Reconnect the temperature probes to their cables.
        iii. Restart the Thermogard by pressing the STANDBY/RUN button.
    d. Thermogard Rewarming & Normothermia
        i. This machine will not automatically switch from cooling to rewarming.
        ii. RN will note time that rewarming is set to occur.
        iii. Place Thermogard in STANDBY mode.
        iv. Push TARGET TEMPERATURE button and use the dial to change setting to desired temperature 36.5 degree Centigrade and then push "enter".
        v. Push Rate Degree Per Hour Button and dial in Controlled Rate. Turn to desired rate of .25 degrees Centigrade per hour and Enter. It will take about 12 hours to go from 33 degrees to 36.5 degrees.
        vi. Place Thermogard back in RUN mode.
11. Line maintenance
    a. Catheter stabilization & Protection of the Patient's Skin: Once catheter is verified to be properly positioned utilize standard Central Venous Catheter care for the site.
    b. Recommended length of time for line use:
        i. Quattro (four balloons) and ICY (three balloons) femoral lines are good for up to 4 days
        ii. The Cool-line inserted via internal jugular or subclavian is good for 7 days
        iii. Triple Lumen ports are not power ports.
        iv. If continued temperature management is desired after dwell time of catheter is up, simply replace catheter with new catheter kit over the wire.
        v. Replace Start up Kit tubing at 7 days or when changing out femoral line.
12. Ending Treatment
    a. Press the STANDY/RUN button. The pump stops turning and the Standby screen appear.
    b. Using aseptic technique, disconnect both tubing connectors from the ZOLL catheter.
    c. Disconnect the primary and secondary patient temperature probes.
    d. Press the knob and, select END PROCEDURE, then choose "download data later" and press knob once to confirm. Or simply turn off system. Patient data will be saved for 21 days.

e. **Prior to catheter removal, uncap and leave uncapped the inflow and outflow lumen. This will allow residual saline within the circuit to be expressed. Use a 20 ml slip-tip syringe from the start up kit to aspirate from the balloons to ensure all the saline is removed prior to the line being removed (optional with the Quattro catheter, as long as the orange luers are open to air).**

f. **The RN or physician can remove the line. It is normal to feel slight resistance as each balloon on the catheter passes out of the patient.**

13. **Troubleshooting & other key points:**
14. **Refer to the Thermogard User's Manual attached to each machine.**
15. **Use FICK cardiac output rather than thermodilution cardiac output on these patients.**
16. **The catheters are MRI compatible.**
17. **The catheters are NOT power injectable.**
18. **Mannitol may run through the ZOLL catheter, however the machine must be put on STANDBY for two minutes and the lumen must be flushed after the Mannitol has infused. This is to ensure the medication has not crystallized**
19. **Check the coolant level each time the machine is initially started. The coolant contains propylene glycol and distilled water. Engineering will replace the propylene glycol annually. The nurse will only need to add distilled water, if needed.**

**REFERENCES:**

1. **Zoll Thermogard Operator's Manual 2015**

## Gaymar Cooling Blanket Instructions for Use

1. **Targeted temperature management may be performed without the use of the Arctic Sun or Zoll Thermogard temperature management systems only if all of the Arctic Sun and Zoll temperature management machines are unavailable.**
   a. **Apply ice packs to the groin, sides of chest, axillae, neck and limbs to initiate cooling.**
   b. **Cold IV saline may also be administered, as ordered, to facilitate rapid cooling.**
   c. **The Gaymar cooling blankets should be placed beneath and on top of the patient, with a sheet between the patient and the blanket to protect the skin.**
   d. **The water temperature in the Gaymar system is adjusted manually to achieve the desired rate of cooling.**
   e. **Ice packs can be removed during the maintenance phase.**
   f. **After 24-hours, the water temperature must again be manually readjusted to achieve slow, controlled rewarming at a rate no faster than 0.5°C per hour.**

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES ~~Policy Manual~~

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **6/08** | **SUBJECT:** | **Visiting Guidelines** |
| **REVISION DATE:** | **5/92, 9/94, 10/96, 1/99, 5/02, 5/03, 12/03, 12/05, 7/07; 02/09; 03/11; 6/14** | **POLICY NUMBER:** | **8610 – 301** |

| | |
|---|---|
| **Department Approval:** | **12/16** |
| **Clinical Policy & Procedures Committee Approval:** | **~~06/14~~01/17** |
| **Nurse Executive Council Approval:** | **~~06/14~~02/17** |
| **Medical Staff Department/Division Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **~~07/14~~03/17** |
| **Board of Directors Approval:** | **07/14** |

A. **PURPOSE:**

1. To promote patient and family focused care in a healing environment while maintaining patient and staff safety, privacy and infection control measures.

B. **POLICY:**

1. Visiting is determined by the healthcare needs of the patient.
   a. Family members/significant others are encouraged to participate in care planning through regular interaction with the patient and the health care team.
   b. Limitations may need to be made due to the clinical condition of the patient or at the patient's request.
2. Recognizing the positive contribution made by patients' family/significant others; the Medical Center is open for visiting 24 hours a day.
3. Special Considerations: Visiting hours may be restricted for medical or emergency situations. All exceptions or restrictions are at the discretion of the Chief Nurse Executive or designee.
   a. Adult supervision is required for children in all areas of the facility. Visitors under the age of 14 must be accompanied at all times by an adult other than the patient when visiting a patient unit.
   b. To provide privacy and confidentiality, visitors may be requested to wait in designated waiting areas during physician examinations, nursing care, and the performance of tests or procedures.
   c. In order to allow opportunity for medical care to be provided and to ensure adequate rest and privacy for patients.
      i. In rooms with adjoining beds (semi-private), 2 visitors per patient at a time are allowed.
   d. To ensure patient safety and infection control, family members/significant others and visitors are not allowed in the bed with a patient; nor allowed in an unoccupied patient care bed.
4. The following areas have special visiting policies. Visitors must check in at the nursing station in the following departments:
   a. Intensive Care Unite
   b. Women's & Children's Services
   c. Neonatal Intensive Care Unit
   d. Emergency Department
   e. **Inpatient** Behavioral Health ~~Unit~~
   f. Surgical Services

5. Visitor responsibilities include but are not limited to:
   a. Observing the visiting hours for the area that they are visiting and leaving the patient room or care area when asked by hospital staff.
   b. Refraining from behavior that may cause annoyance, inconvenience and/or lack of consideration and assisting with the control of noise and the number of visitors.
   c. Consideration of the rights of patients and hospital staff by treating them with courtesy and respect.
   d. Maintenance of patient confidentiality and privacy.
   e. Refrain from damaging or removing any article or property belonging to TCMC.
   f. Refrain from bringing any food, alcohol or medications to the patient without prior approval from the physician.
   g. Reporting any concerns or complaints to the Assistant Nurse Manager, Manager or designee.
   h. Use hand sanitizer or soap and water to wash hands.
6. Violent or aggressive behavior by visitors:
   a. The hospital will not tolerate violence or aggression by visitors towards staff, patients or other visitors.
   b. The following items and behaviors are prohibited at TCMC:
      i. Alcoholic beverages ~~(unless ordered by physician)~~
      ii. Disruptive or violent behavior
      iii. Smoking**/electronic smoking devices**
      iv. Street drugs
      v. Weapons (see Administrative Policy # 284)
   **c.** For the safety of our patients, visitors and staff - visitors who do not comply with safe conduct regulations may be asked to leave or will be escorted off hospital grounds.

**C. RELATED DOCUMENT(S):**

~~c.~~**1. Administrative Policy; Weapons on Medical Center Campus 284**

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**

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

**REVISION DATE:** 11/02, 8/03, 3/06, 02/09, 03/11, 11/13, 04/14 **POLICY NUMBER:** 8610-281

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

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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 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**
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**Administrative Policy Manual**
**District Operations**

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**ISSUE DATE:** 5/91

**SUBJECT:** CODE GRAY: HOSTAGE -RESPONSE PLAN

**REVISION DATE:** 12/03; 9/05; 9/10

**POLICY NUMBER:** 8610-283

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|---|---|
| **Department Approval:** | 02/17 |
| **Administrative Policies & Procedures Committee Approval:** | ~~01/14~~ 2/17 |
| **Medical Executive Committee Approval:** | n/a |
| **Professional Affairs Committee Approval:** | ~~02/14~~03/17 |
| **Board of Directors Approval:** | 02/14 |

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A. **PURPOSE:**

1. **To provide a rapid, organized and thorough response at Tri-City Healthcare District (TCHD) to an incident where there is an individual being held against their will or in a hostage situation while in the facility or in the immediate surrounding parking areas.**~~To assure the proper implementation of a first response Medical Center procedure that will result in the successful resolution of any hostage situation that may emerge. To outline a process that will prepare each involved individual to maintain discipline, determination, and the proper utilization of sound judgment under stressful conditions.~~

B. **POLICY:**

1. **It is the policy of TCHD while responding to a hostage or barricaded suspect situation that the primary aim of personnel is to ensure the safety of all people on the premises, as well as, preserve life and protect property**~~While each and every hostage incident will vary in both complexity and locality within the Medical Center, to assist all involved personnel, the following guidelines should always be considered~~.
2. ~~Contain the movements of both the hostage and the hostage taker in order to keep the situation from further escalating. This guideline should only be safely attempted unless the incident factors force the utilization of another action.~~
3. ~~Control the immediate and orderly removal of all patients, visitors, and staff members from the incident area or department if safely possible to do so.~~
4. ~~Communicate with all involved personnel all the available pertinent facts regarding the hostage incident. Before any action is taken, all personnel must be properly briefed and continually updated on all available information.~~

C. **PROCEDURES ~~CESS~~:**

1. **The TCHD personnel who witnesses or comes upon a hostage situation ~~within the facility~~ shall:**
   - a. **Warn others of the situation by calling out for everyone to "take cover" and also take cover as well.**
   - b. **If a landline is available dial "66" and report "Code Gray" to the PBX Operator,** ~~Whoever first discovers an apparent hostage incident immediately notifies the Medical Center PBX/Operator of a Code Gray,~~ **and advise of** the incident location, and any other pertinent information, such as the number of hostages, a complete description of the hostage taker(s), and the description of any weapons.
     - ~~a.~~**i. The PBX/Operator will announce "Code Gray" three (3) times overhead, followed by the unit, department or location.**
     - ~~b.~~**ii.** The PBX/Operator will immediately notify the Security Department of the Code Gray and the location of the incident.

~~i.~~**iii. The PBX/Operator will also notify Oceanside Police Department via "911" and advise of the current situation.**

c. **TCHD Security Personnel will respond to the incident location and** ~~It~~ **it** will be the responsibility of the ~~Lead~~ Security **Supervisor or designee**~~Officer or Senior Officer~~ to ~~respond to the incident location and~~ assume the primary Officer designation.

i. The~~is~~ **Security Supervisor** ~~Officer will~~ **shall** remain in this capacity until such time that **they are relieved of command by Oceanside Police Department personnel.**~~the Security Supervisor or Designee relieves the Officer~~.

ii. **The Security Supervisor will be responsible to brief Oceanside Police Department personnel of the hostage situation and will supply any requested support or additional personnel.**

iii. **The Security Supervisor will also advise for the facility to be placed into a security lockdown mode until further orders.**

d. ~~The primary Security Officer will ensure that the Oceanside Police Department and the Security Supervisor or Designee is immediately notified and informed of the incident. The Officer will also be responsible for insuring that he/she or the~~ **The** PBX/Operator **will** initiate~~s~~ the following call-out process.

i. The on-duty Administrator / Administrative Supervisor.

ii. The Environment of Care/Safety Officer.

**iii.** The on-call Administrator if after hours.

**1) The Chief Executive Officer (CEO) will notify;**

**a) Board of Directors**

~~iii.~~**b) Chief of Medical Staff**

iv. The Public Information Officer.

v. The Director of Risk Management.

**e.** Security Department personnel will proceed to the incident location and **begin to safely** ~~orderly~~ remove all patients, visitors, and staff members to a safe location and properly **ensure that** ~~secure~~ all approaches into and exits out of the **immediate situation** area **are secured**.

**f. The Emergency** ~~Room~~ **Department and Surgery staff shall be advised of the hostage situation and prepare for possible trauma patients.**

~~e.~~**g.** During or after the evacuation processes any **capable** witnesses will be interviewed **by Security personnel for** ~~regarding~~ pertinent information regarding the **hostage situation**~~incident~~.

~~f.~~**h.** A secure area will be established for use as a command center and central location for the hostage negotiation team. A floor plan of the incident area will be obtained from the **Facilities** ~~Engineering~~ Department and a secured communications system will be established.

**i.** The Administrator or Designee **along with Oceanside Police Department** will obtain any pertinent information from the unit Manager or Designee of the affected area or department, regarding the hostage and hostage taker.~~,~~ ~~and~~

~~g.~~**j. TCHD medical personnel will be** reassign**ed as** needed ~~additional personnel~~ to this area in order to ensure proper staffing and continuance of the necessary medical services **if possible.**~~.~~

~~h.~~**k.** At no time during the hostage situation will any **TCHD** ~~Medical Center~~ personnel attempt to rescue a hostage or disarm a hostage taker. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any **TCHD** ~~Medical Center~~ personnel offer any promises or concessions to the hostage taker.

~~i.~~**l.** It will be the responsibility of the primary Security Officer to ~~assign the chronological~~ documenta~~tion of~~ all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.

~~a. Upon the arrival of the law enforcement personnel, the Security Department will be responsible to supply any requested support or additional personnel.~~

**m.** At the completion of the **Hostage situation**~~incident~~, all involved personnel will remain available for interviewing by local law enforcement personnel and will only return to normal operations after first receiving authorization to do so from the Security Supervisor or Designee.

**D. RELATED DOCUMENTS:**

~~j.~~**1. Emergency Operations Procedure: Code Silver Person with Weapon or Active Shooter**

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**

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**ISSUE DATE:** 6/94 **SUBJECT: CONTROL OF LOCKS AND KEYS**

**REVISION DATE:** 5/03; 2/06; 01/09; 02/11; 04/14 **POLICY NUMBER:** 8610-243

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~04/14~~ 2/17** |
| **Professional Affairs Committee Approval:** | **~~06/14~~03/17** |
| **Board of Directors Approval:** | **06/14** |

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A. **PURPOSE:**

1. To set forth a uniform and systematic control for locks and keys at Tri-City **Health Care District (TCHD)**~~Medical Center (TCMC)~~.

B. **POLICY:**

1. All locks and keys at **Tri-City Medical Center** (TCMC) are the responsibility of the Director of Facilities.
2. Locks:
   a. All door locks in TCMC shall be keyed to the same master keyed system and shall comply with all applicable codes and standards.
   b. Door locks are to be keyed or re-keyed only by approval of the Department Director, Director of Facilities, or area Executive.
   c. Offsite door locks are managed through the Engineering Department.
   d. Any lock that is removed from the Master Key MUST- be approved by the Chief Executive **Officer** or Area Vice President.
3. Keypad combination locks are to be used only where absolutely necessary such as the number of keys to be issued would be impractical. All applicable codes and standards shall be adhered to for installation of keypad combination locks.
   **a.** Keypad combinations for door locks will be coordinated whenever possible provided hospital security is not compromised.
   ~~a.~~**b. Department Directors or Managers shall be responsible to ensure the integrity of the door code, and to change/update the code whenever there is a potential security risk.**
4. Keys:
   a. Keys will be issued to employees on an as needed basis upon approval of the Key Request form by Department Director or Manager,~~ and~~ Director of Facilities,~~ or~~ **A**~~a~~rea ~~Administrator~~ **Vice President** or CEO.
   b. Keypad combinations and keys for medical staff will be distributed through the Medical Staff Office.
   c. All keys and **k**~~K~~eypad combinations issued to **p**~~P~~hysicians and employees are to remain **protected/confidential** with the **p**~~P~~hysician/employee and are not to be ~~given~~ **shared with**~~to~~ anyone else.
   d. Any employee who terminates **employment** or transfers to another Department ~~will~~ **shall** ~~leave~~ **turn-in the** keys with exiting Department Director or Manager who will notify Engineering Department. ~~Keys will be issued to employee of new Department through a Key Request Process.~~
5. Electronic access control systems: The proximity card readers can only be installed with the approval of the CEO or COO.~~.~~

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**

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**ISSUE DATE:** 1/81 **SUBJECT:** HELICOPTERS ON DISTRICT PROPERTY

**REVISION DATE:** 5/89; 8/93; 10/97; 10/99; 5/03; 01/09 9/10; 04/14 **POLICY NUMBER:** 8610-207

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~04/12~~ 2/17** |
| **Professional Affairs Committee Approval:** | **~~06/14~~03/17** |
| **Board of Directors Approval:** | **06/14** |

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A. **PURPOSE**

1. To maintain a safe environment for all personnel on the helipad.

B. **POLICY**

1. The patient's physician shall request helicopter transport.
2. Departments requesting helicopter transport shall notify the Emergency Department (ED) as to the estimated time of arrival.
3. The Emergency Department (ED) Mobile Intensive Care Nurse (MICN) shall make appropriate in-house arrangements for landing and take off.
4. The ED MICN shall be notified by the Aeromedical Dispatcher of helicopter landing.
   a. The ED MICN shall notify Security via the radio in radio room of estimated time of arrival of helicopter.
   b. The Security Department will respond to the elevator alcove (and must turn off air handlers temporarily by pushing red button) to standby in case the fire suppression system needs to be activated. The elevator shall be kept in the locked position, available to the flight crew.
      i. If the patient is incoming, an ED technician shall meet the helicopter with a gurney, oxygen tank and I.V. pole and, when directed, assist the flight crew in the transfer of the patient and equipment.
5. The following safety rules shall be followed at all times.
   a. No running on the helipad.
   b. Doors to the helipad shall remain closed at all times **(except during patient transfers to or from the helicopter)**.
   c. Visitors are not allowed on the helipad unless accompanied by the flight crew or TCMC Security personnel.
   d. Gurneys with mattresses, linens, or IV poles are not permitted within 50 feet of the aircraft when the blades are turning. Make sure all loose objects (i.e., MAST suits; debris) are secured on the helipad.
   e. ~~Unsecured oxygen cylinders shall not be left unsupported in the upright position.~~**Oxygen cylinders must be properly secured at all times (designated cylinder cart or underneath the gurney in the cylinder slot). At no time may cylinders be left unsecured.**
   f. Wait for the pilot's approval before approaching or exiting the aircraft. Approach or exit the aircraft from the front in view of the pilot.
   g. Do not approach the helipad until the aircraft has landed on or lifted off the pad.
   h. Do not approach or exit the aircraft when the blades are turning. Do not allow ancillary personnel to approach the aircraft until the rotors have stopped turning.
   i. Tri City Medical Center heliport weight restriction for all medical air transportation is 10k ~~lbs~~**pounds**~~.~~ maximum with a blade diameter of no more than 36 feet.

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**
**District Operations**

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**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, 02/14

**POLICY NUMBER:** 8610-202

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

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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 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.

6. The Patient Representative will mail identified articles to owners who are unable to come to the hospital. Mail certified, return receipt.
   a. After a period of 90 days all unclaimed items will be donated to a charity as determined by Administration and allowed by law.
7. Anyone who has lost articles may contact Security through the PBX operator..
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.
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.
10. The Director of Risk Management will obtain the signature of the proper administrator.The Patient Representative will obtain the cost center location for charging purposes. The check request will be forwarded to AP in Accounting.
11. 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).
12. The original forms will be filed along with the check information to the Patient Relations Specialist and into the Complaint Resolution file.

E. **RELATED DOCUMENT(S):**
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.***

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

**SUBJECT: AHA ~~/ AWHONN~~: COURSE CARD ACCEPTANCE**

**ISSUE DATE: 8/07;**
**REVISION DATE(S): 3/10; 12/11; 4/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(s):** | **08/07, 04/10, 03/12; 07/13** |

A. **PURPOSE:**

1. To ensure the appropriate documentation is current and valid for all ~~TCMC~~ **Tri-City Healthcare District (TCHD)** employees, Contract Employees, Registry Employees requiring AHA Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Life Support (PALS) course completion.

B. **POLICY:**

1. **American Heart Association**
   a. Course Completion must follow the established guidelines per American Heart Association (AHA) Emergency Cardiac Care (ECC) Course Matrix **2015**~~2010~~.
   b. ~~TCMC~~ **TCHD** Training Center (TC) maintains authorization to review and approve all Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS)/ Pediatric Advanced Life Support (PALS) Provider and Instructor cards from outside Training Centers (TC) and Training Sites (TS). **Military Training Network cards are accepted.**
   c. Employees must present a current AHA BLS/ACLS/PALS Provider and/or Instructor card from an approved AHA Training Center or Training Site that is current and in good standing utilizing the AHA guidelines and curriculum.
   ~~d. TCMC TC will accept cards only from the American Heart Association's Healthcare Provider Online Renewal course if it included a complete Part II skills checklist from an authorized AHA Training Center.~~
   ~~e.~~**d.** ~~TCMC~~ **TCHD** TC will utilize the Course Card Reference Guide for surveillance of AHA provider cards.
   ~~f.~~**e.** Contact Education department for most current list of Training Centers in good standing with the AHA or log onto www.americanheart.org.

~~2. Associated of Women's Health Obstetric and Neonatal Nurses (AWHONN) Fetal Heart Monitoring:~~
   ~~a. Course completion must follow the established guidelines in a workshop focusing on application of essential fetal heart monitoring (FHM) knowledge and skill set required to work in Labor and Delivery unit~~
   ~~b. This AWHONN course endorses and encompasses the updated National Institute of Child Health and Human Development (NICHD) nomenclature that the American College of Obstetricians and Gynecology (ACOG) has endorsed and recommends in clinical practice for common terminology and collaboration.~~
   ~~c. Courses for fetal monitoring certification must be AWHONN approved or sponsored courses.~~
   ~~d. Intermediate or advanced fetal monitoring courses are acceptable for meeting either initial certification or recertification.~~

C. **REFERENCE LIST:**

1. American Heart Association Program Administration Manual, 201~~208~~
~~2. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), (2009). Fetal Heart Monitoring Principles and Practices, 4th Edition. Kendal/Hunt Publishing Company: Dubuque, Iowa~~

~~D. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT MANUAL

**SUBJECT: AHA: CARE AND DECONTAMINATION OF AHA EQUIPMENT**

**ISSUE DATE: 7/05**
**REVISION DATE(S): 08/07, 04/10, 07/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(s):** | **07/13** |

A. **POLICY**

1. To ensure the safety, comfort and health of all participates during AHA courses held in connection with the **Tri-City Healthcare District (TCHD)**~~TCMC~~ AHA Training Center (TC), all Instructors will follow current recommendations in the care and cleaning of equipment and other safety measures during and after all AHA courses.
2. Should a student be in an active state of an infectious disease, or share that they may have been exposed and are not sure, or have dermatologic lesions on their hands, mouth or face the Instructor must request that the student must return to class on another day after these situations have cleared or if possible, assign participant to own manikin to lessen the possibility of contamination and limiting exposure to other participants
3. Students may not eat, drink, smoke or chew gum during class.
4. ~~Before each course the AHA instructor will announce to participants that all equipment is decontaminated after each course and to encourage each participant to use hand sanitizer after each demonstration of skills using manikins and adjunct equipment~~
5. **Use of manikins during course**~~Checking out or up for a course with manikins~~:
   a. It is the responsibility of each Instructor to clean the manikins that are used for each class.
   b. ~~In some scenario a manikin may have been assemble but not used for practice in BLS skills and the manikin is still considered clean. If manikin(s) are not clean or there is a question, the Instructor responsible for the teaching station or checking out manikins must clean and obtain clean parts for manikin assembly before use. See below under the section "Cleaning of Manikins at end of Class."~~
   c. ~~Instructors will wash hands before handling manikins and not eat or drink during class.~~
6. During Class the following guidelines will be used:
   a. Each manikin station will have some type of antimicrobial cleaning agent; this may be alcohol wipes, Sani Cloths, or Gel and cloths. These are to be used by each instructor to wipe down manikin mouth, face and facemask after use.
   b. Each student will be given his or her own face shield or green one-way valve. Extra face shields will be available during class should a student misplace or lose theirs.
   c. Instruct students to use gel for hands in-between each manikin station.
   d. ~~During Obstructed-airway procedure demonstration request students only simulate the finger sweep to avoid contamination of rescuer's finger with any possible exhaled moisture and saliva from previous rescuers.~~
   e. ~~During 2-rescuer CPR training with mouth-to-mouth ventilation, there is no opportunity to disinfect the manikin between rescuers when switching positions. Thus, the second rescuer taking over ventilation will be instructed to simulate ventilations only.~~
   f. ~~Use plastic trash bags at each station for used cloths/wipes to be placed in.~~
   g.**d.** Used green one-way valves will be discarded at the end of each class. They can be offered to the students to take home. Only new green one-way valves will be used for each class.

~~7.~~**6.** Instructors responsibilities for cleaning manikins at end of class:
- a. Instructor should first apply gloves before dismantling manikins.
- b. Remove face and connectors and inspect for any damage. Should any parts be damaged, discard them; otherwise place them in a plastic bag. Report to TCC any equipment that need to be replaced and or ordered in a timely fashion
- c. Remove lungs and discard in trash.
- d. Clean face, internally and externally, jaw, neck and chest with Sani cloths or other cleaning solutions recommended on page 1-93 (chapter 6) in your Instructors manual. Let manikins dry thoroughly.
- e. Manikins deemed too dirty to be easily cleaned (manikin has had direct contact with a student's mouth, contaminates visible):
  - i. Instructor will utilize the manikin parts bag in the carrying case to replace all parts of the manikin with clean parts (lung bag, manikin face, and connector)

~~8.~~**7.** TC's responsibilities for cleaning and care of manikins:
- a. TC will take used parts to Sterile processing for sterilization.
- b. After sterilization, TC will inspect manikin parts for damage and toss if damage has occurred.
- c. The airway and face pieces will replaced after the last class of each month.
- d. These prepared bags of clean manikin parts will be placed in the clearly identified bin in the Manikin Care Station.
- e. TC will be responsible for periodical washing of manikins clothing at least monthly and if obviously soiled.
- f. TC will assume responsibility in caring for any manikins that fall under the situations mentioned in section G.8 above.
- g. The Equipment check-in and checkout log accuracy will be the responsibility of the Instructor.
- h. Any equipment missing from the Training Center and not logged is considered theft of TC property
- i. Reservation for equipment is on a first come first serve basis
- j. Equipment rental process may change periodically
- k. Late returns may result in loss of rental privileges
- l. Payment is expected when equipment is picked up

B. **FORMS**
1. BLS Manikin & Other Equipment Check Out

C. **REFERENCE LIST:**
1. Chapter 6 in BLS Instructor's Manual

~~D. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

## AHA BLS MANIKIN & OTHER EQUIPMENT CHECK OUT

| Date: Checked Out | Name/Contact #: | Video # Or Name | Manikins Checked out: A = adult/ C = child/ B = baby Also please identify by manikin number on bag Or write in other equipment | Manikins Cleaned/Restocked (Y/N) | Date: Checked In |
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Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

**SUBJECT: AHA CONTINUING EDUCATION STATEMENT**

**ISSUE DATE: 8/07**
**REVISION DATE(S): 04/10, 07/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Director Approval Date(s):** | **07/13** |

A. **POLICY**

1. Tri-City **Healthcare District**~~Medical Center~~ AHA Training Center Continuing Education (CE) statement:
   - **a.** The AHA does not issue continuing medical education (CME), continuing education (CE or continuing education hours (CEH) for any AHA ECC courses. Instructors conducting courses for professional groups eligible to receive continuing education credits are encouraged to submit information to the appropriate professional organization.
   - ~~a.~~**b.** **The AHA does issue CE for their Heartcode ACLS and PALS online courses only. Any instructor led events are the responsibility of the Training Site or Center to maintain and issue CE or CME.**

B. **PROCEDURE:**

1. At the end of each ACLS or PALS course the Lead Instructor will calculate the total hours of Instruction and record the number of hours on the course roster.
2. **TCHD**~~TCMC~~ Education Department issues the Continuing Education hours for participants.

~~C. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

**SUBJECT: AHA: MISSION STATEMENT AND GOALS**

**ISSUE DATE: 8/07**
**REVISION DATE(S): 04/10, 07/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(S):** | **07/13** |

A. **POLICY**

~~The American Heart Association's (AHA) mission is build healthier lives, free of cardiovascular diseases and stroke, that single purpose drives all we do.~~

1. **The American Heart Association's (AHA) Emergency Cardiovascular Care (ECC) is inspiring the world to save lives through a dynamic message of hope. As the authority in resuscitation science, research and training, we publish the official AHA Guidelines for CPR and ECC. Because saving lives is why.**

~~1.~~**2.** Tri-City **Healthcare District**~~Medical Center~~'s AHA Training Center supports the AHA mission and goals through administration, education, and quality assurance support of the AHA Instructor members and training sites. Our training center is committed to providing quality and current AHA courses to ~~HCPs~~ **Healthcare Providers and to the public** to provide them with the skills to promote excellence in the delivery of patient/family centered care.

~~2.~~**3.** Our goals are to provide AHA program to the community and support training courses to our community. We operate under a written agreement with the AHA and continue to build relationships with new members of the AHA community network.

~~B. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

**SUBJECT: AHA: QUALITY ASSURANCE PROGRAM**

**ISSUE DATE: 7/05**
**REVISION DATE(S): 08/07, 04/10, 07/13**

| | |
|---|---|
| **Department Approval Date(s):** | **~~04/13~~12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(S):** | **07/13** |

A. **POLICY**

1. **Tri-City Healthcare District (TCHD)** ~~TCMC~~ TC will have a Quality Assurance Plan integrated into the Education Departments Annual Operational Plan and update it annually. Indicators will be chosen that will reflect monitoring of course quality, instructor performance, and TC administrative operations.
2. TC Quality Assurance Monitoring Points to be considered in the annual Quality Assurance Plan and for the dash board are:
   a. Most Current AHA examinations used in all courses and student test scores
   b. Each student has the current appropriate provider textbook readily available for use before, during, and after the course.
   c. A mechanism exists for developing, monitoring, renewing status, and updating Instructors.
   d. AHA core content is taught in every course.
   e. Course completion cards and written exam answer sheets are kept secure.
   f. TC has adequate resources to complete the contracted program requirements, including staff, equipment, budget, etc.
   g. Appropriate cards are issued to each student who has successfully completed course requirements.
   h. A written internal dispute resolution policy is provided to all Instructors.
   i. Sufficient course materials and equipment is on hand to meet course and Instructors needs. That all equipment is clean and in good working order.
   j. All records are complete and filed properly.
   k. TC initiates a process that ensures all TCF, Lead Instructors, and Instructors are adequately trained to fill their roles and are actively involved in the Quality Assurance/Continuous Quality Improvement process.
   l. A mechanism exists to monitor courses taught by all Instructors and Training Centers.
   m. Courses, Instructors and program administration evaluation process are in place.
3. Additional monitoring of program growth and improvement in performance will be assessed through the following indicators:
   a. -Increased training numbers
   b. Participation in chain of Survival activities in the community.
   c. Improved Course evaluations/summaries
   d. Expansion of the TC Training Network (e.g. new Instructors, new Training Sites)

~~B. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

**DELETE – combine with AHA Card Processing Procedure**

**EDUCATION DEPARTMENT MANUAL**

**SUBJECT: AHA TRAINING CENTER: COURSE CARD MANAGEMENT**

**ISSUE DATE: 7/05**
**REVISION DATE(S): 08/07; 04/10, 07/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(s):** | **-07/13** |

A. **POLICY**

1. TCMC Training Center (TC) has been issued a security code by the National Center ECC Department. This code is required to order AHA cards to be issued at the completion of each discipline. Only cards can be issued to the TC for those disciplines the TC has been approved to provide.
2. Only the TCC and his/her designee are authorized to use this security code.
3. TCC may delegate the issuance of cards to a Training Site; however, the TC remains responsible for the issuance of cards in accordance with AHA policies.
4. The AHA regional office may change this security code if deemed necessary to maintain the confidentiality of this code.
5. Each student who successfully completes an AHA ECC course will be issued the appropriate course card that bears the AHA logo.
6. TCMC TC will issue cards only to students of the TC, Aligned Training Sites, and/or Instructors who have met the requirements.
7. To maintain security and accountability for card issuance process only the TCMC TCC and Education Department Secretarial/Support staff will have access to AHA course cards.
8. TCMC TC will issue course cards within 30 days of receipt of paperwork.
9. Each card will be computer printed to reduce the risk of cards being altered and for legibility.
10. AHA Course Cards will be completed following the AHA course card reference guide to quality Control April 2010
    a. Front of Card (Provider and Instructor)
        i. Course Name
        ii. Student's name (first, middle initial, last)
        iii. Issue date (two-digit month and day, and four-digit year) (i.e. 01/03/2010)
        iv. Recommended renewal or expiration date (two years from date of issue) indicated by two-digit month and four-digit year only.
        v. TCMC will honor all AHA cards until the last day of the month of the recommended renewal or expiration date.
    b. Back of Card (Provider and Instructor)
        i.
        ii. Training Center name and ID number
        iii. Training Site if different from TC and address
        iv. First and last name of Course Director/Lead Instructor and instructor's ID #
    c. Student is to sign his/her card in ink upon receipt
11. It is the responsibility of the TC to issue a duplicate card if card is lost or mutilated. TCMC will charge $10 for replacement cards that is lost by the student. TC will verify course attendance before issuing a duplicate card.
12. AHA cards damaged during shipment must be returned to the distributor for replacements.

B. **APPROVAL PROCESS**

1. Clinical Policies & Procedures Committee

~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4.~~1. ~~Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

**SUBJECT: COPYRIGHT POLICY**

**ISSUE DATE: 6/07**
**REVISION DATE: 8/07; 4/10; 7/13**

| | |
|---|---|
| **Department Approval Date(s):** | **12/16** |
| **Medical Executive Committee Approval Date(s):** | **n/a** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(s):** | **07/13** |

A. **PURPOSE:**

~~A.~~**1.** Provides guidelines for duplicating or utilizing copyrighted material.

B. **POLICY:**

1. Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** recognizes that federal law makes it illegal to duplicate copyrighted materials without authorization of the holder of the copyright, except for certain exempt purposes. Severe penalties may be imposed for unauthorized copying or using of audiovisual or electronic/printed materials and computer software, unless the copying or using conforms to the "fair use" doctrine. **The ~~TCMC~~TCHD Staff Medical Library complies with Title 17 section 108 of the U.S. Code which provides specific guidelines for libraries and archives regarding the reproduction of copyrighted materials.**
2. ~~Tri-City Medical Center~~ **TCHD** requires its Staff to comply with the United States Copyright Act. The employees of **TCHD** ~~Tri-City Medical Center~~ are prohibited from reproducing materials not specifically allowed by fair use, copyright law, licenses or contractual agreements or permission. Staff shall download, possess, or store only lawfully acquired copyrighted materials and use, adapt, distribute, or perform them only in ways consistent with the Copyright act, associated case law, the Fair Use principle, and the intellectual property rights of others.
3. Under the "fair use" doctrine, unauthorized reproduction of copyrighted materials is permissible for such purposes as criticism, comment, news reporting, teaching, scholarship or research. If duplicating or changing a product is to fall within the bounds of fair use, these four standards must be met for any of the foregoing purposes:
   a. The purpose and character of the use.
      i. The use must be for such purposes as teaching or scholarship and must be nonprofit.
   b. The nature of the copyrighted work.
      i. Staff may make single copies of the following for use in research, instruction or preparation for teaching: book chapters; articles from periodicals or newspapers; short stories, essays or poems; and charts, graphs, diagrams, drawings, cartoons or pictures from books, periodicals, or newspapers in accordance with these guidelines.
   c. The amount and substantiality of the portion used.
      i. In most circumstances, copying the whole of a work cannot be considered fair use; copying a small portion may be if these guidelines are followed.
   d. The effect of the use upon the potential market for or value of the copyrighted work.
      i. If resulting economic loss to the copyright holder can be shown, even making a single copy of certain materials may be an infringement, and making multiple copies presents the danger of greater penalties.

4. ~~Tri-City Medical Center~~ **TCHD** disapproves of unauthorized duplication in any form. Employees who willfully disregard the copyright policy are in violation and do so at their own risk and assume all liability. Every attempt will be made to assist employees who need information so that they can perform their duties within the intent of the law.

~~C. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

**Tri-City Health Care District**
**Oceanside, California**

**Infection Control Manual**

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**ISSUE DATE: 1/1985**

**SUBJECT: Meningococcal Exposure**

**REVIEW DATE: 9/2007**
**REVISED: 9/2003, 10/2004, 07/2014**

**STANDARD NUMBER: IC. 6.2**

| | |
|---|---|
| **Infection Control Department Approval:** | **~~07/14~~01/17** |
| **Infection Control Committee Approval:** | **~~07/14~~01/17** |
| **Medical Executive Committee Approval:** | **~~07/14~~02/17** |
| **Professional Affairs Committee Approval:** | **~~08/14~~03/17** |
| **Board of Directors Approval:** | **08/14** |

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A. **PURPOSE**:

1. To help prevent the transmission of disease to and colonization of healthcare workers (HCWs).
2. Health care workers may require prophylactic antibiotics after a significant exposure to a patient with an infection (meningitis, bacteremia, or pneumonia) due to *Neisseria* meningitidis Bacterial meningitis infection presents as a sudden onset of fever, headache, and stiff neck. The symptoms of bacterial meningitis can appear quickly or over several days. Typically they develop within 3 – 7 days after exposure.
3. Prophylaxis **is** most effective within the first 4 days post-exposure.
4. Patient is placed in Droplet Precautions if disease is known or suspected before lab confirmation.
5. Chemoprophylaxis is offered to HCWs if:
   a. the patient's CSF gram stain is positive *for* gram negative diplococci, or blood, sputum, or CSF is culture positive for Neisseria meningitis and
   b. (2) HCW had an "intimate exposure" as defined on the Meningococcal Meningitis worksheet (Appendix A), was not wearing appropriate PPE, and the patient was not receiving appropriate antibiotics for at least 24 hours.
   c. Staff Roles (See hyperlink for flow chart):
   d. Microbiology: report significant stains *a*nd cultures to patient's attending physician, public health and Infection Preventionist (M – F 8-am to 5pm) or the Administrative Supervisor after hours and weekends.
   e. Infection Preventionist or Administrative Supervisor: assist in identification of departments or units involved and report to San Diego County Health and Human Services~~.~~ **Epidemiology department: # (619) 692-8499 FAX # (858) 715-6458**~~Reference Infection Control Manual, IC 12 Required Reporting for forms and fax/phone numbers.~~
   f. Charge Nurse: review the patient's chart to identify **exposed** staff~~,. c~~**C**omplete and send attached Meningococcal Meningitis Worksheet (Appendix A) to Employee Health.
   g. ED **Base Coordinator to 1) fill out Communicable Disease Exposure Report Form (from County of San Diego Public Health Department: Division of Emergency Medical Services 2) send form to Infection Control staff for follow up 3) notify the EMS agency's Infection Control Officer of exposure.** ~~MICN: reference Patient Care Services manual, Policy X.B. Exposure to Communicable Diseases for questions related to pre-hospital personnel.~~

~~B.~~**6.** Exposed employee: complete an Injury/Illness Investigation Report and sign in to be seen in Emergency Department.

~~1.~~

**B. RELATED DOCUMENTS:**

~~C.~~**1. Meningococcal Meningitis Worksheet**

**2. Neisseria Meningitis Exposure Flowchart**

**~~D.~~C. REFERENCES:**

1. APIC, Ready Reference to Microbes, Washington DC: **3rd Edition**. Brooks, K, 201207
2. APIC, APIC Text of Infection Control and Epidemiology, Washington, DC: **4th Edition.** Association for Professionals in Infection Control and Epidemiology, 201409.
3. Gilmore A, Stuart J, Andrews N, Risk of secondary meningoccoccal disease in health-care workers. Lancet 2000, 11;356(9242): 1654-1655.
4. ~~4.~~ http://www.cdc.gov/meningitis/bacterial.html

## Meningococcal Meningitis Worksheet

Charge Person/Department Manager: _____

Date:_____ Time:_____ Patient's MR#_____

| Staff Involved: | Exposed | |
|---|---|---|
| 1. | Y | N |
| 2. | Y | N |
| 3. | Y | N |
| 4. | Y | N |
| 5. | Y | N |
| 6. | Y | N |
| 7. | Y | N |
| 8. | Y | N |
| 9. | Y | N |
| 10. | Y | N |
| 11. | Y | N |
| 12. | Y | N |
| 13. | Y | N |
| 14. | Y | N |
| 15. | Y | N |

Exposure is defined as intimate and unprotected (no mask or face shield) contact with a patient with meningococcal disease (*Neisseria meningitis*) prior to antibiotic administration for at least 24 hours. There is a negligible risk of disease following casual contact. The following are examples of an "exposure"

| |
|---|
| Mouth to mouth resuscitation |
| Suctioning without using personal protective equipment (mask and goggles or face shield) |
| Participation in intubation without using personal protective equipment (mask and goggles or face shield) |
| Oral or endoscopic examination without using personal protective equipment (mask and goggles or face shield) |
| Assisting with vomiting patient without using personal protective equipment (mask and goggles or face shield) |
| Other mucus-membrane contact with respiratory secretions. |

All staff identified as "exposed" are directed to the Emergency Department for further evaluation and possible prophylactic treatment.

**Please fax the completed form to Employee Health Services at (760) 940-4005.**

**SUBJECT: Risk Assessment and Surveillance Plan**

**ISSUE DATE: 3/02**
**REVISION DATE: 7/13, 8/14**

| | |
|---|---|
| **Department Approval Date(s):** | **~~07/15~~01/17** |
| **Infection Control Committee Approval:** | **~~07/15~~01/17** |
| **Medical Executive Committee Approval:** | **~~04/16~~02/17** |
| **Professional Affairs Committee Approval:** | **~~05/16~~03/17** |
| **Board of Directors Approval:** | **05/16** |

A. **PURPOSE OF RISK ASSESSMENT**

1. Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City ~~Medical Center~~**Healthcare District**'s **(TCHD)** plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.

B. **PURPOSE OF SURVEILLANCE**

1. The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt prevent or reduce the occurrence of healthcare associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.

C. **RESPONSIBILITY**

1. Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, Directors, Medical Director of Infection Control, Environmental Health and Safety Committee, Patient Safety Officer and the Infection Control Committee, the Infection Preventionist (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control Committee, Quality Improvement Medical Staff Committees **as needed**, Environmental Health and Safety Committee and the Patient Safety Committee and referred to appropriate councils and committees for action.
2. Infection Prevention and Control Services are staffed with **2.0**~~1.8~~ FTE (includes one FTE with certification in Infection Control). There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database and access to the hospital's electronic medical records (**Cerner**~~Compass~~ and Affinity). Telephone with voice mail, and fax access is provided. The office is located within the Surgical Scheduling office.
3. Infection Control Services works in conjunction with others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We believe that all our employees, medical staff, and volunteers play an important role in preventing

and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices.

~~3.~~

D. **LINKS WITH INTERNAL SOURCES**

1. On at least an annual basis, the IP department will meet with the affected departments (i.e. Medical Staff and Employee Health) -to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. The goals are shared with and reviewed by the Infection Control Committee. Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP staff reports to Infection Control Committee quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.

E. **LINKS WITH EXTERNAL SOURCES**

1. The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control department subscribes to automatic notifications available via email from the CDC, San Diego County Public Health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.
2. Healthcare associated infections (HAI) are reported by the IP staff to the external healthcare organizations when the infection was not known at the time of transfer. TCMC receives reports from outside organizations when a patient develops an infection that might meet criteria for a healthcare associated infection. Home Health/Hospice quality review staff report directly to Infection Control Committee.
3. The following conditions will be reported to external healthcare organizations with the intent to satisfy ~~JCAHO~~ **The Joint Commission** IC 02.01.01(and recorded in the patient's chart using PowerForm). The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCMC Infection Prevention and Control Staff:
    a. Positive culture from a surgical site and surgery performed at another facility.
    b. Influenza rapid test is positive and patient was discharged to another healthcare facility prior to results being known.
    c. Positive C difficile toxin test known after the patient was discharged to another healthcare facility.
    d. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.
    e. Unusual occurrences based on the opinion of the Infection Prevention staff in consultation with the Infection Control Medical Director and Director of Regulatory Compliance.

F. **PERTINENT RISK FACTORS**

1. Each facility is unique and we considered the following factors in our planning.
    a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
    b. A review of hospital specific surveillance data from years past.
    c. Medically fragile and at-risk populations such as newborns and those with invasive devices.

d. The increasing antibiotic resistance in our facility and across the United States (as reported by the CDC in by NHSN).
e. The vaccination/immunity rates of the community and employees.

G. **EPIDEMIOLOGICAL FACTORS: INTERNAL AND EXTERNAL**

1. Tri-City Medical Center is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.~~2~~1 million residents, and is anticipated to grow to four million by 2020.
3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).
4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. **Of residents under 18,** 37~~2~~% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate. Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are growing disproportionately compared to the rest of the population.
5. Demographic information on the three cities most often served by Tri-City Medical Center is listed below.

| City | Median income | Total # residents | Percent increase since 2000 | White | Hispanic | Asian & Pacific Islander |
|---|---|---|---|---|---|---|
| Oceanside | $ **48,375**~~59,640~~ | 161,029 (2000) **174**~~2~~**,558**~~794~~ (20143) | **+8.4**~~7.3~~% | **46.78**~~.5~~ % | 36.3~~0~~% | ~~7.~~**66.3**% |
| Vista | $ 45,322 | 89,857 (2000) **98,079**~~96,929~~ (20143) | **+9.2**~~7.9~~% | **46.2**~~42.~~ ~~9~~% | **44.5**~~49.0~~ % | 4.7~~2~~% |
| Carlsbad | $ **82,681**~~78,238~~ | 78,247 (2000) **112,299**~~110,972~~ (20143) | **+43.5**~~41.8~~% | **72.85**~~.2~~ % | **14.53**~~.6~~% | 7.4**94**% |

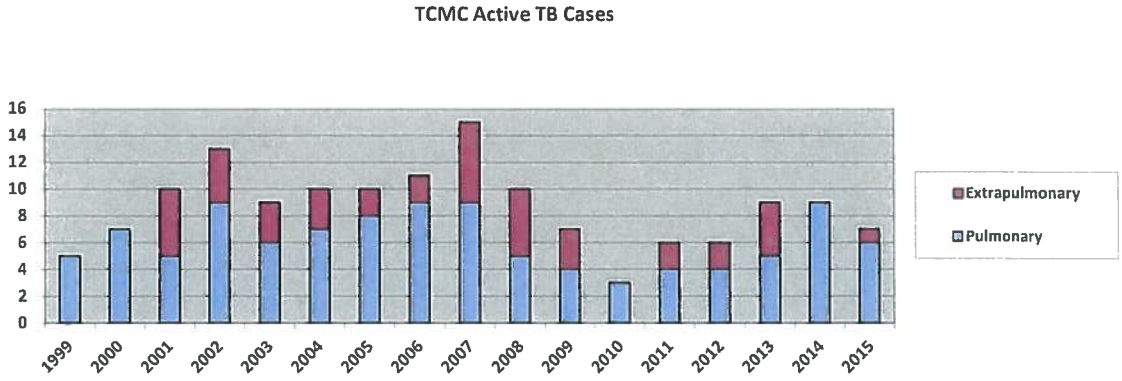
a. http://www.city-data.com/city/Oceanside-California.html
b. http://www.city-data.com/city/Vista-California.html
c. http://www.city-data.com/city/Carlsbad-California.html

6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common mandated reported enteric illnesses in SD County are Campylobacter, Giardia, Hepatitis A, Salmonella and Shigella.
7. In San Diego, overall rates for the three major reportable sexually transmitted diseases (Chlamydia, Gonorrhea & Syphilis) have increased from 201~~4~~5 to **2016**~~2012~~. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California. ~~The proportion of persons of color has increased over time among HIV &~~

~~AIDS cases. Black cases have the highest rate of HIV & AIDS, followed by Hispanics and then Whites.~~

8. In 2014, San Diego County– reported 220 cases of active tuberculosis **while in 2015, 234 cases were reported.** ~~. In 2013, San Diego County reported 206 cases of active tuberculosis.~~ TB drug susceptibility information was available for **100%**~~99%~~ of the culture proven cases for 201**5**4 in San Diego. Multidrug-resistant (MDR-TB) strains were found in **1**~~2~~ **(0.5%)** of the cases. **In 2015,** Tri City Medical Center **reported 1 case**~~reported both cases of~~ **of** MDR-TB.~~in our facility.~~ In SD County, Hispanics ~~-~~had the highest rates of TB at 5**3**~~2~~%, Asian/Pacific Islanders at 3**8**~~2~~%, non-Hispanic Whites at **7**~~19~~% and non-Hispanic Blacks at **2**~~6~~%.TB cases born outside of the US compromised 7**4**~~0~~% of San Diego County's cases.(Source: ~~County of San Diego Health and Human Services Agency, Tuberculosis and refugee Health Branch~~ **County of San Diego Tuberculosis Control Program 2015 Fact Sheet Date March 18, 2016).**~~, April 20, 2015).).~~

9. At TCMC, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 201**5**4, there were **6**~~9~~ patients with pulmonary TB and **1** ~~none~~ with extrapulmonary TB. An additional **27**~~34~~ cases were reported as rule out TB in 201**5**4. The number of active TB patients seen annually at Tri-City Medical Center varies from 5 –12.




10. Tri City Medical Center Financial Characteristics for Fiscal Year 201**6**4

a. The top six insurance coverage seen the acute care setting are as follows: (Not including OB/Newborn, BHU and Rehab):

| | |
|---|---|
| MEDICARE | **33.64%**~~36.03%~~ |
| MEDICARE SR HMO | **15.69%**~~13.46%~~ |
| MEDI-CAL HMO | **12.33%**~~7.85%~~ |
| HMO | **6.91%**~~7.54%~~ |
| **Other Goverrnmental**~~HMO Cap Sr~~ | **7.00%**~~7.47%~~ |
| Medi-Cal | **8.16%**~~6.98%~~ |

i. The majority of insurance coverage for our newborns (nursery and NICU) is funded by Medi-Cal or Medi-Cal HMO (**85.4**~~79.2~~% compared to HMO and PPO insurance (**8.5**~~12.3~~%) and other (**6.1**~~8.5~~%).

b. Patient census:

| | Average. Daily Census | Average. Length of Stay* | Total Pt. Days |
|---|---|---|---|
| Acute Care (excludes all below) | **137.4**~~147.2~~ | **3.89**~~4.04~~ | **50,160**~~53,728~~ |
| ICU* | **16.3**~~17.1~~ | **3.38**~~2.83~~ | **5,945**~~6,245~~ |
| BHU | **17.0**~~23.8~~ | 6.76~~43~~ | **6,209**~~8,703~~ |
| NICU | **15.5**~~14.0~~ | **6.81**~~9.81~~ | 5,660~~121~~ |

| | | | |
|---|---|---|---|
| Rehab Serv. | 6.27 | 13.7015.49 | 2,275432 |

i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

c. In acute care FY 164, the three largest age groups are **56-65**76-85 year olds (19.26%), **66-75**56-65 year olds (18.87.7%), and **76-85**66-75 year olds (**17.8**16.3%).

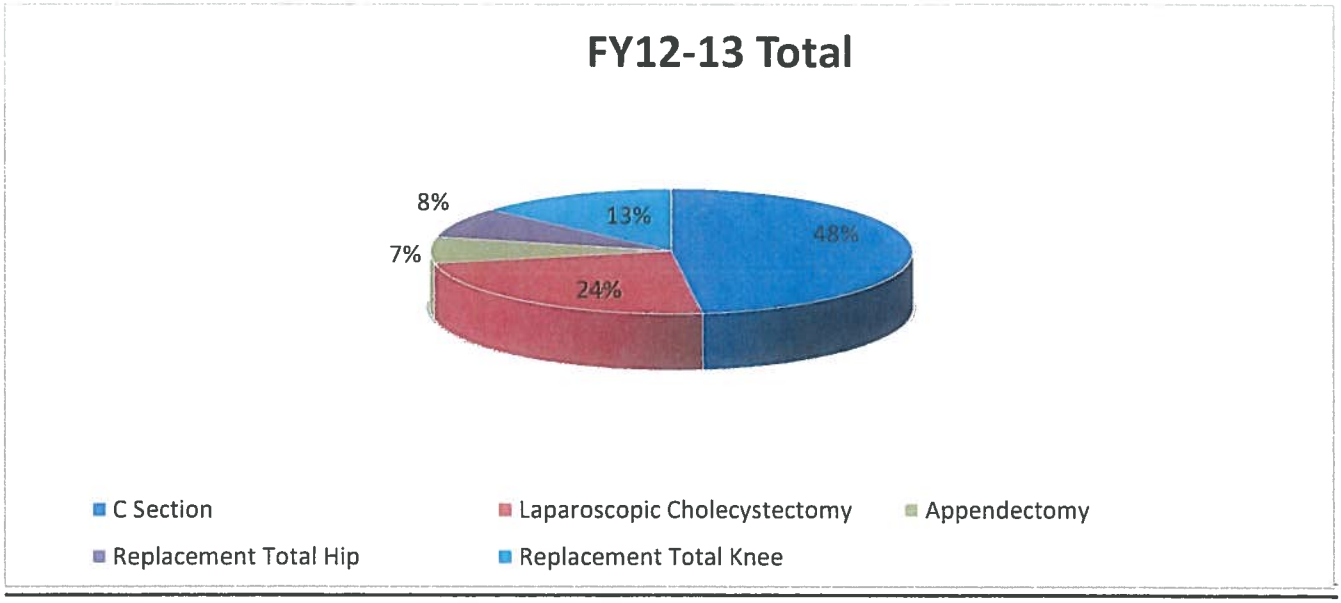
d. **Fourteen**Nineteen percent (**9,386/65,828**10,745/ 57,193) of Emergency Department patients are admitted to the hospital.

11. The total number of employees working at Tri-City Medical Center **FY 2016**(Fiscal Year 2014) is approximately 2,**158**095 with **about**about **1,403 (65%)**1,275 staff providing direct patient care.

12. Tri-City Medical Center's primary focus is on basic community services. In fiscal year 2014, the **The** top ten major **d**Diagnostic categories (DRGs) are the following:
   a. Obstetrics
   b. Newborns & Neonates
   c. **Musculoskeletal & Connective Tissue**Circulatory System
   d. **Circulatory System**Musculoskeletal & Connective Tissue
   e. **Infectious & Parasitic Diseases**Mental diseases
   f. Digestive System
   g. Respiratory
   h. **Nervous System**-Infectious & Parasitic Diseases
   i. **Mental Diseases**Nervous System
   j. Kidney & Urinary Tract

**13.** Top five Inpatient Surgical Procedures (Fiscal Year 2016): **Cesarean section (CSEC), hip prosthesis (HPRO), knee prosthesis (KPRO), spinal fusion (FUSN), and open reduction of fracture (FX).**

3.H.




14.1. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2016**14** in Home Care:

| Average LOS | Top Payers | Top 4 Primary DX |
|---|---|---|

| | | |
|---|---|---|
| 33 days | Medicare- 531% HMO/PPO 309% | ~~Aftercare Surgical/procedure~~ ~~Cardiovascular~~ **~~Malig. Neo-Lung~~** ~~Disease of Skin & Subcutaneous tissue~~ **-Other Health Services for Specific Procedures** **-Diseases of the Cardiovascular System** **-Diseases of the Respiratory System** **-Signs and Symptoms of Ill Defined Conditions** |

~~15.~~**2.** General Process

a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:
   i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
   ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.
   iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.

b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.

c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services, Director of Regulatory Compliance, Medical Director of Infection Control and/or Chair of the Infection Control Committee.

## ~~H.~~I. TARGETED AND FOCUSED SURVEILLANCE FOR FY 2017~~6 (Calendar Year 2015)~~

1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include limiting unprotected exposure to pathogens throughout the organization, Enhancing hand hygiene and limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.
2. Surgical Site Infections:
   a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
   b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.
   c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (-Centers for Disease Control and Prevention).

d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs 25~~6~~ of the procedures, they are listed below:

| | | | |
|---|---|---|---|
| AAA | Abdominal aortic aneurysm repair | Resection of abdominal aorta with anastomosis or replacement | |
| APPY | Appendix surgery | Operation of appendix (not incidental to another procedure) | |
| BILI | Bile duct, liver or pancreatic surgery | Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder) | |
| CARD | Cardiac surgery | Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation | |
| CBGB | Coronary artery bypass graft with both chest and donor site incisions | Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting. | |
| CBGC | Coronary artery bypass graft with chest incision only | Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery | |
| CHOL | Gallbladder surgery | Cholecystectomy and cholecystectomy | |
| COLO | Colon surgery | Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations | |
| CSEC | Cesarean section | Obstetrical delivery by Cesarean section | |
| FUSN | Spinal fusion | Immobilization of spinal column | |
| FX | Open reduction of fracture | Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis | |
| GAST | Gastric surgery | Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication | |
| HPRO | Hip prosthesis | Arthroplasty of hip | |
| HYST | Abdominal hysterectomy | Removal of uterus through an abdominal incision | |
| KPRO | Knee prosthesis | Arthroplasty of knee | |

| | | | |
|---|---|---|---|
| LAM | Laminectomy | Exploration or decompression of spinal cord through excision or incision into vertebral structures | |
| NEPH | Kidney surgery | Resection or manipulation of the kidney with or without removal of related structures | |
| OVRY | Ovarian surgery | Operations on ovary and related structures | |
| PACE | Pacemaker surgery | Insertion, manipulation or replacement of pacemaker | |
| REC | Rectal surgery | Operations on rectum | |
| ~~RFUSN~~ | ~~Refusion of spine~~ | ~~Refusion of spine~~ | |
| SB | Small bowel surgery | Incision or resection of the small intestine; does not include small-to-large bowel anastomosis | |
| SPLE | Spleen surgery | Resection or manipulation of spleen | |
| THOR | Thoracic surgery | Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.) | |
| VHYS | Vaginal hysterectomy | Removal of the uterus through vaginal or perineal incision | |
| XLAP | Abdominal surgery | Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach. | |

e. GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

f. GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria

a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), **V**~~v~~ancomycin resistant enterococci (VRE~~),~~ **), Extended spectrum-beta-lactamase (**ESBL**),** ~~Klebsella, and ESBL *E. coli,* and *Carbapenem- resistant Enterobacteriaceae (CRE)* CRE. A healthcare associated case is defined as a positive culture from any body site on or after the third hospital day, with no prior history of the organism.~~ MDRO and C.difficile ~~i~~Infection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile ~~i~~Infections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).

b. GOAL#1: The number of healthcare associated MRSA infections ~~and colonization~~ will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 **hospital acquired**~~nosocomial~~ **infections**~~acquisitions~~ per 1000 **patient days**~~hospital discharges~~ for the calendar year.

$$\frac{\text{\# Patients with + MRSA and/or VRE cultures}}{\text{\# Hospital Discharges}}$$

c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).

4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).
   a. All positive C. difficile results are entered into NHSN.~~; reports are produced through NHSN.~~ Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.

   b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.
5. Ventilator Associated Event – Adult Critical Care Unit
   a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed.. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator associated pneumonia (PVAP). All three tiers will be reported and each PVAP case will be reviewed.
      i. GOAL: There will be seven consecutive months without a possible ventilator associated pneumonia (PVAP- Tier 3).

$$\frac{\text{VAE cases in ICU x 1000}}{\text{Total \# ventilator days for the month}}$$

6. Central Line Associated Bloodstream Infection (CLABSI) ~~– Intensive Care Units~~
   a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. **Current CDC/NHSN definitions are used to determine CLABSI events.**~~Current CDC/NHSN definitions are used to determine CLA-BSI events through culture review. Actual line-day information is available on-demand through the Compass Explorer program created by IT in 2005. NICU line-day's data is collected by nursing services daily and reported to the Infection Prevention and Control Department at the end of each month. NICU rates are stratified by birth weight as per NHSN data comparison.~~
   b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
7. Catheter Associated Urinary Tract Infection (CAUTI)
   a. Symptomatic urinary tract infection – Patients with **positive urine cultures and indwelling foley catheters are reviewed.**~~an indwelling urinary catheter at the time of or within 7 days before the onset of a positive urine culture will have a chart review using~~ **Current CDC/NHSN definitions are used to determine CAUTI events.**~~current CDC/ NHSN definitions and methodology.~~

# of CAUTI cases x 1000
Estimation of urinary catheter days

b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI rate for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).

8. Hand Hygiene
   a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the **Managers,** Directors, **Regulatory Compliance**~~Joint Commission~~ Committee, and the Infection Control Committee. ~~Number of opportunities per~~ **Tri City Medical Center follows** the World Health Organization's 5 Moments **model for hand hygiene.**. ~~CDC) to perform hand hygiene compared to hand hygiene completed (% compliance) during care of patients.~~
   b. GOAL #1: Hand hygiene observations are performed in every patient care area at least once a month.
   c. GOAL #2: Overall hand hygiene compliance rate will be at least 90% per quarter.
9. Environmental and Patient Care Rounds
   a. Environment of Care rounds are performed monthly ~~and~~ overseen by the Environment**al Health & Safety (EHSC)** ~~of Care~~ Committee. These rounds will identify risks associated with, but not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.
   b. GOAL #1: Infection Control assessments will be represented 90% of the time during scheduled environmental rounds.
   c. GOAL #2 Infection Control assessments will be represented 90% of the time during scheduled tracers.
   d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.
10. Reportable Diseases
   a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).
   b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.
11. Employee Health collects and reports the following:
   a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year
      i. Number of needle sticks injuries and details of department involved, device, and cause.
   b. GOAL#2: 100% of employees will complete the annual tuberculosis screen
      i. # Staff completing annual TB screening (PPD, blood test or survey)/ # Employees in whom compliance is required.
   c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.
      i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.

d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient **Acute** Rehab unit **and Behavioral Health Services** staff (per NHSN definition) will receive influenza vaccine.

12. Home Care, collects and reports the following:
    a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
    b. GOAL #2: There will be less than two CAUTI infections in the calendar year.
        i. # Cases UTIs with foley catheter/Total # device days.
    c. GOAL #3: There will be no infections related to central lines in the calendar year.).
        i. # Cases BSI with Central Line/Total # device days.

## ~~I.~~J. REFERENCES:

1. County of San Diego Public Health & Human Services Agency, (June 2015) Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. **(2016)**~~(2013, February)~~ http://www.cdc.gov/nhsn/acute-care-hospital/index.html
3. County of San Diego Tuberculosis Control and Refugee Health Program. (Ju**ly**~~ne~~ 2015) TB Statistics. Retrieved from **http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/**
~~3. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/ComparativeData2013_final3-13-14Rev1031914.pdf~~
4. Friedman, C. (2014). Infection Prevention and Control Programs in P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014
5. The City of San Diego (2015), Economic development: Populatio**nn.** ~~Retrieved on June 4, 2015: http://www.sandiego.gov/economic-development/sandiego/population.shtml~~ **https://www.sandiego.gov/economic-development/sandiego/**

## ~~J.~~K. RELATED DOCUMENTS:

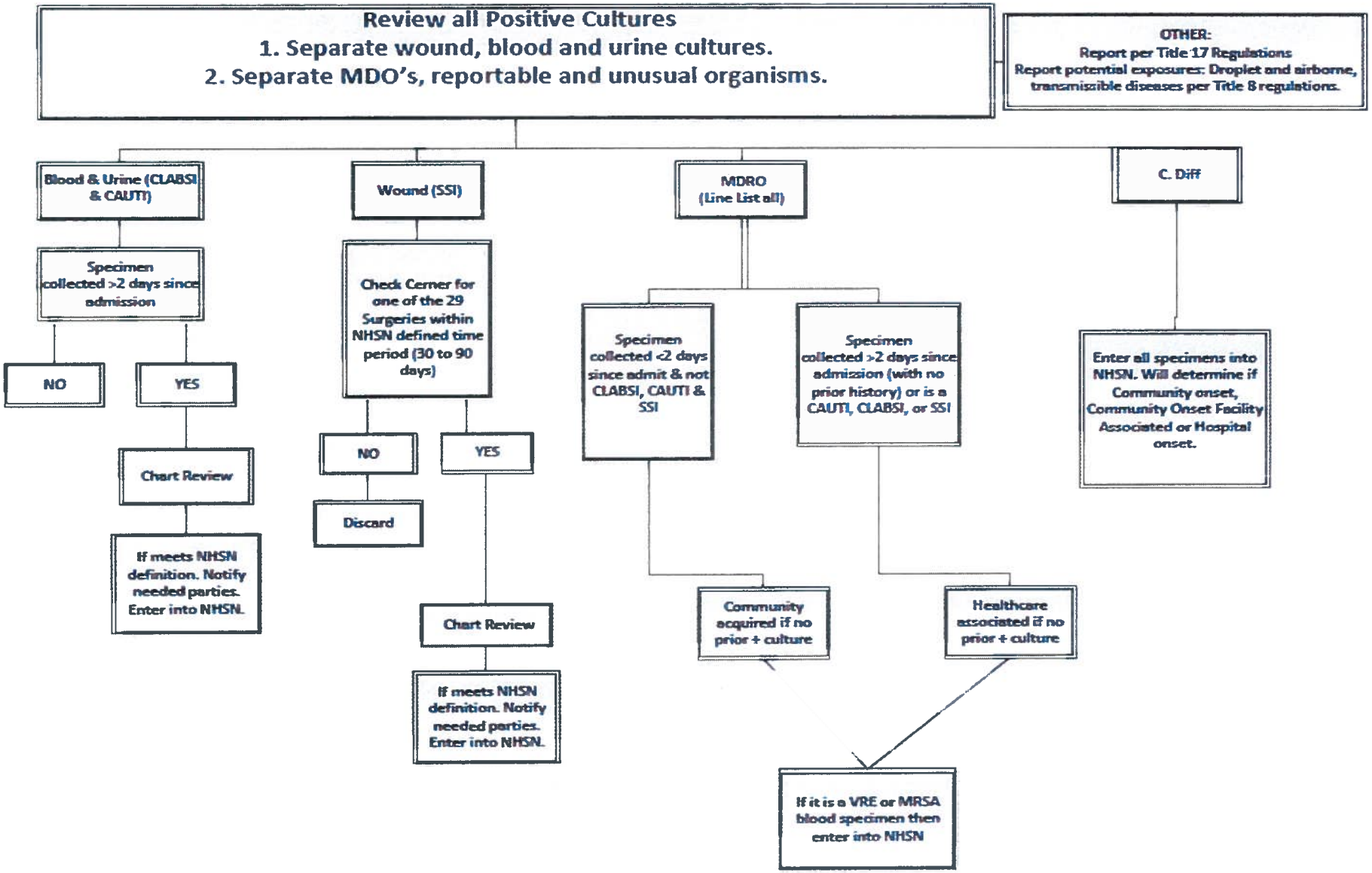
1. Infection Control Policy Manual, Philosophy
2. Infection Control Policy Manual, Epidemiologic Investigation of a Suspected Outbreak
3. ~~Infection Control Policy Manual, Facility Acquired Infections, Defined~~

## INFECTION CONTROL PROGRAM TIMELINE FY 2015

| **Infection Control Committee** | Meet | | | Meet | | | Meet | | | Meet | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Targeted Surveillance** | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June |
| SSI | * | | | * | | | * | | | * | | |
| Multi-antibiotic Resistant Organisms<br>• VRE<br>• MRSA<br>• ESBL<br>• CRE | * | | | * | | | * | | | * | | |
| CLABSI | * | | | * | | | * | | | * | | |
| CAUTI | * | | | * | | | * | | | * | | |
| VAE in ICU | * | | | * | | | * | | | * | | |
| | | | | | | | | | | | | |
| Home Health report of CAUTI and CLABSI rates | * | | | * | | | * | | | * | | |
| Outbreak Investigation and Disease Reporting | * | * | * | * | * | * | * | * | * | * | * | * |
| **OSHA Compliance** | | | | | | | | | | | | |
| • Tuberculosis Exposure Control Plan Review | | | | * | | | | | | * | | |
| • Bloodborne Pathogen Exposure Control Plan Review | * | | | | | | | | | | | |
| **Employee Health** | | | | | | | | | | | | |
| • TB Screening (PPD or questions) | * | | | | | | | | | | | |
| • N95 Fit-testing | * | | | | | | | | | | | |
| • Sharps & BBP Exposures | * | | | * | | | * | | | * | | |
| • Infectious Diseases Exposures | * | | | * | | | * | | | * | | |
| • Influenza Campaign | | | | Begin | | | * | | | * | | |
| **Environment of Care** | | | | | | | | | | | | |
| • Infection control staff review of current construction projects | * | * | * | * | * | * | * | * | * | * | * | * |
| • Sterile Processing Department Report | * | | | * | | | * | | | * | | |
| • Pharmacy Report on Biologicals and findings | * | | | | | | * | | | | | |
| • Environment of Care Officer, Patient Safety Officer and/or Engineering report | * | | | * | | | * | | | * | | |
| **Surveillance Plan** | | | | | | | | | | | | |
| • Managers or Directors Meetings (Education & Planning) | * | * | * | * | * | * | * | * | * | * | * | |
| • Input (Education & Planning) | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| • Present Risk Assessment and Surveillance Plan to ICC | * | | | | | | | | | * | | |
| • ICC Approval of Plan | * | | | | | | | | | * | | |
| • | | | | | | | | | | | | |
| **Performance Improvement Projects** | | | | | | | | | | | | |
| • Reducing Surgical Site Infections | | | | | | | | | | * | | |
| • Hand Hygiene Compliance | * | * | * | * | * | * | * | * | * | * | * | * |
| • Reducing CLABSIs | | | | | | | | | | | | |
| **Education** | | | | | | | | | | | | |
| • New Employees | * | * | * | * | * | * | * | * | * | * | * | * |
| • Unit Based or Topic Specific (As requested)- Performed through Quest, during rounds, presentations, power minute. | * | | Net Learning | * | * | * | * | * | * | | * | * |

*Presented to IC


Review all Positive Cultures
1. Separate wound, blood and urine cultures.
2. Separate MDO's, reportable and unusual organisms.
OTHER:
Report per Title 17 Regulations
Report potential exposures: Droplet and airborne, transmissible diseases per Title 8 regulations.
Blood & Urine (CLABSI & CAUTI)
Specimen collected >2 days since admission
NO
YES
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
Wound (SSI)
Check Cerner for one of the 29 Surgeries within NHSN defined time period (30 to 90 days)
NO
Discard
YES
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
MDRO (Line List all)
Specimen collected <2 days since admit & not CLABSI, CAUTI & SSI
Specimen collected >2 days since admission (with no prior history) or is a CAUTI, CLABSI, or SSI
Community acquired if no prior + culture
Healthcare associated if no prior + culture
If it is a VRE or MRSA blood specimen then enter into NHSN
C. Diff
Enter all specimens into NHSN. Will determine if Community onset, Community Onset Facility Associated or Hospital onset.

**Tri-City Health Care District**
**Oceanside, California**

**Infection Control Manual**

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**ISSUE DATE:** 7/2008 **SUBJEC: Toy Cleaning**

**REVISION DATE:** 7/2014 **STANDARD NUMBER: IC. 9.1**

| | |
|---|---|
| **Infection Control Department Approval:** | ~~07/14~~**01/17** |
| **Infection Control Committee Approval** | ~~07/14~~**01/17** |
| **Medical Executive Committee Approval:** | ~~07/14~~**02/17** |
| **Professional Affairs Committee Approval:** | ~~08/14~~**03/17** |
| **Board of Directors Approval:** | **08/14** |

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A. **BACKGROUND:**~~**PROCEDURE:**~~

1. Children can be in close proximity to one another and spend time in common areas, such as playrooms, where sharing of contaminated toys, equipment, and secretions can occur. Toys may be colonized with infectious pathogens.
2. An outbreak of multiresistant P. aeruginosa on an oncology ward related to bath toys has been described, as has a rotavirus outbreak in a similar population. There are no published guidelines on toy cleaning in the hospital setting, but we extrapolate from experience with community and home care of children.
3. Avoid high-risk toys, such as water-retaining toys, soft/stuffed toys, and others that are difficult to clean and dry. Stuffed and cloth toys quickly become colonized when used by hospitalized patients and have the potential to serve as fomites for infection and are discouraged.

B. **PROCEDURE:**

~~4.~~**1. Toys will be cleaned and disinfected** ~~Appropriate toy cleaning involves scrubbing with soap and water to remove surface dirt, followed by disinfection~~ with **a low level, non toxic** ~~the~~ hospital approved disinfectant~~. Toys are then thoroughly rinsed~~ and air-dried completely between patients.

~~5.~~**2.** Toy cleaning is performed by the Rehab Aide. Therapists perform cleaning on an as needed basis during therapy sessions.

~~6.~~**3.** Phenolics are not used.

~~7. Toys that have become contaminated (such as dropped on the floor or soiled with secretions) during use are segregated and immediately washed with detergent followed by disinfection with a low level, non toxic hospital approved disinfectant. Toys should be air dried completely.~~

~~8. Solid plastic toys can be washed in a dishwasher or on a hot cycle in a washing machine, but this method cannot be used for hollow toys that might fill with water—an outbreak of resistant Pseudomonas aeruginosa infection related to retained water in bath toys has been documented.~~

~~9. Toys and playroom surfaces are cleaned and disinfected daily by Environmental Services Department~~

~~10.~~**4.** Clean toys are clearly separated from dirty ones.

~~11.~~**5.** Sharing of toys between children is avoided to prevent cross-transmission.

~~B.~~**C. REFERENCES:**

1. West, K. L., Nyquist, A., Bair, T., Berg, W. & Spencer, S. (2014). Pediatrics. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed. Vol. 2, 42- to 42-19) Washington, DC: APIC.

| Tri-City Medical Center | Women and Newborn Services<br>Neonatal Intensive Care Unit (NICU) |
|---|---|
| **PROCEDURE:** | **BLOOD PRODUCT ALIQUOT SYRINGES, EMERGENT PREPARATION OF** |
| Purpose: | To facilitate rapid preparation of blood aliquots for emergent use at the bedside. |
| Supportive Data: | Bedside preparation more rapid than procedure required in lab. |
| Equipment: | 1. Neonatal/pediatric syringe set (150u filter and 60cc syringe)<br>2. Alaris smart site<br>**3.** Alaris male/female Luer lock caps<br>~~3.~~**4. Blood warmer** |

A. **PROCEDURE:**

~~1. The charter medical neonatal syringe set with 150-micron filter is designed to prepare syringe aliquots of whole blood, red blood cells, platelets and fresh frozen plasma.~~

~~2.~~**1.** Per physician/**Allied Health Professional (AHP)** order, notify lab of emergent need for "O Negative Uncrossed –Matched Blood."

~~3.~~**2. Gather equipment.** ~~Obtain neonatal/pediatric syringe preparation bag~~

~~4.~~**3.** Confirm patient identity using two-identifier system **per hospital policy**. ~~Refer to Patient Care Services "Identification, Patient" (IV.A) policy.~~

**4.** Perform hand hygiene and don non-sterile gloves.

5. **If emergent blood requires warming, utilize the "Blood Administration Set-Neonatal" with 150 micron filter and spinlock, spike the blood bag, and follow the manufacturer's guidelines for warming.**

~~6. Attach the syringe set to the O negative Aliquot bag.~~

~~7.~~**6.** Slowly withdraw **warmed** blood from unit into ~~attached~~ 60 ml syringe. ~~Holding bag and syringe upright to displace residual air from syringe and gently push it back through filter and tubing~~.

~~8.~~**7.** Multiple syringes may be drawn from the same **unit**~~bag~~.

~~9.~~**8.** Label each syringe with patient label; include on label the blood type, unit number, date and time.

~~10. Utilize from syringe bag, Alaris male/female Luer lock caps for syringes and Alaris smart site on end of filter tubing as needed.~~

~~11.~~**9.** Refer to Patient Care Services **Procedure**: Blood Products Administration for administration procedure.

~~12.~~**10.** Once the unit is empty or blood administration completed, discard all components in biohazardous waste. Do not return blood unit to laboratory.

~~13.~~**11.** Document procedure in patient's medical record.

~~B. EXTERNAL LINKS:~~

**B. RELATED DOCUMENTS:**

**1. Patient Care Services Procedure: Blood Products Administration**

C. **REFERENCES:**


1. Charter Medical Ltd. product information: Neonatal/Pediatric Syringe Sets.

~~1.~~**2. MacDonald, M. G. & Ramasethu, J. (Eds.). (2013).** ***Atlas of procedures in Neonatology, 5th ed.*** **Lippincott Williams & Wilkins.**


~~D. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~Board of Directors~~

| NICU Department Review | Perinatal Collaborative Practice | Division of Neonatology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 09/07, 6/11, 8/12, 12/16 | 01/17 | 01/17 | n/a | 02/17 | 03/17 | |

| Tri-City Medical Center | Women and Newborn Services<br>Neonatal Intensive Care Unit (NICU) |
|---|---|
| **PROCEDURE:** | **CARDIO-RESPIRATORY MONITORING IN THE NICU** |
| Purpose: | ~~To display heart and breathing rates and patterns and to identify events that are dangerous to the patient's health, i.e., apnea, abnormal heart rates~~ **To provide reliable and accurate monitoring of neonatal cardiac and respiratory activity.** |
| Supportive Data: | Cardio-respiratory monitoring should be used in any patient who requires intensive or intermediate care and in any patient at risk for apnea or rhythm disturbances. |
| Equipment: | 1. Cardio-respiratory monitor<br>2. Neonatal monitoring electrodes |
| Issue Date: 9/07 | |

A. **POLICY:**

1. All patients admitted to the NICU will be placed on a cardio-respiratory monitor and continuously monitored until discharged from the NICU.
2. ~~The RN is responsible for monitoring the functioning of equipment.~~
   a. ~~Assure that heart rate and respiratory rate obtained by the monitor are consistent with rates obtained by auscultation.~~
3. ~~In the event of monitor malfunction:~~
   a. ~~Assess patient and provide support as necessary.~~
   b. ~~Check the monitor and electrodes for appropriate placement and settings.~~
   c. ~~If still malfunctioning, obtain a new monitor and notify Bio-Med of equipment failure. The patient will not be left unaccompanied until the monitor is replaced and found to be functioning appropriately.~~
4. ~~Alarms must be on at all times with appropriate limits set.~~
   a. ~~Limits are determined by the age and condition of the child or by a physician's order.~~
   b. ~~When alarms are silenced, they must be reactivated before leaving the patient's bedside.~~
   c. ~~Ensure that alarms and alarm limits are set and checked at the beginning of every shift.~~
5. ~~Check electrode placement and skin contact every shift. Place new electrodes on admission and whenever necessary.~~
6. ~~RN or RCP will respond to all alarms, assess the patient and intervene as necessary.~~

~~B. **REPORTABLE CONDITIONS:**~~

~~Notify the physician for:~~

1. ~~Parameters outside of pre-determined limits.~~
2. ~~Any significant changes in vital signs.~~
3. ~~An abnormal rhythm or heart rate.~~

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

1. **Skin should be clean and dry prior to placement of electrodes.**
2. **Do not place electrodes to broken or bruised skin.**
3. **Avoid placed electrodes directly on the nipples.**
1. ~~Place neonatal electrodes, RA and LA on either side of the anterior chest wall, avoiding the nipple area. Place one (1) electrode on the left upper quadrant of patient's abdomen.~~
4. **Basic three-lead configuration for electrode placement:**
   a. **White: Right lateral chest at level of the nipple line.**
   b. **Black: Left lateral chest at level of the nipple line.**
   c. **Red or green: Left lower rib cage.**
2. ~~Pulse oximetry will be monitored continuously unless discontinued with a physician's order. Refer to NICU "Pulse Oximetry, NICU" procedure.~~

| Department Review | Perinatal Collaborative Practice | Division of Neonatology | Pharmacy and Therapeutics | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 6/09, 6/11, 8/12, 12/16 | 01/17 | 01/17 | n/a | 02/17 | 03/17 | |

~~3.~~**5.** Connect electrodes, matching color/corresponding electrode placement, to the ECG cable attached to the monitor.

~~4.~~**6.** Ensure that the monitor is turned on and in neo mode. **Select the lead that provides the best signal and QRS size.**

**7.** Alarm parameters will be **audible and** ~~determined by the RN in collaboration with the physician based upon patient condition, day of life and gestational age.~~**set per NICU Standards of Care or physician/allied health professional (AHP)'s order.**

- **a. When alarms are silenced, they must be reactivated before leaving the patient's bedside.**
- **b. Ensure that alarms and alarm limits are set and checked at the beginning of every shift.**
- **c. Alarms should prompt immediate patient assessment.**
  - **i. Note alarm indication (i.e. tachycardia, apnea)**
  - **ii. Treat patient condition as necessary or correct the source of any false alarm.**
  - ~~i.~~**iii. Notify physician/allied health professional if indicated.**

~~5.~~**8.** Electrodes will be changed as needed to provide an artifact free monitor tracing.

~~6. Audible alarms will be set at all times.~~

~~7. Patient may be monitored using trend mode at the discretion of the RN.~~

~~8. Place monitor in Lead II when running a strip.~~

## ~~D.~~C. DOCUMENTATION:

The following is to be documented in the patient's medical record:

1. Vital signs **per NICU Standards of Care**.
2. **Episodes requiring intervention.**
3. ~~Treatments~~ **Intervention performed** and **patient's** responses to intervention.~~s.~~
4. Alarm limits every shift.
5. **Physician/AHP notification ad hoc form as necessary.**

## ~~E. EXTERNAL LINKS:~~

## ~~F.~~D. REFERENCES:

1. Aehlert, B. (2009). ECGs Made Easy Pocket Reference, 4th Ed. Mosby: Elsevier.
2. Jacobson, C. (2003). Bedside cardiac monitoring. *Critical Care Nurse*, 21(6); 71-73.
3. Lippincott Manual of Nursing Procedures, 9th Ed. (2009). Lippincott, Williams & Wilkins.
4. **MacDonald, M. G. & Ramasethu, J. (Eds.). (2013). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.**
5. ~~4.~~ Smith-Temple, J. (2009). *Nurses Guide to Clinical Procedures*, 6th Ed. Lippincott, Williams & Wilkins.

## ~~G. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~

~~2. Nurse Executive Council~~

~~3. Medical Executive Committee~~

~~4. Professional Affairs Committee~~

~~5. Board of Directors~~

**SUBJECT: NEONATAL ABSTINENCE SYNDROME, MANAGEMENT OF~~CORING~~**

**ISSUE DATE: 12/08**
**REVISION DATE: 4/09, 6/11, 8/12**

| | |
|---|---|
| **Department Approval Date(s):** | **11/16** |
| **Perinatal Collaborative Practice Approval Date(s):** | **11/16** |
| **Division of Neonatology Approval Date(s):** | **11/16** |
| **Department of Pediatrics Approval Date(s):** | **02/17** |
| **Pharmacy and Therapeutics Approval Date(s):** | **n/a** |
| **Medical Executive Committee Approval Date(s):** | **02/17** |
| **Professional Affairs Committee Approval Date(s):** | **03/17** |
| **Board of Directors Approval Date(s):** | |

A. **DEFINITIONS:**

**1. Neonatal Abstinence Syndrome (NAS):**
- **a. A condition characterized by a constellation of drug withdrawal symptoms in the neonate, following intrauterine exposure to drugs of abuse.**

**~~1.~~2.** Drugs frequently associated with neonatal withdrawal include the following:
- a. High risk drug**s:**~~s include~~ **long-acting** opi**oids**~~ates~~ and narcotics: codeine, fentanyl, heroin and methadone, meperidine, morphine.
- **b.** Low risk/other drugs: **short-acting opioids,** barbiturates, caffeine, cocaine, diazepam and lorazepam, ethanol, marijuana, nicotine **and selective serotonin reuptake inhibitors (SSRI).**
  - **i. Withdrawal from these substances typically requires non-pharmacologic treatment only.**

**3. Long-acting opioids:**
- **a. Fentanyl transdermal patch**
- **b. Methadone**
- **c. Buprenorphine**
- **d. Oxymorphone hydrochloride extended-release (Opana)**
- **e. Oxycodone hydrochloride controlled-release (Oxycontin)**
- **f. Morphine sulfate extended release**

**4. Short-acting opioids:**
- **a. Hydrocodone**
- **b. Hydrocodone + APAP (Vicodin, Norco)**
- **c. Oxycodone + APAP (Percocet or oxycodone IR)**
- **d. Tramadol**
- **e. Fentanyl (IV)**
- **f. Morphine (IV or immediate release)**
- **g. Codeine**
- **~~b.~~h. Hydromorphone (Dilaudid)**

**~~2.~~5.** General signs of drug exposure in the infant include:
- a. Central nervous system dysfunction, such as high-pitched cry, hyperactive reflexes, irritability, and disturbed sleep patterns.
- b. Metabolic, vasomotor and respiratory disturbances, such as sweating, mottling, fever, tachypnea, and sneezing.
- c. Gastrointestinal disturbances such as vomiting, loose stools, and poor feeding.

**~~3.~~6.** Goals of Neonatal Abstinence Syndrome (NAS) evaluation and management.
- a. **Proper feeding and growth.**~~Minimal GI symptomatology~~

b. **Facilitate appropriate development.**~~tMinimally disturbed sleep-wake cycles~~
c. **Foster the maternal-infant bond.**~~Socially interactive with caretaker(s)~~
~~c.~~**d. Prevent neurological sequelae.**

B. **POLICY:**

1. **Maternal use of narcotics and/or other illicit substances during pregnancy can result in the birth of infants with drug dependency with the potential for subsequent complications. The proper identification and care of these infants and their families is essential in minimizing medical complications and improving infant and family outcomes. A team approach involving Obstetrics, Neonatology, Newborn Service, Nursing, Social Work and Occupational Ttherapy will optimize patient outcomes.**
2. **Infants at low risk for NAS from maternal non-narcotic or narcotic short acting prescription medication can generally remain in couplet care for a period of observation.**
3. **Infants at risk for NAS due to maternal use of methadone, heroin, buprenorphine or high dose prescription narcotic exposure should be admitted to the NICU. Infants exposed to multiple psychotropic medication exposure may also need to be considered for NICU admission.**
4. **Proper non-pharmacologic measures may be used to minimize the need for medical treatment and decrease the length of therapy.**
5. **Proper use of NAS scoring will help in consistency of treatment and weaning of medication used to treat NAS.**
6. **Adherence to NAS medication initiation and weaning protocols may assist in shortening the length of NAS therapy.**
7. **Encouraging families to visit daily and care for child may improve infant-parent attachment.**

~~1.~~**8. Discharge planning, including Social Services, should be started as soon as an exposed infant is identified. Detailed planning for the discharge of these high-risk infants may minimize readmission or adverse outcomes after discharge.**

~~2.~~**9. Individuals, who appear under the influence of drugs including alcohol, cannot be allowed to handle the infant and in most instances, should be asked to leave the unit at the discretion of the nursing, medical and social work staff.** ~~1. Neonatal abstinence scoring~~ ~~**should**~~may be conducted for:

~~1. Infants born to drug-dependent mothers or if mother admits recent drug usage (within one month of delivery).~~
~~2. **Infants whose mothers have tested positive on urine drug screen**~~Mothers of infants with a positive drug screen.~~
~~3. Infants **displaying symptoms of withdrawal**~~having withdrawal symptoms.~~
~~4. Infants being weaned from treatment with drugs that **can** use physiological dependence, such as fentanyl **and morphine**.~~

C. **PROCEDURE:**

1. **Infants will be identified as at risk for NAS by:**
   a. **Prenatal identification of mother on narcotic medication.**
   b. **Mother with positive toxicology screen at delivery not explained as an in-hospital administered medication.**
   c. **Mother who discloses prenatal narcotic use at delivery**
2. **A urine and meconium toxicology screen will be sent on all infants delivered to mothers with concern for illicit or known drug use:**
   a. **Urine Toxicology Screen:**
      i. **After delivery, the RN will place urine collection bag on infant or cotton balls in the diaper**
      ii. **Stool contamination does not preclude assessment**
      iii. **If positive screen, notify attending physician or allied health professional (AHP) and social worker.**
3. **Meconium Toxicology Screen:**

a. **Use a tongue depressor to scrape meconium into a sterile container**
b. **Continue collection until all meconium is passed (until transitional stool).**
~~a.~~**c. Provider to follow up on result (can take up to 1 week or longer to result)**

4. **Management of Infants on Mother Baby: Low Risk for NAS (non-narcotic medication, low-dose prescription opiate with a short half-life, THC, methamphetamines):**
   a. **If an infant develops significant symptoms of withdrawal, the RN will notify the infant's provider for evaluation of the symptoms which may require transferring the infant to the NICU.**
   b. **Infants exposed to** marijuana **or methamphetamines do not need extended observation.**
   c. **Infants exposed to multiple medications (such as narcotics and benzodiazepines, or narcotics and multiple psychotropic medications) may not show signs of withdrawal until later; consider longer observation in the hospital and close, frequent follow up in the days after discharge.**
   d. **Consideration of medications, dose, exposure, half-life and complicating factors should be weighed when deciding length of hospital observation.**
5. **Mother Baby Couplet Care**
   a. **Mother and infant will remain together in couplet care for observation until the mother is discharged.**
   b. **Infant will not be on a cardio-respiratory monitor.**
   c. **Infant will be monitored for NAS using the Lipsitz scoring performed by RN every 6 hours and as needed if concern for escalating withdrawal symptoms. First assessment should be done around the time that the infant is transferred to mother baby.**
      i. **Scoring will occur at approximately 30-60 minutes after a feeding, at a time when an infant not at risk for NAS would normally be sedate.**
      ii. **Sleeping infants will not be disturbed and will receive a score of 0**
      iii. **Scoring for factors such as sneezing, yawning and emesis will be taken into consideration the entire period of evaluation since the last scoring.**
      iv. **Parents can be included when gathering information for the score.**
      v. **Infant with Lipsitz score greater than 8 will be transferred and admitted to NICU with orders from Provider.**
6. **Management of Infant at High Risk for NAS:**
   a. **Infant at high risk for NAS** ~~**whose**~~ **or infant in couplet care/newborn nursery with Lipsitz score greater than 8 or significant withdrawal symptoms should be admitted to NICU** for pharmacologic treatment, **per physician/AHP's orders.**
   b. **Finnegan Neonatal Abstinence Sscore** ~~**sheet**~~~~Using the Neonatal Drug Abstinence Sheet (*see attachment*)~~ in patient's electronic medical record.
      i. **The first score should be recorded two hours after birth or admission to Mother Baby/NBN/NICU. -This score reflects all behavior up to this first score.**
      ii. **Scoring is dynamic, all signs and symptoms observed during the scoring interval are included in the point total for that time period.**
      ~~i.~~**iii. Crying infants should be soothed prior to assessing of muscle tone, Moro reflex, and respiratory rate.**
      iv. **Infants will not be woken in order to obtain a Finnegan Score.**
7. **Breastfeeding/Breastmilk: the following mothers will be encouraged to breastfeed:**
   a. **Women engaged in substance abuse treatment program.**
   b. **Women who plan to continue in their substance abuse treatment program in the postpartum period.**
   c. **Women who have been abstinent from illicit drug use or licit drug abuse for 90 days prior to delivery and have demonstrated the ability to maintain sobriety in an outpatient setting.**
   d. **Women who have a negative maternal toxicology testing at delivery except for prescribed medications.**

e. **Women who received consistent prenatal care.**
f. **Women who do not have HIV or other contraindications to breastfeeding.**
g. **Women who are not taking a psychiatric medication that is contraindicated in lactation.**
h. **Women on a stable methadone maintenance regimen wishing to breastfeed, regardless of their methadone dose.**
i. **Women and their partners should be fully informed about the risk of rapid weaning from breastmilk or exposure to street drugs during lactation.**

8. **Non-Pharmacologic Treatment of Neonatal Abstinence:**
   a. **Use of non-pharmacological interventions should be initiated** immediately after birth and **prior to use of pharmacological interventions and include but are not limited to the following:**~~.~~
      i. **Skin to skin contact**
      ii. **Swaddling**
      iii. **Rocking**
      iv. **Massage**
      v. **Decreased sensory/environmental stimulation**
      vi. **Maintaining temperature stability**
      vii. **Protected sleep**
      viii. **Avoiding unnecessary handling and abrupt changes in the infant's environment**
      ix. **Avoiding overstimulation; do one procedure at a time, use partial swaddling with assessment and procedures**
      x. **When feeding, consider alternating use of pacifier and bottle to help compensate for excessive sucking and to assist with decreasing emesis.**
      ~~ii.~~**xi. Use of breastmilk (when appropriate) can help to decrease overall NAS symptoms.**

~~2.~~**9.** Pharmacological interventions:
   a. Begin pharmacological interventions when **Finnegan** scores **are greater than or equal to 8 x 2, the average of any three consecutive scores is 8 or greater (i.e 9, 7, 8), or greater than or equal to 12 x1.**
   b. **Refer to Neonatal Narcotic Withdrawal Syndrome, Pharmacological Treatment of (policy #8710-559) for medication interventions.**

10. **Discharge Planning for infants with diagnosed NAS:**
   a. **Discharge criteria:**
      i. **Infants who are exposed to methadone or buprenorphine but do not show signs of withdrawal severe enough to require narcotic medication should be watched in the hospital for a minimum of 5-7 days.**
      ii. **Infants who have been treated in the NICU for NAS with narcotics should be monitored closely for a minimum of 48 hours off medication before discharge.**
      iii. **Term NAS babies do not need a car seat challenge.**
      iv. **NAS infants are at an increased risk for SIDS and parents or guardians should know the importance of the safe sleep and anti-SIDS measures.**
   b. **Educate parents regarding the challenges associated with taking on the care of a NAS infant, with weeks of fussiness/ crying/ residual NAS symptoms being commonplace in the weeks following discharge.**
   c. **Follow-up developmental screening via High risk Infant Follow Up program may be indicated and depends on the infant's risk profile.**
   d. **If the mother is breastfeeding at discharge inform and provide a copy of the NICU discharge summary to parents for the mother's methadone clinic physician so as to minimize the risk of communication gap regarding breastmilk nutrition or rapid weaning**

**e. Provide clear information in the discharge summary for the infant's pediatrician regarding ongoing concerns, residual NAS symptoms, medications to be weaned, breastmilk provision, and high risk social situations.**

**f. Home health referrals for nursing, social work, and therapy (if needed).**

~~5. Scoring during and after drug treatment for withdrawal symptoms.~~

~~a. Consider drug treatment for withdrawal symptoms if:~~

~~b. The infant's score is at or greater than 12 or greater than 8 for three consecutive periods, and non-pharmacological interventions have not been effective.~~

~~c. The infant may be weaned from drug treatment 72 hours after treatment is initiated if scores continue to be less than 8, per physician's order. Scoring should be continued for a minimum of three days after therapy is discontinued to ensure that symptoms have not redeveloped.~~

~~d. Therapy may have to be restarted if the infant has a score greater than 8. Once therapy is discontinued and there are no scores greater than 8 for a total of three days, the scoring can be discontinued.~~

D. **REFERENCES:**

**1. Academy of Breastfeeding Medicine Clinical Protocol #21. (2015). Guidelines for breastfeeding and the drug-dependent woman. Breastfeeding Medicine;10(3):135-141**

**2. D'Apolito, K., & Finnegan L. (2010). Assessing signs and symptoms of neonatal abstinence using the Finnegan Scoring Tool: An inter-observer reliability program instructional manual (2d ed). Neo Advances, LLC.**

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**4. Gardner, S. et al. (2016). Merenstein & Gardner's Handbook of Neonatal Intensive Care, 8th Edition. St. Louis, MO:Elsevier Inc.**

**5. MacMullen, N.J., Dulski, L. A., & Blobaum, P. (2014). Evidence-based interventions for neonatal abstinence syndrome. Pediatric Nursing, 40 (4), 165-172.**

**6. MacMullen, N.J., Dulski, L. A., & Blobaum, P. (2014). Evidence-based interventions for neonatal abstinence syndrome. Pediatric Nursing, 40 (4), 165-172.**

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~~8. Morris, A. (n.d.). *Policy and procedure manual.* West Covina, CA: Citrus Valley Medical Center.~~

**7. Prenatal Substance Exposure: Management of Neonates Inclusive of Neonatal Abstinence Syndrome (2016). UC San Diego Health System Women and Infant Services Policy and Procedure Manuel.**

~~1.~~**8.** Verklan, T. & Walden, M. (2010). *Core curriculum for neonatal intensive care nursing,* 4th Ed. Philadelphia: Elsevier.

~~2.~~**9.** Zenk, K., Sills, J., & Koeppel, R. (2003). *Neonatal medication and nutrition: A comprehensive guide,* 3rd ed. Santa Rosa, CA: NICU Ink.

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

**SUBJECT: INFANT SAFETY AND SECURITY**

**ISSUE DATE: 9/91**
**REVISION DATE(S): 10/91, 8/94, 9/00, 6/03, 8/09, 06/13**

| | |
|---|---|
| **Department Approval Date(s):** | **01/17~~5~~** |
| **Department of OB/GYN Approval Date(s):** | **n/a** |
| **Department of Pediatrics 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):** | **~~04/15~~03/17** |
| **Board of Directors Approval Date(s):** | **04/15** |

A. **POLICY:**

1. To protect infants from removal by unauthorized persons.
2. Refer to Patient Care Services procedure: "Infant Identification. Follow the procedure regarding banding of infants and mothers.
3. Procedures which address the safety and security of infants will be followed by all staff working at Tri-City Medical Center (TCMC).
4. To ensure that when the infant is removed from nursery and then released to:
   a. Banded birth mother or birth father/significant other or the intended legal parent(s)
   b. Identification band numbers must be presented to nursery staff
   c. The number given must match the number on the infant's identification band before the infant is released.
   d. If there is any question about the number given, hospital staff shall accompany baby to the mother's room and confirm identification band numbers at that time.
5. To ensure newborn infant is only removed from mother's care (hospital room) by authorized Women and Newborn Services' (WNS) staff, WNS staff will wear TCMC photo identification badges with distinctive TCMC Women and Newborn Services' logo.
   a. Mothers will be instructed upon admission regarding the method of identifying WNS photo ID badges.
   b. Staff without ~~w~~**W**omen's and ~~children's~~ **Newborn's** photo ID badges, (i.e., floats, students, outside registry) will wear temporary name tags that shall be distributed by the employee health staff and/or shift supervisor/designee
      i. Temporary name badge shall include staff name, shift, date and the distinctive WNS logo.
      ii. These name tags will be collected by the shift supervisor/designee at the end of the shift and destroyed.
6. Mothers will be instructed to release their infant only to WNS staff wearing this identification. This instruction will be discussed initially in OB education classes, and then reviewed and reinforced upon admission to the WNS unit through direct instruction and information sheets.
7. Newborn infants will be transferred outside the department through halls only in bassinets, attended by ~~two~~ WNS staff members.
   a. Anyone carrying an infant in arms in **WNS** hallways will be questioned.
   b. This information shall be explained by the registered nurse verbally and on preprinted information sheets upon admission to Labor and Delivery and again when transferred to the Mother-Baby unit after delivery.
8. To insure the safety of the mother-baby couplet, all visitors shall be closely monitored by the WNS staff and volunteers.

a. An occupied stroller is allowed on Women and Newborn Services, but not in the NICU area.
b. Car seats and are not permitted in the following areas unless bringing a car seat in for a car seat challenge:
   i. Labor and delivery
   ~~ii. Newborn nursery~~
      ~~1) Receiving nursery~~
   ~~iii. Postpartum~~
   **ii. Mother Baby**
   **iii. NICU**
c. Car seats may be allowed at the time and date of discharge or in the specified areas for pre-scheduled car seat challenge tests, newborn hearing screening or lactation consultation appointments.

9. WNS staff education will include the following:
   a. Upon hire and updated yearly, staff shall be instructed in the above policy.
   b. Staff shall be monitored for compliance by the shift Assistant Nurse Manager/or designee on each shift.
   c. Instructions shall include creating an awareness of the risk of infant abduction and what to look for when observing activity on the unit, i.e., individuals loitering, persons in uniform without appropriate identification badges.
   d. Instruction shall include appropriate action(s) to take when discrepancies in practice or questionable individuals are observed on the unit.
   e. A risk assessment shall be conducted annually by the environment of care officer and submitted to ~~EOC~~ **Environmental Health and Safety** ~~c~~**C**ommittee **(EHSC)**. ~~Individual staff members will be counseled for noncompliance during assessment periods.~~
10. Infant abduction:
   a. In the event of a suspected infant abduction, the attending staff nurse will immediately:
      i. Call "Code Adam" by dialing 66 (see Patient Care Services Code Adam Policy).

B. **RELATED DOCUMENTS:**

1. Patient Care Services Code Adam Policy

# Risk Management & Patient Safety Plan
## FYs 2017-2018

**PURPOSE:** The Risk Management/ Patient Safety Plan is to provide a formal comprehensive and ongoing program to improve patient safety, reduce risk, and preserve organizational assets (human, financial, physical, reputation, and standing in the community). Effective health care error reduction requires an integrated and coordinated approach. The following plan relates specifically to a systematic hospital-wide program to minimize preventable injury or harm for all Tri-City Healthcare District stakeholders.

**INTRODUCTION:** Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. Leaders shall promote a fair and just culture while encouraging organizational learning and process improvement activities. The plan is designed to provide guidance and structure for the organization's clinical and business services that drive quality patient care while fostering a safe environment.

Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for mitigating, reducing, managing, transferring and/or eliminating the associated risks.

**MISSION:** To advance the health and wellness of the community we serve.

**VISION:** Be recognized as a healthcare system of choice in our community

**VALUE:** The needs of our patients come first.

## I. GOALS AND OBJECTIVES:

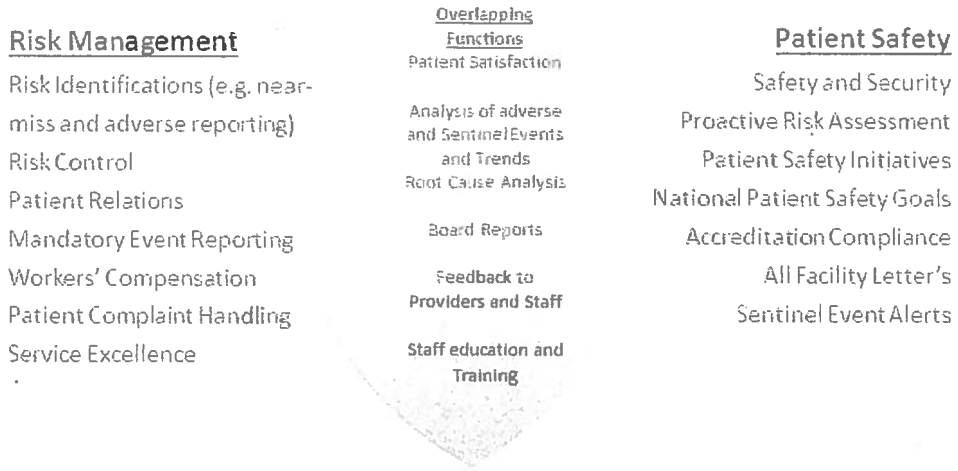
1. Promote safety as everyone's priority
2. Prevent errors, system breakdowns, and harm
3. Minimize clinical risks and liability losses
4. Support regulatory accreditation compliance
5. Protect organizational resources and assets
6. Maintain an effective system of monitoring, analyzing, and reporting events and near misses
7. Ensure medical staff participation in the measurement, assessment, and improvement of patient safety
8. Review the results of root cause analysis and monitor action plans
9. Provide education to hospital staff, medical staff, patients and families on risk management and safety activities
10. Create highly reliable processes that are designed to minimize the chances of human error

## II. PRIORITIES FOR FYs 2017-2018

11. Define Serious Safety Events and develop process to measure the number of serious safety events by June 2017.
12. Beginning in July 2017 measure the number of serious safety events per month to establish a baseline and report to Patient Safety Committee monthly.
13. Increase incident event reporting by 2% per fiscal years 2017 and 2018.

## III. SCOPE:

Risk management and patient safety is a hospital-wide integrated system that encompasses all areas of patient care, visitor, employee, property and medical staff safety. All employees and members of the medical staff who have authority to influence patient care outcomes directly or indirectly are actively involved in the Risk Management Program. The Risk Management Program will pursue occurrences and circumstances that may present the potential for loss.




Risk management will influence, persuade and educate leaders within the following departments in order to achieve quality care in a safe environment and protect the organization's resources:

1. Administration
2. Billing Services
3. Business Development and Marketing
4. Clinical and Ancillary Services
5. Data/Health Information and Privacy Management
6. Employee Health
7. Human Resources

8. Infection Control
9. Legal Services
10. Medical Equipment
11. Medical Staff
12. Patient Relations
13. Quality/Performance Improvement
14. Safety Management/Environment of Care
15. Security Management
16. Utilization Management


## IV. ORGANIZATION AND FUNCTION:

The Patient Safety Committee is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The committee will meet monthly (at least 10 times per year) to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of patient care.

The Patient Safety Committee will be chaired by the designated Patient Safety Officer. Committee membership includes services involved in providing patient care, i.e. Medical Staff PSO, Nursing, Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Control, Imaging, Rehab, and Pulmonary.

## V. AUTHORITY AND RESPONSIBILITY FOR IMPLEMENTATION:

The Director of Risk Management has been authorized by the Chief Executive Officer to provide the overall coordination of the Risk Management Program. It is the Chief Executive Officer, Chief Operating Officer , Chief of Staff, and Chief Nurse Executive who have the authority delegated by the Board of Directors to protect the interests of the hospital and patients by initiating necessary corrective action when the Risk Management Program has identified potentially adverse situations.

The Director of Risk Management and the Patient Safety Officer maintain compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the Risk Management/ Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.

## VI. CONFIDENTIALITY AND CONFLICT OF INTEREST:

Appropriate safeguards have been established to restrict access to highly sensitive and confidential Performance Improvement and Peer Review information, which is protected against disclosure and discoverability through the Health Care Quality Improvement Act and California Evidence Code: Section 1156-1157.

Confidential information may include, but is not limited to, Patient Safety or Risk Management Committee minutes, any associated medical staff committee minutes, organizational performance improvement reports, electronic data gathering and reporting, untoward incident reporting and clinical profiling.

## VII. DATA SOURCES AND REFERRALS:

Risk Management and Patient Safety opportunities are selected by reviewing the hospital's strategic plan, organizational balanced scorecard, departmental balanced scorecards, and care management initiatives, regulatory requirements including Core Measures, National Patient Safety Goals (NPSGs), and recommendations from the following:

1. Board of Directors
2. Medical Executive Committee
3. Quality Assurance Performance Improvement (QAPI) Committee
4. Medical Staff Departments
5. Medical Quality Assurance/ Performance Improvement/Patient Safety Committee
6. Other Hospital Committees
7. Root Cause Analysis and other focused investigations
8. American Hospital Association
9. California Hospital Patient Safety Organization (CHPSO)
10. Hospital Quality Institute (HQI)
11. California Hospital Engagement Network (CHEN)
12. State and Federal Agencies, including Centers for Medicare and Medicaid Services (CMS) and National Healthcare Safety Network (NHSN)
13. The Joint Commission (TJC)

14. National Center for Patient Safety
15. National Patient Safety Foundation (NPSF)
16. Other Benchmarking Resources, American Society for Healthcare Risk Management (ASHRM)

## VIII. MONITORING AND IMPROVING:

A. Aggregate data from internal (Incident Reporting System data collection, incident reports, questionnaires, ORYX reports, Core Measure reports) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories of medical/health care errors include:

- No Harm Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome

Ongoing monitoring of Risk Management/Patient Safety initiatives at the Leadership level in the following forums:

1. Governing Board
2. Professional Affairs Committee
3. Executive Council
4. Medical Executive Committee
5. Quality Assurance and Performance Improvement Committee

Additional monitoring and evaluation is conducted by hospital committees: Risk Management Committee and performance improvement teams at the department and staff levels where appropriate including:

1. Staff opinions and expressed needs
2. Staff perceptions of risks to individuals and suggestions for improving patient safety
3. Staff reporting events in an environment where honest monitoring and reporting is encouraged through RL Solutions incident reporting system
4. Safety huddles
5. Administrative Executive rounding

6. Environment of care rounding

## IX. DOCUMENTATION AND REPORTING MECHANISMS:

Risk Management/Patient Safety reports are standardized in the Joint Commission Root Cause Analysis format to ensure uniformity in documentation. In order to promote the use of appropriate methodology, tools and work group structure, Tri-City Medical Center provides Risk Management/Patient Safety education and training to staff, physicians and hospital leaders.

The TCMC approach to a Sentinel Events is to utilize them as a means to identify system issues that will improve patient safety and prevent further unanticipated outcomes. All potential sentinel events are evaluated for reporting to the California Department of Public Health as required by California State law. Adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable and health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network that are determined to be preventable (See attachment). The same reporting is applied to the California 28 Never Events.

The hospital also receives Sentinel Event updates published by The Joint Commission, which contain information on root causes and prevention of Sentinel Events. These notifications are distributed by the Patient Safety Officer and immediately referred to the appropriate forum for evaluation of recommendations and subsequent action as needed.

The hospital also receives All Facility Letters/AFL updates published by the California Department of Health, which contain information on reported concerns of other Hospitals. These notifications are distributed by the Patient Safety Officer and immediately referred to the appropriate forum for evaluation of recommendations and subsequent action as needed.

The Senior Director of Risk Management and the Patient Safety Officer will submit Annual Reports to the TCHD Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences and identifying topics for process improvement
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Detail of the Failure Mode Effects Analysis selected for improved patient safety
4. Descriptions of the Root Cause Analysis completed for unusual/ unexpected events or near misses.
5. Analysis of results from AHRQ Culture of Safety Employee Survey
6. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles
7. The results of the program that assesses and improves staff willingness to report medical/health care errors
8. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care

## X. INTEGRATION OF ACTIVITIES AND INFORMATION:

Under the auspices of the Risk Management Department, senior leaders review root cause analyses of sentinel and significant events, including tracking and trending the nature of the event and the effectiveness of the action plans in order to develop and implement appropriate systems or to suggest actions to enhance the quality and/or safety of care.

## XI. PROGRAM EVALUATION:

To ensure the appropriate approach to planning processes of improvement, setting priorities for improvement, assessing performance systematically, implementing improvement activities on the basis of assessment, and maintaining achieved improvements, the Risk Management and Patient Safety program is evaluated for effectiveness at least annually and revised as necessary.

## APPROVAL SIGNATURES:

_____

**Marcia M. Cavanaugh, RN, MSN, MBA,**
**CPHRM, CNOR, NEA-BC**
*Sr. Director Clinical Risk Management*
*Quality, and Patient Relations*

_____

***Kevin M. McQueen, MHA, BA HCM,***
***RCP, RRT, CPPS, CM***
*Director of Safety/Environment of Care/*
*Patient Safety Officer*

**DRAFT**

# Governance & Legislative Committee Meeting Minutes
# Tri-City Healthcare District
# March 7, 2017

| | |
|---|---|
| **Members Present:** | James J. Dagostino, DPT, PT, Chairperson; Director Laura E. Mitchell, Director RoseMarie V. Reno; Dr. Paul Slowik, Community Member; Robin Iveson, Community Member; Dr. Cary Mells, Physician Member; Dr. Gene Ma, Chief of Staff ; Sherry Miller, Manager, Medical Staff Office |
| **Non-Voting Members:** | Kapua Conley, COO; Cheryle Bernard-Shaw, Chief Compliance Officer |
| **Others Present:** | Wayne Knight, CSO; Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Adriana Ochoa, General Counsel |
| **Absent:** | Steve Dietlin, CEO; Cheryle Bernard-Shaw, Chief Compliance Officer; Dr. Marcus Contardo, Physician Member |

| | 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.<br><br>Chairman Dagostino welcomed Ms. Robin Iveson to the committee. | | |
| 2. Approval of Agenda | Director Reno requested agenda item 6 b) - Review and discussion of Board Policy 16-037 – Chief Executive Officer and Chief Compliance Officer Succession Planning Policy include discussion of succession planning for the Chief Nurse Executive. General Counsel Ms. Ochoa explained that the Chief Nurse Executive is hired by the CEO and the Board does not have authority over the selection of the CNE. Director Reno questioned if the current CNE must agree to her successor. Again, Ms. Ochoa stated that is within the purview of the CEO. Ms. Ochoa stated it is not necessary to amend the agenda and this issue can be discussed further as part of the policy discussion.<br><br>Ms. Iveson suggested review dates be included on the Board Policies even if no changes are made to the policy. Ms. Ochoa stated it is permissible to reflect a review date however it is helpful for staff to know when a | Agenda approved. | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
|---|---|---|---|



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| | policy was actually revised.<br><br>**It was moved by Director Reno to approve the agenda as presented. Director Mitchell seconded the motion passed unanimously.** | | |
| 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 Mitchell and seconded by Ms. Robin Iveson to ratify the minutes of the February 7, 2017 Governance & Legislative Committee. The motion passed unanimously.** | Minutes ratified. | Ms. Donnellan |
| 5. Old Business | None | | |
| 6. New Business<br><br>a. Medical Staff Rules & Regulations:<br><br>1) Division of General & Vascular Surgery<br><br>2) Division of Urology<br><br>3) Division of Orthopedic Surgery<br><br>4) Department of Obstetrics & Gynecology<br><br>5) Allied Health Professionals | Ms. Sherry Miller stated the Rules & Regulations presented today have been updated to provide consistency. She explained the Privileges have been extracted from the Rules & Regulations as they are often adjusted and it is more efficient for the Privilege Card to be a separate document. In addition Proctoring requirements have been tightened up. Dr. Ma said nothing has radically changed on any of the Rules & Regulations presented today.<br><br>Dr. Ma commented that the Medical Staff has transitioned to a new Medical Staff attorney who is very experienced and the Medical Staff relies on their counsel to be consistent and not put the Medical Staff or the organization at risk.<br><br>Dr. Ma noted one change in the Department of Obstetrics & Gynecology Rules & Regulations related to Emergency Department call. He stated in the past North County Health Services were exempt from Emergency Department call however the Obstetrics Department requested that the change be made to remain consistent with Medical Staff Bylaws which reflect that all physicians on active staff are obligated to take ED Call | | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
|---|---|---|---|

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| | which the exception of those physicians who have been on staff 25 years or more.<br><br>Director Reno questioned if a physician backs up the Certified Midwives. Dr. Ma explained that a physician does indeed back up the Certified Midwife and this falls under North County Health Services. Director Reno suggested that Dr. Ma arrange for a Board educational presentation on Certified Midwives.<br><br>Committee members asked questions that were answered by Dr. Ma and Ms. Miller.<br><br>**It was moved by Reno to recommend approval of the Division of General & Vascular Surgery, Division of Urology, Division of Orthopedic Surgery Department of Obstetrics & Gynecology and Allied Health Professionals Rules & Regulations as presented. Director Mitchell seconded the motion. The motion passed unanimously.**<br><br>**It was moved by Director Reno to recommend Dr. Ma arrange for a Board educational presentation on Certified Midwives. Director Mitchell seconded the motion. The motion passed unanimously.** | Recommendation to be sent to the Board of Directors to approve the Division of General & Vascular Surgery, Division of Urology, Division of Orthopedic Surgery, Department of Obstetrics & Gynecology and Allied Health Professionals Rules & Regulations; items to be placed on Board agenda and included in agenda packet.<br><br>Recommendation that Dr. Ma arrange for a Board educational presentation on Midwives at a future Board meeting. | Ms. Donnellan<br><br>Dr. Gene Ma |
| b. Review and discussion of Board Policy 16-037 – Chief Executive Officer and Chief Compliance Officer Succession Planning Policy | Director Reno stated she placed this item on today's agenda as Trustee Magazine dictates that Boards look for patterns of Chief Executive Officer turnover and she is concerned about a successor should the CEO leave the organization. Director Reno stated additionally she is concerned about a successor to the CNE should she leave the organization. Ms. Ochoa stated the policy clearly outlines the steps that would be taken in the event the CEO were to leave the organization. She noted it is not a rank order but rather a decision that is left to the Board's discretion. She further explained that the Board does not hire the CNE and therefore it is not appropriate to discuss the succession of the CNE in this policy. | None. | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| c. Review and discussion of Board Policy 15-039 – Comprehensive Code of Conduct | Director Reno stated she placed this item on today's agenda to discuss new Board Member orientation. She stated she does not believe new Board members are receiving ample education on Roles and Responsibilities, Bylaws and Policies. It was noted that Board Orientation Binders include all Board Policies, Bylaws as well as other relevant important information and new Board members are encouraged to review the manual in depth and request clarification or additional information as needed.<br><br>Secondly Director Reno stated she believes it is self-serving to the Chair that the Chair fails to appoint Director Reno to a Board Committee Chairperson role. She stated she has been cleared by the FPPC of any 1090 violations. | None. | |
| d. Consider recommending Educational Board Workshop | Director Reno stated she placed this item on today's agenda to consider engaging Ms. Laura Jacobs and the GE Healthcare Camden Group for a Board Workshop. She stated the Camden Group is far and above what other facilities have given us and places emphasis on the Board's roles and responsibilities and what changes might be on the horizon.<br><br>Discussion was held regarding past Board Workshops and changes that were and were not implemented at the suggestion of the Facilitator. Director Reno stated it is a disservice when the Board does not hold an educational session once a year that involves physicians and community members.<br><br>Chairman Dagostino stated in his opinion it would make more sense to engage Jim Rice who facilitated the last Board Workshop to determine what strides have been made since the last Board Educational session.<br><br>It was recommended a two-hour time slot be allotted to the Board at the April 25th Strategic Planning session to discuss whether a Board Educational Workshop is worthwhile and potential facilitators. | | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | Community member Mr. Wayne Knight commented that the Strategic Planning Workshop is typically closed session due to the Trade Secret(s) discussion. Ms. Robin Iveson commented that the more open to transparency we are the better we will be viewed by the community. General Counsel stated discussion of this nature (Board Workshop Philosophy) would be an open discussion item.<br><br>**It was moved by Director Reno that the Board consider allocating two hours of time at the April 25th Strategic Planning Session for Board Workshop Philosophy. Director Mitchell seconded the motion. The motion passed unanimously.** | Recommendation to be sent to the Board of Directors to consider allocating a two-hour time block on the April 25th Strategic Planning Workshop agenda for Board Workshop Philosophy; item to appear on Board Agenda. | Ms. Donnellan |
| e. Consideration to Apply for ACHD Certified District Designation | Director Mitchell stated this item was placed on today's agenda to consider whether the District should apply to ACHD for Certified District Designation status. She explained that ACHD advocates for the District in Sacramento and both she and Director Nygaard believe it is worthwhile to pursue and a good marketing tool. Chairman Dagostino questioned the benefit and expense to the hospital. Director Mitchell stated there is no cost to apply and it is merely a status that is held by other healthcare districts locally. She noted to be considered for District of the Year you must have the ACHD Certified District Designation. Director Reno stated the District previously held Certified District Designation status by ACHD and questioned when we lost that designation. General Counsel, Ms. Ochoa stated the oldest recipient listed on ACHD's website is August, 2014 and it appears this is a relatively new program.<br><br>Director Reno called for the question.<br><br>**It was moved by Director Mitchell to recommend the District apply to ACHD for Certified District** | Recommendation to be sent to the Board of Directors to apply to ACHD for | Ms. Donnellan |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | **Designation status. Director Reno seconded the motion. The motion passed unanimously.**<br><br>*Ms. Miller left the meeting at 1:48 p.m.* | Certified District Designation status; item to appear on board agenda. | |
| 7. Discussion regarding Current Legislation | At Director Reno's request, Mr. Wayne Knight provided background information on the Medicare Alternative Payment Models (under MACRA).<br><br>Director Reno questioned how Tri-City contracts with Team Health. Dr. Ma explained that Team Health is the vendor for Emergency Services only and Team Health bills for the Emergency Department visit rather than the Tri-City Emergency Medical Group and the hospital bills independently. Mr. Knight stated MACRAQ applies to the physician and the hospital would only be affected when you get into global payment models. Director Reno suggested Dr. Ma provide the Board with an educational presentation on Team Health and their role at a future Board meeting.<br><br>The committee also reviewed the latest update on legislation from CHA's perspective.<br><br>*Dr. Ma left the meeting at 2:06 p.m.* | Information only. | |
| 8. Review of FY2017 Committee Work Plan | Due to time restrictions, the FY2017 Committee Work Plan was not discussed. | None | |
| 9. Committee Communications | | | |
| 10. Committee Openings – Two | There is currently one opening on the committee | | |
| 11. Confirm date and time of next meeting | The committee's next meeting is scheduled for Tuesday, April 4, 2017 at 12:30 p.m. | The next meeting of the Committee is April 4, 2017. | |
| 12. Adjournment | Chairman Dagostino adjourned the meeting at 2:25 p.m. | | |

I. **MEMBERSHIP**

The Division of General and Vascular Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Surgery, or able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of General and Vascular 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~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division 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. 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**

The Division of General and Vascular Surgery shall meet at the discretion of the Chief, but at least quarterly. 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~~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, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active Staff 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 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 that Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Accountability for all professional and administrative activities of the Division.
B. Ongoing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division.
C. Ensuring practitioners practice only within the scope of the privileges defined within their delineated privilege form.
D. Recommendations to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division.
E. Recommendations of clinical privileges for each member of the Division.
F. Ensuring 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 by 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~~Department.
B. 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.
C. **Physician Assistants** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.~~In accordance with Department of Surgery rules and regulations~~.
~~D.~~ **Registered Nurse First Assist (RNFA)** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.~~In accordance with Department of Surgery rules and regulations.~~
~~E.~~ **~~Forensic~~ Progressive Care Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the ~~Forensic~~ Progressive Care Outpatient Clinic.

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| ~~Admit Patients~~<br>~~Consultation, including via telemedicine (F)~~<br>~~Perform Medical History & Physical Examination, including via telemedicine (F)~~ | ~~Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience.~~ | ~~Completion of General Surgery proctoring satisfies proctoring for these privileges~~ | ~~N/A~~ |
| ~~**BASIC GENERAL SURGERY PRIVILEGES**~~ | | | |
| ~~• Anal canal biopsy (F)~~<br>~~• Anoscopy (F)~~<br>~~• Arterial catheterization for monitoring~~<br>~~• Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular)~~<br>~~• Biopsy / excision skin & soft tissue lesions (F)~~<br>~~• Central venous catheter placement~~<br>~~• Chemical destruction of anal warts (F)~~<br>~~• Cricothyroidotomy~~<br>~~• Debridement of wound, soft tissue infection~~<br>~~• Excision of neuroma, neurofibroma, neurilemoma~~<br>~~• Excision of skin, soft tissue neoplasm~~<br>~~• I&D abscess (F)~~<br>~~• Intraoperative Endoscopy, concomitant to surgical procedure~~<br>~~• Minor laceration repair~~<br>~~• Neurorrhaphy - Suture of Nerve~~<br>~~• Paracentesis~~<br>~~• Parathyroidectomy~~<br>~~• Radical neck dissection, modified~~<br>~~• Right heart catheterization for monitoring~~<br>~~• Rigid proctoscopy (F)~~<br>~~• Rubber band ligation of internal~~ | ~~• Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience.~~<br>~~• One-hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA accredited residency or clinical fellowship within the previous (24) months.~~ | ~~Ten (10) cases~~ | ~~Sixty (60) cases from this category~~ |

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| ~~hemorrhoids (F)~~<br>• ~~Sentinel lymph node biopsy~~<br>• ~~Sigmoidoscopy, includes rigid or flexible~~<br>• ~~Thoracentesis~~<br>• ~~Thyroidectomy~~<br>• ~~Tracheostomy~~<br>• ~~Tube thoracostomy~~<br>**~~Abdomen and Perineum Surgery:~~**<br>• ~~Abdominal perineal resection~~<br>• ~~Abdominal wall repair, inguinal or femoral hernia, laparoscopic~~<br>• ~~Adrenalectomy, open~~<br>• ~~Anal sphincterotomy~~<br>• ~~Anti-reflux procedures, open~~<br>• ~~Appendectomy, open or laparoscopic~~<br>• ~~Cholecystectomy, open or laparoscopic~~<br>• ~~Choledochoenteric anastamosis~~<br>• ~~Colostomy, closure~~<br>• ~~Colostomy, creation, open or laparoscopic~~<br>• ~~Common bile duct exploration, transcystic, open or laparoscopic~~<br>• ~~Diagnostic laparoscopy with or without biopsy~~<br>• ~~Drainage of anorectal abscess~~<br>• ~~Drainage of intra-abdominal abscess~~<br>• ~~Drainage of pseudocyst~~<br>• ~~Enterolysis~~<br>• ~~Esophageal diverticulectomy, open~~<br>• ~~Esophagogastrectomy~~<br>• ~~Exploratory laparotomy~~<br>• ~~Fasciotomy~~<br>• ~~Gastrectomy, partial or total~~<br>• ~~Hemorrhoidectomy~~<br>• ~~Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral, open or laparoscopic~~<br>• ~~Hernia, repair of diaphragmatic or hiatal, open~~<br>• ~~Ileostomy creation or closure~~<br>• ~~Intestine resection (small or~~ | | | |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| larger intestine), open or laparoscopic<br>• Liver biopsy, open or laparoscopic<br>• Lymphadenectomy<br>• Lysis of adhesions, open or laparoscopic<br>• Pilonidal cystectomy<br>• Repair of anorectal fistula<br>• Repair of rectal prolapse<br>• Splenectomy, open<br>• Ulcer surgery, (Omental patch, V&A, V&O, V&GJ, HSV, etc), open<br>• Vagus transection, for peptic ulcer disease<br>**Breast Surgery:**<br>• Axillary dissection<br>• Biopsy, incisional or excisional<br>• Breast abscess, drainage of<br>• Intraoperative needle localization<br>• Intraoperative ultrasound<br>• Mastectomy, partial<br>• Mastectomy, total<br>• Mastopexy<br>**Urogenital Surgery:**<br>• Bladder repair, incidental<br>• Hydrocelectomy, incidental<br>• Hysterectomy, incidental<br>• Nephrectomy, incidental<br>• Orchiectomy, incidental<br>• Partial cystectomy, incidental<br>• Salpingo-oophorectomy, incidental or in an acute abdominal emergency<br>• Ureteral repair, incidental<br>• Skin grafting | | | |
| **BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES** | | | |
| • Amputation, digital<br>• Amputation, foot<br>• Amputation, knee, above<br>• Amputation, knee, below<br>• Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency)<br>• Operations for venous | Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months. | One (1) case | Five (5) cases |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| ulceration/split thickness skin grafting (STSG)<br>• Sympathectomy - (Including vascular ischemia)<br>• Vein ligation or stripping of varicose veins/phlebectomy<br>• Portal Decompression:<br>• Mesocaval shunt<br>• Portocaval shunt<br>• Splenorenal shunt | | | |
| **ADVANCED GENERAL SURGERY PRIVILEGES:** | | | |
| **Advanced Breast Surgery:**<br>Oncoplastic repair | • Basic General Surgery privileges which effectively covers the need for board certification.<br>• For Oncoplastic Repair privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months. | Three (3) cases | Ten (10) cases |
| **Advanced Laparoscopic::**<br>• Adrenalectomy , laparoscopic<br>• Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet), laparoscopic<br>• Cholecystenteric anastomosis, laparoscopic<br>• Choledochoenteric anastomosis, laparoscopic<br>• Colostomy closure, laparoscopic<br>• Esophageal procedures, laparoscopic<br>• Gastric resection , laparoscopic<br>• Hepatic resection , laparoscopic<br>• Hernia repair, diaphragmatic or | • Basic General Surgery privileges which effectively covers the need for board certification.<br>• Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months. | Three (3) cases from this category | Twenty-four (24) cases from this category |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| hiatal, laparoscopic<br>• Pancreatic procedures, laparoscopicSplenectomy, laparoscopic<br>• Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc), laparoscopic | | | |
| **Advanced Abdominal:** | | | |
| • Esophagectomy, including thoracoabdominal approach<br>• Hepatic lobectomy, open<br>• Hepaticoenterostomy<br>• Pancreatic procedures, open or laparoscopic | • Basic General Surgery privileges which effectively covers the need for board certification.<br>• Two (2) advanced abdominal procedures during the previous twenty-four (24) months. | One (1) case from this category | Two (2) cases from this category |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| **Advanced Head & Neck Surgery:**<br>• Parotid gland<br>• Salivary glands & ducts<br>• Thymectomy | • Basic General Surgery privileges which effectively covers the need for board certification.<br>• Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months. | Two (2) cases from this category | Ten (10) cases from this category |
| **ADVANCED PERIPHERAL VASCULAR SURGERY:** | | | |
| • Aortic, aorto-iliac, aorto-femoral bypass<br>• Axillary-femoral bypass<br>• Bypass of upper extremity vessel<br>• Carotid – Subclavian bypass<br>• Celiac/superior mesenteric axis endarterectomy, repair or bypass<br>• Embolectomy or thrombectomy<br>• Endarterectomy, carotid<br>• Endarterectomy or bypass, vertebral<br>• Endarterectomy, repair or bypass, renal artery<br>• Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery<br>• Femoral to femoral bypass<br>• Femoral to infrageniculate bypass<br>• Femoral to popliteal bypass<br>• Repair of aortic branches<br>• Repair of iliac, femoral, popliteal, or mesenteric aneurysm<br>• Repair of infra or suprarenal aortic aneurysm<br>• Repair of upper extremity vessel<br>• Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures*<br>• Upper and lower extremity deep or superficial vein procedures<br>• Upper or lower extremity fistula, autogenous or artificial | • Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification.<br>• Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.)<br>• *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out. | • Five (5) cases from this category<br>• * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases | • Twenty (20) vascular cases from this category<br>• *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out. |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| placement of central venous catheter placement | | | |
| **SPECIAL PRIVILEGES:** | | | |
| Bariatric Surgery:<br>• Roux en Y gastric bypass, open and laparoscopic<br>• Sleeve gastrectomy, open and laparoscopic<br>• Adjustable gastric banding, open and laparoscopic<br>• Revisional metabolic and bariatric surgery, open and laparoscopic<br>• Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic<br>• Bariatric Endoscopy | • Completion of General Surgery residency program.<br>• Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy.<br>• Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases and (10) Bariatric Endoscopy cases within the previous twenty-four (24) months.<br>• Documentation to indicate malpractice coverage includes bariatric surgery. | Three (3) Bariatric cases and Three (3) Bariatric EGD Cases | • Fifteen (15) cases within the previous twenty-four (24) months<br>• |
| Colonoscopy | Completion of an ACGME accredited training program in General Surgery or Colon and Rectal surgery within the previous twenty four (24) months. If training was completed greater than twenty four (24) months ago, documentation of a refresher training course in lower endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required. | Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior | Ten (10) cases |

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| | | ~~to granting privileges and documentation of fifty (50) cases was provided,~~<br><br>~~Seven (7) cases if training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of a refresher course was provided.~~ | |
| ~~Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures~~ | ~~Initial: Completion of an ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.~~ | ~~Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided.~~<br><br>~~Seven (7) cases if training was~~ | ~~Seven (7) cases within the previous twenty-four (24) months~~ |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| | | completed greater than twenty-four (24) months prior to granting of privileges and documentation of refresher course was provided. | |
| Endovenous Ablative Therapy | Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures | Three (3) cases | Five (5) cases |
| Endovascular Repair of Aortic Aneurysms | Per policy 8710-503 | Per policy 8710-503 | Per policy 8710-503 |
| Fluoroscopy | Per policies 8710-528 and 8710-528A | Per policies 8710-528 and 8710-528A | Per policies 8710-528 and 8710-528A |
| KTP Laser | Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used. | Two (2) cases | Two (2) cases |
| Moderate Sedation | Per policy 8710-517 | Per policy 8710-517 | Per policy 8710-517 |
| Robotic Surgery – (da Vinci)<br>• Multiple Port<br>• Single Port<br>• Assist in robotic surgery | Per policy 8710-563 | Per policy 8710-563 | Per policy 8710-563 |
| Transoral Esophagogastric Fundoplication (TIF) | 1. Completion of ACGME accredited residency program and possess board certification or board eligibility in Surgery; and<br>2. Documentation of completion of product-sponsored training course, or have | Three (3) cases | Six (6) cases |

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| | ~~performed at least five (5) TIF procedures in the previous twelve (12) months~~ | | |
| ~~Placement of Vagal Nerve Stimulator~~ | ~~1. Basic General Surgery privileges which effectively covers the need for board certification.~~<br>~~2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months~~<br>~~1. Must have Carotid Endarterectomy privileges.~~ | ~~Two (2) cases~~ | ~~Five (5) cases~~ |

VII. **REQUIREMENTS FOR REAPPOINTMENT**

A. Active certification by the Division of General and Vascular Surgery 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. 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 TCHD 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 physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

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 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. 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. ~~THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE APPLICANT 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.~~ Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of

procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence

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 at the front desk in the O.R. ~~from the Operating Room Supervisor and/~~or at the Medical Staff ~~Office~~Department and provided to the proctor for completion.

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~~Department.

J. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

IX. **EMERGENCY DEPARTMENT CALL:**

A. 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.

B. It is the policy of the Emergency Department that when a patient indicates that a staff member has previously treated him or her, that member will be given the opportunity to provide further care.

C. The member of the Division 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.

D. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. The care provided by an on-call physician will not create an obligation to provide further care.

E. Provisional or Courtesy staff may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair.

**APPROVALS:**
General & Vascular Surgery Division: 9/10/2015
Surgery Department: 10/01/2015
Medical Executive Committee: 10/26/2015
Governance Committee: 10/6/2015
Board of Directors: 10/29/2015

I. **MEMBERSHIP**

The Division of Urology consists of physicians who are Board Certified or actively pursuing certification by the American Board of Urology, or able to demonstrate comparable ability, training, and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Urology 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 of activities, actions taken thereon, 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 Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of Urology 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/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, experience and demonstrated ability in the clinical area 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 in the office 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~~Medical Staff Department.

~~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.~~B. 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.~~C. Sites:

1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056
2. Privileges annotated with (F) may be performed at the Outpatient ~~Forensic~~ Progressive Care Clinic(s).

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| ~~Admit Patients~~<br>~~Consultation, including via telemedicine (F)~~<br>~~Perform history and physical examination, including via telemedicine (F)~~ | ~~Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.~~ | ~~Successful completion of procedure-specific proctoring satisfies proctoring for these privileges~~ | ~~N/A~~ |
| ~~Basic Urology Privileges~~ | | | |
| ~~Abdominal procedure(s), incidental~~<br>~~Anterior Exenteration~~<br>~~Colporrhaphy~~<br>~~Incisional Hernia, incidental~~ | ~~1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.~~ | ~~Five (5) cases from the Basic Urology Privileges category~~ | ~~Fifty (50) representative blend of cases~~ |

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| ~~Inguinal Hernia, incidental~~<br>~~Lithotripsy~~<br>~~Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic)~~<br>~~Male Genital System – all procedures for:~~<br>• ~~Scrotum~~<br>• ~~Testis~~<br>• ~~Vas Deferens~~<br>• ~~Penis~~<br>• ~~Retroperitoneal Surgery~~<br>~~Radical Cystectomy~~<br>~~Urinary System – all procedures for:~~<br>• ~~Kidney~~<br>• ~~Ureter~~<br>• ~~Bladder~~<br>• ~~Prostate~~<br>• ~~Urethra~~<br>~~Urodynamics - Foley catheter placement (F)~~ | ~~2. Documentation of at least of fifty (50) cases within the previous twenty-four (24) months.~~ | | |
| **~~Special Urology Privileges~~** | | | |
| **~~Laser Privileges:~~**<br>• ~~$CO_2$ Laser~~<br>• ~~Diode (Greenlight) Laser~~<br>• ~~Holmium Laser~~ | ~~1. Documentation of completion of training for specific energy source(s) to be used; or~~<br>~~2.~~1. ~~If training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.~~ | ~~One (1) case for each energy source~~ | ~~One (1) case for each energy source~~ |
| ~~Moderate Sedation~~ | ~~Per policy 8710-541~~ | ~~Per policy 8710-541~~ | ~~Per policy 8710-541~~ |

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| Renal Laparoscopy and/or Laparoscopic Nephrectomy | 1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology that included training in laparoscopy; or<br>2. Successful completion of a hands-on training course for renal laparoscopic and/or laparoscopic nephrectomy procedures; or<br>3.1. Documentation of at least three (3) renal laparoscopic and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months (required if training was completed more than two years prior to application). | Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures | Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures |
| Robotic Surgery – da Vinci<br>Robotic Surgery, assist – da Vinci | Per policy 8710-563 | Per policy 8710-563 | Per policy 8710-563 |

| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
|---|---|---|---|
| ~~Sacral Nerve Stimulation~~ | ~~1. Successful completion of an ACGME or AOA accredited residency program and board certified or actively pursuing board certification in Urology; or successful completion of a urogynecology fellowship program; AND~~<br>~~2. Documentation of successful completion of a training course in sacral neuromodulation therapy; or documentation of performing at least six (6) sacral neuromodulation therapy stimulator tests and implant procedures within the previous twelve (12) months (required if training was completed more than two years prior to application)~~ | ~~One (1) case~~ | ~~Two (2) cases~~ |

VI. **REAPPOINTMENT OF CLINICAL PRIVILEGES:**

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).

IX. **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 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. ~~**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.~~Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence

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 at the front desk in the O.R. ~~from the Operating Room Supervisor and/~~or the ~~Medical Staff Office~~Medical Staff Department and provided to the proctor for completion.

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~~Medical Staff Department.

J. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

## X. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy and Procedure #8710-520.

Provisional staff members may be assigned to the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

**APPROVALS:**

| | |
| --- | --- |
| Division of Urology: | 06/15/2015 |
| Department of Surgery: | 06/18/2015 |
| Medical Executive Committee: | 07/27/2015 |
| Governance Committee: | 08/04/2015 |
| Board of Directors: | 08/27/2015 |

I. **MEMBERSHIP** (5/15)

A. The Division of Orthopedic Surgery consists of physicians who are board certified or in the first thirty-six (36) months of board eligibility and are actively progressing towards certification by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience. (5/15)

II. **FUNCTIONS OF THE DIVISION** (5/15)

A. The general functions of the Division of Orthopedic Surgery shall include:

1. 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;
2. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
3. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;
4. Review and evaluate Division member adherence to:
   - i Medical Staff policies and procedures
   - ii Sound principles of clinical practice
5. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   - i Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   - ii Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
6. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
7. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
8. Recommend/request Focused Professional Practice Evaluation (FPPE) as indicated (pursuant to Medical Staff Policy 8710-509);
9. Approve On-Going Professional Practice Evaluation (OPPE) indicators;
10. 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** (5/15)

A. The Division of Orthopedic Surgery 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.

B. Minutes shall be transmitted to the Department of Surgery, Medical Peer Review Committee, and to the Medical Executive Committee.

C. 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** (5/15)

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Division.

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. The Chief shall be elected by a simple majority of the members of the Division.

C. 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 Medical Staff membership or clinical privileges in the Division. The Division Chief shall be eligible to succeed him/herself if elected. (5/15)

## V. DUTIES OF THE DIVISION CHIEF (5/15)

A. The Division Chief shall assume the following responsibilities:

1. Accountable for all professional and administrative activities of the Division;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Division;
3. Assure practitioners practice only within the scope of their privileges as defined within the delineated privilege form;
4. Recommend to the Department of Surgery and the Medical Executive Committee criteria for clinical privileges in the Division;
5. Recommend clinical privileges for each member of the Division;
6. Assure the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
7. Other duties as recommended by the Department of Surgery or the Medical Executive Committee. (5/15)

## VI. REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES ~~(5/15)~~(1/17)

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department.

B. 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. (5/15)

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).

## VII. CLASSIFICATIONS (5/15)

A. Members of Division of Orthopedics 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 consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
2. Unexpected complications arise which are outside this level of competence.
3. Specialized treatment or procedures are contemplated with which they are not familiar.

## VIII. PRIVILEGES ~~(5/15)~~ See Orthopedic Surgery Privilege Card (1/17)

| Orthopedic Surgeon Privileges (5/15) | | | |
|---|---|---|---|
| **Privileges** | **Initial Appointment** | **Proctoring** | **Reappointment (every 2 years)** |
| Admit patients | As required for Basic Orthopedic Surgery Category privileges | | |
| **BASIC ORTHOPEDIC SURGERY CATEGORY** | | | |
| **Amputations:**<br>• Elective<br>• Traumatic | 1. Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery.<br>2. 1. Documentation of one hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested. | Six (6) cases from this category | Fifty (50) cases from this category reflective of the privileges requested |
| Arthrodesis of Extremities | | | |
| Arthroscopy surgery for knee, shoulder, elbow, hand, ankle, wrist & hip joints | | | |
| Biopsy (bone/soft tissue) | | | |
| Bone Grafting, with or without allografts | | | |
| **Dislocation:**<br>• External Fixation<br>• Internal Fixation | | | |
| Fasciotomy and fasciectomy | | | |
| Foreign body removal | | | |
| **Fractures:**<br>• External Fracture Fixation (includes Taylor Spatial Frame)<br>• Fracture treatment of hand*<br>• Internal Fracture Fixation<br>• Pelvic Fracture Care (open/closed)<br>• Hip hemiarthroplasty* | | | |
| Ligament Reconstruction | | | |
| Management of infections and inflammations of bones, joints, and tendon sheaths | | | |
| Manipulation of joints | | | |
| **Minor total joint Arthroplasty:**<br>• Fingers<br>• Toes | | | |
| Nerve repair of hand* | | | |
| Osteotomy | | | |
| Reconstruction of non-spinal | | | |

| Orthopedic Surgeon Privileges (5/15) | | | |
|---|---|---|---|
| **Privileges** | **Initial Appointment** | **Proctoring** | **Reappointment (every 2 years)** |
| congenital musculoskeletal anomalies | | | |
| Repair lacerations | | | |
| **Skin grafts:**<br>• Muscle and tendon release, repair, and fixation (flexor & extensor tendon repair of hand)*<br>• Tendon transfer<br>• Tendon reconstruction (free graft, staged)<br>• Treatment of infections | | | |
| Soft tissue/bony mass management (debridement, flaps (non-microvascular)) | | | |
| Treatment of cartilage injuries (i.e. autologous chondrocyte implantation (ACI) and osteoarticular transfer system (OATS)/osteochondral allograft) | | | |
| **Total Joint Arthroplasty:**<br>• Ankle<br>• Hip (includes resurfacing)<br>• Knee<br>• Shoulder<br>• Wrist | | | |
| Treatment of trauma | | | |
| **ADVANCED ORTHOPEDIC SURGERY PRIVILEGES (5/15)** | | | |
| **Hand Surgery:**<br>• Fracture treatment of hand<br>• Microsurgical nerve repair and graft of hand<br>• Microvascular replantation<br>• Microvascular/tissue transfer<br>• Neurorrhaphy<br>• Removal of soft tissue mass, ganglion on the palm or wrist, flexor sheath or similar mass<br>• Repair of rheumatoid arthritis deformity<br>• Vascular lesion repair of extremities<br>• Vein graft to vascular lesion in extremities | 1. Successful completion of a fellowship in hand surgery, **or** successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery **and** demonstrate significant clinical experience in hand surgery through documentation of twenty-five (25) hand cases within the previous twenty-four (24) months;<br>2. If hand fellowship was completed more than | Two (2) cases from this category | Ten (10) cases from this category |

| ~~Orthopedic Surgeon Privileges~~ (5/15) | | | |
|---|---|---|---|
| **~~Privileges~~** | **~~Initial Appointment~~** | **~~Proctoring~~** | **~~Reappointment (every 2 years)~~** |
| | ~~twenty-four (24) months prior to application, documentation of twenty-five (25) hand cases from the previous twenty-four (24) months is required.~~ | | |
| **~~Spine Surgery:~~**<br>• ~~Assessment of the neurologic function of the spinal cord and nerve roots~~<br>• ~~Cervical Discectomy~~<br>• ~~Closed reduction of fractures and dislocations of the spine~~<br>• ~~Interpretation of imaging studies of the spine~~<br>• ~~Laminectomy~~<br>• ~~Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and rheumatologic disorders of the spine~~<br>• ~~Open reduction of internal/external fixation of fractures and dislocations of the spine (includes pedicle screws, plating, cages)~~<br>**~~Spinal Arthrodesis:~~**<br>• ~~Cervical~~<br>• ~~Lumbar~~<br>• ~~Thoracic~~ | ~~1. Successful completion of spine fellowship; **or** successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery **and** demonstrate significant clinical experience in spine surgery through documentation of twenty-five (25) spine cases within the previous twenty-four (24) months;~~<br>~~2. If spine fellowship was completed more than twenty-four (24) months prior to application, documentation of twenty-five (25) spine cases from the previous twenty-four (24) months is required.~~ | ~~Two (2) cases from this category~~ | ~~Ten (10) cases from this category~~ |
| ~~Peripheral nerve surgery~~ | ~~1. Basic Orthopedic Surgery Privileges~~<br>~~2. Documentation of ten (10) cases in the previous twenty-four (24) months.~~ | ~~Two (2) cases~~ | ~~Ten (10) cases~~ |
| ~~Vertebral Augmentation~~ | ~~Per Medical Staff Policy 8710-534~~ | | |
| **~~Blue Belt Navio PFS (BBN) guided knee arthroplasty~~** | ~~The surgeon must be currently privileged to perform underlying procedure without BBN guidance, AND have one of the following:~~ | | ~~Four (4) cases~~ |

**Orthopedic Surgeon Privileges** (5/15)

| Privileges | Initial Appointment | Proctoring | Reappointment (every 2 years) |
|---|---|---|---|
| | a. Documentation of training in residency/fellowship and log of ten (10) cases; OR<br><br>b. Certificate of completion of BBN or comparable hands-on training program and documentation of ten (10) cases beyond proctoring from another institution; OR<br><br>c. Certificate of completion of BBN or comparable hands-on training program. | a. One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician.<br><br>b. One (1) cases concurrently proctored by a BBN credentialed/ experienced/ faculty physician.<br><br>c. Three (3) cases concurrently proctored by BBN credentialed/ experienced/ faculty physician. | |
| Assisting at Blue Belt Navio PFS (BBN) guided knee arthroplasty | One of the following:<br>a. Currently privileged to perform BBN-guided knee arthroplasty; OR<br>b. Currently privileged to assist in surgery AND documentation of completion of BBN or comparable hands-on training program. | One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician. If the assistant is privileged to perform BBN-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional | Four (4) cases |

| ~~Orthopedic Surgeon Privileges~~ (5/15) | | | |
|---|---|---|---|
| ~~Privileges~~ | ~~Initial Appointment~~ | ~~Proctoring~~ | ~~Reappointment (every 2 years)~~ |
| | | ~~proctoring is required in the assistant role.~~ | |
| ~~Laser privileges:~~<br>• ~~CO2~~<br>• ~~KTP~~<br>• ~~Argon~~ | ~~Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.~~ | ~~One (1) case for each energy source~~ | ~~Two (2) cases~~ |
| ~~Mazor Surgery:~~<br>• ~~Mazor Robotic Surgery~~<br>• ~~Assist in Mazor robotic surgery~~ | ~~Per Medical Staff Credentialing Policy 8710-566~~ | | |
| ~~Moderate Sedation~~ | ~~Per Medical Staff Policy 8710-517~~ | | |
| ~~Pain Management~~ | ~~Per Medical Staff Policy 8710-541~~ | | |
| ~~**Procedures Outpatient Forensic Clinic:** (5/15)~~ | | | |
| • ~~Aspiration of joints~~<br>• ~~Casting and splinting~~<br>• ~~Closed reduction of fractures using local anesthesia~~<br>• ~~Foreign Body Removal~~<br>• ~~Implant removal, small (i.e. K-wires)~~<br>• ~~Injections into joints or tendon sheaths~~<br>• ~~Minor I&D abscess or hematoma~~<br>• ~~Repair lacerations~~<br>• ~~Soft Tissue Management (Debridement)~~ | ~~As required for Basic Orthopedic Surgery Category privileges~~ | ~~Proctoring complete when released from specialty-specific proctoring~~ | ~~N/A~~ |

~~* Indicates privileges required for participation on the Orthopedic ED-Call Schedule.~~ (5/15)

IX. **ALLIED HEALTH PROFESSIONALS** See Allied Health Professionals Rules & Regulations ~~(5/15)~~1/17)

A. Physician Supervisor for Physician Assistants

1. A Physician Assistant 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.
2. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

3. 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.
4. A physician assistant may not admit or discharge patients.

| ~~Physician Assistant Privileges (5/15)~~ | | | |
|---|---|---|---|
| ~~**Privileges**~~ | ~~**Initial Appointment**~~ | ~~**Proctoring**~~ | ~~**Reappointment (every 2 years)**~~ |
| ~~A physician assistant may also act as first or second assistant in surgery, under supervision of an approved supervising physician.~~ | ~~Per AHP Rules and Regulations~~ | ~~Per AHP Rules and Regulations~~ | ~~Fifty (50) cases~~ |
| ~~Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician.~~ | | | |
| ~~Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.~~ | | | |
| ~~Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.~~ | | | |
| ~~Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.~~ | | | |
| ~~Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.~~ | | | |
| ~~Initiate arrangements for admissions, complete forms and~~ | | | |

| ~~Physician Assistant Privileges (5/15)~~ | | | |
|---|---|---|---|
| **~~Privileges~~** | **~~Initial Appointment~~** | **~~Proctoring~~** | **~~Reappointment (every 2 years)~~** |
| ~~charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.~~ | | | |
| ~~Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.~~ | | | |
| ~~Order and administer medications. A physician assistant may not administer, provide or transmit a prescription for controlled substances in schedules II through V without patient-specific authority by a supervising physician. A physician assistant may not order chemotherapy agents.~~ | | | |
| ~~Assist in Mazor robotic surgery~~ | ~~Per Medical Staff Credentialing Policy 8710-566~~ | | |

B. Orthopedic Surgery Technician – ~~As outlined in the privilege table below. (5/15)~~See Orthopedic Surgery Technician privilege card. (1/17)

| ~~Orthopedic Surgery Technician Privileges (5/15)~~ | | | |
|---|---|---|---|
| **~~Privileges~~** | **~~Initial Appointment~~** | **~~Proctoring~~** | **~~Reappointment (every 2 years)~~** |
| ~~Intraoperative Retractions:~~<br>~~• Retract Tissue or organs by use of hand~~<br>~~• Place or hold surgical retractors~~<br>~~• Pack sponges into body cavity to hold tissues or organs out of the operative field~~<br>~~• Manage all instruments in the operative field~~ | ~~Per AHP Rules and Regulations~~ | ~~Per AHP Rules and Regulations~~ | ~~Fifty (50) cases~~ |

| | | | |
|---|---|---|---|
| ~~Intraoperative Homeostasis:~~<br>• ~~Aspiration of blood and other fluids from the operative site~~<br>• ~~Sponge wounds or other areas of dissection~~<br>• ~~Clamp bleeding tissues or vessels~~<br>• ~~Cauterize and approximate tissue~~<br>• ~~Place hemoclip or ligating sutures on vessels or tissue~~<br>• ~~Connect drainage~~ | | | |
| ~~Intraoperative Wound Closure:~~<br>• ~~Apply surgical dressing~~<br>• ~~Care and removal of drains~~ | | | |
| ~~Other:~~<br>• ~~Assist with applying casts, braces, or plaster splints~~ | | | |

X. **PROCTORING OF PRIVILEGES** ~~(5/15)~~1/17)

A. Each new Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor with current unrestricted privileges as indicated until his or her privilege status is established by a recommendation from the Division Chief to Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. The member is responsible for arranging a proctor.

C. All Active members of the Division will act as proctors. ~~An associate~~ One or all of the associates of the physician being proctored may monitor up to a total of 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.

~~D.~~ Supervision of the member by the proctor will include concurrent review for invasive cases and direct observation of procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence. ~~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 DOUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.~~

~~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.~~ The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

~~G.~~ 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 at the front desk in the O.R. or at the Medical Staff Department and provided to the proctor for completion~~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 member to notify the Operating Room ~~Supervisor~~ personnel 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~~Department.

XI. **EMERGENCY DEPARTMENT CALL** (5/15)

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy #8710-520.

B. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. For future different orthopedic problems, there is no obligation on the part of the physician to provide care.

C. Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.

**APPROVALS:**

| | |
| --- | --- |
| Division of Orthopedic Surgery: | 3/2/15 |
| Department of Surgery: | 4/15/15 |
| Medical Executive Committee: | 4/27/15 |
| Governance Committee: | 5/05/15 |
| Board of Directors: | 5/28/15 |

I. **MEMBERSHIP**

A. The Department of Obstetrics and Gynecology consists of physicians who are board certified or actively progressing towards certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-accredited residency training program in Obstetrics and Gynecology.

B. Any member of the Department of Obstetrics and Gynecology who was Board Eligible when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification within thirty-six (36) months of his/her appointment to the Medical Staff.

II. **GENERAL FUNCTION**

The general functions of the Department of Obstetrics and Gynecology 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 Department 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 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 Committee and Medical Executive Committee concerning:
   1. Department 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 Department 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 Obstetrics and Gynecology shall meet at the discretion of the Chair, but at least quarterly. The Department 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 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 Chair and Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department.

B. The Department Chair and Vice-Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair and Vice-Chair shall be elected by a simple majority of the members of the Department. Vacancies of any officer for any reason shall be filled for the un-expired term through a special election.

C. The Department Chair and Vice-Chair 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 Department. Department officers shall be eligible to succeed themselves.

## V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair, and the Vice-Chair, in the absence of the Chair, shall assume the following responsibilities:

1. Be accountable for all professional and administrative activities of the Department;
2. Continue surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department.
5. Recommend clinical privileges for each member of the Department.
6. Assure that the quality, safety, and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Assume other duties as recommended from the Medical Executive Committee.

## VI. CLASSIFICATIONS

### A. PHYSICIAN

1. Members of Department of Obstetrics and Gynecology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. Such physicians may act as consultants to others and may, in turn, be expected to request consultation 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 with which they are not familiar.

### B. PHYSICIAN ASSISTANT (PA)

1. Physician Assistants may only provide those medical services for which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant, and as privileges granted.
   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, (e.g., surgical assisting).
c. A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures as delegated to the physician assistant until assured of 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. Refer to the AHP rules and regulations for further delineation of sponsoring physician's supervision requirements.
f. A physician assistant may not admit or discharge patients.

2. The Department of Obstetrics and Gynecology requires a physician co-signature as delineated in the AHPs Rules and Regulations.

C. **REGISTERED NURSE FIRST ASSISTANT (RNFA)**

1. A registered nurse first assistant is a healthcare provider who, under the supervision of a physician, performs a variety of pre, intra, and postoperative services for patients undergoing a surgical procedure in the surgical suites. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks in accordance with privileges granted. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. The RN first assistant functions under standardized procedures and must adhere to the AHP's rules and regulations.

D. **CERTIFIED NURSE MIDWIFE (CNM)**

1. The midwife (CNM), a dependent allied health professional (AHP), functions under standardized procedures and must adhere to the AHPs rules and regulations. Refer to CNM standardized procedures for specific criteria.

VII. **PRIVILEGES**

A. The Department of Obstetrics and Gynecology will define privilege criteria requirements on the privilege card. Recommendations for privileges are made to the Department, Credentials Committee, Medical Executive Committee, and Governing Board.
B. All privilege cards are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
C. By virtue of their training and experience all practitioners with Obstetrical privileges are considered competent and able to perform FERN testing and other associated testing within their scope of practice, or for any emergency procedure, which, in the physician's judgment, is deemed indicated.
D. 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.
E. The categories and applicable privileges are as follows:
   1. Obstetrical
   2. Gynecological
   3. Maternal-Fetal Medicine
   4. Gynecological-Oncology

F. Members of Department of Obstetrics and Gynecology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

d. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.

e. Unexpected complications arise which are outside this level of competence.

f. Specialized treatment or procedures are contemplated with which they are not familiar.

VIII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

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).

IX. **PROCTORING**

A. Each new 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 Department to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. An associate may proctor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the proctored 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. 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. 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 Department Chair 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.

X. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

A. The Department of OB/GYN will have a Quality Review Committee (Q.R.C.) compromised of no less than four (4) department members. The committee Chairman is the department's representative to the Medical Staff QA/PI Committee. The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members are able to succeed themselves. At least one (1) member from each OB/GYN "group" will be on the Q.R.C. if possible. The Q.R.C. will meet at least four (4) times per year.

B. General Function:

1. The Q.R.C. provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members to OB/GYN patients in the hospital.

C. Specific Functions. The Q.R.C. is established to:
1. Identify important elements of OB/GYN care in all areas in which it is provided.
2. Establish performance monitoring indicators and standards that are related to these elements of care.
3. Select and approve their performance monitoring indicators.
4. Integrate relevant information for these indicators and review them quarterly.
5. Formulate thresholds for evaluation related to these performance monitoring indicators.
6. Review and evaluate physician practice when specific thresholds are triggered.
7. Identify areas of concern and opportunities to improve care and safety, and provide education to department members based on these reviews.
8. Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member in accordance with Medical Staff Bylaws.
9. If needed, request Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice.
10. 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 OB/GYN that are forwarded for review by other departments.
3. Assist in the collection, organization, review, and presentation of data related to OB/GYN care, safety, and department clinical pathways.
4. Review cases involving any OB/GYN deaths in the hospital.

E. Reports:
1. Minutes are submitted to the Medical Staff QA/PI Committee and the M.E.C. The Q.R.C. will provide minutes and, as needed, verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to the department members and to QA/PI Committee.

## XI. EMERGENCY ROOM CALL

A. Medical Staff Department members within the Department of OB/GYN may participate in the Emergency Department call roster or consultation panel as determined by the medical staff or Department Chair or their designee who:
1. Have been successfully removed from proctoring for Obstetrical Category Privileges, and
2. Have had one (1) Laparoscopic case and one (1) Abdominal Hysterectomy case proctored. This does not preclude complying with proctoring requirements as outlined above.

B. Refer to Medical Staff Policy, #8710-520 Emergency Room Call: Duties of the On-Call Physician.

C. When a patient indicates that she has been previously treated by a staff member, that member will be given the opportunity to provide further care.

D. When a patient presents to the Emergency Department and advises that they are under the care of a community clinic. The community clinic OB physician on call must see any patient, including obstetrical patients, who is under 13 weeks pregnant and who has been seen within the past two years by a primary care provider of that clinic, with the exception of vaccination clinics. Any obstetrical patients greater than 13 weeks with the above-referenced criteria are unassigned patients and will be cared for by the on-call OB/GYN for unassigned patients.

E. The members of the Department of OB/GYN will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, any necessary emergency special care will be provided by the on-call physician.

F. The care provided by an on-call physician will not create an obligation to provide further care.

~~G. The exception to the aforementioned Emergency Department On-Call requirements is North County Health Services call panel.~~

**Approvals:**

| | |
| --- | --- |
| Department of Ob/Gyn: | 10/6/14; 10/16 |
| Medical Executive Committee: | 11/16 |
| Board of Directors: | 12/16 |

I. **DEFINITIONS:**

A. Allied Health Practitioner (AHP) means a health care professional, other than a physician, dentist or podiatrist, who holds a license or other legal credential, as required by California law, to provide certain professional services and who, pursuant to the terms of the Medical Staff Bylaws, are not eligible for Medical Staff membership, but have been granted clinical privileges to provide certain clinical services.

B. Clinical Privileges (or Privileges) means the permission granted to an AHP to provide specified patient care services within his or her qualifications and scope of practice.

II. **QUALIFICATIONS:**

A. An AHP is eligible for clinical privileges at Tri-City Medical Center (TCMC) if he or she:

1. Holds a license, certificate, or other legal credential in a category of AHPs which the Board of Directors has identified as eligible to apply for clinical privileges; and

2. Meets the qualifications described in these Rules and Regulations; and

~~2.~~3. Documents his or her education, experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the Medical Staff; and

~~3.~~4. Is determined, on the basis of documented references to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and

~~4.~~5. Agrees to comply with all Medical Staff and Department and Division bylaws, rules and regulations, policies and procedures, and protocols to the extent applicable to the AHP; and

~~5.~~6. Maintains professional liability insurance, or is covered by the terms of their employer's insurance, with an insurer meeting the requirements specified in Medical Staff Policy 8710-558 (Liability Insurance Requirements), with minimum limits in the amount of $1 million per occurrence and $3 million per aggregate.

~~6.~~7. More specific qualifications may be established by Departments and/or Divisions as stated in their respective rules and regulations and/or other privileging documents.

III. **CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR CLINICAL PRIVILEGES:**

A. The following categories of Allied Health Professionals have been approved by the Board of Directors:

1. Audiologist

~~2. Behavioral Optometrist~~

~~2.~~3. Certified Nurse Midwife

~~3.~~4. Clinical Psychologist

~~4.1~~ ~~Clinical Research Coordinator~~

~~4.~~5. Marriage and Family Therapist Intern

~~5.~~6. Medical Physicist/Radiation Physicist

~~8.7.~~ ~~Neurophysiologist (Evoked Potential)~~
~~9.8.~~ Nurse Practitioner
~~10.9.~~ Orthopedic Surgery Technician
~~11.10.~~ Physician Assistant
~~12.11.~~ Registered Nurse First Assist

B. The Board of Directors shall review the designation of categories at least annually and at other times, within its discretion or upon the recommendation of the Medical Executive Committee (MEC).

IV. **PROCEDURE FOR GRANTING CLINICAL PRIVILEGES:**

A. An AHP whose scope of practice allows independent practice must apply and qualify for clinical privileges and, at the time patient care services are rendered, must designate a physician member of the active medical staff who is responsible, to the extent necessary, for the general medical condition of the patient for whom the AHP proposes to render services in the hospital. This provision currently only applies to clinical psychologists. Each AHP who practices independently must maintain communication with the relevant physician in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient.

B. An AHP whose scope of practice does not allow independent practice must apply and qualify for clinical privileges and must provide services under the supervision of an active Medical Staff member. An AHP under this subsection may apply to work under the supervision of one active Medical Staff member or a group of medical staff members. Such supervision must be in strict accordance with any hospital-developed standardized procedures and with any rules and regulations or other policies developed by the appropriate department/division and approved by the MEC, and does not replace any supervision requirements mandated under state law.

C. All AHP applications for initial granting and renewal of clinical privileges shall be submitted to the Interdisciplinary Practice Committee (IDPC). All such applications shall be processed in a parallel manner to that provided in Articles IV (Membership and Membership Renewal) and V (Clinical Privileges) of the Medical Staff Bylaws, except that the Interdisciplinary Practice Committee shall review all AHP applications prior to the Credentials Committee ~~and the MEC~~review, and except that any reference in the Bylaws to hearing rights shall not apply to any AHP except clinical psychologists.

D. AHPs shall not practice within the hospital until requested privileges have been granted. Temporary privileges may be granted. Granting of temporary privileges shall follow a similar process as prescribed by the Medical Staff Bylaws, Section 5.5 and in Medical Staff Policy 8710-515 (Temporary Privileges).

E. Except as is provided below, ~~under Section VIII.A.4.a., a~~an AHP who (a) has received a final adverse decision regarding his or her application for clinical privileges, ~~or~~ (b) withdrew his or her application for clinical privileges following an adverse recommendation by the IDPC or MEC, ~~or~~ (c) after having been granted clinical privileges, has received a final adverse decision resulting in termination of clinical privileges or (d) has relinquished his or her clinical privileges following the issuance of a ~~Medical Staff~~IDPC, MEC, or Board of Directors recommendation adverse to his or her clinical privileges, shall not be eligible to reapply for clinical

privileges affected by such decision or recommendation for a period of at least ~~six (6)~~18 months from the date the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her clinical privileges. An AHP who reapplies after the waiting period must provide evidence demonstrating to the Medical Staff's satisfaction that the factors that led to the adverse recommendations or actions have been resolved. The waiting period described in this Section shall not apply to an AHP whose application was deemed withdrawn as incomplete, whose application was denied for failing to meet the Specific Credentialing Criteria found in Section XIV, or whose privileges were automatically terminated under Section IX.

F. AHP categories identified as eligible for clinical privileges are identified above. Practitioners who are not in one of those categories ~~All other categories~~ may not apply for clinical privileges, but may submit a written request to the IDPC, requesting that the Medical Staff and the Board of Directors ~~to~~ consider adding an additional category of AHPs eligible to apply for clinical privileges.

1. Upon receipt of such a request, the IDPC shall obtain the recommendation of any affected department or division in order to determine if there is a need for an additional category of AHP and shall forward the recommendation from the respective department or division to the Credentials Committee. The recommendation of the Credentials Committee is then forwarded on to the MEC.
2. The MEC makes the final recommendation to the Board of Directors. The Board of Directors shall consider the recommendation of the MEC, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHPs. If the requested category of AHP fulfills a patient service need as identified by the Board of Directors, the category will be added to the recognized categories of AHP.
3. Once added, the appropriate department/division, IDPC and Credentials Committee (as appropriate), and MEC shall establish clinical privilege requirements, scope of service, and monitoring mechanisms. After approval by the Board of Directors of these requirements, the AHP may apply for clinical privileges.

G. Each AHP who is granted clinical privileges shall be assigned to the department/division appropriate to his or her occupational or professional training. Although AHPs may not be Medical Staff members, they shall, ~~and,~~ unless otherwise specified in these rules and regulations, ~~shall~~ be subject to the ~~terms and conditions~~Basic Responsibilities of Medical Staff Membership and the prohibition against harassment ~~that parallel those~~ specified in Article II (Membership) of the Medical Staff Bylaws, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. In addition, each AHP must adhere to the terms and conditions as delineated in their delegation of services agreement, standardized procedures, protocols, job description, and clinical privileges.

H. If a service provided by a category ~~(ies)~~ of AHP is no longer a service that is being provided by TCMC, the category ~~(ies)~~ may be eliminated without affording the process described in section VIII~~.A~~ of these rules and regulations ~~by~~ to those ~~categories~~ AHPs affected.

V. **PREROGATIVES:**

A. The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the applicable privilege/prerogatives cards reviewed by the Department/Division Chief and the IDPC, and approved by the Medical Executive Committee ~~Medical Staff or applicable Department/Division rules and regulations~~. Such prerogatives may include:

1. Provision of specified patient care services consistent with clinical privileges granted to the AHP and within the scope of the AHP's licensure or certification.
2. Service on Medical Staff and hospital committees except as otherwise expressly provided in the Medical Staff bylaws, rules and regulations. An AHP may not serve as chair of Medical Staff committees.
3. Attendance at meetings of the Department/Division to which he or she is assigned, as permitted by the department/division rules and regulations, and attendance at Medical Staff educational programs in his or her field of practice. An AHP may not vote at department/division meetings.

B. AHPs may not:

1. Admit or discharge patients from the hospital ~~without consultation with physician~~.
2. Give orders, verbal or written, unless they are authorized by the Medical Staff and unless it is within the AHP's scope of licensure.
3. Give telephone orders.
4. Act as a first assistant at any surgical, diagnostic or therapeutic procedure for which the Medical Staff requires the presence of an assisting physician.
5. Inhibit or in any way interfere with the responsibilities of employees of the hospital.

VI. **RESPONSIBILITIES:**

A. Each AHP shall:

1. Meet those responsibilities required by the Medical Staff bylaws, rules and regulations, policies and procedures and TCMC policies and procedures.
2. Retain appropriate responsibility within his/her area of professional competence for the care of each patient in the hospital for whom he/she is providing services.
3. Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his/her same occupation or profession or of an occupation or profession ~~which is governed by~~which has a more limited scope of practice ~~statute~~, and in discharging such other functions as may be required by the Medical Staff from time to time.
4. Prepare and complete, in a timely manner, any documentation relevant to patient care provided.
5. Abide by the ethical and moral principles of their respective profession.

VII. **DEFINITION OF PHYSICIAN SUPERVISION:**

A. Level of Physician Supervision - ~~As defined by the individual category of AHP's scope of practice.~~

1. Each AHP shall be supervised by their supervising physician(s) in a manner consistent with the requirements of the California scope of practice statutes and regulations, as well as in a manner consistent with these Rules and Regulations, the Medical Staff Bylaws, and the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures.
2. Each supervising physician must sign a medical staff-developed form acknowledging his or her responsibilities as a supervising physician.
3. ~~Available~~: Each supervising ~~Physician~~ physician must be available ~~within thirty (30) minutes travel time~~ in the manner detailed by the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures,
4. The supervising physician shall ~~and~~ always be available by electronic communication whenever the AHP he or she is supervising is practicing at the hospital.
5. The following additional supervision requirements apply to the following units and situations:
   ~~2.~~ i. Medical/Surgical Units: Documentation of an examination of the patient by the supervising physician(s) every third day if care is given by the AHP.
   ~~3.~~ ii. ICU/Telemetry Units: Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.
   ~~4.~~ ii. ~~ED & Imaging: The supervision of AHPs by their supervising physician(s) is delineated in the "Delegation of Service Agreement" incorporated in each credential file of the AHP.~~
   ~~5.~~ iii. Non-Scheduled Admission(s): Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.

B. Podiatrists may not supervise physician assistants unless the ~~Podiatrist~~ podiatrist also holds a M.D. or a D.O. license.

C. Physician Co-signature:
1. Order(s) ~~and telephone order(s)~~, verbal or written, may be immediately implemented. ~~and p~~Physician co-signature is required within ~~24~~ 48 hours of AHP's order~~.~~ excluding those covered under an already approved standardized procedure.
2. Any medical record of any patient cared for by an AHP 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~~ 48 hours.
3. The H&P must be co-signed by the supervising physician(s) within ~~24~~ 48 hours.
4. The supervising physician must review and authenticate any progress note within the medical record of any patient(s) documented by an AHP within ~~24~~ 48 hours.

D. Each time an AHP provides care for a patient and enters his/her name, signature, initials, or computer code on a patient's record, chart, or order, the AHP must also enter the name of his/her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he/she must also

state the name of the supervising physician responsible for the patient (16 C.C.R. §1399.546.)

VIII. **TERMINATION, SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES:**

A. ~~GENERAL~~ **PROCEDURES FOR AHPS WHO ARE NOT NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANT**

~~1.~~

1. For the purposes of Section VIII.A. only, the term "AHP" applies only to those professionals who are not nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistant.

2. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the MEC that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the Board of Directors. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

3. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP, other than a clinical psychologist, to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) by filing a written ~~grievance~~ objection (i.e., a letter objecting to the recommended action and requesting an interview) with the MEC within fifteen (15) days of receipt of the Notification Letter. Upon receipt of an ~~grievance~~objection, the MEC or its designee shall afford the AHP an opportunity for an interview concerning the ~~grievance~~objection. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. The MEC shall have sole discretion in determining what evidence may be permitted and how it may be presented. Minutes of the interview shall be retained.

4. Within fifteen (15) days following the interview, the MEC, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may, in its discretion, offer the affected practitioner the right to ~~appeal to the Board or a subcommittee thereof~~discuss the recommendation with the Board or with a

subcommittee of the Board, in a manner and at a time determined by the Board. The Board of Directors shall adopt the MEC's recommendation, so long as it is reasonable and, appropriate under the circumstances. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be promptly provided with notice of the final action, sent by certified mail.

5.

**GENERAL PROCEDURES FOR AHPS WHO ARE NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANTS:**

7.

1. AHPs who are nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistants shall be entitled to the AHP limited-hearing procedures detailed below:

**Purpose**

This Appendix A to the Allied Health Practitioner Rules and Regulations provides the process by which certain Allied Health Practitioners subject to the Allied Health Practitioner Rules and Regulations of the Tri-City Medical Center Medical Staff can challenge adverse actions or adverse recommendations against their practice privileges.

**Scope/Coverage**

This policy applies only to nurse practitioners (NP), certified nurse midwifes (CNM), certified registered nurse anesthetists (CRNA), registered nurse first assists (RNFA), and physician assistants (PA).

**Definitions**

1. **Adverse Action and Adverse Recommendation** mean actions and recommendations, respectively, that constitute grounds for a hearing, as described in the AHP Rules and Regulations.

2. **Allied Health Practitioner (AHP)** for the purposes of this Appendix, means only NPs, CNMs, RNFAs, CRNAs, and PAs.

3. **Limited Hearing** means the process by which AHPs may challenge an adverse action or an adverse recommendation, and is not a hearing that is described in the Medical Staff Bylaws.

**Policy**

Nothing contained in the Medical Staff Bylaws or this Appendix shall be interpreted to entitle an AHP covered by the scope of this Appendix to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP covered by the scope of this Appendix shall have the right to challenge any recommendation which would

constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) as set forth here.

**Procedure**

1. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the Medical Executive Committee (MEC) that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend corrective action and send a Notification Letter to the AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

2. An AHP may request a limited hearing by filing a written objection (i.e., a letter objecting to the recommended action and requesting review) MEC no later than 15 days after receipt of a Notification Letter. Failure to submit a letter within 15 days shall result in a waiver of the right to a limited hearing.

3. Upon receiving the request, the MEC shall make arrangements to convene a limited hearing. The limited hearing shall not constitute a Medical Staff hearing as established in the Hearings and Appellate Review Article of the Bylaws and need not be conducted according to the procedural rules applicable to such hearings.

4. The parties to the limited hearing shall be the MEC and the AHP subject to the adverse recommendation or action. The MEC may select an individual to serve as its representative at the limited hearing; however, that person shall not be an attorney.

5. The Chief of Staff shall appoint at least three unbiased Medical Staff members or AHPs, or a combination of the two, who are in good standing and of good ethics, along with the appointment of at least one member to serve as an alternate, to serve on a review committee. Such appointment shall include designation of the chair. When feasible, at least one member shall hold the same type of license as the AHP party. The review committee members shall gain no direct financial benefit from the outcome of the limited hearing, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude an individual from serving as a member of the review committee. Employers, supervisors, or co-workers of the AHP are not eligible to serve on the review committee.

6. The Chief of Staff may appoint a hearing officer, who shall have the same qualifications described for hearing officers in the Medical Staff Bylaws.

7. The chair of the review committee or hearing officer, if any, shall schedule the limited hearing, with the goal to for the limited hearing to occur no sooner than 30 days, and no later than 60 days, of the request for limited hearing.

8. No later than 20 days prior to the limited hearing, each party shall submit to the review committee a written statement of the party's own position. The written statement should be supported by proposed evidence, which may include, but is not limited to, declarations from witnesses and relevant portions of medical records. Each party must supply a copy of its written statement and the proposed supporting evidence to the other party. No later than 10 days before the limited hearing, each party may submit a rebuttal to the other party's written statement, with proposed supporting evidence. Each party must supply a copy of its rebuttal and proposed supporting evidence to the other party. The hearing officer, or if none is appointed, the review committee, may impose limits as to the length of the written submissions, and decides whether proposed evidence shall be included in the record of the limited hearing proceedings. An AHP applicant shall not be permitted to introduce information requested by the Medical Staff, but not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9. At the limited hearing, each party may make an oral argument addressing the issues raised by the adverse action or recommendation; however, neither party shall present evidence during the limited hearing that had not been presented with the written statement or rebuttal or that had been rejected by the hearing officer or review committee. The Hearing Officer or, if none appointed, the chair may impose appropriate time limits to the oral statements and to the limited hearing as a whole. The review committee may interview or question either party and may invite witnesses to attend the limited hearing in order to be questioned by the committee. No party may question a witness directly, though the parties may submit questions to the chair, which the chair, in his or her discretion, may ask the witness. Neither party may be represented by an attorney at the limited hearing. Minutes of the limited hearing shall be retained.

10. At the conclusion of the limited hearing, the review committee shall meet and deliberate. If a preponderance of the evidence supports the adverse action or recommendation, then the review committee shall recommend to the MEC that it be upheld. An AHP applicant shall bear the burden of persuading the review committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges.

11. Within seven days of the review committee's deliberations, the committee shall submit a written decision to the parties and to the MEC regarding its

recommendation, including facts and conclusions supporting the recommendation.

12. Within 14 days following receipt of the decision, the MEC will consider the review committee's decision and make a final recommendation to the Board of Directors. The MEC, in its discretion, may adopt the review committee's decision as its own, or may modify or reject the recommendation. The MEC shall deliver to each party a copy of its recommendation.

13. AHP shall have the right to appeal the MEC's recommendation to the Board of Directors.

14. The affected AHP shall be informed in writing of his or her right to appeal the final recommendation. The affected AHP shall have ten (10) days after being informed of his or her right to appeal to request an appeal review. The request for appeal shall state with specificity the basis for the appeal.

15. The appeal review shall be conducted within thirty (30) days of the request. The parties to the appeal shall be the MEC and the AHP.

16. Each party shall have the right to present a written statement in support of his, her or its position on appeal. The Board of Directors Chair shall appoint an Appeal Board of up to three people, including at least one Board member. Each party may submit a written statement in support of its position to the Appeal Board within thirty (30) days of the Board's acceptance of the appeal. No party has the right to personally appear and make oral argument, though the Appeal Board, in its discretion, may allow oral argument by both parties. In such cases, neither party shall have the right to representation by counsel at oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

The Appeal Board shall issue written recommendations to the Board of Directors within fifteen (15) days of the conclusion of the appellate review. The Board of Directors shall issue a final decision at its next regular meeting, which shall be delivered to the parties by hand delivery, courier delivery service with confirmed delivery (such as Federal Express or UPS), or certified mail.

~~9.~~

**SUMMARY SUSPENSION:**

Notwithstanding any other provision in Section VIII~~.A.1~~, an AHP's clinical privileges may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the Chief of Staff, the MEC, or the Chair/Chief of the Department/Division to which the AHP has been assigned (or

his/her designee). Unless otherwise stated, the summary action shall become effective immediately upon imposition and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the MEC, and the Chief Executive Officer. The notice shall also inform the practitioner of his or her right to file an ~~grievance~~objection if the suspension is imposed for more than 14 days. The practitioner's right to file an ~~grievance~~objection and subsequent interview procedures shall be in accordance with Section VIII.A and B, except that all reasonable efforts shall be made to ensure that the practitioner is given an interview or limited-hearing as expeditiously as possible and that final action is taken within (15) days or as promptly thereafter as practicable.

ii. Within three (3) working days of the summary action, the affected practitioner shall be provided with written notice of the action. The notice shall include the reason(s) for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.

iii. Within five (5) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the MEC as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within eight (8) days following the imposition of the action, the MEC shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee. Within two (2) working days following the MEC's meeting, the MEC shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

## IX. AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION:

A. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges may be subject to automatic suspension or termination as set forth in this Section IX.

B. ~~Notwithstanding subsection VIII.A, above, a~~An AHP's clinical privileges shall be subject to automatic suspension in the event that:

1. the AHP's license or other legal credential expires. The automatic suspension will continue until proof of renewal is received.
2. With respect to an AHP who must have a physician supervisor:
   i. The medical staff membership or privileges of the supervising physician is terminated, whether such termination is voluntary or involuntary; or
   ii. The supervising physician no longer agrees to act in such capacity, or
   iii. The relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason.

   ~~A.~~ In any of these cases, the automatic suspension will be lifted if the AHP finds a supervising physician within 30 days of the suspension being imposed.

3. The AHP fails maintain professional liability insurance, if any is required.
4. The AHP fails to complete medical records as required by policy and procedure.
5. The AHP fails to provide documentation of Tuberculin testing in accordance with applicable medical staff policy.

6. If the AHP's DEA certificate is revoked, limited or suspended, the AHP shall automatically and correspondingly be suspended of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
7. The AHP fails, without good cause, to appear at a meeting called by the AHP's department chair or section chief or a medical staff committee or officer to discuss a suspected deviation from standard clinical practice, if the AHP has been given at least seven days' written notice of such meeting.

B.C. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges shall automatically terminate in the event that:

1. The AHP's privileges have been automatically suspended for more than 30 continuous days.
2. The AHP's certification, license, or other legal credential is not renewed, is revoked, or is suspended.

~~1.~~

~~2. With respect to an AHP who must practice under physician supervision:~~

~~i The medical staff membership or privileges of the supervising physician is terminated, whether such termination is voluntary or involuntary; or~~

~~ii The supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;~~

~~3. When the AHP's clinical privileges are automatically terminated for reasons specified in (2.a) or (2.b) above, the AHP may apply for reinstatement as soon as the AHP has found another physician member of the active medical staff who agrees to supervise the AHP.~~

C.D. ~~Notwithstanding subsection IX above, i~~In the event that the AHP's certification, ~~or~~ license, or DEA certification is restricted or made the subject of an order of probation, the AHP's corresponding clinical privileges shall automatically be subject to the same restrictions or conditions of probation.

E. Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection VIII.~~A~~ shall not apply and the AHP shall have no right to an interview. The MEC, within its discretion, may, upon the AHP's request, invite the AHP to a meeting to discuss ~~except, within the discretion of the MEC, regarding~~ any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist. Such a meeting shall not be a hearing under the Medical Staff Bylaws or an interview or AHP limited-hearing under Section VIII, above.

~~D.~~

X. **APPLICABILITY OF SECTION VIII:**

A. The rights afforded by Section VIII shall not apply to any decision regarding whether a category of AHP shall be eligible for clinical privileges ~~and~~ or the terms or conditions of such decision.

XI. **REAPPLICATION:**

A. Initial and renewal of clinical privileges shall be for a period of up to two years. Each AHP must reapply for renewed clinical privileges in accordance with Section IV.

XII. **ON-GOING PROFESSIONAL PRACTICE EVALUATION (OPPE):**

A. AHPs are subject to the provisions of the Medical Staff's OPPE process outlined in Medical Staff Policy 8710-509.

XIII. **FOCUS PROFESSIONAL PRACTICE EVALUATION (FPPE)/PROCTORING:**

A. AHPs are subject to the provisions of the Medical Staff's FPPE process outlined in Medical Staff Policy 8710-542 and the applicable Department/Division Rules and Regulations.

B. ~~Unless otherwise~~In addition to what is specified in the applicable Department/Division Rules and Regulations, all AHPs shall be proctored (i.e., initial FPPE) for a minimum of six (6) cases of patient contact.

XIV. **SPECIFIC CREDENTIALING CRITERIA** (in addition to documentation of current competence in scope of privileges and other documentation as requested in accordance with Medical Staff Bylaws and applicable Department/Division requirements):

A. Audiologist:

1. Current, valid Audiologist license issued by the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
2. Masters or doctorate degree in audiology (AuD)
3. Documentation of participation in relevant continuing education activities.

~~B. Behavioral Optometrist:~~

~~1. Current, valid Optometrist license issued by the California State Board of Optometry~~

~~2. Doctorate of Optometry (OD)~~

~~3. Documentation of participation in relevant continuing education activities.~~

~~4. BLS, CPR, or ACLS~~

B. Certified Nurse Midwife (CNM)

1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NM certificate issued by the California Board of Registered Nursing
3. Current Furnishing Number issued by the California Board of Registered Nursing
4. Current certification (or actively pursuing certification; must be certified within one year of initial appointment) by the American Midwifery Certification Board (formerly the ACNM Certification Council, Inc.) College of Nurse Midwives
5. Current, valid NRP certificate
6. Current, valid DEA registration
7. Documentation of participation in relevant continuing education activities.

C. Clinical Psychologist

1. PhD or PsyD degree

2. Current, valid Clinical Psychologist license issued by the California Board of Psychology
3. Documentation of participation in relevant continuing education activities.

~~E.~~D. Clinical Research Coordinator:
1. Current, valid certification by the Association of Clinical Research Professionals (ARCP) or the National Institutes of Health (NIH)
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS
4. In order to administer medications, the individual must have a current, valid RN license issued by the California Board of Registered Nursing

~~F.~~E. Marriage and Family Therapist Intern
1. Masters or doctorate in counseling psychology
2. Registered with the California Board of Behavioral Sciences as an MFT Intern
3. BLS or ACLS
4. Documentation of participation in relevant continuing education activities.

~~G.~~F. Medical Physicist/Radiation Physicist
1. Masters of Science in medical physics or physics; or PhD in related field
2. Certified by the American Board of Medical Physics, the American Board of Radiology, or in the process of obtaining certification.
3. Documentation of participation in relevant continuing education activities.

~~H.~~G. Neurophysiologist (Evoked Potential)
1. Certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRET)
2. Documentation of participation in relevant continuing education activities.

~~I.~~H. Nurse Practitioner (NP) (Non-surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

~~J.~~I. Nurse Practitioner (NP) (Surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

7. Documented completion of a formal Registered Nurse First Assistant training program.

K-J Orthopedic Surgery Technician
1. Certified by the National Board for Certification of Orthopedic Technologists
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS

L-P Physician Assistant (PA)
1. Graduate of an accredited physician assistant education program
2. Current, valid PA license issued by the California Physician Assistant ~~Committee~~ Board ~~of the Medical Board of California~~.
3. Certified by the National Commission on Certification of Physician Assistants
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

M-L Registered Nurse First Assist (RNFA)
1. Current, valid license issued by the California Board of Registered Nursing
2. Current CNOR certification
3. Documentation of successful completion an AORN-approved RNFA course
4. Documentation of participation in relevant continuing education activities.
5. ACLS

**APPROVALS:**

| | |
| --- | --- |
| Interdisciplinary Practice Committee: | ~~06/13/13~~ |
| Credentials Committee: | ~~06/12/13~~ |
| Medical Executive Committee: | ~~06/24/13~~ |
| Board of Directors: | ~~06/27/13~~ |

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #16-037**

**POLICY TITLE: Chief Executive Officer and Chief Compliance Officer Succession Planning Policy**

## I. PURPOSE:

A. The Board of Directors of Tri-City Health Care District ("TCHD" or "District") believes that the continued proper functioning of the District, the maintenance of the highest quality of patient care and the preservation of the District's financial integrity require that the District have a pre-established and orderly process for succession of the Chief Executive Officer ("CEO") and the Chief Compliance Officer ("CCO"). Therefore, it has adopted the following policy to assist the Board in the event of a vacancy in either position ("Vacancy"), as follows:

1. An immediate Vacancy, unanticipated short-term or long-term caused by the death or extended disability or incapacitation of the Chief Executive Officer or the Chief Compliance Officer.

2. An anticipated Vacancy from a long-term notice by the Chief Executive Officer or the Chief Compliance Officer.

3. An impending Vacancy that will occur within several months caused by a notice of resignation.

B. The intent of this policy is to provide clarity for the transition process, upon a Vacancy, with minimal disturbance to the performance and effectiveness of the Health Care District, subsidiaries and related organizations.

## II. PRACTICE

A. It is the responsibility of the Board of Directors in consultation with the Chief Executive Officer of the District to develop and maintain this plan, and to review the plan on an annual basis.

B. In the event of incapacitation of the Chief Executive Officer or the Chief Compliance Officer, the situation will be evaluated by the Board in consultation with the Chief of Staff of Tri-City Medical Staff to determine the need for the immediate appointment of an interim Chief Executive Officer or interim Chief Compliance Officer. For purposes of this policy, "incapacitation" means physical or mental incapacitation due to disease, illness or accident where there is reasonable cause to believe that the incumbent will not be able to perform the duties of his or her office for a period of three consecutive months or more. For purposes of this policy "temporary" incapacitation shall mean less than three

consecutive months. Nothing in this policy shall be construed to abridge any rights an employee may have under his or her contract or any insurance coverage or workers compensation laws.

C. Appropriate arrangements will be made through the District's legal counsel and Chief Financial Officer for the interim Chief Executive Officer or Interim Compliance Officer to have the necessary signing authority where required.

D. After the Board Chair, in consultation with the Vice President of Human Resources, has been made aware of whether the incapacitation or disability is temporary or permanent, the following will occur:

1. In the event of temporary incapacitation, the interim Chief Executive Officer or interim Chief Compliance Officer will continue in that role until the determination is made by the Board that the Chief Executive Officer or Chief Compliance Officer, respectively, can resume the position.

   a. In the event of temporary incapacitation of the Chief Executive Officer, the following list identifies the positions that will be considered by the Board to fill the role for the period of the Chief Executive Officer's incapacitation.

      - Chief Operating Officer;
      - Chief Nurse Executive;
      - Chief Financial Officer;
      - Other qualified members of the senior leadership team.

   b. In the event of temporary incapacitation of the Chief Compliance Officer, the following list identifies the positions that will be considered by the Board to fill the role for the period of the Chief Compliance Officer's incapacitation.

      - The District's legal counsel;
      - Other qualified members of the senior leadership team.

2. In the event of permanent incapacitation, the members of the Board will confer on the process to select and appoint a Search Committee to initiate the search for a new Chief Executive Officer or Chief Compliance Officer.

E. <u>Communications</u>

1. Once a determination has been made, it will be the responsibility of the Board Chair to communicate the plan of action with the District leadership, medical staffs, Auxiliary, Foundation, and employees, as appropriate, the plan of action to be initiated in search of the new Chief Executive Officer or Chief Compliance Officer. This may take the form of special newsletters, e-mails, telephone calls, etc.

2. External audiences to be notified of the plan of action will include, as appropriate, community and business leaders in the district, members of the press, affiliates and partners of TCHD and social service agencies associated with the District.

3. During this period the Board will select the Public Information Officer, the Chair, or other authorized person, to serve as the spokesperson for the District. All requests for information will be directed through the Public Information Officer.

F. Impending Vacancy Caused By Resignation or Termination

1. In the event of an impending Vacancy in the Chief Executive Officer position or the Chief Compliance Officer position, the Board shall meet as soon as practicable and initiate the following plan:

   a. In order to ensure stability at the time of an immediate Vacancy (within 60 days) an interim Chief Executive Officer or Chief Compliance Officer will be named.

   b. The Board, in consultation with the leadership of the medical staff, shall determine whether the use of an outside management firm is appropriate or whether there is adequate internal leadership to assume responsibilities for the Chief Executive Officer or Chief Compliance Officer.

2. The Chair of the Board after consultation with the Vice-Chair and the Vice President of Human Resources will determine and recommend to the Board of Directors the level and extent of compensation (including any incentives and/or benefits) to be paid to the individual assuming the interim Chief Executive Officer's role or the interim Chief Compliance Officer's role during the period in question.

3. Within 60 days of notification by the Chief Executive Officer or Chief Compliance Officer of his or her impending resignation or retirement or in the event of termination, the Board of Directors may form a Search Committee with the Chair to be named by the Chair of the Board of TCHD.

4. Representation on the Search Committee for the Chief Executive Officer may include, but is not limited to:

   a. Members of the TCHD Board;

   b. Representation from the Medical Staff Leadership of Tri-City Medical Center;

5. Representation on the Search Committee for the Chief Compliance Officer may include, but is not limited to:

   a. The Chief Executive Officer;

   b. Staff Members of Tri-City Medical Center.

6. The role of the Search Committee will be:

   a. Manage the search process, including initiation of request for proposals (RFPs) for selection of a search firm;

   b. Interview and recommendation of a search firm, if appropriate;

   c. Review and approve the Success Profile (job description/ requirements) for the Chief Executive Officer or Chief Compliance Officer position;

   d. Interview candidates and screen references;

   e. Recommend the top candidates to the TCHD Board for final interview.

7. The Search Committee will meet within two weeks of their appointment to begin the selection process. The Vice President of Human Resources will serve as staff to the committee.

8. Should the Vacancy date be later than one (1) year or longer, a Search Committee will be formed within six (6) months of the Chief Executive Officer or Chief Compliance Officer leaving the position to allow time for adequate selection of the incumbent's replacement and an effective transition to occur.

9. The Chair of the Search Committee will make regular and timely reports to the Board on the progress of the search.

10. The Search Committee must comply with the public notice and open meeting requirements of the Ralph M. Brown Act, as applicable.

**Reviewed by the Gov/Leg Committee: 09/10/08 & 10/15/08 & 05/13/09**
**Approved by the Board of Directors: 05/28/09**
**Reviewed by the Gov/Leg Committee: 04/01/14**
**Approved by the Board of Directors: 04/24/14**
**Reviewed by the Gov/Leg Committee: 04/05/2016**
**Approved by the Board of Directors: 04/28/16**

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #15-039**

**POLICY TITLE: Comprehensive Code of Conduct**

The following is the Board-approved Code of Conduct for District Board Meetings:

## I. PURPOSES AND GOALS OF CODE OF CONDUCT.

Effective leadership requires the Board to foster effective communication throughout the organization. Effective communication is necessary to encourage the delivery of safe, high quality care, as well as compliance with ethical and legal imperatives. Effective communication occurs best in an atmosphere of mutual respect, in which patients, physicians, hospital staff and members of the public, as well as members of the Board, feel valued and free to express themselves. Effective communication requires thorough preparation for meetings, adherence to approved procedures for the conduct of meetings, including compliance with time limits and courteous conduct during debate and discussion. Effective communication requires an atmosphere free from threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct.

The Board believes that at a minimum, its members must behave as if they are fiduciaries who are expected to honor the same duties of loyalty and care expected of their peers who serve on the boards of non-profit hospitals. Board members should act professionally at all times.

This Code of Conduct is intended to describe: (1) minimum expectations for conduct at, and surrounding Board meetings; (2) how Board members are provided the resources needed for effective, informed governance; (3) rules for ensuring the fairness of proceedings; and to (4) prescribe consequences for misconduct which does not contribute to effective leadership of TCMC, including making Board members ineligible for receipt of discretionary perquisites of office within the jurisdiction of the Board.

## II. MINIMUM EXPECTATIONS FOR CONDUCT OF BOARD MEETINGS

1. Once the Board has a quorum, the meeting should immediately commence. Time periods announced by the Chair for recesses shall be strictly observed.

2. For each agenda item on which there is anticipated action, at the discretion of the Chair or upon request by any Board member, consideration may commence with a staff presentation or other report or public comments, or with a motion and a second. Board discussion shall be permitted following any presentation or public comments, except that:

a. any Board member who must abstain from participation in a matter because of a legal conflict of interest shall ask the Chair for permission to announce the conflict prior to consideration of the item; and

b. any Board member who has had any discussions or received information prior to the meeting with respect to an agenda item which will affect substantial legal rights of a party appearing before the Board such as regarding credentialing of a health care provider, proposed imposition of sanctions on a Board member, or another quasi-judicial matter, shall, prior to consideration of the item, ask the Chair for permission to describe the nature of those contacts. Disclosing such information helps ensure fairness of Board decisions by ensuring that, to the extent possible, all involved have the same information regarding the matter. In case of doubt, a Board member shall err on the side of disclosing relevant information obtained outside of the meeting, including who provided the information and in what circumstances.

c. If the requestor for an item is listed as "Standard," any member may make the first motion. If the anticipated action is based on a recommendation from a Board committee, the first motion should normally be made by the Chair of that committee. If a particular member is listed as the requestor for the item, the first motion on the item should normally be made by that member.

3. If there is no motion on an action item, or if a motion is made and there is no second, the Chair should move to the next agenda item without further comment from the Board members.

4. For each agenda item that has received a motion and a second, the Chair should ask each member in turn as to whether that member wishes to address the motion, starting with the maker of the motion.

5. Each member will be recognized by the Chair and shall be allotted up to 3 minutes to speak to the motion, once recognized. Time for questions and answers addressed by a member to staff or to other Board members is included in the three minutes, unless the Chair grants an exception. Members who anticipate that this time will be insufficient shall, whenever feasible: (1) submit written statements at any time; (2) submit written questions to the Chair and CEO at least 48 hours in advance of a regular meeting when feasible (see II, B, above); or (3) request additional time. Only the member who has been recognized may speak on the motion during that time. Once a member is recognized, a timekeeper selected by the Chair will start the three-minute clock upon the direction of the Chair. A person other than the Chair shall operate the time clock under the direction of the Chair. Upon expiration of the allotted time, the

timekeeper shall notify the Chair by word or sign. Time limits are to be consistently and strictly enforced.

6. When the member's three-minute time allotment has concluded, the Chair should immediately recognize the next member in turn to determine if he/she wishes to speak. When recognized, the member should start speaking and the prior speaker shall promptly yield the floor.

7. Once the Chair has offered each member the opportunity to be heard, the Chair may offer a second round of comments. The Chair should again offer each member a three-minute opportunity to speak.

8. Unless recognized by the Chair, Board members shall not address members of the public who come forward to speak, and should not enter into a dialogue or debate. Members of the public shall be recognized to speak in accordance with Board Policy No. 10-018.

9. Agenda materials are intended to provide answers to as many questions as possible regarding agenda items, prior to the Board meetings. Board members are expected to review the agenda materials thoroughly, prior to the Board meetings, and to timely request additional information or clarification in advance whenever feasible—generally prior to any regular meeting. Questions from Board members at the meetings should be for the purposes of seeking clarification and/or additional information regarding particular agenda items and/or agenda materials.

10. Board members should be courteous and respectful of all meeting participants, including the Chair. Board members shall comply with the legitimate orders of the Chair regarding the orderly conduct of the business before the Board.

11. Conduct while attending Board meetings and other meetings and events related to the Board and Board committees, and while engaged in other Board-related business, which is unsafe, disruptive or which constitutes threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct, willful disturbance of the meeting or which otherwise violates Penal Code section 403 is prohibited. Board members shall comply with, and are subject to the District Harassment policy, which is set forth in Exhibit "A" to this Policy.

12. Board members and other persons shall comply with all applicable Board Policies pertaining to the conduct of board meetings, including but not limited to Board Policy #07-010 (Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings) #07-22 (Maintenance of Confidentiality) and Board Policy 10-018 (Public Comments at the Tri-City Healthcare District Board of Directors Meetings/Committee Meetings).

13. Board Members should attend every Board Meeting and remain for the entirety of each meeting, including returning to the meeting after exclusion from closed session or any portion thereof. The Board Chair shall make an oral announcement of any departure from the meeting and the reason, if available.

## III. BREACHES OF ORDER AT MEETINGS; SANCTIONS.

The Board has a right to make and enforce rules to ensure the conduct of the public's business in an efficient and orderly manner, and without disruption by members of the public or members of the Board. At the same time, the public and Board members shall be free to criticize the policies, procedures, programs and services of the organization, and the acts and omissions of the Board.

Notwithstanding any other policy of the Board, violations of this policy during a Board meeting may be enforced, as follows:

1. The Chair shall call to order, by name, any person who is in violation of any of the rules of conduct established under this policy, and Board Policy No. 10-018, which is committed in the immediate view and presence of the Board. The Chair shall request that person refrain from any further violation, warn that a repetition may violate Penal Code section 403 and result in removal from the meeting, and may specifically state that any further violation may constitute contempt of the Board.

2. If the person repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board (such as by refusing to yield the floor or otherwise disrupting proceedings), the Chair may call a recess of the meeting, stating that the reason for the delay is due to the misconduct of the Board member or other person. If following such recess, the Board member or other person persists in willfully interrupting the meeting such that order cannot be restored, the Chair, with the concurrence of the Board, shall order the disruptive Board member or other person removed from the meeting room by District security personnel, or, as to Board members, may request a motion under paragraph 3. If removal of a Board member is ordered, the Board member shall be entitled to adjourn to attend the balance of the meeting by telephone at the meeting location or other location consistent with the Brown Act, notwithstanding the provisions of any other Board policy.

3. In the alternative, if a Board member repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board, or, following a return from recess of the meeting if called, the Chair may call for a motion holding the Board member in contempt. Such a motion shall take precedence over any other motion, and shall describe the action or actions constituting the violation of this

policy. If such a motion is made and seconded, each board member shall have an opportunity to discuss the motion in accordance with this policy. If the motion is passed, the Board member shall be advised by the Chair that he or she has been held in contempt. A second motion may then be made to prescribe the sanction or sanctions to be imposed, which may include, but shall not be limited to, one or more of the following:

a. A statement of censure, identifying the misconduct;

b. Removal of the offending Board member from membership on one or more Board committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board officers;

c. Removal of the offending Board member from holding any Board office currently held;

d. Removal of the offending Board member from the meeting room and offering the member the right to adjourn to attend the balance of the meeting by telephone at the meeting location or another location consistent with the Brown Act (notwithstanding the provisions of any other Board policy) ; provided that the offending Board member may also be required to attend one or more future meetings by teleconference;

e. A determination that no compensation shall be earned by the offending Board member for attendance at the meeting at which the contempt occurred;

f. A determination that the offending Board member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct or the agenda items whose consideration was wilfully disrupted or prejudicially delayed by the misconduct, based upon the Board member's actual malice;

g. Rendering the offending Board member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings otherwise permitted under Board Policy #07-020 (except those previously-approved for which expenses have been incurred prior to the time of the finding of contempt), for a period of time or subject to conditions specified in the motion;

h. Referral of the matter to the County Criminal Grand Jury pursuant to Government Code section 3060.

i. Referral of the matter to the Fair Political Practices Commission or other prosecuting authority with jurisdiction over the matter.

4. Following the outcome of a motion for sanctions, the Chair shall direct that the order of the Board be carried out by security, the Chief Executive Officer, and/or General Counsel, as appropriate.

5. In the event violations of this Policy occur in a closed session, the Chair may suspend the closed session and return to open session for the purpose of commencing the enforcement process contemplated by this section. All proceedings under this section III shall occur in open session.

## IV. VIOLATIONS OF BOARD POLICIES OUTSIDE OF BOARD MEETINGS.

1. Board members shall not act on behalf of, nor represent themselves as speaking on behalf of, the Board without the Board's express authorization.

2. When a violation of a Board policy by a member of the Board is alleged to have occurred outside of a Board meeting, the Chair or any member of the Board may request that an item be placed on the agenda to consider what sanctions may be appropriate, if any. In such instances, evidence of the misconduct shall be presented by the requesting member. The Board member accused of misconduct shall have an opportunity to present evidence and respond to the allegations made. Formal rules of evidence shall not apply.

3. After consideration of the evidence presented, the Board may take such actions as it may deem appropriate, including but not limited to those described in section III of this policy, other than paragraph III(e).

## V. AUTHORITY OF ADMINISTRATION TO PROVIDE FOR SECURITY.

1. The District Administration is authorized and directed to develop and implement policies and procedures designed, engage employees or contractors to provide security, consistent with applicable law, to promote a secure and orderly environment for Directors, employees, staff, and members of the public. These policies and procedures will include a process for notifying the District Administration in the event that any person feels that he or she has been subjected to conduct which violates this Policy.

2. The District Administration is authorized and directed to take lawful and appropriate action and to pursue lawful and appropriate remedies against any person found to have violated this Policy.

## VI. BOARD ORIENTATION AND TRAINING

1. Every Board member shall participate in an orientation and training to be offered by Tri-City Healthcare District within 60 days of election, re-election to office, or assuming office, as a condition to receiving compensation or allowance of expenses.

2. The required orientation and training shall be offered at times and places convenient to the Board member.

3. The orientation and training shall include:

    a. A tour of the facilities owned or operated by Tri-City Healthcare District

    b. An explanation of Board policies, procedures, committee structure and bylaws, and delivery of a copy of the current Board policies, procedures and bylaws

    c. Briefings delivered by members of the management team regarding:

        i. Health care finance

        ii. District financial management and budgeting practices

        iii. Compliance laws and regulations, including conflict of interest rules under State and Federal law and the accreditation process

        iv. Areas of health care and specialties offered

        v. Medical staff organizations and relationship with the hospital

        vi. Nursing policies, staffing and practices

        vii. The roles and responsibilities of each department

        viii. Legal responsibilities of Board members

4. This orientation and training shall supplement the training required by law under AB 1234.

**Reviewed by the Gov/Leg Committee: 1/13/10**
**Approved by the Board of Directors: 1/28/10**
**Reviewed by Gov/Leg Committee: 4/13/11**
**Approved by the Board of Directors: 4/28/11**
**Reviewed by Gov/Leg Committee: 9/14/11**

**Approved by the Board of Directors: 9/29/11**
**Reviewed by Gov/Leg Committee: 4/11/12**
**Approved by the Board of Directors: 4/26/12**
**Approved by the Board of Directors: 5/31/12**
**Reviewed by the Gov/Leg Committee: 6/04/13**
**Approved by the Board of Directors: 6/27/13**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov/Leg Committee: 10/6/15**
**Approved by the Board of Directors: 10/29/15**

# ACHD Certified Healthcare Districts

(http://www.achd.org/wp-content/uploads/sites/6/2015/06/certified-logo.png)

As Public Entities, Healthcare Districts have well defined obligations for conducting business in a manner that is open and transparent. To assist ACHD Members in demonstrating compliance with these obligations, the ACHD Governance Committee has developed a core set of standards referred to as Best Practices in Governance. Healthcare Districts that demonstrate compliance with these practices will receive the designation of ACHD Certified Healthcare District.

Antelope Valley Healthcare District
November, 2014

Beach Cities Health District
October, 2014

Eden Township Healthcare District
November, 2015

Fallbrook Healthcare District
November, 2016

Grossmont Healthcare District
May, 2016

John C. Fremont Healthcare District
March, 2015

Los Medanos Community Healthcare District
April, 2016

Marin Healthcare District
August, 2016

Mark Twain Healthcare District
April, 2016

Palomar Health District
August, 2014

Peninsula Health Care District
November, 2015

Petaluma Health District
May, 2015

Pioneers Memorial Healthcare District
February, 2017

Sequoia Healthcare District
August, 2014

Sonoma Valley Healthcare District
April, 2016

Tahoe Forest Health System
May, 2016

To request application materials to begin the Certification process please contact Ken Cohen (mailto:ken.cohen@achd.org)

## CONTACT US

(916) 266-5200
Email Us (mailto:info@achd.org)

## RECENT NEWS

- Kaweah Delta earns top quality rating among local hospitals (http://www.achd.org/2017/02/24/kaweah-delta-earns-top-quality-rating-among-local-hospitals/)
- Pioneers Memorial Healthcare District Receives District Certification (http://www.achd.org/2017/02/17/pioneers-memorial-healthcare-district-receives-district-certification/)
- Department of Health Care Services (http://www.achd.org/2017/02/14/department-health-care-services/)
- Flexing Muscles: 70 Strong (http://www.achd.org/2017/02/13/flexing-muscles-70-strong/)
- Antelope Valley Hospital Blood Donor Center Exchanges "Pies for Pints" Feb. 14-16 (http://www.achd.org/2017/02/07/antelope-valley-hospital-blood-donor-center-exchanges-pies-pints-feb-14-16/)

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(https://twitter.com/ACHDnews)

**Tri-City Medical Center**
**Audit, Compliance & Ethics Committee**
**March 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; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member |
| **Non-Voting Members**: | Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO |
| **Others Present:**, | Jody Root, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp; Director, Education, Clinical Informatics & Staffing; Joni Penix, Director, Revenue Cycle Operations; Lisa Mattia, Infection Preventionist |
| **Absent:** | Cary Mells, M.D.; Physician Member |

| | 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. Jack Cumming and seconded by Director Dagostino to approve the agenda as presented. The motion passed unanimously.** | **Agenda approved.** | |
| 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 – February 16, 2017 | **It was moved by Mr. Leslie Schwartz and seconded by Director Dagostino to approve the minutes as presented. The motion passed unanimously.** | **Minutes ratified.** | |
| 5. Old Business | None | | |
| 6. New Business | | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| A) Administrative Policies & Procedures:<br><br>1) 8610-278 – Contract Review | Ms. Kathy Topp stated Policy 8610-278 was brought to the committee at a prior meeting and pulled for further revisions. Ms. Topp reviewed the changes that were made at the suggestion of the committee.<br><br>The committee had extensive discussion regarding the contract approval process and signature authority. Mr. Dietlin explained there is a separate Signature Authority Policy 8610-232 that is referenced in the policy.<br><br>Ms. Bernard-Shaw commented on the Procedure for Legal Review. She explained that certain contracts will need review by outside legal counsel however we have attempted to standardize the contracts as much as possible to efficiently utiize our legal services.<br><br>Discussion was held regarding Conflicts of Interest and the definition of a "family member". Chairman Schallock noted there is a separate policy that defines "family member". Ms. Bernard-Shaw stated potential conflicts need to be disclosed, however in many situations the conflict can be remedied.<br><br>*General Counsel, Mr. Jody Root joined the meeting at 8:43 a.m.*<br><br>Mr. Root recommended the Policy be pulled for several reasons. He stated Exhibit A Standard Form Agreements has not been updated and the process followed by the Finance, Operations & Planning Committee is not consistent with the policy. Mr. Root further explained that the Exhibit implies that the Board approved all items listed which is not the case. Ms. Bernard-Shaw agreed that there are a number of templates that need to be reviewed. Director Grass questioned how long it might take to get the templates reviewed. Ms. Bernard-Shaw responded approximately one month. In the interest of time and getting the Policy through the review process Mr. Dietlin suggested the Exhibit be amended to reflect the Templates that have | **Standard Contract Templates to be reviewed; Policy to be amended to be consistent with Finance, Operations & Planning process.** | Ms. Bernard-Shaw |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | been approved and add additional templates as they are approved. The committee urged Ms. Bernard-Shaw to review the templates and bring the policy back to the committee as soon as possible, | | |
| 2) 8610-279 – File Maintenance for Contract and Leases (DELETE) | Ms. Kathy Topp suggested Policy 8610-279 be pulled as it is tied to Policy 8610-278. | **Policy 8610-279 will be brought back to the committee in conjunction with Policy 8610-278.** | Ms. Donnellan |
| 3) 8610-292 – Internal Charge Audit | Ms. Kathy Topp introduced Ms. Joni Penix, Director of Revenue Cycle Operations who is here today to answer any questions related to Policy 8610-292 – Internal Charge Audit. Ms. Topp stated the policy was pulled in November for clarification and is brought forward today for consideration.<br><br>Minor formatting changes were suggested.<br><br>Ms. Penix explained the various types of audits and how often these audits might occur.<br><br>*Ms. Penix left the meeting at 9:04 a.m.* | | |
| 4) 8610-530 – Emergency Response Employees, Notification of | Ms. Topp introduced Ms. Lisa Mattia, Infection Preventionist. Ms. Topp explained Ms. Mattia is here today to answer any questions related to the policy. Ms. Topp stated Policy 8610-530 was revised as recommended by the Committee to clarify The Ryan White Comprehensive AIDS Resources Emergency Care Act. Ms. Mattia noted the word "offices" in section B. 1. should be struck and replaced with "officers".<br><br>Discussion was held regarding the acronym MICN. Ms. Mattia stated the acronym stands for Mobile Intensive Care Nurse, however the term used most often at Tri-City is Base Hospital Coordinator. It was recommended MICN be defined and placed in brackets<br><br>*Ms. Mattia left the meeting at 9:08 a.m.* | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 5) 8610-562 – Respondig to Compliance Issues; Remedial Action | Ms. Topp stated Policy 8610-562 is presented today for its normal review process. She stated changes to the policy are minor and the correct process was included under Corrective Action.<br><br>At Mr. Schwartz's request, Ms. Topp provided clarification on the language "terminate" and "intent to terminate".<br><br>Director Grass requested clarification on paid Administrative Leave. Ms. Topp explained when a staff is placed on Administrative Leave it is always paid leave as it is investigatory until the issue is resolved. Ms. Bernard-Shaw stated this policy is consistent with our union agreement. | | |
| 6) 8750-574- Tracking, Remuneration & Use of Items & Services to and from Referral Source and Tracking; use of TCHD Resources by Referral Sources | Ms. Bernard-Shaw stated Policy 8750-574 codifies our current processes for nonmonetary compensation items provided to physicians. She explained we are required to track what is routinely given to any physician or physician group that is a member of our organized Medical Staff. Ms. Bernard-Shaw stated Policy 8750-574 outlines our internal process for tracking other things that might be provided to a physician. She noted failure to track could result in a Stark violation.<br><br>Mr. Schwartz questioned if there is a mechanism in place to ensure employees are aware of the policy and their responsibility to track. Ms. Bernard-Shaw stated training is provided to employees on an annual basis and employees are made aware of the maximum dollar amount allowed for the current year.<br><br>Ms. Fitzwilliam questioned how expenses are tracked. Ms. Bernard-Shaw stated physician's expenses are tracked and reconciled on an annual basis.<br><br>**It was moved by Mr. Cumming to recommend approval of Policies 8610-292 – Internal Charge Audit, 8610-530 – Emergency Response Employees, Notification of, 8610-562 – Responding to Compliance Issues; Remedial** | **Recommendation to send Policies 8610-292 – Internal Charge Audit, 8610-530 – Emergency Response** | Ms. Donnellan |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | **Action and 8610-574 – Tracking Renumeration & Use of Items& Sesrvices and and from Referral Source and Tracking Use of TCHD Resources by Referral Sources. Mr. Schwartz seconded the motion. The motion passed unanimously.**<br><br>*Ms. Topp left the meeting at 9:18 a.m.* | **Employees, Notification of, 8610-562 – Responding to Compliance Issues; Remedial Action and 8610-574 – Tracking Renumeration & Use of Items& Sesrvices and and from Referral Source and Tracking Use of TCHD Resources by Referral Sources to the Board for approval; items to be placed on Board agenda and included in agenda packet.** | |
| B) Review of FY2017 Year to Date Financial Statement Results | Chairman Schallock stated the financials are typically presented on a quarterly basis however due to the full agenda last month we deferred the presentation to this month and will report the FY2017 year to date financials. Chairman Schallock stated it is important for the committee to hear the quarterly financial presentation so that when the Audit comes forward for review the Committee has an indication of where we are headed.<br><br>Mr. Rivas gave a brief report on the Fiscal 2017 YTD financial results as follows (Dollars in Thousands):<br><br>• Net Operating Revenue – $195,285<br>• Operating Expense – $196,359<br>• EROE - $11,735<br>• EBITDA - $2,869<br><br>Other Key Indicators for the current year included the following:<br><br>• Average Daily Census - 183<br>• Adjusted Patient Days – 66,495<br>• Surgery Cases – 3,690 | **Information Only.** | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | • Deliveries – 1,580<br>• ED Visits – 37,155<br><br>Mr. Rivas also presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits, EROE and EBITDA.<br><br>Mr. Cumming questioned why we are off budget. Mr. Rivas stated some of our initiatives did not kick off as quickly as anticipated. Mr. Conley noted Emergency Department visits are down not only at Tri-City but across the board.<br><br>Mr. Dietlin stated that although we are not seeing the volumes as projected, we were able to control the costs associated with that.<br><br>Mr. Dietlin also discussed the spike that initially occurred with Obamacare.<br><br>Mr. Cumming questioned what Tri-City's readmission rate is. Mr. Conley stated our readmission rate is 7.6%, down from 8% last year and close to leading the county. He noted we track all admissions, not just Medicare admissions.<br><br>Mr. Dietlin stated the balance sheet will look much different in March. He reported the District has been pursuing long term financing for quite some time and last week we completed a 25-year, $85.8 million mortgage financing issued by the United States Department of Housing and Urban Development (HUD). He explained Lancaster Pollard is the lender and HUD is the guarantor in the transaction. Mr. Dietlin stated the 25-year fixed rate financing with an interest rate below 5% is a significant step towards securing our future, giving the district some much needed liquidity.<br><br>Committee members expressed their appreciation to Mr. Dietlin for his diligence in securing the long term financing. Mr. Dietlin stated it was a group effort. He explained there is | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | a community requirement to be part of the HUD 242 program. As such, mayors of all three cities as well as Chamber CEOs of all three cities met with HUD officials during their site visit to show their support of the hospital. In addition, all Board members and several members of the Medical Staff also met with HUD during their site visit. Mr. Dietlin stated HUD was impressed with our cohesive partners. | | |
| 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. Leslie Schwartz to go into closed session at 9:45 a.m. The motion passed unanimously.** | | |
| 9. Open Session | The committee returned to open session at 10:05 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 | Chairman Schallock welcomed Ms. Faith Devine to the committee. | | |
| 12. Date of Next Meeting | Chairperson Schallock stated the Committee's next meeting will be held on April 20, 2017. | **The committee's next meeting is scheduled for April 20, 2017.** | |
| 13. Adjournment | Chairperson Schallock adjourned the meeting at 10:05 a.m. | | |

# AUDIT COMPLIANCE AND ETHICS COMMITTEE
## March 16th, 2017

| Administrative Policies & Procedures | Policy # | Reason | Recommendations |
|---|---|---|---|
| 1. Contract Review 278 | 278 | 3 year review, practice change | Pulled for further review |
| 2. File Maintenance for Contract and Leases 279 | 279 | DELETE | Pulled for further review |
| 3. Internal Charge Audit | 292 | 3 year review, practice change | Forward to BOD for approval with revisions |
| 4. Emergency Response Employees, Notification of 530 | 530 | 3 year review, practice change | Forward to BOD for approval with revisions |
| 5. Responding to Compliance Issues; Remedial Action 562 | 562 | 3 year review, practice change | Forward to BOD for approval |
| 6. Tracking Remuneration & Use of Items & Services to & from Referral Source and Tracking Use of TCHD Resources by Referral Sources 574 | 574 | 3 year review, practice change | Forward to BOD for approval |
| | | | |
| | | | |

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**

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**ISSUE DATE:** 12/10 **SUBJECT: INTERNAL CHARGE AUDIT**

**REVISION DATE:** **POLICY NUMBER: 8610-292**

| | |
|---|---|
| **Department Approval:** | **01/16** |
| **Administrative Policies & Procedures Committee Approval:** | **~~01/11~~08/16** |
| ~~**Executive Council Approval:**~~ | ~~**01/11**~~ |
| ~~**Finance & Operations Committee Approval:**~~ | ~~**01/11**~~ |
| **Organizational Compliance Committee Approval:** | **10/16** |
| **Audit, Compliance and Ethics Committee Approval:** | **03/17** |
| **Board of Directors Approval:** | **01/11** |

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A. **PURPOSE:**

1. Provide the structure by which the hospital may realize organizational benefits through improvements in internal processes.
2. Improve the provider service relationship by prompt response to patients' billing questions.
3. Identify deficiencies in charge pathways and processes, and strengthen the controls necessary for high-quality fiscal and clinical data.

B. **POLICY:**

1. To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges.

C. **PROCEDURE:**

1. The scope of a medical billing audit is limited to verifying that charges on the detailed hospital bill are accurate, represent services rendered to the patient, and are ordered by a physician. However, services or items may be provided based upon standard hospital practices and/or ~~Nursing~~ **Medical** protocols and procedures.
2. The audit does not assess the "reasonableness" of the charges, or medical necessity related to patient bills. A review of medical necessity for the services provided may be performed, but the billing audit process does not encompass these tasks.
3. Documentation—In concert with the position taken by the American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992), the hospital does not attempt to make the patient's Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by ~~Nursing~~ **Medical** protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that may be used to substantiate charges. In a business relationship, the hospital will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient.
4. ~~HOSPITAL AUDITOR RESPONSIBILITIES~~**Hospital Auditor Responsibilities**:
   a. The hospital will designate an individual to be responsible for coordinating all medical billing audit activities (i.e., Patient Account Auditor; hereafter referred to as Chart Auditor). Medical billing audit activities are prompted via both internal and external processes, and include concurrent, focus, miscellaneous, patient request, and insurance defense audit types. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits), the Chart Auditor will serve as the primary liaison between the hospital and all outside parties requesting patient account audits. All medical billing audit activities are to be documented and logs maintained within the hospital. All audit-related

account adjustments are to be processed only after appropriate facility-level sign off approval has been obtained. All audit related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with applicable hospital record retention policies.

D. **CONCURRENT ACCOUNT ~~AUDITS~~ INTERNALLY PROMPTED MEDICAL BILLING AUDIT ACTIVITIES**

1. The Chart Auditor will perform concurrent account audits on a monthly basis to identify charge issues that may indicate deficiencies in charge pathways and processes. A concurrent audit is defined as a complete audit of an account completed within 30 days of patient discharge. The audit samples for concurrent review will be determined by the ~~Compliance Committee~~**Senior Director Revenue Cycle Integrity, Finance**.

~~2. Acute care, psychiatric, and rehabilitation are required to perform additional concurrent account audits. A monthly sample will be determined by the **Senior Director Revenue Integrity, Finance**Compliance Committee.~~

~~3. The Chart Auditor shall be a core member of the Hospital Medical Audit Committee, which is a subcommittee of the Compliance Committee. He/she shall communicate all concurrent audit statistics and identified problems to administrative management within five working days of completion. Concurrent audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

~~4.~~ ~~After review and signature by the Hospital Chief Financial Officer, all concurrent audit statistics, Medical Audit Committee Meeting Minutes, and Departmental Corrective Action Plans are to be sent to the Finance Department by the fifth of each month.~~

~~5.~~**2. ~~FOCUS AUDITS~~Focus Audits**

a. The Chart Auditor will perform audits on claims chosen to target a specific departmental issue or concern. Focus audits take an in-depth look at very small segments of the hospital's charging structure to make a determination, decision, or conclusion about specific billing or charging practices.

b. Focus audits, which are performed on a select group of claims, may be self-prompted by the Chart Auditor or may come from a committee, group, or entity within the hospital or Tri-City Medical Center. Focus audits are designed to address a variety of issues, including, but not limited to:

   i. Validate or quantify a trend or pattern of billing errors noticed during routine/concurrent audits.
   ii. Complete a quality check on a new service line or new charge capture mechanism.
   iii. Check on the effectiveness of a previously implemented corrective action plan.
   iv. Retrospectively correct accounts in which a specific billing error has been identified.

c. Prior to starting a focus audit, the Chart Auditor must define and document the impetus, approach, timeframe, and extent of the review. This documentation is to be included in the medical billing audit activity logs.

~~d. The Chart Auditor shall communicate all focus audit statistics and identified problems to administrative management within five working days of completion. Focus audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

~~6.~~**3. ~~MISCELLANEOUS AUDITS~~Miscellaneous Audits**

a. Internal requests for single account audits from various individuals or departments within the hospital are processed at the discretion of hospital administration. These single account audit requests originate from, but are not limited to, Clinical departments, Business Office, Medical Records, and Finance. ~~A clearly defined internal process for these requests is the responsibility of the Chart Auditor at the direction of hospital~~

~~administration.~~ Documentation of miscellaneous audit activity is recorded and maintained in the medical billing audit activity logs.

b. ~~The Chart Auditor shall communicate all miscellaneous audit statistics and identified problems to administrative management within five working days of completion. Miscellaneous audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

## E. EXTERNALLY PROMPTED MEDICAL BILLING AUDIT ACTIVITIES

1. ~~PATIENT REQUEST AUDITS~~**Patient Request Audits**
   a. The hospital will establish and maintain an internal policy for processing patients' questions regarding the validity of itemized charges.
   b. The hospital's Patient Request Audit Policy must address the following issues:
      i. Procedure for referring requests to the Chart Auditor.
      ii. Procedure for communicating audit information to Business Office and Accounts Receivable departments.
      iii. Procedure for communicating audit results to the patient.
      iv. Audit fees (if any).
   c. In the event that a patient's questions can be answered without auditing the bill, notes to that effect must be entered into appropriate hospital files. (i.e., a patient may want to know when or why a particular item or service was provided and has no further billing questions.) If the patient requests a complete bill audit, the following points should be noted:
      i. The entire bill will be audited, not just one department or one section.
      ii. Inform the patient that the bill will be audited for both overcharges and undercharges, and that the claim will be corrected to reflect all billing errors as a result.
      iii. Debits and credits will impact the total charges, but depending on reimbursement methodology, the patient's out-of-pocket expenses may or may not be impacted.

~~d.~~**2.** The Chart Auditor shall **provide summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party defense) completed during the month to the Director Revenue Cycle.** ~~**Corrective action plans will be provided by Department Director/Manager with a 5% or greater error rate**communicate all patient request audit statistics and identified problems to administrative management within five working days of completion. Patient request audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee~~.

## ~~F. MEDICAL AUDIT COMMITTEE~~

~~1. Tri-City Medical Center will have a Medical Audit Committee, which is a subcommittee of the Compliance Committee. The purpose of the Medical Audit Committee is to provide a forum for communicating audit results, discussing problematic charge practices, and identifying, initiating, and monitoring corrective actions. The Medical Audit Committee will meet at least nine times annually.~~

~~2. The Medical Audit Committee will include at a minimum: CFO, Director of Patient Business Services, Chart Auditor, HIM director or representative, Nursing director(s), and department directors/managers from Central Supply, Pharmacy, Radiology, Laboratory, and Surgery, as determined necessary by facility. The Medical Audit Committee must be comprised of appropriate representation at a level which ensures problem resolution and decision making.~~

~~3. Department directors/managers are required to attend based on identified error rates:~~
   ~~a. 0 % - 4.99 % error rate: department director/manager is not required to attend Medical Audit Committee meeting~~
   ~~b. 5% or greater error rate: department director/manager attends Medical Audit Committee meeting until all action items are resolved. Director/Manager provides an explanation of the source of errors, how errors may be corrected and presents a detailed corrective action plan addressing root causes; corrective action plans shall include education to prevent recurrence.~~

4. ***THE MEDICAL AUDIT COMMITTEE SHALL:***
   a. Analyze the summarized concurrent audit findings presented by the Medical Billing Auditor. The analysis should:
      i. Identify departments demonstrating an error rate of greater than 5% in overcharges and undercharges.
      ii. Discuss possible reasons why overcharges and undercharges are occurring; i.e., failure to properly document services, failure to process credits, failure to accurately capture charges, incomplete documentation on Medication Administration Record, inaccurate charge sheets, lack of departmental charge reconciliation, etc.
      iii. Discuss corrective action plans. Action plans are designed to assist the departments in moving progressively toward a 0% error rate. Department directors/managers are responsible for establishing control mechanisms to ensure timely, accurate charging and documentation of services rendered.
      iv. Ensure corrective action plans are implemented no later than 30 days from the date the error rate was identified.
      v. Monitor and evaluate the effectiveness of all open action plans. Corrective action plans are considered closed when the error rate is below 5% for two consecutive months.
   b. Analyze the Monthly Late Charge Summary Report. The analysis should:
      i. Identify departments showing a trend of late charges. Evaluate departments exhibiting late charges greater than 1% of monthly department gross charges.
      ii. Discuss possible reasons why charges are not processed on a timely basis; i.e., charges not submitted on weekends, failure to batch charges regularly, failure to cross-train personnel on charging practices, incomplete charge information sent to Data Processing, charges generated by the NIC/NMC, lack of departmental reconciliation, etc.
      iii. Discuss ideas for corrective action by departments exhibiting late charges.
      iv. Ensure corrective actions are implemented no later than 30 days from the date the late charge rate was reported.
      v. Monitor and evaluate the effectiveness of all open action items. Corrective actions are considered closed when the applicable department late charge rate is less than 1% for two consecutive months.
   c. Analyze summarized focus, patient request, miscellaneous, and insurance defense audit findings.

5. ***MEDICAL AUDIT COMMITTEE DOCUMENTATION***
   a. The CFO must review and sign all documented Medical Audit Committee activity, which shall include the following:
      i. Medical Audit Committee meeting agenda and minutes;
      ii. Signed roster of Medical Audit Committee meeting attendees;
      iii. Corrective action plans;
      iv. Summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party defense) completed during the month.

6. ***REPORTING TO COMPLIANCE COMMITTEE***
   a. The Medical Audit Committee shall provide monthly reports to the facility's Compliance Committee, including Medical Audit Committee meeting minutes, overall facility error rate trended over 12 months, department error rates trended over 12 months and corrective action plans for any department with an error rate of 10 % or greater. The Compliance Officer or the Compliance Committee shall determine if further audits are required for evaluation and will coordinate this through appropriate channels.

7. ***ENFORCEMENT***
   i. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy.

~~Failure to comply with this policy will be subject to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination.~~

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy Manual**
**Compliance**

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**ISSUE DATE:** 5/04

**SUBJECT:** ~~Emergency Response Employees~~, Notification ~~of~~to Pre-Hospital Personnel; Exposure to Infectious Disease

**REVISION DATE:** 7/04; 12/05; 05/09

**POLICY NUMBER:** 8610-530

| | |
|---|---|
| **Department Approval:** | **10/16** |
| **Administrative Policies & Procedures Committee Approval:** | **~~05/09~~10/16** |
| ~~**Operations Team Committee Approval:**~~ | ~~**05/09**~~ |
| **Organization Compliance Committee Approval:** | **11/16** |
| **Medical Executive Committee Approval:** | **01/17** |
| **Audit, Compliance and Ethics Committee Approval:** | **03/17** |
| ~~**Professional Affairs Committee Approval:**~~ | ~~**06/09**~~ |
| **Board of Directors Approval:** | **06/09** |

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A. **PURPOSE:**

1. Both federal and California law establish requirements for reporting exposures of pre-hospital emergency medical personnel to certain infectious diseases.

B. **DEFINITIONS:**

1. Pre-hospital emergency medical care personnel may include: Paramedic, Registered Nurse (RN), Emergency Medical Technician (EMT), lifeguard, fire fighters, peace officers, **federal officers,** volunteers, and physicians who provide pre-hospital emergency medical care or rescue services.
2. Reportable disease or condition means those diseases listed in Section I and prescribed by Title 17, CCR Sections 2500-2640 **and Title 8, CCR Section 5199 Appendix A.**
3. **Mobile Intensive Care Nurse (MICN): a Registered Nurse specialized in pre-hospital care. The MICN works with medics, EMTs, and pre-hospital staff to provide patient care while following San Diego protocols.**

C. **CALIFORNIA REPORTING LAW:**

1. Under specified circumstances, pre-hospital emergency medical care personnel exposed to a person afflicted with a disease or condition listed as reportable and transmitted through oral contact or secretions of the body must be notified that they have been exposed to a disease as defined in Section I [Health and Safety Code Section 1797.188
2. Notification of exposure: The pre-hospital emergency medical care person who provided services must give their name and phone number to the TCMC Base Hospital Coordinator **(MICN)** ~~or the **MICN** "Radio Nurse"~~ at the time patient is transferred from their care to the admitting health facility. Pre-hospital emergency medical care persons may also give their name and phone number to the transporting party to relay to the hospital.
3. The **Tri-City Medical Center** (TCMC) Base Hospital Coordinator, **MICN, or Emergency Department Charge nurse facilitates the completion of the County of San Diego Communicable Disease Exposure Report. The report is then forwarded to the Infection Control department. The Base Hospital Nurse Coordinator will follow up with the EMS Coordinator/Infection Control Officer** of **the appropriate EMS agency.** ~~or the "Radio Nurse" shall complete the "Confidential Morbidity Report (CMR Form)" and submit to the California Department of Public Health (CDPH)~~.
4. Exposed personnel arriving at TCMC are directed to Occupational Health/Emergency Department for evaluation and treatment.

5. If the exposed personnel do not arrive at TCMC, the TCMC Base Hospital Coordinator or MICN must report the name(s) and telephone number(s) to the county health officer, as soon as the patient is diagnosed with a reportable disease or condition. The phone number to call is 619-515-6620 (San Diego County Community Epidemiology Branch).
6. The County Health Officer is then responsible for informing the involved pre-hospital emergency medical care personnel of the exposure. The statute does not provide for any release of information from hospitals to pre-hospital emergency medical care personnel.
7. Furnish other pertinent information related to the occurrence as may be requested by the local health officer or CDPH.

D. **FEDERAL LAW:**

1. The Ryan White Comprehensive AIDS Resources Emergency Care Act, requires medical facilities to give a report to the "designated officer" (DO) of the pre-hospital emergency response service when personnel are exposed to specified infectious diseases (see Section I for list of diseases) during the transport of a patient to the hospital. The TCMC Base Hospital Coordinator or designee maintains a current list of facilities and designated officers.
2. The hospital is responsible for initiating reports only regarding infectious pulmonary tuberculosis. Reports regarding questions about all other infectious conditions (i.e. Hepatitis B, HIV infection (including AIDS), Diphtheria, Meningococcal disease, Plague, Hemorrhagic fevers (ex. Lassa, Marburg, Ebola, Crimean-Congo), Rabies, and others yet to be identified) will be initiated by the DO of the pre-hospital emergency response service.

E. **SCOPE OF RESPONSIBILITY:**

1. The duties of Tri-City Healthcare District terminate upon discharge of the patient for conditions arising from the emergency or at the end of the 60-day period (beginning on the date the victim is transported by the emergency response employee to the hospital), whichever period is shorter. A response must be made as soon as possible but not later than 48 hours after the request is made.
2. This time period can be extended to a maximum of 90 days if the request for information is received within 30 days of the applicable 60-day period.
3. ~~The~~ **The Ryan White Comprehensive AIDS Resources Emergency Care Act** ~~Act~~ does not authorize or require a facility to test any patient for any infectious disease.
4. ~~The~~ **The Ryan White Comprehensive AIDS Resources Emergency Care Act** ~~Act~~ does not authorize or require any facility, designated officer or emergency response employee to disclose identifying information with respect to a patient or an emergency response employee.
5. The designated officer and any emergency response employee to whom disclosure is made must maintain the confidentiality of HIV test results and may be personally liable for unauthorized release of any identifying information about the HIV results.

F. **EVALUATION:**

1. TCMC receives by mail, fax, phone, or in person a request from the DO for information about possible exposure to one of the above infectious diseases.
2. These are all referred to and evaluated by the TCMC Base Coordinator.
3. After hours and on weekends, the ED "Radio Nurse" will review the request.
4. If the request is made without a Confidential Morbidity Form, one is completed by the TCMC Base Coordinator or "Radio Nurse" to gather appropriate information.
5. Infection Control can be contacted for assistance.
6. One of the following determinations is made:
   a. The pre-hospital emergency medical personnel were exposed.
   b. The pre-hospital emergency medical personnel were not exposed.
   c. Facts about the case are insufficient to determine an exposure.
7. **Infection Control will notify TCMC Base Coordinator of potential exposure if a patient was transferred via ambulance/EMS.**

G. **RESPONSE:**

1. All requests must be answered and shall be made in writing ASAP but no later than 48 hours after receiving the request. The response will be sent by fax whenever possible. The information

provided to the DO will include the name of the infectious disease, the date the patient was transported and the run number of the EMS call.

2. If a response is sent by mail, the DO will be notified by telephone that the response has been sent. The DO, within 10 days, must inform the facility whether the notification has been received.
3. The local public health officer will be contacted when:
   a. The hospital reviewer is unable to make an independent determination that the pre-hospital emergency medical personnel were exposed to a reportable disease or condition.
   b. The public health officer will resubmit the request to TCMC after evaluation. TCMC staff will make the follow-up report to the DO.
4. If the patient dies and a different facility is responsible for determining the cause of death, a copy of the request will be sent to that facility for the follow-up.

H. **CONFIRMED AIRBORNE DISEASES:**

1. If a patient is transported by pre-hospital emergency medical personnel to TCMC and is determined to have infectious pulmonary tuberculosis, the Infection Control Practitioner or designee will send a notice to the DO of the Emergency Medical Service that transported the patient.
2. This notice shall be made as soon as is practicable, but no later than 48 hours after a positive Mycobacterium tuberculosis culture is obtained or notification of a positive culture is received from San Diego Health and Human Services TB Control Program.
3. Notice will include the date, run number, and infectious disease involved.

I. **REPORTABLE DISEASE LIST, TITLE 17, CALIFORNIA CODE OF REGULATIONS, SECTION 2500:**

1. The following communicable diseases can be transmitted through oral contact (for example mouth to mouth respirations) or by mucus membrane or non-intact skin contact with secretions (including blood) from the patient.
   a. Acquired Immune Deficiency Syndrome (AIDS)
   b. Diphtheria
   c. Human Immunodeficiency Virus infection (HIV)
   d. Hepatitis, Viral
   e. Invasive Group A Streptococcal Infection
   f. Leprosy (Hansen Disease)
   g. Measles (Rubella)
   h. Meningococcal Infections *(Neisseria meningitidis)*
   i. Mumps
   j. Pertussis (Whooping cough)
   k. Plague, Pneumonic
   l. Poliomyelitis, Paralytic
   m. Rabies
   n. Rubella (German Measles)
   o. Tuberculosis
   p. Viral Hemorrhagic Fevers (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
   q. Anthrax
   r. Botulism (infant, food-borne, wound, other)
   s. Cholera
   t. Food-borne Disease
   u. Smallpox

J. **REFERENCES:**

1. California Healthcare Association Current Consent Manual
2. Title 22, California Code of Regulations, Section 70737 (General Acute Care Hospital) and 71535 (Acute Psychiatric Hospital).
3. **https://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf**
4. **https://www.dir.ca.gov/title8/5199a.html**
~~2.~~5. **http://www.dir.ca.gov/title8/5199.HTML**
6. **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Ryan White Care**

**Act, Ryan White, Pub.L. 101-381, 104 Stat. 576, enacted August 18, 1990)**

~~3.~~**7. Title 8, CCR Section 5199 Appendix A**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

**ISSUE DATE:** 05/12

**SUBJECT:** Responding to Compliance Issues; Remedial Action

**REVISION DATE:** 12/12

**POLICY NUMBER:** 8750-562

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|---|---|
| **Department Approval Date(s):** | ~~01/16~~ 01/17 |
| **Administrative Policies and Procedures Approval Date(s):** | ~~01/16~~ 01/17 |
| **Organizational Compliance Committee Date(s):** | 01/17 |
| **Medical Executive Committee Approval Date(s):** | ~~02/16~~02/17 |
| **Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):** | 03/17 |
| **Board of Directors Approval Date(s):** | 12/12 |

A. **PURPOSE:**

1. This policy sets forth Tri-City Healthcare District's (TCHD) policy governing remedial actions taken in response to identified misconduct, and procedures to ensure that TCHD's practices are consistent with the stated policy.

B. **PROGRAMMATIC CORRECTIVE ACTIONS:**

1. TCHD shall take appropriate remedial actions to correct internal operational or programmatic deficiencies identified by the **Chief** Compliance Officer, ~~Internal~~ **Organizational** Compliance Committee, Audit, ~~&~~ Compliance **and Ethics** Committee, or Board of Directors in connection with a report prepared per Policy 8750-561.
   a. If the violation involves an ongoing activity or practice,
      i. **T**~~t~~he activity or practice shall be stopped, and
      **ii.** **T**~~t~~he ~~Legal~~ **Compliance** Department shall be notified of the violation.
      ~~ii.~~**iii.** **The Compliance Department shall notify outside legal counsel when appropriate.**
   b. If the violation involves federal or state health care programs, the **Chief** Compliance Officer, in conjunction with regulatory counsel, shall evaluate the violation and determine an appropriate course of action.
   c. If the same or a similar violation could or might be prevented in the future by making changes to TCHD's Compliance Program, such changes shall be considered, developed, instituted, and promptly communicated to all affected employees.

C. **CORRECTIVE AND/OR DISCIPLINARY ACTION:**

1. An employee who has violated any laws, regulations, policies, or the Code of Conduct shall be subject to a corrective plan of action and/or disciplined, as appropriate.
2. TCHD also may take corrective and/or disciplinary action against supervisors who fail to detect or report misconduct on the part of employees under their supervision.
3. Any employee who intentionally files a false report of misconduct also shall be subject to corrective and/or disciplinary action.
4. Corrective and/or disciplinary action shall take one or more of the following forms:
   a. Imposition of a corrective action plan, which may include training, education and/or other remedial measures
   b. Verbal warning
   **c.** Written warning

~~c.~~**d. Final written warning**
~~d.~~**e.** ~~Probation~~**Administrative leave with pay**
~~e.~~**f.** Suspension with**out** pay
~~f.~~**g.** ~~Suspension without pay~~**Intent to terminate**
~~g.~~**h.** Termination

5. When corrective and/or disciplinary action is appropriate, the severity of the disciplinary action will depend on a variety of factors, including:
   a. the nature and severity of the violation
   b. whether the violation was committed intentionally, recklessly, negligently, or accidentally
   c. whether the employee had previously violated any laws, regulations, or policies or the Code of Conduct
   d. whether the employee self-reported his or her misconduct
   e. whether (and the extent to which) the employee cooperated with TCHD in connection with its investigation of the misconduct
6. The determination as to the appropriate disciplinary action will be made by members of senior management (in consultation with the **Chief** Compliance Officer and the employee's supervisor, as appropriate).

D. **DISCLOSURE; RESTITUTION:**

1. If the **Chief** Compliance Officer believes that there has been a material violation of any laws or regulations, **outside** Legal **counsel** shall be consulted to determine whether District should
   a. make a report to appropriate government authorities and/or
   b. make a repayment of any kind to the government or other entity or person (if a program overpayment has been determined), and/or
   c. perform another type of remedial action.

E. **CONTINUAL MONITORING AND FOLLOW-UP AUDITS:**

1. Any issue for which corrective action is taken (whether or not in the form of a formal corrective action plan), will be targeted for monitoring and review in future audits of that department or area. Investigative findings will be incorporated into department education and training.

F. **DOCUMENTATION:**

1. TCHD shall document any remedial actions taken pursuant to this policy and maintain such documentation in the Compliance Program files consistent with TCHD's document retention policies. This is in addition to any documentation maintained by the Human Resources Department.

G. **RELATED DOCUMENTS:**

**1. Administrative Policy 8750-561; Responding to Compliance Issues; Reports of Suspected Misconduct; Confidentiality**
**~~1.~~2. Administrative Policy 8610-424; Coaching and Counseling for Work Performance**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

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**ISSUE DATE:**

**SUBJECT:** **Tracking Physician Remuneration and Non-Monetary Compensation ~~Use of Items and Services to and from Referral Source and Tracking Use of Tri-City Healthcare District (TCHD) Resources by Referral Sources~~**

**REVISION DATE(S):**

**POLICY NUMBER: 8750-574**

| | |
|---|---|
| **Department Approval Date(s):** | **~~06/16~~ 01/17** |
| **Administrative Policies and Procedures Approval Date(s):** | **01/17** |
| **Organizational Compliance Committee Approval Date(s):** | **01/17** |
| **Medical Executive Committee Approval Date(s):** | **02/17** |
| **Audit, Compliance and Ethics Committee Approval Date(s):** | **~~03/13~~03/17** |
| **Board of Directors Approval Date(s):** | **03/13** |

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A. **PURPOSE:**

1. ~~The purpose of this policy is t~~To ensure compliance with the federal Anti-Kickback statute and Stark law and the regulations, directives, and guidance related to those statutes.

B. **GENERAL POLICIES:**

1. Each **Tri-City Healthcare District** (TCHD) department shall track remuneration, items, and services provided to or received from Referral Sources. Every Department is responsible for ensuring that, prior to execution; all Referral Source Arrangements are reviewed and approved through TCHD's Contract Approval system (See Administrative Policy 278). TCHD's ~~Legal~~ **Compliance** Department has adopted a number of policies specific to particular types of Referral Source Arrangements, and each department is responsible for complying with the applicable policies.

C. **DEFINITIONS:**

1. Referral Source - means any individual or entity in a position to make or influence referrals to, or otherwise generate business for TCHD. Examples include physicians, medical device companies, pharmaceutical companies, ambulance companies, emergency services providers, etc.
2. Federal health care program - means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, Tricare/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corps Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.
3. Referral Source Arrangement - means any documented arrangement or transaction that involves, directly or indirectly, the offer or payment of anything of value and is between TCHD and any actual source of referrals from Federally funded health care programs; or an arrangement that is between TCHD and a physician (or physician's immediate family member) who makes a referral to TCHD for designated health services as defined under the Stark law.
4. Remuneration - means anything of value, including, but not limited to, cash, items or services.

D. **SCOPE OF POLICY:**

1. This policy applies to (1) TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tri-City Healthcare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

E. **PROCEDURE:**

1. Department
   a. Step 1 – Tracking Remuneration:
      i. Each TCHD Department shall designate an individual or individuals responsible for tracking all remuneration to and from Referral Sources. Such tracking should occur on a regular periodic basis and should be conducted at least once per calendar year for each Referral Source. This tracking shall ensure that all payments to Referral Sources are made in accordance with an approved written agreement.
   b. Step 2 – Tracking Use of Tri-City Health Care District Resources:
      **i.** Each department shall develop and maintain a reasonable system of monitoring procedures and other internal controls designed to ensure that any services, leased space, medical supplies, medical devices, equipment, or other items provided to Referral Sources are provided pursuant to a written agreement reviewed and approved in advance in accordance with the applicable policy.
   **c. The Department staff person responsible for logging remuneration to a physician, or physician group or other entity involving physicians should record the description of the remuneration, the dollar value and the name of the physician in the Shared Folder. They should also note the department reporting the remuneration and the name and position of the person logging the information. The date the remuneration was provided and the date of the entry in the Shared Folder should also be listed.**
   **d. No later than The second Friday in December, all departments reporting remuneration should log all remuneration provided to physicians, physician groups or other physician entities during the calendar year in the Shared Folder.**
   **e. No later than the third Friday in December, the Compliance Department paralegal shall reconcile all remuneration provided to physicians and confirm and reconcile this information with the reporting departments. For any physician exceeding the Remuneration Limit (which could change each year), repayment by the physician, physician group or physician entity shall be made.**
   ~~c.~~**f. Documentation of the Repayment must be noted** ~~on~~ **in the designated** ~~Shared~~ **folder on the Shared Drive.**
2. ~~Enforcement~~ All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject employee to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **REFERENCE LIST:**

1. Legal Department Contracting Policies
2. Stark Law, 42 U.S.C. §1395nn, and implementing regulations
3. Anti-Kickback Law, 42 U.S.C. §1320a-7b(b), and implementing regulations
4. 42 C.F.R. § 411.357

G. **RELATED DOCUMENT:**

1. **Administrative Policy 8610-278; Contract Review**

**~~4.~~2. Administrative Policy 8750-569; Referral Source Policies ; Contractual Arrangement with Physicians and Other Referral Sources**

# TRI-CITY HEA CARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS

| Vendor | Contract Number | Contract Type | Responsible Party, Primary | Responsible Dept. | Expiration Date | Reviewed/ Completed | PHI REQ | PHI RCD | ACE Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|
| 3M Company | 1007.3088C | License Agreement | Terry Moede | Information Systems | 5/31/2017 | 11/14/2016 | yes | yes | 3/16/2017 | |
| Abbvie US LLC | 1007.2587C | Supplies Agreement | Thomas Moore | Supply Chain Management | 7/5/2017 | 11/1/2016 | no | no | 3/16/2017 | |
| Accolade Staffing (Terminated) | 1021.3400A | Professional Service Agreement | Norma Braun | Human Resources | 1/15/2016 | 12/22/2016 | no | no | 3/16/2017 | |
| Accretive Health Inc | 1021.3361C | Services Agreement | Joni Penix | Patient Accounting | 10/9/2017 | 11/7/2016 | yes | yes | 3/16/2017 | |
| Aegis Health Group | 1007.3452C | Supplies Agreement | Wayne Knight | Business Development | 6/30/2018 | 2/22/2017 | no | no | 3/16/2017 | |
| Aidin (Terminated) | 1007.3417C | Services Agreement | Stephen Chavez Matzel | Case Management | 1/7/2019 | 11/16/2016 | yes | yes | 3/16/2017 | |
| Aionex | 1007.2805C | Software License & Service Agmt | Terry Moede | Information System | 3/31/2020 | 11/14/2016 | yes | yes | 3/16/2017 | |
| Airstrip Operations | 1007.3073C | Services Agreement | Stephen Chavez Matzel | Case Management | 10/9/2019 | 11/16/2016 | no | no | 3/16/2017 | |
| Alerus Retirement and Benefits | 1007.3461C | Miscellaneous Revene Agreement | Quinn Abler | Human Resources | Evergreen | 12/22/2016 | no | no | 3/16/2017 | |
| ALSCO | 1007.3441C | Linen Supply Contract | Thomas Moore | Food and Nutrition | 8/30/2019 | 11/1/2016 | no | no | 3/16/2017 | |
| American Heart Assn | 1007.2787C | Service Agreement | Liz Fleming | Education | 12/1/2016 | 11/18/2016 | no | no | 3/16/2017 | |
| American Society of Composers and | 1007.2312C | License Agreement | Susan McDowell | Wellness Center | 9/1/2017 | 10/27/2016 | no | no | 3/16/2017 | |
| API Healthcare Corp | 1007.3151C | Software License & Service Agmt | Kathy Topp | Bed Control Staffin | 9/14/2017 | 11/4/2016 | no | No | 3/16/2017 | |
| Aramark Clinical Technology Services | 1007.1064C | Services Agreement | Kevin McQueen | Building Engineering | 4/30/2017 | 10/26/2016 | no | no | 3/16/2017 | |
| Arizant Healthcare | 1007.169C | Equipment: Purchase | Mary Diamond | Supply Chain Management | 6/26/2017 | 11/7/2016 | no | no | 3/16/2017 | |
| ASA Entertainment Group | 1007.3420C | Sponsorship Agreement | Susan McDowell | PA and Marketing | 12/31/2017 | 10/27/2016 | no | no | 3/16/2017 | |
| Ascend HR Corp | 1007.3469C | Professional Services Agreement | Norma Braun | Human Resources | 1/28/2017 | 12/22/2016 | no | no | 3/16/2017 | |
| Awarepoint Corp | 1007.977C | Equipment: Rental Agreement | Kevin McQueen | Surgery | 9/30/2019 | 2/9/2017 | no | no | 3/16/2017 | |
| Axiom Group Ltd. | 1007.2284C | Software License & Service Agmt | Charlene Carty | Finance | 10/23/2019 | 10/26/2016 | no | no | 3/16/2017 | |
| B. Braun Medical | 1007.3268C | Equipment: Rental Agreement | Tori Hong | Pharmacy | 6/30/2018 | 11/4/2016 | no | no | 3/16/2017 | |
| Bank of the West | 1007.2503C | Commercial Card | Charlene Carty | Finance | 6/20/2017 | 10/26/2016 | no | no | 3/16/2017 | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Bard Peripheral Vascular | 1007.2647C | Supplies Agreement | Thomas Moore | Supply Chain Management | Evergreen | 11/1/2016 | no | no | 3/16/2017 | |
| Baro-Serv, LLC | 1007.3199C | Physician-Coverage A | Sharon Schultz | Anesthesiology | 6/30/2017 | 11/5/2016 | no | no | 3/16/2017 | |
| Barton & Associates | 1007.3493C | Staffing Agreement | Joy Melhado | Nursing Admin | 9/18/2017 | 11/6/2016 | no | no | 3/16/2017 | |
| Baxter Healthcare | 121.3393C | Services Agreement | Thomas Moore | Supply Chain Management | 12/31/2018 | 11/1/2016 | no | no | 3/16/2017 | |
| Baxter Healthcare | 1007.3439C | Services Agreement | Tori Hong | Pharmacy | 3/6/2021 | 11/4/2016 | no | no | 3/16/2017 | |
| BB&T Insurance Services of California, Inc | 1007.3083C | Consulting Agreement | Sharon Schultz | Wound Care Carlsbad | 12/9/2016 | 11/5/2016 | no | no | 3/16/2017 | |
| BB&T Insurance Services of California, Inc | 1007.3133C | Services Agreement | Norma Braun | Human Resources | 3/31/2018 | 12/22/2016 | no | no | 3/16/2017 | |
| BIG Inventory | 1007.3377C | Services Agreement | Thomas Moore | Supply Chain Management | 3/9/2019 | 11/1/2016 | no | no | 3/16/2017 | |
| Boston Scientific Inc | 1007.174C | Consignment Agreement | Mary Diamond | Supply Chain Management | 2/8/2017 | 11/7/2016 | no | no | 3/16/2017 | |
| Boston Scientific Inc | 1007.3246C | Services Agreement | Eva England | Radiology | 12/31/2017 | 10/19/2016 | yes | yes | 3/16/2017 | |
| Boston Scientific Inc | 1007.3488C | Consignment Agreement | Thomas Moore | Supply Chain Management | 3/31/2019 | 11/1/2016 | no | no | 3/16/2017 | |
| Bottling Group LLC | 1007.3426c | Services Agreement | Thomas Moore | Cafeteria | 4/30/2019 | 11/1/2016 | no | no | 3/16/2017 | |
| Buchanon & Associates | 1007.2997E | Independent Contract | Susan McDowell | Public Affairs Mktg | 1/31/2017 | 10/27/2016 | no | no | 3/16/2017 | |
| Business Software Service | 1007.1578C | Software License & Service Agmt | Charlene Carty | Information Systems | 9/28/2017 | 12/23/2016 | no | no | 3/16/2017 | |
| California Business Bureau | 1021.1595C | Services Agreement | Joni Penix | Finance | 5/29/2017 | 11/7/2016 | yes | yes | 3/16/2017 | |
| California Dept of Transportation | 1007.3376C | Services Agreement | Michael Parent | Business Development | 1/31/2021 | 10/26/2016 | no | no | 3/16/2017 | |
| California Transplant Services | 1021.997C | Services Agreement | Mary Diamond | Surgery | 3/24/2017 | 11/7/2016 | yes | yes | 3/16/2017 | |

## TRI-CITY HEALTHCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Canient Search Partners (Terminated) | 1007.3098C | Professional Service Agreement | Norma Braun | Human Resources | 6/5/2017 | 12/22/2016 | no | no | 3/16/2017 | |
| Cardinal Health 200 | 1007.3163C | Services Agreement | Thomas Moore | Supply Chain Management | 9/30/2017 | 11/1/2016 | no | no | 3/16/2017 | |
| Cardinal Health 200 | 1007.2914C | Supplies Agreement | Thomas Moore | Supply Chain Management | 8/31/2017 | 11/1/2016 | no | no | 3/16/2017 | |
| Cardinal Health 414 | 1007.418C | Equipment: Purchase | Steve Young | Nuclear Medicine | 12/31/2017 | 10/19/2016 | yes | yes | 3/16/2017 | |
| Cardinal Pointe Communications | 1007.2249C | Services Agreement | Susan McDowell | Wellness Center | 12/31/2017 | 10/27/2016 | no | no | 3/16/2017 | |
| Carefusion 2200 | 1007.188C | Supplies Agreement | Chuck Sawyers | Supply Chain Management | 3/31/2017 | 11/9/2016 | n | No | 3/16/2017 | |
| Carefusion Solutions | 1007.183C | Supplies Agreement | Thomas Moore | Supply Chain Management | 7/1/2017 | 11/1/2016 | no | no | 3/16/2017 | |
| Carefusion Solutions | 1007.2479C | Equipment: Rental Agreement | Thomas Moore | Supply Chain Management | 5/24/2021 | 11/1/2016 | no | no | 3/16/2017 | |
| Cedaron Medical | 1007.858C | Software License & Service Agmt | Eva England | Information Systems | 5/31/2017 | 10/19/2019 | n | no | 3/16/2017 | |
| Cerner Corp | 1007.1635C | Services Agreement | Terry Moede | Information Systems | 3/31/2020 | 11/14/2016 | yes | yes | 3/16/2017 | |
| Cerner Corp | 1007.2283C | Business Associate Agreement | Terry Moede | Information Systems | 7/1/2017 | 11/14/2016 | yes | yes | 3/16/2017 | |
| Cerner Corp | 1007.3192C | Services Agreement | Wayne Knight | Business Development | 9/28/2019 | 2/22/2017 | no | no | 3/16/2017 | |
| City of Vista | 1007.926C | Consulting Agreement | Sharon Schultz | Education | 9/30/2017 | 11/5/2016 | yes | yes | 3/16/2017 | |
| City of Vista Fire Department | 1007.1663C | Consulting Agreement | Sharon Schultz | Education | 12/10/2016 | 11/5/2016 | No | No | 3/16/2017 | |
| Clancy Medical Group | 1007.3351C | Professional Services Agreement | Wayne Knight | Business Development | 11/30/2020 | 2/22/2017 | no | no | 3/16/2017 | |
| CloudMed LLC | 1007.3494C | Services Agreement | Colleen Thompson | Medical Records | 8/7/2017 | 10/24/2016 | yes | yes | 3/16/2017 | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| CMRE Financial Services | 1021.1673C | Finance Agreement | Joni Penix | Finance | 3/23/2018 | 11/7/2016 | yes | yes | 3/16/2017 | |
| Code-It Consulting | 1007.3523C | Consulting Agreement | Joni Penix | Finance | 1/10/2017 | 11/7/2016 | yes | yes | 3/16/2017 | |
| Collaboration Alliance for Nursing Outcomes | 1007.2468C | Services Agreement | Sharon Schultz | Administration | 5/9/2017 | 11/5/2016 | yes | yes | 3/16/2017 | |
| Collaborative California Transplant | 1021.997C | Services Agreement | Mary Diamond | Surgery | 3/24/2017 | 11/7/2016 | no | no | 3/16/2017 | |
| Colliers International CA | 1006.3341C | Professional Services Agreement | Wayne Knight | Business Development | 1/31/2017 | 2/22/2017 | no | no | 3/16/2017 | |
| Colliers International CA | 1007.3340C | Professional Services Agreement | Wayne Knight | Business Development | 1/31/2017 | 2/22/2017 | no | no | 3/16/2017 | |
| Colliers International CA | 1020.3360C | Professional Services Agreement | Wayne Knight | Business Development | 1/31/2017 | 2/22/2017 | no | no | 3/16/2017 | |
| Colliers International CA | 1020.3363C | Professional Services Agreement | Wayne Knight | Business Development | 1/31/2017 | 2/22/2017 | no | no | 3/16/2017 | |
| Comprehensive Pharmacy Services | 1007.2451C | Services Agreement | Tori Hong | Nursing Admin | 2/17/2018 | 11/4/2016 | no | no | 3/16/2017 | |
| Conifer Patient Communications | 1007.3419C | Services Agreement | Brian Greenwald | Business Development | 3/31/2018 | 10/27/2016 | yes | yes | 3/16/2017 | |
| Contract Management Strategies | 1007.301C | Professional Service Agreement | Charlene Carty | Finance | 4/30/2018 | 10/26/2016 | yes | yes | 3/16/2017 | |
| Cook Medical Inc. | 1007.3292C | Consignment Agreement | Thomas Moore | Supply Chain Management | 8/31/2019 | 11/1/2016 | no | no | 3/16/2017 | |
| CortiCare Inc. (Terminated) | 1007.3099C | Services Agreement | Mary Diamond | NICU | 6/30/2017 | 11/7/2016 | yes | yes | 3/16/2017 | |
| CorVel Corp. | 1021.1704C | Services Agreement | Norma Braun | Administration | 2/28/2017 | 1/16/2017 | no | no | 3/16/2017 | |
| Corvel Enterprise | 1007.3186C | Services Agreement | Rudy Gatelum | Employee Health | 12/31/2017 | 11/2/2016 | no | no | 3/16/2017 | |
| County of San Diego | 1007.909C | Services Agreement | Sharon Schultz | Administration | 8/31/2017 | 11/5/2016 | yes | yes | 3/16/2017 | |
| County of San Diego | 1021.1708C | Services Agreement | Colleen Thompson | Medical Records | Evergreen | 10/24/2016 | yes | yes | 3/16/2017 | |
| County of San Diego | 1007.1711C | Services Agreement | Kevin McQueen | Security | 6/30/2018 | 10/26/2016 | no | no | 3/16/2017 | |
| Covidien Sales | 1007.3256 | Equipment: Support and Services | Mary Diamond | Surgery | 1/3/2022 | 3/16/2017 | no | no | 3/16/2017 | |
| Cox Communications California | 1007.3534C | Services Agreement | Terry Moede | Information System | 9/5/2021 | 11/14/2016 | no | no | 3/16/2017 | |
| CPM Ltd. dba Manpower San Diego | 1007.3266 | Professional Service Agreement | Norma Braun | Human Resources | 3/15/2018 | 12/22/2016 | no | no | 3/16/2017 | |
| CPU Medical Management | 1007.973C | Business Associate Agreement | Terry Moede | Information System | Evergreen | 11/14/2016 | yes | yes | 3/16/2017 | |
| Craneware, Inc. | 1021.1719C | License Agreement | Joni Penix | Finance | 5/26/2012 | 11/7/2016 | yes | yes | 3/16/2017 | |

# TRI-CITY HEALTHCARE DISTRICT
# MINUTES FOR A REGULAR MEETING
# OF THE BOARD OF DIRECTORS

## February 23, 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 February 23, 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 RoseMarie V. Reno
Director Larry Schallock

Absent was Director Julie Nygaard

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

   Chairperson Dagostino reordered the Closed Session agenda.

   **It was moved by Director Kellett to approve the agenda as amended. Director Schallock seconded the motion. The motion passed (6-0-1) with Director Nygaard absent.**

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the February 23, 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 February 23, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; three (3) matters of Potential Litigation; one Report Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding four (4) matters of Existing Litigation; Public Employee Evaluation: General Counsel and Chief Compliance Officer and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

**It was moved by Director Kellett and seconded by Director Mitchell to go into closed session at 1:35 p.m. The motion passed (6-0-1) with Director Nygaard absent.**

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 RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Nygaard

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.

Chairman Dagostino reported the Board agreed by a (6-0-1) vote with Director Nygaard absent to engage defense counsel Greenberg Traurig.

10. Director Grass 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. Community Update –

1) Accountable Care Organization (ACO) Report – Wayne Knight

Mr. Wayne Knight provided background information on the North Coast Medical Accountable Care Organization (ACO) whose purpose is to reduce the spend on Medicare fee for service and was approved by Medicare to go into effect in July of 2012. Mr. Knight stated the ACO was profitable every one of those years it was in active participation with a healthy distribution the first year and continued profitability in the second and third year however we were unable to make a distribution in the final year even though we had achieved savings as Medicare requires that you have 5,000 beneficiaries. A beneficiary is defined as someone who receives the preponderance of their services from a primary care physician. Mr. Knight stated we initially had 6,800 members in our ACO when it was formed however in the last year two medical groups were moved out of the North Coast Medical ACO reducing the number of beneficiaries. Mr. Knight stated when we applied for renewal we were denied due to the number of beneficiaries, thus we are not actively managing an Accountable Care Organization. Mr. Knight explained the ACO still exists legally, and we are talking with potential partners to consider reapplication in 2018.

In closing, Mr. Knight stated in the first year Tri-City Medical Center was one of 28 Medicare savings ACOs that actually made money and was able to make distribution to its providers.

13. Report from TCHD Foundation, Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer reported on past and present activities of the Foundation as follows:

1) Shoe and Sock Drive – A new event inspired by a nurse here who gave a patient her own shoes. There will be collection boxes placed throughout the hospital and in community businesses where people can come and drop off a pack of brand new socks, a pair of shoes, adult sizes, above size 8. There will also be a drive through drop off at the main entrance to the hospital on March 15th where volunteers will be out there to collect those items. Mr. Newhart stated you can also go to the Website and donate $10 and the Foundation will buy the shoes for them. He explained Social Services will store the shoes and distribute as needed. Mr. Newhart stated the engagement and interest in this event is bigger than some of the Foundation's signature events and has drawn interest from a variety of people.

2) Doctors Day 2017 – The theme for Doctor's day is "Have you thanked your doctor today". Donors have the opportunity to recognize their physicians and send them a thank-you note. Honored doctors will also receive a Doctor's Day Lapel Pin.

3) Social Media – We are working hard in engaging a social media presence. Mr. Newhart provided an example of a Facebook post "Tri-City is the safest place to have your baby" that was seen by over 12,000 women and shared many times. Dr. Movahhedian actively engaged in responding to the posts.

3) Women's Imaging Services Lobby project is underway. It will be redesigned with an updated, yet timeless look. Mr. Newhart stated the redesign coincides with the generous donation of the SonoCine System, an ultrasound technology for women with dense breasts and creates a movie to detect cancers at a smaller level. \\

4) Havana Nights Casino Party will be held on May 20th with proceeds benefitting Women's Health Services. Mr. Newhart stated he expects another sold out evening on behalf of the hospital.

No action was taken.

14. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO reported we are seven months into 2017 and continue to move forward with initiatives to expand access for quality healthcare service in the Tri-City community. He explained that we do this in a number of ways – through our affiliation with UCSD and how that has worked with Cardiothoracic Surgery, the IORT program, Neurosurgery, etc. In addition, we reach out to the community in recruitment efforts to bring fine physicians to this community.

Mr. Dietlin stated we continue to focus efforts on reduced ED wait times and throughput.

Mr. Dietlin stated Mr. Rivas's financial report will reflect a positive financial bottom line year to date and a positive variance versus budget, however we do have a current month loss for the month of January which reminds us it is critical to not only focus on growth but on managing our costs with the revenue structure we have here at the hospital.

Mr. Dietlin stated we are looking forward to our FY2018 Strategic Planning Sessions with the Board and collaborating to produce a cohesive Fiscal Year 2018 Strategic Plan.

Mr. Dietlin stated we continue to move forward with placing long term capital as part of our Strategic Plan and have locked a rate below 5% with HUD and look forward to refinancing the Wellness Center debt as well as additional debt that was placed over 25 years ago through a bond to 25-year financing. Mr. Dietlin noted there is no guarantee until financing occurs however we remain extremely optimistic and hope to bring a Resolution to the Board for consideration within the next 30 days.

No action was taken.

15. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date Financials as follows (Dollars in Thousands):

- Operating Revenue – $195,285

- Operating Expense – $196,359
- EBITDA- $11,735
- EROE - $2,869

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 183
- Adjusted Patient Days – 66,495
- Surgery Cases – 3,690
- Deliveries – 1,580
- ED Visits – 37,155

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $28,711
- Operating Expense – $29,565
- EBITDA - $1,010
- EROE – ($226)

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 188
- Adjusted Patient Days – 9,377
- Surgery Cases – 549
- Deliveries – 217
- ED Visits – 5,166

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.0
- Days in Net Accounts Receivable – 50.0

Mr. Rivas noted that we weren't as effective in budgeting our labor this month.

No action was taken.

16. New Business

a. Consideration to approve a Physician Recruitment Agreement with Dr. Geehan D'Souza – Wayne Knight, Chief Strategy Officer

Mr. Wayne Knight, Chief Strategy Officer stated he is here to today to request support for the recruitment of a new Plastic and Reconstructive Surgeon. Mr. Knight stated in our Community Needs Assessment it was determined Plastic and Reconstructive Surgery is a medical necessity that is not being met.

Mr. Knight provided a summary of Dr. D'Souza's background and experience. Mr. Knight stated Dr. Wallace at UCSD trained Dr. D'Souza and speaks very highly of him.

Mr. Knight also presented the financial terms of the recruitment that includes a two-year income guarantee and a three-year forgiveness period. Mr. Knight stated there

is a total income guarantee of $585,000 and incremental startup of $50,000 and relocation fee of $2,500 for a total expenditure of $637,500.

Mr. Knight stated with the addition of Dr. D'Souza we will have a comprehensive breast cancer treatment team from beginning to end.

Dr. Ma expressed his appreciation to Mr. Knight for his diligence in securing this type of physician as it is a significant need.

**It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment Agreement with Dr. Geehan D'Souza not to exceed $637,500 in order to facilitate this Plastic Surgeon practicing medicine in the communities served by the District as recommended by the Finance, Operations & Planning Committee. Director Reno seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

b. Consideration to engage Moss Adams to conduct the Fiscal Year 2017 Financial Statement Audit

**It was moved that the Tri-City Healthcare District Board of Directors engage Moss Adams to perform the Fiscal Year 2017 Financial Statement Audit according to the terms presented. Director Kellett seconded the motion.**

Director Reno stated that although the Board accepted the FY2016 Fiscal Year audit she believes it lacked some oversight. She stated that Moss Adams has been Tri-City's auditor for an extended period of time and she believes it is time to make a significant change.

Director Grass stated she will be voting "no" due to her perceived lack of transparency in the FY2016 Fiscal Year Audit.

The vote on the motion was as follows:

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Kellett, Mitchell, and Schallock** |
| **NOES:** | **Directors:** | **Grass, Reno** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

c. Consideration of North County Back Pack Program for North County Schools

Chairman Dagostino reported a presentation was made to the Community Healthcare & Alliance Committee about the ability to provide needy students with a food supply for the entire week. The Committee was interested in looking at a

methodology to be a participant and help students from low income families who live in the area.

Director Reno questioned what the cost would be associated with the program. Mr. David Bennett stated the Food Bank would fund the program or perhaps get local Chambers and businesses to adopt a school. Chairman Dagostino stated he sees Tri-City as orchestrating the program.

**It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors direct staff to explore the North County Back Pack Program for North County Schools with input from the Community Healthcare & Alliance Committee. Director Reno seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

d. Consideration to appoint Director Leigh Anne Grass to the Employee Fiduciary Subcommittee

**It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors appoint Director Leigh Anne Grass to the Employee Fiduciary Subcommittee as recommended by the Human Resources Director Reno seconded the motion.**

Director Kellett explained the Employee Fiduciary Subcommittee is a component of the Human Resources Committee that reviews the Pension Plan for the employees. Director Kellett stated the subcommittee would be pleased to have Director Grass join the subcommittee.

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

e. Consideration to appoint Ms. Robin Iveson to a two-year term on the Audit, Compliance & Ethics Committee

**It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors appoint Ms. Robin Iveson to a two-year term on the Governance & Legislative Committee as recommended by the committee. Director Schallock seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

f. Consideration to appoint Ms. Faith Devine to a two-year term on the Audit, Compliance & Ethics Committee

**It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors appoint Ms. Faith Devine to a two-year term on the Audit, Compliance & Ethics Committee, as recommended by the Committee. Director Mitchell seconded the motion.**

Chairman Dagostino invited Ms. Devine to the podium to introduce herself to the Board. Ms. Devine stated she is a retired attorney for the Department of Justice and felt volunteering with Tri-City would be a great opportunity.

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **Reno** |
| **ABSENT:** | **Directors:** | **Nygaard** |

17. Old Business

a. Report from Ad Hoc Committee on Electronic Board Portal

Director Mitchell reported the Ad Hoc Committee has completed their research on Board Portals. A report was distributed at the Dais that described options available and she asked that the Board review the report and be prepared to come to a decision at the March meeting. Director Mitchel commented on the possibility of developing a web page that would be used strictly for Board business.

Director Reno expressed concern with the cost associated with a Board Portal and our finances.

Mr. Brian Greenwald, Web Site Content Specialist stated a new Web Page for the Board would be quite easy to develop and costs would be minimal. Mr. Moser noted agendas and agenda packets are currently posted on the Tri-City website.

No action was taken.

18. Chief of Staff

a. Consideration of February 2017 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 21, 2017.

**It was moved by Director Mitchell to approve the February 2017 Credentialing Actions and Reappointments involving the Medical Staff and Allied Health Professionals, as recommended by the Medical Executive Committee at their meeting on February 21, 2017 with the amendment to the status of Dr. Chibals from Honorary to Affiliate. Director Schallock seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

b. Approval of Privilege Cards

**It was moved by Director Kellett to approve the Neonatology and Orthopedic Tech Privilege Card as recommended by the Medical Executive Committee on February 21, 2017. Director Schallock seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

**19. Consent Calendar**

**It was moved by Director Schallock to approve the Consent Calendar. Director Kellett seconded the motion.**

**It was moved by Director Reno to pull item 19 (1) D a. 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 Bidding Policy. Director Schallock seconded the motion.**

**It was moved by Director Reno to pull item 19 (1) D. e. 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. Director Kellett seconded the motion.**

**It was moved by Director Reno to pull item 19 (1) E. in its entirety. Director Grass seconded the motion.**

**It was moved by Director Reno to pull item 19 (1) G. 8750-539 – Screening Covered Contractors. Director Kellett seconded the motion.**

**The vote on the main motion minus the items pulled was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

**The vote on the main motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

20. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 19 (1) D a. 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 commented on the importance of adhering to this policy.

**It was moved by Director Schallock to approve item 19 (1) D a. 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. Director Mitchell seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

Director Reno who pulled item 19 (1) D. e. Agreement with Key Healthcare Consulting, LLC requested an explanation of the service provided by Key Healthcare. Mr. Rivas explained Key Healthcare captures charges and records charges in the coding process. Ms. Schultz stated Key Healthcare does a much better job of capturing charges and it is a beneficial service.

**It was moved by Director Grass to approve item 19 (1) D. e. 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. Director Schallock seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

Director Reno who pulled item 19 (1) E. in its entirety questioned whether the policies listed under the Professional Affairs Committee were previously Administrative Policies. Ms. Schultz explained the policies listed are Patient Care Policies and therefore are presented to the Professional Affairs Committee for consideration.

Ms. Schultz stated we will include in future Board agenda packets the Policy Approval Process algorithm for reference.

**It was moved by Director Kellett to approve item 19 (1) E. in its entirety. Director Grass seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

Director Reno who pulled item 19 (1) G. 8750-539 – Screening Covered Contractors questioned whether the policy should go through the Finance, Operations & Planning Committee rather than the Audit, Compliance & Ethics Committee. Director Mitchell stated due to the fact that the policy is a compliance policy it is brought through the Audit committee.

**It was moved by Director Schallock to approve item 19 (1) G. 8750-539 – Screening Covered Contractors. Director Kellett seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Nygaard** |

21. Reports (Discussion by exception only)

22. Legislative Update

Chairman Dagostino reviewed CHA legislative materials that were presented to the Governance & Legislative Committee.

23. Comments by members of the Public

There were no comments by members of the public.

24. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

25. Board Communications

Director Schallock congratulated Mira Costa's Nursing program and stated we are fortunate to have their students and graduates come to Tri-City. He stated Mira Costa ranks third in their passing and that is a significant honor.

Director Reno stated she attended the Auxiliary's Past Presidents Luncheon and it was a remarkable event attended by approximately 15 Past Presidents who have spent their time and talent serving Tri-City Medical Center.

Director Reno commented on the "Meet the Leaders" event presented by the Vista Chamber of Commerce on March 24th in which Darrell Issa and Patricia Bates will be in attendance.

Director Reno stated the public has commented to her on the lack of KOCT coverage at the Board meetings and feel they are being cheated.

Director Reno commented on the advertising for new committee members. She stated she does not believe the Coast News reaches the Vista population. She noted there is no Vista Board member and the only Vista community members are those who have been appointed to the Community Healthcare & Alliance Committee.

Director Mitchell did not have any comments.

Director Grass stated she appreciated the discussion related to the Back Pack program as we forget about those who go hungry.

Director Grass expressed her appreciation to the Foundation for bringing forward the Shoe and Sock Drive that was inspired by one of our own nurses.

Director Kellett expressed his appreciation to the staff, physicians and administration for the good work they do for Tri-City Medical Center.

30. Report from Chairperson

Chairman Dagostino commented on his observations while attending the Palomar Finance, Operations & Planning Committee. He stated they have a much less formal and a collegial atmosphere in which there are no refreshments or community members on the committee. Chairman Dagostino stated he has been invited to attend Palomar's Community Healthcare & Alliance Committee as well as their Board meeting and plans to attend and observe and see what we might learn from them.

31. There being no further business Chairman Dagostino adjourned the meeting to closed session at 5:09 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**

**March 2, 2016 – 7:00 o'clock p.m.**
**Assembly Room 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 7:00 p.m. on March 2, 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
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 7:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Grass led the Pledge of Allegiance.

2. Approval of agenda.

   **It was moved by Director Reno to approve the agenda as presented. Director Kellett seconded the motion. The motion passed unanimously (7-0).**

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

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 item listed on the March 2, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report on Trade Secrets with a disclosure date of March 2, 2017.

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 unanimously (7-0).**

6. Chairman Dagostino adjourned the meeting to Closed Session at 7:05 p.m.

8. The Board returned to Open Session at 7:49 p.m. with all Board Members present.

9. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

10. New Business

1) Consideration to approve amendment to the Tri-City Healthcare District Bylaws.

**It was moved by Director Nygaard that the Tri-City Healthcare Board of Directors amend the Bylaws to comply with the United States Department of Housing and Urban Development (HUD) financing loan documents. 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** |

2) Consideration of Resolution No. 781, A Resolution of the Tri-City Healthcare District Authorizing Borrowing

**It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve Resolution No. 781, A Resolution of the Tri-City Healthcare District Board of Directors authorizing the CEO to execute and deliver any and all documents deemed necessary or advisable in order to consummate HUD financing and otherwise to effectuate the purpose of said Resolution. Director Nygaard seconded the motion.**

**The vote on the roll called motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **None** |

Chairman Dagostino read the following statement into the record:

"One year ago The Tri- City Healthcare District (TCHD) Board agreed unanimously to pursue long term funding from Housing and Urban Development (HUD) to secure the healthcare future of our District. That decision has come to fruition with the initial $86 million dollar refinancing package agreed to by both parties. This 25 year commitment to financing will allow our healthcare district to

guarantee that we will be both seismically complaint and modernized so that we may better serve the healthcare needs of our communities."

"This partnership bears responsibilities on both parties. HUD has placed their trust and confidence in the communities of Vista, Carlsbad, and Oceanside by selecting us as their financial partner. Your Tri- City Board has committed to responsibly use this financing to advance the health and wellness of our citizens."

11. Comments by members of the public.

There were no comments by members of the public.

12. There being no further business, Chairman Dagostino adjourned the meeting at 7:55 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A SPECIAL MEETING**
**OF THE BOARD OF DIRECTORS**

**March 10, 2017 – 7:30 o'clock p.m.**
**Assembly Room 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 7:30 p.m. on March 10, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass (via teleconference)
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Adriana Ochoa, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Cheryle Bernard-Shaw, Chief Compliance Officer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 7:30 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

**It was moved by Director Kellett to approve the agenda as presented. Director Mitchell seconded the motion.**

**The roll call 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** |

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Consideration to waive Board Policy 14-006 #3 related to audio taping of Open Session

**It was moved by Director Kellett to waive Board Policy 14-006 #3 related to audio taping of today's open session. Director Schallock seconded the motion.**

**The roll call 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** |

5. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Ms. Ochoa, made an oral announcement of the item listed on the March 10, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one (1) matter of Potential Litigation and one (1) matter of Existing Litigation.

6. Motion to go into Closed Session

**It was moved by Director Kellett and seconded by Director Schallock to go into Closed Session.**

**The roll call 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** |

7. Chairman Dagostino adjourned the meeting to Closed Session at 7:40 p.m.

8. The Board returned to Open Session at 8:20 p.m. with all Board members present with the exception of Director Grass who participated via teleconference.

9. Open Session

10. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

11. New Business

1) Discussion and possible action regarding emergency piping repairs in basement and actions taken under Resolution No. 775.

Mr. Conley reported on February 28th, Hospital leadership, responding to continual flooding in the kitchen discovered a mainline extending into basement offices. Based on the discovery, it was determined that the kitchen/cafeteria operations would be off-line for an indefinite timeframe. Based on the scope of the repair and impact to patients, it was determined that Tri-City would need OSHPD, CDPH and San Diego County Department of Environmental Health Services approval before operations could go back online. As a result this repair was considered an internal disaster/emergency.

Mr. Conley explained Administration immediately began repairs on the basement pipes as permitted under Board Resolution No. 775 which authorizes the CEO to award certain emergency contracts up to $250,000. He explained the urgency of the event and impact on operations prevented staff from following the traditional public bid process. Further investigation revealed repairs related to the piping are estimated to exceed $250,000. Therefore a Resolution is being brought forward for consideration to increase the CEO's authority for this internal emergency.

2) Consideration to approve Resolution No. 782, A Resolution of the Board of Directors of Tri-City Healthcare District Increasing the Authority of the Chief Executive Officer to Award Certain Emergency Contracts Relating to Piping Repairs in Basement

**It was moved by Director Reno that the Board of Directors of Tri-City Healthcare District authorize the CEO to execute emergency contracts on behalf of the District not exceeding a total value of $650,000 in order to repair or replace public facilities and property damaged by the Failure, and to take immediate actions required directly relating to the Failure, without seeking competitive bids. Director Kellett seconded the motion.**

It was noted the total value requested is $775,000, rather than $650,000.

**It was moved by Director Kellett to amend the motion to reflect the correct amount of $775,000. Director Reno seconded the motion.**

Mr. Conley assured the Board that we have taken every precaution to make sure our patients and staff are safe.

**The roll call 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** |

**The roll call vote on the amended motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **None** |

12. Comments by members of the public.

There were no members of the public present.

13. Motion to go into Closed Session

**It was moved by Director Kellett and seconded by Director Schallock to return to Closed Session.**

**The roll call 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** |

14. The Board returned to Open Session at 8:51 p.m. with Directors Dagostino, Grass (via teleconference), Kellett, Mitchell, Nygaard and Schallock present.

15. 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 8:52 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A SPECIAL MEETING**
**OF THE BOARD OF DIRECTORS**

**March 16, 2017 – 3:00 o'clock p.m.**
**Assembly Room 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 March 16, 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:

Adriana Ochoa, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Cheryle Bernard-Shaw, Chief Compliance Officer
Norma Braun, Chief Human Resource Officer
Chris Miechowski, Director Facilities Management
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 Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   **It was moved by Director Nygaard to approve the agenda as presented. Director Schallock seconded the motion. The motion passed unanimously (7-0).**

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Consideration to waive Board Policy 14-006 #3 related to taping of Open Session

   **It was moved by Director Schallock to waive Board Policy 14-006 related to taping of today's Open Session. Director Reno 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** |

5. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Ms. Ochoa, made an oral announcement of item listed on the March 16, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one (1) matter of Potential Litigation.

6. Motion to go into Closed Session

   **It was moved by Director Kellett and seconded by Director Schallock to go into Closed Session. The motion passed unanimously (7-0).**

7. Chairman Dagostino adjourned the meeting to Closed Session at 3:05 p.m.

8. The Board returned to Open Session at 3:30 p.m. with all Board Members present.

9. Open Session

10. Report from Chairperson on any action taken in Closed Session.

    Chairperson Dagostino reported no action was taken in Closed Session

11. New Business

    1) Discussion and possible action regarding emergency piping repairs in basement and actions taken under Resolutions No. 775 and No. 782.

       Mr. Chris Miechowski summarized the actions and expenditures taken last week under Resolution No. 775 – A Resolution of the Tri-City Hospital District Board of Directors Authorizing the Chief Executive Officer to Award Certain Emergency Contracts and Resolution No. 782 – A Resolution of the Board of Directors of the Tri-City Healthcare District Authorizing the Chief Executive Officer to Award Certain Emergency Contracts Relating to Piping Repairs in Basement. He explained that last week it was predicted that repairs related to the piping would not exceed the $750,000 authorized by Resolution No. 782; however upon further analysis it was determined that further repairs will need to be made at a total eventual cost of approximately $1million dollars. Additionally, further investigation revealed that more of the sewer mainline is compromised, necessitating the replacement of nearly double the amount of sewer pipe originally contemplated, which is anticipated to bring the new total cost of repairs to roughly $1.75 million. This is why the Board is being presented with adopting Resolution No. 783. General Counsel Ms. Ochoa stated discussion was held with staff regarding the possibility of bidding the additional repairs out, however the delay would impede the kitchen, thereby not remedying the emergency, and a pump would need to be run until the repairs were made at $15,000 per day. It was determined the competitive bid process would not be cost effective in this emergent situation.

Director Reno called for the question.

2) Consideration to approve Resolution No. 783, A Resolution of the Board of Directors of Tri-City Healthcare District Increasing the Authority of the Chief Executive Officer to Award Certain Emergency Contracts Relating to Piping Repairs in Basement

**It was moved by Director Reno that the Tri-City Healthcare District Board of Directors hereby increase the authority conferred upon the Chief Executive Officer to execute emergency contracts on behalf of the District to a new total not-to-exceed amount of $1,750,000 in order to repair or replace facilities and property damaged by the Failure, and to take any immediate actions required directly relating to the Failure, without seeking competitive bids. The not-to-exceed amount reflected in this Resolution No. 783 is meant to encompass all contracts executed from February 27, 2017 until the repairs to the damages caused by the Failure are completed. Director Kellett 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** |

12. Comments by Members of the Public

There were no comments by members of the public.

13. There being no further business, Chairman Dagostino adjourned the meeting at 3:35 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

Stakeholder Experience

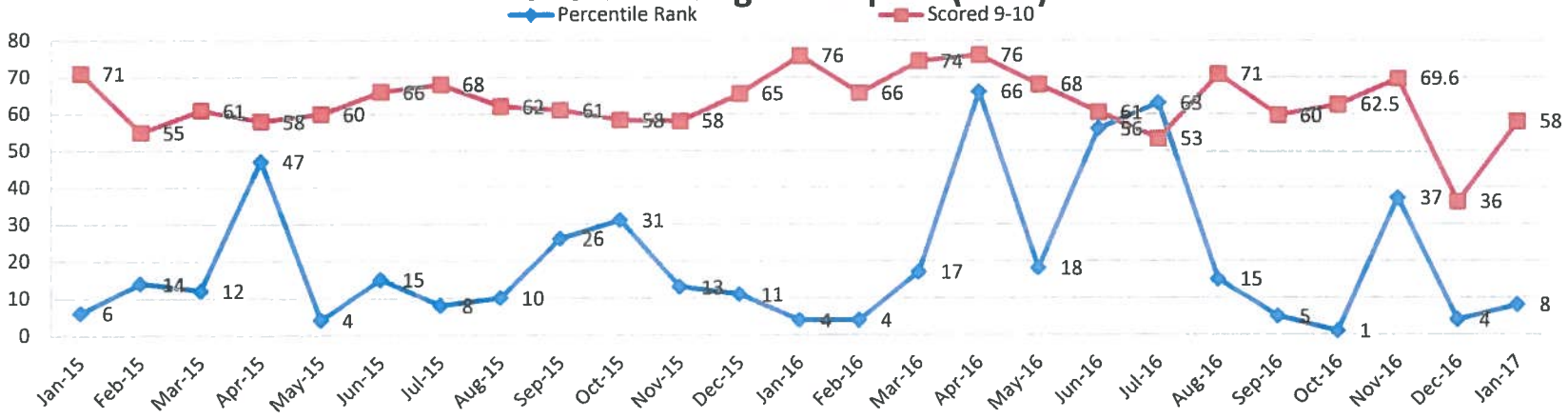
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

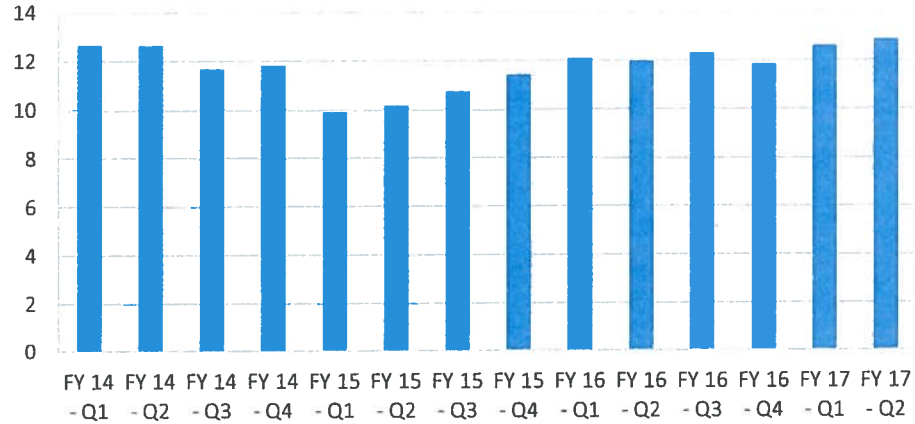
# HCAHPS (Top Box Score)

*Hospital Consumer Assessment of Healthcare Providers & Systems*

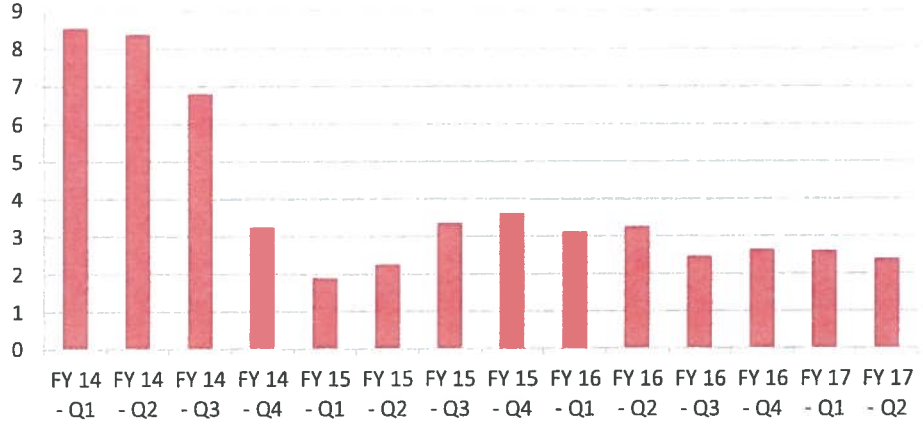
## Overall Rating of Hospital (0-10)



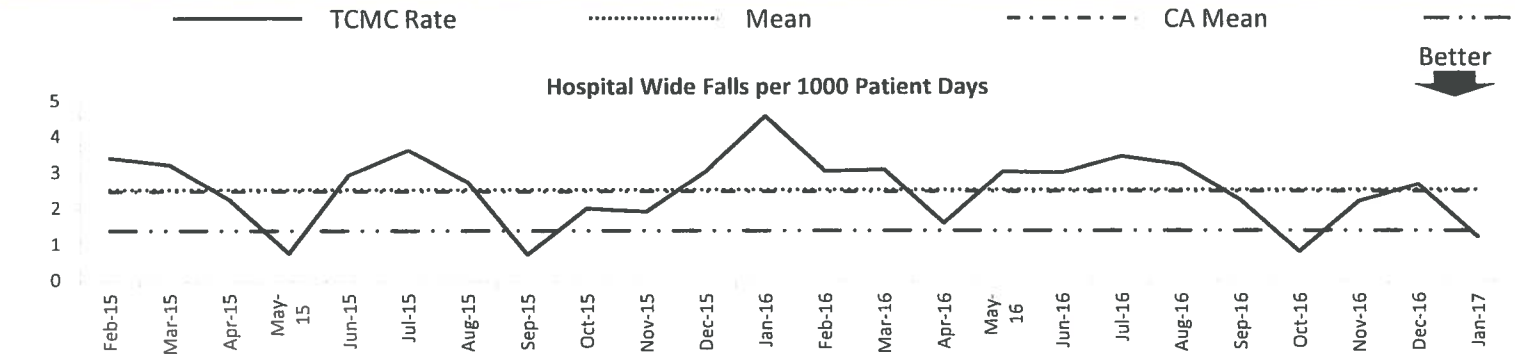

## Voluntary Employee Turnover Rate




## Involuntary Employee Turnover Rate

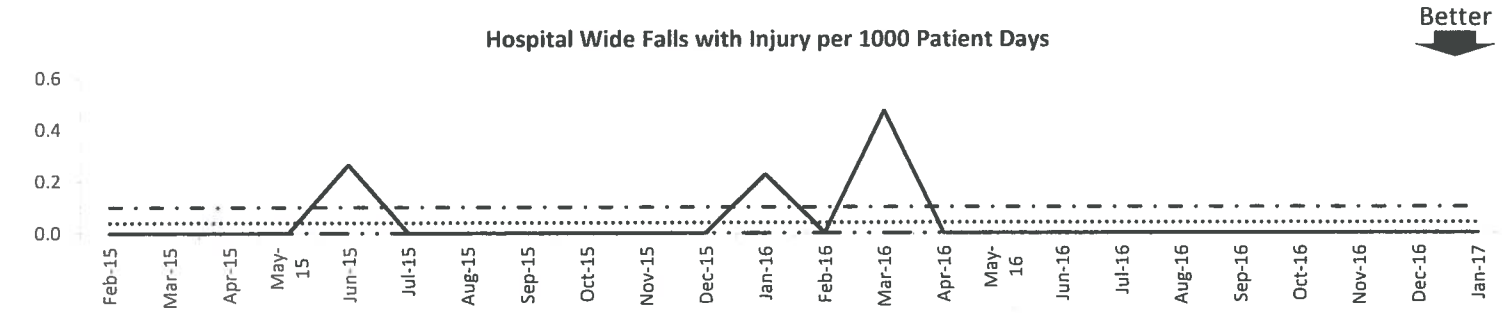


# Fall & HAPU's



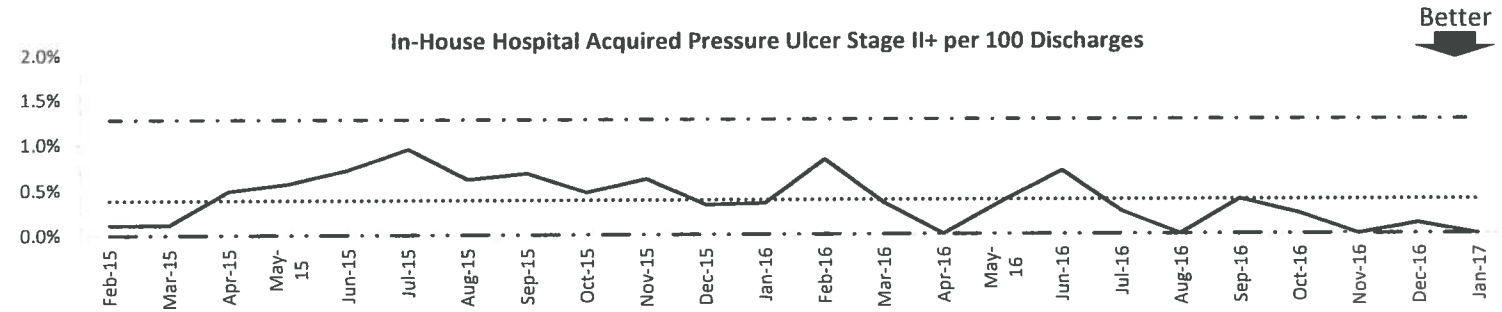

## Action Plan

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

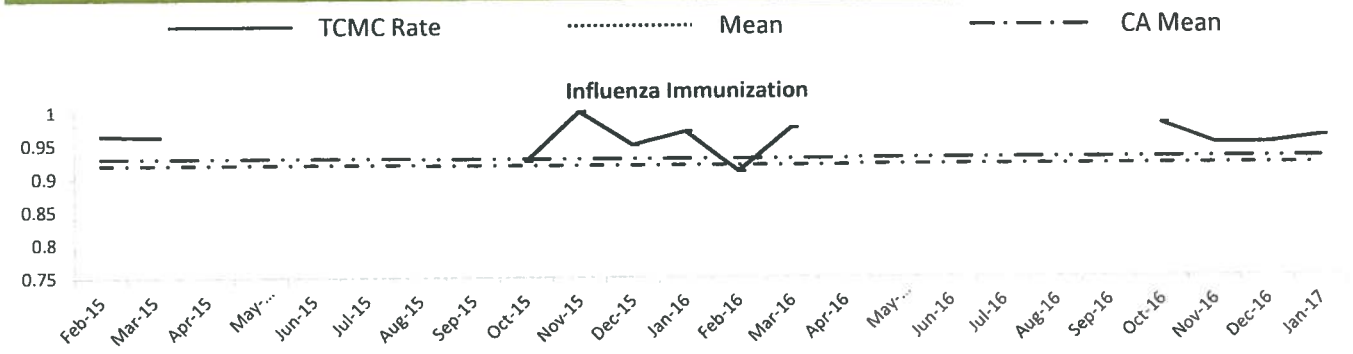
(Cont) We appreciate a 16% decrease in FY2016 compared to FY 2015 related to the TST Falls prevention tool.
9 consecutive months without a Fall with Injuries.




## Action Plan

Units are working on unit based skin champions, rounding, and increasing the comfort level of skin integumentary changes. Staff is continuing to work on prevention of pressure injuries implementing interventions and general awareness of Skin assessment.

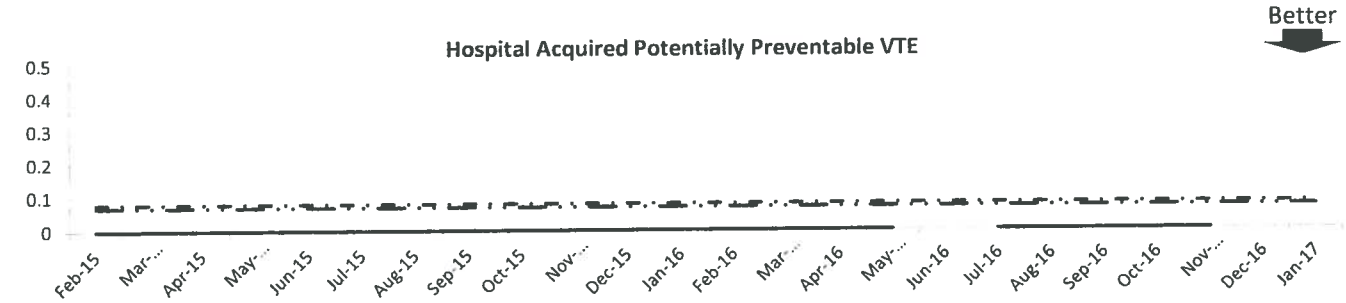
# Core Measures




Better

**Action Plan**

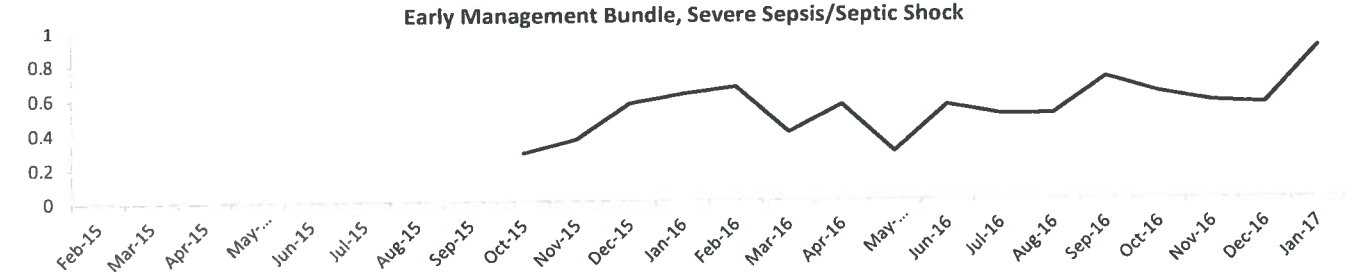
Consistently above our goal.




Better

**Action Plan**

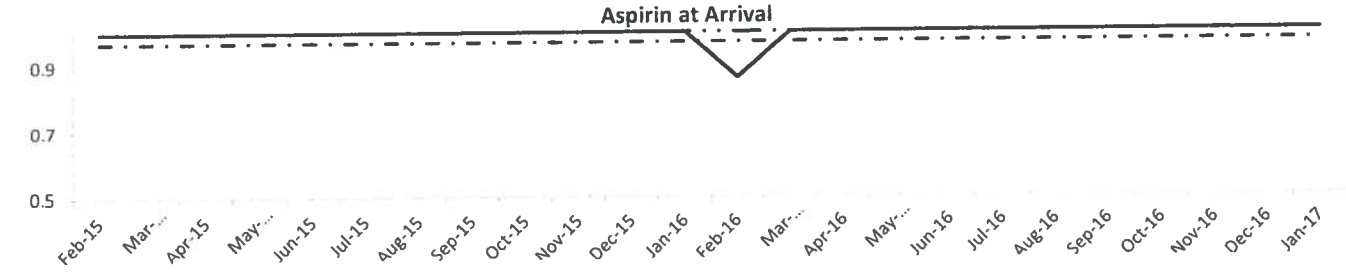
Consistently at 0%.




Better

**Action Plan**

Efforts to improve documentation and meet all criteria showing promise. January pass is highest to date at 86%.



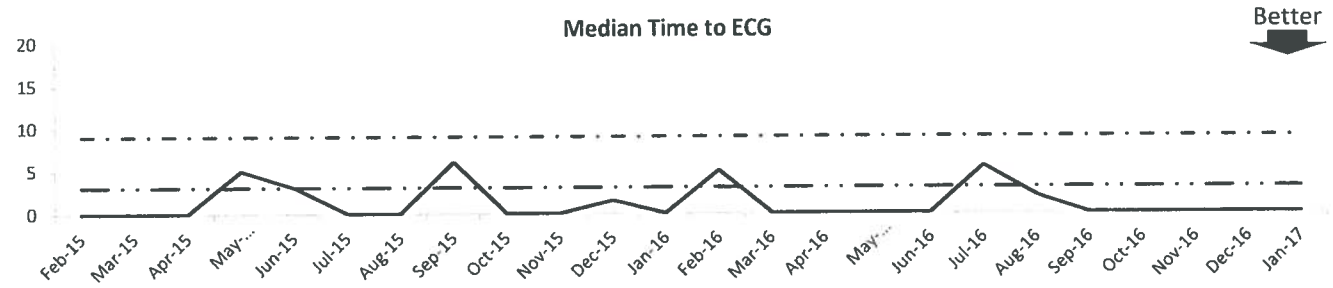

Better

**Action Plan**

Consistantly at 100%.

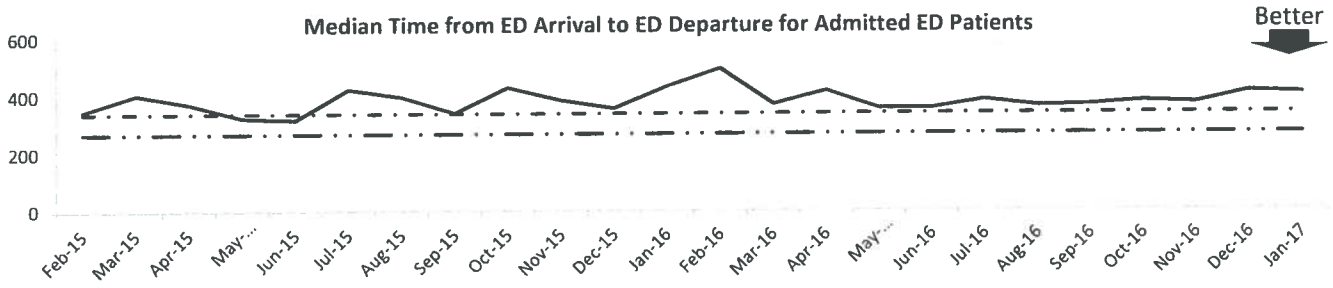
# Core Measures

TCMC Rate ····· Mean — · — CA Mean — · · — TCMC Target



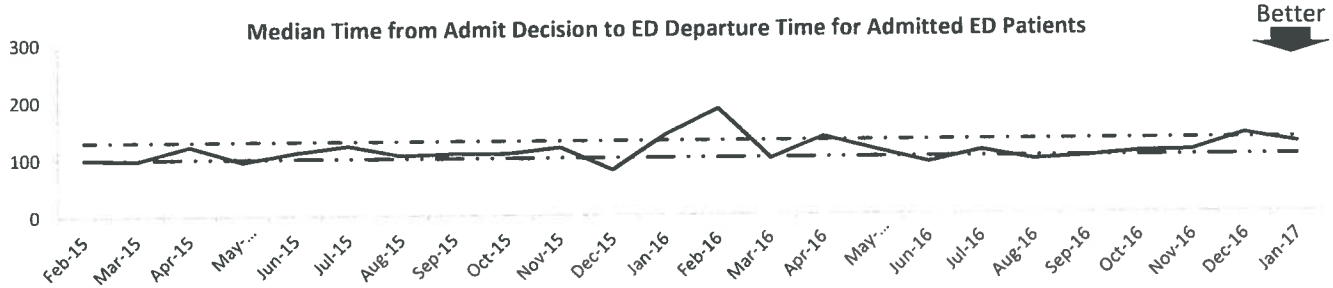

**Action Plan**

Consistently at "0" minutes arrival to 1st ECG. Below national top 10%.



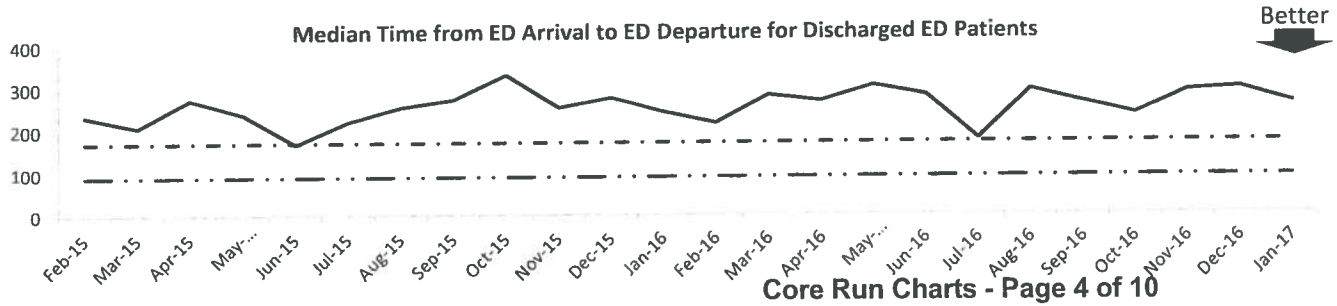

**Action Plan**

Holding steady the last six months, continue to work on initiatives to further lower this rate. A trial will start utilizing the ACS RNs to start the admission process in the ED.




**Action Plan**

Rate has been steady for many months, continue to work on improving admission process to floors. By trialing the new process outlined above, the nurses will give bedside report to each other. This will reduce the time it takes to give report prior to admission.

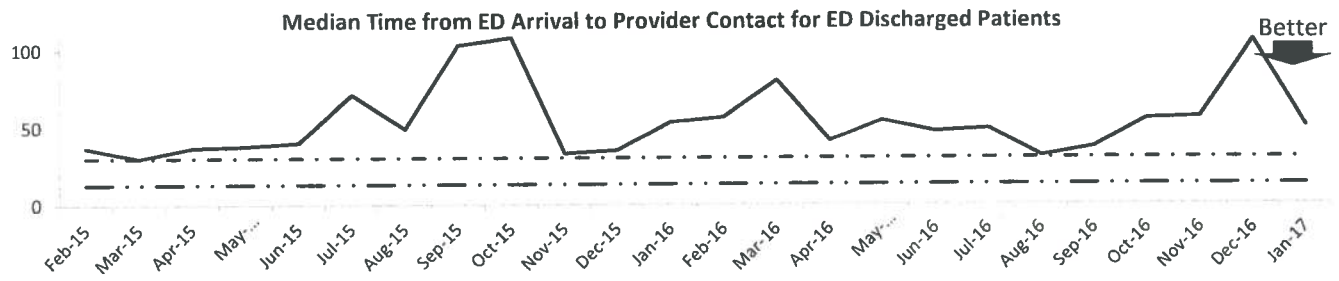



**Action Plan**

Seeing an increase in time, in part due to backlog of CSU patient throughput as well as ED Staffing issues. 3/17, a trial start by placing a ED MD in triage from 12N-8P to see more lower acuity patients and discharge them directly from Team Triage.

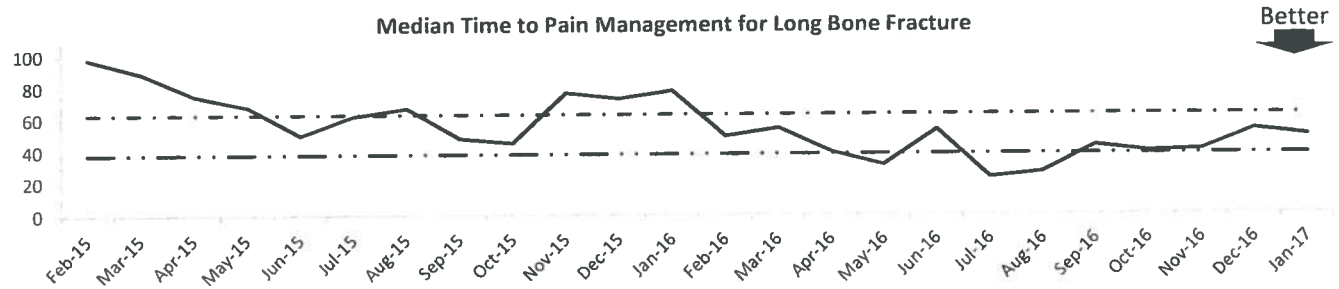
# Core Measures

TCMC Rate ..... Mean — · — · — CA Mean — · — · · · TCMC Target



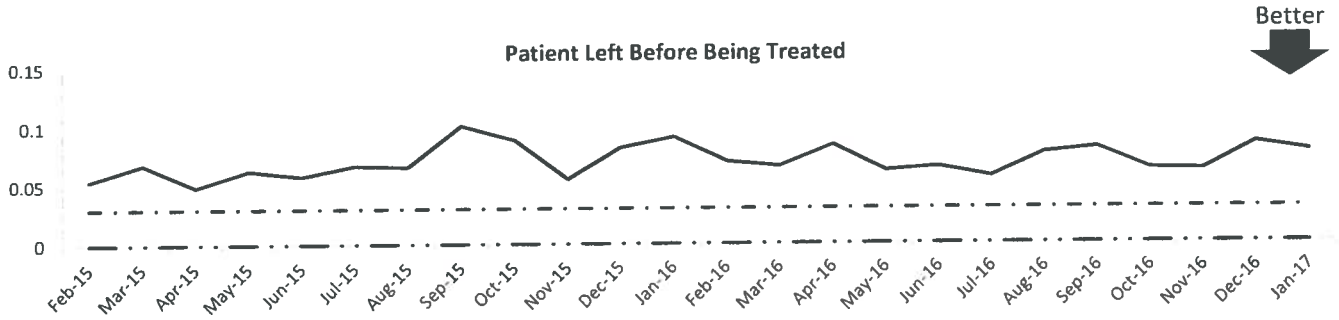

**Action Plan**

Team Triage has expanded hours, should be seeing a reduction in these times and a further reduction with the new MD in triage process.




**Action Plan**

CMS criteria is pain med administration within 60 min of arrival. Currently below that level. Process redesign and education still awaiting resultant benefit.




**Action Plan**

This rate increases when saturation hits the ED, so the ED PAs are making contact with every patient checking in to be seen at their initial contact with the ED Triage RN. This encourages patients to stay for treatment by this direct contact with a provider.


Tri-City Medical Center

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# Volume

Spine Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 28 | 22 | 13 | 25 | 27 | 23 | 19 | 23 | | | | 180 |
| 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 | 8 | | | | 77 |
| 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 | 10 | | | | 82 |
| 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 | 16 | | | | 145 |
| 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 | 30 | | | | 261 |
| 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 | 14.8 | | | | 15.7 |
| 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 | 5.9 | | | | 6.3 |
| 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 | 11.7 | | | | 15.7 |
| 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 | 177.8 | | | | 182.0 |
| 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 | 197 | | | | 1777 |
| 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 | 11 | | | | 102 |
| 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 | 2 | | | | 36 |
| 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 | 6 | | | | 63 |
| 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 | 1.73 | | | | 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


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# 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 | 49.0 | | | | | 49.8 | 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 | 47.5 | 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 | 79.9 | | | | | 84.9 | 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 | 85.2 | 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) | $181 | | | | | $3,050 | $1,901 |
| FY16 | $862 | $612 | $182 | ($189) | ($513) | $965 | ($1,784) | ($411) | ($220) | $331 | $315 | ($1,842) | ($276) | |

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% | 0.67% | | | | | 1.37% | 0.83% |
| 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% | -0.13% | |


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 | $1,428 | | | | | $13,163 | $12,342 |
| FY16 | $2,046 | $1,817 | $1,357 | $1,011 | $644 | $2,155 | ($594) | $797 | $1,019 | $1,530 | $1,598 | ($558) | $9,233 | |

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% | 5.28% | | | | | 5.92% | 5.37% |
| 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% | 4.18% | |

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 | 6.14 | | | | | 6.05 | 6.00 |
| 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 | 5.92 | |

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 | 1.37 | | | | | 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 | $34.6 | | | | | |
| 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

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Building Operating Leases

Month Ending February 28, 2017

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. | | Total Rent per current month | Lease Term Beginning | Lease Term Ending | Services & Location |
|---|---|---|---|---|---|---|---|
| **American Health & Retirement**<br>DBA: Vista Medical Plaza<br>140 Lomas Santa Fe Dr., Ste 103<br>Solona Beach, CA 92075<br>V#82904 | 1,558 | $2.25 | (a) | 5,585.14 | 01/27/17 | 05/31/20 | **Venus OBGYN Clinic**<br>2067 W. Vista Way, Ste 160<br>Vista, CA 92083 |
| **Camelot Investments, LLC**<br>5800 Armada Dr., #200<br>Carlsbad, CA 92008<br>V#15608 | Approx 3,563 | $1.85 | (a) | 10,226.49 | 4/1/2016 | 01/31/20 | **PCP Clinic - Radiance**<br>3998 Vista Way, Ste. C<br>Oceanside, CA 92056 |
| **Creek View Medical Assoc**<br>1926 Via Centre Dr. Suite A<br>Vista, CA 92081<br>V#81981 | Approx 6,200 | $2.63 | (a) | 20,106.00 | 2/1/2015 | 01/31/20 | **PCP Clinic - Vista**<br>1926 Via Centre Drive, Ste A<br>Vista, CA |
| **Eflin Investments, LLC**<br>Clancy Medical Group<br>20136 Elfin Creek Trail<br>Escondido, CA 92029<br>V#82575 | 3,140 | $2.49 | (a) | 9,265.25 | 12/01/15 | 12/31/20 | **PCP Clinic**<br>2375 Melrose Dr. Vista<br>Vista, CA 92081 |
| **GCO**<br>3621 Vista Way<br>Oceanside, CA 92056<br>#V81473 | 1,583 | $1.92 | (a) | 3,398.15 | 01/01/13 | 02/28/17 | **Performance Improvement**<br>3927 Waring Road, Ste.D<br>Oceanside, Ca 92056 |
| **Investors Property Mgmt. Group**<br>c/o Levitt Family Trust<br>2181 El Camino Real, Ste. 206<br>Oceanside, Ca 92054<br>V#81028 | 5,214 | $1.86 | (a) | 10,032.46 | 09/01/12 | 08/31/17 | **OP Physical Therapy**<br>**OP OT & OP Speech Therapy**<br>2124 E. El Camino Real, Ste.100<br>Oceanside, Ca 92054 |
| **Melrose Plaza Complex, LP**<br>c/o Five K Management, Inc.<br>P O Box 2522<br>La Jolla, CA 92038<br>V#43849 | 7,247 | $1.37 | (a) | 10,101.01 | 07/01/16 | 06/30/21 | **Outpatient Behavioral Health**<br>510 West Vista Way<br>Vista, Ca 92083 |
| **OPS Enterprises, LLC**<br>3617 Vista Way, Bldg. 5<br>Oceanside, Ca 92056<br>#V81250 | 4,760 | $4.00 | (a) | 25,580.00 | 10/01/12 | 10/01/22 | **Chemotherapy/Infusion Oncology Center**<br>3617 Vista Way, Bldg.5<br>Oceanside, Ca 92056 |
| **Ridgeway/Bradford CA LP**<br>DBA: Vista Town Center<br>PO Box 19068<br>Irvine, CA 92663<br>V#81503 | 3,307 | $2.11 | (a) | 5,039.70 | 10/28/13 | 03/03/18 | **Vacant Building**<br>510 Hacienda Drive Suite 108-A<br>Vista, CA 92081 |
| **Tri City Wellness, LLC**<br>6250 El Camino Real<br>Carlsbad, CA 92009<br>V#80388 | Approx 87,000 | $4.08 | (a) | 246,428.00 | 07/01/13 | 06/30/28 | **Wellness Center**<br>6250 El Camino Real<br>Carlsbad, CA 92009 |
| **Total** | | | | **$345,762.20** | | | |

**(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.**

**Education & Travel Expense**
**Month Ending 2/28/17**

| Cost Centers | Description | Invoice # | Amount | Vendor # | Attendees |
|---|---|---|---|---|---|
| 7290 | MEDICARE TRAINING | 21417 | 380.00 | 14369 | M. TRUDEAU, C. BOATRIGHT |
| 7400 | ACLS-BLS COURSE | 12717 | 205.00 | 82903 | BRENDA RUSSELL |
| 8390 | 340B COALITION-CONFERENCE | 1201162 | 1,072.11 | 79349 | TORI HONG |
| 8510 | PAYROLL LAW 2017 | 22717 | 149.00 | 37911 | PAYROLL STAFF |
| 8620 | CHA HEALTH POLICY LEGISLATIVE DAY | 13115 | 245.00 | 81163 | JAMES DAGOSTINO |
| 8620 | COMPLIANCE CONFERENCE | 13115 | 895.00 | 81163 | JAMES DAGOSTINO |
| 8620 | LEADERSHIP ACADEMY - REGISTRATION | 13117 | 150.00 | 81163 | JULIE NYGAARD |
| 8620 | LEADERSHIP ACADEMY - AIRFARE | 13117 | 190.90 | 81163 | JULIE NYGAARD |
| 8620 | 2017 LEGISLATIVE RECEPTION | 13117 | 125.00 | 81163 | JULIE NYGAARD |
| 8620 | CHA HEALTH POLICY LEGISLATIVE DAY | 13115 | 245.00 | 81163 | LARRY SHALLOCK |
| 8620 | LEADERSHIP ACADEMY - AIRFARE | 13115 | 203.90 | 81163 | LEIGH ANN GRASS |
| 8650 | ADVANCED SKILLS OF EMP LEAVE | 11917 | 549.00 | 82746 | NORMA BRAUN |
| 8720 | CARE COORDINATION SUMMIT | 11917 | 795.00 | 79251 | SHARON SCHULTZ |
| 8740 | ACLS COURSE | 20817 | 155.00 | 52607 | MELISSA PICOTTE |
| 8740 | SCANN CONFERENCE | 12617 | 160.00 | 82900 | LAKETA DUCAT |
| 8740 | CERTIFICATION IN INFECTIOUS CONTROL | 20217 | 200.00 | 42078 | LISA F. MATTIA |
| 8740 | ACLS COURSE | 20817 | 200.00 | 80084 | COURTNEY NELSON |
| 8740 | ACLS COURSE | 20817 | 200.00 | 81490 | CLAUDIA MOOREHEAD |
| 8740 | ACLS COURSE | 20817 | 200.00 | 82376 | BARBARA HORNICK |

**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.

March 16, 2017

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

California Hospital Association Health Policy Legislative Day March 14 &15 2017 Sacramento, CA

Larry Schallock and I attended the CHA Leg day in Sacramento. We were an integral part of the San Diego Team representing CHA on legislative issues important to us. We were joined by our colleagues from Palomar, Scripps, Sharp and UCSD. Since Mr. Schallock and I were part of the leadership team, the Tuesday was spent on briefing us on the legislation.

Four bills were placed on the top priorities list and some time was devoted to the budget.

1 SB 481(Support) This bill created a process that will allow patients in skilled nursing facilities unable to consent to medical care to have medical treatment decisions made for them by their doctor. Prior system for this was determined unconstitutionally law and so CHA with the author created a system to guarantee that care could be rendered to these individuals. This process is needed as without a medical team determining appropriate care skilled nursing facility would most likely for the patient to an emergency room. Support of this bill seeks to make sense for all concerned.

2 SB 647 (Support)- This bill is in "spot bill format " but would allow provider networks that are "leased out" the guarantee that all of their contractual agreements must be adhered to. It seems that networks of providers are put together by large insurance carriers. Smaller insurers or trust funds will use that provider network their own companies. It seems that smaller institutions want the lower discounted rates but do not want to share in the other benefits to the provider this contract may net. CHA supports this bill because it supports the providers who work in their institutions.

3 AB 387 – (Oppose)) This bill would would mandate that students in healthcare training programs such as radiology technicians clinical laboratories physical occupational therapist and other community college programs would be paid minimum wage they are on their internships. Institution has agreed to accept these students will be required to pay than minimum wage. CHA opposes this bill because the increase economic burden of the institutions would tend to reduce clinical internship spots.

4 SB 687 (Oppose) This bill would require that prior to a nonprofit agency closing or reducing its emergency department services would have to seek permission the Atty. Gen. California. You would have to give the Atty. Gen. written notice could launch an investigation hiring experts. The hospital would be burdened with those costs of the experts. CHA opposes this bill as there are remedies in place when an institution is forced to reduce services. Bill was deemed burdensome to struggling institutions and can further economically harm an institution trying to survive.

5 Budget considerations- It seems as if the governor's budget takes opposition 56 money ( Tobacco tax) and throws it back into the Medi-Cal general fund. That money was supposed to be used for increasing fees for providers as well as guaranteeing funding for graduate medical education. CHA opposes this transfer funds. Also, budget talks about expanding the 340 B drug program to Medi-Cal managed care. Since the 340 B drug program is a fee-for-service type program CHA feels that institutions that have a difficult time implementing the economics of the 340 B program in a managed care environment.

Mr. Schallock and I were both team leaders felt that that position allowed us to be quite knowledgeable on pending legislation. The legislative breakfast in the morning we spent personal time with Assemblyman Chavez and Sen. Bates. We took the lead on the legislative presentations in both of their offices and met with them personally.

We spent time with her counterpart Aaron Byzak from UCSD and got an update on the future planning of the University. We talked about other subjects that may be valuable to both institutions and I personally would suggest that we spend more time with our new partner discussing these types of issues.

# Health Care Coverage

CALIFORNIA HOSPITAL ASSOCIATION

# Keep Californians Covered

## California Leads the Nation in Expanding Health Care Coverage

Having health care coverage helps individuals get the appropriate care when needed, including preventive services and primary care. Getting the proper level of treatment in a timely manner helps reduce health care costs.


**The uninsured rate fell from 17% to 9% over the last two years**

- 1 in 3 Californians depends on the Medi-Cal program for health care coverage[1].
- Close to 4 million Californians received coverage through the Medicaid expansion[2].
- 1.4 million residents have purchased coverage through Covered California, the state's insurance marketplace[3].

1 California Health Care Foundation
2 California Department of Health Care Services
3 Covered California

## Coverage for Those in Need

Many of the newly insured are the working poor, families with children living in poverty and young adults.

Poverty is one of the greatest threats to our health — and California has the highest poverty rate of all states. An estimated 6.3 million[4] Californians, including 1.9 million[5] children, live in poverty.

Using the Supplemental Poverty Measure[6] (SPM) — which takes into account life in the 21st century, including contemporary social and economic realities and government policy — the U.S. SPM is 16 percent. For California, the SPM is 23.8 percent.


**California has the highest poverty rate in the nation**

4 United States Census Bureau
5 Children in Poverty, Anne E. Casey Foundation
6 United States Census Bureau, Supplemental Poverty Measure

**91%**

**of all Californians now have health care coverage**

Repealing the ACA without meaningful replacement would result in millions of Californians losing the health care coverage they need. If coverage is reduced, payments will decline. When that happens, services also decline or may become unavailable — and that hurts everyone.

# Let's work together to repair our nation's health care system.

- Repeal of the ACA should only be pursued IF replacement is simultaneous and meaningful.
- We must build on coverage, essential consumer protections and delivery system reforms.
- Hospitals must have the ability to continue to innovate and develop high-quality, efficient models of patient care.

## Hospital Innovations Lead to Lower Costs and More Affordable Care

California hospitals have worked hard to reduce costs through delivery system reform, care coordination and clinical efficiencies. These innovations mean patients often recover quicker and can return home sooner. This lower utilization results in lower costs.

Across the board, California hospitals consistently perform better than the national average. Here are key community health indicators that show usage for every 1,000 individuals:[7]

| | California | U.S. Average | Highest |
|---|---|---|---|
| Hospital Beds | 1.8 | 2.5 | 5.4 |
| Hospital Admissions | 82.3 | 103.7 | 193.2 |
| Hospital Days | 420.9 | 565.9 | 1403.0 |
| Emergency Visits | 327.1 | 427.6 | 755.3 |
| Hospital Costs | $2,285 | $2,537 | $6,241 |

**California's health care costs are lower than the U.S. average.**

7 AHA Hospital Statistics 2016 Edition American Hospital Association

## Communities are Strengthened by the Economic Contributions of Hospitals

Hospitals have a huge impact on the viability of local communities. California hospitals are often the largest employer in their community, providing well-paying jobs to nurses, doctors, health professionals and others. The economic contribution is further realized through the purchase of goods and services, equipment, education and training, and more.

**$84 B**
Salaries and Benefits

**$145 B**
Economic Output in Goods/Services

**$229 B**
Total Contribution to California[9]

**Nearly 1 million jobs result from hospital employment.**

9 Compiled using IMPLAN multipliers and 2015 Office of Statewide Health Planning and Development data; includes direct economic impact and ripple effect

## California Hospital Association

The statewide leader representing the interests of California's hospitals and health systems. Proudly representing:

**400+** hospitals and health systems

**97%** of California hospital beds

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### California hospitals.
### We are there when you need us.

**Each year:**

- 500,000 babies are born in California hospitals.
- Californians make 48 million visits to hospitals.
- Californians make 15 million visits to the ER.

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**Regional Association Partners:**

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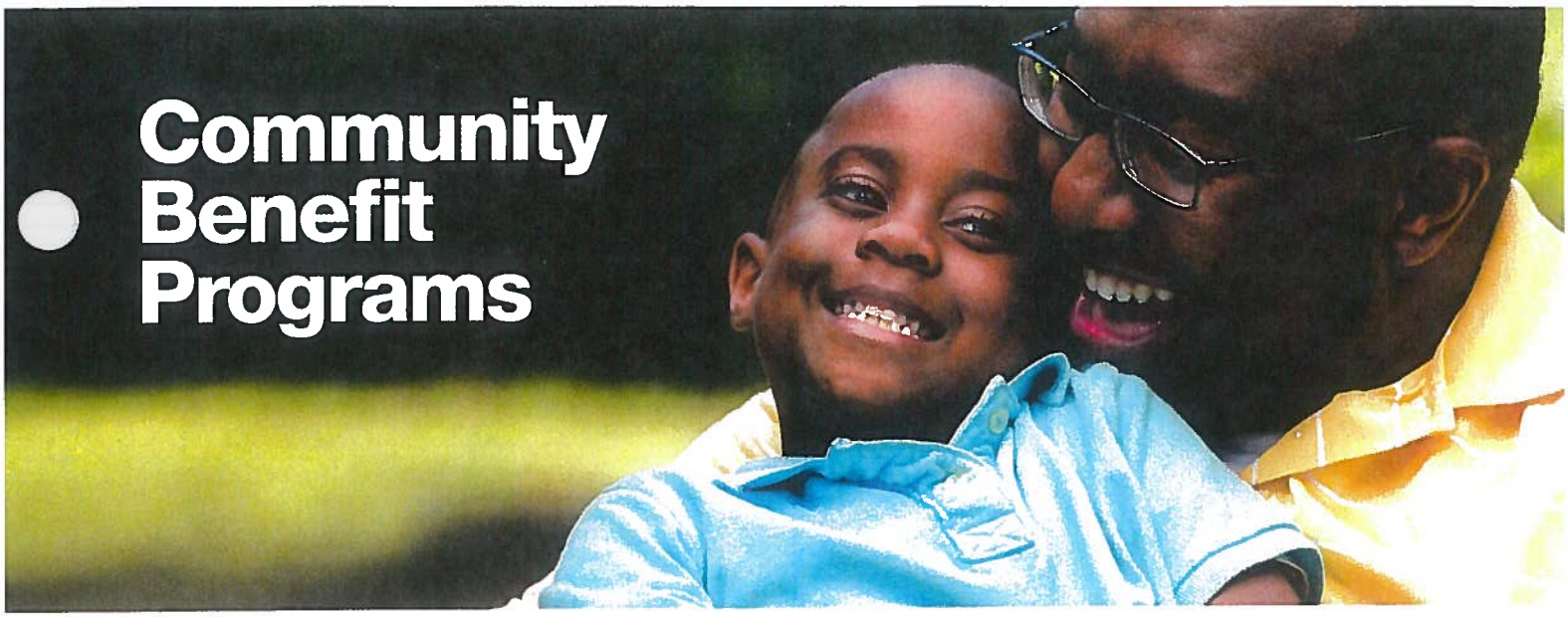
Hospital Association of Southern California
Hospital Association of San Diego and Imperial Counties

# Community Benefit Programs

Not-for-Profit Hospitals
Meeting the Health Needs of
the Communities They Serve

CALIFORNIA HOSPITAL ASSOCIATION

# Community Benefit Programs



## California's Community Benefit History

For more than 20 years, California's not-for-profit (NFP) hospitals have led the nation in ensuring that vulnerable populations have access to much needed health care services and health improvement programs.

In 1994, NFP hospitals' missions were affirmed by a state law[1] that constructed the framework for conducting a community health needs assessment (CHNA) and developing a community benefit plan[2]. This framework served as a national model for similar provisions in the Affordable Care Act, enacted in 2010[3]. Today, NFP hospitals continue their tradition of commitment by investing an estimated $12 billion annually in their communities[4].

## Community Benefit Programs and Activities Reflect Local Communities

Flexibility in local planning and decision making is crucial to meeting the diverse health needs and priorities of communities. NFP hospitals, in partnership with community stakeholders, identify and help address significant health needs with programs and activities delivered at the right place and at the right time.

## Elements of a Community Benefit Program

Community benefits are programs or activities that respond to identified community health needs and meet at least one of these objectives:

- Improve access to health services
- Enhance public health
- Increase general knowledge through education and research
- Relieve government's burden to improve health

Community health needs can be identified by conducting a CHNA, responding to a request from a public health agency or community group, or involving unrelated partners in a program or activity that improves community health.

1 Senate Bill 697 (Chapter 812, Statutes of 1994)
2 Federal version is called "implementation strategy"
3 Patient Protection and Affordable Care Act, Public Law 111 – 148 (2010)
4 Campbell, T., Wazzan, C., Tanimura, J., et al. *An Economic Assessment of Public Policies to Compel Unreimbursed Services To Be Provided By Nonprofit Hospitals in California*. Berkeley Research Group, Jan. 2014, plus, uncompensated care as reported by OSHPD (2015).

**$12 billion**
**contributed each year**

California's not-for-profit hospitals contribute an estimated $12 billion each year to their communities in community benefit programs and activities.

# Not-for-Profit Hospitals Partner With Communities to Assess Community Health Needs

Every three years, California's NFP hospitals, in partnership with their local communities, conduct a community health needs assessment and develop a community benefit plan. Hospitals engage a broad range of organizations and individuals with knowledge and expertise about the community's health needs to accomplish this important work.

## 1 Analyze and Identify

Information is collected and analyzed to determine health needs. Sources include quantitative health statistics from publicly available sources, including the health department, and qualitative data gathered from interviews, surveys or community meetings.

## 2 Prioritize

Communities may have many health needs, and some are more significant than others. Identified health needs are evaluated to determine the urgency, effectiveness of potential intervention and availability of existing hospital and community resources to address the health need.

## 3 Develop and Implement

A formal community benefit plan is developed and implemented to address the prioritized health needs of the community. Partners are identified for many programs, and measurable outcomes and goals are established.

## 4 Publicly Report

NFP hospitals' CHNA and community benefit plans are readily available to the public. Look to California's Office of Statewide Health Planning and Development website for the community benefit report and plan. The CHNA and federal implementation strategy are posted on hospitals' websites.

## Flexibility in Program Development is Critical

Since every community is unique, all community benefit programs and activities are created specifically to meet the prioritized health needs of the local population.

### Community Benefit Programs and Activities Can Take Many Forms

**Community benefit includes the costs of delivering community health programs or activities, such as:**

- Community health improvement services, including immunizations, free screenings, mobile units serving disadvantaged families, classes on disease management and violence prevention, and school-based health programs.
- Health professions education programs that train the next generation of health care providers.
- Research in clinical and community health that contributes to evidence-based practices.
- Cash and in-kind contributions to other local NFP organizations and community clinics providing services to underserved populations.
- Community building activities that protect or improve the community's health or safety, including housing, economic development, environmental improvements, and leadership development and training for community members.
- And much more.

**NFP hospitals also provide community benefits by helping patients who can't afford to pay for their health care, such as:**

- Charity care or discounted care.
- Accepting shortfalls from government-sponsored health care programs, including Medi-Cal and Medicare[5], the state Children's Health Insurance Program and medically indigent programs.
- Subsidized health services for neonatal intensive care, addiction recovery, inpatient psychiatric units, emergency and trauma services, satellite clinics for low-income communities and home health programs.

5 Medicare shortfall is reported at the federal level and counts as community benefit in California — this is important given California's aging population is projected to double over the next 20 years

## Underfunded Government Programs

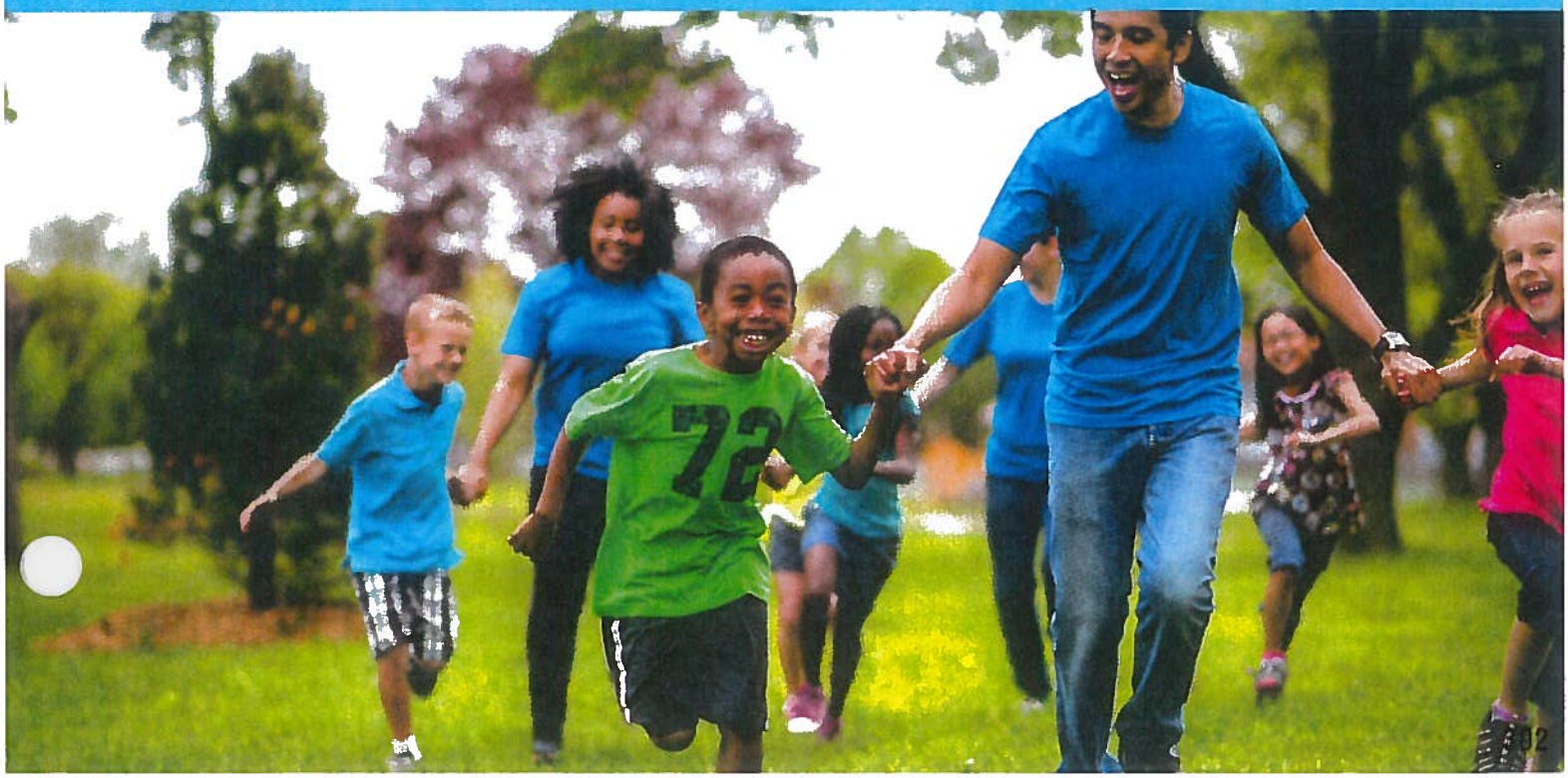
Although charity care has decreased under the ACA, hospitals continue to assume the responsibility for uncompensated care from chronically underfunded Medi-Cal and Medicare programs.

| Uncompensated Care | 2013 | 2015 |
|---|---|---|
| Medi-Cal shortfall[6] | $2.0B | **$2.8B** |
| Medicare shortfall[7] | $5.6B | **$6.8B** |
| Charity/Discounted/ Indigent Care[8] | $2.0B | **$.7B** |
| **Totals** | **$9.6 billion** | **$10.3 billion** |

6. Estimated
7. Per OSHPD (2015)
8. Per OSHPD (2015)

# Serving the Community — First and Always

California's not-for-profit (NFP) hospitals are committed to improving the health and well-being of the communities they serve. This valuable work is inherent in NFP hospitals' mission and symbolizes a commitment to help create healthy communities outside of the hospital walls — especially in high need and vulnerable communities. At NFP hospitals, all resources are invested in health care services or into their communities.



## California Hospital Association

The statewide leader representing the interests of California's hospitals and health systems. Proudly representing:

**400+** hospitals and health systems

**97%** of California hospital beds

---

### Want to Learn More?

For more information on community benefit programs or to read about community benefit success stories, visit www.calhospital.org/community-benefit-programs.

Or contact:

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Hospital Association of Southern California
Hospital Association of San Diego and Imperial Counties

# CHA Health Policy Legislative Day 2017

**Advocating for patients and your hospitals**

## Ensure Medically Necessary Care for Unrepresented Patients

# Support SB 481

- Existing law regarding patient notification was found deficient by a court ruling.
- SB 481 would address deficiencies in current law regarding care for thousands of vulnerable patients who cannot speak for themselves.
- SB 481 will protect patient/resident rights and assure timely access to medically necessary care.

### Issue

California's skilled-nursing facilities (SNFs) strive to provide appropriate medical services to all residents in their care. Existing law must be updated to ensure that vulnerable SNF residents who are unable to speak for themselves and have no family to make decisions for them, have timely access to medically necessary care, and avoid unnecessary, disruptive and costly hospitalizations.

### Position

CHA is a co-sponsor of SB 481 (Pan, D-Sacramento) along with the California Association of Health Facilities. SB 481 will update previous law by including a new requirement that the physician, SNF or intermediate care facility — prior to implementing a medical intervention that requires informed consent — notify a patient/resident that it has been determined that the resident lacks capacity, that no family can be found to make decisions for them and that treatment has been recommended to them. SB 481 will protect the patient/resident's rights by establishing a clear process for patient notification.

### Analysis

Current law provides a process for SNFs to use an interdisciplinary team to make medical decisions for patients who lack capacity and have no family or other representative to make decisions. However, a 2015 court decision, *California Advocates for Nursing Home Reform v. Chapman (Director of the Department of Public Health)* declared the current legal process to be unconstitutional. Among the court's findings was the determination that the current law does not include adequate patient/resident notification.

The lack of a legal process to facilitate or authorize decisions for unrepresented patients can delay access to medically necessary services and undermines the long-term outcomes for our most vulnerable patients. When there is a delay in care, SNFs often send patients to hospitals. Unnecessary hospitalization is not in the best interests of the patient and leads to increases in hospital readmissions and greater congestion in hospital emergency departments. In addition, SNFs may decline to admit unrepresented patients lacking capacity because of the lack of a clear legal process for medical decision making. When this happens, patients may remain in the hospital unnecessarily, increasing lengths of stay.


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# Protect the Integrity of the Health Care Providers' Bill of Rights

## Support SB 647

- The Providers' Bill of Rights has protected providers and consumers for the last 15 years from unfair practices.
- A recent court decision subjects consumers to claim denials, delays in claim resolution and retroactive denials of previously authorized treatment.
- Third parties seeking the benefit of a contract between a health plan and provider must also be required to accept the obligations that are part of that contract.

### Issue

A court has narrowly interpreted the Health Care Providers' Bill of Rights to conclude that a third-party payer may obtain the benefits of the discounted rates of a "leased network," but is not required to comply with the other obligations of the underlying contract between the health plan and the network providers. Instead, the court imposed a duty on health plans to ensure that the terms of all of their provider contracts are "consistent" with the terms of all of their contracts with third party payers. The court decision increases uncertainties and risks for all parties, including consumers, and may eventually lead to the benefits of these arrangements no longer being available. For example, consumers are subject to unfair practices such as claim denials based on medical necessity, excessive delays in claim resolution and retroactive denials of previously authorized treatment.

### Position

CHA is a co-sponsor of SB 647 (Pan, D-Sacramento) along with the California Medical Association.

SB 647 would restore the Legislature's intent in enacting the Providers' Bill of Rights by clarifying that a third party seeking the benefit of a contract between a health plan and a provider must also accept the obligations that are part of that contract.

SB 538 (Monning, D-Carmel) is a related bill that may soon be amended to address the Providers' Bill of Rights issue and other unrelated issues that may impose new restrictions on contracting and leasing of networks. CHA will work with supporters of SB 538 to protect consumers and providers when a third-party payer leases a health plan provider network.

### Analysis

Health plans establish networks of health care providers, including hospitals and physicians, to provide health care services to enrollees. Consumers who receive services from a network provider are only required to pay their co-pays and deductibles, and are not billed for additional fees. Health plans and providers enter into contracts that govern their network relationship, including providers agreeing to discount their services.

Once a health plan has established a network of providers, it may "lease" the network to a separate third-party payer who assumes all the obligations of the underlying health plan/provider contract, including the benefit of the discounted rates. This allows the benefits of high-value networks to be extended to more consumers. Millions of Californians obtain their health care coverage through these arrangements.

In the late 1990s and early 2000s, some third-party payers began to take advantage of the discounted rates in their "leased" network while ignoring the underlying contract's other obligations. As a result, the Legislature enacted the Health Care Providers' Bill of Rights to require the third-party payer to comply with the entire underlying contract between the health plan and provider.

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*(continued next page)*

CHA
Health Policy
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2017

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# Allied Health Trainee Minimum Wage: Reduces Training Programs

## Oppose AB 387

- AB 387 would require hospitals to pay allied health students minimum wage for time spent in training required for the students' licensure.
- AB 387 would cost hospitals hundreds of millions of dollars and therefore put training programs at risk of closure.
- Without adequate training sites, allied health programs would close, which would exacerbate current workforce shortages.
- AB 387 would limit training programs to the detriment of students, training programs, hospitals and patients.

### Issue

AB 387 would require health care entities to pay allied health students minimum wage for time spent in clinical or experiential training required for state licensure. This new requirement would put allied health training programs at risk of closure. The programs, many of which are offered by California's community colleges, would not be able to meet accreditation requirements without sufficient clinical training placements. A decrease in the number of training programs and an evaporation of scarce clinical training slots would exacerbate allied health care workforce shortages.

### Position

CHA opposes AB 387 (Thurmond, D-Richmond) because it would result in significant constriction of allied health training sites which, in turn, would lead to the closure of allied health educational programs.

### Analysis

Many allied health professions require students to participate in clinical or experiential training at a hospital to obtain a degree and/or be qualified for licensure or certification. These occupations include radiologic technologists, clinical laboratory scientists, respiratory therapists, physical therapists, occupational therapists and speech therapists, among others. Hospitals are critical partners in the education and training of health professionals as they are uniquely poised to provide clinical experience. CHA estimates that hospitals statewide train more than 40,000 allied health students each year.

Hospital training programs are funded exclusively by hospitals -- costs are not reimbursed by Medi-Cal, private insurance or other sources. Hospitals invest hundreds of millions of dollars each year in these programs in the form of paid staff time for supervisors and mentors who train students, loaning licensed staff to serve as faculty at educational institutions, and investing in training facilities and special equipment.

AB 387 fails to recognize that for patient care-related training programs, various state and federal law prohibits students from providing unsupervised care. For example, students in radiologic technologist programs can only perform procedures if a qualified licensed individual is physically present to observe, verify and correct as needed the student's use of the equipment. Therefore, these students are in learning mode and not lawfully allowed to deliver care except within the strict laws outlining supervision requirements. The students are obtaining the necessary experience to become a fully licensed professional at the hospital's expense.

Students facing challenges with paying for school and training are very often eligible for financial aid and grants through state and federal programs, such as Cal-Grant B. In addition, when students complete their training and become licensed, they often become employees of their training program sponsor (the hospital), which in many cases offers loan forgiveness and tuition reimbursement should the student want to further his or her education and training.

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*(continued next page)*

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# Attorney General Approval of Emergency Department Service Reductions or Closure

## Oppose SB 687

- SB 687 creates an unrealistic expectation that EDs stay open while the attorney general holds public meetings and conducts an analysis at the hospital's cost.
- Financially distressed hospitals would incur greater losses during a notice period, which could adversely impact all hospital services.
- Under current law, nonprofit hospitals must follow a rigorous process with the attorney general before entering into transactions with other entities.

### Issue

SB 687 would require a nonprofit hospital to notify and seek approval from the attorney general prior to reducing services or closing an emergency department (ED). Hospitals would be required to provide a written notice to the attorney general no later than 90 days prior to a planned reduction in the level of emergency services or an elimination of those services. The attorney general would conduct a public meeting to hear comments from interested parties, and may also hire experts or consultants to assist in reviewing the proposed changes to the level of emergency services provided — costs that would be paid for by the hospital. The attorney general would have the discretion to consent, give conditional consent, or not consent any elimination or reduction of services.

### Position

CHA opposes SB 687 (Skinner, D-Berkeley). Hospitals generally do not reduce services or close an ED if the patient volume is sufficient to remain open. Financially distressed hospitals would incur greater losses during a notice period, which could adversely impact all hospital services.

### Analysis

Hospital EDs are the most expensive setting in which to provide care because of the required staffing, clinical expertise, and available ancillary and other services. Financially troubled hospitals may be unable to sustain continued ED losses, especially if patient volume is insufficient to keep them open. Forcing hospitals to keep EDs open during a review by the attorney general could adversely impact the entire hospital and its services to the community.

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CALIFORNIA HOSPITAL ASSOCIATION

# CHA Health Policy Legislative Day 2017

**Advocating for patients and your hospitals**

## 2017-2018 Proposed State Budget: Oppose Funding Reductions

### Oppose Funding Reductions

- Proposition 56 funding should be used for reimbursement rate increases for physicians and other providers.
- Funding to the UC program should be restored so that Proposition 56 GME funding is not compromised.
- GME funding to the Song-Brown Program should be restored to ensure there are enough primary care physicians to treat Medi-Cal patients.
- 340B program changes should be eliminated or delayed at least one year to allow hospitals time to implement the necessary operational changes.

### Issue

The 2017-18 proposed State Budget includes cuts to the Medi-Cal program and graduate medical education.

**Proposition 56 Dollars Not Going to Improve Medi-Cal Rates**
With the November passage of Proposition 56, which increased taxes on tobacco products, California is expecting an additional $1.7 billion in revenue during fiscal year 2017-18. The budget allocates most of this amount — $1.2 billion — to support the growth in Medi-Cal spending. CHA and several other organizations hoped the increase in Medi-Cal funding would instead be used to increase reimbursement rates for physicians and other providers.

**Proposition 56 Dollars for GME Cause Cut in UC Base Funding**
Proposition 56 also directs $40 million toward graduate medical education (GME) programs to the University of California (UC) for the purpose of increasing the number of primary care and emergency physicians trained in the state. The program is to be developed and implemented by UC. All accredited residency programs in California that meet the guidelines set forth in Proposition 56 are eligible to apply for funding. However, in the state budget, this source of funding for GME was characterized as revenue for the UC. As a result, the state budget proposes to cut the UC budget in the amount of the GME funding. This cut compromises the intent and provisions of Proposition 56 that UC serve as the public entity responsible for administration of this new program.

**Graduate Medical Education Cuts to Song-Brown Program**
The state budget proposal also includes a cut to funding for GME for primary care through the Song-Brown Program, which is administered by the Office of Statewide Health Planning and Development (OSHPD). Last year's budget allocated $100 million to the Song-Brown Program for GME funding, with $33.4 million to be distributed each year for three years. This budget year was to be the first year of the distribution; however, the 2017-18 proposed budget reverses the proposal entirely.

**Drug Purchase Program Changes – 340B**
The budget proposes clarifying statutory provisions related to the use of and reimbursement for drugs purchased under the 340B program in Medi-Cal. Existing statute requires 340B entities that provide drugs to Medi-Cal beneficiaries to use only drugs purchased under the 340B program and bill at their actual 340B acquisition cost plus any applicable dispensing fee. The Department of Health Services is proposing clarifying language that explicitly applies these requirements to both Medi-Cal fee for service and Medi-Cal managed care. Significant concerns exist about hospitals' ability to meet these new requirements, and as a result, the proposal would reduce reimbursement for drugs purchased under the 340B program.

CALIFORNIA HOSPITAL ASSOCIATION

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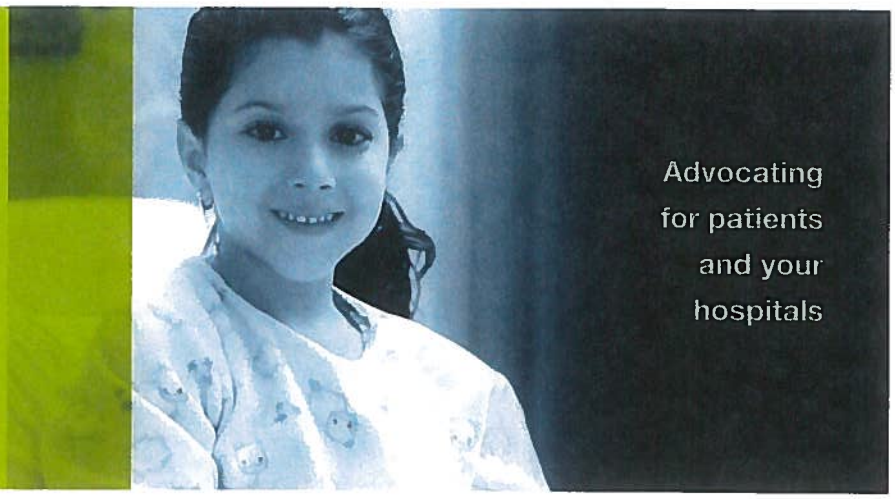
# CHA Health Policy Legislative Day 2017




## Background Papers

These are background papers on current health care policy issues. The papers are intended to give a snapshot of the key issue, as well as CHA's position along with a brief analysis. They have been provided in case conversations on these topics come up during the meetings with legislators.

If you would like additional information on a topic, please contact the CHA issue manager listed on the paper.

# CHA Health Policy Legislative Day 2017

**Advocating for patients and your hospitals**

## Emergency Care Systems Initiative

- California's emergency care system is at a breaking point with increasing ED visits and diversion hours.
- Demand for ED services is outpacing capacity.
- The ECSI will convene a consortium of stakeholders, gather data and information, find solutions and take action.
- The solution is to care for patients in the appropriate setting, resulting in lower costs and improved patient well-being.

### Issue

The demand for hospital emergency department (ED) services is outpacing current ED capacity, despite increased beds and innovative programs within and outside hospital EDs. Californians are turning to hospital EDs in record numbers because they cannot get the care they need elsewhere. California EDs have become the last resort for care due to a myriad of access barriers, including insufficient primary care access, and lack of essential mental health and substance use disorder resources, post-acute and rehabilitative services, and home- and community-based services. This places extraordinary demands on hospitals and their EDs, as well as the entire emergency care system, leaving gaps in care delivery and threats to quality and patient safety. Most importantly, it compromises California's emergency systems core mission — to be prepared at all times for emergent trauma, illness, disaster and mass casualty incidents.

How can Californians access appropriate care, and preserve EDs and our statewide emergency system for those who truly need lifesaving care?

This is both a daunting question that demands our attention and a societal problem that compromises patient care, increases health care costs and overburdens California's emergency care system.

### Position

CHA and the regional associations — the Hospital Council of Northern and Central California, the Hospital Association of Southern California and the Hospital Association of San Diego and Imperial Counties — have created the Emergency Care Systems Initiative (ECSI), which will work to alleviate emergency system pressures and ED crowding with a roadmap for change. Solving systemic and site-specific problems requires setting ambitious goals within an organized framework that will engage stakeholders, identify root causes, and align solutions and change in a coordinated, data-driven effort. Systemic changes can relieve ED crowding as evidenced by Washington state's "ER is for Emergencies[1]" statewide collaborative, which in one year effectively decreased overall ED visits by 9 percent, reduced frequent ED user visits by 10 percent, decreased the rate of narcotic drugs prescribed by 34 percent and saved an estimated $33 million.

1 www.wsha.org/quality-safety/projects/er-is-for-emergencies

CALIFORNIA HOSPITAL ASSOCIATION

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# CHA Health Policy Legislative Day 2017

**Advocating for patients and your hospitals**

## Leading the Way — Addressing California's Growing Behavioral Health Crisis

- One in six Californians suffers from behavioral health issues, and nearly one in 20 has a serious mental illness that impedes daily activities.
- Behavioral health care should be treated with the same urgency as physical health care.
- More than 1 million individuals with a behavioral health diagnosis arrive at California hospital emergency rooms each year.
- Approximately 70 percent of individuals who present in EDs don't require hospital-based inpatient psychiatric care and are more appropriately served in the community.

### Issue

There is a growing need for behavioral health to be treated with the same urgency as physical health care. With a legacy of scarce resources and scarcer attention, California's behavioral health crisis continues to be wrought with challenges. What is needed for improvement is a more effective system of care that:

- Focuses on prevention and early intervention
- Ensures prompt evaluation and treatment
- Guarantees and protects public safety
- Encourages the full use of existing agencies, professional personnel and public funds to accomplish these objectives
- Prevents duplication of services and unnecessary expenditures

### Position

Long-term systemic change requires alignment around a single shared strategy. To this end, CHA and the National Alliance for the Mentally Ill, California, have partnered to create a coalition of more than 50 statewide associations, advocates and provider groups. Coalition meetings are facilitated by Darrell Steinberg, author of the California Mental Health Services Act — Proposition 63 (November 2004).

The charge of this new, diverse coalition is to accomplish what an individual organization cannot independently achieve — long-term systemic change, in which behavioral health is managed in parity with physical health. The goal is to operate on common ground, develop shared goals, define tasks and actions, and jointly craft and advocate for agreed-upon solutions.

The medical community's interest in protecting individual rights to medical treatment for behavioral health conditions should focus on:

- Patient Well-Being — Assess and treat in a timely manner, in the least restrictive way possible, with voluntary assessment and treatment preferred.
- Efficiency and Equity — Ensure a high standard of mental health services; promote equal priority for behavioral and physical health; and achieve efficient delivery of resources and equitable distribution of services, regardless of funding mechanisms.

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# CHA Health Policy Legislative Day 2017

**Advocating for patients and your hospitals**

## SB 562 — Single-Payer Health Care System

- CHA is working diligently to assure successful repair of federal health care reform.
- Enactment of a single-payer system would shift financing of health care into an underfunded, budget-driven public system.
- Universal responsibility is required for universal coverage to be successful.
- Employers, individuals and providers should have a reasonable choice of health care delivery systems.
- Any health care system must have sufficient funding and payment levels to support the provision of quality health care.
- Universal coverage can be achieved without single-payer funding and control.

### Issue

SB 562 creates the Californians for a Healthy California Act, which would state the Legislature's intention to establish a comprehensive universal single-payer health care coverage program and health care cost control system for the benefit of all California residents.

### Position

SB 562 (Lara, D-Bell Gardens and Atkins, D-San Diego) is a spot bill to address the issue of establishing a single-payer health care system. CHA has no position on SB 562 in its current form, but will evaluate the bill when it is amended to include substantive language.

**Contact:**

*Anne McLeod*
*CHA senior vice president, health policy and innovation*

*(916) 552-7536 or*
*amcleod@calhospital.org*

CALIFORNIA HOSPITAL ASSOCIATION

# Key State Issues

Latest News on Key Bills in the State Legislature

CALIFORNIA HOSPITAL ASSOCIATION

February 17, 2017

Today marks the deadline for legislators to introduce bills. So far, 1,643 bills have been introduced. Some bills are in spot bill form, meaning that they include the Legislature's intent but provide few details. These bills will be amended prior to their hearing in policy committees. Details on high-priority health care-related bills CHA is tracking this legislative session are provided below. CHA's Health Policy Legislative Day, March 14-15 in Sacramento, offers members an opportunity to meet with state legislators about the potential impact of proposed legislation. To register, visit www.calhospital.org/legislative-day. 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 33 | Dodd (D-Napa) | Would prohibit a business from requiring, as a condition of entering into a contract for the provision of goods or services, that a customer waive any legal right — including right to a jury trial or to bring a class action lawsuit — that arises as a result of fraud, identity theft or other act related to the wrongful use of personal identifying information. | To be heard in Senate Judiciary and Appropriations Committees | Oppose, Unless Amended | Lois Richardson/ Connie Delgado |
| **Emergency Services** | | | | | |
| AB 259 | Gipson (D-Carson) | Co-sponsored by CHA, this spot bill will be amended to address emergency services, specifically emergency department (ED) overcrowding. CHA and the Regional Associations have been engaged in numerous activities to alleviate this escalating issue, and recently formed the Emergency Care Systems Initiative to convene a consortium, gather data, find solutions and take action. | In the Assembly | Cosponsor | BJ Bartleson/ Connie Delgado |
| **Labor** | | | | | |
| AB 5 | Gonzalez Fletcher (D-San Diego) | Would require an employer to offer additional hours of work to an existing employee who, in the employer's reasonable judgment, has the skills and experience to perform the work before hiring any additional employees or subcontractors, including hiring an additional employee or subcontractor through the use of a temporary employment agency, staffing agency, or similar entity. The bill would not apply where it would result in payment of overtime, and would also require the employer to use a transparent and nondiscriminatory process to distribute the additional hours of work among existing employees | To be heard in Assembly Labor and Employment Committee. | Pending Review | Gail Blanchard-Saiger/Kathryn Scott |

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Labor (continued)** | | | | | |
| AB 387 | Thurmond (D-Richmond) | Would expand the definition of "employee" to include any individual, other than doctors or nurses, engaged in supervised work experience to satisfy requirements for licensure, registration or certification as an allied health professional. Would treat hospitals and other facilities that offer clinical experience to allied health professionals — including pharmacists, therapists, clinical lab scientists, technicians and technologists — as their employers, and would require them to pay those individuals minimum wage. This change could extend to other aspects of the employment relationship. | In the Assembly. | Oppose | Gail Blanchard-Saiger/Kathryn Scott |
| AB 402 | Thurmond (D-Richmond) | Would require Cal/OSHA to convene, by June 1, 2018, an advisory committee to develop regulations requiring hospitals to evacuate or remove plume — noxious airborne contaminants generated as byproducts from specific devices used during surgical, diagnostic and therapeutic procedures. The proposed regulations must be submitted to the Cal/OSHA Standards Board by June 1, 2019, and the board must adopt regulations by July 1, 2020. | In the Assembly. | Under Review | Gail Blanchard-Saiger/Kathryn Scott |
| **Medi-Cal** | | | | | |
| AB 205 | Wood (D-Healdsburg) | Would implement a provision of recently enacted Medicaid managed care rules that allows Medi-Cal beneficiaries to file an appeal up to 120 days after the date of notice, instead of 90 days in existing state law. AB 205 also states the Legislature's intent to implement newly revised federal regulations governing Medi-Cal managed care. AB 205 is an identical companion bill to SB 171 (Hernandez, D-Azusa). | To be heard in Assembly Health Committee. | Follow, Hot | Amber Kemp/ Barbara Glaser |
| SB 171 | Hernandez (D-Azusa) | Would implement a provision of recently enacted Medicaid managed care rules that allows Medi-Cal beneficiaries to file an appeal up to 120 days after the date of notice, instead of 90 days in existing state law. SB 171 also states the Legislature's intent to implement newly revised federal regulations governing Medi-Cal managed care. SB 171 is an identical companion bill to AB 205 (Wood, D-Healdsburg) | To be heard in Senate Health and Appropriations Committees. | Follow, Hot | Amber Kemp/ Barbara Glaser |
| **Medical Records** | | | | | |
| SB 241 | Monning (D-Carmel) | Would harmonize state law with the federal health information privacy regulations adopted under the Health Insurance Portability and Accountability Act (HIPPA) of 1996 | In the Senate. | Support | Lois Richardson/ Connie Delgado |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Medical Staff** | | | | | |
| AB 148 | Mathis (R-Porterville) | Would lower the eligibility threshold for rural practice settings participating in the Steven M. Thompson Physician Corps Loan Repayment Program. The program provides financial incentives, including repayment of educational loans, to a physician or surgeon who practices in a medically underserved area. Currently, eligible practice settings include community clinics, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population. These settings must be located in a medically underserved area and at least 50 percent of patients must be from medically underserved populations. This bill would lower the eligibility threshold for serving the above described populations to 30 percent for practice settings located in rural areas. | To be heard in Assembly Health Committee. | Support | Peggy Wheeler/ Connie Delgado |
| **Mental Health** | | | | | |
| AB 191 | Wood (D-Healdsburg) | Would amend current law to authorize a licensed marriage and family therapist or a licensed professional clinical counselor to certify an individual for an extended involuntary hold. This bill would require that the signatory have participated in an evaluation of the individual, and stipulates that he or she must be the second signature. This authority would only pertain to involuntary holds exceeding 72 hours that require an additional period of intensive treatment not to exceed 14 days, or 30 days under specified conditions. | To be heard in Assembly Health Committee | Support | Sheree Lowe/ Alex Hawthorne |
| **Public Health** | | | | | |
| SB 43 | Hill (D-San Mateo) | Would establish a statewide public health surveillance system for tracking antibiotic resistant infections and deaths. Specifically, the bill would require doctors to list an antibiotic resistant infection as a cause of death if, in the attending physician's professional judgment, the resistant infection was a factor in a patient's death. It would also require hospitals and clinical labs, beginning July 1, 2018, to conduct and submit to the California Department of Public Health (CDPH) an annual antibiogram (a summary of all the antibiotic resistant infections in the previous year). However, hospitals are already creating antibiograms as part of their antibiotic stewardship programs. CDPH would be required to publish an annual report on the occurrence of antibiotic resistant infections and deaths, based on death certificate information. This report would break down the data by facility type, type of resistant infection and geography; facility names would not be included. CHA is currently reviewing the bill and working closely with the Senator's office and other stakeholders. | To be heard in Senate Health Committee. | Follow, Hot | Debby Rogers/ Alex Hawthorne |

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Skilled-Nursing Facilities** | | | | | |
| SB 481 | Pan (D-Sacramento) | Co-sponsored by CHA, this spot bill will be amended to address CANHR v. Chapman, which, if upheld on appeal, would render current law for treating unrepresented patients in skilled-nursing facilities unconstitutional. | In the Senate. | Co-sponsor | Patricia Blaisdell/ Lois Richardson/ Alex Hawthorne |

**Tailor this letter to your hospital and place on hospital letterhead.**

**Please send your letter to CHA at dvicari@calhospital.org or by fax to (916) 554-2275.**

Date

The Honorable Tony Thurmond
Chair Assembly Labor and Employment Committee
State Capitol, Room 4005
Sacramento, CA 95814

**SUBJECT: AB 387 (Thurmond) – OPPOSE**

Dear Assemblymember Thurmond:

INSERT YOUR ORGANIZATION HERE is writing today in opposition of AB 387 (Thurmond, D-Richmond), which would require health care entities to pay allied health students minimum wage for time spent in clinical or experiential training that is required for state licensure. AB 387 fails to recognize that for patient care-related training programs, myriad state and federal laws prohibit students from providing unsupervised care. Because they are in training, these students are not lawfully permitted to deliver care except within strict supervision requirements. They are not employees, and the cost of treating them as such will have the adverse consequence of reducing students' opportunities to benefit from hospital-provided training and clinical experience and exacerbating workforce shortages.

Many allied health professions require students to participate in clinical or experiential training at a hospital to obtain a degree and/or qualify for the licensure or certification exam. These occupations include radiologic technologists, clinical laboratory scientists, respiratory therapists, physical therapists, occupational therapists and speech therapists, among others — all of which are in high demand and pay good wages. Hospitals are critical partners in the education and training of health professionals as they are uniquely poised to provide clinical experience.

INSERT FACTS ABOUT YOUR ALLIED HEALTH TRAINING EFFORTS HERE (number of students, diversity, various professions, estimated costs of training, how many slots would be impacted by this legislation if passed, and colleges you partner with). Hospital training programs are funded exclusively by hospitals — costs are not reimbursed by Medi-Cal, private insurance or other sources.

YOUR ORGANIZATION opposes AB 387 because it would result in a significant decrease in our ability to partner with local colleges to train the allied health workforce needed to provide care for California's patients now and in the future. The effects of this significant decrease in capacity within the current training system would exacerbate existing allied health care workforce shortages and put the development of a strong and diverse pipeline of future caregivers in jeopardy.

For the above reasons, YOUR ORGANIZATION respectfully asks for your "NO" vote on AB 387.

Sincerely,

cc: The Honorable Members of Assembly Labor and Employment Committee