TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 31, 2016 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: SEIU Employee organization: UFCW		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: March 31, 2016 d. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) TCHD vs. Burlew Case No. 37-2014-00034015-CU-NP-NC (2) Tri-City Healthcare District vs. Michael Vu, et al. Case No. 37-2016-00003989-CU-WM-NC (3) TCHD vs. National Union Insurance Case No. 16-CV-60382-JLS-JLB		

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
	(4) TCHD vs. Paul Mazur, M.D., and DOES 1-50 Case No. 37-2016 00002803-CU-O-NC		
	e. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (7 Matters)		
	f. Public Employee Evaluation: Chief Compliance officer (Authority: Government Code, Section 54957)		
	g. Approval of prior Closed Session Minutes		
	h. Public Employee Appointment: Chief Executive Officer (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 (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Introduction: 1) Steven L. Dietlin, Chief Executive Officer	5 min.	Chair
13	Community Update Patient Safety Report – Kevin McQueen, Director of Safety & Environment of Care	15 min.	K. McQueen
14	Report from TCHD Foundation	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business		
	a. Approval of actions necessary for establishment of new OB/GYN Clinic	10 min.	W. Knight/J. Raimo (FOP)
	b. LAFCO Study Regarding Expansion of District Boundaries	10 min.	W. Knight

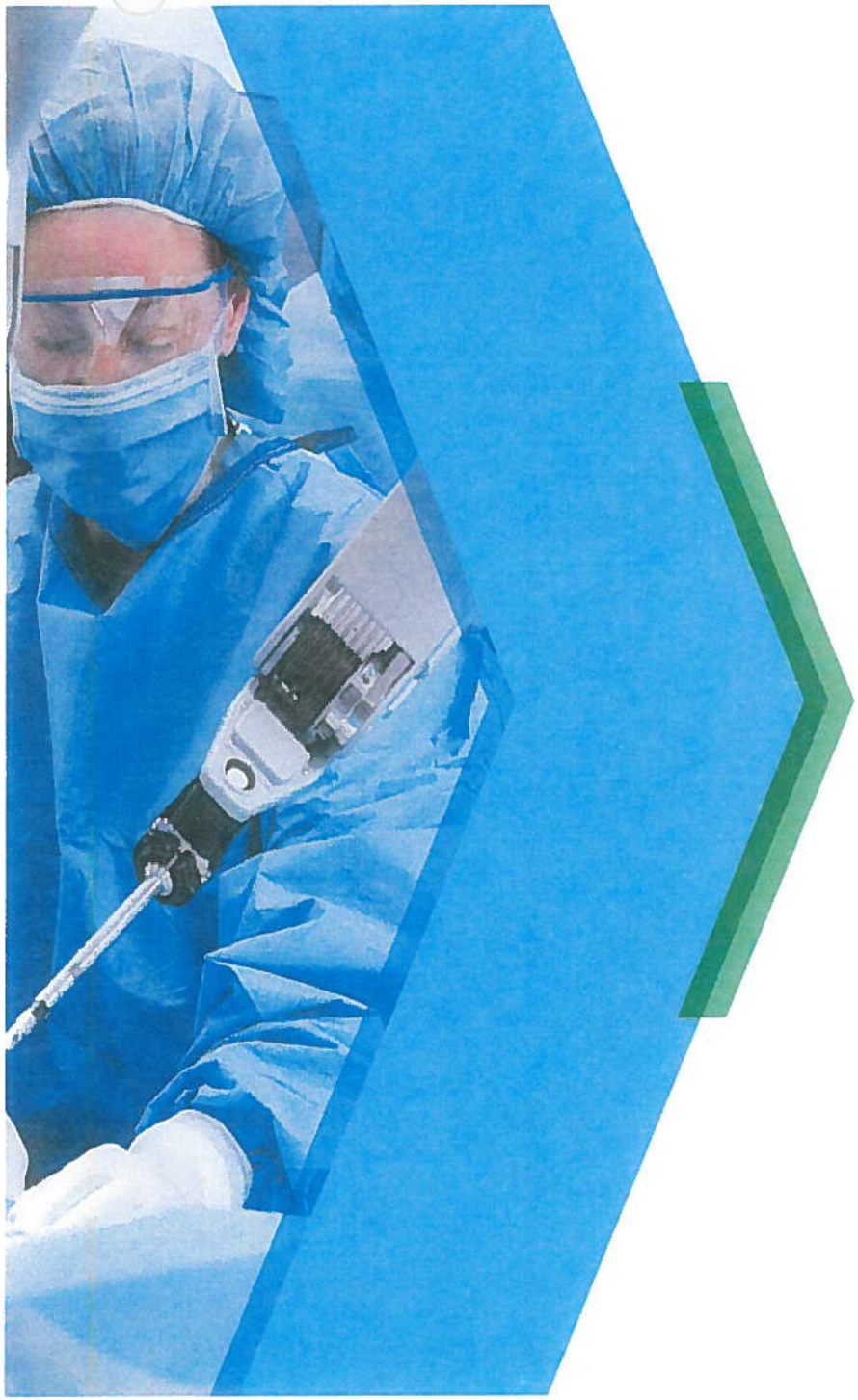
	Agenda Item	Time Allotted	Requestor
18	Old Business a. Report from Ad Hoc Committee on electronic Board Portal	5 min.	Ad Hoc. Comm.
19	Chief of Staff a. Consideration of March 2016 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for March 2016 – Reappointments	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) **Approval of Policies & Procedures** a. 8610-400 - Telecommuting **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *(No meeting held in March)* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 2 (Committee minutes included in Board Agenda packets for informational purposes) **D. Finance, Operations & Planning Committee** Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of an agreement with San Diego Dialysis, Inc. dba Fresenius Medical Care, North America at an average monthly cost of $73,000 for a term of 12 months, beginning April 1, 2016 through March 31, 2017 for a total cost not to exceed $876,000. 2) Approval of the purchase and installation of the Siemens Uroskop and Surgical Light for Operating Room 11 at a total cost not to exceed $627,780. 3) Approval of an agreement for Orthopedic Institute Co-	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	Management for a term of 28 months, beginning March 1, 2016 through June 30, 2018 for an annual cost not to exceed $750,000 and a total cost not to exceed $1,750,000. 4) Approval of an Emergency Department On-Call Agreement with Drs. Blumenfeld, Choudry, Desadier, Frishberg, Lobatz, Nielsen, Oh, Paduga, Rosenberg, Sadoff, Sahagian, Schim, Anchi Wang, Chunyang Tracy Wang and Zupancic for Neurology coverage for a term of 12 months, beginning July 1, 2016 through June 30, 2017 at a daily rate of $740, for a total cost for the term of $270,100. 5) Approval of an Emergency Department On-Call Agreement with Dr. Thomas Nowak for Neurosurgery coverage, for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at a daily rate of $800, for a total cost for the term of $292,000. 6) Approval of an Emergency Department On-Call Agreement with Drs. Hardy, Jeswani, Marcisz, Stern and Yoo for Neurosurgery and Spine coverage for a term of 12 months, beginning July 1, 2016 through June 30, 2017, at a daily rate of $800 (Neurosurgery) and $400 (Spine), for an annual cost of $292,000 for Neurosurgery and $146,000 for Spine and a total cost for the term of $438,000. 7) Approval of an Emergency Department On-Call Agreement with Drs. Bennett, Clarkson, Gil, Hawkins, Karanikkis, Lopez, Mazarei, Muhtaseb for OB/GYN coverage, for a term of 24 months, beginning July 1, 2016 through June 30, 2018 at a daily rate of $800 (weekday) and $1,000 (weekend/holiday) for an annual cost of $204,800 and $109,000 and an annual cost of $202,400 and $112,000 and a total cost for the term of $628,200. 8) Approval of an Emergency Department On-Call Agreement with Drs. Davies, Greider, Hudson, Jain, Iyengar, Krall, Mellgren, Pendleton, Smith and Zaveri for Ophthalmology coverage, for a term of 24 months beginning July 1, 2016 and ending June 30, 2018, at a daily rate of $300 and an annual cost of $109,500 and a total cost for the term of $219,000. 9) Approval of an Emergency Department On-Call Agreement with Drs. Devereaux, Krol, Shad, Shim, and Viernes, for Gastroenterology-General and Gastroenterology – ERCP, for a term of 12 months, beginning July 1, 2016 through June 30, 2017 at a daily rate of $700 (Gastro-General) and $500 (Gastro-ERCP), for an annual cost of $255,500 for Gastro-General and $182,500 for Gastro-ERCP, for a total cost for the term of $438,000. **E. Professional Affairs Committee** Director Mitchell, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.)		PAC

	Agenda Item	Time Allotted	Requestor
	1) **Patient Care Services** a. Code Blue Response Plan Policy b. Code Caleb Team Mobilization Policy c. Code Pink Response Plan Policy d. Communicating with Physician Using SBAR Policy e. Interpretation and Translation Services f. Massive Transfusion Protocol g Patient Safety in Surgical Areas Policy h. Pre, Intra and Post-op Assessment of Fetal Heart Rate and Uterine Activity Procedure 2) **Administrative Policies & Procedures** a. Equipment Transfer, Storage Trade-in, and Disposal 200 b. Provision of Education during Hospitalization 391 3) **Unit Specific** **A. Infection Control** a. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection b. Management of Patients with MRSA IC 6-3r (DELETE) c. Management of Patients with MRSA IC 6-3r (DELETE) **B. Neonatal Intensive Care (NICU)** a. Cue Based Feeding b. High Risk Infant Follow-Up Program c. High Risk Infant Follow Up Clinic Perinatal Data d. High Risk Infant Follow-up Clinic Coordinator, Role of (DELETE) e. High Risk Infant Follow-up Clinic Dietician, Role of (DELETE) f. High Risk Infant Follow-up Clinic Physical Therapist, Role of (DELETE) g. High Risk Infant Follow-up Clinic Registered Nurse, Role of (DELETE) **C. Outpatient Behavioral Health** a. Co-treatment of Patients b. Physician Progress Note **D. Patient Care Management** a. Discharge Planning **E. Rehabilitation** a. Audiology Services Inpatient Rehabilitation Services b. Discharge Criteria – 501 c. Documentation of Progress Note and Discharge d. Modalities Used Thermal Agents 616 (DELETE) e. NICU Follow-Up High Risk Infant Follow Up (HRIF) – 604 (DELETE) f. Occupational Therapy Policy – 702 g. Patient & Caregiver Education – 507 h. Physical Therapy Department Policy – 603 i. Pre-OP Teaching Physical Therapy Occupational Therapy		

	Agenda Item	Time Allotted	Requestor
	– 614 j. Scope of Services k. Speech Pathology Services Department Policy – 802 l. Swallow Evaluations Power Outage System Failure – 804 (DELETE) m. Therapeutic Recreation Acute Care – 904 (DELETE) n. Traction Cervical & Lumbar (DELETE) **F. Telemetry** a. Admission & Discharge Criteria b. Weighing Telemetry Patients **G. Women & Newborn Services** a. Amnioinfusion b. Obstetrical Hemorrhage c. Preeclampsia Care d. Vibroacoustic Stimulation (VAS) (Fetal Acoustic Stimulation Test (FAST) **H. Formulary Requests** a. Praxbind – Trade Name Idarucizumab – Generic Name b. Tretinoin – Trade Name All-Trans Retinoic Acid (ALTA) – Generic Name **I. Forms** a. 7883-1002 High Risk Infant Follow Up b. 8720-1018 Progress Note 4) Approval of Clinical Contracts as listed on spreadsheet **F. Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) *(No meeting held in March)* **G. Audit, Compliance & Ethics Committee** Director Finnila, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.) *(No meeting held in March)* (2) Minutes – Approval of: a) Special Board of Directors Meeting – February 16, 2016 b Regular Board of Directors Meeting – February 25, 2016 c) Special Board of Directors Meeting – March 3, 2016 d) Special Board of Directors Meeting – March 8, 2016 e) Special Board of Directors Meeting – March 17, 2016 (3) Meetings and Conferences a) 24th Annual Health Form & the American Hospital Association Leadership Summit – July 17-19, 2016, San Diego, CA - $995.00/attendee		Gov. & Leg. Comm. Audit, Comp. & Ethics Comm. Standard Standard

	Agenda Item	Time Allotted	Requestor
	(4) Dues and Memberships a) Trustee Magazine Subscription Renewal - $55/Subscription		Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (February, 2016) (d) Reimbursement Disclosure Report – (February, 2016) (e) Seminar/Conference Reports - 1) CHA Legislative Days – Chairman Dagostino	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	**2 hrs/ 30 min**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		



Patient Safety

BOD Report
March 2016

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Patient Safety Events

- National Patient Safety Awareness Week (NPSAW)

  Tri-City Medical Center held our Annual Patient Safety Symposium on Monday, March 14th in celebration of NPSAW . The conference included five presentations on how to provide the safest care possible. The event was co-sponsored with the *HASDIC, HQI* and *The PSF Collaborative*.

HOSPITAL ASSOCIATION of San Diego and Imperial Counties
ADVOCATES FOR ACCESS TO HEALTH CARE FOR ALL CALIFORNIANS

Hospital Quality Institute
Leadership in quality and patient safety

Patient Safety First...
a California Partnership for Health

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

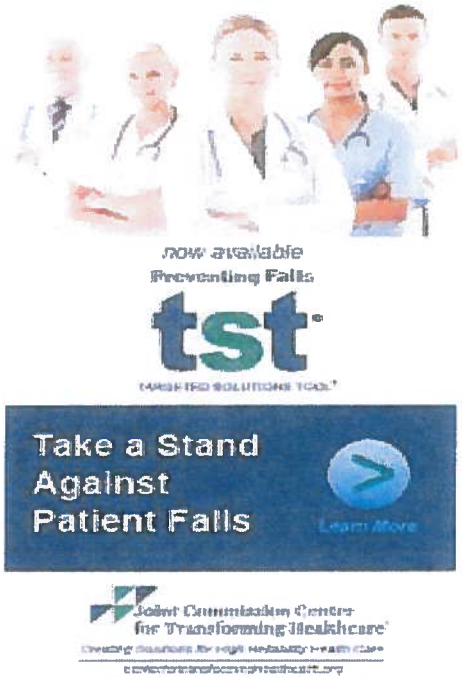
Patient Safety Rounding

- Daily Administrative Rounds in patient care areas
  - The goals of the rounding are to check with frontline employees about any safety concerns
  - Team includes: Chief Operating Officer, Patient Safety Officer, Director of Facilities, Environmental Care Services and Information Technology
- Daily Leadership Team "Safety Huddles"
  - Morning huddle to discuss any safety concerns or items that need immediate attention

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Patient Safety Collaborative

- Tri-City Medical Center is currently participating in a project with the Joint Commission Center for Transforming Healthcare to reduce falls.



Targeting Solutions Tool (TST)

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Patient Safety Collaborative FY16

- Tri-City Medical Center is working with the *Hospital Quality Institute & Scott Griffith* with the aim of improving systems designs to achieve the highest quality levels and patient safety.

Hospital Quality Institute
Leadership in quality and patient safety

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Major Accomplishments

- Major Accomplishments
  - Leap Frog safety rating of an "A" (Five consecutive reporting periods)
  - Five (+) years without a Central Line Associated Blood Stream Infection (CLABSI) in the NICU
  - 2015 Mission Lifeline Gold-Plus award from the American Heart Association
  - Recertified by the Joint Commission for Primary Stroke Center
  - Recertified by the Joint Commission for Diabetes Care

THE LEAPFROG GROUP
A HOSPITAL SAFETY SCORE

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 9, 2016

Attachment A

INITIAL APPOINTMENTS

None

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:

None

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

None

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
March 9, 2016

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 3/31/2016, unless specified otherwise)

PRIVILEGE RELATED CHANGES

• FERBER, Jeffrey M.D.	Family Medicine
• GEORGY, Bassem M.D.	Radiology
• HANNA, Karen M.D.	General/Vascular Surgery
• MCDONALD, April NP	Allied Health Professional
• NIELSEN, Amy D.O.	Neurology
• ROSENBURG, Jeffrey M.D.	Cardiothoracic Surgery
• WEARY, Yong CNM	Allied Health Professional

STAFF STATUS CHANGES

- **None at this time**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
March 9, 2016

Attachment C

PROCTORING RECOMMENDATIONS (Effective 3/31/2015, unless otherwise specified)

• ALLEN, MATTHEW PA-C	Allied Health Professional
• CHASE, Nicole PAC	Allied Health Professional
• DEMBITSKY, Zachary M.D.	Emergency Medicine
• EBRAHIMI-ADIB, Tannaz, M.D.	OB/GYN
• JAMSHIDI-NEZHAD, Mohammed MD	General/Vascular Surgery
• GUY, Moltu M.D.	Anesthesia
• KARANIKKIS, Christos D.O.	OB/GYN
• NIELSEN, Amy D.O.	Neurology
• PHILLIPS, Jason M.D.	Urology
• PRITCHARD, Amy D.O.	Emergency Medicine
• WACLAWSKI, Richard M.D.	Anesthesia

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
March 9, 2016

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 4/01/2016 –3/31/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 4/01/2016 through 3/31/18, 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:

- GUNTA, Sujana S./Pediatrics/Active
- HOSSEINI, Puya M.D./Anesthesiology/Active
- MUDD, Brian D.D.S./Oral & Maxillofacial Surgery/Active
- OLONAN, Christopher M.D./Internal Medicine/Active
- PROCHERA, Ann Marie M.D./Anesthesiology/Active
- SCHMITTER, Stephen P., M.D./Radiology/Active
- TALLMAN, Garrett M.D./Orthopedic Surgery/Associate
- VICARIO, Daniel M.D./Oncology/Active
- WONG, Darryl M.D./Dermatology/Affiliate
- YAMANAKA, Mark M.D./Pulmonary Medicine/Active
- YOO, Frank M.D./Neurosurgery/Active

RESIGNATIONS: (Effective date 3/31/2016 unless otherwise noted)

Voluntary:

- BEISER, Jonathan PA-C/Allied Health Professional
- EBERSOHL, Tiffany PA-C/Allied Health Professional
- GUPTA, Monika M.D./Neurology/Affiliate
- LUU, Dan M.D./Family Medicine/Provisional
- WECHTER, Victor M.D./Ophthalmology/Affiliate

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
March 8, 2016

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director Laura Mitchell, Dr. Gene Ma, Dr. Martin Nielsen Dr. Hamid Movahedian, Virginia Carson, Joe Quince, Gwen Sanders, Salvador Pilar
Non-Voting Members Present:	Kapua Conley, COO; Sharon Schultz, CNE; Esther Beverly, VP of HR;
Others Present:	Quinn Abler, Frances Carbajal
Members Absent:	Tim Moran, CEO; Cheryle Bernard-Shaw, CCO

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of March 8, 2016. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the February 9, 2016 meeting. Director Reno moved and Dr. Gene Ma seconded the motion.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
	The motion was carried unanimously.		
5. Old Business			
a. Update on TCHD Observed Holidays	The Committee discussed observed TCHD, state and federal holidays. The committee addressed other community hospitals practice and decided to continue with our current practice without any change.		Esther Beverly
b. Update on Lincoln Record Keeping Services	The Committee discussed Lincoln's counter proposal for the recordkeeping services proposed fee increase. Chair Kellett called for a motion to approve since the new proposed rate is within market for other service providers. Director Reno moved and Ginny Carson seconded the motion. The motion was carried unanimously.		Esther Beverly
c. Policy Discussion/Action Policy 8610-400 Telecommuting Policy	The Committee reviewed the revamped Telecommuting Policy. Chair Kellett called for a motion to approve the Telecommuting Policy with minimal edits. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Esther Beverly
6. New Business			
d. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.	Vacancy rates and benchmarking data to be added for comparison.	Chair Kellett
e. Review HR Metrics	Quinn Abler, HR Director presented the quarterly metrics. Quarterly headcount and annual turnover rates by each union & overall. TCHD turnover rates are overall low & within national benchmarks and fluctuate throughout the year but stay consistent overall.	Generational to be added at next update.	Esther Beverly
7. Work Plan	The work plan was reviewed.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**April 12, 2016**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 1:30 p.m.		Chair Kellett

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Human Resources

SUBJECT: Telecommuting **POLICY NUMBER: 8610-400**

ISSUE DATE: TBD
REVISION DATE(S): N/A

Human Resources Department Approval Date(s): TBD
Human Resources Committee Approval Date(s): TBD
Board of Directors Approval Date(s): TBD

A. **DEFINITION(S):**

1. Telecommuting: Working at a location other than the traditional office on a regular basis. Not all provisions of this procedure will apply for employees who only occasionally work from an off-site location.

B. **POLICY:**

1. Allow the flexibility to better meet TCHD's business goals and to be competitive in the market to recruit and retain qualified candidates..
2. Telecommuting is not a formal, universal employee benefit. Management has the right to refuse to make Telecommuting available to an employee and to terminate a Telecommuting arrangement at any time.

C. **PROCEDURE:**

1. TCHD will allow eligible employees to accomplish some work at off-site locations, including an employee's home, for the mutual benefit of TCHD and the employee. Telecommuting is a management option, not an employee benefit or entitlement.
2. Eligibility
   a. Employees will be selected based on the suitability of their jobs. Upon acceptance to the program, the employee will be expected to complete a Telecommuters agreement.
   b. In addition to the above, all business requirements must be reviewed and approved to take into consideration compliance, risk, etc. Individuals working with medical information will need a more controlled environment such as locking files, etc.
3. Compensation and Work Hours
   a. The employee's compensation, benefits, work status and work responsibilities will not change due to participation in the Telecommuting program. The amount of time the employee is expected to work per day or pay period will not change as a result of participation in the Telecommuting program.
4. Guidelines
   a. A telecommuting arrangement may be initiated upon formal written request by the employee and must be approved by the employee's Manager/Director and Human Resources
   b. The employee and Manager/Director must complete all assessments, agreements, and obtain signatures before an employee may begin a telecommuting arrangement:

   By signing the agreement, the employee certifies that he/she has reviewed, understands, and agrees to abide by the provisions of TCHD's policies and procedures as well as the Telecommuting Agreement form (including Ergonomic guidelines, meal and rest periods, and overtime regulations). Copies of all of the forms are sent to the Human Resources department for permanent record in the Employee file.

c. If a telecommuting arrangement or request to renew an arrangement is denied, the employee will be notified as to what the circumstances are or timing of when a new request can be submitted.
d. The employee remains obligated to comply with all TCHD rules policies, practices, and instructions that would apply if the employee were working at the regular worksite.
e. Work products developed or produced by the employee while telecommuting are the property of TCHD.
f. Benefits, salaries, compensation, and time-off scheduling will not be changed as a result of participating in a telecommuting schedule and will continue to be governed by applicable TCHD policies and procedures.
g. Requests to work overtime must be approved, in writing, in advance by the employee's Manager/Director. If sick or unable to work due to personal needs while telecommuting, the telecommuter will contact his/her Manager/Director and will take paid time off (scheduled or unscheduled).
h. The employee's telecommuting hours will conform to a schedule agreed upon by the employee and his/her Manager/Director. The schedule and methods for communication between the telecommuter and Manager/Director will be mutually agreed upon and included in the Telecommuting Agreement.
i. Prior to the approval of telecommuting the Manager/Director informs the employee as to the appropriate method of recording time (including start of shift, start of meal period, end of meal period, end of shift) for the hours worked while telecommuting, either: 1) directly into the electronic timekeeping system through remote network access completing the Kronos log. Employees must comply with all wage and hour policies and regulations, including meal and rest period and overtime policies. Non-exempt employees who telecommute 100% of the time would be on a 40 hour/week schedule and not an 8/80 schedule.
j. If the employee is unable to meet work obligations due to equipment issues, the employee agrees to notify his/her Manager/Director immediately and may be required to travel to the workplace to perform his/her job functions until the issue has been resolved. Failure to report to work as directed may jeopardize the employee's participation in the telecommuting program and be subject to disciplinary action in accordance with TCHD attendance and other policies and procedures.

5. Employee Telecommuting Participation and Renewal Criteria
a. The employee's continued participation in a telecommuting program is contingent upon acceptable performance standards as determined by their Manager/Director. The Manager/Director may conduct periodic reviews of the employee's telecommuting performance. Participation in a telecommuting program may be terminated by the employee or Manager/Director with reasonable notice or participation may be terminated immediately if required for the employee to meet his/her work obligations. Every effort will be made to come to a mutually agreed upon time period to start and/or terminate the program with the final decision being the responsibility of the C-Suite/Manager/Director.
b. Failure to comply with any employee telecommuting policies, participation criteria, TCHD rules or practices may result in the termination of the employee's participation in the telecommuting program.
c. Telecommuting is not a substitute for any home-care arrangements (infant care, eldercare, etc.) that require the employee to provide a significant amount of time away from his/her primary work duties. The employee must contact Employee Health to take an approved leave of absence under TCHD leave of absence policies if the employee must act as a primary caregiver on scheduled work time.
d. The telecommuter's participation may be revoked by TCHD due to new or modified job tasks, workload needs, or other TCHD business requirements/needs.
e. The employee's Manager/Director has the right to modify the telecommuting agreement based on need due to holidays, vacations, business need or other special circumstances.
f. The feasibility of providing proper equipment and supplies necessary to the job assignment at a reasonable cost must be demonstrated. Office supplies will be provided

by TCHD as needed. Out-of-pocket expenses for other supplies will not be reimbursed unless by prior approval of the employee's manager.

g. The length of an approved term of agreement for telecommuting is established by the Manager/Director. If the employee wishes to renew an agreement, he/she will formally request renewal in writing. Renewal of the agreement is subject to review and approval by the Manager/Director.

6. Equipment, Maintenance, Supplies
   a. TCHD agrees to provide specific tools/equipment for the employee to perform his/her current duties. This may include computer hardware, computer software, email, connectivity to host applications, and other applicable equipment as deemed necessary. Information technology must scan and modify computer equipment to ensure that no patient/employee confidential equipment is on the equipment and that appropriate safeguards are set on the computers. This must be completed prior to work beginning at home. IT requires that the remote connection supports download speeds of 10 Megabits per second (Mbps) and upload speeds of 2 Mbps (cable modem or DSL).
   b. Any use of equipment, software and data supplies that may be provided by TCHD for use at the remote work location is limited to authorized persons and for purposes relating to TCHD business. TCHD will provide for repairs to TCHD equipment. When the employee uses her/his own equipment, the employee is responsible for maintenance and repair of equipment.
   c. TCHD resources and electronic equipment must be used primarily for TCHD business as governed by TCHD guidelines. The inappropriate use of TCHD resources may result in the revocation of the employee's telecommuting program at management's discretion.
   d. The employee agrees to take reasonable steps to protect any TCHD property from theft, damage, or misuse. The employee agrees to report to his/her Manager/Director instances of loss or damage to TCHD property, or known unauthorized access, at the earliest reasonable opportunity. Depending on the circumstances, the employee may be responsible for any damage of, or loss of, TCHD property.
   e. The employee will return TCHD equipment, records, and materials, upon request and/or termination of this agreement. The employee may be responsible for any costs necessary to return, repair, or replace TCHD property due to negligence or misuse at the discretion of TCHD management.
   f. TCHD is not liable for loss, destruction, or injury that may occur in or to the employee's home. This includes family members, visitors, or others that may become injured within or around the employee's home.

7. Communication

Employees must be available by phone and email during core hours. All in-person client interactions will be conducted on a client or TCHD site and cannot be transacted at the employee's home. Participants will still be available for work-site staff meetings, and other meetings deemed necessary by management. TCHD will reimburse work-related voice and data communication charges for dedicated lines for TCHD use only. TCHD will not reimburse for telephone or data communication lines that are also available for the employee's personal use. Isolated charges on a personal phone line (such as for documented long-distance calls) may be reimbursed on a case-by-case basis.

8. Telecommuting Site Safety and Ergonomics
   a. The employee agrees to maintain a safe and ergonomically correct workstation (see Home Office Ergonomics and Safety Guidelines). If employee fails to maintain a safe and ergonomically correct workstation, the Telecommuting Agreement may be terminated.
   b. The employee may be covered by workers' compensation for job-related injuries that occur in the course and scope of his/her employment while telecommuting. Any travel to and from work to drop off or pick up work or items is not covered under workers' compensation and is at the employee's own risk. Travel to and from work is considered part of a normal commute and therefore not covered for workers' compensation purposes. The employee is responsible to report work-related injuries to his/her Manager/Director

immediately. Failure to timely report a work-related injury may jeopardize the employee's rights to workers' compensation benefits.

c. The employee is responsible for proving that he/she has the appropriate facilities, equipment, furniture and other specified requirements to set up a remote workspace. If the employee does not meet these requirements, his/her request to telecommute will be denied.

d. The employee remains liable for any and all liability and/or injuries to third parties and/or members of the employee's family on the employee's premises and associated with the use of TCHD property.

9. Legal and Tax Implications

The employee is responsible for tax and legal consequences, if any, of this arrangement. It will be the employee's responsibility to determine any income tax implications of maintaining a home office area. TCHD will not provide tax guidance nor will TCHD assume any additional tax liabilities. Employees are encouraged to consult with a qualified tax professional to discuss income tax implications.

10. Dependent Care

Telecommuting is not a substitute for dependent care. Telecommuters will not be available during TCHD core hours to provide dependent care.

11. Data Security

a. TCHD's Telecommuting Remote Access Information can be accessed through the TCHD accessible through the VPN. If the employee uses a computer workstation, owned by the employee or TCHD, he/she agrees to take reasonable steps regarding data security, including:

i. Keeping security configurations up-to-date to protect that workstation from intrusions;

ii. Ensuring that TCHD data on the workstation is safe from inappropriate access and is backed up to TCHD network on a daily basis;

iii. Ensuring communication between the workstation and TCHD is appropriately secure.

b. Data security and record confidentiality must be maintained in accordance with standard TCHD procedures.

c. The employee will comply with all copyrights and licensing agreements for all software owned by TCHD.

d. The employee is responsible for maintaining the confidentiality of any hardcopy materials produced at the remote worksite or transported from a TCHD facility.

e. The employee is to utilize TCHD's e-mail system for business-related e-mails, not a personal e-mail account, to ensure the data is encrypted and secured.

f. If the employee handles patient/employee data, employees must only utilize TCHD owned equipment. Patient/Employee data should not be stored or handled on employee-owned equipment.

g. These requirements may change based upon business need, regulatory requirements, etc.

12. Computing Environment

a. The employee should enable automatic security updates and install all security updates as they become available.

b. It is mandatory that Anti-virus software is to be installed on all TCHD computers. The software should be set to automatically update at boot-up. Encryption software should be used to encrypt patient confidential, or sensitive data.

c. The employee agrees not to share passwords with anyone, including family members, or have passwords automatically saved and entered by the system.

13. Computer Set-up and Repair

a. Employees who are working from a remote location and are using a TCHD computer will receive all necessary media and software which will be set up for them. IT phone support is available if help is needed loading this software.

b. Employees who experience hardware problems on TCHD owned systems may bring them to the workplace to be repaired. Any employee working remotely who experiences computer-related problems is required to promptly return to their TCHD work location until their systems are repaired.

14. Evaluation
The employee shall agree to participate in all studies, inquiries, reports and analyses relating to this program. The employee remains obligated to comply with all TCHD rules, practices and instructions.

D. **FORM(S):**
1.

E. **RELATED DOCUMENT(S):**
1.

F. **EXTERNAL LINK(S):**
1.

G. **REFERENCE LIST:**
1.

Employee Fiduciary Subcommittee
(No meeting held in March, 2016)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 17, 2016
Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Jim Dagostino; Director/CHAC Chairperson Julie Nygaard, Director Larry Schallock, Dr. Victor Souza MD, Carol Brooks, Carol Herrera, Don Reedy, Guy Roney, Jack Nelson, Linda Ledesma, Marge Coon, Xiomara Arroyo, Mary Lou Clift, Sandy Tucker

NON-VOTING MEMBERS: David Bennett, Sr. VP & CMO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO, Fernando Sanudo

MEMBERS ABSENT: Barbara Perez, Bret Schanzenbach, Darryl Hebert, Gigi Gleason, Marilyn Anderson, Marylou de la Rosa Hruby, Rosemary Eshelman, Alisha Cordova (Interim for Roma Ferriter), Audrey Lopez

OTHERS PRESENT: Susan McDowell, CHAC Coordinator; Celia Garcia, CHAC Coordinator, Brian Greenwald, Website Content Specialist

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The March 17, 2016, Community Healthcare Alliance Committee meeting was called to order at 12:35 pm by Director and CHAC Chair Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Don Reedy motioned to approve the March 17, 2016 agenda. The motion was seconded by Director Jim Dagostino and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Dagostino requested one correction to page 5, a secretarial error under CMO Update. A motion of correction was made by Don Reedy and seconded by Director Dagostino. By motion from Director Dagostino and seconded by Carol Brooks, the February 18, 2016 meeting minutes were approved with corrections.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 17, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation	Sarah Joyyousi, Operations Manager and Charlene Moore, Community Liaison for Outpatient BHU presented information to the committee regarding the unit's current program and future goals, highlighting the following: 1. Review of common mental health issues. 2. Review of Symptoms of Schizophrenia, Bi-polar and Depression. 3. Current CDC data concerning the rise in depression patients. 4. Behavioral Health Treatment Options. 5. The process of recovery. Sarah and Charlene concluded their presentation by addressing audience questions. The committee thanked each of them for a very informative discussion.		
CEO Presentation	No CEO Presentation		
Chief Operations Officer Update	Chief Compliance Officer, Kapua Conley, provided updates as follows: 1. Congratulations were extended to Steve Dietlin who became the recipient of San Diego Business Journal's CFO of the Year award for the Business Non-Profit Category. 2. A large "Pardon Our Progress" vinyl banner has been installed to inform the community of TCMC's construction areas and progress. 3. Traffic Mitigation construction is expected to begin towards the end of May.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Chief Operations Officer Update	4. Recently met with the City Manager regarding the campus redevelopment plan. 5. Review is taking place concerning how to keep the interior hospital areas cooler during warm summer months. Kapua noted that they are looking at improvements to the aging chillers currently used in the hospital. 6. The new CT has been installed and will be tested with Dr. Ponic in April. Kapua noted that TCMC is the only hospital in San Diego County with this technology. 7. Recently met with Oceanside City Councilman, Jerry Kern, to discuss a Homeless Placement Initiative to find solutions for patients that have no place to go once discharged from the hospital or have no place to go in general. 8. Currently working on an IT integration program between TCMC and UCSD. 9. Collaborations underway with UCSD for cardiac rehab at the Wellness Center.		
Chief Marketing Officer Update	Chief Marketing Officer, David Bennett, updated the group as to the following: 1. The TCMC / UCSD co-branding process is underway. 2. The Wellness Center / UCSD monument sign is moving forward. 3. Marketing is currently preparing the next TC commercial which will feature the Cardio Rehab and the Wellness Center. 4. David Bennett will be meeting with Councilman Jerry Kern regarding the proposed electronic display sign at the hospital. 5. The LPGA begins next week. This is a high-visibility event for TCMC.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 17, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CHAC Committee Vacancies	Upon motion made by Director Dagostino and seconded by Director Schallock, the following CHAC appointments were approved: • Sandy Tucker, Senior Commission Nominee, City of Oceanside • Alisha Cordova, LVN, interim Ex-Officio Member, NCHS • Mary Donovan, Mayoral Recommendation by Mayor Judy Ritter, Vista Committee members were again urged to make recommendations for community members who would like to serve in one of the currently open positions.		
Grant Application Update	CHAC Chair, Julie Nygaard, updated the group regarding the CHAC Grant Applications and resubmittals. The CHAC Review Committee will be meeting in April to finalize their recommendations to the Board of Directors.		
Committee Communications	The following CHAC Committee members commented: 1. Fernando Sanudo noted that TCMC's Casino Night event went very well and was a fun event to attend. 2. Carol Herrera announced the upcoming Heroes of Vista event in April at CSUSM. 3. Mary Donovan noted that Operation Hope will be re-opening as a "year-round" organization in the near future. 4. Don Reedy addressed the Homeless Vets issues facing North County and suggested a meeting to further discuss a potential TCMC role in this issue. COO Kapua Conley agreed.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	5. Director Larry Schallock noted the upcoming Relay for Life event that is being sponsored by TCMC.		
Public Comments	No public comments.		
Next Meeting	The next meeting is scheduled for Thursday, April 21, 2016 at 12:30pm.		
Adjournment	The March 2016 CHAC Committee meeting was adjourned at 1:44pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
March 15, 2016

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

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Kellett called the meeting to order at 12:34 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Nygaard, Ms. Mendez seconded, and it was unanimously approved to accept the agenda of March 15, 2016.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Kellett read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of February 16, 2016	Minutes were ratified, with the requested edit on page 7, which was the removal of dollar sign by	Minutes were ratified. **MOTION** **It was moved by Director Nygaard, Mr.**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	FY Avg. Days in Net A/R.	**Lingenfelter seconded, that the minutes of February 16, 2016, be approved with the one requested correction.**	
5. Old Business			
6. New Business			
a. San Diego Dialysis Services, Inc., dba Fresenius Medical Care, North America	Kathy Topp conveyed that this was renewal agreement with new rates for a 12-month period. Fresenius will provide hemodialysis, advanced renal replacement options, peritoneal dialysis treatments, as well as apheresis treatments and therapeutic whole blood phlebotomy treatments to TCMC patients. Jody Root announced that this agreement had not been reviewed by Procopio.	**MOTION** **Director Nygaard, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with San Diego Dialysis Services, Inc., dba Fresenius Medical Care, North America at an average monthly cost of $73,000, for a term of 12 months, beginning April 1, 2016, and ending March 31, 2017, for a total cost not to exceed $876,000.**	Kathy Topp
b. Siemens Medical Urology System, Purchase and Installation Proposal	Sharon Schultz explained that this is a replacement for the Urology table and surgical lamp head in OR #11, which was selected by the urologists for its technology and flexibility, and has been reviewed by Director of Radiology for integration with our current system. The present urology table was manufactured in 1995, and both it as and the surgical lamp are no longer supported by the vendor. Jody Root announced that this agreement had not been reviewed by Procopio.	**MOTION** **Mr. Keane moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the purchase and installation of the Siemens Uroskop System and Surgical Light for Operating Room 11 at a total cost not to exceed $627,780.**	Mary Diamond / Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
c. Orthopedic & Spine Institute Co-Management Agreement Proposal	Jeremy Raimo stated that this is a renewal agreement, which provides structure consistent with the Institute's guiding principles of hospital physician collaboration and integrated leadership. He emphasized that the management and incentive fees are unchanged from the original agreement.	**Mr. Lingenfelter moved, Mr. Keane seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement for Orthopedic Institute Co-Management for a term of 28 months, beginning March 1, 2016 and ending June 30, 2018 for an annual cost not to exceed, $750,000, and a total cost not to exceed $1,750,000.**	Jeremy Raimo / Wayne Knight
d. Physician Agreement for ED On-Call Coverage: • Neurology • Neurosurgery	Sherry Miller conveyed that the following write-ups were for panel agreement renewals and the rates remained unchanged for each agreement.	**Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Andrew Blumenfeld, MD; Bilal Choudry, MD; Laura Desadier, MD; Benjamin Frishberg, MD; Michael Lobatz, MD; Amy Nielsen,DO; Irene Oh, MD; Remia Paduga, MD; Jay Rosenberg, MD; Mark Sadoff, MD; Gregory Sahagian, MD; Jack Schim, MD; Anchi Wang, MD; Chunyang Tracy Wang, MD; Michael Zupancic, MD as the Neurology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at daily rate of $740, for an annual cost of $270,100 for FY 2017, for a total cost for the term of $270,100.** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance,**	Sherry Miller

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Neurosurgery/Spine • OB/GYN		**Operations and Planning Committee recommend that the TCHD Board of Directors authorize Thomas Nowak, MD, as a Neurosurgery ED-Call Coverage Physician for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at daily rate of $800, for an annual cost of $292,000 for FY 2017 for a total cost for the term of $ 292,000.** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Tyrone Hardy, Sunil Jeswani, Thomas Marcisz, Mark Stern, Kevin Yoo, as the Neurosurgery and Spine ED-Call Coverage Physicians, for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017, at daily rate of $800 (Neurosurgery), and $400 (Spine), for an annual cost of $292,000 for Neurosurgery and $146,000 for Spine in FY 2017, for a total cost for the term of $438,000.** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. John Bennett, Chunjai Clarkson, Orna Gil, Melissa Hawkins, Christos Karanikkis, Sandra**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Lopez, Rahele Mazarei, Talal Muhtaseb as the OB/GYN ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2016 and ending June 30, 2018 at daily rate of $800 (weekday) and $1,000 (weekend/holiday), for an annual cost of $204,800 and $109,000 for FY 2017, and an annual cost of $202,400 and $112,000 for FY 2018 for a total cost for the term of $628,200.	
• Ophthalmology		**Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. James Davies; Bradley Greider; Henry Hudson; Atul Jain; Srinivas Iyengar; Peter Krall; Sally Mellgren; Robert Pendleton; Mark Smith; Maulik Zaveri as ED On-Call Coverage Physicians for a term of 24 months beginning July 1, 2016 and ending June 30, 2018. Not to exceed a daily rate of $300 and an annual cost for the term of $109,500 for FY2017 and $109,500 for FY2018, for a total cost for the term of $219,000.**	
• Gastroenterology		**Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Christopher**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Devereaux, Thomas Krol, Javaid Shad, Michael Shim and Matthew Viernes, as the Gastroenterology/ERCP ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at daily rate of $700 for Gastro-General and $500 for ERCP, for an annual cost of $255,500 for Gastro-General, and $182,500 for Gastro-ERCP, for a total cost for the term of $438,000.	
e. Financials	Steve Dietlin presented the financials ending February 29, 2016 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $ 220,856 Operating Expense $ 222,723 EBITDA $ 9,233 EBITDA Excl. Settlement $ 11,311 EROE $ (276) EROE Excl. Settlement $ 1,802 **TCMC – Key Indicators – FYTD** Avg. Daily Census 193 Adjusted Patient Days 75,620 Surgery Cases 4,250 Deliveries 1,759 ED Visits 44,113 **TCHD – Financial Summary – Current Month** Operating Revenue $ 26,838 Operating Expense $ 27,666 EBITDA $ 797 EROE $ (411) **TCMC – Key Indicators – Current Month** Avg. Daily Census 203		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Adjusted Patient Days 9,610 Surgery Cases 509 Deliveries 183 ED Visits 5,607 **<u>Net Patient A/R & Days in Net A/R By Fiscal Year</u>** FY Avg. Net Patient A/R (in millions) $ 41.2 FY Avg. Days in Net A/R 47.5 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EBITDA and EROE, Quarterly		
f. Work Plan – Information Only	Director Kellett reported that these agenda items were for review only, but Committee members were welcome to ask questions.		
• Aionex / Throughput	Kathy Topp reviewed the Aionex Executive Summary and the accompanying spreadsheet; discussion ensued.		Kathy Topp
• Dashboard	**<u>Dashboard:</u>** No discussion		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
7. Comments by Committee Members		None	Chair
8. Date of next meeting	April 19, 2016		Chair
9. Community Openings (none)			
10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)			Jody Root, Procopio
11. Motion to go into Closed Session		**MOTION** **Director Nygaard moved, Ms. Mendez seconded, and it was unanimously approved to go into Closed Session at 1:02 pm**	
16. Open Session		**MOTION** **Director Nygaard moved, Ms. Mendez seconded, and it was unanimously approved to go into Open Session at 1:08 pm**	
17. Report from Chairperson of any action taken in Closed Session (Authority: Government code, section 54957.1)	No report made.		
18. Adjournment	Meeting adjourned 1:09 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
Fresenius Dialysis and Apheresis Services Proposal

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

Vendor's Name: San Diego Dialysis Services, Inc.
dba Fresenius Medical Care, North America

Area of Service: Dialysis and Apheresis Services

Term of Agreement: 12 months, Beginning, April 01, 2016 – Ending, March 31, 2017

Maximum Totals:

Average Monthly Cost:	Total Term Cost Not to Exceed:
$73,000	$876,000

Description of Services/Supplies:

- Provide hemodialysis, advanced renal replacement options, and peritoneal dialysis treatments for TCMC patients
- Provide apheresis treatments and therapeutic whole blood phlebotomy treatment for TCMC patients

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

Person responsible for oversight of agreement: Kathy Topp, Director of Education, Clinical Informatics & Staffing; Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors authorize the agreement with San Diego Dialysis Services, Inc., dba Fresenius Medical Care, North America at an average monthly cost of $73,000, for a term of 12 months, beginning April 1, 2016, and ending March 31, 2017, for a total cost not to exceed $876,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
Siemens Urology System Purchase and Installation Proposal

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

Vendor's Name: Siemens Medical Solutions, USA

Area of Service: Surgery

Description of Services/Supplies

- Replacement of Urology table in OR 11, to include replacement of surgical lamp head
- Our current GE Uroview 2600 table was manufactured in 1995, and is no longer supported
- Service/repair calls are becoming more frequent (3-4 times per month), and repair parts are no longer available, even from third party vendors
- The surgical lamp head also needs replacement as parts are not available to repair these lights
- Our case volume in endourology averages 42 cases per month.
- Siemens Uroskop table was selected by our urologists for its technology and flexibility
- Equipment has also been reviewed by our Radiology Director for integration with our current systems

Project Costs:	
Siemens Uroskop Table and accessories:	$454,978
Removal of Existing Table:	$4,000
Berchtold F Generation Surgical Lights	$23,165
Construction/General Contractor Fees	$ 145,637
Total:	**$627,780**

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	X	No

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the purchase and installation of the Siemens Uroskop System and Surgical Light for Operating Room 11 at a total cost not to exceed $627,780.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
Orthopedic & Spine Institute Co-Management Agreement Proposal

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

Vendor's Name: TCMC Orthopedic Institute, LLC
Area of Service: Tri-City Orthopedic & Spine Institute
Term of Agreement: 28 months, Beginning, March 1, 2016 – Ending, June 30, 2018

Maximum Totals, Not to Exceed:

Base Management Fee		
Monthly Cost:	**Annual Cost:**	**Total Term Cost:**
$29,167	$350,004	$816,676
Performance Improvement Incentive Fee		
Monthly Cost:	**Annual Cost:**	**Total Term Cost:**
$33,333	$399,996	$933,324

Description of Services/Supplies:

- Provides structure that is consistent with the Institute's guiding principles of hospital physician collaboration and integrated leadership
- Establishes an entity that is consistent with integrated delivery and provides a foundation for business and payer initiatives
- The management fee and incentive fees are unchanged from the original agreement

Legal:

The original agreement was established in October 2011, and structured by the law firm of Squire, Sanders and Dempsey LLP, and approved by TCHD Counsel.

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

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 for Orthopedic Institute Co-Management for a term of 28 months, beginning March 1, 2016 and ending June 30, 2018 for an annual cost not to exceed, $750,000, and a total cost not to exceed $1,750,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
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, MD; Bilal Choudry, MD; Laura Desadier, MD Benjamin Frishberg, MD; Michael Lobatz, MD; Amy Nielsen,DO; Irene Oh, MD; Remia Paduga, MD; Jay Rosenberg, MD; Mark Sadoff, MD; Gregory Sahagian, MD; Jack Schim, MD; Anchi Wang, MD; Chunyang Tracy Wang, MD; Michael Zupancic, MD

Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 12 months, Beginning, July 1, 2016 – Ending, June 30, 2017

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	FY17: 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.

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

Person responsible for oversight of agreement: Sherry Miller, Medical Staff Manager / 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, 2016 and ending June 30, 2017 at daily rate of $740, for an annual cost of $270,100 for FY 2017, for a total cost for the term of $270,100.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - NEUROSURGERY

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

Physician's Name: Thomas Nowak, MD

Area of Service: Emergency Department On-Call: Neurosurgery

Term of Agreement: 12 months, Beginning, July 1, 2016 – Ending, June 30, 2017

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
$800	FY17: 365	$292,000

Position Responsibilities:

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

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Thomas Nowak, MD as a Neurosurgery ED-Call Coverage Physician for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at daily rate of $800, for an annual cost of $292,000 for FY 2017 for a total cost for the term of $ 292,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – NEUROSURGERY / SPINE

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

Physician's Names: Tyrone Hardy, MD; Sunil Jeswani, MD; Thomas Marcisz, MD; Mark Stern, MD; Kevin Yoo, MD

Area of Service: Emergency Department On-Call: Neurosurgery and Spine

Term of Agreement: 12 months, Beginning, July 1, 2016 – Ending, June 30, 2017

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
Neurosurgery	$800	FY17: 365	$292,000
Spine	$400		$146,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurosurgery and Spine 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.

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Tyrone Hardy, Sunil Jeswani, Thomas Marcisz, Mark Stern, Kevin Yoo, as the Neurosurgery and Spine ED-Call Coverage Physicians, for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017, at daily rate of $800 (Neurosurgery), and $400 (Spine), for an annual cost of $292,000 for Neurosurgery and $146,000 for Spine in FY 2017, for a total cost for the term of $438,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Names: John Bennett, MD; Chunjai Clarkson, MD; Orna Gil, MD; Melissa Hawkins, MD; Christos Karanikkis, DO; Sandra Lopez, MD; Rahele Mazarei, DO; Talal Muhtaseb, MD

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

Term of Agreement: 24 months, Beginning, July 1, 2016 – 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 - Rate/Day	Panel Days per Year	Panel Annual Cost
Weekday $800 Weekend/holiday $1000	FY17: 256 FY17: 109	$204,800 $109,000
Weekday $800 Weekend/holiday $1000	FY18: 253 FY18: 112	$202,400 $112,000
Total Term Cost:		**$628,200**

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.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. John Bennett, Chunjai Clarkson, Orna Gil, Melissa Hawkins, Christos Karanikkis, Sandra Lopez, Rahele Mazarei, Talal Muhtaseb as the OB/GYN ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2016 and ending June 30, 2018 at daily rate of $800 (weekday) and $1,000 (weekend/holiday), for an annual cost of $204,800 and $109,000 for FY 2017, and an annual cost of $202,400 and $112,000 for FY 2018 for a total cost for the term of $628,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - OPHTHALMOLOGY

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

Physicians Names: James Davies, MD; Bradley Greider, MD; Henry Hudson, MD; Atul Jain, MD; Srinivas Iyengar, MD; Peter Krall, MD; Sally Mellgren, MD; Robert Pendleton, MD; Mark Smith, MD; Maulik Zaveri, MD

Area of Service: ED On-Call: Ophthalmology

Term of Agreement: 24 months, Beginning, July 1, 2016 – 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
$300	FY2017: 365 FY2018: 365	$109,500 $109,500

Position Responsibilities:

- Provide 24/7 patient coverage for Ophthalmology 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.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. James Davies; Bradley Greider; Henry Hudson; Atul Jain; Srinivas Iyengar; Peter Krall; Sally Mellgren; Robert Pendleton; Mark Smith; Maulik Zaveri as ED On-Call Coverage Physicians for a term of 24 months beginning July 1, 2016 and ending June 30, 2018. Not to exceed a daily rate of $300 and an annual cost for the term of $109,500 for FY2017 and $109,500 for FY2018, for a total cost for the term of $219,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 15, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - GASTROENTEROLOGY

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

Physician's Name: Christopher Devereaux, MD; Thomas Krol, MD; Javaid Shad, MD; Michael Shim, MD; Matthew Viernes, MD

Area of Service: Emergency Department On-Call: Gastroenterology - General and Gastroenterology - ERCP

Term of Agreement: 12 months, Beginning, July 1, 2016 – Ending, June 30, 2017

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage:

Rate/Day	Panel Days per Year	Panel Annual Cost
GI $700 ERCP $500	FY17: 365	$255,500 $182,500

Position Responsibilities:

- Provide 24/7 patient coverage for all Gastroenterology/ERCP 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.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Devereaux, Krol, Shad, Shim and Viernes, as the Gastroenterology/ERCP ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2016 and ending June 30, 2017 at daily rate of $700 for Gastro-General and $500 for ERCP, for an annual cost of $255,500 for Gastro-General, and $182,500 for Gastro-ERCP, for a total cost for the term of $438,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
March 10, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Director Ramona Finnila, Dr. Marcus Contardo, Dr. Gene Ma and Dr. Scott Worman.

Non-Voting Members Present: Kapua Conley, COO/ Exec. VP and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Quality, Cli. Risk Mgt. & Patient Safety, Jami Piearson, Director for Regulatory and Compliance, Kathy Topp, Steve Sims, Meggan Mcgraw, Sharon Davies, Isabel Escalle, Mary Diamond, Thomas Moore, Mike Parent, Lisa Mattia, Nancy Myers, Sarah Jayyousi, Priya Joshi, Priscilla Reynolds, Oska Lawrence, Patricia Guerra and Karren Hertz.

Members Absent: Sharon Schultz, CNE/ Sr. VP and Dr. James Johnson.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:05 p.m. in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Schallock and seconded by Director Finnila.	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 2016.	Director Mitchell called for a motion to approve the minutes from February 11, 2016 meeting.	Minutes ratified. Director Finnila moved and Director Schallock seconded the motion to approve the minutes from February 2016.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	Jami Piearson reported that some of the measures in the current dashboard will be retired. Some measures will be pulled out and sepsis measures will be added. Jami also mentioned that there are six (6) priority projects that are currently ongoing of which quality measures are being tracked by the PI department.	**ACTION:** The Rehab quality report will be updated to reflect all the activities that have been added from the last time it was presented.	Jami Piearson
b. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Code Blue Response Plan Policy	The definition of adult will be taken out on this policy.	**ACTION:** The Patient Care Services policies and procedures were all approved. Director Finnila moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Code Pink Response Plan Policy	There was a quick discussion regarding the existence of the Braslow cart in the unit.		
3. Code Caleb Team Mobilization Policy	The section on outpatient centers should be modified as "Areas out of the hospital but not limited to..:" Also, the Vista Palomar Park will be taken out of the list.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Communicating with Physicians	No discussion on this policy.		Patricia Guerra
5. Interpretation and Translation Services	Isabel Escalle established to the group that there is a separate policy for the hearing impaired (deaf) people.		
6. Massive Transfusion Protocol	Dr. Contardo stated that the massive transfusion protocol also applies to OB patients and procedures.		
7. Patient Safety in Surgical Areas	No discussion on this policy.		
8. Pre, Intra and Post-op Assessment of Fetal heart Rate and Uterine Activity Procedure	The committee made a clear distinction between skilled and regular obstetrical people manning the uterine activity for OB patients.		
Administrative Policies and Procedures			
1. Equipment Transfer, Storage Trade-In, and Disposal 200	The group agreed that this policy is pretty universal so there is no need to make any changes.	**ACTION:** The Administrative policies and procedures were all approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Provision of Education for Pediatrics During Hospitalization	The title was modified to be Provision of Education for Adolescents as pediatrics is only for children up to a certain age.		
3. Storage of Legal Weapons (Moving from Security Manual)	This policy is being pulled out since there were some questions and issues associated with the storage of legal weapons.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific Infection Control 1. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection 2. Management of Patients with MRSA IC 6-3r 3. Management of patients with VRE IC 6-6r	No discussion on these policies. This policy is a combination of Policy #2 and 3 which are being deleted consequently.	**ACTION:** The Infection Control policies and procedures were all approved. Dr. Worman moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
NICU 1. Cue Based Feeding 2. High-Risk Infant Follow-Up Program 3. High-Risk Infant Follow-Up Clinic- Perinatal Data Manager, Role of 4. High-Risk Infant Follow-Up Clinic- Coordinator, Role of 5. High-Risk Infant Follow-Up Clinic- Dietitian, Role of 6. High-Risk Infant Follow-Up Clinic- Physical Therapist, Role of 7. High-Risk Infant Follow-Up Clinic- Registered Nurse, Role of	There is no discussion on this policy. These 7 policies are being broken up so there were no discussion on these policies.	**ACTION:** The NICU policies and procedures were all approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health 1. Co-treatment of Patients 2. Physician Progress Notes	The term Nurse Practitioner (NP) used in this policy will be replaced by Allied Health	**ACTION:** The Outpatient Behavioral Health policies and	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	Practitioner (AHP).	procedures were all approved. Dr. Contardo moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	
Patient Care Management			
1. Discharge Planning	There was no discussion on this policy.	**ACTION:** The Patient Care Management policies and procedures were all approved. Dr. Worman moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation			
1. Audiology Services Inpatient Rehab Services 2. Discharge Criteria 3. Documentation of Progress Notes and Discharge Summary 4. Modalities Used Thermal Agents 616 5. NICU Follow-Up High Risk Infant Follow-Up (HRIF) 6. Occupational Therapy Policy 702 7. Patient and Caregiver Education	It was noted that audiology services are being used only for 5-6 times a year only. The audiologist brings the equipment when called in. Even though the need is not that great, it is still beneficial for the hospital to have these services, the group concurred.	**ACTION:** The Rehabilitation policies and procedures were approved and are moving forward for Board approval. Director Finnila moved and Director Schallock seconded the motion to approve these policies.	Patricia Guerra
8. Physical Therapy Department Policy	Dr. Worman added that goals are set up in acute care setting accordingly to each patient's pain level.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Pre-Op Teaching Physical Therapy Occupational Therapy 614 10. Scope of Services 11. Speech Pathology Services Department Policy 12. Swallow Evaluations: Power Outage System Failure 13. Therapeutic Recreation: Acute Care 14. Traction Cervical & Lumbar	Pre-op education is highly encouraged as it aids the patients in achieving good outcomes. This policy has an overlap of neonatal and geriatric. .		
Telemetry 1. Admission and Discharge Criteria 2. Weighing Telemetry Patient	It was reported that Class 2 or 3 classification is well known by all. This classification criteria is in conjunction with AC report. Director Mitchell asked for clarification that the facility has more than one Hoyer lift; ICU beds have scales; and most newer beds do.	**ACTION:** The Telemetry policies and procedures were approved and are moving forward for Board approval. Dr. Ma moved and Director Schallock seconded the motion to approve these policies.	
Women and Newborn Services 1. Amnioinfusion 2. Obstetrical Hemorrhage 3. Preeclampsia Care 4. Vibroacoustic Stimulation (VAS) (Fetal Acoustic Stimulation Test- FAST)	No discussion on these policies.	**ACTION:** The Women and newborn Services policies and procedures were approved and are moving forward for Board approval. Dr. Worman moved and Director Schallock seconded the motion to approve these	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Formulary Requests 1. Praxbind- Trade Name- Idarucizumab- Generic Name 2. Tretinoin- Trade Name – All-Trans Retinoic Acid **FORMS:** 1. 7883-1002 High Risk Infant Follow-Up **2.** 8720-1018 Progress Note	This formulary has very low usage and is considered as a drug with no formulary reversal. This commonly used to treat Aneurysm.	policies. **ACTION:** The formulary requests were approved and are moving forward for Board approval. Director Schallock moved and Dr. Worman seconded the motion to approve these policies.	
6. Clinical Contracts	In compliance with CMS as emphasized in the last survey, the clinical contracts that were approved in MEC are being brought forward to this committee.	**ACTION:** The clinical contracts from M to Z were presented and they were all approved by the committee.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Finnila seconded and it was unanimously approved to go into closed session at 1:05 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No Comments.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Adjournment	Meeting adjourned at 2:24 PM		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
March 10th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code Blue Response Plan Policy	3 year review, practice change	Forward to BOD for approval with revisions
2. Code Caleb Team Mobilization Policy	3 year review, practice change	Forward to BOD for approval with revisions
3. Code Pink Response Plan Policy	3 year review, practice change	Forward to BOD for approval with revisions
4. Communicating with Physician Using SBAR Policy	3 year review, practice change	Forward to BOD for approval with revisions
5. Interpretation and Translation Services	3 year review, practice change	Forward to BOD for approval
6. Massive Transfusion Protocol	NEW	Forward to BOD for approval with revisions
7. Obstetrical Patients Triage Policy	3 year review, practice change	Pulled for further review
8. Patient Safety in Surgical Areas Policy	Practice change	Forward to BOD for approval
9. Pre, Intra and Post-op Assessment of Fetal Heart Rate and Uterine Activity Procedure	3 year review, practice change	Forward to BOD for approval with revisions
Administrative Policies & Procedures		
1. Equipment Transfer, Storage Trade-in, and Disposal 200	3 year review, practice change	Forward to BOD for approval
2. Provision of Education during Hospitalization 391	3 year review	Forward to BOD for approval with revisions
3. Storage of Legal Weapons (moving from Security Manual)	3 year review, practice change	Pulled for further review
Unit Specific		
Infection Control		
1. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection	NEW	Forward to BOD for approval
2. Management of Patients with MRSA IC 6-3r	DELETE	Forward to BOD for approval
3. Management of Patients With VRE IC 6-6r-	DELETE	Forward to BOD for approval
Neonatal Intensive Care (NICU)		
1. Cue Based Feeding	3 year review, practice change	Forward to BOD for approval with revisions
2. High Risk Infant Follow-Up Program	3 year review, practice change	Forward to BOD for approval
3. High Risk Infant Follow Up Clinic Perinatal Data Manager, the Role of	3 year review, practice change	Forward to BOD for approval
4. High Risk Infant Follow-up Clinic Coordinator, Role of	DELETE	Forward to BOD for approval
5. High Risk Infant Follow-up Clinic Dietician, Role of	DELETE	Forward to BOD for approval
6. High Risk Infant Follow-up Clinic Physical Therapist, Role of	DELETE	Forward to BOD for approval
7. High Risk Infant Follow-up Clinic Registered Nurse, Role of	DELETE	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
March 10th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Outpatient Behavioral Health		
1. Co-treatment of Patients	3 year review, practice change	Forward to BOD for approval with revisions
2. Physician Progress Note	3 year review, practice change	Forward to BOD for approval with revisions
Patient Care Management		
1. Discharge Planning	3 year review, practice change	Forward to BOD for approval
Rehabilitation		
1. Audiology Services Inpatient Rehabilitation Services -	3 year review, practice change	Forward to BOD for approval
2. Discharge Criteria – 501	3 year review, practice change	Forward to BOD for approval
3. Documentation of Progress Note and Discharge	3 year review, practice change	Forward to BOD for approval
4. Modalities Used Thermal Agents 616	DELETE	Forward to BOD for approval
5. NICU Follow-Up High Risk Infant Follow Up (HRIF) - 604	DELETE	Forward to BOD for approval
6. Occupational Therapy Policy – 702	3 year review, practice change	Forward to BOD for approval with revisions
7. Patient & Caregiver Education - 507	DELETE	Forward to BOD for approval
8. Physical Therapy Department Policy - 603	3 year review, practice change	Forward to BOD for approval with revisions
9. Pre-OP Teaching Physical Therapy Occupational Therapy – 614	3 year review, practice change	Forward to BOD for approval with revisions
10. Scope of Services	3 year review, practice change	Forward to BOD for approval
11. Speech Pathology Services Department Policy – 802	3 year review, practice change	Forward to BOD for approval
12. Swallow Evaluations Power Outage System Failure - 804	DELETE	Forward to BOD for approval
13. Therapeutic Recreation Acute Care - 904	DELETE	Forward to BOD for approval
14. Traction Cervical & Lumbar	DELETE	Forward to BOD for approval
Telemetry		
1. Admission and Discharge Criteria	3 year review, practice change	Forward to BOD for approval with revisions
2. Weighing Telemetry Patients	3 year review, practice change	Forward to BOD for approval
Women and Newborn Services		
1. Amnioinfusion	3 year review, practice change	Forward to BOD for approval
2. Obstetrical Hemorrhage	3 year review, practice change	Forward to BOD for approval
3. Preeclampsia Care	NEW	Forward to BOD for approval
4. Vibroacoustic Stimulation (VAS) (Fetal Acoustic Stimulation Test (FAST))	3 year review, practice change	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
March 10th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Formulary Requests		
Praxbind – Trade Name Idarucizumab – Generic Name		Forward to BOD for approval
Tretinoin – Trade Name All-Trans Retinoic Acid (ALTA) – Generic Name		Forward to BOD for approval
Forms		
7883-1002 High Risk Infant Follow Up		Forward to BOD for approval
8720-1018 Progress Note		Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**12/02**	**SUBJECT:**	**Code Blue Response Plan**
REVISION DATE:	**11/02; 3/03; 5/05, 5/06, 11/07; 1/08; 1/09; 2/10; 5/11**	**POLICY NUMBER:**	**IV.T**

Clinical Policies & Procedures Committee Approval:	**12/14**
Nursing Executive Council Approval:	**12/14**
Department of Emergency Medicine Approval:	**01/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**
1. To provide a systematic method for responding to a cardiopulmonary emergency on adults or children age 14 or older within the hospital and outside of the facility on hospital property.

B. **DEFINITIONS:**
1. Code Blue Response Areas:
   a. Patient Care Areas – areas in the main building with crash carts and AED/defibrillators readily available (for example Cardiac Rehabilitation building and Magnetic Resonance Imaging (MRI) building).
   b. Non-patient Care Areas: areas on the main campus where crash cart and AED/defibrillators not readily available (for example the Business Administration Management (BAM) building, registration and parking area).

C. **POLICY:**
1. A Code Blue shall be called on any apneic and/or pulseless adult or child age 14 or older.
2. Any person may initiate a Code Blue by dialing "66" on the telephone. The Operator shall announce "Code Blue" and the location over the P.A. system three times, twice.
3. Response to the Code shall occur according to the following response plan.

D. **RESPONSE PLAN WITHIN PATIENT CARE AREAS:**
1. Initial response in non-cardiac monitored areas
   a. Staff shall initiate Basic Life Support (BLS) measures until Code Blue Response Team arrives.
2. Initial response in cardiac monitored areas
   a. Staff shall initiate BLS and Advanced Cardiac Life Support (ACLS) measures and initiates the Code Blue and Emergency Care Standardized Procedure until Code Blue Response Team arrives
3. Code Blue response team
   a. The following staff shall respond to the Code Blue :
      i. Two Intensive Care Unit (ICU) Code Blue Nurses:
         1) Brings Code Blue Cart (contains defibrillator/pacemaker, ambu bag and emergency intubation medications) to the scene.
            a) If the code blue occurs in the Cardiac Wellness Center, the responding Code Blue Team members are responsible for bringing the emergency intubation drugs only
         2) Initiates and implements the Standardized Procedure for Code Blue and Emergency Care until the physician arrives

3) Remain with patient until released by physician or patient is transferred to receiving unit
   a) Inpatients shall be transferred to the Intensive Care Unit or appropriate level of care based on physician order
4) Ensures the Emergency Event form in the patient's electronic health (EHR) record is completed

ii. Emergency Department (ED) Physician:
1) Responds when available and shall be responsible for leading resuscitative efforts

iii. Primary Nurse :
1) Remains in room to assure responders have current patient information.
2) Accesses patient's record and assures responders have information requested (i.e., lab, x-ray, reports)
3) Documents in the EHR:
   a) Pre-code assessment findings
   b) Interventions implemented prior to Code Blue team arrival
4) Notifies the family member/significant other or ensures the physician or receiving RN notifies family member/significant other of change in condition

iv. Respiratory Care Practitioner:
1) Ventilates patient
2) Obtains arterial blood gases and "Code Blue lab panel" as ordered
3) Documents interventions performed on the Emergency Event record

v. ECG Technician:
1) Brings ECG machine

vi. Lift Team):
1) Brings gurney and backboard to area
2) Assists with CPR
3) Transports patient to receiving unit.

vii. Assistant Nurse Manager/Relief Charge Nurse:
1) Assigns recorder role, if not already done
2) Ensures paperwork and documentation is completed on the Cardiopulmonary Arrest Record Emergency Event form in the patient's electronic health (EHR) record are completed is completed
3) Ensures, post code the "medication tray" inside of the crash cart is re-locked with a secure tie (located in the crash cart) for containment at end of code
4) Ensures, post Code, the "opened" crash cart is locked with the plastic key lock externally, is placed in a secured area, and the Sterile Processing Department (SPD) is notified to pick up the used cart

viii. Unit Secretary:
1) Assures patient's chart is in room, phone is available in room, and places call to primary physician as directed

ix. Security Personnel:
1) Maintains scene safety and keeps area clear of congestion

x. Sterile Processing Department:
1) Sends an adult crash Cart and two infusion pumps to the area involved
2) Retrieves used crash cart and intubation tray post code

E. **RESPONSE PLAN FOR CODE BLUE IN NON-PATIENT CARE AREAS:**

1. Code Blue response team
   a. Two Intensive Care Unit (ICU) Code Blue Nurses
      i. Brings Code Blue Cart (contains defibrillator/pacemaker, ambu bag and emergency intubation medications) to the scene inside main hospital building

1) Exception to areas when bringing the cart will delay the response

ii. Ensures BLS measures have been implemented and facilitates patient transport to the ED

b. Emergency Medical Technicians (EMTs):
   i. Brings a defibrillator, airway bag, ambu bag, gurney and backboard to the scene
c. ED Physician:
   i. Responds when available and leads resuscitative efforts
d. Respiratory Care Practitioner:
   i. Brings oral airway, ambu bag and resuscitation bag to the scene
   ii. Ventilates patient and manages airway
e. Security Personnel:
   i. Maintains scene safety and keeps area clear of congestion.

F. **RESPONSE PLAN AT AFFLIATED CENTERS:**

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center
   k. Tri-City Wellness Center: Cardiac Rehab & Outpatient Rehab
2. The staff of the above mentioned areas are to initiate BLS measures and call 911 to facilitate management and transport of the patient to the ED.
3. The staff in Home Care, Partial Hospitalization, and Outpatient Rehabilitation Services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

G. **REFERENCES:**

1. American Heart Association. (2010). BLS for healthcare providers: *Professional Student Manual*.
2. American Heart Association (AHA) (2010). Highlights of 2010 AHA guidelines for CPR
3. American Heart Association (AHA) (2010). Handbook of emergency cardiovascular care for healthcare providers. .
4. Pediatric advanced life support. (2010). American Heart Association (AHA).

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 11/2011	**SUBJECT: Code Caleb Response Plan**
REVISION DATE: 02/12	**POLICY NUMBER: IV.ZZ**

Clinical Policies & Procedures Committee Approval:	**01/15**
Nurse Executive Council Approval:	**02/15**
Division of Neonatology Approval:	**01/15**
Department of Emergency Medicine Approval:	**01/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary event and/or other emergent clinical conditions for infants up to 30 days old within the hospital and outside of the facility on hospital property.

B. **DEFINITIONS:**

1. Infant: newly delivered, which includes prematurely, and up to 30 days old
2. Code Caleb Response Areas:
   a. Patient Care Areas- areas in the main building where neonatal crash carts are readily available (for example Emergency Department (ED), Women and Newborns Services, Neonatal Intensive Care Unit (NICU)).
   b. Non-Patient Care Areas- areas on the main campus where neonatal crash carts are not readily available (for example the lobby, registration area, and parking area).

C. **POLICY:**

1. A Code Caleb shall be called for any infant in need of stabilization or resuscitation.
2. Any person may initiate a Code Caleb by dialing "66" on the telephone. The operator shall announce "Code Caleb" and the location over the Public Announcement (P.A.) system three times, twice.
3. The Neonatal Resuscitation Program (NRP) guidelines shall be used to direct the resuscitation efforts for those infants on the Labor and Delivery (L&D), Mother Baby Unit and Neonatal Intensive Care Unit (NICU).
4. The Pediatric Advanced Life Support (PALS) and/or NRP guidelines may be used to direct the resuscitation efforts for those infants requiring assistance in the ED and Non-Patient Care Areas based on the responder's training.
5. It is expected that the first responders begin infant CPR until the Code Caleb Response Team arrives.
6. The following personnel make up the Code Caleb Response Team:
   a. NICU Nurse:
      i. Supports resuscitation interventions and initiates Standardized Procedure for Code. Caleb until the Neonatologist arrives.
      ii. Starts intravenous (IV) line, assists with central line placement as indicated.
      iii. Ensures temperature loss is minimized especially if the infant is premature.
      iv. Prepares medications for administration and may delegate the task.
      v. Brings the "Infant Resuscitation Bag" when responding to a Non-Patient Care Areas.

b. RCP:
   i. Provides airway management.
   ii. Assists with intubation.
   iii. Obtains arterial blood gases (ABG's) as indicated.
   iv. Brings oral airway and pediatric airway bag if responding to Non-Patient Care Areas.

c. Neonatologist:
   i. Responds, when available, and is responsible for leading the resuscitative efforts.
   ii. Responsible for intubation and central line placement as indicated.
   iii. Determines where the infant will be transported for stabilization.

7. Other support roles and responsibilities during the Code Caleb include:
   a. Security Personnel:
      i. Maintains scene safety and keeps area clear of congestion.
   b. Assistant Nurse Manager / Relief Charge Nurse
      i. Assigns recorder role, if not already done.
      ii. Ensures paperwork and documentation on the Neonatal Resuscitation Record and the Emergency Event form in the patient's electronic health record (EHR) are completed.
      iii. Ensures the medication tray inside the neonatal crash cart is relocked with a secure tie (located in the crash cart) for containment post code.
      iv. Ensures the "opened" crash cart is locked with the plastic key lock externally, is placed in a secured area. and the Sterile Processing Department (SPD) is notified to pick up the used cart post code.
   c. Ancillary Support (Social Worker , Chaplain)
      i. Provides support to the family by providing comfort, presence and updates as available.
   d. SPD:
      i. Brings another Neonatal Crash Cart and (1) infusion pump with (1) channel and (1) syringe pump attached to the scene.
8. The response to the Code shall occur according to the following response plans.

D. **RESPONSE PLAN IN L&D AND MOTHER BABY UNIT:**

1. First responder at emergent event:
   a. Calls for assistance.
   b. Moves the infant to the radiant warmer for resuscitation.
      i. On the Mother Baby Unit/ 2 S overflow, infant CPR shall begin as the infant is transported in an open crib to the radiant warmer in the transition nursery or infant treatment area.
   c. Begins ventilating the infant using positive pressure ventilation (PPV) per NRP guidelines until Code team arrives.
2. Unit Secretary / Available Staff member:
   a. Initiates a Code Caleb:
      i. Uses the white phone line to call the NICU directly.
         1) Pages the Neonatologists
         2) Pages the RCP
      ii. May dial "66" to have Code announced over the P.A. system if needed.
3. Second Responder:
   a. Assists with resuscitation per NRP guidelines until Code team arrives.
   b. Attaches pulse oximetry lead.
   c. Assists with chest compressions.
4. Obstetrical Technician, Acute Care Technician/ Perioperative Aide:
   a. Brings the Neonatal crash cart to the scene.
   b. Brings the Neonatal Transporter to the scene.
   c. Acts as a runner for supplies, labs, etc.

E. **RESPONSE PLAN IN THE NICU:**

1. First Responder:
   a. Calls for assistance.
   b. Begins CPR and moved infant to radiant warmer for resuscitation.
   c. Begins ventilating infant per NRP guidelines.
2. Unit Secretary/ Available Staff member:
   a. Calls/pages the Neonatologists.
   b. Calls/pages the RCP.
3. Second/Third Responders:
   a. Brings Neonatal crash cart to the bedside.
   b. Assists with resuscitation per NRP guidelines.
   c. Assists with line placement as needed, medication preparation.

F. **RESPONSE PLAN IN THE ED:**

1. First Responder:
   a. Calls for assistance.
   b. Begins CPR per PALS guidelines until Code Team arrives.
2. Unit Secretary/ Available Staff member:
   a. Dials "66" and requests Code Caleb be announced.
3. Second Responder:
   a. Assists with resuscitation per PALS guidelines until Code Team arrives.
4. Emergency Medical Technician (EMT):
   a. Brings the infant radiant warmer to the scene, plugs it in and turns the warming power to 100%.
   b. Brings the Neonatal crash cart to the scene.
5. ED Nurse:
   a. Responsible for the initial resuscitation efforts.
   b. Collaborates with the NICU nurse and Code Caleb response team upon arrival.
   c. May attempt IV access, as indicated.
   d. Ensures infant temperature loss is minimized especially if premature.
6. ED Provider:
   a. Directs initial resuscitation efforts.
   b. Works collaboratively with Neonatologist upon arrival.
   c. May intubate and place an Interosseous (IO) device.

G. **RESPONSE PLAN IN NON-PATIENT CARE AREAS**

1. First Responder:
   a. Calls for assistance
   b. Begins CPR until the Code Caleb Response Team arrives.
2. The NICU Nurse, RCP and Neonatologist:
   a. Ensure PALS or NRP guidelines have been implemented.
   b. Arrange for transport to the ED or NICU as soon as possible.

H. **RESPONSE PLAN AT AFFILIATED CENTERS:**

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center

k. Tri-City Wellness Center

2. The staff members are to initiate CPR and call 911 to facilitate management and transport of the infant to the ED.
3. The staff in home care, partial hospitalization, and outpatient rehabilitation services must clearly indicate the facilities are located in Vista to ensure the appropriate authorizes respond.

I. **FORM:**

1. Neonatal Resuscitation Record

J. **RELATED DOCUMENTS:**

1. Patient Care Services (PCS) Code Caleb Standardized Procedure
2. PCS Code Pink Response Plan Policy
3. PCS Code Pink Standardized Procedure

K. **REFERENCES**

1. Neonatal Resuscitation Program (NRP), 6th Edition (2011). American Academy of Pediatrics and American Heart Association.
2. Pediatric Advanced Life Support (PALS). 2011. American Heart Association and American Academy of Pediatrics

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**12/02**	**SUBJECT:**	**Code Pink Response Plan**
REVISION DATE:	**11/02; 3/03; 5/05, 5/06, 11/07; 1/08; 1/09; 2/10; 5/11**	**POLICY NUMBER:**	**IV.T**

Clinical Policies & Procedures Committee Approval:	**12/14**
Nursing Executive Council Approval:	**12/14**
Department of Emergency Medicine Approval:	**01/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary emergency on children greater than 30 days old through age of 13 within the hospital and outside of the facility on hospital property.

B. **DEFINITIONS:**

1. Child: pediatric patient greater than 30 days old through 13 years. Pediatric Advanced Life Support (PALS) guidelines shall be used to direct resuscitative efforts.
2. Code Pink Response Areas:
   a. Patient Care Areas – areas in the main building with crash carts and AED/debrillators readily available (for example Cardiac Rehabilitation building and Magnetic Resonance Imaging (MRI) building).
   b. Non-patient Care Areas: areas on the main campus where crash cart and AED/debrillators not readily available (for example the Business Administration Management (BAM) building, registration and parking area).

C. **POLICY:**

1. A Code Pink shall be called on any apneic and/or pulseless child.
2. Any person may initiate a Code Blue or Code Pink by dialing "66" on the telephone. The operator shall announce "Code Pink" and the location over the P.A. system three times, twice. .
3. Response to the Code shall occur according to the following response plan.

D. **RESPONSE PLAN WITHIN PATIENT CARE AREAS:**

1. Code Pink initiation
   a. Staff shall initiate Basic Life Support (BLS) measures until Code Pink Response Team arrives.
2. Code Pink response team:
   a. Emergency Department Code Pink Nurse :
      1) Brings cardiac monitor/defibrillator and emergency Rapid Sequence Intubation (RSI) intubation drugs.
      2) Initiates Standardized Procedure for Code Pink Resuscitation until the physician arrives.
      3) Remain with patient until transport team arrives or nurse transports patient to appropriate area as ordered by physician.

4) The Code Pink Nurse ensures paperwork and documentation on the Cardiopulmonary Arrest Record and the Emergency Event form in the patient's electronic health (EHR) record is completed.

b. ED Physician:
   i. Responds when available and leads the resuscitative efforts.

c. Respiratory Care Practitioner (RCP):
   1) Brings the pediatric airway bag to the scene.
   2) Ventilates patient.
   3) Assists with airway management.
   4) Obtains arterial blood gases and "Code Blue lab panel" as ordered.

d. Emergency Medical Technicians (EMTs):
   i. Brings an oxygen tank, airway bag, ambu bag, gurney and backboard to the scene.
   ii. Assists with CPR.
   iii. Acts as a runner to the ED.
   iv. Transports patient to receiving unit.

e. Assistant Nurse Manager/Relief Charge Nurse (ED only):
   i. Assigns a recorder if not already done
   ii. Ensures appropriate paperwork and documentation on the Cardiopulmonary. Arrest Record and the Emergency Event Form in the patient's electronic health record (EHR) are completed.
   iii. Ensures post code, the "medication tray" inside the crash cart is re-locked with a secure tie (located in the crash cart) for containment at end of code.
   iv. Ensure, post code, the "opened" crash cart is locked with the plastic key lock externally, is placed in a secured area, and the Sterile Processing Department (SPD) notified to pick up the used cart.

f. Primary Nurse:
   i. Remains in room to assure responders have current patient information.
   ii. Accesses patient's record and assures responders have information requested (i.e., lab, x-ray, reports).
   iii. Documents in the EHR:
      1) Pre-code assessment findings.
      2) Interventions implemented prior to Code Blue team arrival.

g. Unit Secretary:
   i. Assures patient's chart is in room, phone is available in room, and places call to primary physician as directed.

h. Security Personnel:
   1) Maintains scene safety and keeps area clear of congestion.

i. Sterile Processing Department:
   i. Sends another pediatric crash cart and two infusion pumps to the area.
   ii. Retrieves used crash cart and intubation tray post code.

E. RESPONSE PLAN FOR CODE PINK IN NON-PATIENT CARE AREAS:

1. Staff shall initiate BLS measures until Code Pink Response Team arrives.
2. Code Pink Response Team:
   a. Emergency Department Code Pink nurse:
      i. Ensures BLS measures have been implemented and facilitates transport the patient to the ED.
   a. ED Physician:
      i. Responds when available and leads the resuscitative efforts.
   b. Respiratory Care Practitioner (RCP):
      i. Brings the pediatric airway bag to the scene.
      ii. Assists with airway management.
      iii. Ventilates patient.

c. EMT/ ED Personnel :
   i. Brings an oxygen tank, airway bag, ambu bag, gurney and backboard to the scene.
   ii. Assists with CPR.
   iii. Acts as a runner to the ED.
   ii. Transports patient to receiving unit
d. Security Personnel:
   iii. Maintains scene safety and keeps area clear of congestion

F. **RESPONSE PLAN AT AFFLIATED CENTERS:**

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center
   k. Tri-City Wellness Center: Cardiac Rehab & Outpatient Rehab
2. The staff of the above mentioned areas is to initiate BLS measures and call 911 to facilitate management and transport of the patient to the Emergency Department.
3. The staff in Home Care, Partial Hospitalization, and Outpatient Rehabilitation Services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

G. **REFERENCES:**

1. American Heart Association. (2010). BLS for healthcare providers: *Professional Student Manual*.
2. American Heart Association (AHA) (2010). Highlights of 2010 aha guidelines for CPR
3. American Heart Association (AHA) (2010). Handbook of emergency cardiovascular care for healthcare providers. .
4. Pediatric advanced life support. (2010). American Heart Association (AHA).

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**10/06**	**SUBJECT:**	**Communicating with Physicians/Allied Health Professionals (AHP) Using the SBAR Process**
REVISION DATE:	**07/09; 9/12**	**POLICY NUMBER:**	**IV.F.1**

Clinical Policies & Procedures Committee Approval:	**01/16**
Nursing Executive Committee:	**01/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **POLICY:**

1. The SBAR (Situation Background Assessment Recommendation) process shall be utilized to communicate with physicians/AHP, the Rapid Response Team, and Code Team members regarding patient status or a critical situation.

B. **PROCEDURE:**

1. Prior to calling the physician/AHP, follow these suggestions:
   a. Assess patient
   b. Discuss situation with resources (i.e. Assistant Nurse Manager (ANM) or designee, resource nurse, rapid response nurse)
   c. Review the chart for appropriate physician/AHP
   d. Know the admitting diagnosis and date of admission
   e. Read the most recent progress notes and review charting from the nurse who worked the prior shift
   f. Have available when speaking with physician/AHP:
      i. Patient's chart
      ii. List of current medications, allergies, intravenous (IV) fluids
      iii. Most recent vital signs
      iv. Most recent lab results
      v. Code status
2. When calling the physician/AHP, follow the SBAR process:
   a. (S) Situation: What is the situation you are calling about?
      i. Identify self, unit, patient, and room number.
      ii. Briefly state the problem, when it began, and how severe.
   b. (B) Background: Pertinent background information related to the situation may include the following:
      i. The admitting diagnosis and date of admission
      ii. List of current medications, allergies, IV fluids
      iii. Most recent vital signs
      iv. Lab results: provide the date and time test was completed and results of previous tests for comparison
      v. Other clinical information
      vi. Code Status
      vii. Relevant past medical history
   c. (A) Assessment: Pertinent physical assessment findings
   d. (R) Recommendation: What is the nurse's recommendation? Examples may be:

i. Transfer patient to critical care
ii. Come to see the patient at this time
iii. Talk to the patient or family about code status
iv. Any diagnostic tests needed
v. A change in treatment order

3. Document the change in patient's condition and physician/AHP notification in the medical record.

C. **RELATED DOCUMENTS:**

1. Sample SBAR Report to Physician

SAMPLE SBAR Report to Physician

SBAR report to physician about a critical situation (Ask physician "Are you familiar with this patient?")

S	**Situation** **I am calling about** <patient name and location> **The patient's code status is** <code status> **The problem I am calling about is < state what you are calling about>** (I am afraid the patient is going to arrest) **I have just assessed the patient personally:** **Vital signs are: Blood pressure ___/___, Pulse ___, Respiration ___ and temperature ___** **I am concerned about the:** Systolic blood pressure because it is less than 90 mm/Hg or greater than 200 mm/Hg Heart rate because it is less than 50 or greater than 130 beats per minute Respiratory rate because it is less than 8 or greater than 28 breaths per minute or threatened airway Oxygen saturation level is less than 92% despite oxygen therapy at _____liters via NC or _____ Temperature because it is less than 35.5 or greater than 40 degrees Celsius **Urine output** is less than 50 mL in 4 hours **Acute significant bleed**, new, repeated or prolonged seizures **Level of consciousness**, sudden unexplained agitation and confusion **Change in skin tone** (pale, dusky, gray, or blue) **Failure to respond** to treatment for an acute problem/symptom **The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.**
B	**Background** **The patient's mental status is:** Alert and oriented to person place and time. Confused and cooperative or non-cooperative. Agitated or combative Lethargic but conversant and able to swallow. Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold/warm **The patient is not or is on oxygen.** The patient has been on ____(l/min) or (%) oxygen for ____minutes (hours) The oximeter is reading ____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** **This is what I think the problem is** <state what you think is the problem> The problem seems to be **cardiac infection neurologic respiratory** _____ I am not sure what the problem is but the patient is deteriorating. **The patient seems to be unstable and may get worse, we need to do something.**
R	**Recommendation** **I suggest or Request that you** <say what you would like to see done> Transfer the patient to critical care Come to see the patient at this time Talk to the patient or family about code status Ask the on-call family practice resident to see the patient now **Are any test needed:** Do you need any test like: CXR, ABG, ECG, CBC, Labs {i.e. CBC, C7, C12, Magnesium CPK, Trop Other test? _____ **If a change in treatment is ordered then ask:** How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better when would you want us to call again?

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11	**SUBJECT: Interpretation and Translation Services**
REVISION DATE: 10/13; 01/14; 01/15	**POLICY NUMBER: II.J**

Clinical Policies & Procedures Committee Approval:	**12/15**
Nurse Executive Council Approval:	**01/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To outline the policy and procedure for provision of interpretation services within Tri-City Healthcare District (TCHD) for patients with limited English proficiency.

B. **DEFINITIONS:**

1. Communicatively Impaired: A communicatively impaired individual has expressive or receptive language deficits that may be present after an illness or injury. This may include individuals with: voice disorders, laryngectomy, glossectomy, cognitive disorder, or temporary disruption of the vocal cords due to intubation or medical treatment.
2. Limited English Proficiency (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.
3. Primary or Preferred Language: the language the patient wants to use to communicate with his/her provider(s).
4. Interpretation and Translation: Interpretation involves the immediate communication of meaning from one language (the source language) into another (the target language). An interpreter conveys meaning orally, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments. A translation conveys meaning from written text to written text. A sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Interpretation and translation require different skills.
5. Interpreters:
   a. Bilingual Employees: Personnel with validated competency that specifies the parameters within which the employee, in the course of providing services, may communicate directly with patients, family members, surrogate decision makers and visitors in a foreign language. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   b. Dual-Role Employees: Personnel with validated competency that specifies the parameters within which the employee may serve as interpreter in the course of providing services within their unit or in emergency situations. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   c. Medical/healthcare Information Interpreter: Personnel with validated competency to interpret critical medical communications including but not limited to medical care, treatment, medical decision making.
   d. Service Information Interpreters: Personnel with validated competency to interpret limited topics related to critical service information.
   e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.

f. Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.
g. Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.

6. Critical Medical Communications: Generally includes but not limited to:
   a. Consent and/or acknowledgement of information discussion
   b. Advance directive discussion
   c. "Do Not Resuscitate" (DNR) and discussion
   d. Explaining any diagnosis and plan for medical treatment
   e. Explaining any medical procedures, tests or surgeries
   f. Initial medication education
   g. Patient complaints
   h. Final discharge instructions
7. Critical Service Information: Generally includes but not limited to:
   a. Agreement for Services
   b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
   c. Applications to participate in a program or activity or to receive hospital benefits or services.

C. **POLICY**

1. TCHD provides qualified interpreters at no cost to patients whenever a language or communication barrier exists. Interpretation services are available on the premises or accessible by telephone or video remote interpreting (VRI) 24 hours a day, seven (7) days a week.
2. TCHD qualified interpreters will be utilized for interpretation appropriate to their level of competency.
   a. The telephone interpretation service or VRI shall be used in the absence of a TCHD qualified interpreter whenever necessary for any language.
3. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs.
   a. Patient refusal of TCHD's interpretation service must be documented in the medical record in addition to the name of the individual that the patient has selected to perform interpretation.
   b. Staff members may access a TCHD medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the patient and may have a hospital-designated interpreter monitor the communication.
4. Documents and forms shall be either provided in the preferred language of patient/family when available or explained verbally.
5. Notices advising patients and families of availability of interpretation services, procedures for obtaining assistance and lodging complaints are displayed in public areas on the Patient Rights posters and patient handbooks.
6. Education on interpretation services shall be provided in New Employee Orientation and as needed in department/committee meetings.

D. **PROCEDURE**

1. Registration
   a. Upon first encounter (registration, check-in), Access personnel shall identify the patients preferred language for discussing health care. The designation shall be documented in the electronic health record as appropriate.
      i. A service information interpreter shall be utilized as needed
2. Inpatient or Outpatient Areas

a. Assess and document patient needs and preferred methods(s) for interpretation services in the medical record and incorporate into the plan of care.
b. Contact TCHD qualified interpreter based on the level of interpretation services (general information or critical medical communication) needed (see definitions and reference Tri-City Healthcare District qualified interpreters information on the Intranet).
c. If a TCHD qualified interpreter is not available, contact either the facility designated telephone interpreting service (see Language Services Associates instructions on the Intranet), or facility designated video remote interpreting services (see Language Services Associates , NexTalk and Status instructions on the intranet).

E. **DOCUMENTATION**

1. Document the use of all interpretation/translation services, including patient selected individual for medical interpretation in the patient's medical record and include: date, interpreter's name or ID number, language, and reason for interpretation / call (i.e., "John Smith, patient's wife or "Mary Jones, Official Interpreter, or "telephone Interpreter ID # 123, Language: Korean, Reason: to discuss surgical procedure).

F. **FORM/RELATED DOCUMENTS:**

1. Interpretation and Translation Resources – Quick Reference & User Guides

G. **REFERENCES**

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. 42 CRF 124.602(c)
3. 45 CFR 84.52 (c) and (d)
4. Section 504 of Rehabilitation Act of 1973
5. Title VI of Civil Rights Act of 1964
6. Section 1259, California Health & Safety Code
7. National Standards for Culturally and Linguistic Appropriate Services (CLAS)
8. National Association for the Deaf: www.nad.org
9. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
10. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
11. Limited English Proficiency (LEP) A Federal Interagency Website (www.lep.gov).

INTERPRETATION AND TRANSLATION RESOURCES

QUICK REFERENCE & USER GUIDES

CONTENT

Patient-Centered Communications

Resources Available and How to Access Them

User Guides for Telephonic Interpreting (corded and cordless), including 3-way calling

Video Remote Interpreting (Stratus, NexTalk, LSA)

Document Translation Services

Language Assessment for Dual-Role Employees

Patient-Centered Communications

TCMC provides interpretation and translation services to communicate with patients, their families, friends, support persons and surrogate decision-makers in their preferred language.

- Know what resources are available at TCMC and learn how to use them.
- Do not use family members to interpret unless the patient specifically requests it. Note the patient's choice in his/her EMR.
  - You may have a TCMC qualified interpreter monitor the communication.
- Chart the interpretation service in the patient's EMR.
  - Go to AdHoc, then click on Interpreter Service Form.

Need in-house demonstration/training on interpretation equipment?
Contact Isabel Escalle: 760-940-**5614** • escallei@tcmc.com
OR the In-House Spanish-English Interpreter: **760-802-2656**

INTERPRETATION RESOURSES AVAILABLE AND HOW TO ACCESS THEM

In-House Medical Interpreter(s) 760-802-2656

Full-time medical/healthcare interpreter: Spanish/English interpretation and translation. Interpreters are available per schedule. Call the number above to request service.

Dual-Role Bilingual Employees: Dual-role employees are assessed and qualified individuals that can communicate in a language other than English and can serve as interpreters within their department and hospital-wide only during emergency situations. The level of service that they can provide depends on their assessment score (more information on pages 12-13).

Telephone Interpreters 855-273-6410

- Interpretation via telephone is available in **over 200 languages** through dedicated analog lines.
- Dedicated telephones are available throughout the hospital, are labeled, and display instructions.
- The contracted service provider is **Language Services Associates (LSA)** and the service is called InterpreTalk.
- Interpretation telephones should ONLY be used to provide interpretation services.

Video Remote Interpreters

Stratus VRI contracted service (iPads) • Mobile unit(s) are available at every nurses' station.

American Sign Language and **Spanish** are offered 24/7, 365 days. Fifteen other languages are available during hours that are specified on the language selection screen.

LSA and **NexTalk** contracted services (PCs) • Mobile units are found in: ER, ICU, L&D, PBX (located in the basement across from surgery scheduling. This is a shared unit), and wound care in Carlsbad.

American Sign Language and **Spanish** are offered 24/7, 365 days.
NexTalk also provides **Spanish Sign Language.**

IMPORTANT: Please return equipment to its station after each use and plug it into an electrical outlet so the computer remains charged and ready to use.

Face-to-face interpreters for American Sign Language (ASL)

Signs of Silence Interpreting Services **760-580-3562**
Provides interpreters in our area that can generally be available within 30-45 minutes.

Deaf Community Service **619-398-2488**

Network Interpreting Service **800-284-1043**

Telephonic Interpretation

In over 200 languages
24/7, 365 days

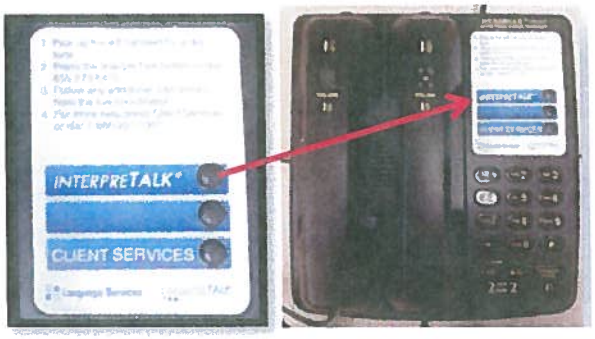
Instructions for Corded Telephones

Language Services Associates (LSA) is the contracted provider of this service

1) Press the INTERPRETALK button

   or dial **1-855-273-6410.**

2) The automated system will give these choices to connect directly to an interpreter: Press **1** for Spanish, **2** for Mandarin, **3** for Cantonese, **4** for Arabic.



Corded telephones for interpretation

   *Or press **9** to speak with a coordinator if you need another language or if you do not know the language of the patient/person with whom you will be speaking.*

3) An automated voice will introduce you to the interpreter with their **6-digit ID number** Remember to write down this information to include in the Interpreter Service Form in the EMR/EHR.

4) When asked, please provide:

1. Name of patient care unit in which the interpretation is taking place
2. The Cost Center of that unit
3. Your first and last names
4. Patient's Medical Record Number

Note: This information is needed for documentation and accounting purposes.

5) You may explain the objective of the call to the Interpreter. Then proceed by speaking directly to the Limited English Proficient speaker in the first person. **For example: "What is your name?" NOT "Ask her what her name is"**

Once the call is completed, say thank you and hang up. The time of the interpretation service will be automatically recorded.

Chart the interpretation call in the electronic medical/health record.

Sanitize the phones.

These telephones and the line they are connected to are for interpretation ONLY.

Telephonic Interpretation

In over 200 languages
24/7, 365 days

Instructions for Cordless Telephones

1. Dial **1-855-273-6410** or press the **BLACK SOFT key** at top left labeled: "Phone Book".
2. Press **# 5** (the display will show LSA).
3. Press **"Talk"** - The automated system will give these choices to connect directly to an interpreter: Press **1** for Spanish, **2** for Mandarin, **3** for Cantonese, **4** for Arabic.

   *Or press **9** to speak with a coordinator if you need another language or if you do not know the language of the patient/person with whom you will be speaking.*
4. An automated voice will introduce you to the interpreter with their 6-digit ID number Remember to write down this information to include in the Interpreter Service Form in the EMR/EHR.
5. When asked, please provide:

- Name of patient care unit in which the interpretation is taking place
- The Cost Center of that unit
- Your first and last name
- Patient's Medical Record Number

Note: This information is needed for documentation and accounting purposes.

5. You may explain the objective of the call to the Interpreter. Then proceed by speaking directly to the Limited English Proficient speaker in the first person. For example: "What is your name?" NOT "Ask her what her name is."

Chart the interpretation call in the electronic medical/health record.
These telephones and the line they are connected to are for interpretation ONLY.

AFTER USE

- **Sanitize the handsets.**
- **Return them to their appropriate base as shown below.**

The phones must be charged in order to work. Repeated discharges will damage the battery.

Make sure to place handset **1** on the main, larger base.
Give handset **1** to the Limited English proficient person.

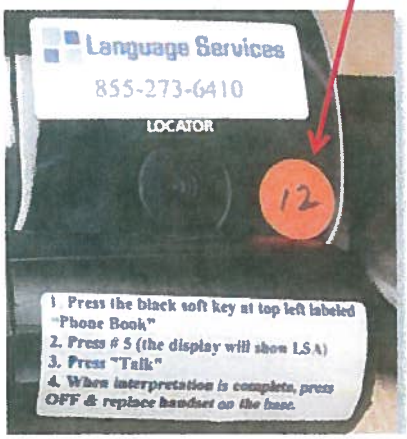
The number **1** appears here.

The number **2** appears here.

Handset **2** goes on the smaller base.

Use handset **2** for yourself.

The numbers on the base and handsets should match. In this case, all should be labeled 12.



Telephonic Interpretation

In over 200 languages
24/7, 365 days

Instructions for 3-Way Calling (page 1 of 2)

Three-way calling (also referred to as 3rd party calling) connects provider, interpreter and patient/3rd party. LSA is a contracted provider of interpretation services via telephone for Limited English Proficiency (LEP) individuals.

LSA can place the call to the 3rd party – or you can (see p. 2)

1. From a **TCMC desk telephone,** dial **80-1-855-273-6410** to connect with LSA/an interpreter.

2. The automated system will provide these choices to connect directly to an interpreter: Press **1** for Spanish, **2** for Mandarin, **3** for Cantonese, **4** for Arabic.

   *Or press **9** to speak with a coordinator if you need another language or if you do not know the language of the person you are calling.*

3. An automated voice will introduce you to the interpreter with their **6-digit ID number.** Remember to write down this information to include in the Interpreter Service Form.

4. When asked, please provide:

   - Name of patient care unit in which the interpretation is taking place
   - The Cost Center of that unit
   - Your first and last names
   - Patient's Medical Record Number

   Note: The above information is needed for documentation and accounting purposes!

5. Tell the interpreter that you wish to call a third party, state the reason of your call and provide the interpreter with the telephone number of the person you wish to call.

   The interpreter will then place the 3-way call.

6. When all three parties are connected, proceed by speaking directly to the LEP speaker in the first person. For example:

"My name is Jane Doe and I am calling from Tri-City Medical Center to ...?"
not "Tell her that my name is Jane Doe and that I am calling from ..."

Once the call is completed, say thank you and hang up.

The time of the interpretation service will be automatically recorded.

Chart the interpretation call in the electronic medical/health record.

Telephonic Interpretation

In over 200 languages
24/7, 365 days

Instructions for 3-Way Calling (page 2 of 2)

You can directly place the call to the 3rd party

1. From a **TCMC desk telephone,** dial **80-1-855-273-6410** to connect with LSA/an interpreter.

2. The automated system will provide these choices to connect directly to an interpreter: Press **1** for Spanish, **2** for Mandarin, **3** for Cantonese, **4** for Arabic.

   *Or press **9** to speak with a coordinator if you need another language or if you do not know the language of the person you are calling.*

3. An automated voice will introduce you to the interpreter with their **6-digit ID number.** Remember to write down this information to include in the Interpreter Service Form.

4. When asked, please provide:

   - Name of patient care unit in which the interpretation is taking place
   - The Cost Center of that unit
   - Your first and last names
   - Patient's Medical Record Number

   Note: The above information is needed for documentation and accounting purposes!

5. Once the interpreter is on the line, let him/her know that you will be placing the call to a 3rd party and explain the objective of the call.

6. Look at the TCMC phone's screen. Press the "**Conf**" button (on the bottom left corner of the screen and dial the number of the person you wish to call.

7. Press the "**Connect**" button on the TCMC telephone, which will set-up a conference call between you, the person you wish to call, and LSA/the interpreter.

8. Proceed by speaking directly to the LEP speaker in the first person. For example:

   "My name is Jane Doe and I am calling from Tri-City Medical Center to ...?" **not** "Tell her that my name is Jane Doe and that I am calling from ..."

Once the call is completed, say thank you and hang up.

The time of the interpretation service will be automatically recorded.

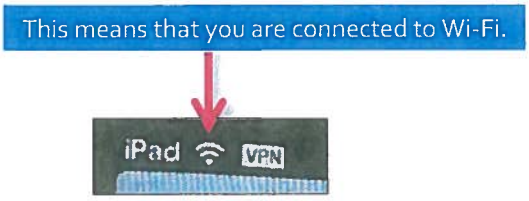
Chart the interpretation call in the electronic medical/health record.

Stratus User Guide

Video Remote Interpreting

LOG IN - If log-in does not occur automatically when you awaken the **iPad,** then type/retype the **Username** and **Password.** They are the same 10-digit number which is written on the instructions attached to the iPad.

1. Look at the top LEFT corner of the iPad to make sure that you are connected to the **wireless network.**

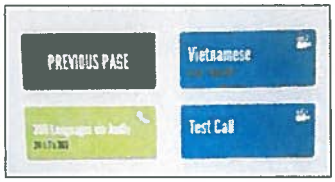


2. Then click on the **Stratus icon (the one with the bird)** to open the Stratus VRI application and access an interpreter.

3. You will see the screen below. **Select the language.**

American Sign Language (ASL) and Spanish are available 24/7, 365 days.

Other languages are available during specified schedules that appear under the language name.

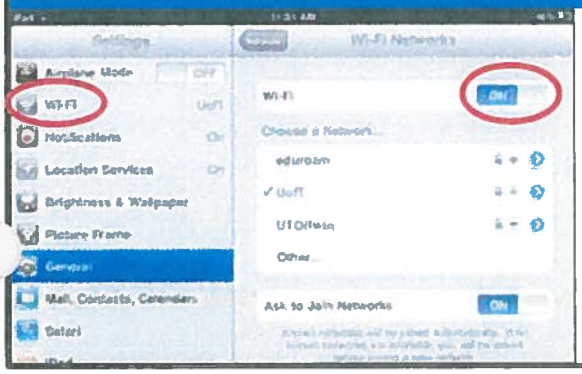


4. Provide the interpreter:

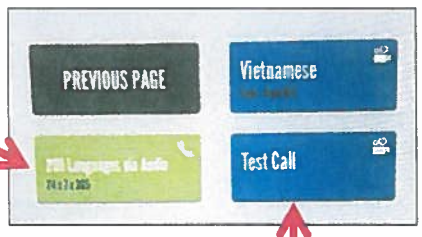
6. **Your full name** (first and last)
7. **Cost center AND Name** of the patient care unit where the interpretation service is taking place.
8. **MRN** (Patient Medical Record Number)

5. Sanitize the equipment and **return it to where it is normally securely kept.** **Plug it into an electrical outlet to keep the computer charged and ready when needed.**

NOTE: The iPad needs to be connected to the wireless network - also called "WIFI" in order for any of the above to work. If off, to connect to wireless, go to Settings, click on Wi-Fi, swipe to ON.



Interpretation iPads offer the option to relay to **telephone** (audio only, no video) services. Telephone interpretation is provided by LSA in over 200 languages 24/7, 365 days.



Testing a call can be useful to know that the camera and the microphone are working properly.

NexTalk User Guide

Video Remote Interpreting

THE EQUIPMENT

The computer **should ALWAYS be ON.**
Keep it plugged into electrical outlet.

Plug the power chord into outlet to turn ON the laptop. If it doesn't turn on, see below.

Press the power button on the right-hand side of the cart.

The monitor is turned ON when the power button is green.

Note: If you do not see a green light check to make sure the power cable is firmly attached on the bottom of the monitor and to the power strip at the other end. Plug and unplug the computer as needed if there is a glitch.

This system is equipped with high-definition video and audio that may pick-up voice ad images in surrounding areas. Protect the privacy or our patients!

Contact the IT Department for in-house technical support.

NEXTALK SCHEDULING SERVICES AND SUPPORT

A few other languages are available with prior scheduling (48 hours ahead). To schedule an interpreter and for technical support:

801-274-6001

kody.lamberton@nextalk.com

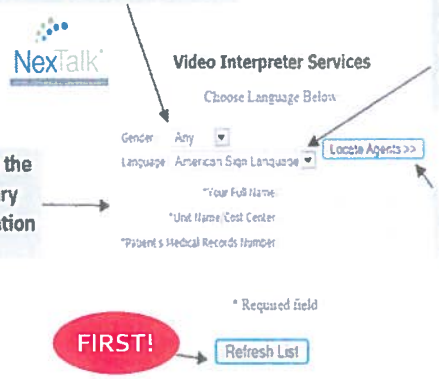
1

1. Launch the NexTalk application by double-clicking on the desktop icon pictured on right. **When the screen below appears, FIRST click on Refresh list at the bottom,** then fill-in the necessary information.

Select the preferred gender of the interpreter. "Any" will reach the first available, regardless of gender.

Select the language.

The options are:
- **American Sign Language**
- **Spanish Sign Language**
- **Spanish**



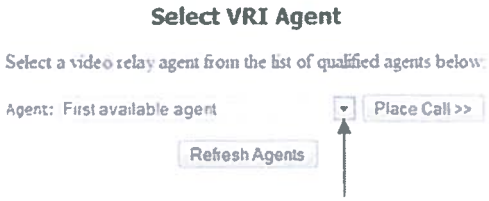
Provide the necessary information

LAST: Click on Locate Agents

If you are having technical problems and have determined they are isolated to the NexTalk application, please call: 801-274-6001

2

2. When the screen below appears, click on "Place Call"



The email of the available interpreter(s) will show when you click here.

3

3. When the interpretation session is finished, let the interpreter know that you are done, then click on the **Hangup** button then on **Close Session** (interpreters will not hang-up first!). You can then click on the "X" on the browser to close the application and return to the desktop.

Close Session

4

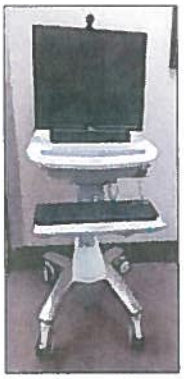
Sanitize the equipment.
Return it to where it is securely kept.
Plug it into an electrical outlet to keep the computer charged and ready when needed.

LSA Video User Guide

Video Remote Interpreting

THE EQUIPMENT

The computer **should ALWAYS be ON.**
Keep it plugged in except to move it where it is needed.



Plug the power chord into outlet to turn ON the laptop.
If it doesn't turn on, see below.

Press the power button on the right-hand side of the cart.

The monitor is turned ON when the power button is green.

Note: If you do not see a green light check to make sure the power cable is firmly attached on the bottom of the monitor and to the power strip at the other end. Plug and unplug the computer as needed if there is a glitch.

This system is equipped with high-definition video and audio that may pick-up voice ad images in surrounding areas. Protect the privacy or our patients!

Contact the IT Department for in-house technical support.

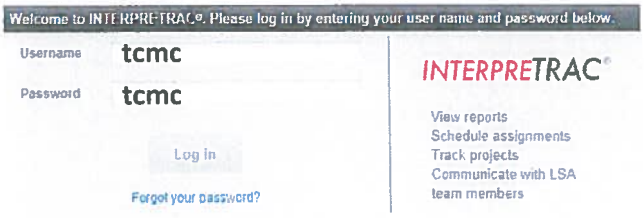
SCHEDULING SERVICES AND SUPPORT

A few other languages are available with prior scheduling (48 hours ahead).
Scheduling is done via the online menu only.

Technical support 24/7
855-874-8555 • vri@lsaweb.com

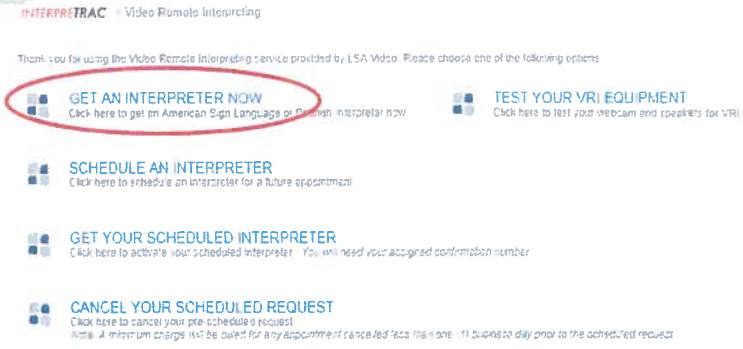
Customer service
866-221-1301 • clientservices@lsaweb.com

1 Log in. Access the service by double-clicking on the desktop icon pictured on the right (could be either)

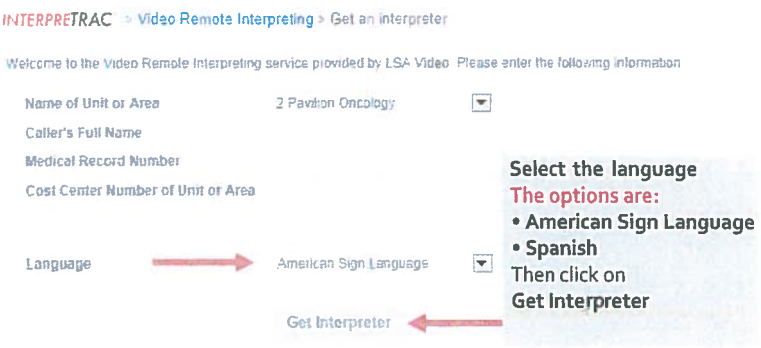


2 Click on VIDEO REMOTE INTERPRETING

3 Select GET AN INTERPRETER NOW



4 Provide the necessary information, select language and click on Get Interpreter



LSA Video User Guide – Page 2 of 2

Toolbar Button Description

Change screen layout (only functions with 3+ participants)

Share an application window with other participants

Toggle among shared application windows

Turn on/off Self-view (the ability to see yourself), including Picture-in-Picture (PiP)

Speaker volume-up/down and muted

Microphone volume-up/down and muted

Privacy (Turns your camera off and on)

Dial pad for calls to legacy and voice (telephone) endpoints (via VidyoGateway™)

Configuration

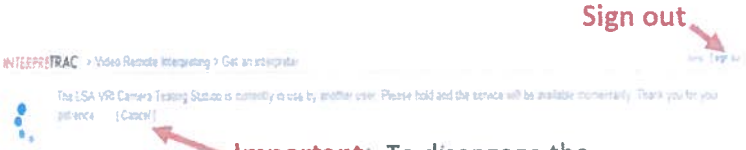
Disconnect Button

Full Screen Mode

5 The main **LSA VRI window** will appear.
You will then be connected to an interpreter and may begin the interpretation session.
Once the interpretation is complete, click the **Disconnect button (not the X)**

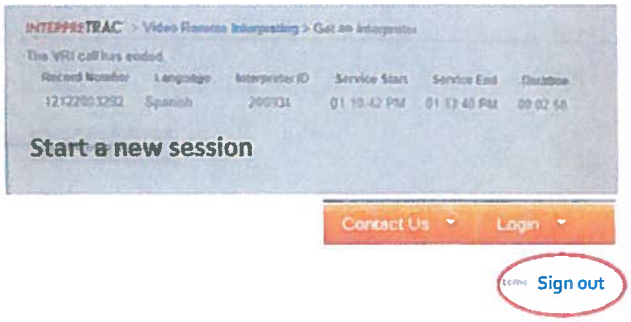
Proper Disconnect button

Found below the X



Important: To disengage the session prior to reaching an interpreter please click on **[cancel]**.

6 Interpretation session details will automatically display after session ends. You may begin a new interpretation session by clicking **Start a new session**. Otherwise, please **SIGN OUT**. **Make a note of the name and/or interpreter ID and chart the interpretation service in the patient's EMR.**



7 Sanitize the equipment.
Return it to where it is safely kept.
Plug it into an electrical outlet to keep the computer charged and ready when needed.

DOCUMENT TRANSLATION SERVICES

Translation services are provided **in-house** or are **contracted,** depending on the size of the document and urgency.

You may send documents to be translated to Isabel Escalle via email: escallei@tcmc.com, via fax: 760-940-5790 or hand them to the in-house interpreter. Receiving editable documents via email is appreciated and expedites the process.

Please note that translation required unique skills. A good interpreter may or may not be a good translator, and documents translated in-house are crafted carefully to maintain consistency, accuracy and ease of reading/understanding.

You may also request a translation from **Language Services Associates (LSA).** Steps are described below:

How to request and obtain translation (including sight translations) via LSA:

Note: A **sight translation** is when an interpreter translates a document on the spot, basically reading the document in the foreign language.

1) Place the call (855-273-6410) and state that you need translation services (or specify a sight translation). You may indicate that you do not know the language. Provide the name of the unit/department and its cost center, and your name and contact information so they can send you the translation.

2) Then, you will either fax the document to be translated to **215-259-7364** (**you must call FIRST so that they expect it**), or email it as instructed.

3) Once LSA has the document, an interpreter will call you back to sight translated it **OR** the translation will be emailed or faxed to you when completed.

LANGUAGE ASSESSMENT
Required for Bilingual TCMC Employees/Dual-Role Interpreters

Key points about the assessment

The assessment is offered to employees at no cost and is available in several foreign languages. The content of the assessment is not department-specific.

The assessment determines language ability by score (see chart below) and establishes the qualification of bilingual employees and "dual-role interpreters." This means that the employee may serve as interpreter within the unit/department to which he/she is assigned and hospital-wide only in emergency situations.

Please communicate with your supervisor or department manager about taking the assessment.

Why take the assessment

Tri-City Hospital District policy requires that employees that communicate with Limited English Proficiency (LEP) patients and their families, friends, support persons, and surrogate decision makers in a foreign language be assessed. Their assessment score determines their qualification and ability to communicate in the foreign language according to the chart below. Bilingual employees that have not yet been assessed may only use very simple language such as greetings and cannot use any medical terminology or provide critical service information.

Reference Patient Care Policy Number II.J – Interpretation and Translation Services. The document can be found at: eTCMC → Essentials → Click on "Please Click Here to Access the Policies and/or Procedures → Click on Global Manuals → Scroll down and click on Patient Care Services (all) → Click on folder "I" → Then click on Interpretation and Translation Services.

How to prepare for the assessment

The assessment evaluates current knowledge of the language. Read the **California Standards for Healthcare Interpreters** carefully to be able to address questions about interpreter role. Refresh or expand your vocabulary by consulting medical dictionaries, reputable Internet links, translating documents that contain useful medical language, and practicing with colleagues.

What happens after submitting the assessment request form

The completed form will be forwarded to Language Services Associates (LSA), the company contracted to perform the assessment. The assessment has two parts: a **written** component (taken online) and an **oral** component (over the telephone). LSA will send you, via email, a link to the online (written) component, which you must take first. Try not to delay completing the written assessment! LSA will then coordinate a convenient time for the oral assessment.

Each component of the assessment has a 50-minute allocation and there is no stop-and-go. Most employees complete each component in about 20 or 30 minutes. Give yourself the time so as not to be rushed or interrupted so plan ahead and schedule the 50 minutes.

What happens after taking the assessment

The results are usually delivered within a few days to the Multicultural Department manager, who will discuss the results with both the employee and his/her supervisor. Both must be present at the same time.

Qualification of the individual is based on the assessment score
Note: See definitions on TCHD Policy II.J

LEVEL I NOT QUALIFIED	LEVEL III QUALIFIED CLINICAL INTERPRETERS	LEVEL IV FULLY-QUALIFIED CLINICAL INTERPRETERS
Individuals with scores below 50% should not be allowed to conduct any kind of interpretation. **LEVEL II** **NON-CLINICAL INTERPRETERS** Individuals with scores between 50% and 69% are considered qualified to conduct interpretation as follows: • Capture basic data, set appointments and give general information. • Are not allowed to conduct any kind of medical interpretation.	Individuals with scores between 70% and 79% are considered qualified to conduct MEDICAL interpretation as follows: • Are allowed to provide interpretation for medical and pre-operation procedures. • Are not allowed to provide interpretation for clinical sessions, sight translations, consent forms, or discharge.	Individuals with scores of 80% and above are considered fully qualified to conduct MEDICAL interpretation as follows: • Are allowed to provide interpretation for medical and pre-operation procedures. • Are allowed to provide interpretation for clinical sessions, sight translations, from doctor to doctor and for psychiatric sessions. • Note: A clinician has to be present when these individuals provide interpretation services for encounters requiring a clinical, licensed staff member.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT: Massive Transfusion Protocol**

REVISION DATE(S):

Clinical Policies and Procedures Approval Date(s):	**01/16**
Nurse Executive Committee Approval Date(s):	**01/16**
Blood Utilization Review Approval Date(s):	**01/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **DEFINITION(S):**

1. Massive Transfusion Protocol (MTP): Acute administration of 4-5 Red Blood Cell Units(RBC) in 1 hour or 8-10 RBC units in 24 hours. Alternative definition: replacement of 1 or more blood volumes/24 hours, using 70 mL/kg in a 70KG adult (5000 mL in 24 hours).
2. Protocolized transfusion has been shown to improve clinical outcomes as well as transfusion efficiency in trauma patients who require massive transfusion. This document provides guidelines for utilization of the massive protocol (MTP) at Tri-City Medical Center.

B. **POLICY:**

1. Patients meeting the definition of MTP with current ongoing or impending use should be considered for activation of massive transfusion protocol (MTP).
   a. Activation of massive transfusion protocol should be considered for patients who will/have received greater than 4 RBC units in 1 hour and appear to have an on-going requirement for RBC use.
2. MTP should only be activated by the Physician/Allied Health Professional (AHP) in the Operating room (OR), Interventional Radiology (IR), Emergency Department (ED), Intensive Care Unit (ICU)or Women and Newborn Services.
   a. The requesting department should identify a primary contact person for communicating with the Blood Bank when possible.
3. If the patient needs to have additional RBC on hand at all times but does not need the MTP, order "Transfuse RBC" with a Comment to Keep Ahead X#-RBC.

C. **PROCEDURE:**

1. Activate MTP upon order of Physician/AHP:
   a. Order "Massive Transfusion Protocol (MTP)" using CPOE (no call required).
   b. Call the Blood Bank (BB) at extension 7904 and staff will take a phone order and enter the orders electronically including:
      i. Patient name
      ii. Patient MRN
      iii. Patient diagnosis or source of bleeding: abdominal aortic aneurysm, gunshot wound etc.
      iv. Estimated blood loss/rate of loss
      v. Patient gender/age
      vi. Current or intended location
   c. BB personnel may refuse to implement MTP when callers are not authorized to activate protocol.

2. A Type and Cross match must be ordered unless already done and sample is in Blood Bank (BB). Obtaining a pre-transfusion sample is imperative. The type and cross match should be collected prior to the start of the transfusion.
   a. The first five (5) units may be "Emergency Released" if type and cross match not completed per physician order. The type and cross match must be obtained as soon as possible.
3. The initial MTP blood product will consist of:
   a. Five (5) units RBC to be issued in one (1) cooler. BB Staff will then keep ahead five (5) units RBC until the end of event or alternative Physician/AHP instruction.
      i. If blood products are issued as "Emergency Released", each Transfusion Record must have the statement at the bottom of the form initialed by a Physician/AHP, "Due to Critical Condition of Patient, I accept unit without crossmatch Physician/AHP's Name" This is a regulatory and accreditation requirement.
      ii. BB staff to notify provider if history of clinically significant antibody and determine with pathologist input how to proceed.
      iii. Computer Crossmatch as soon as possible (ASAP) to complete orders and generate unit tags.
      iv. Turnaround time expected to be 20 minutes if crossmatch already completed and to issue blood.
   b. Four (4) units Thawed Frozen Plasma (FP). BB staff will then keep ahead four (4) units FP until end of event or alternative Physician/AHP instruction
      i. 30 minutes to thaw FP and label if second Clinical Laboratory Scientist (CLS) available in Blood Bank.
      ii. Turnaround time to issue 45 minutes.
      iii. Issued in cooler to maintain storage temperature of 1-6^0 Celsius (C).
   c. One (1) plateletphersis (PLPH) normally on hand, will label and keep 1-ahead
      i. Issued as required for immediate transfusion.
      ii. BB staff will pull PLPH already assigned as next day OR, Infusion Center and previously set up PLPH units as needed and back fill from San Diego Blood Bank (SDBB) when event is concluded.
      iii. STAT order SDBB as required to obtain additional products as necessary.
   d. Cryoprecipitate (Cryo) will be set up as ordered by the clinical team. Normally 5-unit Pools in single bags are available within 25-30 minutes. Cryo is more likely to be needed if original event is late the resuscitation and/or the clinical team feels that fibrinogen may have been low from the beginning. (Note: short shelf life of 6-Hours for product. Up to 20 units of out-of-group-cryo are allowable).
   e. Orders to keep ahead will be maintained until initialing Physician/AHP notifies end-of-event or updates orders.
4. Dispensing Blood Products for use:
   a. Products are picked up by a designated TCMC staff presenting a correctly-completed "Transfusion Request Form" for the products.
   b. Plateletpheresis and cryoprecipitate pools are placed in a dual bag delivery system after dispense is completed in Cerner. Do not infuse after expiration date and do not store in coolers.
   c. BB staff may call patient location to verify continuation of MTP. Default is to continue MTP until verbally discontinued by ordering Physician/AHP.
5. Endpoints/termination
   a. When appropriate endpoints, as judged by the clinical team, are reached, the MTP must be discontinued, by Phone-Notification to the Blood Bank, to limit resource wastage.
   b. Most reliable transfusion endpoint is a collaborative decision based on operative field examination, laboratory results, and clinical parameters.
   c. At the completion of the case, the department will be responsible for the return of all coolers to the blood bank.
   d. Any products returned and not acceptable for reissue will be discarded.

D. **FORMS:**

1. Sample Transfusion Request Form

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

_____, M.D.

SPECIAL PATIENT REQUIREMENTS: ❑ IRRADIATED

OTHER: _____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)	Quantity
❑ **O NEG UNCROSSMATCHED RBC'S**	_____
❑ RANDOM RBC'S, LEUKOPOOR	_____
❑ AUTOLOGOUS RBC'S	_____
❑ DONOR SPECIFIC RBC'S, LEUKOPOOR	_____
❑ PLATELET PHERESIS, LEUKOPOOR	_____
❑ THAWED PLASMA	_____
❑ CRYOPRECIPITATE	_____

❑ OTHER BLOOD COMPONENT: _____

ADDITIONAL ORDER NOTES: _____

Transfusion Service Identification Band Number: _____.

Order verified by: _____ , R.N. Date: _____ Time: _____

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

TRANSFUSION REQUEST

7500-1009
(Rev. 5/14)

White - Chart Yellow - Blood Bank

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY

ISSUE DATE: 4/94	**SUBJECT: Patient Safety in Surgical Areas**
REVISION DATE: 7/13; 01/14	**POLICY NUMBER: IV.VV**

Clinical Policies & Procedures Committee Approval:	**11/15**
Nursing Executive Committee:	**12/15**
Operating Room Committee	**02/16**
Medical Executive Committee Approval:	**02/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide guidelines for the implementation of safe care to patients and assist in the identification of potential hazards.

B. **POLICY:**

1. Potential hazards associated with controlling the patient's temperature shall be identified, and safe practices shall be established.
   a. When assessing the need for devices to monitor and/or control patient temperature, the following factors shall be considered:
      i. Patient's age
      ii. Patient's physical status
      iii. Type of anesthesia used
      iv. Ambient room temperature
      v. Length and type of surgical procedure
   b. Maintenance of optimum patient temperature shall begin in the preoperative phase and continue into the postoperative phase. Perioperative nursing interventions include, but are not limited to:
      i. Applying forced air pre-warming gown and device in pre-operative area
      ii. Applying warm blankets to the patient on his/her arrival to the surgical area, and after sterile drapes have been removed
      iii. Limiting the amount of patient skin surface exposure during positioning and skin preparation (alcohol-based preps must be allowed a minimum of 3 minutes to dry before draping)
      iv. Limiting the time between skin prepping and surgical draping
      v. Preventing surgical drapes from becoming wet, if possible
      vi. Adjusting the room temperature
      vii. Using heat/cooling maintenance devices intraoperatively
      viii. Providing surgical team members with warmed/cooled irrigation/infusion solutions as necessary
   c. Temperature regulating devices shall be used according to manufacturer's recommendations
      i. Forced air warming devices must only be used with the manufacturer recommended blanket/gown. "Hosing," or applying the hose of the forced air warming device directly under blankets or drapes, is not allowed.
      ii. Direct patient skin contact with plastic surfaces (for example Hosing) of temperature regulating blankets/gowns shall be avoided.
      iii. Folds and creases in temperature regulating blankets/gowns shall be avoided.

iv. Do not allow the hose of the forced air warming device to contact the patient, even when using the properly attached gown or blanket. Maintain adequate tension on the hose to keep it from touching the patient.

d. Temperature regulating devices shall be assigned identification numbers (or use the serial numbers) and documented in the OR Record.

e. Skin integrity shall be inspected before, periodically during (if possible), and after the use of temperature regulating devices.

f. Irrigation/infusion solutions shall be warmed / cooled to temperatures appropriate for the surgical needs and according to manufacturer's recommendations.

i. Microwave ovens/autoclaves shall not be used to warm solutions.

2. Potential hazards associated with chemicals used in surgery shall be identified, and safe practices shall be established for their use.

a. Personnel shall be informed of the hazards associated with the chemicals used in their practice setting.

b. Safety Data Sheets (SDS) shall be accessible within the practice setting.

c. The mixing/combining of chemicals shall be avoided unless safe outcomes can be ensured.

d. Decanting or transferring of solutions/chemicals from the primary container to another container should be avoided unless no other option exists or the solution/chemical is intended to be decanted.

i. Containers used for decanted solutions must be labeled with all appropriate and necessary product information including name, strength, uses, precautions and SDS information.

3. Potential hazards associated with the use of electrical equipment in surgery shall be identified, and safe practices established.

a. All electrical equipment shall be inspected before use, including but not limited to:

i. Checking power outlet and switch plates for damage

ii. Checking power cords and plugs for fraying or other damage

iii. Biomedical or electrical safety inspections of all new, rented, leased, or borrowed equipment before it is placed in the practice setting

b. Equipment cord length shall be appropriate for the intended use of the item:

i. Extension cords shall not be used in the surgical setting

ii. Power strips may be used in the surgical setting under the following conditions:

1) Only use hospital-grade power strips which have been approved by Clinical Engineering and Biomed departments

2) Do not exceed 75% of the power strip capacity

c. Line isolation monitoring systems or ground fault interrupting systems shall provide continuous monitoring of electrical current leakage.

d. Any malfunctioning electrical equipment shall be immediately removed from use:

i. Equipment failures which involve potential injury, injury or death to a patient will be secured, investigated and reported in accordance with Local, State and Federal Regulations.

ii. These incidents shall be immediately reported to the Charge Nurse, Supervisor, Biomedical Engineering, Safety Officer and Risk Management.

4. Potential environmental hazards that affect patient care shall be identified, and safe practices shall be established.

a. The use of medical gases in the surgical area shall meet all established regulations and standards including, but not limited to:

i. No flammable gases shall be used in the surgical area

ii. All free standing gas cylinders shall be properly chained for support or in a portable holder or storage container

iii. All anesthesia machines and related equipment shall be constructed so that connections for different gases are not interchangeable

iv. Staff members shall demonstrate knowledge concerning the use, handling, storage, and disposal of gas cylinders

v. Cylinders shall be stored in designated locations, in a quantity allowed by policy

b. The number of air exchanges per hour, temperature, and humidity in anesthetizing locations shall meet the established regulations and standards (California Code of Regulations Title 24).
   i. Temperature and relative humidity levels in anesthetizing locations are maintained and tracked by Plant Operations.
      1) The Building Management System shall be programmed to track and record the relative humidity levels continuously and alert the duty plant engineer if the humidity drops below 20%.
      2) Plant engineering staff shall take corrective action and notify Surgery department when relative humidity drops below 20%.
      3) Temperature/humidity monitors are located in each OR for staff reference.
      4) Batteries on the OR temperature/humidity monitors will be changed every 6 months.
   ii. When notified by Plant Operations that temperature or humidity are out of range, the Engineering Department (high or low temperature or humidity) are consulted to determine appropriate actions.
   iii. Cases in progress will be completed, and the OR room will be closed for use until notified by Engineering that humidity is within acceptable range.
   iv. The use of portable humidifiers or dehumidifiers in the OR is not permitted.

c. Floors shall be clean, dry, unobstructed, and in good repair.

d. Lighting shall be adequate for:
   i. Illuminating the surgical field
   ii. Monitoring the patient
   iii. Performing perioperative duties

5. Isolation techniques for preventing the transmission of infectious agents shall be identified and established.
   a. Specific techniques shall relate to the risk levels of the infectious agents and be developed in conjunction with Infection Control practitioners using the Centers for Disease Control and Prevention guidelines and other appropriate agencies.

C. **REFERENCES:**

1. California Code of Regulations Title 24

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**PRE, INTRA AND POST OPERATIVE ASSESSMENT OF FETAL HEART RATE AND UTERINE ACTIVITY FOR NON-OBSTETRIC PROCEDURE/SURGERY**
Purpose:	To outline the nursing management and assessment **practices** regarding fetal heart rate and uterine activity monitoring for gravid, non-obstetric surgical patient in the pre, intra, and post-operative periods.
Supportive Data:	Improvements in surgical techniques and anesthesia permit surgical interventions during pregnancy. The ideal time for surgery in the antenatal period is the second trimester (14 to 26 weeks gestation). Teratogenicity for spontaneous abortion is a potential complication of surgery during the first trimester; preterm labor is a more common potential complication of the third trimester, secondary to increased uterine to endogenous uterotonic agents (e.g. oxytocin). At a minimum pregnant women who are 24 or more weeks of gestation shall have electronic fetal heart rate and contraction monitoring performed before and after the procedure to assess fetal well-being and the absence of contractions.
Equipment:	1. Portable external fetal monitor with external ultrasound and tocodynamometer. 2. Conductive gel 3. Labor and Delivery Charge Sheet 4. Initial Fetal Monitor Strip Label
Personnel:	1. A skilled obstetric nurse who can interpret the results shall perform all external fetal heart rate and uterine activity monitoring.. 2. The labor and Delivery Assistant Nurse Manager (ANM)/designee/relief charge will work with the patient's physician main Operating Room (OR) and Post Anesthesia Care Unit (PACU) to coordinate obstetrical monitoring.

A. PRE-OPERATIVE:

1. All pregnant patients undergoing a non-obstetric surgical procedure require an obstetric consult.
   a. Including unexpected emergencies whenpossible
   b. The consult should include review of the gestational age, pregnancy complications, any need for pre-treatments, positioning, and recommendations for fetal monitoring.
2. For patients who are between 14 and less than 24 weeks gestation, fetal heart tones (FHTs) shall be obtained and documented both pre- and post-operatively.
3. For patients 24 weeks and greater, obtaining an electronic fetal heart rate (FHR) and uterine activity monitoring strip of 20 to 30 minutes prior to the induction of anesthesia is recommended
   a. If the surgical procedure is an emergency,obtaining FHTs is acceptable.
4. It is the responsibility of the operating surgeon/clinic staff to inform the OR scheduling staff that the patient is pregnant and ensure an obstetrical consult is identified and available.
   a. If the patient's obstetrician is not on staff or unavailable, the surgeon should consult with the obstetrician on "unassigned call."
5. Staff responsible for scheduling surgeries and preadmission testing should notify the Labor and Delivery (L&D) charge nurse of the patient's monitoring requirements, at the earliest possible convenience so a L&D nurse can be available.
   a. Notification should occur at least 24 hours prior to elective surgeryand as soon as possible for urgent/emergency surgery.
6. L&D unit shall supply the monitoring equipment and qualified nursing staff to perform the external fetal monitoring.
7. The L&D nurse shall notify the obstetrician consulted of any FHR and/or uterine activity concerns.

Review / Revision Date	Clinical Policies & Procedures	Nurse Executive Committeel	Department of OB/GYN	Operating Room Commitee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
7/03, 2/06, 12/08, 4/09, 2/10, 04/15	04/10, 05/15	05/10, 05/15	12/15	02/16	05/10; 02/16	06/10; 03/16	06/10; 03/16

8. The obstetrician consulted should notify the neonatologist of an impending surgery for a patient carrying a potentially viable fetus.
9. The OR should be prepared for the possibility of an emergency cesarean delivery.
    a. Ensure , instrument tray, infant warmer and infant crash cart from L&D are available.
    b. Notify Neonatal Intensive Care Unit(NICU) shift supervisor/or designee of impending surgery and potentially viable fetus
    c. Request NICU staff bring transport incubator if called to the OR for cesarean delivery

B. INTRAOPERATIVE:

1. In select circumstances, continuous fetal monitoring may be considered, but is usually not possible.
    a. A provider with obstetrical priviledges must be available and willing to intervene during the surgical procedure for fetal indications.

C. POSTOPERATIVE:

1. For patients who are between 14 and less than 24 weeks gestation, fetal heart tones (FHTs) shall be obtained and documented post-operatively.
2. For patients 24 weeks and greater, external FHR and uterine activity monitoring should begin in the Post-Anthesia Care Unit (PACU) and continue until the patient has recovered from anesthesia or per provider order.
3. The L&D nurse shall observe the patient closely for contractions as increased uterine activity can occur after surgery.
    a. Notify attending obstetric physician for $\geq$ 3 contractions in 10 minutes or $\geq$ 6 contractions in 60 minutes.
    b. Notify the obstetrican for any FHR assessment concerns.
4. After discharge from PACU, continuous or intermittent fetal monitoring may be ordered by either the obstetrician or the surgeon.

D. REFERENCES:

1. American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (20012). *Guidelines for perinatal care (7thh ed.).*
2. Martin, E.J. (2009). *Intrapartum management modules* (3rd ed.). Lippincott, Williams, & Wilkins.
3. Tucker, S.M., Miller, L.A., & Miller, D.A. (2009). *Fetal monitoring and assessment* (5th ed.). Mosby Elsevier.
4. American Society of Anesthesiologists (2009). Statement on Non-Obstetric Surgery During Pregnancy.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 9/75

SUBJECT: EQUIPMENT TRANSFER, STORAGE, TRADE-IN, AND DISPOSAL

REVISION DATE: 5/88; 5/03; 4/09; 12/12

POLICY NUMBER: 8610-200

Administrative Policies & Procedures Committee Approval:	**12/15**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. By adopting this Equipment Transfer, Storage, Trade-in and Disposal Policy, the Board of Directors of Tri-City Healthcare District (TCHD) hereby resolves to provide guidelines for the inter-department reassignment of capital Equipment within TCHD, storage of Equipment temporarily removed from service, and trade-in of Equipment toward the replacement of Equipment, and further approves methods of disposing of surplus Equipment.

B. **DEFINITIONS:**

1. Equipment: a capital asset acquired by TCHD, excluding real property.
2. Surplus Equipment: Equipment determined by the CEO, his/her designee, or the Engineering Department to be no longer necessary for TCHD's use, excluding Equipment held by TCHD for the purpose of exchange, for emergencies or as backup.
3. Equipment Transfer: the reassignment or physical relocation of Equipment within TCHD, including reassignment from one cost center to another.
4. Equipment Storage: the retention of Equipment for probable later use including a temporary removal from service and/or physical relocation.
5. Equipment Trade-in: the exchange-in-trade of Equipment toward the replacement or purchase of a new capital acquisition (see AP # 252, Purchase of Budgeted Capital Assets).
6. Equipment Disposal: the permanent removal of Equipment from TCHD.

C. **GENERAL PROVISIONS:**

1. Each department Director is responsible for Equipment assigned to his/her respective cost centers.
2. Equipment deposited in storage areas without the proper identification detailed in this policy may be considered abandoned. The Engineering Department will take responsibility for all abandoned Equipment and make every effort to recover and reconcile such Equipment. As appropriate, the Engineering Department may designate abandoned Equipment as surplus and proceed with disposition as provided by this policy.
3. Equipment will not be removed from TCHD without prior authorization.
4. No TCHD directors or employees or members of their immediate family shall be permitted to purchase Surplus Equipment from TCHD or any agent of the TCHD.
5. No Equipment that is subject to a lease or lien may be transferred, removed, traded-in disposed of or used for any other purpose until clearance for such transfer, removal, disposition or use has been provided in writing by TCHD.

D. **EQUPMENT DISPOSITION REQUISITION PROCESS:**

1. Responsible department Director shall identify Equipment to be transferred, stored, traded-in, or disposed using an Equipment Disposition Requisition form. An Equipment Disposition Requisition form will be completed as follows:

a. The responsible department Director will complete Section I, Originating Department for all Equipment transfers to storage, trade-in, or disposal and will approve the action by signing in the "Requested By" section.
b. For equipment Transfer to a different cost center, the receiving department Director will indicate the department name and cost center in Section III, Equipment Transfer and will acknowledge receipt of the transferred equipment by signing in the "Received By" section.
c. For Equipment Storage, the responsible department Director will indicate such in Section III, Equipment Transfer.
d. For equipment Trade-in, the responsible department Director will check the trade-in box in Section IV, Equipment Disposals and complete the boxes for vendor and trade-in allowance.
e. For equipment Disposal, the responsible department Director will check only the sold box in Section IV, Equipment Disposals.
f. The responsible department Director shall ensure that the "Yellow Copy" of the Equipment Disposition Requisition is attached to the Equipment being removed. No Equipment will be removed from a department without being appropriately tagged. The "Pink Copy" of the requisition is to be retained by the originating department.

2. For Equipment Trade-in, the remaining copies of the completed Equipment Disposition Requisition must be attached to the Capital Purchase Requisition. A Requisition for replacement or trade-in Equipment will not be processed unless and until disposal paperwork for the Equipment to be replaced has been provided.
3. For Equipment Transfer, Storage, or Disposal, all remaining copies of the completed Equipment Disposition Requisition must be forwarded to the Accounting Department.
4. The Accounting Department will review the Equipment Disposition Requisition to track Equipment movement, trade, or disposal. Incomplete forms shall be returned for completion to the department Director requesting the transfer, trade-in, or disposal.
   a. The Accounting Department will record the transfer, trade-in, or disposal in the asset management system.
   b. The Accounting Department will complete Section II, Accounting Department for Equipment Transfers, Trade-in, or Disposal. Equipment Storage requires no additional information.
   c. The Accounting Department will retain the "Goldenrod Copy" of the Equipment Disposition Requisition and forward all remaining copies to the Supply Chain Management Department.
   d. For Equipment Trade-in, the Equipment Disposition Requisition will be attached to the Capital Purchase Requisition and forwarded to Supply Chain Management once the replacement has been approved (see AP 252, Purchase of Budgeted Capital Assets).
5. The Supply Chain Management Department will review the Equipment Disposition Requisition for disposition. Incomplete forms shall be returned for completion to the Accounting Department. The Supply Chain Management Department will retain the "White" and "Green" copies of the Equipment Disposition Requisition.
   a. For Equipment Transfer, Storage, or Disposal, Supply Chain Management will notify the Environmental Services Department of Equipment needing to be moved between departments, to storage, or to the disposal staging cage. Equipment will not be moved without the completed information and authorizations on the Equipment Disposition Requisition.
   b. Equipment Trade-in, will be arranged with the seller at the time of purchase by the Purchasing Department. At the actual time of trade-in, the Shipping and Receiving Department will remove any hospital identification tag and/or Bio-medical tag and attach such tags to the "Green" copy of the Equipment Disposition Requisition.
   c. For equipment Transfer, Storage, Trade-in, or Disposal, Supply Chain Management will notify Clinical Engineering of the disposition of Equipment.

d. Engineering will be responsible for maintaining the records of Equipment transferred or stored and will be responsible for controlling access to Equipment storage areas. To the extent possible, Engineering will work with the originating department to assess Equipment stored in excess of six (6) months to determine if storage should continue or if disposal is appropriate.

e. For equipment Disposal, the Supply Chain Management Department may conduct the sale or may contract with an approved to conduct the sale as provided for herein. Upon disposal, Engineering will forward the "Green" copy of the Equipment Disposition Requisition, with documentation of the sale, to the Accounting Department for their actions in removing the asset from the records.

6. Departments requesting return of Equipment from storage will contact the Environmental Services Department. The Environmental Services Department will transport Equipment from storage to the originating department, as appropriate. The "Yellow" copy of the Equipment Disposition Requisition will be returned by Environmental Services to the Supply Chain Management Department to complete its record. Upon notification from Environmental Services, Engineering will forward the "Green" copy of the Equipment Disposition Requisition to the Accounting Department.

E. SALE OF EQUIPMENT:

1. TCHD Equipment is considered "public property"
2. The sale of TCHD Equipment will be conducted by TCHD's Director of Supply Chain Management, or by a vendor and process approved by the TCHD Board of Directors.
3. For sales conducted by TCHD's Director of Supply Chain Management, a description of the Equipment for sale will be publically listed on the TCHD website with a minimum two (2) week auction bid time. A bid opening appointment will also be listed on the auction with an invitation for bidders to be present when the sealed bids are opened. A least one other TCHD Director shall be present during the bid opening. When the winner (highest bidder) is determined, that party will have 72 hours to provide payment and a release, and to complete any other conditions as may be required by TCHD. If the winning party fails to do so, then the item will be offered to the next highest bidder. This process will continue until a sale is completed.
4. As a condition of sale, all purchasers of Equipment must provide TCHD a release of liability relating to the Equipment prior to taking possession.
5. If Equipment does not sell after reasonable efforts, the Equipment will be considered to have no fair market value and may be disposed of by other means.

F. DISPOSITION OF SURPLUS EQUIPMENT

1. Any Surplus Equipment disposed of pursuant to this policy will be considered disposed of at fair market value within the meaning of Health & Safety Code § 32121.2, except that Surplus Equipment may be donated or sold at less than fair market value in any of the following circumstances:
   a. To a nonprofit organization or public agency to use or maintain for the benefit of the communities served by TCHD.
   b. To another local hospital district in California.
2. Surplus Equipment may be disposed of at fair market value by any method approved of by the TCHD Board of Directors pursuant to Health & Safety Code § 32121.2.
3. Any equipment containing a hard drive must be removed by the applicable department or vendor prior to disposition or destruction of the equipment.

G. FORMS/RELATED DOCUMENTS :

1. Equipment Disposition Requisition
2. Capital Purchase Requisition
3. Release of Liability Form

H. REFERENCES:

1. Administrative Policy #252 Purchase of Budgeted Capital

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

EQUIPMENT DISPOSITION REQUISITION

SECTION I — ORIGINATING DEPARTMENT

Department Name	Cost Center	Request Date	Requested By
Item Description		Manufacturer	Department Phone #
Model #	Serial #	Is a service contract in effect on this equipment? ☐ Yes ☐ No	
Hospital Tag #	BioMed Tag #		
PO #	Purchase Date	Vendor Name	PO #

SECTION II — BIOMEDICAL ENGINEERING

Comments: _____

Signature: _____ Print Name: _____ Date: _____

SECTION III — ACCOUNTING DEPARTMENT

set #	Initial Purchase Price	Accumulated Depreciation	
Net Book Value	Gain (Loss) on Disposal	Recorded By	Date

SECTION IV — EQUIPMENT TRANSFER

☐ Transferred To	Department Name	Cost Center	Date
☐ Transferred To	Storage	Total Pieces	Received By

SECTION V — EQUIPMENT DISPOSALS

☐ SOLD	Buyer Address Selling Price	Director, Materials Management
☐ DONATED	Company Address	Director, Materials Management
☐ DESTROYED		Director, Materials Management
☐ TRADE IN		Director, Materials Management

8402-1014
(Rev. 07/11)

White - Materials Management Canary - Accounting Pink - Originating Dept

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

CAPITAL PURCHASE REQUISITION

FUNDING SOURCE: ☐ CAPITAL BUDGET ☐ FOUNDATION ☐ AUXILIARY ☐ OTHER

ITEM IS: ☐ A REPLACEMENT OF AN EXISTING ASSET * ☐ A NEW ASSET

WAS A WRITTEN PRICE QUOTE OBTAINED? ☐ YES (ATTACH COPY) ☐ NO

DEPARTMENT NAME	DEPARTMENT NO.	REQUESTED BY	PHONE NO.

DATE OF REQUEST	DATE REQUIRED	RECOMMENDED VENDOR	PHONE NO.

QUANTITY	CATALOG NUMBER	ITEM DESCRIPTION	BUDGET NUMBER	UNIT COST	EXTENDED COST

ADDITIONAL COMMENTS: LIST TRADE-IN INFORMATION, TRAINING EXPENSES, MAINTENANCE AGREEMENT EXPENSES, CONSTRUCTION COSTS.

TAX	
FREIGHT	
TOTAL ▶	
APPROVED BUDGET (IF ANY)	
ADDITIONAL FUNDS NEEDED	

SOURCE OF ADDITIONAL FUNDS:

TRANSFER FROM BUDGET NUMBER(S): _____ / _____ / _____

☐ LEASE PURCHASE
☐ CASH PURCHASE

DEPARTMENT MANAGER/APPROVAL LEVEL - 300	CHIEF EXECUTIVE OFFICER	FOR MATERIAL SERVICES USE ONLY
		PURCHASING MANAGER
AREA ADMINISTRATIVE/APPROVAL LEVEL - 2500	INFORMATION SYSTEM, COMPUTER EQUIPMENT OR SOFTWARE REQUIRES P.C. TASK FORCE APPROVAL	PURCHASE ORDER NUMBER
CHIEF FINANCIAL OFFICER/APPROVAL LEVEL - 2500	DIRECTOR, FACILITIES MANAGEMENT	PROCESSED BY
CHIEF OPERATING OFFICER/APPROVAL LEVEL - 5000		ORDER DATE

EQUIPMENT DISPOSITION REQUEST MUST ACCOMPANY THIS REQUISITION IF THIS ITEM IS REPLACING AN EXISTING ASSET

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 04/06

SUBJECT: Provision of Education for Adolescents during Hospitalization

REVISION DATE: 02/09; 02/11

POLICY NUMBER: 8610-391

Clinical Policies and Procedures Committee Approval:	**12/15**
Nurse Executive Committee	**01/16**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To address the specific academic education needs of adolescents by supporting continuity of education during hospitalization.

B. **POLICY:**

1. Parents will be informed upon admission that assistance in communicating with the adolescent's school during hospitalization will be provided after the 14th day of hospitalization.
2. Collaboration with the adolescent's school will be facilitated upon parental request and permission.
3. The Case Manager will communicate with the adolescent's school regarding coordination of appropriate educational services to meet both the adolescent's academic and medical needs during hospitalization.
4. The Case Manager will facilitate coordination of educational services provided by the school district.
5. The Case manager will contact the school district representative/ adolescent's teacher to assist with transition upon the adolescent's return to regular school or for home follow-up after discharge.

SUBJECT: Management of Patients with Multi-Drug Resistant Organism (MDRO) and/or C. Difficile Infection

ISSUE DATE: 03/16
REVISION DATE(S):

Department Approval Date(s):	**10/15**
Infection Control Committee Approval Date(s):	**10/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **DEFINITIONS:**

1. Multi-drug resistant Organism (MDROs) and Clostridium Difficile are organisms of epidemiological significance in the health care setting. MDROs are defined as microorganisms that are resistant to one or more classes of antimicrobial agents. The clinical manifestations are often similar to infections caused by susceptible pathogens; however the options for treatment are limited. MDROs and C. Difficile infection increase the length of stay, costs and mortality of patients. The MDROs of significance are:
   a. Vancomycin Resistant Enterococci (VRE)
   b. Methicillin Resistant Staphylococcus aureus (MRSA)
   c. Resistant Acinetobacter baumannii
   d. Carbapenem- resistant Enterobacteriaceae (CRE)
      i. Klebsiella pneumonia
      ii. Escherichia coli
   e. Extended Spectrum beta Lactamase Producers (ESBL)
      i. Klebsiella pneumonia
      ii. Escherichia coli
   f. Other MDROs as identified by Laboratory identification and/or Physician
2. The risk factors for obtaining an MDRO (Infection or colonization) include those with severe disease, ICU stay, compromised host defenses, recent surgery or indwelling medical devices.
3. The risk factors for obtaining C.difficile infection are: antimicrobial exposure, acquisition of C.difficile, advanced age, underlying illness, immunosuppression, tube feeds and gastric acid suppression. The purpose of this policy is to prevent the transmission of MDROs and C.Difficile Infection.
4. C.Difficile Infection: This policy applies to patients who have active C.difficile Infection as defined by those with a recent positive test for C.diff during current admission or recent positive test and still has active diarrhea.
5. Cohorting is the placement of patients with the same microorganism in the same room. Usually done when private rooms are not available.
6. Recommendations for MRSA active surveillance culturing are focused on high-risk populations and the delay inherent in identifying MRSA in clinical cultures makes it impossible to know the MRSA status of every patient when they are admitted. The use of Standard Precautions and most importantly hand hygiene will reduce the risk of cross transmission from unknown cases. Please note: Routine screening for other types of MDROs is not recommended.

3. **POLICY**

1. Transmission:
   a. Transmission may occur through direct contact with a MDRO carrier and ineffectively disinfected equipment. The use of Standard and Contact Precautions to break the chain of transmission is recommended in the acute care hospital.
2. Strategies To Reduce Risk Of Cross Transmission:
   a. Because of the difficulty in treating MDRO infections, it is imperative that health care workers prevent the transmission of MDRO from colonized or infected patient to other patients or personnel.
   b. Compliance with Standard Precautions and Contact Precautions will reduce the risk of transmission between patients. Place patients in contact precautions in the following cases :
      i. MRSA, ESBL, VRE, and C.difficile positive tests trigger an auto order in the Cerner record for Contact Precautions as recommended by CDC HICPAC. Electronic methods for identification of patients with MDRO history are available to the Infection Control Department.
      ii. Patients with a history of ESBL and VRE are placed in Contact precautions by entering an order for Isolation – Contact precautions. The history can be found in Cerner- Patient Problem List.
      iii. MRSA perform the following in addition to above.
         1) Unresolved History of MRSA: All patients with an unresolved history of MRSA infection or colonization on the problem list are placed in Contact Precautions by entering an order for Isolation – Contact Precautions for duration of hospitalization or if readmitted within $\leq$ 29 days of discharge. This information can be found in Cerner-Patient Problem List.
         2) Resolved history of MRSA: Do not need to be placed into Contact precautions unless there is a new MRSA positive culture
   c. Perform hand hygiene before and after gloving. Hands of health care workers can become transiently colonized which is the most common mode of transmission of healthcare associated MDROs.
      i. Wear gloves for contact with membranes, damaged skin, or with any moist body substance (i.e., oral secretions, sputum, blood, urine, feces, and vomitus).
      ii. Change gloves between patients and on the same patient when an episode of care has multiple components such as care at different anatomical sites involving moist body substances or mucous membranes.
         1) Wearing gloves does not take the place of hand washing. Perform hand hygiene after removing gloves.
      iii. Wear a new pair of gloves with each patient. Failure to change gloves between patient contacts is an infection control hazard.
      iv. Wear a plastic apron or a gown if it is likely that clothing will be soiled. Change aprons/gowns between patients.
   d. Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal and hand hygiene, clothing and hands do not come in contact with environmental surfaces (doorknobs and curtains).
   e. Follow Standard Precautions and wear face protection if it is likely that eyes, nose or mouth will be splashed with moist body substances or secretions (e.g. during wound care or suctioning an intubated patient).
   f. Environmental cleaning is an important measure to reduce risk of transmission.
   g. Use of dedicated non-critical patient care equipment is recommended. Reusable equipment must be disinfected before being used on another patient.
   h. C.difficile Infection perform the following in addition to above:
      i. Wash hands with soap and water after removing gloves.
      ii. Ensure purple "D" sign is posted along with the contact precautions sign outside patient room
      iii. Room is cleaned with bleach product by EVS staff

iv. Reusable equipment is cleaned after patient use by bleach product (if product tolerates bleach product otherwise utilize hospital approved disinfectant)

3. Cohorting:
   a. Single patient room preferred.
   b. Cohorting (patients with same MDROs sharing a room) is permitted for the following:
      i. MRSA: Cohort patients with current or past unresolved history of MRSA (not cleared by screening culture or previously resolved on problem list).
      ii. VRE: Cohort patient with current or past history of VRE
      iii. ESBL, CRE, or C. Difficile: Do not cohort patients without consulting Infection control for the following organisms (past or current history).
   c. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consult with infection control staff when there are questions about patient placement. Also consider the conditions of the individual patients and the ability to transmit the infection in giving them priority for single room placement, for example stool incontinence and/or uncontained drainage.
4. Discharge, Transfer, And Transport Of Patient:
   a. Isolation Signs communicate isolation status to visitors and Healthcare workers when entering the room. "D" Sign is placed to communicate to Healthcare workers if a patient has C.difficile infection.
   b. The Cerner problems list communicates MDRO status across admissions for ESBL, VRE and "unresolved" MRSA.
      i. MRSA patients with a "resolved" history of MRSA do not need to be placed in contact precautions unless a new MRSA culture is identified.
      ii. C.difficile infection is not placed on the problem list since past history does not define isolation in future admissions.
   c. Hand off communication includes isolation information to receiving unit and transporters.
   d. Patient Transfer: try to cover or contain potentially infectious body fluids prior to transport. The transporter should discard contaminated PPE before transport. Perform good hand hygiene. Don clean PPE at destination to handle the patient.
   e. When arranging transfer communicate information to nursing home, home health agency or other hospital receiving patient
   f. Infection Control communicates final lab results to receiving facilities if they are not available until after discharge in the following situations:
      i. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO
      ii. Positive C.difficile tests known after the patient was discharged to another healthcare facility.
5. Discontinuation of Contact Precautions:
   a. ESBL, CRE, and other MDROs are not able to be discontinued from Contact precautions.
   b. C.Difficile Infection: This policy applies to patients who have active C.difficile Infection should stay in isolation for duration of their stay.
   c. MRSA: Patient with a history of MRSA may be discontinued from contact precautions:
      i. If readmitted with a prior unresolved history and discharged $\geq$30 days- Screen nares and review any cultures ordered by the physician. Maintain Contact Precautions until culture results are known. Discontinue Contact Precautions if screening and clinical cultures are MRSA negative (See Patient Care Services: Standardized Screening Procedure: MRSA Screening
   d. VRE: Isolation may be discontinued after obtaining three consecutive negative stool, rectal or peri-rectal cultures one or more weeks apart.

6. Patient Education:
   a. Patients discovered to have MRSA, VRE or ESBL colonization or infection, or C.difficile Infection is given pre-printed educational handouts provided through Micromedex. Micromedex: CareNotes Procedure

C. **RELATED DOCUMENTS**

1. Infection Control Manual Standard and Transmission Based Precautions.
2. Infection Control Manual Disease Index: Type and Duration of Precautions
3. Patient Care Services Standardized Procedure: Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Procedure

D. **REFERENCES:**

1. APIC Guide. (2010) Guide to the Elimination of Methicillin Resistant Staphylococcus aureus (MRSA) transmission in Hospital Settings, 2nd edition.
2. APIC Text of Infection Control and Epidemiology Fourth edition 2014.
3. Centers for Disease Control and Prevention. Guidance for Control of Carbapenem-resistant Enterobacteriaceae 2012. Available at http://www.cdc.gov/hai/pdfs/cre/CRE-guidance-508.pdf
4. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 *http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf*
5. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

Delete from Infection Control Manual. Refer to the New Management of patients with MDRO & C.Diff

ISSUE DATE: 11/99	**SUBJECT:** Management of Patients with MRSA
REVISION DATE: 4/10, 01/12	**POLICY NUMBER:** IC.6.3

Department Approval Date(s):	10/15
Infection Control Committee Approval:	10/15
Medical Executive Committee Approval:	01/16
Professional Affairs Committee Approval Date(s):	03/16
Board of Directors Approval:	03/16

A. GENERAL INFORMATION:

1. *Staphylococcus aureus* is a gram-positive bacteria that can invade tissue, causing infections that may be either localized and superficial (e.g., pustules, superficial wound infections), or systemic and deep (e.g., bacteremia, pneumonia, osteomyelitis, endocarditis).
   a. The natural reservoir for *Staphylococcus aureus* is the anterior nares of humans. Persons who carry the organism but who are not clinically infected are colonized. Both colonized and infected persons can transmit the organism to others and can serve as reservoirs for transmission, usually by the hands of health care workers.
   b. Methicillin-Resistant *Staphylococcus aureus* (MRSA) is a strain of *Staphylococcus aureus* resistant to antibiotics traditionally used to treat staphylococcal infections, such as oxacillin and cefazolin.
2. Community Acquired and Healthcare Associated MRSA - MRSA was once almost exclusively found in healthcare facilities. Unfortunately, the prevalence of MRSA is increasing dramatically in the United States as a community acquired and a healthcare associated pathogen. Some community-acquired infections can be particularly severe. Treatment options may be further limited if MRSA develops resistance to the remaining effective antibiotics used in therapy for infection. MRSA is also increasingly common in patients admitted from crowded conditions, extended care facilities and prisons. This means that physicians may no longer be able to treat Staphylococcal infections empirically with penicillin or cephalosporins, but must switch to the more expensive and toxic drugs until the results of antimicrobial susceptibility testing is known confirming the presence of MRSA. Recommendations for active surveillance culturing are focused on high-risk populations and the delay inherent in identifying MRSA in clinical cultures makes it impossible to know the MRSA status of every patient when they are admitted. The use of Standard Precautions and most importantly hand hygiene will reduce the risk of cross transmission from unknown cases.

B. TRANSMISSION:

1. Transmission may occur through direct contact with a MRSA carrier and ineffectively disinfected equipment. The use of Contact Precautions to break the chain of transmissions is recommended in the acute care hospital.

C. STRATEGIES TO REDUCE RISK OF CROSS TRANSMISSION:

1. Because of the difficulty in treating MRSA infections, it is imperative that health care workers prevent the transmission of MRSA from colonized or infected patient to other patients or personnel.
2. Compliance with Standard Precautions and Contact Precautions will reduce the risk of transmission between patients.
3. Perform hand hygiene before and after gloving. Hands of health care workers can become transiently colonized which is the most common mode of transmission of healthcare associated MRSA.

a.Wear gloves for contact with membranes, damaged skin, or with any moist body substance (i.e., oral secretions, sputum, blood, urine, feces, vomitus).

b.Change gloves between patients and on the same patient when an episode of care has multiple components such as care at different anatomical sites involving moist body substances or mucous membranes

i.Wearing gloves does not take the place of hand washing. Perform hand hygiene after removing gloves.

c.Wear a new pair of gloves with each patient. Failure to change gloves between patient contacts is an infection control hazard.

4.Wear a plastic apron or a gown if it is likely that clothing will be soiled. Change aprons/gowns between patients.

5.Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal and hand hygiene, clothing and hands do not come in contact with environmental surfaces (doorknobs and curtains).

6.Follow Standard Precautions and wear face protection if it is likely that eyes, nose or mouth will be splashed with moist body substances or secretions (e.g. during wound care or suctioning an intubated patient)

7.A private room is indicated but patients with MRSA can share the same room (cohorting) regardless of the culture source. This means that a patient with respiratory MRSA can room in with a patient MRSA in their wound or urine.

8.All patients with an unresolved history of MRSA infection or colonization on the problem list are placed in Contact Precautions by entering an order for Isolation – Contact Precautions for duration of hospitalization or if readmitted within ≤ 29 days of discharge. The patient will be placed in a private room or cohorted with another MRSA patient every time they are admitted to the hospital. This information can be found in Compass (Cerner) Patient Problem List. Check the computer for proper room assignment.

9.If readmitted with a prior unresolved history and discharged ≥30 days) Screen nares and review any cultures ordered by the physician. Maintain Contact Precautions until culture results are known. Discontinue Contact Precautions if screening and clinical cultures are MRSA negative.

10. Active Surveillance culturing for MRSA in patients at high risk for MRSA acquisition should be considered when indicated. Populations at risk are assessed annually through Tri-City Medical Center's MRSA risk assessment.

11.MRSA positive cultures trigger an auto order in the Cerner record for Contact Precautions as recommended by CDC HICPAC. Electronic methods for identification of patients with MRSA history are available to the Infection Control Department.

12.Place patient in a private room or cohort patients with the same microorganism. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control professionals is advised when there are questions about patient placement.

13.Environmental cleaning is an important measure to reduce risk of transmission. Environmental disinfectants are selected based on the manufacturers label claims. TCMC provides environmental cleaners that have effective disinfection claims for MRSA. Because of this there is no special cleaning agents used for MRSA isolation rooms.

D.**DISCHARGE, TRANSFER, AND TRANSPORT OF PATIENT:**

1. Isolation Signs communicate isolation status to visitors and Healthcare workers when entering the room

2.The Cerner problems list communicates MRSA status across admissions

3.Hand off communication includes isolation information to receiving unit and transporters

4.When arranging transfer communicate information to nursing home, home health agency or other hospital receiving patient

5.Infection Control communicates final MRSA lab results to receiving facilities if they are not available

until after discharge.

E. **PATIENT EDUCATION:**

1. Patients discovered to have MRSA colonization or infection are given pre-printed educational hand outs provided through Micromedex. See Patient Care Services Policy **MICROMEDEX: CARENOTES PROCEDURE**

F. **REFERENCES:**

1. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007; CDC HICPAC
2. Siegel, J., Rhinehart, E., Jackson, M., & Chiarello, L. (2006). Management of Multidrug-Resistant Organisms In Healthcare Settings, CDC Healthcare Infection Control Practices Advisory Committee retrieved from http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf
3. Amori, G. Isolation Systems in: APIC Text of Infection Control and Epidemiology. Washington DC; 2000:15.1-8. http://www.cdc.gov/mrsa/mrsa_initiative/skin_infection/mrsa_hcp.html. MRSA Information for Healthcare Personnel.
4. Participation of Staff in the Infection Control Program IC. 7
5. Disease Index, IC.5.1
6. Hand Antisepsis IC.8
7. Cleaning and Disinfection IC.9
8. Isolation System: Standard and Transmission-Based Precautions IC.5

TRI-CITY MEDICAL CENTER
Oceanside, California
INFECTION CONTROL MANUAL

Delete from Infection Control Manual. Refer to the New Management of patients with MDRO & C.Diff

ISSUE DATE: 11/1999

SUBJECT: Management of Patients With VRE

STANDARD NUMBER: IC. 6.6

~~CROSS REFERENCE: Participation of Staff in the Infection Control Program IC. 7~~
~~Disease Index IC. 5.1~~
~~Hand Antisepsis IC. 8~~
~~Cleaning and Disinfection IC. 9~~
~~Standard and Transmission Based Precautions IC.5~~

~~REVISED: 10/2008 APPROVAL: Infection Control Committee 10/2011~~

Department Approval Date(s):	**10/15**
Infection Control Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Date(s):	**01/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~1.General Information~~

~~The Centers for Disease Control and Prevention has reported an increase in the number of nosocomial enterococcal infection due to Vancomycin Resistant Enterococcus (VRE). The trend has been noted in intensive care units as well as non-ICU patients. Certain patient populations have been found to be at risk for VRE infections and/or colonization: critically ill or immunocompromised patients such as those in the intensive care, oncology and transplant units, patients who have undergone intra-abdominal or cardiothoracic surgeries, patients who have indwelling urinary or central venous catheters, and patients who have prolonged hospital stay that required multiple antibiotics and/or vancomycin therapy.~~

~~Because enterococci are part of the normal flora of the GI and female genital tracts, most infections arise from endogenous sources. However, VRE can also be transmitted by direct contact through the hands of healthcare workers and/or indirectly through inanimate objects such as side rails, call bells, bedpans, thermometers and other patient care equipment.~~

~~The problem is intensified by high-level resistance of enterococci to penicillin and aminoglycosides limiting the treatment to combination of antibiotics. There is also the potential for emergence of Vancomycin resistance in clinical isolates of *Staphylococcus aureus* and *Staphylococcus epidermidis*, which pose a serious public health concern.~~

~~2.The following practices are recommended for the prevention of the spread of Vancomycin resistance:~~

- ~~Prudent use of vancomycin~~
- ~~Acceptable use of vancomycin~~
  - ~~For treatment of serious infections due to beta lactam resistant gram positive microorganism~~
  - ~~For treatment of infections due to gram positive microorganism in patients with serious allergies to beta lactams~~
  - ~~When antibiotic associated colitis (AAC) fails to respond to metronidazole therapy or if AAC is life threatening~~
  - ~~Prophylaxis is recommended by the American Heart Association for endocarditis following certain procedures in patients at high risk for endocarditis~~
  - ~~Prophylaxis for major surgical procedures involving implantation of prosthetic materials at institutions with high rate of infections due to MRSA or MRSE.~~

3.Discourage the use of Vancomycin in the following:

- Routine surgical prophylaxis
- Empiric antimicrobial therapy for febrile neutropenia
- Treatment in response to a single blood culture positive for coagulase negative staphylococcus
- Continued empiric use for presumed infections in patients with negative cultures for beta lactam resistant gram positive microorganisms
- Systemic or local prophylaxis for infections or colonization of indwelling, central or peripheral catheters
- Selective decontamination of the GI tract
- Eradication of MRSA colonization
- Primary treatment of AAC
- Routine prophylaxis for every low-birth-weight infants
- Routine prophylaxis for patients on CAPD
- Treatment of infections due to beta lactam sensitive gram-positive microorganisms in patients with renal failure.
- Use of Vancomycin solution for topical application or irrigation

4. Infection Control staff reviews clinical cultures daily to identify VRE cases.

5. VRE transmission prevention measures are communicated through Infection Control educational programs.

.Screen for detecting VRE: Routine screening is not recommended. Clinical cultures are processed withantimicrobial susceptibility testing on all identified enterococci and reports are reviewed by the Infection Control Department. Positive VRE cultures automatically trigger an isolation order for Contact Precautions as recommended by CDC HICPAC.

7.Prevention and control of healthcare associated transmission of VRE

7.1.Contact Isolation Precautions

i.Place VRE-infected or colonized patients in a private room or cohort with another patient with VRE. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control professionals is advised when there are questions about patient placement.

- Wear gloves. A change of gloves may be necessary after contact with materials that may contain high concentration of VRE such as stool
- Wear gowns when substantial contact with patient and environment is anticipated.
- Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal and handwashing, clothing and hands do not come in contact with environmental surfaces (doorknobs, curtains)
- Use of patient care items such as stethoscope, sphygmomanometer, or rectal thermometers should be dedicated to the VRE patient only.

7.2.Isolation may be discontinued after obtaining three consecutive negative cultures one or more weeks apart

8.A system to highlight patient condition for easy recognition and initiation of isolation during readmission is in

place. Check Affinity (Clinical Circumstances, Infection Control History) for this information to assure proper room assignment.

9.Discharge, Transfer, and Transport of patient

9.1.Communicate information to receiving unit and transporters

9.2.Communicate information to nursing home, home health agency or other hospital receiving patient

10.Environmental cleaning is an important measure to reduce risk of transmission. Environmental disinfectants are selected based on the manufacturers label claims. TCMC provides environmental cleaners that have effective disinfection claims for VRE. Because of this there is no special cleaning agents used for VRE isolation rooms.

11.Patient Education

11.1Patients found to have VRE colonization or infections are given pre-printed educational hand outs provided through Micromedex. See Patient Care Services Policy **MICROMEDEX: CARENOTES PROCEDURE**

Reference

The Hospital Infection Control Practices Advisory Committee (HICPAC) : Hospital Infections Program, National Center for Infectious Disease, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta, Georgia. 1995

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007; CDC HICPAC Amori, G. Isolation Systems in: APIC Text of Infection Control and Epidemiology. Washington DC;2000:15.1-8.

http://www.cdc.gov/ncidod/dhqp/ar_VRE_publicFAQ.html VRE: Information for Healthcare Personnel.

Tri-City Medical Center	Women and Newborn Services Manual Neonatal Intensive Care Unit (NICU)

PROCEDURE: **CUE-BASED FEEDING**

Purpose:

1. To provide a standardized protocol for feeding premature infants ≥ 33 weeks post conceptual age (PCA). Feedings will be based on the infant's behavior, assessment by the caregiver regarding readiness to feed, nipple feeding quality assessment, as well as feeding-induced stress cues.

A. **POLICY:**

1. Feedings will be started only once ordered by a Physician/Allied Health Professional (AHP). The protocol guidelines will promote safe, functional, nurturing, and developmentally appropriate feedings for medically stable premature infants.

B. **PROCEDURE: INFANT-DRIVEN FEEDING SCALE (IDFS) ASSESSMENT**

1. Criteria for use:
   a. Infant is ≥ 33 weeks post conceptual age (PCA).
   b. Infant is medically stable.
   c. Stable respiratory status
2. Ordering and scoring Infant-Driven Feeding
   a. A feeding readiness assessment score of 1 to 2 at least 5 times in a 24 hour period will alert the nurse to pursue an order for infant driven feeding.
   b. Feeding readiness is assessed and scored **prior to each feeding time**.
      i. If readiness assessment score is 1 or 2 the infant may attempt to PO feed (breast or bottle).
      ii. If readiness assessment score is 3-5, the infant should be gavage fed the full volume of the feeding.
         1) If parent present, recommend skin to skin or holding during gavage feeding.
   c. Breastfeeding infant
      i. If mother plans to Dry Breastfeed (DBF) defer the first oral feeding to her.
      ii. Educate the mother to empty the breast by pumping until milk is no longer being expressed, and to do this within 10 minutes of the DBF session.
      iii. Non-nutritive sucking on an empty breast may be offered to a stable infant if there is a physician/LIP order.
      iv. Refer to lactation consultants and occupational therapist (OT) as needed.
      v. If mother plans to DBF, staff should encourage mother to DBF each feeding (when scoring 1 or 2) for a protected amount of time. (For example, the first 72 hours) During this protected time no bottles should be given to the infant. After each DBF the infant may be gavage fed according to IDF breastfeeding algorithm.
      vi. After the protected breastfeeding window, the healthcare team should discuss whether to continue exclusive DBF or include bottle feeding as well.
      vii. Supplementation after DBF should be done via gavage feeding until the gavage tube is removed for ad lib feeding. A bottle may then be used.
   d. Bottle Feeding Infant
      i. Schedule first feeding with the parents when possible so that the parents can participate.
      ii. When feeding, the infant should be swaddled with hands close to face, knees and legs tucked up for added postural support and head in neutral position.

Department Review	Division of Neonatology	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12	12/15	02/16	n/a	02/16	03/16	03/16

iii. When initiating feeding gently offer infant a taste of EBM or formula to warn infant that a feeding is going to begin. Lightly drag the nipple from the nose to the chin and put a couple drops of EBM or formula on the tongue.
iv. PO feedings should be limited to the time when the infant is actively engaged. When infant displays stress cues or is no longer displaying alertness, hunger cues, adequate tone, and autonomic stability, the feeding should be stopped and the remainder gavaged.
v. The most effective feeding usually occurs within the first 20 minutes. With few exceptions, the feeding should not exceed 30 minutes.
vi. The RN/OT should offer feeding techniques as needed to facilitate a safe and timely suck/swallow/breathe pattern.

e. Assessment and Documentation of Feeding Quality
i. After each PO feeding document in the electronic health record (EHR)
1) Readiness assessment score
2) Feeding method
3) Interventions
4) Stress cues displayed
5) Feeding quality assessment score

f. Percentage of Oral Feeding Intake
i. Once PO feedings are initiated the multidisciplinary team will track the percentage of PO volume from total expected volume for each 24 hour period.
1) Percent of PO feeding will be reported to oncoming shift and in daily rounds.
2) Once the infant is able to take 80% of total volume PO with consistent Nipple Quality scores of 1-2, a shift minimum feeding volume will be ordered by the Physician/AHP.
3) After the infant has taken full feeding volume for 24 hours the NG tube may be removed and the Neonatal Intensive Care (NICU) multidisciplinary team will discuss transitioning the infant to ad lib on demand feedings.
4) Weight gain/loss will be monitored.
5) Infant will demonstrate adequate weight gain and feeding quality prior to discharge.

g. Parent Education
i. Parents will be encouraged to participate in as many feedings as possible.
ii. Parents will be educated on the transition to oral feedings.
iii. Parents will be educated on the use of the Infant-driven feeding scale/cue based feeding.
iv. The RN/OT will be a resource for parents while they are feeding their infant.

C. **ASSESSMENT SCALES/ALGORITHM:**

1. Infant-Driven Feeding Breastfeeding Algorithm
a. DBF 0-5 minutes (Quality Score 1-5): Gavage full feeding volume
b. DBF 5-10 minutes (Quality Score 1-3): Gavage 2/3 full feeding volume
c. DBF 10-15 minutes (Quality Score 1-3): Gavage 1/3 full feeding volume
d. DBF >15 minutes (Quality Score 1-3): Do not gavage feeding

2. Infant-Driven Feeding Scale Readiness Assessment
a. 1- Alert or Fussy prior to care. Rooting and/or hands to mouth behavior. Good tone.
b. 2-Alert once handled. Some rooting or takes pacifier. Adequate tone.
c. 3-Briefly alert with care. No hunger behaviors. No Change in tone.
d. 4-Sleeping throughout care. No hunger cues. No change in tone.
e. 5-Significant change in HR, RR, O2, or work of breathing outside of safe parameters.

3. Infant-Driven Feeding Scales Quality Assessment
a. 1- Nipples with a strong Coordinated SSB throughout feed.

b. 2- Nipples with strong coordinated SSB but fatigues with progression.
c. 3- Difficulty coordinating SSB despite consistent suck.
d. 4- Nipples with a weak/inconsistent SSB. Little to no rhythm.
e. 5- Unable to coordinate SSB pattern. Significant change in HR, RR, O2, work of breathing outside safe parameters of clinically unsafe swallow during feeding.

4. Infant-Driven Feeding Scales Interventions
   a. Modified Side lying: Position infant in inclined side lying position with head midline to assist with bolus management.
   b. External Pacing: Tip bottle downward/break seal at breast to remove or decrease the flow of liquid to facilitate SSB.
   c. Specialty Nipple: Use nipple other than standard for specific purpose i.e. nipple shield, slow-flow, Haberman.
   d. Cheek Support: Provide gentle unilateral support to improve intra oral pressure.
   e. Frequent burping: Burp infant based on behavioral cues not on time or volume completed.
   f. Chin support: Provide gentle forward pressure on mandible to ensure effective latch/tongue stripping if small chin or wide jaw excursion.
   g. Increase FiO2 of Flow Rate: Increase FiO2 5-10% higher than baseline FiO2 requirements during feeding in order to provide necessary support throughout feeding.

D. **REFERENCES:**

1. Ludwig, S.; Waitzman, K.A. (2013). 7 Risky Mistakes NICUs Make with Oral Feeding Every Day. Infant-Driven Feeding LLC.
2. Ludwig, S.; Waitzman, K. A. (2007). Changing Feeding Documentation to Reflect Infant Driven Practice. Newborn & Infant Nursing Reviews. 7(3). 155-160.

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**HIGH RISK INFANT FOLLOW-UP PROGRAM (HRIF)**
Purpose:	To provide periodic follow-up developmental assessments of high-risk infants discharged from TCMC's NICU, from birth to 3 years of age.To make referrals to appropriate community services.To provide education to parent/caregiver regarding infant's/child's developmental status, with a home program provided as needed.
Supportive Data:	In order to identifying neonates, infants and children who may develop a CCS-eligible medical condition and provide better outcomes for infants at high risk due to extreme pre-maturity, low birth weight and/or medical eligibility criteria that require support and/or treatment beyond the normal birthing experience. Follow-up programs have been instituted to assist families in addressing their social and medical needs.
Equipment:	1. Treatment Room 2. Scale and length board 3. Bayley Scales of Infant and Toddler Development
Issue Date:	08/06

A. **POLICY:**

1. It is the policy of Tri-City Medical Center's NICU to provide high risk follow up care that is compliant with the California Children's Services (CCS) guidelines.

B. **PROCEDURE:**

1. As part of the NICU discharge planning process, the NICU must identify and refer to the CCS Program clients identified as potentially eligible for the HRIF Program.
   a. It is the responsibility of the discharging to home CCS NICU/Hospital or the last CCS NICU/Hospital providing care to make the referral to the HRIF Program.
2. Eligibility for High Risk Infant Follow-up program:
   a. Infants discharged from a CCS (California Children Services)-approved NICU with a CCS-eligible condition, or without a CCS-eligible condition but who continue to be at risk of developing a CCS-medically eligible condition, shall be followed for the first three years of life. Infants who are discharged from a CCS-approved hospital after transfer from an approved NICU are similarly eligible.
3. Criteria for High Risk Infant Follow-up program includes the following:
   a. Meets CCS medical eligibility criteria for NICU care in a CCS approved NICU (regardless of length of stay)(as per numbered letter 05-0502, Medical Eligibility in a CCS Approved NICU).
      Or
   b. Had a CCS eligible medical condition in a CCS-approved NICU (regardless of length of stay), (as per California Code of Regulations, Title 22, Section 41800 through 41872, CCS Medical Eligibility Regulations).
      And
   c. The birth weight was less than 1500 grams or more and the gestational age at birth was less than 32 weeks.
      Or
   d. The birth weight was 1500 grams or more and the gestational age at birth was less than 32 weeks or more and one of the following criteria was met during the NICU stay:
      i. Cardiorespiratory depression at birth (defined as pH less than 7.0 on an umbilical blood sample or a blood gas obtained within one hour of life) or an Apgar score of less than or equal to three at five minutes.
      ii. A persistently and severely unstable infant manifested by prolonged hypoxia, acidemia, hypoglycemia and/or hypotension requiring pressor support.
      iii. Persistent apnea, which required medication (e.g., caffeine) for the treatment of apnea at discharge.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/08, 06/09, 6/11, 8/12, 01/15	04/15	n/a	01/16	03/16	06/13; 03/16

iv. Required oxygen for more than 28 days of hospital stay and had radiographic finding consistent with chronic lung disease (CLD).
v. Patients placed on extracorporeal membrane oxygenation (ECMO).
vi. Patients who received inhaled nitric oxide greater than four hours for persistent pulmonary hypertension of the newborn (PPHN).
vii. History of documented seizure activity.
viii. Evidence of intracranial pathology, including but not limited to, intracranial hemorrhage (grade II or worse), periventricular leukomalacia (PVL), cerebral thrombosis, cerebral infarction, developmental central nervous systems (CNS) abnormality or "other CNS problems associated with adverse neurologic outcome."
ix. Other problems that could result in a neurologic abnormality (e.g., history of CNS infection, documented sepsis, bilirubin in excess of usual exchange transfusion level, cardiovascular instability, hypoxic ischemic encephalopathy, et cetera).

4. Eligible infants shall receive the following evaluations:
   a. An interim comprehensive history and physical examination (including neurological assessment) at 4-6 months, 9-12 months, and 18-36 months corrected age. Evaluation is done by a physician.
   b. A development assessment including a standardized developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition is performed. This may be done by a physician, nurse practitioner, physical therapist, occupational therapist, speech therapist, or a developmental specialist – all with training in the evaluation of motor, sensory, language and social development of high-risk infants.
   c. A family psychosocial assessment is performed by a clinical social worker with expertise in this area or by the assessment team.
5. Eligible infants may receive the following referrals:
   a. Audiological Screening: It is expected that all infants will be screened prior to discharge. Infants not screened in the hospital or infants whose hospital screening was abnormal should be screened once through the HRIF program.
   b. Ophthalmologic assessment to be performed by a CCS-paneled ophthalmologist. For evaluation of retinopathy of prematurity, infants should be examined at 4-6 weeks of life if clinical condition permits; subsequent examinations should be performed until retinae are mature, as deemed appropriate by the ophthalmologist. (In general, the retinae are considered mature by 42 weeks, post-conceptual age.) Outpatient visits may be scheduled.
   c. A Home Assessment for the purpose of evaluating the family for specific needs within the home environment may be provided by a Health Home Agency (HHA) nurse.
   d. Based on clinical findings referrals are made by Social Services and therapists to outside agencies. Infants in need of a more definitive evaluation or those requiring a long-term diagnostic evaluation should be referred to the general CCS program for such diagnostic follow-up until a suspected diagnosis is either established or ruled out.
   e. Referral outcomes are reviewed via returned information from agencies and subsequent HRIF visits.

C. **ROLES AND RESPONSIBILITIES OF THE MEMBERS OF THE HIGH RISK INFANT FOLLOW-UP TEAM:**

1. NICU Medical Director
   a. May be one of the following: Pediatrician or Neonatologist
   b. Ensures that the HRIF Program fully participates in the CCS Program evaluation, including submission of required information and data.
2. HIRF Coordinator
   a. May be one of the following: CCS-approved: pediatrician or neonatologist, pediatric nurse practitioner, nurse specialist, psychologist, social worker, physical therapist, or occupational therapist. The pediatric nurse practitioner only requires CCS-approval when functioning in the CCS HRIF Program as a HRIF Coordinator.
   b. The specific responsibilities of the coordinator are:
      i. Serve as the primary person coordinating HRIF services among the County CCS Programs, other HRIF Programs located in CCS-approved Regional, Community,

and Intermediate NICUs, State Regional Offices, clients/families, and others in matters related to the client's HRIF services.

ii. Participate in NICU discharge planning process or multidisciplinary rounds.
iii. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.
iv. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office.
v. Ensure copies of the authorizations are distributed to HRIF team members and consultants.
vi. Gather medical reports and assessments for review by team members, and prepare a summary report.
vii. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.
viii. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.
ix. Assist families in establishing a Medical Home for the infant or child.
x. Assist clients/families in making linkages to necessary medical and social services.
xi. Ensure there is a system in place to follow-up with families including those who have missed appointments. Collect documentation of the reason for missed appointments and develop a plan of action for improving HRIF Program adherence for evaluations and assessments.
xii. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.
xiii. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.
xiv. Coordinate follow-up service needs among the CCS-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.

c. The Coordinator will facilitate the following Client Referral Services and Follow-Up and Education Services Program:

i. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.
ii. Ensure referrals are made to the Regional Center when those services are appropriate.
iii. Ensure referrals to HRIF diagnostic consultations and assessments are made with CCS-approved providers. High Risk Infant Follow-Up Quality Of Care Initiative: Manual Of Definitions – Release 01.15 13
iv. Ensure referrals to CCS Medical Therapy Program (MTP) are made as needed. Reminder: CCS Program eligibility and referral criteria for MTP are different from CCS/CPQCC HRIF data collection definitions for MTP eligibility.
v. Provide referral and resource information for other social and developmental programs within the community, as required.
vi. Provide education and outreach about the HRIF Program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs with which there is a NICU Regional Cooperation Agreement to CCS-approved Community and Intermediate NICU's and other community referral agencies, as appropriate.
vii. Develop and provide education to parents and family members about the high risk infant's medical condition(s), care and treatment, special needs and expected outcomes of care.
viii. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.

3. Social Worker

a. The responsibilities of the Social Worker includes:

i. Participate in NICU discharge planning process or multidisciplinary rounds.

ii. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.
iii. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office. (See Section IV.B.)
iv. Ensure copies of the authorizations are distributed to HRIF team members and consultants.
v. Assist families in establishing a Medical Home for the infant or child.
vi. Assist clients/families in making linkages to necessary medical and social services.
vii. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.
viii. Ensure referrals are made to the Regional Center when those services are appropriate.
ix. Provide referral and resource information for other social and developmental programs within the community, as required.
x. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.

4. History and Physical Exam Team
   a. May include the following: pediatrician or neonatologist, pediatric nurse practitioner, nurse specialist, and/or psychologist.
   b. The responsibilities of the History and Physical Exam Team include:
      i. Perform a Comprehensive History and Physical Examination, including neurologic assessment, at approximately 4 to 8 months, 12 to16 months, and 18 to 36 months (adjusted for chronological age).
      ii. Participate in NICU discharge planning process or multidisciplinary rounds.
      iii. Ensure identification of HRIF eligible clients according to HRIF eligibility criteria.
      iv. Gather medical reports and assessments for review by team members, and prepare a summary report.
      v. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.
      vi. Assist families in establishing a Medical Home for the infant or child.
      vii. Assist clients/families in making linkages to necessary medical and social services.
      viii. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.
      ix. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.
      x. Coordinate follow-up service needs among the CCS-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.
      xi. Ensure and document referrals are made to the Early Start (ES) Program for children who meet ES eligibility criteria.
      xii. Ensure referrals are made to the Regional Center when those services are appropriate.
      xiii. Ensure referrals to HRIF diagnostic consultations and assessments are made with CCS-approved providers.
      xiv. Ensure referrals to CCS Medical Therapy Program (MTP) are made as needed.
      xv. Provide referral and resource information for other social and developmental programs within the community, as required.
      xvi. Provide education and outreach about the HRIF Program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs with which there is a NICU Regional Cooperation Agreement to CCS-approved Community and Intermediate NICU's and other community referral agencies, as appropriate.
      xvii. Develop and provide education to parents and family members about the high risk infant's medical condition(s), care and treatment, special needs and expected outcomes of care.

xviii. Provide education to parents and family members about the system of care and services (including social services) available to help them nurture, support, and care for the high risk infant.

5. Developmental Assessment Team
   a. May include the following: a CCS-approved pediatrician or neonatologist, pediatric nurse practitioner, CCS-approved nurse specialist (registered nurse with a Bachelor's of Science Degree in Nursing), CCS-approved physical therapist, CCS-approved occupational therapist, and/or CCS-approved psychologist, all of whom have training in the evaluation of motor and sensory development of high risk infants.
   b. The responsibilities of the Developmental Assessment Team include:
      i. Perform a Developmental Assessment at each of the three Standard Visits (4 to 8 months, 12 to 16 months, and 18 to 36 months). At the 3rd and final Standard Visit (18 to 36 months), a developmental test such as the Bayley Scales of Infant Development (BSID) 3rd edition must be performed.
      ii. Gather medical reports and assessments for review by team members, and prepare a summary report.
      iii. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.
      iv. Confer with parents regarding services provided and results of clinical evaluations and assessments of their infant or child.
      v. Assist clients/families in making linkages to necessary medical and social services.
      vi. Provide coordination between the HRIF Program and the infant's or child's (pediatric) primary care physician, specialists, and County CCS Program or Regional Office when appropriate.
      vii. Coordinate HRIF services with the County CCS Program and Regional Offices and other local programs.
      viii. Coordinate follow-up service needs among the CCS-approved Regional, Community and Intermediate NICUs within the community catchment area and with those NICUs that provide HRIF referrals to their agency.

6. Administrative Support Team
   a. May include the following: receptionist, secretary, referral coordinator, registration clerk, aide, and/or access management personnel.
      i. Ensure the NICU discharge planning process includes referral and SAR submission to the County CCS Program or Regional Office.
      ii. Ensure copies of the authorizations are distributed to HRIF team members and consultants.
      iii. Gather medical reports and assessments for review by team members, and prepare a summary report.
      iv. Ensure that a copy of the summary report is sent to the County CCS Program or Regional Office.
      v. Assist in registration, scheduling appointments, contact and notification for appointments, preparation of forms and caregiver letters, medical record keeping, billing.

D. **EXTERNAL LINKS:**

1. https://www.ccshrif.org/download/Version%2001.15/2015%20HRIF-QCI%20Manual%20of%20Defintions%20v01.15.pdf

E. **REFERENCES:**

1. High Risk Infant Follow-up Quality of Care Initiative: Manual of Definitions, Release January 2015. California Children's Services (CCS) & California Perinatal Quality Care Collaborative (CPQCC), State of California.

SUBJECT: HIGH RISK INFANT FOLLOW-UP CLINIC PERINATAL DATA MANAGER, ROLE OF

ISSUE DATE: 2/07 REVISION DATE: 05/08, 02/09, 04/09, 6/11, 8/12

Department Approval Date(s):	**06/15**
Division of Neonatology 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):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~A. **PURPOSE:**~~

~~1. The purpose of this document is to define the role of the perinatal data manager in the High Risk Infant Follow-Up Clinic (HRIF).~~

~~B. **POLICY:**~~

~~1. To have a perinatal data manager in place with defined responsibilities that will ensure patients who are at risk for any developmental delays, are scheduled for evaluations in the HRIF program to receive the benefits of care offered to them through California Children's Services (CCS) guidelines.~~

~~C. **RESPONSIBILITIES:**~~

~~1. The perinatal data manager will send a letter of invitation to the parents, inviting them to bring their infant/child in for a developmental assessment. This letter will be sent one month prior to the visit and provide the appointment date and time.~~

~~2. The perinatal data manager contacts the parents the night before the appointment to remind them of the following day's appointment.~~

~~3. Prepares the patient's chart the night before the visit and ensures that they are in the HRIF program by the following morning.~~

~~4. Following the visit, the perinatal data manager inputs charges for the visit into the computer billing system.~~

~~D. **EXTERNAL LINKS:**~~

~~E. **REFERENCES:**~~

~~F. **APPROVAL PROCESS:**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

DELETE - Information incorporated into Women and Newborn Services High Risk Infant Follow-Up Policy

WOMEN'S AND CHILDREN'S SERVICES MANUAL

SUBJECT: HIGH RISK INFANT CLINIC COORDINATOR, THE ROLE OF

ISSUE DATE: 2/07 REVISION DATE: 06/11, 8/12

Department Approval Date(s):	**01/14**
Division of Neonatology 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):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~A. **PURPOSE:**~~

~~1. To be a facilitator in providing follow up care of NICU infants who are at risk for developmental delays after discharge from TCMC, provided by the High Risk Infant Follow-Up program. It is also the responsibility of this coordinator to ensure compliance with CCS regulations and guidelines.~~

~~B. **POLICY:**~~

~~1. It is the policy of Tri-City Medical Center to have a program in place per CCS guidelines to ensure that diagnostic follow-up, referral, and education services are provided to families of eligible infants and children with a High Risk Infant Coordinator in place who has defined responsibilities.~~

~~C. **COORDINATION RESPONSIBILITIES:**~~

~~1. Coordinate care for infants in CCS programs with other HRIF programs located in CCS approved regional NICUs and other referring community and intermediate NICUs with state CMS regional offices; and for clients/families and others in matters related to the client's HRIF services.~~
~~2. Participates in NICU discharge planning process or multidisciplinary rounds.~~
~~3. Assists social worker in ensuring identification of HRIF eligible clients according to HRIF eligibility criteria established in CCS policy known as numbered letters, and requests authorizations from county CCS program or regional offices.~~
~~4. Ensures that copies of the authorizations are distributed to HRIF team members and consultants.~~
~~5. Gathers medical reports and assessments for review by team members and prepares a summary report.~~
~~6. Ensures that copies of the summary reports are sent to the county CCS program, the identified primary care physician and the Children's Medical Services branch as required by CCS policy.~~
~~7. Confers with caregivers regarding services provided and results of clinical evaluations and assessments of their infant or child.~~
~~8. Assists social worker and RN with families to establish a medical home for the infant or child (via social worker referral for PHN visit). A list of available clinics and providers will also be provided.~~
~~9. Assists social worker in assuring and assisting clients/families in making linkages to necessary medical and social services.~~
~~10. Ensures that there is a system in place to follow-up with families including those who have missed appointments. Collects documentation of the reason for missed appointments and develops a plan of action for improving HRIF program adherence to keep appointments for evaluations and assessments. The coordinator will call the family to reschedule the appointment. After two attempts with no response from the family, the case will be closed and reported to the local CCS program that the case is closed.~~
~~11. Provides coordination between the HRIF program and infants or child's pediatric primary care physician, specialists, county CCS program and regional office, when appropriate.~~
~~12. Collaborates with social services to ensure authorizations are in place for the HRIF clinic.~~
~~13. Coordinates follow-up service needs between the CCS approved regional community and intermediate NICUs that provide HRIF referrals to Tri-City Medical Center.~~

14. Keeps data and provides feedback annually on the show rate (percentage) to NICUs that refer infants to the HRIF program at Tri-City Medical Center.

D. **CLIENT REFERRAL SERVICES AND FOLLOW-UP:**

1. Assists social worker in ensuring and documenting referrals that are made to the Early Start Program for children who meet early start eligibility.
2. Assists social worker in ensuring referrals are made to the regional center when those services are appropriate.
3. Ensures referrals to HRIF diagnostic consultations and assessments are made with CCS-approved providers.
4. Assists social worker in providing referral and resource information for other social and developmental programs within the community as required.

E. **EDUCATION SERVICES PROGRAM:**

1. Assists social worker in providing education and outreach about the HRIF program and services, clinical care, required documentation on transfer, and referral options, including outreach to NICUs with which there is a NICU Regional Cooperation Agreement (RCA), to CCS-approved community and intermediate NICUs and other community referral agencies, as appropriate.
2. Develops and provides education to caregivers and family members about the high risk infant's medical condition(s), care and treatment, special needs and expected outcomes of care.
3. Assists social worker in providing education to caregivers and family members about the system of care and for the high-risk infant.

F. **HRIF PROGRAM REPORTING REQUIREMENTS:**

1. The HRIF coordinator will be responsible for ensuring that data is collected and reported to CMS branch and CPQCC. The HRIF coordinator will:
   a. Coordinate the collection, collation and reporting of the required data.
   b. Ensure required data is submitted accurately and timely to the appropriate agencies, including CPQCC and State CMS Branch or as instructed.
   c. Ensures copies of all reports are submitted to the local CCS program and to the referring and primary care physicians involved in the care of the patient and documents provision of these forms in the patient chart.
   2. In collaboration with the NICU medical director, ensures that the HRIF program fully participates in the CMS branch program evaluation.
3. Provides data and information that is required for the evaluation.

G. **EXTERNAL LINKS:**

H. **REFERENCES:**

I. **APPROVAL PROCESS**

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

Tri-City Medical Center
Oceanside, California

DELETE - Information combined into Women and Newborn Services High Risk Infant Follow-Up Policy

WOMEN'S AND CHILDREN'S SERVICES MANUAL - NICU

SUBJECT: HIGH RISK FOLLOW UP CLINIC DIETICIAN, ROLE OF

ISSUE DATE: 2/07 REVISION DATE: 06/11, 8/12

Department Approval Date(s):	**12/15**
Division of Neonatology Approval Date(s):	**12/15**
Department of Pediatrics Approval Dates(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~A. **PURPOSE:**~~

~~1. To ensure that patients who meet the CCS criteria and who are at risk for inappropriate growth patterns or who have any nutritional disorder, as well as feeding intolerance receive appropriate assessments following discharge from the NICU.~~

~~B. **POLICY:**~~

~~1. It is the policy of TCMC to provide a nutritional assessment for those infants and children who are nutritionally at risk after leaving the NICU. An assessment by a dietician will be completed per clinical coordinator's request.~~

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

~~1. Participates in the multidisciplinary rounds with identification of HRIF patients.~~
~~2. Review patient's case history and familiarize self with prior visit outcomes.~~
~~3. Assess infants and children; report results to family/caregivers on nutritional assessment.~~
~~4. Document results.~~
~~5. Based on findings, recommends return to clinic.~~
~~6. Reports findings to physician.~~
~~7. Participates in patient care conference with SW/PT/OT, SLP, physician, and RN.~~

~~D. **EXTERNAL LINKS:**~~

~~E. **REFERENCE LIST:**~~

~~F. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

Information combined into
Women and Newborn Services
High Risk Infant Follow-Up Policy

WOMEN'S AND CHILDREN'S SERVICES - NICU

SUBJECT: HIGH RISK FOLLOW UP PROGRAM PHYSICAL THERAPIST, ROLE OF

ISSUE DATE: 2/07 REVISION DATE: 05/08, 06/09, 6/11, 8/12

Department Approval Date(s):	**12/15**
Division of Neonatology Approval Date(s):	**12/15**
Department of Pediatrics Approval Dates(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~A. **PURPOSE:**~~

~~1. To ensure that patients who are at risk for developmental delays receive appropriate assessments, as well as ensuring that the appropriate required forms from California Children's Services (CCS) will be sent to the designated CCS programs.~~

~~B. **POLICY:**~~

~~1. It is the policy of TCMC to provide developmental assessments for those infants and children who are at risk for developmental delays after leaving the Neonatal Intensive Care Unit (NICU). An assessment by a physical therapist will be completed.~~

~~C. **RESPONSIBILITIES RELATED TO THE HIGH RISK INFANT FOLLOW-UP (HRIF):**~~

~~1. The physical therapist will reserve and set up the rooms, remove and put away unneeded equipment, in preparation of the HRIF program.~~
~~2. Reads the patient's history and reports from any prior visits.~~
~~3. Provides a developmental assessment of the child's physical development; milestones achieved and compare to age appropriate levels of functioning.~~
~~4. Informs caregiver as well as the physician of the findings.~~
~~5. Provide findings to RN for documenting and inputting information to CCS via electronic forms.~~
~~6. Makes recommendations for any return visits to clinic or referrals to an outside agency for more intensive physical, occupational, and/or speech therapy issues, if appropriate, to the physician.~~
~~7. Disinfects toys, mats, and prepares the room between visits.~~
~~8. Assists in clean up of rooms at the end of the clinic and returns to previous condition.~~

~~D. **EXTERNAL LINKS:**~~

~~E. **REFERENCES:**~~

~~F. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

DELETE - Information incorporated into Women and Newborn Services High Risk Infant Follow-Up Policy

WOMEN'S AND CHILDREN'S SERVICES - NICU

SUBJECT: HIGH RISK INFANT FOLLOW-UP CLINIC REGISTERED NURSE, ROLE OF

ISSUE DATE: 1/08 REVISION DATE: 6/09, 6/11, 8/12

Department Approval Date(s):	**01/15**
Division of Neonatology Approval Date(s):	**01/15**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~A. **PURPOSE:**~~

~~1. To ensure that patients who are at risk for developmental delays, and who meet the CCS criteria, receive appropriate assessments following discharge from the NICU, in order to intervene and promote optimal outcomes for these infants and children.~~

~~B. **POLICY:**~~

~~1. It is the policy of TCMC to provide developmental assessments for those infants and children who are at risk for developmental delays after leaving the NICU. The clinic will be staffed with a CCS paneled registered nurse.~~

~~C. **RESPONSIBILITIES RELATED TO HIGH RISK INFANT FOLLOW-UP CLINIC (HRIF):**~~

~~1. Brings scale for weighing and other supplies to the HRIF program on clinic days.~~
~~2. Assures patient charts and past HRIF program information are in the clinic and all forms are in proper order.~~
~~3. Completes nursing assessment on each patient.~~
~~4. Assists the physician with the history and physical exam; assess weight, length and head circumference and documents in patient's chart.~~
~~5. Coordinates/participates in patient case conference with SW, PT/OT, MD, and dietician.~~
~~6. Coordinates clinic appointments and functions between visits with families and team members.~~
~~7. Assists others in assuring that all forms, including CCS forms, are completely filled in.~~
~~8. Assists the HRIF team in implementing team recommendations for the HRIF program.~~
~~9. Assists with contacting the caregivers two weeks before the appointment to remind them of the upcoming HRIF appointment.~~
~~10. Communicates with HRIF coordinator regarding clinic issues and needs.~~
~~11. Assists Coordinator and Social Worker in documenting and inputting information to CCS via electronic forms.~~

~~D. **EXTERNAL LINKS:**~~

~~E. **REFERENCES:**~~

~~F. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. 0Board of Directors~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Unit

SUBJECT: **Co-treatment of Patients**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16

Department Approval Date(s):	**11/15**
Division of Psychiatry Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **PURPOSE:**

1. To provide guidelines on provision of physician Co-Treatment of patients by attending psychiatrists.

B. **POLICY:**

1. Co-treatment by attending psychiatrists will be facilitated if a patient has a primary psychiatrist in the community who will continue to manage medications while patient is attending the program. The Program physician will oversee treatment of the patient in Behavioral Health Outpatient program and will collaborate with the community physician with regard to medications, and post Program follow up. Co-treatment will be directed and certified as medically necessary by the attending program psychiatrist.

C. **PROCEDURES:**

1. Who May Perform/Responsible: Psychiatrists
   a. Patients will be admitted and followed by an attending Program psychiatrist. The Program psychiatrist will complete the admission order, and psychiatric evaluation. Monthly progress notes will be completed by the psychiatrist and/or Allied Health Professional (AHP) and will indicate medical necessity and patient's progress toward treatment goals.
   b. The Program psychiatrist and AHP will be encouraged to communicate regularly with the community psychiatrist to update him/her on the patient's progress and any medication issues.
   c. The Program psychiatrist will direct all treatment planning. The co-treating physicians are informed regarding any patient concerns and treatment progress.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Unit

SUBJECT: **Physician Progress Note**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16

Department Approval Date(s):	**11/15**
Division of Psychiatry Approval Date(s):	**01/16**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **PURPOSE:**
1. To define expectations for Physician and Allied Health Professional's (AHP's) Progress Notes.

B. **POLICY:**
1. All patients are evaluated on a regular basis by the attending psychiatrist or AHP.

C. **PROCEDURES:**
1. Who May Perform / Responsible: Program psychiatrist
   a. Physicians and AHP's are expected to evaluate patients and complete a progress note at least monthly for all Outpatient Behavioral Health Service (OPBHS) patients.
   b. Physicians must see the patient periodically to oversee the care and ensure quality of services delivered in OPBHS.
   c. Physicians must review AHP's notes to ensure quality care provision.
   d. Open problems on the treatment plan should be addressed in the progress notes.
   e. The progress note is to include a mental status exam, treatment plan, and justification for continued treatment, interval history, medication changes and any changes in diagnosis.
   f. All progress notes are signed, dated and filed in the medical record.

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

SUBJECT: **Discharge Planning**

ISSUE DATE: **11/2010**
REVISION DATE: **11/10, 12/10, 06/12, 11/12, 4/14, 03/16**

Department Approval Date(s):	**11/15**
Utilization Review Committee Approval Date(s):	**11/15**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **PURPOSE:**
1. To collaborate with patient and/or family and/or their representative to assess, facilitate, plan and advocate for the patients' ongoing needs on an individual basis. Through collaboration with the multidisciplinary team members as needed, the Case Manager shall initiate and implement an individualized transition plan (discharge plan) as necessary, through monitoring and re-evaluation to accommodate changes in treatment or progress.
2. The discharge planning process applies to all Inpatients; discharge planning is not required for outpatients.

B. **POLICY:**
1. Refer to Patient Care Services Policy: Discharge Planning for additional information.

C. **RELATED DOCUMENTS:**
1. PCS Policy: Discharge Planning

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: AUDIOLOGY SERVICES

SSUE DATE: 12/02
REVISION DATE(S): 1/06, 1/09, 5/12, 03/16

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY**:
1. Audiology Service Provider is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
2. Audiology Staff reports to the Leadership Structure in fulfilling duties responsibilities

B. **REQUESTS FOR SERVICE:**
a. All requests for audiology services must be in the form of a written prescription from a licensed physician or non-physician practitioner.
b. Verbal requests for audiology services will be accepted, but must be followed by a written.
c. The speech pathology department will notify the licensed and contracted audiologist.

C. **HOURS OF SERVICE:**
1. The audiologist will respond to order within 72 hours and will set up a time to complete the evaluation.

D. **RESPONSIBILITIES:**
1. Provides audiology evaluations and treatment as prescribed by a licensed physician or non-physician practitioner.
2. Administers a pure tone audiometric assessment using standardized testing equipment and techniques to evaluate patient's hearing status.
3. Develops recommendation for each individual based upon the individual's medical condition, assessment and personal goals.
   a. Makes recommendations regarding assistive hearing devices as needed.
   b. Refer patients for further assessment or to other services and agencies as needed.
4. Documents patient treatment and treatment outcomes in patient's legal record .
5. ASHA Preferred Practice Patterns for the Profession of Audiology. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.
6. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.
7. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.

8. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

E. **REFERENCE LIST:**

1. American Speech-Language-Hearing Association. (2004). *Scope of practice in audiology*. Available from www.asha.org/policy.
2. Centers for Medicare & Medicaid Services. (2015, May). *Therapy Services.* Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
3. Centers for Medicare & Medicaid Services. (2015, May). *Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.* Retrieved from www.cms.gov

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: DISCHARGE CRITERIA **POLICY NUMBER: 501**

ISSUE DATE: 10/88
REVISION DATE(S): 1/91, 1/94, 4/95, 9/97, 3/00, 1/06, 3/12, 03/16

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY:**

1. To establish guidelines for discharging patients from Physical Therapy, Occupational Therapy, Speech Therapy, and Therapeutic Recreation Services.

B. **PROCEDURE:**

1. Criteria
   a. Rehabilitation Services are no longer clinically indicated and medically necessary for the treatment of the individual's illness or injury.
   b. There are no longer valid expectations for significant practical improvement in the level of functioning within a reasonable length of time. Care is at a maintenance level.
   c. Specified goals and/or prior level of function have been met.
   d. With surgery or major medical complication, patient treatment will be put on hold or the patient will be considered for discharge pending physician or non-physician practitioner orders.
   e. The patient's mental function is insufficient to participate or recall information and no family nor caregiver available for training.
   f. Failure to show for two consecutive outpatient appointments without notification.
   g. Patient is unable or repetitively refuses to follow through with the established treatment plan as established upon therapy evaluation.
   h. Patient is transferred to another facility, discharged from the hospital, or expires.
2. Process
   a. It is the responsibility of the physician to determine discharge from the Rehabilitation Service the patient is receiving.
   b. In the course of treatment, the therapist may determine the patient no longer requires therapy services, or that intervention for the medical problem for which services were being provided is no longer indicated, and is documented in the Medical Record.
   c. A discharge summary may be documented in the medical chart showing progress or lack of progress made during the therapy sessions. A final progress note or discharge summary is sent to the referring physician for Outpatient Services.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Documentation of Progress Note and Discharge Summary**

ISSUE DATE: **7/91**
REVISION DATE(S): 2/94, 9/97, 1/00, 1/03, 1/06, 1/09, 5/12, 03/16

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY:**

1. All documentation of treatments performed will adhere to Centers for Medicare and Medicaid Services (CMS) Guidelines in accordance with Medicare Benefits Policy Chapter 15 Section 220.0 through 220

B. **PROCEDURE:**

1. Information regarding progress will be displayed in the patient's medical record. Progress notes or discharge summaries will be documented on the appropriate form and will be provided for referring or treating physicians.
2. Documentation must reflect status regarding the long and/or short-term goals that have been met or which have been modified if necessary, the plan of care for continued treatment, if indicated, or any changes in focus or frequency of treatment, including discharging current services.
3. Each documentation for progress note or discharge summary may include, but is not limited to the following information:
   a. Background information with admitting diagnosis, evaluation date, admitting physician, type of therapy and total therapy visits to date
   b. Objective measure of therapy outcome for current goals.
   c. Assessment of patient's deficits, strengths, and rehabilitation potential, and education provided according to patient/family education needs
   d. Recommended plan of care or termination of skilled therapy services, which may or may not include updating functional short and/or long-term goals, and prognosis
   e. Therapist's signature and/or co-signature for supervised providers as indicated.

C. **REFERENCE LIST:**

1. Centers for Medicare and Medicaid Services. (2014, December 31). *Medicare Benefits Policy, Chapter 15, Section 220.0-220.4.* Retrieved July 3, 2015, from www.cms.gov: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Delete Policy Included In Physical Agent Modality Procedure

TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE: 10/07	**SUBJECT: MODALITIES USED – THERMAL AGENTS**
REVISION DATE: 4/12	**STANDARD NUMBER: 616**
REVIEW DATE: 1/09	**CROSS REFERENCE:**
	APPROVAL:

Department Approval Date(s):	**08/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**02/16**
Board of Directors Approval Date(s):	**03/16**

This Policy / Procedure applies to the following Rehabilitation Services' locations:

☑ 4002 Vista Way, Oceanside, CA

☑ 2124 El Camino Real, Suite 100, Oceanside, CA

☑ 6250 El Camino Real, Carlsbad CA

A. PURPOSE

1. To establish guidelines to administer treatment with use of thermal agents to a patient.
2. To outline indications and contraindications to treatment with use of thermal agents.

B. POLICY

1. Indications for use: reduce pain, reduce muscle spasm/trigger points, promote relaxation, increase extensibility of superficial tissue, and reduce stiffness of superficial joints.
2. Contraindications for use: acute injury, poor circulation to the direct and surrounding area being treated, decreased sensation, decreased mental status, patients with decreased thermoregulatory function (geriatric, infant and pediatric populations), patients with skin or lymphatic cancer, infected skin lesions.

C. PROCEDURE

1. Before beginning all application of thermal agents:
   a. Explain the purpose and what to expect
   b. Position and drape the patient appropriately
   c. Inspect the area to be treated for open or infected wounds, or indications of circulatory problems
2. Commercial hot packs – made of silica gel in a canvas cover

~~a. Technique for application:~~
~~(1) Place six to twelve layers of toweling between the patient and the hot pack.~~
~~(2) Cover pack with additional towels if needed.~~
~~(3) Secure the hot pack so it does not slip off the patient.~~
~~(4) Erythema is normal; mottled erythema indicates overheating, and hot pack should be removed.~~
~~(5) Keep call light/bell within patient's reach for assistance.~~
~~(6) With appropriate layering, patients can lie on top of the hot packs.~~
~~b. Treatment duration: per recommendation of the treating therapist/therapist assistant, after 20 minutes if continued heating is required, the pack should be replaced.~~

~~3. Paraffin – mixture of paraffin wax and mineral oil melted in a paraffin bath tank.~~
~~a. Specific contraindication to paraffin: open wounds on the extremity being treated.~~
~~b. Technique for application:~~
~~(1) Remove all jewelry and wash extremity.~~
~~(2) Check temperature of paraffin bath to ensure the range is between 118º and 130º Fahrenheit.~~
~~(3) Dip extremity into the tank, then remove and let wax harden.~~
~~(4) Keep fingers or toes abducted during the application.~~
~~(5) Repeat the dip-and-harden process 8 to 10 times.~~
~~(6) Wrap the extremity being treated in a plastic bag, then a towel to retain the heat.~~
~~(7) If a potential for pooling edema exists, then elevate the extremity above the heart during treatment.~~
~~c. Treatment duration: per recommendation of the treating therapist/therapist assistant, 10-20 minutes.~~

~~4. Fluidotherapy – machine containing a heating element, either tiny silicon or corn-cob particles, in an enclosed container.~~
~~a. Technique for application:~~
~~(1) Wash and dry part to be treated.~~
~~(2) Remove all jewelry.~~
~~(3) Check for open wounds; if present, then cover extremity with a plastic bag prior to insertion.~~
~~(4) Insert extremity into the machine and close sleeve around it.~~
~~(5) Patient can exercise or stretch the extremity while being treated.~~
~~b. Treatment duration: per recommendation of the treating therapist/therapist assistant, up to 20 minutes.~~

TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside, California

DELETE – Duplication of NICU HRIF Policy

REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE: 10/91	**SUBJECT:** **NICU FOLLOW-UP: HIGH RISK INFANT FOLLOW UP (HRIF)**
REVISION DATE: 1/94, 5/97, 3/00, 1/06, 6/12	**STANDARD NUMBER: 604**
REVIEW DATE: 1/03	**CROSS REFERENCE:**
	APPROVAL:

Department Approval Date(s):	**01/15**
Division of Neonatology Approval Date(s):	**01/15**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☐ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☐ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To provide periodic follow-up developmental assessments of high-risk infants discharged from TCMC's NICU, from birth to 3 years of age.~~
~~2. To make referrals to appropriate community services.~~
~~3. To provide education to parent/caregiver regarding infant's/child's developmental status, with a home program provided as needed.~~

~~B. POLICY~~

~~1. A developmental assessment shall be provided for all eligible high-risk infants following discharge from the NICU.~~

~~C. PROCEDURE~~

~~1. Eligibility for high-risk infant (HRI) follow-up program:~~
~~a. Infants discharged from a CCS (California Children Services)-approved NICU without a CCS-eligible condition, but who continue to be at risk of developing a CCS-medically eligible condition, shall be followed for the first three years of life. Infants who are discharged from a CCS-approved hospital after transfer from an approved NICU are similarly eligible.~~
~~2. Criteria for HRI follow-up shall include one or more of the following:~~
~~a. Weight less than 1,500 grams at birth/or gestational age at birth was less than 32 weeks.~~
~~b. Assisted ventilation for longer than 48 hours during the first 28 days of life.~~
~~c. Prolonged perinatal hypoxemia, acidemia, and symptomatic neonatal hypoglycemia.~~
~~d. Cardiorespiratory depression at birth which may include: infants with Apgar scores 0-3 at 5 minutes, infants who fail to institute spontaneous respiration by 10 minutes, and infants with hypertonia persisting to 2 hours of age.~~
~~e. History of seizure activity.~~
~~f. Documented intracranial abnormality or pathology, including intracranial hemorrhage (other than Grade 1 intraventricular) and cerebral thrombosis.~~
~~g. Other potential neurological problems (i.e. history of central nervous system infection, bilirubin in excess of usual exchange transfusion level, etc.).~~
~~h. Major congenital anomalies.~~
~~3. Eligible infants shall receive the following evaluations:~~

a. An interim comprehensive history and physical examination (including neurological assessment) at 4-6 months, 9-12 months, and 18-36 months corrected age. Evaluation is done by a physician.
b. A development assessment (equivalent to the Bayley Screening Test) at ages specified above. This may be done by a physician, nurse practitioner, physical therapist, occupational therapist, speech therapist, or a developmental specialist – all with training in the evaluation of motor, sensory, language and social development of high-risk infants.
c. A family psychosocial assessment is performed when requested by a parent, at least one time during the follow-up period, by a clinical social worker with expertise in this area or by the assessment team.

4. The following evaluations may also be scheduled:
   a. Audiological Screening: It is expected that all infants will be screened prior to discharge. Infants not screened in the hospital or infants whose hospital screening was abnormal should be screened once through the HRI Outpatient program. Infants in need of a more definitive evaluation or those requiring a long-term diagnostic evaluation should be referred to the general CCS program for such diagnostic follow-up until a suspected diagnosis is either established or ruled out.
   b. Ophthalmologic assessment to be performed by a CCS-paneled ophthalmologist. For evaluation of retinopathy of prematurity, infants should be examined at 4-6 weeks of life if clinical condition permits; subsequent examinations should be performed until retinae are mature, as deemed appropriate by the ophthalmologist. (In general, the retinae are considered mature by 42 weeks, post-conceptual age.) Outpatient visits may be scheduled.
5. Scheduling
   a. The neonatologist screens all NICU-discharged patient charts for appropriate candidates. The clinical coordinator contacts the infant's parent to schedule clinic appointment at intervals outlined above via telephone and by mail. Each infant is seen at a 1:1 ratio for the above evaluations, which lasts generally for 1 hour.
6. Referrals
   a. Based on clinical findings referrals are made by Social Services and therapists to outside agencies utilizing a referral list (see attached).
   b. Referral outcomes are reviewed via returned information from agencies and subsequent HRIF visits.
7. Documentation
   a. Documentation of all findings is recorded in the patient's medical record located in Medical Records Department for 21 years, as per Medical Records' Storage & Retention Policy & Procedure.
8. Review
   a. The HRIF procedures and care provided are reviewed via the Medical Center's Quality Assurance Program.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Occupational Therapy Policy **POLICY NUMBER: 702**

ISSUE DATE: 09/91
REVISION DATE(S): 01/94, 09/97, 03/00, 01/03, 01/06, 01/09, 03/10, 04/12

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY:**

1. Occupational Therapy is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
2. Occupational Therapy Staff reports to the Leadership Structure in fulfilling duties and responsibilities.

B. **PROCEDURE:**

1. Requests For Service
   a. All requests for occupational therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP).
   b. Verbal requests for occupational therapy services will be accepted, but must be followed by a written order.
   c. A new order is required for any change in medical status or treatment ordered.
2. Hours Of Service
   a. Inpatient care: Monday through Sunday, 0800 to 1630 for inpatient care.
   b. Outpatient: Monday through Friday, 0700 to 1630.
   c. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities
   a. Provides occupational therapy evaluations and treatment as prescribed by a licensed physician or AHP.
   b. Administers an assessment of Occupational Performance.
   c. Develops an Intervention Plan for each individual with designated goals based upon the individual's medical condition, assessment and personal goals.
   d. Develops Outcomes and Measures to assess the individual's progress or regression.
   e. Implements the Intervention Plan, utilizing specific activities or methods to develop or restore function, compensate for dysfunction or minimize debilitation.
   f. Engages in Intervention Plan Review, modifying treatment based on established Outcomes and Measures, as clinically indicated and medically necessary.
   g. Treatment may include but is not limited to:
      i. Use of therapeutic tasks and purposeful activities to promote psychological, cognitive, physical, sensory integrative and developmental functioning.
      ii. Facilitate and educate in graded self-care and daily-living tasks, socialization skills, pre-vocation skills, vocational roles, and community reintegration with regard to patients' privacy and dignity. This may involve instructing in the use of

compensatory techniques; selecting, constructing and instructing in the use of adaptive devices, orthoses, and prostheses; ordering appropriate equipment and recommending adaptation of the individual's physical environment to enable optimal function.

iii. Use of exercises and other specific techniques such as those to promote relaxation, restore movement, strength and posture in preparation for functional training.

h. Documents patient treatment and treatment outcomes in patient's legal record per American Occupational Therapy Association/Centers for Medicare and Medicaid Services Guidelines for Documentation of Occupational Therapy.

i. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.

j. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.

k. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.

l. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

C. **REFERENCES:**

1. American Occupational Therapy Association.(2014).Occupational therapy practice framework: Domain and process (3rd ed.).*American Journal of Occupational Therapy, 68*(Suppl.1), S1–S48.http://dx.doi.org/10.5014/ajot.2014.682006
2. Gloria Frolek Clark, M. J. (2013). Guidelines for Documentation of Occupational Therapy. (T. C. 2012, Ed.) *American Journal of Occupational Therapy, 67*(November/December), 32-38.
3. Centers for Medicare & Medicaid Services. (2015, May). *Therapy Services.* Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
4. Centers for Medicare & Medicaid Services. (2015, May). *Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.* Retrieved from www.cms.gov:

DELETE this policy. This information is included in the Dept Policy and Documentation

TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

~~**ISSUE DATE:** 7/94~~	~~**SUBJECT: PATIENT AND CAREGIVER EDUCATION**~~
~~**REVISION DATE:** 9/97, 3/00, 12/03, 1/06~~	~~**STANDARD NUMBER: 507**~~
~~**REVIEW DATE:** 1/03, 1/09, 4/12~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL:**~~

Department Approval Date(s):	**08/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To define the role of Rehabilitation Services in patient/caregiver education.~~

~~B. POLICY~~

~~1. Patient and caregiver education is an integral aspect of evaluation and treatment in the Rehabilitation Services Department.~~

~~2. Patients and caregivers will be instructed in the aspects of rehabilitation as they pertain to the individual patient with consideration of level of alertness, age-specific considerations, cultural, religious practices, emotional barriers, desire and motivation to learn, physical and cognitive limitations, language barriers, and financial implications of care choices, and as identified through the evaluation process.~~

~~3. Areas of patient or caregiver education may include but are not limited to instruction in the use of:~~

~~a. Home exercise program~~
~~b. Home evaluations~~
~~c. Worksite evaluations~~
~~d. Safety awareness including precautions specific to diagnosis~~
~~e. Leisure counseling~~
~~f. Adaptive equipment~~

~~C. PROCEDURE~~

~~1. A variety of training methods are used, such as demonstrations, handouts, booklets, multimedia, and verbal discussions.~~

~~2. The therapist assesses the patient's/caregiver's learning needs, abilities, preferences, and readiness to learn.~~
~~3. The therapist ensures that the patient or caregiver is competent to follow through with the therapy instructions and home exercise programs and observe precautions through demonstration by the patient and/or family. If competency is not achieved, reasons are documented (e.g. patient refusal, cognition impaired, etc.)~~
~~4.~~**1.** ~~The therapist will document evidence of any patient/caregiver training, as well as response to instruction in the therapy progress notes in the medical chart.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Physical Therapy**

ISSUE DATE:
REVISION DATE(S): 1/91, 1/94, 9/97, 3/00, 1/03, 1/06, 1/09, 3/10, 4/12, 03/16

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY:**

1. Physical Therapy is accountable through the Rehabilitation Services Leadership Team and/or Medical Director of the rehabilitation program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate Administrative Executive to the Administrator for carrying out the policies and procedures as approved by the Governing Board.
2. Physical Therapy staff report directly to the Rehabilitation Services Leadership Team in fulfilling duties and/or responsibilities.

B. **PROCEDURE:**

1. All requests for Physical Therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP). AHP must be working in collaboration with a physician.
2. Verbal requests for Physical Therapy services will be accepted, but must be followed by a written prescription.
3. A new signed prescription is required for any change in medical status or treatment ordered.
4. Outpatient appointments are scheduled between 0700 and 1800 Monday through Friday.
5. Inpatients are seen between 0800 and 1630 Monday through Sunday according to prioritization policy.
   a. Therapy provision may occur outside of these time frames on an as needed basis.
6. Physical Therapy evaluations and treatment will be provided as prescribed by a licensed physician or an AHP.
7. Appropriate assessments/tests will be administered to develop a treatment plan.
8. A written treatment plan will be provided with time frames for each individual with designated functional goals, based upon the individual's medical condition, evaluation and test results, and personal goals.
9. Initial and ongoing treatment will be implemented utilizing specific activities or methods to develop or restore function, relieve pain, compensate for dysfunction or minimize debilitation. Treatment may include but is not limited to:
   a. The use of physical agents such as thermotherapy, cryotherapy, hydrotherapy, electrical stimulation, ultrasound, and mechanical traction.
   b. Therapeutic exercise and activities, manual therapy and joint mobilizations.
   c. Neuromuscular re-education, gait training, vestibular integration.
   d. Manual lymphatic drainage and bandaging.
10. Treatment will be modified based upon progression towards therapeutic goals as clinically indicated and medically necessary.

11. Patient treatment and treatment outcomes will be documented in the patient's legal record according to appropriate documentation policies.
12. Patient's physician will be provided with a written summary of the patient's evaluation, progress and designated discharge plan for treatments.
13. All therapy equipment will be maintained in quality condition.
    a. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.
14. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.
15. Appropriate operational and administrative records will be maintained, may include but not limited to licensure, certifications, timecards, training records, and billing sheets.
16. Reporting and consulting with appropriate healthcare professionals regarding patient's current status will be maintained and documented.

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

1. Documentation of Evaluations
2. Documentation of Daily Notes
3. Documentation of Progress Notes
4. Documentation of Discharge Summaries

D. **REFERENCE LIST:**

1. California Physical Therapy State Practice Act. (n.d.). Physical Therapy Board of California. Retrieved July 7, 2015, from Physical Therapy Board of California Website: http://leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2620-2634

SUBJECT: **PRE-OP TEACHING**

ISSUE DATE: **6/93**
REVISION DATE(S): **2/94, 1/97, 6/97, 1/06, 1/09, 5/12, 03/16**

Department Approval Date(s):	**08/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **PURPOSE:**

1. A physical therapist and occupational therapist will provide education for total joint replacement patients at the Pre-Op Class, including precautions, safety instructions with daily activity, and exercise plan.

B. **PROCEDURE:**

1. The Pre-Op Class schedule will be provided by the Ortho-Spine Institute and patients will be encouraged to attend.
2. The pre-op teaching will include emphasis on safety and early mobilization.
3. The following is an overview of the anticipated course of treatment:
   a. Initial visits (Day of Surgery or Post-Op Day 1) :
   b. Instruction by a therapist to include:
      i. Evaluate affected joint range of motion
      ii. Evaluate unaffected joints range of motion and strength
      iii. Evaluate general mobility:
         1) Bed mobility
         2) Transfer to side of bed; dangle
         3) Stand with walker; attempt steps
      iv. Evaluate Activities of Daily Living (ADLs), discuss Durable Medical Equipment (DME)
      v. Instruct in precautions
      vi. Weight bearing status if applicable
      vii. Fall prevention education and provide equipment resource information.
      viii. Follow-up visits (try to remember to ask for pain medication prior to therapy session)
      ix. Transfer and bed mobility; keep in mind THR precautions
      x. Gait training:
         1) Instruct in use of walker or crutches, whichever is appropriate for each individual patient
         2) Training on stairs or curb
      xi. Exercise program: Review protocol exercises.

SUBJECT: Scope of Services

ISSUE DATE: 7/91
REVISION DATE(S): 1/94, 5/95, 4/97, 10/00, 5/01, 2/03, 1/06, 1/09, 3/12, 03/16

Department Approval Date(s):	**07/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **POLICY:**

1. The Department of Rehabilitation Services includes Physical, Occupational, and Speech Therapies, Audiology, and Therapeutic Recreation. Using a multidisciplinary collaborative team approach, services and programs are available to meet the needs of all patients with a wide variety of diagnoses, including physical and psychosocial disabilities. The overall objective of the Department is to foster a healing environment for patients to regain their functional independence in all areas of daily life as rapidly as possible. Assessment identifies the patient's physical, cognitive, behavioral, communicative, emotional and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include:
   a. Emotional, behavioral or mental disorders
   b. Cognitive disorders
   c. Communicative disorders
   d. Developmental disabilities
   e. Vision or hearing impairments or disabilities
   f. Physical impairments or disabilities
   g. Pain interfering with optimal level of function or participation in rehabilitation
2. Each patient, inclusive of neonatal through geriatric ages, will be treated with dignity and respect. Optimal health care services will be delivered to each patient regardless of gender, size, disability, race, creed, or ethnic origin.
3. Physical Therapy - The goals of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning. Physical Therapy Services shall include, but are not limited to, evaluation/assessment, development of treatment plans and goals, instruction, education and consultation services.
4. Occupational Therapy - The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skills required for daily living activities. Services include evaluation and treatment for impairments of physical, psychosocial, cognitive, developmental and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and compensate for or cope with disabling conditions.
5. Speech Pathology - Speech-Language Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders. These include, but are not limited to, impairments of articulation, language comprehension and expression, cognition, fluency, voice, reading, writing and swallowing. Education and counseling for families of patients exhibiting the aforementioned disorders are also provided.

6. Audiology Services – Audiology Services include assessment of hearing acuity and status in patients who may be at risk for changes in hearing due to medical or treatment issues, including medication, age or diagnosis. Instruction and education of patients and family members is provided to increase the involved person's understanding of their deficits.
7. Therapeutic Recreation - Therapeutic Recreation Services provide goal-oriented programs that promote wellness and improve the patient's quality of life through leisure. Therapeutic Recreation treatment may be individual or done in groups. Services include, but are not limited to, leisure assessment and evaluation, skill development, social programs, special events, leisure education, leisure counseling and resource development. Family education and counseling are included to improve patient's attitude, skill level and socialization.

SUBJECT: Speech Pathology Services Department Policy
ISSUE DATE: 7/88
REVISION DATE(S): 1/91, 1/94, 3/97, 1/00, 1/03, 1/06, 1/09, 5/12, 03/16

Department Approval Date(s):	**08/15**
Department of Medicine Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

A. **DEFINITION(S):**

1. Speech: The production, intelligibility and fluency of verbalization, to include articulation of phonemes, rate of speech, prosody, phrasing and motor planning, and sequencing of speech.
   a. Disorders of speech may include:
      i. Dysarthria: Distorted articulation and/or prosody, secondary but not limited to cerebrovascular accident, brain injury, Parkinson's Disease, amyotrophic lateral sclerosis, myasthenia gravis, multiple sclerosis, cerebral palsy, or oral cancer.
      ii. Apraxia of Speech: Inability to plan and sequence motor movements efficiently for speech production, secondary but not limited to cerebrovascular accident or brain injury.
      iii. Developmental Phonological or Articulation Delay or Disorder: Misarticulations, phonological processes or deficits in phonological awareness.
      iv. Dysfluency: Repetitions of sounds or words, inappropriate cessation of speech or secondary characteristics involving facial or body movements, or abnormally fast or irregular speech rate
2. Language: The arbitrary set of symbols which has meaning and which is used for interpersonal communication. Receptive language skills involve the comprehension of spoken, visual, or written language. Expressive language skills involve the formulation of verbal, gestural, augmentative or written language to communicate thoughts and needs.
   a. Disorders of Language may include:
      i. Receptive Aphasia: Impaired comprehension of verbal or written language.
      ii. Expressive Aphasia: Impaired expression of verbal or written language.
      iii. Alexia: Impaired comprehension of written language.
      iv. Agraphia: Impaired expression of written language.
      v. Developmental Language Delay: Impairment in development of language function.
      vi. Pragmatics: Interpretation and use of nonverbal language including facial expression, body language, gestures, appropriateness of actions based on setting, company and prosody
3. Voice: Phonation through respiratory support and approximation of the vocal cords, in the parameters of quality, pitch, loudness and resonance.
   a. Disorders of Voice may include impairments in the following areas:
      i. Volume: Vocal loudness insufficient or excessive for the speaker's size, age, or gender.
      ii. Pitch: Vocal pitch inappropriate for the speaker's size, age, or gender
      iii. Quality: Altered vocal quality, including hoarseness, breathiness, harshness, or aphonia.

iv. Resonance: Imbalanced nasal resonance

4. Cognition: The skills of orientation, attention, memory and executive function.
   a. Disorders of Cognition may include:
      i. Disorientation: Inability to identify personal, temporal, spatial, and general information
      ii. Decreased attention: Inability to attend to stimuli appropriately.
      iii. Memory impairment: Decreased short-term, long-term immediate and working memory for information presented in verbal, visual, written or tactile modalities.
      iv. Executive function impairment: Decreased insight, awareness of deficits, problem-solving, safety awareness, reasoning, thought organization, insight and/or initiation, management off attention.
5. Swallowing: The functional oropharyngeal process involved in swallowing various consistencies of food, liquids, and own oral secretions.
   a. Disorders of swallowing many include:
      i. Oral or pharyngeal dysphagia: Impairment in oral or pharyngeal swallow function.
      ii. Oral feeding disorder: Inability to tolerate various consistencies of foods and/or liquids secondary to but not limited to oral weakness, dyscoordination, aversion or tactile defensiveness.

B. **POLICY:**
1. Speech-Language Pathology services will be available to inpatients, acute rehabilitation patients, and outpatients at Tri-City Medical Center.

C. **PROCEDURE:**
1. Speech Pathology service personnel are accountable per rehabilitation services leadership structure and/or the Medical Director of each program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate administrative executive to the administrator for carrying out the policies and procedures as approved by the Governing Board.
   a. Administer appropriate assessment.
   b. Provide a written plan/report for each individual including history, results, recommendations, plan, treatment and education with designated goals based upon the individual's medical status, evaluation and test results, considering personal goals, when appropriate Provide Speech Therapy evaluation and treatment as prescribed by a licensed physician.
   c. Provide Speech Therapy treatment as the licensed therapist deems appropriate with a plan of care signed off on by a licensed physician, nurse practitioner, or physician's assistant.
   d. Implement initial and ongoing treatment program utilizing specific activities or methods to develop or restore functional communication, cognition, or swallowing, compensate for dysfunction or minimize debilitation.
   e. Modify treatment program or diet consistency recommendation based upon progress, lack of progress or regression, or as requested by the patient's physician.
   f. Provide documentation of patient's progress in medical chart on a daily, weekly and/or monthly basis.
   g. Provide patient's physician with a written summary of the patient's progress and recommended discharge plan.
   h. Maintain all therapy equipment in safe and functional condition.
   i. Secure and conserve therapeutic equipment and supplies.
   j. Maintain and implement the departmental budget in a manner that maintains designated income and expense ratios.
   k. Maintain appropriate operational and administrative records.
   l. Maintain ongoing reporting and consultative roles with appropriate health care professionals regarding patient's current communicative and swallowing status.

m. Provide educational in-services regarding speech pathology evaluation and treatment approaches, the nature of communication and swallowing disorders, diagnostic and therapeutic approaches to the deficits, and measures to prevent or alleviate communication and swallowing disorders.

DELETE. MERGED WITH
Modified Barium Swallow
POLICY #803

TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE: 8/99	SUBJECT: SWALLOW EVALUATIONS: POWER OUTAGE/SYSTEM FAILURE
REVISION DATE: 1/03, 1/06, 1/09, 5/12	STANDARD NUMBER: 804
REVIEW DATE: 1/00	CROSS REFERENCE:
	APPROVAL:

Department Approval Date(s):	08/15
Department of Medicine Chiefs Approval Date(s):	02/16
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	02/16
Professional Affairs Committee Approval Date(s):	03/16
Board of Directors Approval Date(s):	03/16

This Policy / Procedure applies to the following Rehabilitation Services' locations:

☑ 4002 Vista Way, Oceanside, CA

☐ 2124 El Camino Real, Suite 100, Oceanside, CA

☐ 6250 El Camino Real, Carlsbad CA

A. PURPOSE

1. To provide for the event of no accessibility to videofluoroscopy equipment in the event of an extended power outage.

B. POLICY

1. In the event of an extended power outage, disabling fluoroscopy equipment, Clinical Swallow Evaluations will be substituted for Modified Barium Swallow studies.

C. PROCEDURE

1. Orders will be addressed in the order of time received, unless otherwise indicated.
2. Food and liquid will be provided by Food and Nutrition Services.
3. Until equipment is available, orders for Modified Barium Swallow studies will be addressed as a Clinical Swallow Evaluation, as follows:
   a. Complete Clinical Swallow Evaluation.
   b. Report results and recommendations to physician, as communication systems will allow.
   c. Swallow precautions will be posted, as indicated.
   d. Findings, precautions, strategies will be discussed with physician(s), nursing staff, patient, and caregivers, as appropriate.
   e. Determination will be made if Modified Barium Swallow study is indicated upon restoration of power/equipment availability.

DELETE this policy. It is included in policy #901 Therapeutic Recreation Department Policy

~~TRI-CITY MEDICAL CENTER~~
~~4002 Vista Way, Oceanside, California~~

~~REHABILITATION SERVICES POLICY MANUAL~~

~~**ISSUE DATE:** 9/91~~	~~**SUBJECT: THERAPEUTIC RECREATION: ACUTE CARE**~~
~~**REVISION DATE:** 1/94, 2/97, 3/00, 1/03, 1/06~~	~~**STANDARD NUMBER: 904**~~
~~**REVIEW DATE:** 1/09, 4/12~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL:**~~

Department Approval Date(s):	**08/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☐ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☐ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To provide patient with the opportunity for the development and participation in appropriate leisure activities.~~

~~B. POLICY~~

~~1. Patients who are referred to Therapeutic Recreation will be evaluated for treatment if patient can be set up on an independent leisure program or supervised by Nursing.~~

~~C. PROCEDURE~~

~~1. A physician's order is required for Therapeutic Recreation.~~
~~2. Patients will be evaluated within 3-5 days of receiving order, and appropriate treatment plan will be established.~~
~~3. Patients will be seen at bedside unless otherwise indicated. Leisure materials may be left for unsupervised individual use at bedside, with Nursing informed as to safety issues and program continuity.~~
~~4. Therapeutic Recreation staff will document initial evaluation and progress note in the patient's record.~~
~~5.~~**1.** ~~Priority will be given to patients on the Acute Rehab Unit. Patient coverage for acute, including maternity, is subject to staffing availability.~~

DELETE this policy.
Included in Physical Agent Modalities Procedure

~~TRI-CITY MEDICAL CENTER~~
~~4002 Vista Way, Oceanside, California~~

~~REHABILITATION SERVICES POLICY MANUAL~~

~~ISSUE DATE: 10/07~~	~~SUBJECT: TRACTION – CERVICAL & LUMBAR~~
~~REVISION DATE: 4/12~~	~~STANDARD NUMBER: 617~~
~~REVIEW DATE: 1/09~~	~~CROSS REFERENCE:~~
	~~APPROVAL:~~

Department Approval Date(s):	**08/15**
Department of Medicine Chiefs Approval Date(s):	**02/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval Date(s):	**03/16**

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☐ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To establish guidelines to administer treatment with the use of mechanical lumbar and cervical traction to a patient.~~

~~2. To outline indications and contraindications to treatment with the use of mechanical lumbar and cervical traction.~~

~~B. POLICY~~

~~1. Indications: Patients who will benefit from traction include those with radicular compression, facet joint pathology, muscle spasms, and disc problems, such as disc protrusions and degenerative disk disease.~~

~~2. Effects~~

~~a. Mechanoreceptor stimulation (pain modulation)~~
~~b. Elongation of the long ligaments (disc centripetal effect)~~
~~c. Increased extensibility of the soft tissues~~
~~d. Pump action at segment~~

~~3. Results~~

~~a. Reduction of pain and spasm~~
~~b. Reduction of the externality of the disc lesion~~
~~c. Stretch of muscle, long ligaments, and apophyseal joints~~
~~d. Improvement in arterial, venous and lymphatic flow~~

~~4. Considerations to make when applying traction~~

~~a. The condition being treated~~
~~b. Position in which traction is to be applied (neutral, flexion or extension)~~
~~c. Dose (poundage, session frequency, intermittency)~~

~~5. To ensure safe application, traction should not be used within the following conditions:~~

~~a. Unstable spine~~
~~b. Vertebral fractures~~
~~c. Extruded disc fragmentation~~
~~d. Ruptured disc~~
~~e. Spinal cord compression~~
~~f. Acute strain or sprain~~

g. Joint hypermobility
h. Osteoporosis
i. Malignancy
j. Pregnancy
k. Infection
l. Hernia
m. Meningitis
n. Rheumatoid arthritis
o. Cardiovascular or pulmonary conditions
p. Vertebral artery insufficiency

C. PROCEDURE
1. Before beginning application of traction
a. Explain the purpose and what to expect
b. May demonstrate the position to make the patient feel at ease
2. Cervical traction setup
a. Remove any jewelry (especially earrings), eyeglasses, and anything else in the cervical region that may get in the way or create discomfort for the patient. Loosen the shirt collar or have the patient change into a gown in order to better expose the neck region. *Cervical traction is only effective if the traction unit is in direct contact with the skin of the neck – not over clothing.*
b. Determine the patient's body weight. Tension should be up to 7%-10% of body weight.
c. Determine the amount of neck flexion that is necessary and adjust the traction machine accordingly.
(1) Upper cervical region = 10° (slide stand in upper-most position)
(2) Middle cervical region = 15° (slide stand in middle position)
(3) Lower cervical region = 20° (slide stand in lower-most position)
d. Instruct the patient to lie supine on the treatment table with the neck between the neck wedges of the cervical traction device. Adjust the neck wedges appropriately so that they are snug around the patient's neck. If necessary, have the patient sit up and adjust the neck wedges; then have the patient lie back down.
e. Once the patient is in place, refer to the protocols for guidelines on the tension amount, angle of pull, and treatment time for specific diagnoses.
3. Lumbar traction setup
a. Patient should be wearing loose, comfortable clothing. Avoid wearing clothing that is smooth or slick, such as workout sweats. It may be necessary to change clothing or remove belts and other accessories before beginning traction.
b. Determine the patient's body weight. Target tension should be up to 40%-50% of body weight.
c. Instruct the patient to lie supine or prone on the lumbar traction device. The area of the lumbar spine that is to be treated needs to be placed between the 2 belts of the device. It may be necessary to slide the patient up or down on the device to position them correctly.
d. Secure the belts around the thoracic and pelvic girdle of the patient. Make sure that the belts are tight to prevent them from slipping.
e. Once the patient is in place, refer to the protocols for guidelines on the tension amount, angle of pull, treatment time, type of belt, and opening/keeping the table closed for specific diagnoses.

Tri-City Medical Center
Oceanside, California

TELEMETRY UNIT SPECIFIC POLICY

SUBJECT: Admission and Discharge Criteria **POLICY NUMBER: 6150-100**

ISSUE DATE: 10/06
REVISION DATE(S): 8/10, 11/10,12/10,1/11,2/12, 2/15, 3/16

Department Approval Date(s):	**03/15**
Division of Cardiology Approval Date(s):	**01/16**
Medical Executive Committee Approval Date(s):	**02/16**
Professional Affairs Committee Approval Date(s):	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To ensure Telemetry monitored beds are available and used assigned appropriately.
   a. Cardiac Telemetry patients will be assigned beds on 2-East, 2-West, 4-East or 4-West
   b. Medical or surgical Telemetry patients will be assigned beds on 3 Pavilion
2. To provide guidelines to determine admission, discharge, and triage of hospitalized patients requiring monitoring on the Telemetry Unit.
3. It is the policy of Tri-City Medical Center (TCMC) to screen and triage all Telemetry patients daily for potential discharge or transfer to the appropriate level of care.
4. A patient may be admitted or transferred to Telemetry by order of a physician or his/her designee.
5. The Telemetry unit is inappropriate for the following patients:
   a. Hemodynamic instability
   b. Ongoing suggestive of myocardial ischemia or symptoms not resolved with treatment
   c. Presence of more than one femoral line
   d. Thrombolytic therapies (tPA, Streptokinase, Urokinase), vasopressors or antidysrhythmics requiring titration
   e. Medical or surgical patients not requiring cardiac monitoring or Telemetry unit specific care.
6. Assignment of Telemetry Beds;
   a. All patients will be assigned a room on Telemetry by a Telemetry Assistant Nurse Manager (ANM) or Relief Charge Registered Nurse (RN)
   b. Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W
      i. These patients will not be assigned a room on 3P.
   c. Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon will be assigned a room on 3P.
   d. Telemetry overflow patients assigned to 4P will have their care provided by a Telemetry RN.
   e. The ANM or Relief Charge RN will assign patient beds based on the criteria identified in this policy and bed availability.
   f. Administrative Supervisors (AS) will inform a Telemetry ANM/Relief Charge RN of patients requiring Telemetry level of care. The Telemetry ANM/ Relief Charge RN will determine bed placement and inform the Administrative Supervisor.

B. **POLICY:**

1. Physiologic Parameters-clinical indicators of patient illness reflecting the need for admission to the Telemetry

a. Vital signs or neurological monitoring requiring no more frequently then every 2 hours with the exceptions of ischemic or hemorrhagic stroke patients requiring National Institute of Health Stroke Scale Assessment (NIHSS) assessment per admission guidelines or post-surgical and post interventional cardiology patients requiring frequent checks.
b. Frequent nursing interventions, vital signs and post-surgery/procedure monitoring requiring every hour or less for a limited period of time not exceeding 24 hour
c. Cyanosis
d. Altered mental status/unconsciousness
e. Dyspnea
f. Oliguria

2. Neurological, but not limited to the following:
a. Ischemic and hemorrhagic stroke patients downgraded to telemetry status.
b. Patients with signs and symptoms of a potential stroke (refer to the In-House Code Stroke Algorithm)
c. Post neurosurgical patients with underlying cardiac or respiratory problems requiring cardiac monitoring (see cardiovascular and respiratory criteria)
d. Neurology patients with bradyarrhythmias
e. Evaluation of syncope of unknown etiology
f. History of status epilepticus or seizure disorder and risk for sudden death Physiologic Parameters-clinical indicators of patient illness reflecting the need for admission to Telemetry
g. Vital signs or neurological checks monitoring requiring no more frequently then every 2 hours with the exceptions of the ischemic or hemorrhagic stroke patients requiring NIHSS.
h. Altered mental status/unconsciousness

3. Pulmonary, but not limited to the following:
a. Long-term ventilated patients with secured airway tracheostomy and endotracheal awaiting placement of a tracheostomy or extubation
b. High flow oxygen
c. Ventilator-dependent
d. Patients requiring Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP)
e. Pulmonary embolus
f. Respiratory illness associated with uncontrolled arrhythmias
g. Hypoxia requiring continuous oximetry

4. Cardiovascular Monitoring Reference

Patients with the following conditions shall have telemetry monitoring for 24 to 48 hours or as ordered: Class I	Patients with the following shall be monitored for 48 to 72 hours or longer as ordered Class II
• Acute Coronary Syndrome (ACS) hemodynamically stable with normal cardiac enzymes	• Unstable angina: rule out myocardial infarction (MI) or potential for MI
• Low probability of myocardial infarction (MI), to rule out MI	• Hemodynamically stable MI and unstable ACS or MI
• Any hemodynamically stable dysrhythmias requiring initiation, loading, and maintenance of IV or oral antidysrhythmics	• Any hemodynamically unstable dysrhythmias, not including potentially lethal dysrhythmias which required continuous cardiac monitoring and/or IV or oral antidysrhythmics
• Recent symptoms suggestive of MI and are currently pain free	• Post cardiac surgery greater than 23 hours post-operative
• Immediate post Percutaneous Coronary Intervention (PCI) with femoral arterial and/or venous sheaths and are hemodynamically stable	• Heart failure without shock and requiring urgent interventions
• Diagnostic angiography	• During initiation of type I or type III

	antidysrhythmics
• Overdose or drug toxicity without dysrhythmias	• Postoperative surgery in patients with angina, ST-segment and T wave changes, MI or preoperative stress test, dysrhythmias, hypotension or heart failure
• Syncope until treatment is initiated or rationale determined	• Overdose or drug toxicity with dysrhythmias or high potential for dysrhythmias
• Pre and post permanent pacemaker and Internal Cardioverter Defibrillator placement	• Syncope in patients with heart failure or respiratory failure
• Heart failure controlled with treatment	• Pericardial Effusion
• Cardiac contusion without hemodynamic instability	• Pericarditis
• Pacemaker or Internal Cardioverter Defibrillator (AICD) implantation	• Post-operative thoracic surgery
• Carotid Endarterectomy	• Post-operative Cardiovascular surgery
• Pre-Operative Cardiovascular Surgery (CVS)	• Post-operative vascular surgery
• Class III Cardiac monitoring is not recommended.	

5. Nephrology and medical/surgical
6. Chemistry, but not limited to the following:
   a. Troponin I of greater than 0.4 with unresolved chest pain or ischemia by ECG
   b. CPK MB greater than 4.0 with index greater than 1.0 with unresolved chest pain or ischemia by ECG
   c. Myoglobin of greater than 80 with chest pain or ischemia by ECG
   d. Serum potassium less than or equal to 3.0 mg/dl
   e. Serum potassium greater than or equal to 6.0 mg/dl
   f. Serum Magnesium less than or equal to 1.5 mg/dl
   g. Presence of toxic level of drugs/chemical associated with cardiac arrhythmias
7. Intensity of Service-includes continuous telemetry cardiac monitoring and two of the following criteria: *but not limited* to the following:
   a. Monitoring at least every 2 hours or as ordered
      i. Temperature, Pulse and Respiration (TPR)
      ii. Blood Pressure (BP)
      iii. Neurological vital signs
      iv. Urine output
      v. Pulse oximetry
      vi. Treatments/Medication
      vii. IV Potassium replacement
      viii. IV Calcium replacement
      ix. IV Calcium channel blockers i.e., Diltiazem, Verapamil or Cardene
      x. IV antidysrhythmics may include but are not limited to the following:
         - Amiodarone
         - Lidocaine
         - IV Beta-Blockers i.e., Metoprolol, Esmolol
         - Procainamide
   b. New or altered regimen of oral antidysrhythmics may include but are not limited to the following:
      i. Amiodarone
      ii. Disopyramide
      iii. Metoprolol
      iv. Flecainide

v. Procainamide
vi. Quinidine
vii. Sotalol

c. IV Vasoactive Medications may include by are not limited to the following:
i. Dopamine fixed dose no greater than 10 mcg/kg/min
ii. Dobutamine fixed dose no greater than 10 mcg/kg/min
iii. Nitroglycerin no greater than 20mcg/min with resolution of chest pain
iv. Milrinone or Amrinone infusion

d. IV antithrombin and antiplatelet inhibitors may include but are not limited to the following:
i. Angiomax
ii. ReoPro
iii. Integrilin

e. Inotrope, Cardiac Glycoside i.e., Digoxin

f. Inotrope, Phosphodiestrase (PDE) inhibitors may include by are not limited to the following:
i. Milrinone
ii. Inocor
iii. Nesiritide

C. **PROCEDURE:**

1. All Telemetry patients requiring cardiac monitoring shall be transported with an RN and a cardiac monitor capable of defibrillation. See Interruption or Discontinuing of Cardiac Monitoring in this policy for further information. Review the Management of Telemetry Patients policy for exceptions
   a. The transporting Registered Nurse (RN) shall be a Telemetry core RN, Intensive Care Unit (ICU) RN, or an Advanced Cardiac Life Support (ACLS) RN assigned by the Telemetry Assistant Nurse Manager (ANM)/Relief Charge RN or receiving department's designee.
2. Patients admitted from the Emergency Department (ED) or transferred from in-house units/departments must have an order for Telemetry.
3. Direct admissions may be admitted per physician's request.
4. Bed assignments for patients meeting admission guidelines are coordinated by the Telemetry ANM / Relief Charge Nurse, who will further facilitate communication (may include obtaining a pre-transfer report, as appropriate from the site of transfer/admission).
5. If the patient does not meet the unit's admission criteria, either the ANM designee may contact the admitting physician to discuss more appropriate placement.
6. In times of low census, the Telemetry will admit overflow patients that do not require cardiac monitoring.
7. All patients admitted to Telemetry requiring cardiac monitoring shall be on a cardiac monitor capable of defibrillation and accompanied by an RN.
8. An RN shall accompany all patients transferred from Acute Care Services (ACS) to Telemetry.

D. **RELATED DOCUMENTS:**

1. Plan for Nursing Care

E. **REFERENCE LIST:**

1. American Heart Association (AHA). (2004). An American heart association scientific statement from the councils on cardiovascular nursing, clinical cardiology and cardiovascular disease in the young. Retrieved October 13, 2010, from http://www.circ.ahajournals.org
2. American Association of Critical Care Nurses (AACN). (nd). Progressive care fact sheet. Retrieved January 2010 from http://www.aacn.org

Tri-City Medical Center	TELEMETRY
PROCEDURE:	**WEIGHING TELEMETRY PATIENTS**
Purpose:	To identify the Telemetry patient populations requiring admission, daily and weekly weights
Supportive Data:	Admission weight is a baseline for establishing fluid volume status, nutritional status and medication administration. Daily weights are used in fluid management and are important until the weight stabilizes at a dry weight. Weekly weights are used for tracking body weight i.e. muscle or fat. Obtaining accurate weights requires outlining a set time of day for weighs, ensuring the patient wears the same clothing, and the use of the same scale. A weight gain of 1 (one) kilogram in 24 hours represents 1000 mL (1 liter) of additional fluid retention.
Equipment:	Scale: bed scale, chair scale, standing scale, or Hoyer lift.
Issue Date:	12/09

A. **POLICY:**

1. The primary Registered Nurse (RN) shall ensure all patients admitted to Telemetry are weighed on arrival to the unit in kilograms.
   a. A physician's order is not required.
   b. Stated weights are not acceptable.
2. Patients transferred to Telemetry from departments other than the Intensive Care Unit (ICU) shall be weighed as soon as possible after arrival to the unit, if not weighed on admission or if admission weight is greater than 3 days.
3. Daily and weekly weights shall be obtained and documented in the Electronic Health Record (EHR) by 0600 using the same scale.
4. All patients shall be weighed using a chair scale unless contraindicated.
   a. If it is contraindicated to use a chair scale use a bed scale, Hoyer lift scale or standing scale may be used
5. All beds with scales shall be zeroed per manufacturers' recommendation prior to the patient's arrival to the unit and after bed is cleaned after a patient is discharged or transferred.
6. The following patients shall be weighed daily and RNs shall use the following table as a guide to place patients on fluid restriction or as per physician order. Advanced Care Technicians (ACTs) will post fluid restriction or fluid limit signage as directed by the primary RN. .

Diagnosis	Fluid Restriction
Acute Renal Injury	Fluid restriction may not be required for this patient population. Restrict fluids as ordered by the physician..
Renal Failure on Dialysis	Fluid restriction per physician's order. If no orders exist, the RN shall ask the patient for their home fluid restriction value or request an order from the physician.
Heart Failure	Fluid restriction per physician's order. If no orders exist, fill patient's pitcher with 500 mL per shift.
Post-operative Cardiovascular Surgery	Fluid restriction per physician's order. If no orders exist, fill patient's pitcher with 500 mL per shift.

7. Patients receiving the following treatments shall be weighed on Sunday or Monday prior to 0600. See the Standards of Care for Adults
   a. Long term ventilators
   b. Patients receiving Total Parental Nutrition (TPN), and/or Tube Feedings
8. The primary RN is responsible for ensuring weights are completed and documented accurately.

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8/10, 2/11, 08/15	01/16	n/a	01/16	03/16	03/16

9. The primary RN is responsible for reviewing daily weights entered in the EHR by ACTs or Registry Certified Nursing Assistants (CNA)/Nursing Assistants (NA) prior to the end of their shift for discrepancies. If the patient's weight is equal to or exceeds 1 kg in 24 hours perform the following interventions:
    a. Ensure the patient was weighed as outlined in this procedure.
    b. Review patient's intake and output.
    c. Reassess the patient for signs and symptoms of fluid overload i.e. change in respiratory status, changes from previous pulmonary assessment, positive fluid balance, new or increased edema.
        i. Document reassessment in the EHR.
    d. After validating the weight entered in the EHR.
        i. Inform the oncoming RN during hand-off.
            1) The oncoming RN will discuss the weight and possible changes in orders with a physician.
    e. The lift team shall be notified as needed to assist with weights.
    f. ACTs and/or CNAs/NAs are responsible for entering accurate values in the EHR.

B. **WEIGHING A PATIENT USING A CHAIR SCALE:**

1. Place pillow case in seat of chair.
2. Zero chair scale in kilograms.
3. Ensure patient removes personal clothing (underwear may be worn).
4. Assist patient into a hospital gown and skid proof slippers.
5. Assist patient to chair scale.
6. Remove or hold Telemetry box away from patient.
7. Ensure foley catheters, rectal tubes have been emptied, if present.
8. Press the weigh button.
9. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
10. Document the patient's weight in the EHR and document "Chair Scale" in the comments.
11. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

C. **WEIGHING A PATIENT USING THE STANDING SCALE:**

1. Zero scale in kilograms.
2. Ensure patient removes personal clothing (underwear may be worn).
3. Assist patient into a hospital gown and skid proof slippers.
4. Assist patient to scale.
5. Remove or hold Telemetry box away from patient.
6. Ensure foley catheters, rectal tubes have been emptied, if present.
7. Press the weigh button.
8. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
9. Document the patient's weight in the EHR and document "Standing Scale" in the comments.
10. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

D. **WEIGHING A PATIENT USING THE BED SCALE:**

1. Use the bed scale only if contraindicated.
2. Ensure bed scale has been zeroed. If unsure, refer topic Zeroing a Bed Scale in this policy.
3. Lower head of bed; bed must be flat prior to weighing patient.
4. Ensure patient removes personal clothing (underwear may be worn).
5. Remove additional patient equipment from bed and/or bed frame i.e. compression stockings, ventilator tubing, additional pillows and/or blankets, wound vac, constavac etc.
6. Remove or hold Telemetry box away from patient.
7. Ensure foley catheters, rectal tubes have been emptied, if present or hold away from bed.
8. Press the weigh button per manufacturers' recommendations.

9. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
10. Document the patient's weight in the EHR and document "Bed Scale" in the comments.
11. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

E. **WEIGHING A PATIENT USING A HOYER LIFT:**

1. The primary nurse or ACT shall be present in the patient's room when the following patients are weighed:
   a. Ventilator patients
   b. Trached patients
   c. Patients with central venous lines
   d. Patients with multiple equipment
2. The primary nurse shall ensure the following:
   a. The Hoyer lift is zeroed using the sling, patient gown and one top sheet.
   b. Telemetry box is removed or held away from patient.
   c. Foley catheters, rectal tubes have been emptied, if present.
   d. Tubing(s) are lifted from sling.
3. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
4. Document the patient's weight in the EHR and document "Hoyer Scale" in the comments.
5. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

F. **ZEROING A BED SCALE:**

1. All beds with scales shall be zeroed per manufacturers' recommendation prior to the patient's arrival to the unit and after bed is cleaned post transfer or discharge.
2. Zero bed scale prior to placing a patient in the bed as follows:
   a. Lower head of bed; bed must be flat prior to zeroing.
3. Raise upper side rails.
4. Zero bed with the following linen:
   a. One flat sheet
   b. One fitted sheet
   c. One blanket (do not use bath blankets)
   d. One pillow
   e. One pillow case
   f. One patient gown
   g. One draw sheet or paper chux
5. Write on patient board "Bed Zeroed, the date and time.

G. **REFERENCE LIST:**

1. Mosby's Skills. (2006-2014). Admission, 2014. Retrieved from TCMC Intranet
2. Tri-City Hospital District Standards of Care for Adults. Retrieved from TCMC intranet.
3. Urden, L.D., Stacy, K.M., & Lough, M.E. (2014). Critical care nursing: Diagnosis and management. (7th ed.). Elsevier St. Louis: MO.

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**AMNIOINFUSION**
Purpose:	Amnioinfusion is a procedure used during the intrapartum period for pregnancies complicated by oligohydramnios to eliminate repetitive variable decelerations by augmenting the amniotic fluid volume to prevent or relieve umbilical cord compression during labor.
Supportive Data:	Amnioinfusion has been shown to decrease the occurrence and severity of variable and prolonged decelerations by providing "cushioning" for the umbilical cord when utilized in labor. Note: Prophylactic amnioinfusion for oligohydramnious (≤ 50 mm) does not appear to confer any advantage over therapeutic amnioinfusion after the development of an abnormal FHR pattern (Spong, 2009). Amnioinfusion does not significantly reduce the risk of meconium aspiration syndrome and is not indicated for prophylactic use for meconium-stained amniotic fluid in the absence of repetitive decelerations (AAP & ACOG, 2007; Spong, et Ross, 2009
Equipment:	1. Infusion pump and tubing 2. Normal Saline 500ml bag – room temperature 3. Intrauterine pressure catheter (IUPC), double lumen 4. Electronic Fetal Monitor

A. **POLICY:**

1. Indications for the use of amnioinfusion in labor include:
   a. Less than 32 weeks gestation:
      i. Intermittent or recurrent variable decelerations with a documented amniotic fluid index of ≤ 7.0cm.
   b. Greater than or equal to 32 weeks gestation:
      i. Intermittent or recurrent variable decelerations
   c. Oligohydramnios
2. Contraindications:
   a. Vaginal bleeding
   b. Thick meconium and/or meconium stained amniotic fluid without variable decelerations
   c. Uterine anomalies
   d. Active infection such as human immunodeficiency virus (HIV) or herpes
   e. Impending delivery
   f. Anomalous fetus

B. **DEFINITIONS**:

1. Recurrent decelerations – decelerations that occur with > 50% of uterine contractions in any 20 minute window.
2. Intermittent decelerations – decelerations that occur with < 50% of uterine contractions in any 30 minute window.

C. **PROCEDURE:**

1. Requires ruptured membranes to proceed.
2. Verify provider order.
3. Explain procedure to patient and obtain verbal consent.
4. Position patient for insertion and assist provider in placement of an Intra Uterine Pressure Catheter (IUPC). Double lumen allows for continuous measurement of intrauterine pressure during infusion.

Department Review/Revision Date	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
4/97; 6/99; 5/03; 5/09, 02/15	06/09, 06/15	12/15	02/16	03/16	6/03, 03/16

5. An external tocodynamometer or manual palpation may also be used during infusion to assess for increased intrauterine pressure.
6. An infusion pump is recommended to prevent a rapid rate of infusion, and to limit the volume of fluids infused. Set up Alaris infusion pump, and attach in the following order:
   a. Prime tubing with normal saline or lactated ringers.
   b. Insert tubing into Alaris infusion pump.
   c. Attach to IUPC.
7. Administer 250 - 500 mL of normal saline or lactated ringers via infusion pump over 30 minutes per provider's orders.
8. After initial infusion, if recurrent variable decelerations persist continue infusion of 150 mL per hour up to a maximum infusion of 1000 mL can be given.
   a. Notify provider if recurrent variable decelerations remain unresolved.
9. DO NOT heat fluid in the microwave or blanket warmer. Infuse at room temperature.
   a. Warming of the fluids may be appropriate for preterm or growth restricted fetuses via blood warmer or IV fluid warmer if temperatures are regulated, acceptable temperatures are 93-96° F (34-37°C).
10. Monitor fetus continuously for improvement of FHR pattern or aberrant changes.
11. Monitor uterine contractions for hypertonus and tachysystole and uterine baseline for unrest or increased tone secondary to over-distension.
12. Assess for:
    a. Fluid return by weighing underpads (1mL of fluid equals= 1g of weight)
       i. As a general consideration, if 250mL has infused with no return, the infusion should be discontinued until fluid return is noted.
    b. Over distention, notify provider.

D. REFERENCES:

1. AWHONN. (2006). Fetal Heart Monitoring Principles & Practices, 4th Edition.
2. Simpson, K. R. and Creehan, P. A. (2014). Perinatal Nursing (4th Ed). Philadelphia: Lippincott Williams and Wilkins
3. Spong, C.Y., & Ross, M.G., (2009). Amnioinfusion: Indications and outcome. ©2009 *UpToDate®*. Retrieved February 5, 2009 from http://www.uptodate.com

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**OBSTETRICAL HEMORRHAGE**
Purpose:	To provide guidelines for the optimal response of the multidisciplinary team in the event of obstetric hemorrhage and to assist all care providers in recognizing patients at risk for hemorrhage, identifying stages of hemorrhage, and primary treatment goals.
Supportive Data:	Approximately one-third of maternal deaths are related to postpartum hemorrhage, which is defined as a blood loss greater than 500ml in the first 24 hours after delivery. Major causes of postpartum hemorrhage (PPH) include uterine atony, lacerations, hematomas, retained placental fragments, uterine inversion and blood coagulation disorders, (e.g., disseminated intravascular coagulation (DIC)).
Equipment:	1. Additional Intravenous (IV) fluid (e.g., normal saline, lactated ringers) 2. Additional IV tubing 3. Transfusion administration set 4. Foley catheter 5. Oxytocin 10 units per mL, uterotonic medications as ordered by provider 6. Infusion pump 7. Syringes for Intramuscular (IM) administration 8. Oxygen delivery equipment (e.g. simple mask) 9. OB Hemorrhage Cart & (Crash Cart, as needed) NOTE: Equipment for this procedure may vary, based on the clinical situation

A. **POLICY STATEMENTS:**

1. Optimal response to obstetrical (OB) hemorrhage requires the coordination of effort of team members from multiple disciplines and departments.
   a. Births shall have active management & assessment practices in place to minimize OB hemorrhage
      i. Patients admitted for labor will have IV access which may be by normal saline lock. An 18 gauge IV catheter is desired.
      ii. Patients will be assessed and monitored for OB hemorrhage as follows:
         1) Completing a risk factor screen for hemorrhage risk, on admission.
         2) Ongoing assessments for vaginal bleeding – during intrapartum period, 3rd stage/ recovery, admission to postpartum, and every shift until discharge.
         3) Active management of the 3rd stage of labor to include:
            a) Fundal massage immediately following the delivery of the placenta and then at regular intervals as defined in Women and Newborn Services (WNS) Standards of Care.
            b) Patient receiving an oxytocin infusion of 20 units/1000 mL solution with rate adjustments made according to uterine tone OR if no IV, oxytocin 10 units IM, as ordered by provider (Obstetrician/ Physician/ Certified Nurse Midwife (CNM)).
         4) Evaluation of vaginal bleeding amount, to include weight measurements, as ordered by provider.
         5) Ongoing evaluation of vital signs (VS) during recovery and postpartum periods.
   b. The nursing unit, anesthesia, blood bank, operating room, and other appropriate services shall work together to mount an efficient and coordinated response to OB hemorrhage.

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01/11, 05/15	07/12, 06/15	12/15	05/13; 02/16	06/13; 03/16	06/13; 03/16

c. The WNS department will maintain and have OB Hemorrhage Carts available for urgent hemorrhage management on Labor and Delivery (L&D), L&D Post Anesthesia Care Unit (PACU), and 2 South.
   i. Uterotonic medications shall be kept together in the Pyxis refrigerator, as an OB Hemorrhage Kit, which is supplied by the pharmacy.

d. In the event of an uncontrolled patient hemorrhage, a CODE MATERNITY shall be initiated. Refer to Patient Care Services (PCS) Procedure; Code Maternity Team Mobilization.

B. **DEFINITIONS:**

1. General hemorrhage:
   a. Vaginal birth: estimated blood loss greater than 500 mL blood loss
   b. Cesarean birth: estimated blood loss greater than 1000 mL blood loss
2. Massive hemorrhage: greater than 1500 mL blood loss for ANY birth mode
3. Additional Clinical Triggers:
   a. Heart rate ≥ 110
   b. Blood pressure ≤ 85/45 (> 15% drop)
   c. O2 sets < 95%
4. Risk assessment: Recognition and screening for risk factors upon admission and throughout the intrapartum and postpartum period is essential in hemorrhage management anticipation.
   a. Low Risk: Type and Rh upon admission
   b. Medium Risk: Type and Screen
   c. High Risk: Type and Crossmatch 2 units Red Blood Cells (RBC).

C. **PROCEDURE FOR HEMORRHAGE MANAGEMENT- STAGE 1 (VAGINAL Delivery >500 ml <1000 ml blood loss. CESAREAN Delivery : >1000 ml <1500 ml blood loss):**

1. ASSESSMENT
   a. Complete fundal and vaginal bleeding checks as indicated in WNS Standards of Care. Notify provider, obtain and administer PPH/Uterine atony medication, as ordered by provider.
      i. If patient's provider is a CNM, co-management with a Physician is recommended.
   b. Notify Charge Nurse of hemorrhage concern.
   c. Monitor VS and apply O2 saturation monitor. Begin more frequent vital sign monitoring, at a minimum every 5-15 minutes.
   d. Review delivery history and consider possible causes for hemorrhage to include the four T's:
      i. Uterine Atony (TONE)
      ii. Retained placenta (TISSUE)
      iii. Vaginal vault or cervical lacerations (TRAUMA) or
      iv. Coagulopathy issues (THROMBIN).
2. MEDICATIONS/PROCEDURES
   a. Establish IV access, (16-18 gauge, preferred), per provider order.
   b. Increase IV fluid rates (Lactated Ringers preferred) and increase oxytocin infusion rate as ordered by provider (500 ml/hour of 20-40 units/1000 mL normal saline (NS).
   c. Provider may provide vigorous bimanual fundal massage.
   d. Administer Uterotonic drugs, as ordered by provider:
      i. Misoprostol (Cytotec)
      ii. Methylergonovine (Methergine)
         1) NOT recommended, if patient is hypertensive
      iii. Carboprost (Hemabate)
         1) NOT recommended, if patient has hepatic disease, asthma, or active cardiac/pulmonary disease

e. Administer oxygen via face mask to maintain oxygen saturation >95%.
f. Assess patient's bladder, provider may order a Foley catheter placement. (Consider one with an urimeter, if hourly output monitoring is expected).
g. Keep the patient head of the bed flat to increase perfusion to the brain/heart and keep patient warm.
h. Have charge nurse notify the Blood Bank, via RED PHONE, that patient condition is Hemorrhage STAGE 1 and order Type & Cross match for 2 Units RBCs, if not already done and per provider's request.

3. BLOOD BANK CONSIDERATIONS:
   a. Type and Crossmatch for 2 units RBC STAT, per provider request.
4. If patient stabilizes, provide increased postpartum surveillance.

D. PROCEDURE FOR MASSIVE HEMORRHAGE- STAGE 2 (1000-1500 ml Blood Loss):

1. ASSESSMENT
   a. Call Physician to the bedside.
   b. Notify Charge Nurse of continued hemorrhage concern and Initiate "Code MATERNITY" (Refer to PCS Procedure; Code -Maternity Team Mobilization).
   c. Request that OB Hemorrhage Cart brought to the patient room.
   d. Continue to monitor VS every 5-10 minutes.
   e. Weigh bloody materials on gram scale (1 gm = 1 mL).
   f. Anticipate Physician may perform a complete evaluation of the vaginal wall, cervix, placenta and uterus.
   g. Draw and send additional labs per Physician's request: H&H with Platelet Count (purple top tube), DIC Panel (blue tube for PT, PTT, and Fibrinogen), and electrolytes with Liver Function Tests (ALT, AST, and uric acid green top tube).
      i. May repeat labs every 30-60 minutes, per Physician order.
      ii. WNS Charge Nurse to contact Lab ext 7913, if blood draw results not entered into computer within 30 minutes of being drawn.
   h. Monitor intake and output (I&O)'s
2. MEDICATIONS/ PROCEDURES
   a. Administer Uterotonic drugs, as ordered by Physician.
   b. Establish second IV access with at least an 18 gauge, as ordered by Physician.
      i. Second IV site should be used for blood product administration
   c. Continue to assess uterine tone.
   d. Be prepared to transfuse 2 units of RBCs per patient's clinical signs and Physician order.
      i. Do NOT wait for lab results
      ii. Utilize blood tubing and blood warmer for transfusion.
      iii. Refer to Tri City Medical Center Patient Care Services (PCS) procedure: Blood Products Administration
   e. Consider moving the patient to the L&D Operating Room (OR)/ L&D PACU per Physician direction.
   f. Ask Charge Nurse to update the Blood Bank of Hemorrhage Stage 2 via RED PHONE.
3. BLOOD BANK CONSIDERATIONS
   a. Prepare 2 units of RBCs for transfusion per order request.
      i. Two units O negative blood or group specific (if known) and available should be ready for transfusion, as soon as possible.
      ii. A request may be made for a "keep ahead" order for 2-4 units per Physician order.
   b. Consider thawing Fresh Frozen Plasma (FFP), if transfusing >2 units of RBCs.
   c. Determine availability of additional RBCs, FFP, and cryoprecipitate and notify WNS Charge Nurse.
   d. Anticipate the possibility of massive hemorrhage and obtain laboratory support as needed.

4. If patient stabilizes, anticipate increased monitoring requirements postpartum.
5. Notify Blood Bank of patient stabilization and blood product adjustments/requirements per Physician order.

E. **PROCEDURES FOR MASSIVE HEMORRHAGE- STAGE 3 (Blood Loss > 1500 ml/ >2 units RBC's given, VS unstable OR suspicion for DIC exists:**

1. ASSESSMENT
   a. Patient may be transferred to the L&D OR or the Main OR, per the direction of the Physician.
   b. Physician may consider consulting/gaining assistance from: Advanced GYN surgeon, 2nd anesthesia provider, OR staff, and an Adult Intensivist.
   c. Continue to monitor patency of IV lines, blood administration process, VS and strict I&O.
   d. Repeat labs per Physician order: H&H, Platelet Ct, DIC panel electrolytes with Liver Function Tests (ALT, AST, and uric acid). Repeating lab work every 30-60 minutes, should be considered.
   e. Charge Nurse should consider consulting a Social Worker to provide family support.
2. MEDICATIONS/ PROCEDURES
   a. Physician may consider performing:
      i. Laparotomy: B-lynch Suture, uterine artery ligation, hysterectomy, and/or administering vasopressor support.
   b. Prepare to circulate in the OR
   c. Physician may consider selective embolization (Interventional Radiology).
      i. Prepare patient for transport
   d. Anesthesiologist may consider
      i. Placing a Central/Arterial line
      ii. Obtaining an arterial blood gas (ABG)
      iii. Intubation
      iv. Providing perfusion support by utilizing
         1) Fluid warmer and rapid infuser
         2) Upper body warming device
         3) Sequential compression stockings.
   e. Charge Nurse shall notify the Blood Bank via RED PHONE to indicate a massive transfusion protocol has been initiated.
3. BLOOD BANK CONSIDERATIONS
   a. Anticipate alternating the following transfusion products, as ordered by Physician:
      i. PRBCs and Fresh Frozen Plasma (FFP) 5 units of each are to be prepared for immediate distribution with a "keep ahead 2 units" request..
      ii. 5-10 units cryoprecipitate, pooled as needed. (indicated for decreased fibrinogen levels)
      iii. 1- unit Apheresis platelet consideration for every 6 units of RBCs/FFP infused
   b. Prepare to transfuse aggressively with varied products, per provider order. Suggested ratios may include:
      i. Consider: 1:1 PRBC/FFP during acute hemorrhage management
      ii. Either 6:4:1 PRBCs/FFP/Platelets
      iii. Or 4:4:1 PRBCs/FFP/Platelets
4. If patient has unresponsive coagulopathy after 8-10 units of PRBCs and coagulation factor replacement, Physician may consider risk/benefit of Factor VIIa, to be provided by pharmacy (Ext. 3012).
   a. Provisional dosing range 60 – 90 units/kg
5. When patient stabilizes, Physician may consider transferring patient to Intensive Care Unit.
6. Notify Blood Bank of patient stabilization and blood product adjustments/requirements per provider order

F. **SPECIAL CONSIDERATAIONS: JEHOVAH'S WITNESSES AND OTHERS WHO MAY DECLINE BLOOD PRODUCTS:**

1. There is a wide range of acceptable blood interventions within the Jehovah's Witness community and 50% will actually take some form of blood transfusions.
2. It is imperative that the provider and health care team review all possible options with the patient refusing to receive blood products.
   a. Use of the specific Jehovah's Witness Blood Product and Technique Informed Consent Checklist form should be given to the patient and reviewed on admission.
   b. Anesthesia shall be consulted when the patient is admitted.
   c. The OB provider shall review surgical options and other specific techniques for consideration to manage hemorrhage concerns to include but not limited to:
      i. Early Interventional Radiology involvement
      ii. Use of Fibrin/ Thrombin glues

G. **DOCUMENTATION:**

1. Document assessment findings and interventions provided in patient medical record.
2. Document all medications, IV & blood products on eMAR and I/O forms in patient electronic medical record, as appropriate.
3. Complete documentation requirements for blood transfusion per Patient Care Services (PCS) procedure: Blood Products Administration.
4. May use Code MATERNITY report sheet to document events when Code MATERNITY is initiated, see PCS Procedure; Code Maternity Team Mobilization.

H. **REFERENCES:**

1. California Maternal Quality Care Collaborative (CMQCC). (2015). *Obstetric Hemorrhage Version 2.0 Toolkit*. Retrieved on 3/24/2015:
2. Elmer, J, Wilcox, S. R. &Raja, A. S. (2013). Massive transfusion in traumatic shock. Journal of Emergency Medicine, 44(4): 829-838.
3. Sheilds, L., Chagolla, B., Fulton, J., Pelletreau, B. (2013). Comprehensive maternal hemorrhage protocols reduce utilization of blood products and improve patient safety. American Journal of Obstetrics and Gynecology. 208; S49-50.
4. Simpson, K. and Creehan, P. (2014). Perinatal Nursing 4th Edition. Philadelphia, PA

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**PREECLAMPSIA CARE GUIDELINES**
Purpose:	To outline the nursing management of inpatients who have preeclampsia including special considerations for the management of patients requiring antihypertensive medications and management of eclampsia.
Supportive Data:	Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage which may impact the cardiovascular, renal, hematological, neurological, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology. Preeclampsia is characterized by new onset of hypertension and proteinuria after 20 weeks gestation in a previously normotensive woman.
Issue Date:	06/14

A. **DEFINITIONS:**

1. PREECLAMPSIA without severe features (mild):
   a. Hypertension (HTN): Blood pressure (BP) greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart in a woman with a previously normal BP.
   b. Completed a minimum of 20 weeks gestation AND
   c. Proteinuria:
      i. Greater than 300 mg protein per 24 hr. urine collection
      ii. Protein/Creatinine ratio greater than or equal to 0.3 mg/dl
      iii. Dipstick reading of(1+) protein (used only if other quantitative methods unavailable)
   d. In the absence of proteinuria if the patient has new onset HTN and new onset of any of the following:
      i. Platelet count less than 100,000/microliter
      ii. Serum creatinine concentration greater than1.1mg/dl or a doubling of the serum creatinine in the absence of other renal disease.
      iii. Elevated blood concentrations of liver transaminases to twice normal concentration
      iv. Pulmonary edema
      v. Cerebral or visual symptoms
2. SEVERE PREECLAMPSIA:
   a. If one or more of the following are present:
      i. BP of 160 mm Hg systolic or higher or 110 mm Hg diastolic or higher on two occasions at least 4 hours apart while patient is on bed rest. (Hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy)
      ii. Completed a minimum of 20 weeks gestation
      iii. New onset cerebral or visual disturbances
      iv. Pulmonary edema or cyanosis
      v. Epigastric or right upper quadrant pain
      vi. Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent RUQ or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses or both
      vii. Thrombocytopenia (platelet count less than 100,000/microliter)

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/14	12/14	n/a	12/15	02/16	03/16	03/16

viii. Progressive renal insufficiency(serum creatinine concentration greater than 1.1 mg/dl or a doubling of serum creatinine concentration in the absence of other renal disease)

3. ECLAMPSIA:
   a. Presence of new onset grand mal seizures in a pregnant women with preeclampsia (rule out idiopathic seizure disorder or other central nervous system pathology such as intracranial hemorrhage, bleeding arteriovenous malformation, ruptured aneurysm)
   b. New onset seizures 48-72 hours postpartum (other central nervous system pathology is the likely reason for the seizure after7 days)
4. CHRONIC HYPERTENSION:
   a. A BP of 140mmHg systolic or greater and 90 mmHg diastolic or greater predating conception and/or patient taking hypertensive medications before pregnancy.
   b. Elevated BP detected BEFORE 20 weeks gestation.
5. GESTATIONAL HYPERTENSION:
   a. A BP of 140 mmHg or greater systolic or 90 mmHg or greater diastolic WITHOUT proteinuria occurring AFTER 20 weeks gestation.
   b. May evolve to preeclampsia
   c. May be recurrence of chronic hypertension abated in mid-pregnancy
6. SUPERIMPOSED PREECLAMPSIA/ECLAMPSIA:
   a. Patients with underlying renal or vascular disease and those with chronic hypertension are at risk.
   b. Sudden increase in proteinuria if already present in early gestation
   c. Sudden increase in BP
   d. Development of headache, scotomata, or epigastric pain
7. HELLP SYNDROME (Hemolysis, Elevated Liver enzymes, Low Platelets):
   a. Patients with severe preeclampsia that develop hepatic and hematologic manifestations as the predominant clinical picture and is associated with increased risk of adverse outcomes.

B. **ADMISSION CONSIDERATIONS:**

1. Assess maternal vital signs including: BP, respiratory rate, and heart rate.
2. Obtain BP using an appropriate sized cuff with patient sitting or in the upright position with the patient's arm at the level of the heart.
   a. Do not reposition the patient to her left side and retake the BP, as this can give a false lower reading.
3. Apply external fetal monitor (if viable gestational age) and perform monitoring and assessment per fetal heart rate (FHR) surveillance policy for antepartum and intrapartum periods.
4. Assess for the presence of:
   a. Headache
   b. Visual changes
   c. RUQ or epigastric pain
   d. Nausea/ vomiting
   e. General malaise
5. Assess upper or lower deep tendon reflexes.
6. Auscultate lung sounds, noting any presence of rales, rhonchi, wheezing, etc.
7. Assess for generalized edema and significant, rapid weight gain.
8. Obtain intravenous (IV) access as ordered by the provider.
9. Prepare to administer medications to lower BP and prevent seizure activity. See Administration of Magnesium Sulfate Procedure, Patient Care Services.

10. Monitor patient's intake and output (I&0) at a minimum every two hours.
11. Maintain activity as ordered by the provider. If on bed rest, maintain side-lying position as much as possible to increase uteroplacental perfusion if patient antepartum or intrapartum, and change patient position every two hours or more often as needed.
12. Obtain lab work as ordered by provider and review results.
13. Ensure oxygen and suction equipment are available and functioning.
14. Implement measures to decrease stress levels, such as maintaining a quiet environment with low lighting.
15. Consider implementing seizure precautions, per Mosby procedure for severe preeclampsia diagnosis.
16. Provide emotional support and opportunity for patient family to verbalize questions and concerns.
17. Reportable conditions; notify the provider for:
    a. Repeated BP greater and 160 systolic OR greater than 105-110 diastolic (taken at least 15 minutes apart).
    b. New or worsening complaint of any of the following:
        i. Headache
        ii. Visual changes
        iii. Right upper quadrant (RUQ) or epigastric pain
    c. Abnormal lab values
    d. Urine output less than 30 mL in an hour or less than 120 mL in 4 hours.

C. **MEDICATION CONSIDERATIONS FOR HYPERTENSION:**

1. A sustained systolic blood pressure greater than or equal to 160 mg Hg or diastolic pressure greater than or equal to 110 mm Hg on two consecutive occasions at least 15 minutes apart is considered "severe hypertension" and needs to be treated with IV antihypertensive medication to protect the patient from cerebral vascular accident.
    a. Oral antihypertensive medication should only be considered if IV access has not been established and Nifedipine is the medication of choice.
    b. Patients shall receive medication to reduce the blood pressure within 60 minutes of the finding.
    c. A single, elevated "severe range" blood pressure finding requires further monitoring and evaluation.
2. The goal of treatment is to obtain a diastolic blood pressure of 90-100 mm Hg to maintain perfusion.

D. **ANTIHYPERTENSIVE MEDICATION ADMINISTATION PROCEDURE:**

1. Ensure the patient has a patent IV site
2. Monitor FHR continuously, per FHR surveillance policy if antepartum or intrapartum.
3. Monitor BP, Pulse and Respiratory Rate every 5-15 minutes, per provider order, for a minimum of one hour following IV medication administration to assess for BP reduction.
    a. Maintain bed rest during and for three hours following medication administration.
        i. Assess for postural hypotension prior to ambulation
4. If medication does not reduce the blood pressure to a diastolic reading between 90-100 mm Hg, contact the provider to discuss other medication options.
5. HYDRALAZINE (Apresoline) Administration Considerations based on provider orders:
    a. Hydralazine is a vasodilator and results in vasodilation of vascular smooth muscle.
    b. Administer initial dose IV push (IVP) over 1-2 minutes. (Usual dose range is 5-10 mg.)
    c. May repeat dose at 20 minute intervals until desired blood pressure is achieved. Consider giving 10 mg hydralazine IVP if elevated BP continues after initial dose.

d. Cumulative dose should not exceed 40mg.
e. After 20 minutes if BP continues to be elevated, consider 20 mg of Labetalol IVP be given.

6. LABETALOL Administration Considerations based on provider orders:
   a. Labetalol is a combined alpha and beta- blocker, resulting in the decreased peripheral vascular resistance without altering heart rate or cardiac output. Its use is contraindicated in patients with bronchial asthma, heart block and severe bradycardia.
   b. IV PUSH- Administer initial dose IVP over 2 minutes. (Usual dose is 20 mg)
      i. A repeat dose may be given at 10 minute interval.
      ii. After first 10 minutes if BP continues to be elevated consider 40 mg of Labetalol IVP.
      iii. If 40 Mg did not reduce the BP after 10 minutes, consider administering 80 mg labetalol.
      iv. If no reduction in BP after 80 mg of labetalol IVP, consider Hydralazine.
   c. CONTINUOUS IV- If required, consult with the Intensive Care Unit shall be done
      i. Continuous Cardiac monitoring is required
      ii. Infuse labetalol on an infusion pump at ordered rate by provider until diastolic pressure is 90-100 mm Hg.
      iii. Maximum dose is 300 mg in 24 hours.
   d. An ORAL dose of Labetalol 200 mg can be given if no IV access and is used primarily to control elevated BP's with systolic value less than 160 mm Hg or diastolic value less than 110 mm Hg.
      i. BP shall be checked in 30 minutes

7. NIFEDIPINE Administration Considerations based on provider orders:
   a. Nifedipine is a calcium channel blocker and produces vascular and smooth muscle relaxation.
   b. In the event that acute treatment is needed for patients with severe hypertension (systolic BP greater than 160 or diastolic BP greater than 110) in a patient without IV access, ORAL Nifedipine shall be used.
   c. Suggested dose is 10 mg by mouth which can be repeated in 30 minutes if indicated.

8. Reportable conditions to notify the provider include:
   a. Diastolic BP less than 80 mm Hg or greater than 105-110 mm Hg following medication administration.
   b. Category II or III FHR tracing observed following antihypertensive medication administration.
   c. Sustained maternal heart rate less than 50 or greater than 120 during or within 30 minutes following medication administration.

E. **SEIZURE PREVENTION MEDICATION ADMINISRATION CONSIDERATIONS:**

1. Magnesium Sulfate is administered as a first line drug to prevent maternal eclamptic seizures and exerts its effect by depressing the central nervous system.
2. Use is supported for those patients with severe preeclampsia and eclampsia.(See Magnesium Sulfate Administration procedure in Patient Care Services Manual)
3. For patients diagnosed with "preeclampsia without severe features (mild)" the American Congress of Obstetrics and Gynecology (ACOG) suggests that magnesium sulfate not be administered universally for the prevention of preeclampsia. Administration shall be based on provider assessment and patient symptoms.

F. **ANTEPARTUM ONGOING ASSESSMENT (See Table 1):**

1. Assess for signs of severe or worsening preeclampsia symptoms or development of eclampsia
2. Prolongation of pregnancy to optimize fetal maturation shall be weighed against risk of pregnancy continuation.
3. Preeclampsia without severe features (mild):
   a. Obtain blood pressure, pulse, respirations every 4 hours. Include oxygen saturation values if patient is receiving magnesium sulfate.
   b. Assess lung sounds every 4 hours.
   c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
   d. Obtain nonstress test (NST) or monitor fetal heart rate with uterine activity for a minimum of 30 minutes every shift, as condition warrants, and per provider order
   e. Assess for fetal movement each shift
   f. Monitor intake and output (I&O) at a minimum every 2 hours.
4. Severe Preeclampsia:
   a. Obtain blood pressure, pulse, respirations and O2 sats hourly.
   b. Assess lung sounds every two hours
   c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
   d. Monitor FHR and uterine activity continuously
   e. Monitor I&O hourly

G. **INTRAPARTUM ONGOING ASSESSMENT (See Table 1):**

1. Preeclampsia without severe features (mild):
   a. Obtain blood pressure, pulse and respirations hourly Include oxygen saturation values if patient is receiving magnesium sulfate.
   b. Assess lung sounds every 4 hours.
   c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
   d. Monitor FHR and uterine activity continuously
   e. Monitor I&O at a minimum every 2 hours.
2. Severe Preeclampsia:
   a. Obtain blood pressure, pulse, respirations and O2 sats every 30 minutes.
   b. Assess lung sounds every 2 hours
   c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
   d. Monitor FHR and uterine activity continuously.
   e. Monitor I&O hourly.

H. **POSTPARTUM TO DISCHARGE ONGOING ASSESSMENT(See Table 1):**

1. Preeclampisa without severe features (mild):
   a. Obtain blood pressure, pulse and respirations every four hours. Include oxygen saturation values if patient is receiving magnesium sulfate.
   b. Assess lung sounds every four hours
   c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
   d. Monitor I&O at a minimum every 2 hours, while on Magnesium Sulfate or every 4 hours, otherwise
2. Severe Preeclampsia:
   a. Obtain blood pressure, pulse, respirations and O2 sats every hour for the first 24 hours after delivery then every four hours.

b. Assess lung sound every 2 hours for the first 24 hours after delivery and then every four hours
c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.
d. Monitor I&O hourly until Magnesium Sulfate discontinued.

I. REFERENCES:

1. Druzin, M, Shields, L, Peterson, N, Cape, V, (2013). Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed under contract #11-10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division, Published by the CMQCC.
2. ACOG. Diagnosis and Management of Preeclampsia and Eclampsia #33. American Congress of Obstetricians and Gynecologists Practice Bulletin Number 33. 2002 (Reaffirmed 2012).
3. ACOG. Hypertension in Pregnancy: Report of the American College of Obstetricians and Gynecologists' Task Force on Hypertension in Pregnancy. Obstet Gynecol. 2013; 122(5): 1122-1131.
4. Payne B, Magee L, Cote A, et al. PIERS proteinuria: Relationship with adverse maternal and perinatal outcome. Journal of Obstetrics and Gynaecology Canada. 2011; 33:588-597.
5. ACOG Committee Opinion no. 514. Emergent therapy for acute-onset, severe hypertension with preeclampsia or eclampsia. Obstet Gynecol. 2011; 118: 1465-1468.
6. Simpson K, Crehan P. Perinatal Nursing 4th ed. Philadelphia: Wolters/Kluwer/Lippincott Williams & Wilkins; 2014.

J. RELATED DOCUMENT(S):

1. Patient Care Services Procedure: Administration of Magnesium Sulfate in the Obstetrical Patient
2. Women and Newborn Services Policy: Fetal Heart Rate Surveillence and Monitoring

TABLE 1. NURSING ASSESSMENT FREQUENCY

A. Preeclampsia without Severe Features (Mild)

	Preeclampsia without Severe Features (mild)		
	Antepartum *	**Intrapartum***	**Postpartum***
BP, Pulse, Respirations, SaO2	Every 4 hours	Hourly	Every 4 hours
Lung Sounds	Every 4 hours	Every 4 hours	Every 4 hours
Level of Consciousness Edema Assessment for headache, visual disturbances, epigastric pain	Every 4 hours	Every 4 hours	Every 4 hours
Fetal Status and uterine activity	Every shift	Continuous	N/A
Temperature	Per Department Standards of Care		
I& O	Every 2 hours	Every 2 hours	Every 2 hours

(*) This is the minimum frequency recommended for the patient NOT on Magnesium Sulfate.

B. Severe Preeclampsia Nursing Assessment Frequency

	Severe Preeclampsia Intrapartum and Postpartum on Magnesium Sulfate
BP, Pulse, Respirations, SaO2	Every 30 minutes during maintenance Magnesium Sulfate Administration. Continuous SaO2 during Magnesium Sulfate infusion for intrapartum. For Postpartum patient check with Vital Signs.
Lung Sounds	Every 2 hours
Level of Consciousness Edema Assessment for headache, visual disturbances, epigastric pain	Every 4 hours
Fetal Status and uterine activity	Continuous Fetal Monitoring
Temperature	Per Department Standards of Care
I& O	Intake: Total hourly intake should be less than125 mL/hr. NPO with ice chips or as permitted by provider. Output: Consider Foley placement with urometer Hourly- Calculate end of shift total and 24 hour totals

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**VIBROACOUSTIC STIMULATION (VAS)**
Purpose:	To evaluate fetal acid base status and to evaluate fetal well being during antepartum testing or during intrapartum fetal heart rate monitoring.
Supportive Data:	This screening test is a method of evaluating fetal status by observing fetal heart rate (FHR) response following acoustic stimulation. A single startle response and acceleration of the FHR in response to VAS is associated with a functional brainstem regardless of fetal age. VAS should be performed when the FHR is within a normal baseline range.
Equipment:	1. Electronic fetal monitor 2. Acoustic stimulator

A. **INDICATIONS:**

1. VAS may be considered as a method to evaluate fetal well-being when
   a. A non-reactive, non-stress test (NST) is observed after 20 – 40 minutes of monitoring.
   b. Absent or minimal FHR variability and absence of accelerations is noted during a 50 - 90 minute period of antepartum or intrapartum electronic fetal monitoring.
   c. Estimated Gestational Age (EGA) is > 25 weeks.

B. **CONTRAINDICATIONS:**

1. VAS should NOT be performed during episodes of:
   a. FHR bradycardia
   b. FHR tachycardia
   c. FHR decelerations

C. **PROCEDURE:**

1. Explain the procedure to the patient.
2. Position/reposition the FHR and uterine monitors to obtain an interpretable/recordable tracing.
3. Position the VAS on the maternal abdomen near the fetal head and apply the sound stimulus for one to two seconds.
   a. If the FHR remains non-ractice, the VAS may be repeated at one minute intervals up to three times, progressing to a maximum stimulation duration of three seconds.
4. Do not apply stimulus during a contraction.
5. A FHR acceleration ≥ 15 bpm above the baseline and duration ≥ 15 seconds is a POSITIVE response to the VAS and a reassuring sign of fetal well-being in pregnancies greater than 32 weeks EGA.
   a. For an EGA less than 32 weeks, a FHR acceleration >10 bpm above the baseline, lasting 10 seconds is considered a POSITIVE response. See WNS Fetal Heart Rate Surveillance Policy.
6. In the absence of a FHR acceleration:
   a. The VAS may be repeated at one-minute intervals up to three times.
   b. If FHR continues to have no accelerations, alternate tests may need to be considered to assess for fetal well-being. (A Contraction Stress Test or Biophysical Profile may be added per provider order.

D. **PROVIDER NOTIFICATION:**

1. Notify the provider for the absence of an acceleration following VAS attempt.
2. Inform the provider for the presence of a Category II or III FHR pattern after VAS attempt.

E. **DOCUMENTATION:**

1. Document procedure in the electronic medical record.

Review/Revision Date	Department of OB/GYN	Division of Neonatology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
2/06, 12/12, 01/16	01/13, 01/16	n/a	n/a	05/13; 02/16	06/13; 03/16	06/13; 03/16

REFERENCES:

1. Lyndon, A. & Ali, Linda (2015)), Fetal Heart Monitoring Principles in Practices 5th Ed). Washing ton D.C.: Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN). Washington D. C. , Kendall- Hunt Publishing.

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion { }**

Date: 12/01/2015

Requestor: Oska Lawrence, PharmD

Trade Name: Praxbind

Generic Name: Idarucizumab

Dosage form(s): 2.5 g/50ml vial

Indications:

1) Reversal of anticoagulant effects of dabigatran

Efficacy:

In the approval study, the plasma level of unbound dabigatran was below or close to 20 ng/dL (a level that exerts minimal or no dabigatran activity) in samples drawn after the second vial in all but one patient. Furthermore, the dTT normalized in 98% and 93% of the evaluable patients in Group A and Group B respectively. The ECT normalized in 89% and 88% of evaluable patients in Group A and B respectively

Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:

1) Thrombotic events: Risk is unknown at this time. Based on interim data from the approval study 5 patients experienced thrombotic events thought to be caused by underlying pathology and not induced by idarucizumab

Cost comparison with similar Formulary products:
Drug: N/A

Other considerations:

Novel oral anticoagulants (dabigatran, rivaroxaban, apixaban) have become popular alternatives to warfarin. Unlike warfarin, these agents do not have specific reversal agents available. Idarucizumab is the first reversal agent approved by the FDA for the specific reversal of the anticoagulant effects of dabigatran. A reversal agent is a potentially life-saving measure in the setting of a life-threatening bleed and/or need to have an urgent and invasive life-saving procedure.

Recommendation:

1. Add to TCMC formulary for the indications of dabigatran related life-threatening bleeding

and/or the emergent reversal of dabigatran to facilitate an invasive procedure carrying a moderate-high risk of bleeding

2. Implement basic criteria for use:
    a. Restrict to emergency room, surgery, anesthesia, and hematology departments
    b. Known or suspected dabigatran ingestion within the last 48 hours and elevated baseline aPTT
    c. Life-threatening bleeding and/or need for invasive procedure which cannot be delayed for at least 8 hours after admission

Process/Plan to monitor Patient Response:

1) Monitor hemodynamics, CBC, aPTT

References:

1. **Pollack CV, Reilly PA, Eikelboom J et al Idarucizumab for dabigatran reversal. *N Engl J Med* 2015;373: 511-20.**
2. **Praxbind (idarucizumab) [Package Insert]. Ridgfield, CT: Boehringer Ingelheim Pharmaceuticals, Inc; 2015.**
3. **Lexicomp**

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion { }**

Date: 12/02/2016 **Requestor:** Dr. Nayyar Siddique

Trade Name: Tretinoin **Generic Name:** All-Trans Retinoic Acid (ATRA)

Dosage form(s): Capsule, Oral: 10mg

Indications:

1) Acute promyelocytic leukemia (APL) remission induction
2) Acute promyelocytic leukemia (APL) consolidation therapy
3) Acute promyelocytic leukemia (APL) maintenance therapy

Efficacy:

1) NCCN Guidelines Version 1. 2015 Acute Promyelocytic Leukemia: first line agent for induction treatment : ATRA 45 mg/m^2 daily until count recovery
2) Complete remission rate of over 90% achieved in a study with 3,000 patients

Safety:

Propensity for medication error: Unknown

Abuse potential: none

Sentinel event potential:

1) **APL Differentiation Syndrome**: About 25% of patients with APL treated with tretinoin have experienced APL differentiation syndrome, which is characterized by fever, dyspnea, acute respiratory distress, weight gain, radiographic pulmonary infiltrates, and pleural or pericardial effusions, edema, and hepatic, renal, and/or multi organ failure.
2) **Leukocytosis**: About 40% of patients will develop rapidly evolving leukocytosis. A high WBC at diagnosis increases the risk for further leukocytosis and may be associated with a higher risk of life-threatening complications.
3) **Teratogenicity**: If treatment with tretinoin is required in women of childbearing potential, two reliable forms of contraception should be used during and for 1 month after treatment.

Cost:

Tretinoin 10mg capsules - $19.31/capsule, $579.43/package (available in #30 caps/package)

Other considerations:
Acute promyelocytic leukemia (APL) is the most malignant form of acute myeloid leukemia (AML), comprising approximately 10% of AML cases. APL is distinguished with a distinct morphology and clinical presentation that may be associated with high early death rate due to potentially fatal coagulopathy. To minimize fatality due to coagulopathy, APL patients should start ATRA immediately. Without treatment, APL has a median survival of less than one month.

Recommendation:

1. Add to TCMC formulary for the indication of acute promyelocytic leukemia induction, consolidation, and maintenance therapies
2. Implement basic criteria for use:
    a. Restrict to Hematology/Oncology Physicians
    b. Diagnosis of APL suspected by Oncologist based upon cytology and clinical criteria. Therapy may be initiated before definitive cytogenetic confirmation of the diagnosis has been made
    c. Patient must be transferred to Telemetry or higher level of care if not already admitted to these patient care areas due to need for acute monitoring with initiation of ATRA therapy (risk of APL Differentiation Syndrome)

Process/Plan to monitor Patient Response:
1) Response to induction therapy: bone marrow aspiration and biopsy performed after approximately 30-35 days

References:

1. **Package insert: www.accessdata.fda.gov/drusatfda_docs/label/2004/20438s004lbl.pdf**
2. **Lexicomp**
3. **NCCN Guidelines Version 1.2015 Acute Promyelocytic Leukemia**
4. **Degos L, Dombret H, Chomienne C et al. All-*trans*-retinoic acid as a differentiating agent in the treatment of acute promyelocytic leukemia. Blood 1995;85:2643-2653**

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

Required Field

of Visit: ☐☐/☐☐/☐☐☐☐ **(MM/DD/YYYY)**

VISIT ASSESSMENT

Core Visit	☐ #1 (4-8 months)	☐ #2 (12-16 months)	☐ #3 (18-36 months)
Zip Code of Primary Caregiver: ☐☐☐☐☐			
Chronological Age: ☐☐ Months ☐☐ Days		Adjusted Age: ☐☐ Months ☐☐ Days	

Interpreter Used	☐ No			
	☐ Yes:	☐ Spanish	☐ Arabic	☐ Armenian
		☐ Cambodian/Khmer	☐ Cantonese	☐ Farsi/Persian
		☐ Hmong/Miao	☐ Korean	☐ Mandarin
		☐ Russian	☐ Sign Language	☐ Tagalog
		☐ Vietnamese	☐ Other	☐ Unknown
		☐ Declined		

Insurance (Check all that apply)

☐ CCS	☐ Commercial HMO	☐ Commercial PPO	☐ Healthy Families
☐ Medi-Cal	☐ Point of Service/EPO	☐ No Insurance/Self Pay	☐ Other
☐ Unknown			

PATIENT ASSESSMENT

Weight	**Length**	**Head Circumference**
☐☐.☐☐ (kg)	☐☐☐.☐ (cm)	☐☐☐.☐ (cm)
or ☐☐(lbs) ☐☐ (oz)	**or** ☐☐.☐☐ (in)	**or** ☐☐.☐☐ (in)

GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk? ☐ Exclusively ☐ Some ☐ None

Living Arrangement of the Child	☐ Both Parents	☐ One Parent	☐ One Parent/Other Relatives
	☐ Other Relatives/Not Parents	☐ Non Relative	☐ Foster/Adoptive Family
	☐ Foster Family/CPS	☐ Pediatric Subacute Facility	☐ Other
	☐ Unknown		
Education of Primary Caregiver	☐ <9th Grade	☐ Some College	☐ Other
	☐ Some High School	☐ College Degree	☐ Unknown
	☐ High School degree/GED	☐ Graduate School or Degree	☐ Declined
Caregiver Employment	☐ Full-Time	☐ Multiple Jobs	☐ Unknown
	☐ Part-Time	☐ Work From Home	☐ Declined
	☐ Temporary	☐ Not Currently Employed	

Routine Child Care

☐ **None** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply:

☐ Child Care Outside of Home	☐ Home Babysitter/Nanny	☐ Not Used Routinely
☐ Specialized Medical Setting	☐ Other	

Caregiver Concerns of the Child

☐ **None** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply:

☐ Behavioral	☐ Calming/Crying	☐ Feeding & Growth
☐ Frequent Illness	☐ Gastrointestinal/Stooling/Spitting-up	☐ Hearing
☐ Medications	☐ Motor Skills, Movement	☐ Pain
☐ Sensory Processing	☐ Speech & Language	☐ Stress
☐ Sleeping/Napping	☐ Vision	☐ Other

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

INTERVAL MEDICAL ASSESSMENT

Does the Child have a Primary Care Provider? ☐ No ☐ Yes ☐ Unknown

Does the Primary Care Provider Act as the Child's Medical Home? ☐ No ☐ Yes ☐ Unknown

Hospitalizations Since Last Visit

☐ No ☐ Yes: ☐☐ Number of Hospitalizations ☐ Unknown

If Yes, Check all that apply

Hospitalization Reasons	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Gastrointestinal Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meningitis infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nutrition/Inadequate Growth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Tract Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Rehospitalization(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having Surgeries During Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Surgeries Since Last Visit

☐ No ☐ Yes: ☐☐ Number of Surgeries ☐ Unknown

If Yes, Check all that apply

- ☐ Cardiac Surgery
- ☐ Inguinal Hernia Repair
- ☐ Tracheostomy
- ☐ Other Gastrointestinal Surgical Procedures
- ☐ Other Surgical Procedures
- ☐ Circumcision
- ☐ Retinopathy of Prematurity
- ☐ Tympanostomy Tubes
- ☐ Other Genitourinary Surgical Procedures
- ☐ Unknown
- ☐ Gastrostomy Tube Placement
- ☐ Shunt/Shunt Revision
- ☐ Other ENT Surgical Procedures
- ☐ Other Neurosurgical Procedures

Medications Since Last Visit

☐ No ☐ Yes ☐ Unknown

If Yes, Check all that apply

- ☐ Actigall
- ☐ Antibiotics/Antifungal
- ☐ Cardiac Medications
- ☐ Diuretics
- ☐ Inhaled Steroids (daily)
- ☐ Anti Reflux Medication
- ☐ Antihypertensive
- ☐ Chest Physiotherapy (daily)
- ☐ Inhaled Bronchodilators (daily)
- ☐ Inhaled Steroids (inter.)
- ☐ Anti Seizure Medication
- ☐ Caffeine
- ☐ Chest Physiotherapy (inter.)
- ☐ Inhaled Bronchodilators (inter.)

☐ Nutrition Supplements (make selection): ☐ Enteral Nutrition ☐ Dietary Supplements

☐ Oral Steroids

☐ Oxygen (if discontinued also enter chronologic post-natal age: _____ months _____ days)

☐ Viagra (Pulmonary Hypertension) ☐ Synagis/Palivizumab ☐ Other

☐ Unknown

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

INTERVAL MEDICAL ASSESSMENT - *continue*

Equipment Since Last Visit	☐ No ☐ Yes ☐ Unknown If Yes, Check all that apply		
	☐ Apnea/CR Monitor	☐ Braces/Castings/Orthotics	☐ Enteral Feeding Equipment
	☐ Helmet	☐ Nebulizer	☐ Ostomy Supplies
	☐ Tracheostomy	☐ Ventilator/CPAP/BIPAP	☐ Wheelchair
	☐ Other	☐ Unknown	

MEDICAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Medical Services?
☐ No (Skip to Neurosensory Assessment) ☐ Yes (Complete below) ☐ Unknown (Skip to Neurosensory Assessment)

Audiology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Cardiology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Craniofacial	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Endocrinology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Gastroenterology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Hematology/Oncology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Metabolic/Genetics	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Nephrology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

MEDICAL SERVICES REVIEW *continue*

Neurosurgery	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Ophthalmology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Orthopedic	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Otolaryngology (ENT)	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Pulmonology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Surgery	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason
Urology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	Referred, but Not Receiving (check reason) ☐ Missed Appointment ☐ Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Parent Declined/Refused Service ☐ Service Not Available ☐ Other/Unknown Reason

NEUROSENSORY ASSESSMENT

Vision Assessment History

Does the Child Have History of Retinopathy of Prematurity (ROP)? ☐ No ☐ Yes

Eye Surgery and/or Treatment with Anti-VEGF (i.e. Avastin)? ☐ No ☐ Yes ☐ Scheduled ☐ Unknown

Location of ROP: ☐ Unilateral ☐ Bilateral ☐ Unknown

Does the Child Have Visual Impairment?

☐ No (Skip to Hearing Assessment History)

☐ Yes A. Impairment Due To: (check all that apply)

☐ No, Type of Impairment at Visit

☐ Strabismus:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Cataract:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Retinoblastoma:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled

☐ Cortical Visual Impairment ☐ Refractive Errors

☐ Nystagmus ☐ ROP

☐ Other ☐ Unknown

B. Location of Impairment:	☐ Unilateral	☐ Bilateral	☐ Unknown
C. Corrective Lens(es) Recommended:	☐ No	☐ Yes	☐ Unknown
D. Corrective Lens(es) Used:	☐ No	☐ Yes	☐ Unknown

E. Is There Functional Vision? ☐ Yes ☐ No *(complete below)*

Location of "Blindness" ☐ Unilateral ☐ Bilateral ☐ Unknown

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

*Required Field

NEUROSENSORY ASSESSMENT *continue*

☐ Unknown Visual Impairment

Why is Visual Impairment Unknown?

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but insurance/HMO Denied Services
- ☐ Referred for Functional Vision Assessment
- ☐ No Ophthalmology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ Referred, but Messed Appointment
- ☐ Functional Vision Assessment in Progress

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?

☐ No (Skip to Neurologic Assessment)

☐ Yes A. Is There Loss in One or Both Ears? ☐ One ☐ Both ☐ Assessment in Progress ☐ Unknown

B. Does the Child Use an Assistive Listening Device (ALD):

- ☐ No
- ☐ Yes, ALD Recommended and Received
- ☐ Yes, ALD Recommended, but Not Received
- ☐ Unknown

C. Type of ALD(s) Used (check all that apply) ☐ BAHA ☐ Cochlear Implant ☐ FM System ☐ Hearing Aid ☐ Other ☐ Unknown

☐ Unknown Hearing Loss

Why is Hearing Loss Unknown?

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but Insurance/HMO Denied Services
- ☐ No Audiology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ Referred, but Missed Appointment

☐ Hearing Assessment in Progress (Skip to Neurologic Assessment)

NEUROLOGIC ASSESSMENT

*Was a Neurologic Exam Performed During this Core Visit?

☐ Yes

Date Performed: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ No Reason Why Exam **NOT** Performed:

- ☐ Acute Illness
- ☐ Known SEVERE Developmental Disability
- ☐ Significant Sensory Impairment/Loss
- ☐ Behavior Problems
- ☐ Primary Caregiver Refused
- ☐ Other Medical Condition
- ☐ Examiner Not Available
- ☐ Primary Language
- ☐ Other

Summary of Neurologic Assessment

☐ Normal (skip to Developmental Assessment)

☐ Abnormal

☐ Suspect

A. Oral Motor Function – Age Appropriate Responses for the Following:

Feeding:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Swallowing:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Management of Secretions:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine

B. Muscle Tone

Neck	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Trunk	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

*Required Field

NEUROLOGIC ASSESSMENT *continue*

C. Is There Scissoring of the Legs on Vertical Suspension? ☐ No ☐ Yes

D. Deep Tendon Reflexes:

Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine

E. Are Persistent Primitive Reflexes Present? ☐ No ☐ Yes ☐ Unknown

F. Are Abnormal Involuntary Movements Present? ☐ No ☐ Yes (check all that apply) ☐ Unknown
☐ Ataxia ☐ Choreoathetoid ☐ Tremors

G. Quality of Movement and Posture: ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Functional Assessment

A. Bimanual Function ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Only Complete if the Child is ≥ 15 Months Adjusted Age

B. Right Pincer Grasp ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine
C. Left Pincer Grasp ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

CEREBRAL PALSY (CP)

Does the Child Have Cerebral Palsy (CP)?
☐ No (skip to Developmental Assessment)
☐ Yes
☐ Suspect

Gross Motor Function Classification System (GMFCS) Adjusted Age: (check only one)

Child 18 - 24 months of age adjusted for prematurity		*Child ≥ 24 - 36 months of age adjusted for prematurity*	
☐ Level I	☐ Level IV	☐ Level I	☐ Level IV
☐ Level II	☐ Level V	☐ Level II	☐ Level V
☐ Level III	☐ Unable to Determine	☐ Level III	☐ Unable to Determine

☐ Unable to Determine

DEVELOPMENTAL CORE VISIT ASSESSMENT

*Was a Developmental Assessment Screener or Test Performed During this Core Visit?

☐ Yes
Date Performed: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ No Reason Why Assessment **NOT** Performed:
☐ Acute Illness ☐ Behavior Problems ☐ Examiner Not Available
☐ Known SEVERE Developmental Disability ☐ Primary Caregiver Refused ☐ Primary Language
☐ Significant Sensory Impairment/Loss ☐ Other Medical Condition ☐ Other

DEVELOPMENTAL SCREENERS

Bayley Infant Neurodevelopmental Screener (BINS) – *check appropriate range*

Overall Classification	☐ Low Risk	☐ Medium Risk	☐ High Risk	☐ Unable to Assess

Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - *check appropriate range*

Adaptive Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Communication	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess

Affix Patient Label

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

DEVELOPMENTAL SCREENERS *continue*

Bayley Scales of Infant and Toddler Development Screening Test, 3rd Edition (Bayley-III Screener) - *check appropriate range)*

Cognitive	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess

The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) *enter score*

Language Auditory (CLAMS)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Adaptive (CAT)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Full Scale Capute	Score: _____	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Screener: _____ - *check appropriate range*

Cognitive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
[illegible]er	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Hardcopy" - *enter score*

Cognitive Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Computer" - *enter score*

Receptive Language Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

DEVELOPMENTAL TESTS *continue*

Battelle Developmental Inventory, 2nd Edition (BDI-2) - *enter score*			
Adaptive Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Revised Gesell and Amatruda Developmental and Neurologic Examination (Gasell) - *enter score*			
Language Development	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Mullen Scales of Early Learning - AGS Edition (Mullen) - *enter score*			
Gross Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Visual Perception	Score: _____	☐ Unable to Assess	☐ Did Not Assess
[illegible] Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
[illegible]ceptive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Early Learning Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Test: _____ ***- check appropriate range***

Cognitive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

AUTISM SPECTRUM SCREEN (Optional)

Was an Autism Spectrum Screen Performed During this Visit? ☐ No ☐ Yes *(complete below)*

Screening Tool Used: ☐ M-CHAT ☐ CSBS DP ☐ PDDST-II ☐ Other/Not Listed

Screening Results: ☐ Pass ☐ Did Not Pass

Was the Infant Referred for Further Autism Spectrum Assessment? ☐ No ☐ Yes

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

EARLY START (ES) PROGRAM

Is The Child Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? Check all that apply:

☐ No ☐ Yes ☐ Referred ☐ Referral Failure ☐ Parent Refused Service ☐ Determine Ineligible by ES ☐ Unknown

MEDICAL THERAPY PROGRAM (MTP)

Is The Child Receiving Services Through CCS Medical Therapy Program (MTP)? Check all that apply:

☐ No ☐ Yes ☐ Referred ☐ Referral Failure ☐ Parent Refused Service ☐ Determine Ineligible by ES ☐ Unknown

SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?

☐ No (Skip to Resources and Social Concerns) ☐ Yes (Complete below) ☐ Unknown

Behavior Intervention

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:

☐ Early Intervention Specialist
☐ Other
☐ Licensed Clinical Social Worker
☐ Unknown
☐ Psychologist

Feeding Therapy

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:

☐ Early Intervention Specialist
☐ Occupational Therapist
☐ Registered Dietitian
☐ Other
☐ Certified Lactation Consultant
☐ Physical Therapist
☐ Registered Nurse
☐ Unknown
☐ Home Health Agency
☐ Public Health Nurse
☐ Speech/Language Pathologist

Infant Development Services

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:

☐ Early Intervention Specialist
☐ Physical Therapist
☐ MSW
☐ Unknown
☐ Licensed Clinical Social Worker
☐ Psychologist
☐ Speech/Language Pathologist
☐ Occupational Therapist
☐ Registered Nurse
☐ Other

Hearing Services

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:

☐ Audiologist
☐ Speech/Language Pathologist
☐ Unknown
☐ Early Intervention Specialist
☐ Teacher of the Deaf
☐ ENT
☐ Other

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

SPECIAL SERVICES REVIEW *continue*

Nutritional Therapy

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ Certified Lactation Consultant
☐ Registered Dietitian
☐ Unknown
☐ Public Health Nurse
☐ Registered Nurse
☐ Physician
☐ Other

Occupational (Therapy (OT)

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ Occupational Therapist
☐ Other
☐ Unknown

Physical Therapy (PT)

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ Physical Therapist
☐ Other
☐ Unknown

Speech/Language Communication

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ American Sign Language
☐ Speech/Language Pathologist
☐ Early Intervention Specialist
☐ Other
☐ Teacher of the Deaf
☐ Unknown

Social Work Intervention

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ Licensed Clinical Social Worker
☐ Physician
☐ Unknown
☐ Marriage & Family Therapist
☐ MSW
☐ Psychologist
☐ Other

Visiting, Public Health, and/or Home Nursing

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:
☐ Licensed Vocational Nurse
☐ Registered Nurse
☐ Physician
☐ Other
☐ Public Health Nurse
☐ Unknown

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: _____ **(Last, First)** **HRIF I.D. #** _____

SPECIAL SERVICES REVIEW *continue*

Visitors Services

☐ Does Not Need
☐ Receiving
☐ Complete
☐ Referred at Time of Visit

Referred, but Not Receiving (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

Service Provider:

☐ Low Vision Specialist (Optometrist)
☐ Orientation & Mobility Specialist
☐ Other
☐ Low Vision Specialist (Ophthalmologist)
☐ Physical Therapist
☐ Unknown
☐ Occupational Therapist
☐ Teacher of the Visually Impaired

SOCIAL CONCERNS AND RESOURCES

Caregiver-Child Disruptions or Concerns *Single parent, divorce, prolonged separation (incarceration, military service) multiple changes in caregivers/daycare, caregiver chronic illness*	☐ No ☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Economic/Environmental Concerns/Stressors *Housing insecurity, lack of resources-$$, insurance (or high co-pay), lack of reliable transportation for medical needs*	☐ No ☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Community & Relationship Concerns *Emotional support from family/friends, supportive and safe intimate relationship, safe neighborhood, and resources for needs*	☐ No ☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Parent-Child Concerns *Feeding & growth, calming, behavior, sleep, other*	☐ No ☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources

CHILD PROTECTIVE SERVICES (CPS)

Is a Child Protective Services Case Currently Opened?

☐ No ☐ Yes ☐ Referred at Time of Visit

DISPOSITION *(Required Field)*

☐ Scheduled to Return ☐ Will be Followed by Another CCS HRIF Program (1)

DISCHARGED

☐ Graduated
☐ Family Moving Out of State/Country
☐ Will be Followed Elsewhere
☐ Closed Out of Program
☐ Family Withdrew Prior To Completion
☐ Completed HRIF Core Visits, Referred For Additional Resources

(1) Complete the Transfer Patient Records Process for patient's who will be followed by another CCS HRIF Program.

MD / NNP	DATE / TIME	SW	DATE / TIME
RN	DATE / TIME	RD	DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

Affix Patient Label

7883-1002

HRIF STANDARD VISIT FORM

Unapproved Abbreviation	*Preferred Term*
c.c.	**"mL"**
U	**"Units"**
IU	**"International Units"**
Q.D.	**"Daily"**
Q.O.D.	**"every other day"**
T.I.W.	**"3 times weekly" or "three times weekly"**
Trailing zero (X.0 mg)	**Never write a zero by itself after a decimal point (X mg)**
Lack of leading zero (.X mg)	**Always use a zero before a decimal point (0.X mg)**
MS MSO_4	**"morphine sulfate"**
$MgSO_4$	**"magnesium sulfate"**
S.C. or S.Q.	**"Sub-Q", or "subQ"**
μg	**"mcg" or "micrograms"**
DO NOT use abbreviations for chemotherapeutic agents	

DATE	TIME	Note: Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, instruction to Patients.

Affix Patient Label

Tri-City Medical Center

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PROGRESS RECORD

8720-1018
(Rev. 02/16)

	Vendor Name	Contract Numbe	MEC Review Date	Rating	PAC Review	Board Review
1	Coastal Hospitalist	1007.2243C	2/22/2016		3/10/2016	
2	Marcisz, Thomas J	1007.8C	2/22/2016		3/10/2016	
3	Matthews, Oscar A	1007.80C	2/22/2016		3/10/2016	
4	Mazarei, Rahele DC	1007.81C	2/22/2016		3/10/2016	
5	Mazur, Paul MD	1007.2277C	*deferred*		3/10/2016	
6	McGraw, Charles M	1007.3313C	*deferred*		3/10/2016	
7	Mehta, Ritvik P MD	1007.2360C	2/22/2016		3/10/2016	
8	Melden, Mark DO	1007.86C	2/22/2016		3/10/2016	
9	Melikyan, Arkady M	1007.3234C	2/22/2016		3/10/2016	
10	Mellgren, Sally G M	1007.88C	2/22/2016		3/10/2016	
11	Moazzaz, Payam, M	1007.2224C	2/22/2016		3/10/2016	
12	Brian Mudd, DDS	1007.2318C	2/22/2016		3/10/2016	
13	Muhtaseb, Talal, M	1007.2965C	2/22/2016		3/10/2016	
14	Nielsen, Amy, DO	1007.2960C	2/22/2016		3/10/2016	
15	North County Neor	1007.99C	*deferred*		3/10/2016	
16	North County Oncc	1007.2736C	2/22/2016		3/10/2016	
17	Noud, Michael, M.I	1007.2448C	2/22/2016		3/10/2016	
18	Nowak, Thomas P M	1007.104C	2/22/2016		3/10/2016	
19	Oh, Irene MD	1007.105C	2/22/2016		3/10/2016	
20	Orna Gil, MD	1007.2978C	2/22/2016		3/10/2016	
21	Paduga, Remia MD	1007.923C	2/22/2016		3/10/2016	
22	Pashmforoush, Mo	1007.2989C	2/22/2016		3/10/2016	
23	Pendleton, Robert	1007.109C	2/22/2016		3/10/2016	
24	Phillips, Jason, MD	1007.3170C	2/22/2016		3/10/2016	
25	Ponec, Donald J MI	1007.112C	2/22/2016		3/10/2016	
26	Reisman, Bruce K M	1007.115C	2/22/2016		3/10/2016	
27	Rosenberg, Jay H M	1007.117C	*deferred*		3/10/2016	
28	Rypins, Eric B MD	1007.119C	2/22/2016		3/10/2016	
29	Sadoff, Mark N MD	1007.120C	2/22/2016		3/10/2016	
30	Sahagian, Gregory J	1007.122C	2/22/2016		3/10/2016	
31	Sarkaria, Paul D MI	1007.123C	2/22/2016		3/10/2016	
32	Saxon, Richard R M	1007.125C	2/22/2016		3/10/2016	
33	Schim, Jack D MD	1007.127C	2/22/2016		3/10/2016	
34	Shad, Javaid A MD	1007.129C	2/22/2016		3/10/2016	
35	Sheth, Manish V M	1007.2469C	2/22/2016		3/10/2016	
36	Shim, Michael MD	1007.132C	2/22/2016		3/10/2016	
37	Smith, Mark D MD	1007.138C	*deferred*		3/10/2016	
38	Spellman, Christop	1007.139C	2/22/2016		3/10/2016	
39	Spiegel, David A MI	1007.140C	2/22/2016		3/10/2016	
40	Stern, Mark S MD	1007.12C	2/22/2016		3/10/2016	
41	Sunil Jeswani, MD	1007.3148C	2/22/2016		3/10/2016	
42	Tantuwaya, Lokesh	1007.3304C	2/22/2016		3/10/2016	
43	Toosie, Katayoun M	1007.144C	2/22/2016		3/10/2016	
44	Tri-City Emergency	1007.28C	2/22/2016		3/10/2016	
45	Viernes, Matthew I	1007.145C	2/22/2016		3/10/2016	
46	Wadhwa, Ashish K	1007.146C	2/22/2016		3/10/2016	
47	Wang, Anchi MD	1007.148C	2/22/2016		3/10/2016	
48	Wang, Chunyang T	1007.3167C	2/22/2016		3/10/2016	
49	Warshawsky, Arthu	1007.149C	2/22/2016		3/10/2016	
50	Yoo, Kevin MD	1007.157C	2/22/2016		3/10/2016	
51	Zalewski Zaragoza,	1007.158C	2/22/2016		3/10/2016	
52	Zaveri, Maulik, MD	1007.3009C	2/22/2016		3/10/2016	
53	Zupancic, Michael,	1007.2632C	2/22/2016		3/10/2016	

Governance & Legislative Committee
(No meeting held in March, 2016)

Audit, Compliance & Ethics Committee (No meeting held in March, 2016)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

February 16, 2016 – 3:00 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on February 16, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, DPT, PT
Director Cyril F. Kellett, MD
Director Ramona Finnila
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Finance Officer
Sharon Schultz, Chief Nurse Executive
Cheryle Bernard-Shaw, Chief Compliance Officer
Esther Beverly, VP/Human Resources
David Bennett, Chief Marketing Officer
Wayne Knight, SVP, Medical Affairs
Glen Newhart, Chief Development Officer
Greg Moser, General Legal Counsel
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 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Nygaard and seconded by Director Kellett to approve the agenda as presented. 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.

6. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of items listed on the February 16,

2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Legal Counsel on one matter of Potential Litigation, one matter of Existing Litigation and Public Employee Evaluation of the Chief Executive Officer.

7. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

8. Chairman Dagostino adjourned the meeting to Closed Session at 3:05 p.m.

9. The Board returned to Open Session at 5:17 p.m. All Board members were present.

10. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action had been taken in closed session.

11. There being no further business, Chairman Dagostino adjourned the meeting at 5:17 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

February 25, 2016 – 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 25, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Rahul Reddy, Associate
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
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. Mr. Moser introduced his associate Mr. Rahul Reddy.

2. Approval of Agenda

   Directors requested the following items be added to today's agenda:

   - Public Performance Evaluation: Chief Executive Officer (closed session)
   - Consideration to amend Chief Compliance Officer Agreement related to relocation fee reimbursement (open session).

   Chairman Dagostino requested agenda item 6 e. (2) TCHD vs. Cigna Healthcare of California Inc. be struck from the closed session agenda.

   It was moved by Director Kellett to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the February 25, 2016 Regular Board of Directors Meeting 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 the items listed on the February 25, 2016 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; two Reports Involving Trade Secrets; Conference with Legal Counsel regarding seven (7) matters of Existing Litigation (includes the removal of the TCHD vs. Cigna Healthcare matter) one matter of Potential Litigation, Approval of Closed Session Minutes and the addition of Public Performance Evaluation: Chief Executive Officer.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Schallock to go into closed session at 1:35 p.m. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:41 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 Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Cheryle Bernard-Shaw, Chief Compliance Officer
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in open session.

10. Director Kellett 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 24.

12. Special Award Presentation – American Cancer Society Tri-City Team - Relay for Life Award

Ms. Sharon Schultz, Chief Nurse Executive reported Tri-City has a cancer committee and cancer program as well as a team that has been very involved in the Relay for Life for a number of years. She stated Ms. Renee Salas has been the Chairperson of the team for over nine years and is this year's top fundraiser. Ms. Schultz explained the event raises money for local cancer patients, programs and research and many Tri-City cancer patients attend the event.

Ms. Schultz invited Ms. Salas and her team to the podium and presented them with a plaque in recognition from the American Cancer Society for their participation and leadership on the Tri-City Relay for Life Team.

Ms. Salas expressed her appreciation to Tri-City for their support of the event and stated she hopes this brings more awareness to the community. She encouraged others to join the Relay for Life Team.

13. Community Update – None

14. Report from TCHD Auxiliary – Sandy Tucker, President

Ms. Sandy Tucker introduced First Vice President, Mr. Pat Morocco who will likely be the Auxiliary's new President in the coming year.

Mr. Morocco commented that Human Resources recently approached the Auxiliary regarding giving tours to the new hires at Tri-City. He stated the Auxiliary were excited to provide this service and now average two tours a month for approximately 15-30 new hires. Mr. Morocco stated the tour has been well received by the new employees.

Ms. Tucker reported the Auxiliary is in the process of refreshing all volunteers in the Safety, Health issues, as well as the new Code Silver.

Ms. Tucker reported the volunteers have logged 75,898 hours of volunteer service for 2015.

Ms. Tucker stated the Auxiliary has recently instituted a "suggestion box" to get feedback on how the Auxiliary is doing.

Lastly, Ms. Tucker reported the 3rd Annual *Tails on the Trails* event is scheduled for May 21st with proceeds benefiting the Auxiliary Pet Therapy Program and the Oceanside Police Department K-9 Unit. She encouraged everyone to attend the event.

No action was taken.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer reported we have a number of activities we are working on as result of the Board's decision to affiliate with the UCSD Health System including our agreement to work together with respect to our Cardiac Rehab program. Mr. Moran stated this is the first real "leg" of what is going to be a long standing relationship with UCSD. He explained the agreement will allow UCSD to refer patients to our Cardiac Rehab facilities.

Mr. Moran reported another item related to our affiliation is our focus on physician recruitment. He stated he anticipates two new Neurosurgeons as well as a Surgical Oncologist.

Mr. Moran reported prior to obtaining our Certificate of Occupancy in the new Medical Office Building we will need to complete traffic mitigation work and we will see evidence of the work starting very soon and hope to have the work completed by Memorial Day weekend. Mr. Moran stated there will be signage so that the public understands what we are doing.

With regard to concerns with our Behavioral Health needs, Mr. Moran stated we are continuing to try to get an agreement together with the county for our Crisis Stabilization Unit which is a critical project for our community.

Mr. Moran reported we will be going on the "breakfast, lunch and dinner circuit" to talk to the community about our campus development planning work as well as our affiliation with UCSD.

Director Reno commented on the need to alert the public that our traffic mitigation will be occurring and communicate with the fire departments as well.

No action was taken.

16. Report from Chief Financial Officer

Mr. Steve Dietlin reported on the first seven months of FY 2016 as follows:

- Net Operating Revenue – $194,018
- Operating Expense – $195,058
- EROE - $135
- EBITDA – $8,436
- EBITDA Excl. Settlement - $2,213

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 192
- Adjusted Patient Days – 66,010
- Surgery Cases – 3,741
- Deliveries - 1,576
- ED visits – 38,506

Mr. Dietlin reported on the following indicators for FY16 Average:

- Net Patient Accounts Receivable - $41.0
- Days in Net Accounts Receivable – 47.3

Mr. Dietlin also reported on the current month financials as follows: (dollars in thousands):

- Net Operating Revenue – $128,269
- Operating Expense – $28,540
- EROE - ($1,784)
- EROE Excl. Settlement - $294
- EBITDA – ($594)
- EBITDA Excl. Settlement - $1,484

Mr. Dietlin also presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

Director Reno had questions related to the variance in Adjustment Patient Days and Surgery Cases. Mr. Dietlin provided clarification.

Director Finnila commented that the settlement reported in the financials was the result of errors made in prior administrations that were found and disclosed. She stated that thanks to our current administration we have solved those issues and fines were paid in a timely fashion.

Director Reno commented that resolution of this matter is important to our audit.

No action was taken.

16. New Business

a. Consideration to approve Amendment No. 3 to the Tri-City Healthcare District Flexible Benefit Plan.

It was moved by Director Schallock to approve Amendment No. 3 to the Tri-City Healthcare District Flexible Benefit Plan. Director Nygaard seconded the motion.

Chairman Dagostino explained the purpose of this amendment is to bring the Capital Accumulation Benefit Plan to levels consistent with the market.

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration to appoint Mr. Steve Harrington to an additional two-year term on the Finance, Operations & Planning Committee as recommended by the committee.

It was moved by Director Kellett to appoint Mr. Steve Harrington to an additional two-year term on the Finance, Operations & Planning Committee as recommended by the committee. Director Finnila seconded the motion.

Chairman Dagostino stated the committee unanimously supported the reappointment of Mr. Harrington to an additional two-year term.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Consideration to amend Chief Compliance Officer Employment agreement (addition to agenda).

It was moved by Director Nygaard to amend the Chief Compliance Officer's employment agreement to allow advancement of moving expenses rather than reimbursement of moving expenses. Director Kellett seconded the motion.

Director Dagostino explained Ms. Bernard-Shaw has requested that her employment agreement be amended to allow moving expenses already approved be advanced rather than reimbursed to assist in a home purchase. Chairman Dagostino clarified this is not a new expense but rather a redesignation of relocation expenses. Director Reno questioned if Ms. Bernard-Shaw's request is within the legal parameters. Mr. Moser stated the Board does have authority to approve Ms. Bernard-Shaw's request.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Mr. Moser indicated he will draft an amendment to the Chief Compliance Officer's Employment Agreement per the Board's direction.

18. Old Business

Report from Ad Hoc Committee on electronic Board Portal

Director Mitchell reported one and potentially two demonstrations will be presented to the Ad Hoc Committee on electronic Board Portals.

No action taken.

19. Chief of Staff

a. Consideration of February 2016 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 22, 2016.

It was moved by Director Finnila to approve the February 2016 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 22, 2016. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration of Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 22, 2016.

It was moved by Director Finnila to approve the February Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 22, 2016. Director Reno seconded the motion.

Director Finnila explained information related to the Medical Staff's new appointments and reappointments is discussed in detail by the Board in closed session. She further explained that the Medical Executive Committee guarantees our physicians are up to community and Joint Commission standards and they recommend who is appointed and continues on their Medical Staff.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Finnila to pull item 20 G. 1) Approval of FY2016 Financial Statement Auditor Proposal. Director Nygaard seconded the motion.

It was moved by Director Reno to pull item 20 D. 7) Approval of an agreement with Dr. Chris Guerin, Medical Director for the Diabetic Services/Program for a term of 24 months, beginning July 1, 2016 through June 30, 2018, not to exceed 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost not to exceed $28,800 and a total cost for the term not to exceed $57,600. Director Kellett seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 20 D. 7) related to an agreement with Dr. Chris Guerin questioned if she should abstain from the vote due to the fact that Dr. Guerin is her Endocrinologist. Mr. Moser advised that Director Reno may abstain however it is not required due to the physician/patient relationship.

It was moved by Director Finnila to approve item 20 D. 7) Approval of an agreement with Dr. Chris Guerin, Medical Director for the Diabetic Services/Program for a term of 24 months, beginning July 1, 2016 through June 30, 2018, not to exceed 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost not to exceed $28,800 and a total cost for the term not to exceed $57,600. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Finnila who pulled item 20 G. 1) Approval of FY2016 Financial Statement Auditor Proposal stated she would like to give Mr. John Blakey and Ms. Mary Nguyen an opportunity to introduce themselves as the proposed audit team (along with Ms. Stacy Stelzriede, Concurring Reviewer) to perform the FY2016 Financial Statement Audit.

Mr. Blakey stated he is extremely pleased to continue their professional relationship with Tri-City Healthcare District. He stated when an engagement continues over a span of time it is best practice to get a "fresh set of eyes" and therefore following the policy of partner rotation. Mr. Blakey stated he will be taking over for Mr. Devon Wiens and will oversee the engagement.

Mr. Blakey provided a summary of his background and experience, noting he has been with Moss Adams since 2004 with a focus on healthcare in hospitals and health plans. He stated he has worked closely with district hospitals.

Mr. Blakey introduced Ms. Mary Nguyen, Senior Manager with Moss Adams. He stated Ms. Nguyen has over nine years experience with Moss Adams and has worked with Tri-City on their audit for the two years. Ms. Nguyen stated she is looking forward to working again with Tri-City.

Director Schallock questioned if there were any changes in fees from the past year. Mr. Blakely responded there is no change in the in fees in the audit proposal and the fees remain constant.

It was moved by Director Reno to approve the FY2016 Financial Statement Auditor Proposal. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Reports (Discussion by exception only)

22. Legislative Update

Chairman Dagostino expressed his appreciation to Mr. Moran and Ms. Schultz for their efforts with the county in attempting to obtain justifiable behavioral health funds.

Chairman Dagostino reported Senator Hueso is carrying Senate Bill 957 which will allow district hospitals to use the design build concept. Chairman Dagostino stated he does not anticipate much opposition to the Bill.

Chairman Dagostino reported he and Mr. Moran will be attending CHA Legislative Days on March 15th and 16th in Sacramento as well as AHA Legislative Days in Washington, D.C. in May. He noted colleagues from UCSD will also be attending to present a united effort.

23. Comments by members of the Public

Chairman Dagostino recognized Mr. Steve Matthews.

Mr. Matthews stated he is the labor representative for CNA and represents 650 professional registered nurses here at Tri-City. Mr. Matthews expressed concern regarding the financial matters of the district and stated the union is respectful of the prudent decision by the Board not to raise the pay of the Chief Executive Officer.

Chairman Dagostino recognized Ms. Molly Woods Drake.

Ms. Drake stated she represents 839 of our front line caregivers in the SEIU-UHW union. She spoke regarding the union's request last month to divide the seven board seats into geographical zones to fairly represent the District. She urged the Board once again to adopt a resolution that divides the District into seven board seats; hold a public hearing and implement zone elections for the November 8th election.

24. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

25. Board Communications

Director Schallock did not have any comments.

Director Nygaard referred Board members to the information contained in today's agenda packet related to completion of the Form 700 which she received recently from ACHD.

Director Mitchell commented that she completed her Form 700 electronically.

Director Reno did not have any comments.

Director Finnila stated as a public health organization we have to abide by rules we don't set and must be flexible enough to make change as applicable. She stated that we make every effort to treat and compensate all of our employees fairly and are doing a number of things to make our facility safe and secure. Director Finnila noted some Board members will be attending next week's Employee Forums and encouraged staff to ask questions of board members directly.

Director Kellett congratulated Mr. Moran on the *San Diego Business Journal's* Most Admired CEO award for mega nonprofit companies. Director Kellett described the programs that Mr. Moran has been instrumental in seeing to fruition.

26. Report from Chairperson

Chairman Dagostino also congratulated Mr. Moran for the Most Admired CEO award. He stated it is very rare that a North County Chief Executive Officer receives this kind of award and it is a special honor for Mr. Moran.

Chairman Dagostino stated SEIU has been aggressively involved in the political arena and chose the ballot issue to cap the salaries of the executive staff and expand the voting districts. Chairman Dagostino stated he takes exception to these tactics and urged the union to be diligent in their bargaining and place their efforts there rather than in the political arena.

Lastly, Chairman Dagostino encouraged everyone's support of the 3rd Annual *Tails on Trails* event.

27. Oral Announcement of Items to be Discussion in Closed Session

Chairman Dagostino reported the Board would be returning to Closed Session to complete unfinished closed session business.

28. Motion to return to Closed Session.

Chairman Dagostino adjourned the meeting to closed session at 4:37 p.m.

29. Open Session

At 5:30 p.m. Chairman Dagostino reported the Board was back in open session. All Board members were present.

30. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in closed session.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:32 p.m.

James J Dagostino, DPT
Chairman

ATTEST:

Ramona Finnila, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

March 3 2016 – 1:00 o'clock p.m.
Assembly Rooms 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 1:00 p.m. on March 3, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Finance Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Esther Beverly, VP/Human Resources
David Bennett, Chief Marketing Officer
Wayne Knight, Chief Strategy Officer
Glen Newhart, Chief Development Officer
Gene Ma, M.D., Chief of Staff
Jody Root, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   Chairman Dagostino requested that the agenda be reordered to move item 6 (b) Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees to the last item of the closed session item 6 (g).

   It was moved by Director Kellett and seconded by Director Reno to approve the agenda as presented and amended. 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. Open Session

5. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Root, made an oral announcement of items listed on the March 3, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, Conference with Legal Counsel on two matters of Existing Litigation, one Report on Trade Secrets with various disclosure dates and Public Employee Evaluation of both the CEO and CCO.

6. Motion to go into Closed Session

   It was moved by Director Reno 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 1:05 p.m.

8. The Board returned to Open Session at 7:00 p.m.

9. Chairman Dagostino reported no action was taken in Closed Session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 7:00 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

March 8 2016 – 2:00 o'clock p.m.
Assembly Room 1 – 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 2:00 p.m. on March 8, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director RoseMarie V. Reno
Director Larry W. Schallock

Director Nygaard joined the meeting via teleconference.

Also present were:

Greg Moser, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 2:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Reno and seconded by Director Schallock to approve the agenda as presented. The vote on the motion passed (6-1) with Director Reno opposed.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

5. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of items listed on the March 8, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Consideration of Public Employee: Discipline/Dismissal Release.

6. Motion to go into Closed Session

It was moved by Director Reno 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 2:05 p.m.

8. The Board returned to Open Session at 3:33 p.m.

9. Chairman Dagostino reported no action was taken in Closed Session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 3:33 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

March 17 2016 – 2:00 o'clock p.m.
Assembly Room 2 – 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 2:00 p.m. on March 17, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Acting CEO
Cheryle Bernard-Shaw, CCO
Greg Moser, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 2:00 p.m. in Assembly Room 2 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Reno and seconded by Director Finnila to approve the agenda as presented . The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda.

   Chairman Dagostino recognized Ms. Angela Green, an employee and member of SEIU.

   Ms. Green read a statement expressing the Union's frustration with Mr. Moran's leadership.

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. Moser, made an oral announcement of items listed on the March 17, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, Conference with Legal Counsel related, one matter of potential litigation,

one Report Involving Trade Secrets and Public Employee Evaluation of the Chief Compliance Officer.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Finnila to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Dagostino adjourned the meeting to Closed Session at 2:10 p.m.

8. The Board returned to Open Session at 6:00 p.m.

9. Report from Chairperson on any action taken in Closed Session

Chairman Dagostino reported the Board unanimously appointed Mr. Steve Dietlin as the Chief Executive Officer for Tri-City Healthcare District.

10. **It was moved by Director Finnila to adjourn the meeting. Director Nygaard seconded the motion. The motion passed unanimously (7-0).**

. There being no further business, Chairman Dagostino adjourned the meeting at 6:00 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

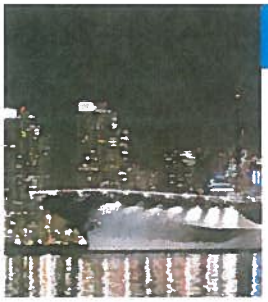
24th Annual
Health Forum and the American Hospital Association
LEADERSHIP SUMMIT
July 17 – 19, 2016 San Diego, California
Manchester Grand Hyatt

NETWORKING OPPORTUNITIES

WELCOME RECEPTION

SUNDAY, JULY 17 5:30 –7:30 PM

The perfect way to end the first day at the Summit with the opening of the Exhibit Hall. A chance to renew acquaintances, network with colleagues, and discuss what you've learned at the day's sessions. Attendees can get an early look at the new products and services offered by the companies that support the Summit.



GALA RECEPTION

MONDAY, JULY 18 6:30 –8:30 PM

Join your colleagues for some unforgettable fun aboard the longest-serving aircraft carrier in the U.S. Navy history. Experience a living piece of American history as you enjoy refreshments and entertainment on the flight deck of the USS Midway. Guest tickets are available for attendees who would like to bring family or friends.

EDUCATIONAL POSTER DISPLAYS

Health care excellence is in the field—share your innovations with your peers through a poster display. Visit the Summit website for guidelines on submitting a poster proposal.

CONTINUING EDUCATION CREDIT

Health Forum is approved by the following organizations to award 15.5 continuing education credits for the 2016 Leadership Summit.

- American College of Healthcare Executives
- California Board of Registered Nursing
- College of Healthcare Information Management Executives Certified Healthcare CIO Program

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HOTEL AND TRAVEL

SUMMIT HOTEL

Manchester Grand Hyatt
1 Market Place
San Diego, CA 92101

HOTEL RESERVATIONS

Rate: $269 for a single/double room.
(Ten dollars of the room rate underwrites the Summit.)

Cut-off date: June 8, 2016

Online reservations:
Visit www.healthforum-edu.com/summithotel

Phone reservations: Call (888) 421-1442 and ask for a reservation for the Health Forum / AHA Leadership Summit.

TRAVEL DISCOUNTS

Visit the Summit website for information on discounts from select airlines and rental car companies.

GROUND TRANSPORTATION

The Manchester Grand Hyatt is located approximately 4 miles from the San Diego International Airport. Taxis are available at designated airport transportation plazas at a cost of approximately $17 one way.

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Expect pleasant temperatures ranging from 65-75F. Business casual attire is appropriate for all events.

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24th Annual
Health Forum and the American Hospital Association
LEADERSHIP SUMMIT
July 17 – 19, 2016 San Diego, California
Manchester Grand Hyatt

KEYNOTE SPEAKERS

SUNDAY, JULY 17 | 1:00 PM

THE POLITICS AND CULTURE OF THE GLOBAL ECONOMY

FAREED ZAKARIA

Host of CNN's *Fareed Zakaria GPS*, contributing editor at *The Atlantic*, and *Washington Post* columnist

Fareed Zakaria is widely respected for his thoughtful analysis and ability to spot economic and political trends. *Esquire* magazine described him as "the most influential foreign policy adviser of his generation." In this presentation, he explores how globalization will affect you, your business, and your country. Understanding this requires mapping out the forces that have produced the global economy, assessing the lessons learned from the economic crisis, and determining how the different dimensions of globalization will change and exert their influence in the future. Understanding the global economy—and how people, corporations and governments fit into it—requires a far more complex understanding of the interaction of politics, culture, technology and economics.

SUNDAY, JULY 17 | 2:45 PM

HEALTH CARE'S NEXT FRONTIER: THE RACE TO INNER SPACE

PATRICK KENNEDY

U.S. House of Representatives (1995-2011); Co-Founder, One Mind for Research and Founder, The Kennedy Forum on Community Mental Health

More than 50 years ago, President John F. Kennedy's cutting-edge approach to governing was to set audacious, seemingly unreachable goals... and exceed them. One of those goals was a call to reach the moon in a decade, catalyzing the "space race." Today, Patrick Kennedy believes we are in a new space race—a race to "inner-space," a quest to understand the brain and brain health as much as we sought to understand the surface of the moon. The stakes are clear—1 in 4 Americans are touched by mental illness. Kennedy will describe new advances in science and policy that are leading the way toward a deeper understanding of "inner space," and the role we all play in achieving the goal of making mental health care as routine, accessible, and understandable as physical health care.

MONDAY, JULY 18 | 8:30 AM

THE WINNER WITHIN

PAT RILEY

President of the NBA's Miami Heat

Pat Riley is one of the brightest figures to ever coach in the NBA. He understands the psychology of teamwork and personal excellence and is a master at creating organizations whose achievements are greater than the sum of their parts. Sharing a vision of how to go above and beyond, he offers an approach to ride with the cycles of team change and make the most of every opportunity. Riley also cites ways for individuals to draw out their natural leadership abilities and explores how one person can make a difference for an entire team.

MONDAY, JULY 18 | 2:00 PM

THE ROAD TO CHARACTER

DAVID BROOKS

Best-selling author of *The Social Animal* and *New York Times* columnist

David Brooks has a gift for bringing audiences face to face with the spirit of our times with humor, insight and quiet passion. He is a keen observer of the American way of life and a savvy analyst of present-day politics and foreign affairs. David's newest book, *The Road to Character*, explains why selflessness leads to greater success. In this urgent and soul-searching presentation he tells the story of 10 great lives that illustrate how character is developed, and how we can all strive to build rich inner lives, marked by humility and moral depth. In a society that emphasizes success and external achievement, *The Road to Character* is a book about inner worth.

MONDAY, JULY 18 | 4:00 PM

NEVER GONNA KEEP ME DOWN

LARA LOGAN

Foreign Affairs Correspondent, CBS News *60 Minutes*

From her professional challenges—breaking into the boys club of warzone reporting and living in warzones with the troops—to personal tragedies—facing breast cancer and surviving sexual assault—Lara Logan has made it her mission to not just endure but to overcome. In this powerful, must-hear speech, Lara shares the inspirational true stories of her life and offers lessons on perseverance and success.

TUESDAY, JULY 19 | 10:00 AM

THE DIGITAL DOCTOR: HOPE, HYPE AND HARM AT THE DAWN OF MEDICINE'S COMPUTER AGE

ROBERT WACHTER, MD

Interim Chair of the Department of Medicine, University of California, San Francisco and author of *The Digital Doctor: Hope, Hype and Harm at the Dawn of Medicine's Computer Age*

Everyone had high hopes computers would be the magic bullet to improve the safety, quality and efficiency of health care. In the past five years, medicine has finally, reluctantly, gone digital. Drawing from personal experiences and real-life case examples, Dr. Wachter explores some of the unforeseen consequences of information technology—including the movement to hire scribes so doctors and patients can look each other in the eye again, and the tendency for clinicians to defer to a new kind of authority (an electronic one)—and offers proposed solutions. He also touches on core issues in medicine, such as what it means to be a doctor—and a patient—in the digital age.

PRE-SUMMIT WORKSHOPS

SUNDAY, JULY 17 8:30 – 11:30 AM

WORKSHOP #1 THE QUEST FOR QUALITY: ACHIEVING THE INSTITUTE OF MEDICINE'S SIX QUALITY AIMS

As health care delivery becomes more focused on value, population health, and outcomes and experience of care for patients, the IOM's six quality aims of safety, effectiveness, patient-centered care, timeliness, efficiency, and equity are more relevant than ever. In this highly interactive workshop with the 2016 AHA-McKesson Quest for Quality honorees, you will expand your understanding of how to fully engage everyone in the hospital in quality improvement and develop a collaborative team-focused environment. Hear about the roadmaps and the challenges and detours they've encountered, and learn what has worked best for their organizations.

WORKSHOP #2 STUCK IN THE MIDDLE WITH YOU: INNOVATING IN AN ERA OF AMBIGUITY

JAMES E. ORLIKOFF, President, Orlikoff & Associates, Inc., Chicago, IL and **JEFF JONES**, Managing Director, Huron Consulting Group, Chicago, IL

The transition from volume to value is proceeding slowly in most markets. At the same time, downward pressure on traditional reimbursement makes the fee-for-service world more challenging, and consumerism and retail healthcare are emerging as entirely new models. In this era of ambiguity, leaders must find ways to innovate that lead to success under both current and future payment models. Meeting this challenge requires developing capabilities and skills that can be leveraged for all payment models. This workshop offers a perspective on where the field stands on the path to value-based care, outlining the uncertainties, and challenging participants to consider the strategies, structure, and capabilities that will prepare them for this uncertain future, while providing benefits under current payment models. Discussion will be structured around a Capability Model, consisting of operational skills and core competencies that will enable health systems to innovate and prosper in an era of ambiguity.

WORKSHOP #3 HOW TO OPERATIONALIZE AND CONTRACT FOR POPULATION HEALTH

JON BURROUGHS, MD, MBA, FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Glen, NH

Health care transformation is being driven by large employers that need to reduce their cost structures through value based health systems that incentivize high quality/low cost outcomes. This requires a capital investment in a population health infrastructure and complete alignment with stakeholders and investors. Clinical and business analytics are key so that contracts with payers, providers, and delivery systems can be dynamic and transparent. The patient (consumer) will also be 'at risk' to promote full engagement so that optimum outcomes can be realized in a new system that promotes health and wellbeing. This workshop will explore the economic mandate for clinical delivery and business model redesign towards population health and review key operational components including palliative care, disease management, post-acute care, retail medicine, and e-health. You will learn how to move your care plan in synchrony with your business plan.

AGENDA

SUNDAY, JULY 17

8:30–11:30 am	Pre-Summit Workshops
10:00–11:00 am	AHA Town Hall
1:00–2:30 pm	Keynote Presentation
2:30–2:45 pm	Break
2:45–4:00 pm	Keynote Presentation
4:00–4:15 pm	Break
4:15–5:30 pm	Educational Track Sessions
5:30–7:00 pm	Welcome Reception in the Exhibit Hall

MONDAY, JULY 18

7:00–8:15 am	Continental Breakfast and Sunrise Sessions
8:30–10:15 am	Keynote Presentation
10:15–11:00 am	Break in the Exhibit Hall
11:00 am–12:15 pm	Educational Track Sessions
12:15–2:00 pm	Lunch in the Exhibit Hall
2:00–3:30 pm	Keynote Presentation
3:30–4:00 pm	Break in the Exhibit Hall
4:00–5:30 pm	Keynote Presentation
6:30–8:30 pm	Gala Reception on the USS Midway

TUESDAY, JULY 19

7:00–8:15 am	Continental Breakfast and Sunrise Sessions
8:30–9:45 am	Educational Track Sessions
9:45–10:00 am	Break
10:00–11:30 am	Keynote Presentation

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Registration includes admission to educational and networking sessions, including official meal functions.

	Member*	Non-Member
EARLY BIRD Registration (register between January 1 and June 1, 2016)	$995	$1095
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Optional Pre-Summit Workshop	$200	

*Member affiliations: AHA, Center for Healthcare Governance and AONE. If you are unsure as to whether your organization is an AHA member, please contact AHA Member Relations at 312-422-2750.

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Register three people from the same organization for the Summit and the fourth registration is complimentary. To qualify, a form is needed for each registrant and team forms must be submitted at the same time.

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If you cannot attend the Leadership Summit, you can send a substitute, even at the last minute. If you must cancel entirely, your request for a refund — minus a $250 processing fee — must be made in writing to registration@healthforum.com no later than

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Join us at the 24th Annual Leadership Summit July 17-19, 2016 in San Diego!
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Trustee

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ADMIN
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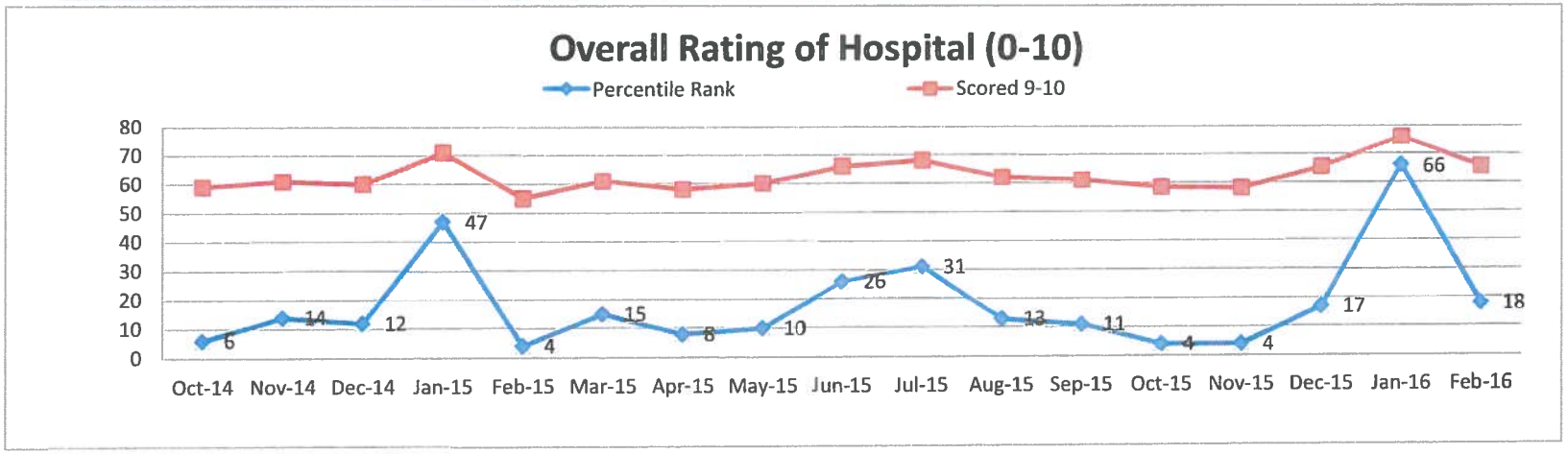
Stakeholder Experience

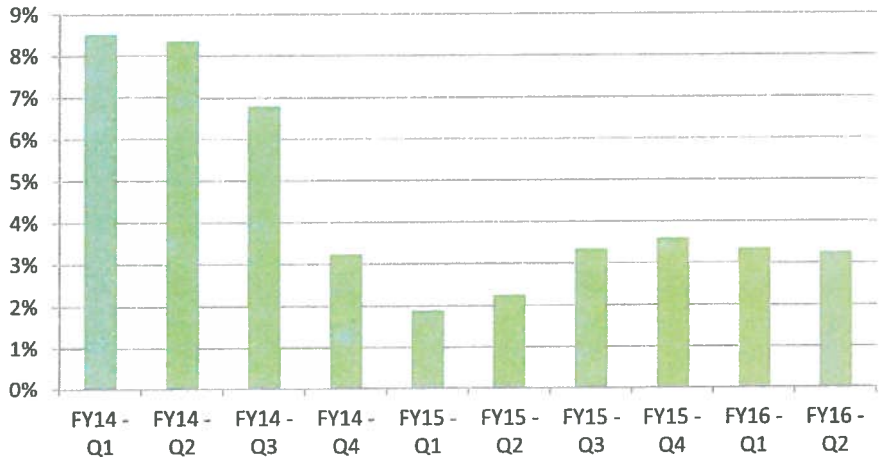
Tri-City Medical Center

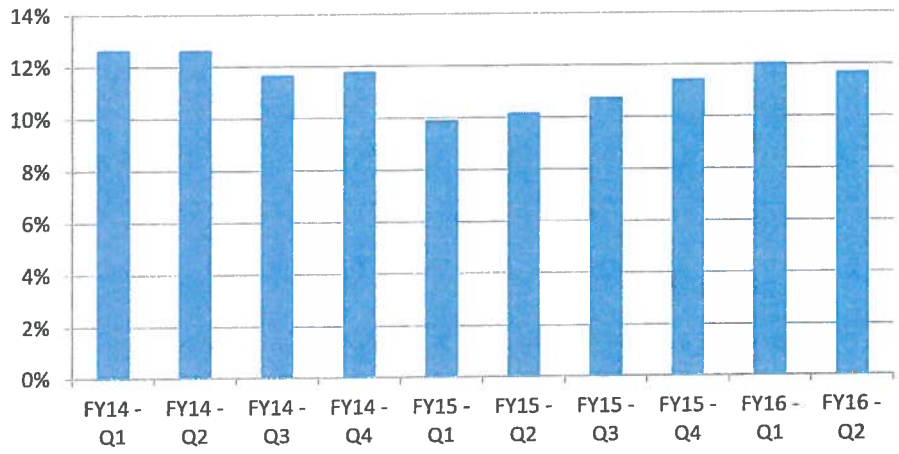
ADVANCED HEALTH CARE FOR YOU

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems



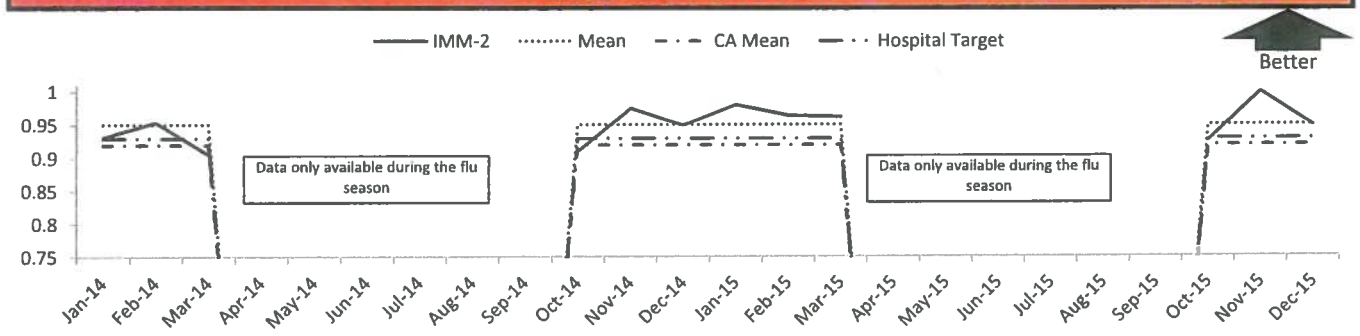




Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

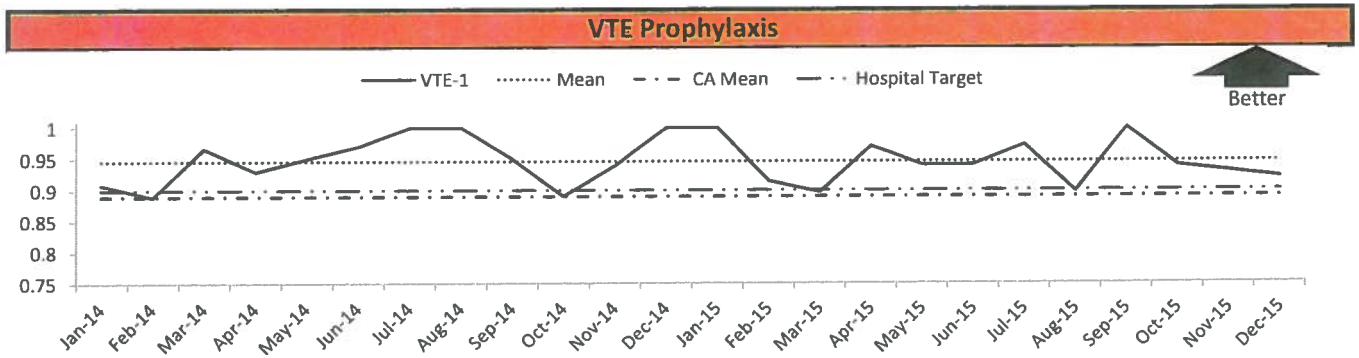
Influenza Immunization



Action Plan

Consistently above threshold. Most common fall out is Immunization on the MAR but not administered prior to discharge. Submitted as medication errors in RL Solutions.

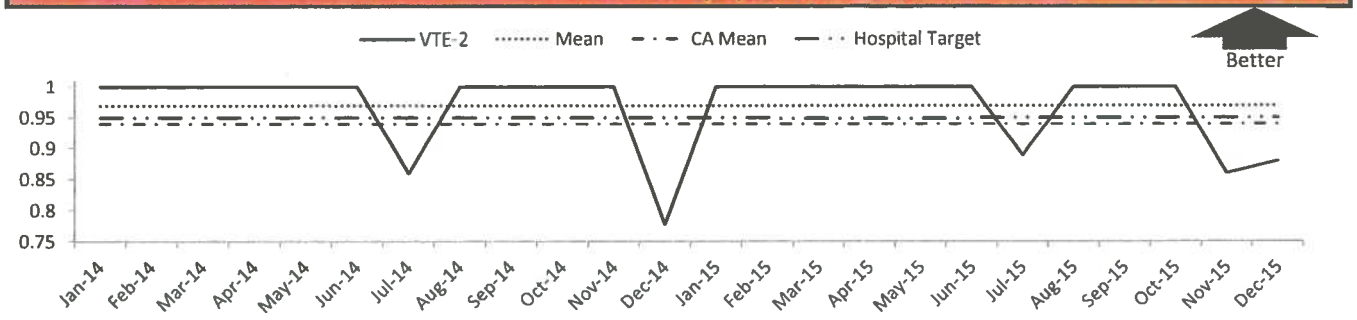
VTE Prophylaxis



Action Plan

CMS retired VTE-1, 2, 3, and 4 starting January 1st 2016 due to high compliance rates. We will no longer be tracking these measures.

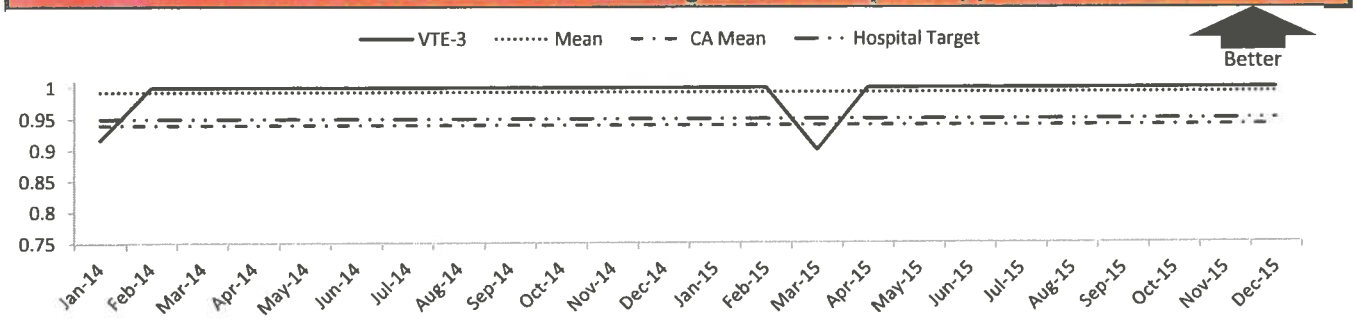
ICU VTE Prophylaxis



Action Plan

Sudden dip in compliance in this measure. We will provide education to physicians to address this on admission. Already a mandatory field in Admission Order sets. **Retired 1/1/16.**

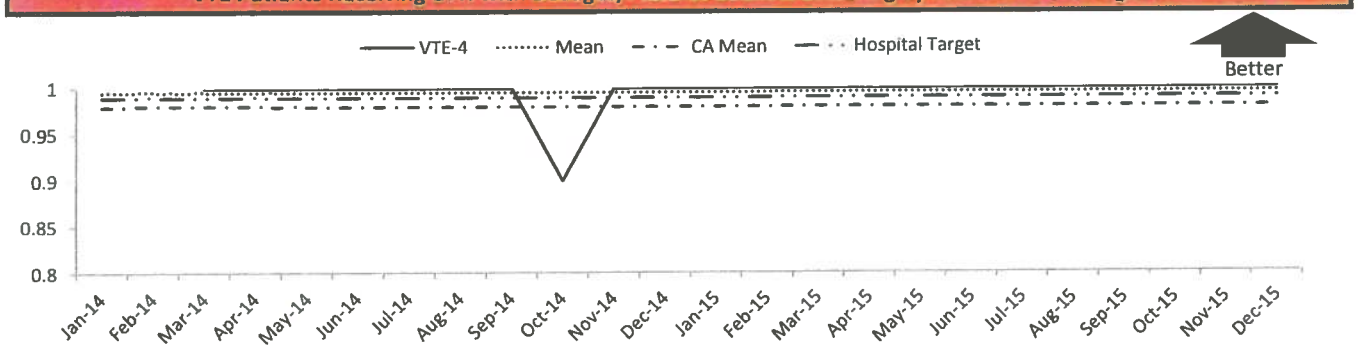
VTE Patients With Anticoagulation Overlap Therapy



Action Plan

Consistently above threshold. **Retired 1/1/16**

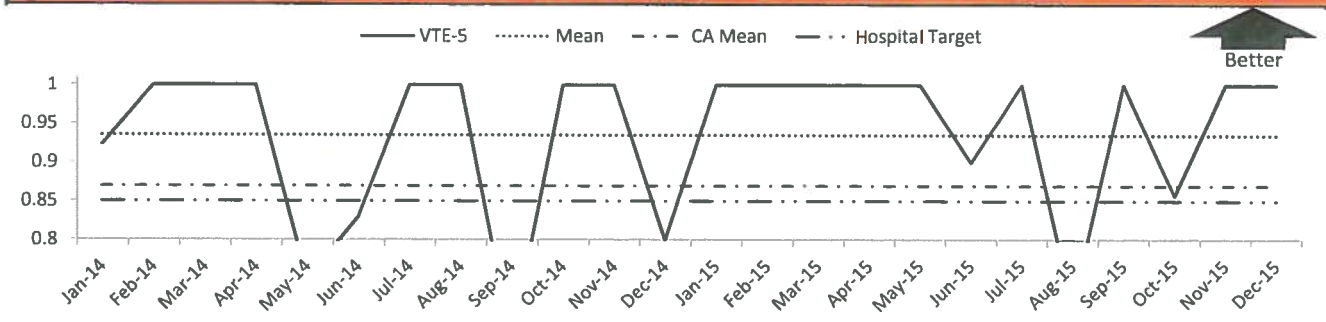
VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Consistently above threshold. **Retired 1/1/16**

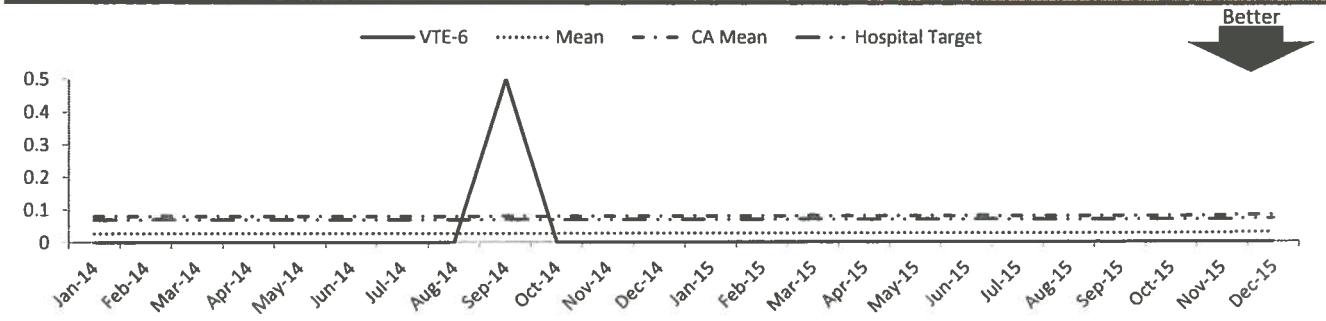
VTE Warfarin Therapy Discharge Instructions



Action Plan

Consistently well above target.

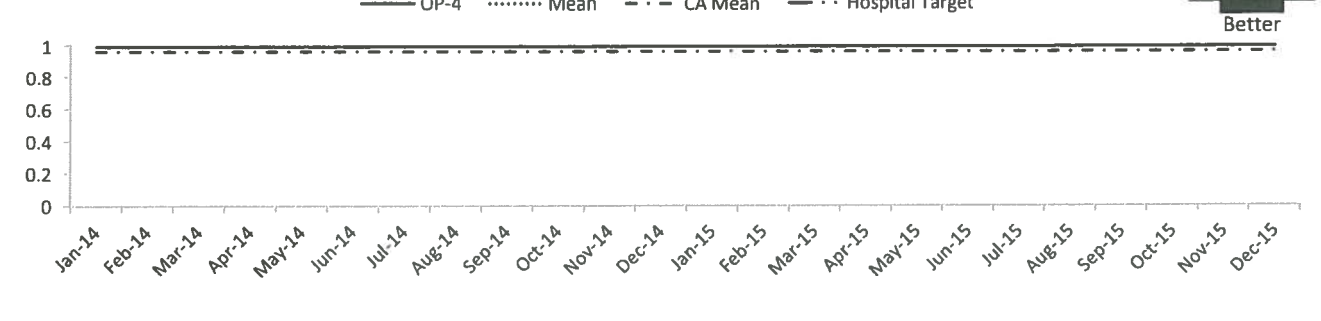
Hospital Acquired Potentially Preventable VTE



Action Plan

Consistently at zero, well below (better than) target.

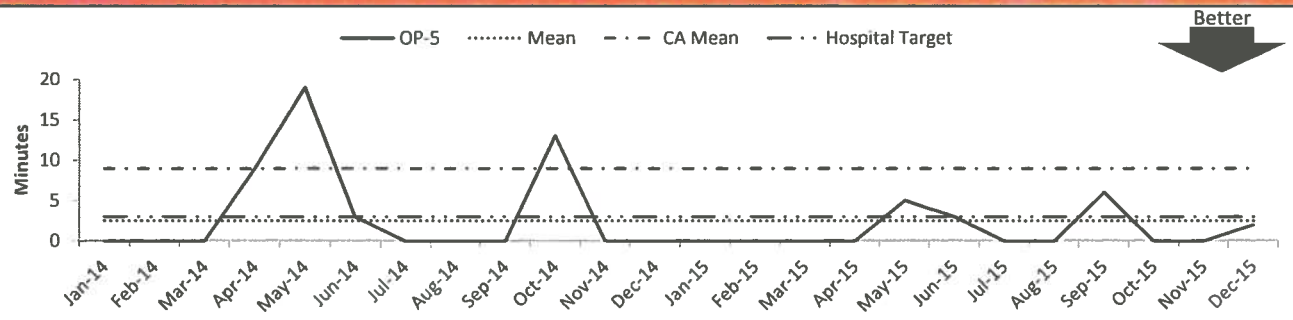
Aspirin at Arrival



Action Plan

Consistently at 100%

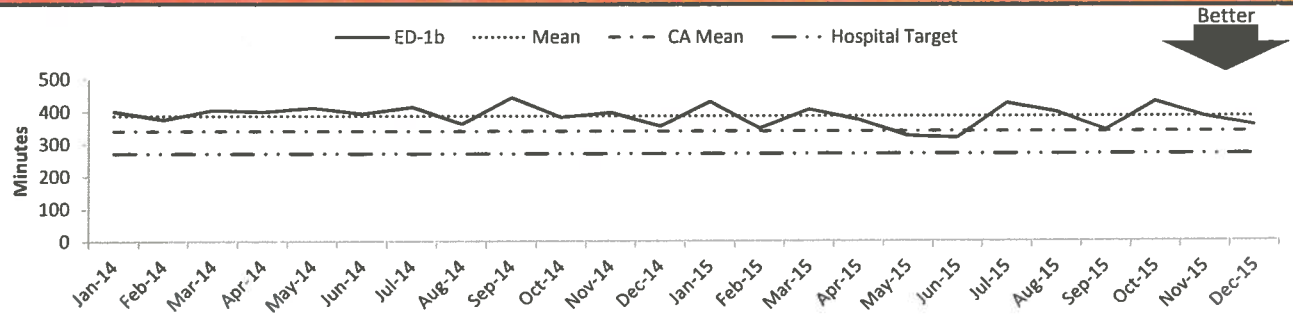
Median Time to ECG



Action Plan

Consistently better than national top 10%. Most Chest pain patients have ECG done prior to arrival which provides a zero minutes door to ECG time.

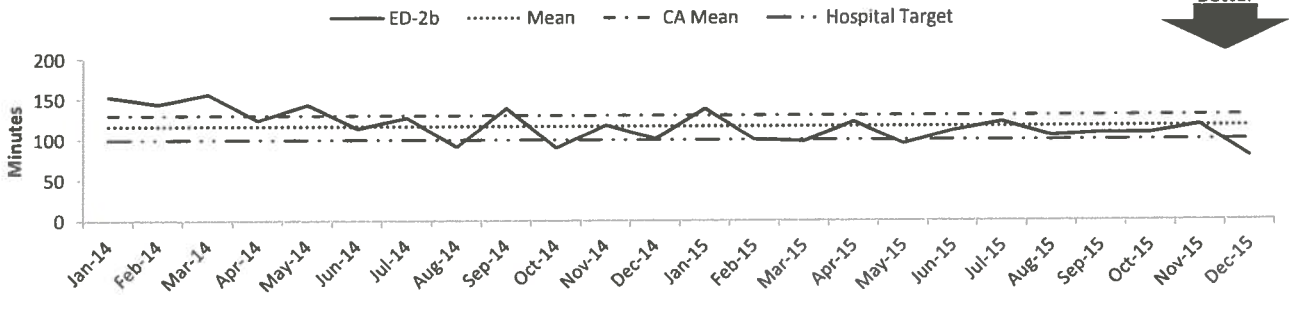
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Patient Throughput committee is:
- Awaiting approval by union for 6 EMTs for patient transport.
- Team Triage during busiest hours. Generally 9a-9p
- Continue efforts toward earlier discharge of inpatients to make beds available for admission from ED.

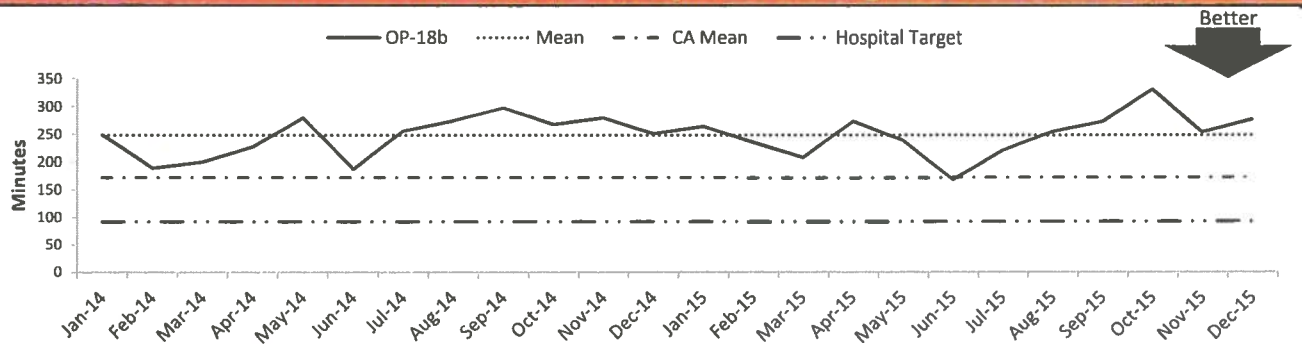
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Patient Throughput Committee efforts to improve including:
- New icons in Cerner/FirstNet to alert staff when bed is ready.
- Starting bed request by ED physicians when patient is a likely admit.
- Increased utilization Aionex bed management program.

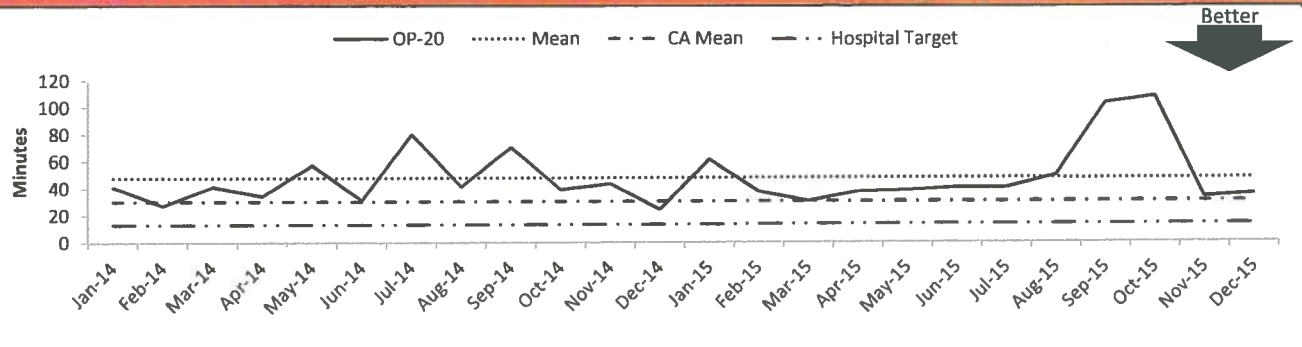
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Efforts to improve this measure include:
- Opening Behavioral Health ED unit.
- Expanding Team Triage efficiency, e.g. longer hours with PAs

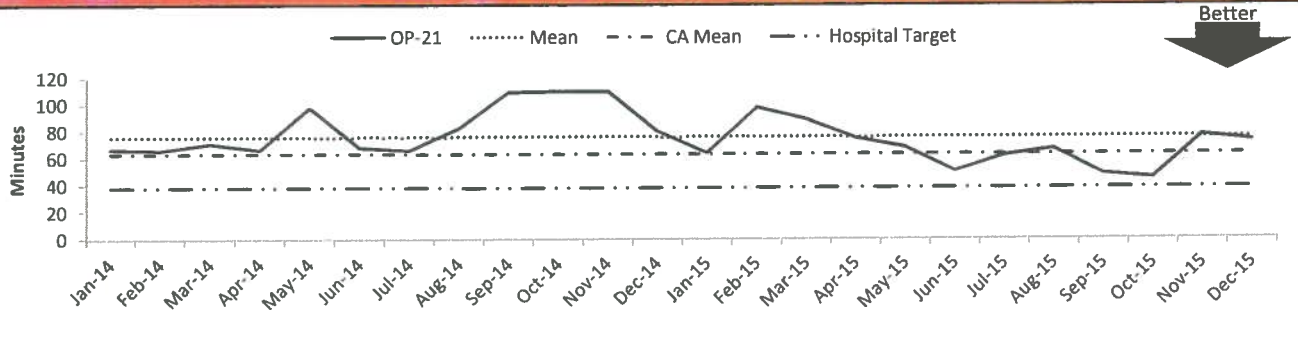
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Sept and Oct were high census months and State removed our ability to use hallway gurneys for patients. Includes previous 3 Action Plans.

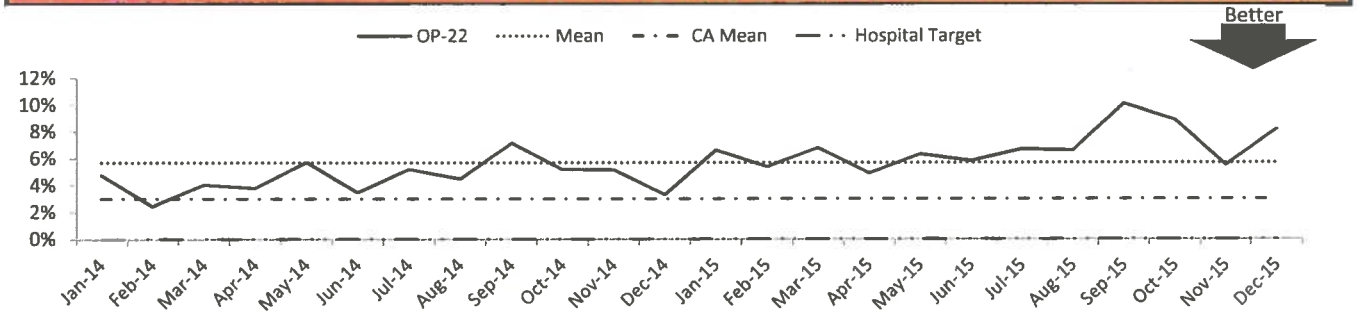
Median Time to Pain Management for Long Bone Fracture



Action Plan

Educating staff to increase awareness of need for earlier administration of pain medication for possible arm or leg fractures.

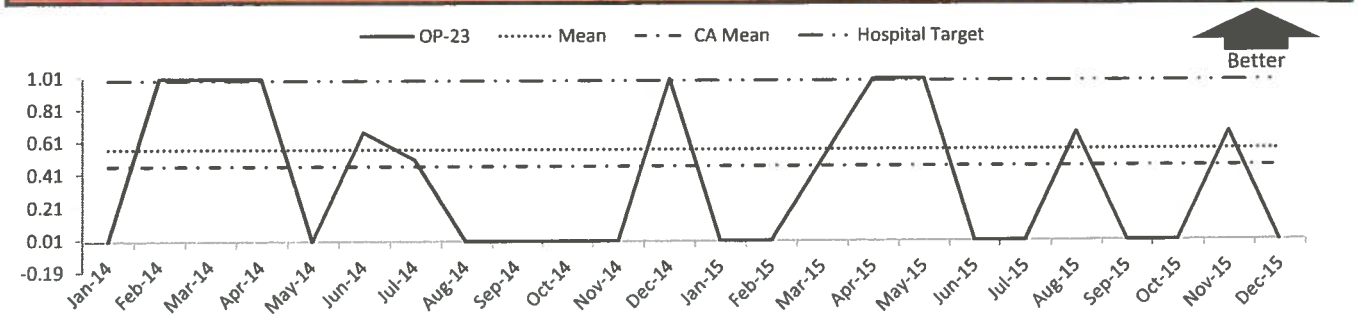
Patient Left Before Being Seen (LWOT)



Action Plan

Census and limited bed availability continue to be main driver in LWOTs.
- Refined definitions of LWOT vs AMS vs Elopement
- Can not see Team Triage patients in 2 rooms to increase capacity for early patient contact.

Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Number of cases very low.
2014 8:13 - Jan, May, Nov - no cases shows as 0% compliant.
2015 9:13 - Jan, Feb, June, July, Oct no cases shows 0% compliant.
We also had a couple of hemorrhagic stroke that needed to be intubated prior to CT, and were then transferred to another hospital.

Control Chart Interpretation

Legend

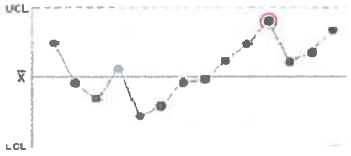
- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

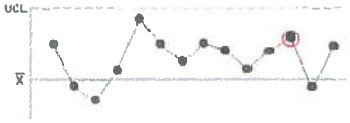
Hospital Mean is the average value we can expect based on the data collected.

Hospital Rate is the actual value.

Hospital UCL (Upper Control Limit) is the highest level of quality that is still considered "normal" given the data history. It is usually 3 standard deviations from the mean.

CA Mean is the average value for all California Hospitals.





One point is more than 3 standard deviations (UCL) from the mean.	One sample (two shown in this case) is grossly out of control.
Six (or more) points in a row are continually increasing (or decreasing).	A trend exists. Procedures in place have an effect on outcomes either positive or negative.
8 (or more) points in a row are on the same side of the mean	Some prolonged bias exists.

Tri-City Medical Center

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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
FY16	46.7	45.7	45.7	45.3	47.0	49.1	51.7	48.9					47.5	48-52
FY15	46.3	48.8	48.5	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9	46.4	49.0	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
FY16	83.6	85.8	92.1	88.7	84.0	82.5	83.6	81.1					85.2	75-100
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	82.6	82.8	83.7	78.5	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
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)					($276)	$3,370
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814	($471)	$2,456	

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
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%					-0.13%	1.48%
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%	-1.61%	1.11%	

Tri-City Medical Center

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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
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797					$9,233	$14,214
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136	$724	$13,122	

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
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%					4.18%	6.26%
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%	2.48%	5.93%	

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
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43					5.92	6.07
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89	6.26	6.03	

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	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73					1.10	
FY15	1.55	1.60	1.52	1.49	1.20	1.24	1.32	1.45	1.53	1.51	1.77	1.81	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5					
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4	$35.3	

Tri-City Medical Center

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Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	49	29	30	30	23	29	22	28					240
FY15	35	32	46	48	35	33	39	35	31	35	37	27	433

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	20	19	15	23	12	13	16	15					133
FY15	14	9	22	24	18	21	19	13	21	19	19	20	219

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	9	10	8	8	13	11	9	13					81
FY15	6	10	9	8	12	11	9	7	16	14	6	7	115

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	19	13	4	7	9	15	20					103
FY15	10	7	10	12	13	7	11	8	9	21	11	15	134

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	40	36	37	44	34	33	44	37					305
FY15	45	51	32	43	49	27	33	43	37	39	40	41	480

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5					17.6
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5	17.9	20.7

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6					6.4
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9	5.1	5.4

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3					15.7
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7	13.5	16.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0					192.9
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5	179.7	191.0

Performance compared to prior year: Better | Same | Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	215	214	252	227	232	220	216	183					1759
FY15	246	263	244	233	194	233	199	159	208	186	218	198	2581

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	9	19	12	16	10	11	15					108
FY15	16	19	12	19	17	11	15	8	12	22	23	21	195

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	3	7	4	5	7	6	6					45
FY15	4	6	2	1	4	8	1	15	4	3	5	1	54

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	14	4	6	7	10	2	8					58
FY15	10	9	10	10	12	12	12	5	12	10	6	13	121

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63					1.61
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.65	1.66	1.61

Performance compared to prior year: Better Same Worse

Building Operating Leases
Month Ending Feb 29, 2016

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$19,672.00	2/1/2015	10/31/2018	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA
Eflin Investments, LLC 20136 Elfin Creek Trail Escondido, CA 92029 Clancy Medical Group	3,140	$2.49		7,818.60	12/01/15	12/31/20	**PCP Clinic** 2375 Melrose Dr. Vista Vista, CA 92081
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	239,250.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	3,398.15	01/01/13	02/29/16	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	6,108.15	05/01/13	04/30/16	**Vacant Building** 3861 Mission Ave, Ste B25 Oceanside, CA 92054
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	9,742.36	09/01/12	08/31/17	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.22	(a)	10,101.01	07/01/11	07/01/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$3.55	(a)	24,931.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$1.10	(a)	4,984.83	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		7,709.79	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		12,429.98	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056
Total				**$346,145.87**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Education & Travel Expense
Month Ending 2/29/16

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	ICU NURSING STAFF
6070	NEONATAL ORIENTATION	22216	2,750.00	77316	NICU NURSING STAFF
6150	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	TELEMETRY NURSING STAFF
6171	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	FORENSICS NURSING STAFF
6183	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	ORTHO NURSING STAFF
6184	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	MS PAVILION NURSING STAFF
6185	ONS CERTIFICATIONS	11116	139.00	80797	MARIA SIOMIN
6185	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	ONCOLOGY NURSING STAFF
6186	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	MONITORED MED NURSING STAFF
6340	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	BHU NURSING STAFF
6385	NEONATAL ORIENTATION	22216	1,000.00	77316	NEONATAL NURSING STAFF
7010	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	ER MEDICAL STAFF
7400	NEONATAL ORIENTATION	22216	1,000.00	77316	LABOR & DELIVERY NURSING STAFF
8390	CA HOSP ASSOC MEDICAL RECORDS	121415	151.96	81328	THERESA VIDALS
8420	CRISIS PREVENTION INSTITUTE	10068635	719.40	80934	SECURITY STAFF
8620	ACHD 2016 LEADERSHIP ACADEMY EXPENSE REIMB	20116EXP	452.87	81380	JULIANNE L NYGAARD
8620	ACHD 2016 LEADERSHIP ACADEMY EXPENSE REIMB	20116EXP	933.55	81515	JAMES DAGOSTINO
8710	INDTITUTE FOR HEALTHCARE IMP	126162	1,975.00	36586	MICHELLE HARDIN
8740	ACLS	21116	110.00	82580	ASHLEY DROLSHAGEN
8740	SHS PALS COURSE	12816	119.00	80879	MARY T. STEINHOFF
8740	EDDU CONFERENCE	12816	150.00	79784	DEANNA DALY
8740	CANCER CARE SYMPOSIUM	21116	200.00	75743	CYNTHIA ZAJAC
8740	NEONATAL TOUCH COURSE	20416	200.00	77388	PRISKA BATTIG
8740	ACLS	21816	200.00	78174	DEBBIE DELUNA
8740	LACTATION TRAINING	21116	200.00	78906	RACQUEL BENAS
8740	CERTIFIED LACTATION	21816	200.00	79537	MISA LE
8740	ACLS	21816	200.00	80056	DENISE DOUGLASS
8740	CERTIFIED LACTATION	21816	200.00	80975	ELENA NAYERMAN
8740	ACLS	21116	200.00	81430	EVELINDA RODRIGUEZ
8740	BSN COURSE	21816	2,000.00	78896	EMELY BOLSTON
8758	INTERVENTIONAL STROKE CONVENTION	22216	400.48	79956	CAROL REELING
8790	JOINT COUNTER TERRISOM	22516	112.24	42308	KEVIN MCQUEEN

**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 19, 2016

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

California Hospital Association Legislative Day March 15, 16, 2016, Sacramento

I attended CHA Leg Day representing our district. I participated in the leadership forum with our colleagues from UCSD, Scripps and Palomar. The following pieces of legislation with a focus of our legislative visits

1 AB 1300 (Support) a bill that would update the Lanterman-Petris- Short (LPS) Act. The bill would allow non-designated hospitals emergency physicians to place and remove a hold in the case of 5150 patients entering the emergency system. The bill was viewed as only a compromise update of the law that approximately 50 years old.

2 AB 2467(Oppose) this bill would require that a hospital report any employee with a total compensation exceeds $250,000 year. Although this is only reporting bill is believed by CHA to be cumbersome duplicative and possibly leading to the situation TCHD faces with our ballot initiative.

3 AB 1252(Oppose) this bill would require hospital to inform a patient prior to any treatment which physicians are contracted with the patient's insurance plan. Also the bill requires an estimate of the costs of all participating treaters in their care. CHA v opposes this bill because it is impossible to interfere with the corporate practice of medicine require physicians to accept assignment of insurance. With the number of contracting physicians that change consistently would be impossible for hospital to know each physicians contracts and fees.

4 SB 1365(Oppose) This bill would not allow hospital outpatient departments to Georgia facility fee when performing services with contracted physicians. CHA opposes this bill because facility fees are what allow hospitals to get reimbursed for the costs of these types of arrangements. Without physician hospital outpatient clinics CHA believes people who run the Medi-Cal program would not have access to these types of services.

I spent time with Aaron Byzak, Government Relations UCSD. Aaron was interested in how we were going to handle the leadership change. He reiterated UCS support for Tri-City and when we made legislative visits together we coupled our conversation with phrases like partners. Both agreed that demonstrating that UCSD in Tri-City committed to the same ideals would be of benefit to our relationships.