## TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING OF THE BOARD OF DIRECTORS January 28, 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 <br> Allotted | Requestor |
| :--- | :--- | :---: | :---: |
| 1 | Call to Order | 3 min. | Standard |
| 2 | Approval of agenda |  |  |
| 3 | Public Comments - Announcement <br> Members of the public may address the Board regarding any item listed on <br> the Closed Session portion of the Agenda. Per Board Policy 14-018, <br> members of the public may have three minutes, individually, to address the <br> Board of Directors. | 3 min. | Standard |
| 4 | Oral Announcement of Items to be Discussed During Closed Session <br> (Authority: Government Code Section 54957.7) |  |  |
| 5 | Motion to go into Closed Session | Closed Session <br> a. Conference with Labor Negotiators <br> Agency Negotiator: Tim Moran <br> Employee organization: SEIU 54957.6) <br> Employee organization: UFCW | 2 Hours |
| 6 | b. Hearings on Reports of the Hospital Medical Audit or <br> Quality Assurance Committees <br> (Authority: Health \& Safety Code, Section 32155) |  |  |
|  | c. Conference with Legal Counsel - Existing Litigation <br> (Authority Government Code Section 54956.9(d)1, (d)4 <br> (1) TCHD vs. Burlew <br> Case No. 37-2014-00034015-CU-NP-NC |  |  |
| 7 | d. Approval of prior Closed Session Minutes |  |  |
| 8 | e. Conference with Legal Counsel - Potential Litigation <br> (Authority Government Code Section 54956.9(d) (4 Matters) | Motion to go into Open Session <br> Open Session <br> Open Session - Assembly Room 3 - Eugene L. Geil Pavilion (Lower <br> Level) and Facilities Conference Room - 3:30 p.m. |  |

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 |  |
| :--- | :---: | :---: | :---: |


| 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 <br> Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. <br> NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications. | 2 min . | Standard |
| 12 | Special Award Presentation <br> a. Recognition of Director Larry W. Schallock for his leadership as Chairman of the Tri-City Healthcare District Board of Directors - 2013-2015 | 5 min . | Chair |
| 13 | Community Update - <br> a. Quarterly Marketing Update - David Bennett, Chief Marketing Officer | 15 min. | CMO |
| 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. Consideration of position on Ballot Initiative | 10 min . | Chair |
|  | b. Consideration to appoint Ms. Virginia Carson to an additional two-year term on the Human Resources Committee as recommended by the Committee | 5 min . | HRC Comm. |
|  | c. Consideration to appoint Mr. Salvador Pilar to an additional two-year term on the Human Resources Committee as recommended by the Committee | 5 min . | HRC Comm. |
|  | d. Consideration to appoint Gwen Sanders to a two year term on the Employee Fiduciary Subcommittee as recommended by the Committee | 5 min . | HRC Comm. |
|  | e. Report from Ad Hoc Committee on electronic Board Portal | 10 min. | Director Mitchell |
|  | f. Consideration to approve contract review process | 10 min . | CCO |
| 18 | Old Business - None |  |  |
| 19 | Chief of Staff <br> a. Consideration of January 2016 Credentialing Actions Involving the Medical Staff - New Appointments Only <br> b. Medical Staff Credentials for January 2016 - Reappointments | 5 min . | Standard |


|  | Agenda Item | Time |  |
| :--- | :---: | :---: | :---: |



|  | Agenda Item | Time <br> Allotted | Requestor |
| :---: | :---: | :---: | :---: |

4) Approval of an Emergency Department On Call agreement with Dr. Neeta Varshney, Ophthalmology for a term of 16 months beginning March 1, 2016 through June 30, 2017, at a daily rate of $\$ 300$ for a FY2016 cost of $\$ 36,600$ and for FY2017 \$109,50 and a total cost for the term of $\$ 146,100$.
5) Approval of acquisition of cardiac monitors for the Emergency Department for a total cost not to exceed $\$ 448,864$.
E. Professional Affairs Committee

Director Mitchell, Committee Chair
(Committee minutes included in Board Agenda packets for informational purposes.)

1) Patient Care Services
a. Fall Risk Procedure and Score Tool Procedure
b. Lumbar Drains, Care of Procedure
c. Organ Donation, Including Tissue, and Eyes
d. Privacy Code
e. Restraints, Used for Non Violent/ Non-Self Destructive Behavior
2) Administrative Policies \& Procedures
a. Consent for Operative or Other Procedures
b. Fiscal Year End Inventory 8610-286
c. Patient Complaints and Grievances
d. Voicemail Access 8610-617
e. Wireless Communication (Wireless network) 8610-624

## 3) Unit Specific <br> Infection Control

a. Aerosol Transmissible Diseases and Tuberculosis Control Plan

Neonatal Intensive Care (NICU)
a. Pulse Oximetry, NICU

## 4) Rehabilitation

a. Performance Evaluations (DELETE)
b. Pool Charges (DELETE)
c. Pool Contamination
d. Therapy Pool
e. Therapy Referrals Orders and Charges (DELETE)
f. Use of Pool by Recreation Specialists (DELETE)
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 January, 2016
G. Audit, Compliance \& Ethics Committee

Director Finnila, Committee Chair
Open Community Seats - 0
(Committee minutes included in Board Agenda packets for

|  | Agenda Item | Time Allotted | Requestor |
| :---: | :---: | :---: | :---: |
|  | informational purposes.) <br> 1) Approval of Administrative Policies \& Procedures: <br> a. 8610-525 - Use and Disclosure of Protected Health Information (PHI) for Fundraising <br> b. 8610-516 - Patient Access to PHI: Patient Record <br> c. 8610-517 - Patient Access to Mental Health Records (DELETED) <br> d. 8750-548 - Education \& Training: Specific Training Programs <br> e. 8750-550 - Education \& Training - Compliance Notices/Updates <br> f. 8610-551 - Monitoring Compliance-Auditing \& Reporting Introduction: General Policies <br> g. 8750-556 - Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities <br> h. 8610-278 - Contract Review <br> (2) Minutes - Approval of <br> a) December 10, 2016 - Regular Board of Directors Meeting <br> b) January 7, 2015 - Special Board of Directors Meeting <br> (3) Meetings and Conferences <br> a) CHA Health Policy Legislative Days - Sacramento, CA March 15-16, 2016 <br> b) iProtean Symposium - La Jolla, CA March 6-8, 2016 <br> (4) Dues and Memberships <br> a) Governance Institute Standard Membership - \$22,350.00 <br> (5) Proposed 2016 Board Committee Assignments |  | Standard <br> Standard <br> Standard |
| 21 | Discussion of Items Pulled from Consent Agenda | 10 min . | Standard |
| 22 | Reports (Discussion by exception only) <br> (a) Dashboard - Included <br> (b) Construction Report - Included <br> (c) Lease Report - (November/December, 2015) <br> (d) Reimbursement Disclosure Report - (November/December, 2015) <br> (e) Seminar/Conference Reports - <br> 1) CHA Governance Forum Report - Director Schallock | 0-5 min. | Standard |


|  | Agenda Item | Time | Allotted |
| :---: | :---: | :---: | :---: | Requestor | R |
| :---: |


| 23 | Legislative Update | 5 min. | Standard |
| :--- | :--- | :---: | :--- |
| 24 | Comments by Members of the Public <br> NOTE: Per Board Policy 14-018, members of the public may have three (3) <br> minutes, individually, to address the Board. | $5-10$ <br> 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 <br> (Includes 10 minutes for recess to accommodate KOCT tape change) | 2.68 <br> hours |  |
| 28 | Oral Announcement of Items to be Discussed During Closed Session <br> (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 <br> (Authority: Government Code, Section 54957.1) -(If Needed) |  |  |
| 32 | Adjournment |  |  |

## ANNUAL CONTRACT SERVICE EVALUATION SUMMARY

Name of Contractor:
Service Provided:
Expiration Date of Contract:
Individual (s)/Title Completing The Summary Form:

Directions: Evaluate each aspect of the contract as noted below:

| Review Criteria |  | Rating | Comments/Actions |
| :---: | :---: | :---: | :---: |
| 1. | Is the nature and scope of service defined in the contract? | Yes No |  |
| 2. | Does the contract require contractor to meet the Joint Commission and other applicable regulatory standards? | Yes No |  |
| 3. | Does the contract require contractor to maintain general liability, workers comp, and professional liability insurance such as medical staff requirements per bylaws (\$1 million per occurrence and $\$ 3$ million in aggregate)? | $\begin{aligned} & \text { Yes No } \\ & \text { NA } \end{aligned}$ |  |
| 4. | Does the contract require contractor/its representative to comply with the bylaws, rules and regulations and policies of the facility and its medical staff? | $\begin{aligned} & \text { Yes No } \\ & \text { NA } \end{aligned}$ |  |
| 5. | Does the contract require contractor to submit, at the hospital's request, any documents, record, and/or other information, as may be requested in furtherance of its quality improvement, utilization review and/or risk management programs? | $\begin{aligned} & \text { Yes No } \\ & \text { NA } \end{aligned}$ |  |
| 6. | Have the Human Resource requirements of the contract service been met? | $\begin{aligned} & \text { Yes No } \\ & \text { NA } \end{aligned}$ |  |
| 7. | Have all requirements of the contract been met | Yes No |  |
| 7 b | Contractor Understands the expectations? | Yes No |  |
|  | During the past 12 months: |  |  |
| 8 a . | Have issues/concerns been received from customers of this service? | $\begin{array}{ll} \hline \text { Yes } & \text { No } \\ \text { NA } \end{array}$ |  |
| 8 b . | Has a patient been injured as a result of this contractor? | $\begin{array}{\|l} \text { Yes No } \\ \text { NA } \\ \hline \end{array}$ |  |
| 8 c . | Have delays in service been experienced? | Yes No |  |
| 8d. | Has a physician or staff (s) voiced concerns regarding this contractor? | $\begin{array}{\|l} \hline \text { Yes No } \\ \text { NA } \\ \hline \end{array}$ |  |
| 8 e | Has there been any incident reports or other risk management issues related to contract service | $\begin{array}{\|l} \hline \text { Yes No } \\ \text { NA } \end{array}$ |  |

Evaluate each aspect of this contract service ( $1=$ Poor Service, $5=$ Excellent Service):

| Review Criteria | Rating | Comment if scored a 1 or 2 |
| :---: | :---: | :---: |
| Customer Service | $\begin{array}{ccccc} 1 & 2 & 3 & 4 & 5 \\ & & \mathrm{NA} \end{array}$ |  |
| Staff/Personnel | $\begin{array}{lcccc} 1 & 2 & 3 & 4 & 5 \\ & & \text { NA } & \\ \hline \end{array}$ |  |
| Overall Staff Competency | $\begin{array}{llcll} 1 & 2 & 3 & 4 & 5 \\ & & \text { NA } \end{array}$ |  |
| Documentation of Staff Competencies | $\begin{array}{llccc} 1 & 2 & 3 & 4 & 5 \\ & & & \mathrm{NA} \\ \hline \end{array}$ |  |
| Compliance with hospital policies/procedures | $\begin{array}{lcccc} 1 & 2 & 3 & 4 & 5 \\ & & & \text { NA } & \\ \hline \end{array}$ |  |
| Compliance with hospital patient safety initiatives | $\begin{array}{lcccc} 1 & 2 & 3 & 4 & 5 \\ & & \text { NA } & \\ \hline \end{array}$ |  |
| PI reports appropriate based on the required indicators | $\begin{array}{lcccc} 1 & 2 & 3 & 4 & 5 \\ & & \text { NA } & & \\ \hline \end{array}$ |  |
| Equipment | $\begin{array}{llccc} 1 & 2 & 3 & 4 & 5 \\ & & & \text { NA } \\ \hline \end{array}$ |  |
| Timeliness of Response | $\begin{array}{llccc} 1 & 2 & 3 & 4 & 5 \\ & & \text { NA } & & \\ \hline \end{array}$ |  |
| Appropriateness of Service as related to Hospital's Mission/Vision and Goals | $\begin{array}{llcll} 1 & 2 & 3 & 4 & 5 \\ & & \mathrm{NA} & & \\ & \end{array}$ |  |
| Overall Service | $\begin{array}{lllll} 1 & 2 & 3 & 4 & 5 \\ & & \mathrm{NA} & & \\ \hline \end{array}$ |  |


| ADMINISTRATION | MEDICAL STAFF | GOVERNING BODY |
| :--- | :--- | :--- |
| $\square$Recommend approval of <br> Contract as is | Recommend approval of <br> Contract as is | Recommend approval of Contract <br> as is |
| aRecommend approval of <br> Contract with changes (see <br> attached) <br> $\square$Recommend Contract NOT be <br> renewedRecommend approval ofContract with changes (see <br> attached) <br> Recommend Contract NOT be <br> renewed <br> Recommend approval of Contract <br> with changes (see attached)Recommend Contract NOT be <br> renewed |  |  |

$\overline{\text { Chief Nursing Officer Date Chief Executive Officer } \quad \text { Date }}$


INITIAL APPOINTMENTS (Effective Dates: 1/29/2016-12/31/2017)
Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective $1 / 29 / 2016$ through 12/31/2017:

- BANSAL, Preeti M.D./Ophthalmology
- BREESE, Mark DMD/Oral \& Maxillofacial Surgery
- CHAMMAS, Joseph M.D./Cardiothoracic Surgery
- GUALBERTO, Gary M.D./Neurology
- MARZAN, Yolanda M.D./Anesthesiology
- TYAGL, Avishkar M.D./Teleradiology


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

## TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals: None

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:
None

# Tri-City <br> Medical Center <br> MEDICAL STAFF <br> TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT - 1 of 3 <br> January 13, 2016 

## Attachment B

## BIENNIAL REAPPOINTMENTS: (Effective Dates 2/01/2016-1/31/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective $2 / 01 / 2016$ through $1 / 31 / 18$, 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:

- AMINLARI, Amy M.D./Emergency Medicine/Provisional
- BRION. Paul H. M.D./Rheumatology/Active
- CHAYA, Nina M.D./Anesthesiology/Active
- FOX, Robert H., M.D./Anesthesiology/Active
- GILBERT, Rebecca, M.D./Anesthesiology/Active
- GOLDSZTEIN, Hernan, M.D./Otolaryngology/Provisional
- GOODING, Isaac A. M.D./Anesthesiology/Active
- GUERENA, Michael P., M.D./Urology/Active
- GUPTA, Anui M.D./Pain Medicine/Provisional
- HAINIK, Christopher A., M.D./Orthopedic Surgery/Provisional
- HAN James DPM/Podiatric Surgery/Active
- HEIFETZ, Susan D., M.D./Internal Medicine/Provisional
- HELGAGER. James A.. M.D./Orthopedic Surgery/Active
- LOBATZ, Michael A., M.D./Neurology/Consulting
- MARC-AURELE, Krishelle L., M.D./Neonatology/Consulting
- MARFORI, Beatriz B., M.D./Psychiatry/Affiliate
- MILLER, Donald T., M.D./Pediatrics/Active
- MORRIS, Jeffrey B., M.D./Ophthalmology/Consulting
- NOWAK, Thomas P., M.D./Neurological Surgery/Active
- OSTRUP, Richard C.. M.D./Neurological Surgery/Courtesy
- PEREIRA, Isabel I., M.D./Internal Medicine/Active
- PERKOWSKI, David I., M.D./Cardiovascular Surgery/Courtesy
- ROTUNDA, Edward S., M.D./Emergency Medicine/Active
- SEBAHAR, Michael I., M.D./Pain Medicine/Consulting
- STERN, Mark S., M.D./Neurological Surgery/Active
- WARSHAWSKY, Arthur B., M.D./Urology/Active
- WISNIEWSKI, Morris, M.D./Internal Medicine/Active
- ZIZZO, Paola V., D.O./Internal Medicine/Consulting

RESIGNATIONS: (Effective date 1/29/2016 unless otherwise noted) Voluntary:

- AGUILAR, Giselle T., M.D./Neurology/Active
- AMINLARI, Amir M.D./Emergency Medicine/Provisional
- BLASKIEWICK, Donald, MD/Neurosurgery/Consulting

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# Tri-City <br> Medical Center <br> MED|CALSTAFF <br> TRI-CITY MEDICAL CENTER <br> MEDICAL STAFF CREDENTIALS REPORT - 1 of 3 <br> January 13, 2016 

- DUNLAP Janet M.D./Orthopedic Surgery/Active
- FAN John, M.D./Radiology/Associate
- GAREY, Donna M., M.D./Neonatology/Consulting
- GHOSH, Sutapa, M.D./OB/GYN/Active
- HUANG, Zhicong MP/Medicine/Oncology
- ISACESCU, Valentine, M.D./Psychiatry
- KAN, Jack, M.D./ Anesthesiology/Active
- KURLAN, Julia, M.D./Dermatology/Allergy/Affiliate
- OTT, Kenneth, MD/Neurosurgery/Consulting
- PLETCHER, Jacob, MD/Anesthesiology/Provisional
- SPELLMAN, Christopher, MD/Surgery/Active


## NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective

Date: 1/29/2016, unless specified otherwise)

## PRIVILEGE RELATED CHANGES

- Vayser, Dean DPM
- Wilke, Lindsey DPM

Podiatry
Podiatry

## STAFF STATUS CHANGES

- None at this time


## PROCTORING RECOMMENDATIONS (Effective $1 / 29 / 2015$, unless otherwise specified)

- Esfandari, Raheleh M.D.
- Rypins, Eric M.D.
- Smith, Angela M.D.

OB/GYN
General/Vascular Surgery
Anesthesiology

# Tri-City <br> Medical Center <br> MEDICALSTAFF <br> TRI-CITY MEDICAL CENTER 

## INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following AHPs have met the basic requirements of staff and are therefore recommended for appointment effective $1 / 26 / 2016$ through $12 / 31 / 2017$ :

- HAMILTON James PA-C


## INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified) Allied Health Professionals: <br> None

## TEMPORARY PRIVILEGES: allied Health Professionals: <br> None

## Tri-City <br> Medical Center <br> MEDICAL STAFF <br> TRI-CITY MEDICAL CENTER <br> INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT - 1 of 3 <br> January 18, 2016

Attachment B

## BIENNIAL REAPPRAISALS: (Effective Dates 2/1/2016-1/31/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective $2 / 1 / 2016$ through $1 / 31 / 18$, 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:

- Packard, Lori, PAC/Allied Health Professional Supervising Physician
- SPRUEL, Candyce E., MFT/Allied Health Professional Supervising Physician Mark Melden, DO
- TARR, Leanne, PAC/Allied Health Professional Supervising Physician


## RESIGNATIONS: (Effective date 1/29/2016 unless otherwise noted)

- None

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: $1 / 29 / 2016$, unless specified otherwise)

## PRIVILEGE RELATED CHANGES

- DiCaro, Audra PA-C
- Kimber,James PA-C


## STAFF STATUS CHANGES

- None at this time

Allied Health Professional
Allied Health Professional

## PROCTORING RECOMMENDATIONS (Effective $1 / 29 / 2016$, unless otherwise specified)

- HERMANN, Linda PA-C
- Lees Shannon AUD
- King, John AUD

Allied Health Professional Allied Health Professional Allied Health Professional

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


| 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 January 12, 2016 meeting with the the addition of item 6.f. Director Reno moved and Gwen Sanders 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 November 10, 2015 meeting. Director Mitchell moved and Director Reno seconded the |  | Chair Kellett |


|  | motion. The motion was carried unanimously. |  |  |
| :---: | :---: | :---: | :---: |
| 5. Old Business |  |  |  |
| None |  |  |  |
| 6. New Business |  |  |  |
| a. B.O.D Dashboard- Stakeholder Experience | The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed \& discussed. | Employee Satisfaction results to be presented annually only | Chair Kellett |
| b. Consideration to appoint Virginia Carson to a second term on the committee | Chair Kellett called for a motion to appoint Virginia Carson to a second term on the Human Resources Committee. Director Reno moved and Dr. Martin Nielsen seconded the motion. The motion was carried unanimously. |  | Chair Kellett |
| c. Consideration to appoint Salvador Pilar to a second term on the committee | Chair Kellett called for a motion to appoint Salvador Pilar to a second term on the Human Resources Committee. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously. |  | Chair Kellett |
| d. Consideration to appoint Gwen Sanders to the Employee Fiduciary Retirement Subcommittee | Chair Kellett called for a motion to appoint Gwen Sanders to the Employee Fiduciary Subcommittee. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously. |  | Chair Kellett |
| e. Policy Discussion/Action Policy 8610-NEW Timecards Policy | The Committee reviewed the new Timecard Policy. Chair Kellett called for a motion to send the Timecard Policy to the Board of Directors for approval. Gwen Sanders moved and Ginny Carson seconded the motion. The motion was carried unanimously. | Timecard Policy to be sent to Board of Directors for approval after HR meets \& confers with the unions | Esther Beverly |
| f. Employee Market Increases Breakdown | Esther Beverly, HR presented the employee market increases breakdown. The committee reviewed \& discussed. |  | Esther Beverly |
| 7. Work Plan | The work plan was reviewed. |  | Chair Kellett |
| 8. Committee Communications | None |  | Chair Kellett |



# Tri-City Medical Center 

Oceanside, California

Administrative Manual

## ISSUE DATE: 6/87

REVISION DATE: 5/88, 2/97, 12/99, 10/02, 2/03, 7/05, 1/08, 7/10
$\begin{array}{ll}\text { Human Resources Committee Approval: } & \text { 09/14 } \\ \text { Board of Directors Approval: } & 09 / 14\end{array}$

## A. PURPOSE:

1. In order to ensure that TCHD provides the highest quality services, employees must report to work on a consistent and timely basis and must seek, except under extraordinary circumstances, to inform their supervisors reasonably in advance of unscheduled absences or tardiness.

## B. DEFINITIONS:

1. Absence: An absence that is not authorized or previously scheduled under the District's Leave of Absence Policy \#435 or Paid Time Off (PTO) Policy \#433.
2. No-Call. No-Show: Any absence on a scheduled workday along with the failure to notify the employee's supervisor/department manager at least two (2) hours prior to the scheduled starting time or in accordance with specific departmental policy.
3. Tardiness or Tardy: Reporting and being ready to work after the beginning of a scheduled shift, or after an authorized rest or meal period. Each instance of tardiness is counted as a separate occurrence, thus an employee may have multiple tardies within a single shift.
4. Abandonment of Position: Any of the following will be deemed abandonment of an employee's positions: (a) no call, no show for three (3) consecutive scheduled work days, (b) failure to return to work following authorized leave or scheduled PTO, (c) absence during any period for which the employee has requested authorized leave or scheduled PTO when such request has been denied, or (d) leaving the work assignment without authorization.
C. POLICY:
5. Except where such notice is not reasonably feasible, each employee will notify, by telephone, his/her supervisor/department manager or designee of any absence at least two (2) hours prior to the employee's scheduled starting time (or in accordance with specific departmental policy). Except as provided in C. 2 below, any employee who fails to provide the required advance notice shall be considered a "no call, no show."
6. A supervisor/department manager may, at histher sole-discretion, shall attempt to contact an employee who has not reported to work at the beginning of a scheduled shift to inquire whether the employee will report to work. In such event, the employee must inform the supervisor/department manager when the employee expects to report to work, and if the employee does report to work at the time specified, the employee shall not be considered a No call, No show but shall be considered tardy. This provision C. 2 shall apply to the beginning of scheduled shifts only and not to failures to report following authorized rest or meal periods. The employee may not use PTO for the tardy arrival.
7. In any instance where the employee is a no call, no show, the employee's supervisor/department manager may replace the employee for the shift. In such case, the employee shall not be permitted to report to work and shall also be deemed absent for the entire shift. The employee may not use PTO for the "No call, No show."
8. When an employee's absence extends beyond one day, the employee must provide the required advance notice to his/her immediate supervisor/department manager or designee for each day of the absence. In the case of absence due to the employee's own illness or injury, an employee may satisfy this requirement by providing a medical certification from the employee's health care provider showing the employee's anticipated date of return to work. If the employee complies with this Section C.4, the absence over multiple days shall be counted as a single occurrence.
9. Under some circumstances, an absence may be converted to authorized leave or PTO if the employee can demonstrate that he/she meets the requirements for such leave or PTO but only with the approval of the supervisor/department manager. Conversion of an absence on any day with respect to which the employee has requested and been denied PTO or other scheduled leave, or on any day immediately preceding or following a recognized holiday under Policy \# [433] shall require the approval of the COO or CNE.
10. Supervisors/department managers are responsible for reporting absences, no call, no shows and tardiness to [payroll].
11. Employees who are absent from work for more than three (3) consecutive scheduled work days must call Employee Health Services to verify whether a physician's release is required before the employee may return to work. Any employee who fails to obtain a required release shall not be permitted to return to work and shall be treated as a "no call, no show" and as absent from work.
12. All employees must inform their supervisors/department managers if leaving the District grounds anytime during an assigned shift other than during an authorized rest or meal period or on District business approved in advance by the employee's supervisor/department manager.
13. If an employee is unable to complete his/her assigned shift, the supervisor/department manager will determine if this occurrence is an absence. Employees who fail to be present during his or her scheduled shift for unauthorized absences will be subject to appropriate disciplinary action up to and including termination.
a. An unscheduled absence after denial of a request for time off or an unscheduled absence following corrective action or any misrepresentation of facts relating to attendance may result in disciplinary action up to and including termination.
b. Any violation of this policy will result in disciplinary action, up to and including termination.

## D. EXEMPT EMPLOYEES:

1. Exempt employees are expected to be present and available to work during regular business hours for TCHD or their departments.

## TRI-CITY MEDICAL CENTER <br> EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE OF THE BOARD OF DIRECTORS January 12, 2016

| Voting Members Present: | Chair Dr. Cyril Kellett, Director Rosemarie Reno, Ginny Carson |
| :--- | :--- | :--- |
| Non-Voting Members Present: | Tim Moran, CEO; Kapua Conley, COO; Esther Beverly, VP of HR; Cheryle Bernard-Shaw |
| Others Present: | BOD Chair James Dagostino, Quinn Abler, Maureen Peer, Dena' Baker, Gary Allen, <br> Frances Carbajal |
| Members Absent: Discussion Action <br> Topic Follow-up  | Person(s) <br> Responsible |


| 1. Call To Order | Chair Kellett called the meeting to order at 11:00 <br> a.m. | Chair Kellett |  |
| :--- | :--- | :--- | :---: |
| 2. Approval of Agenda | Chair Kellett called for a motion to approve the <br> January 12, 2016 meeting agenda. Chair Kellett <br> moved to approve and Ginny Carson seconded <br> the motion. The motion was carried <br> unanimously. | Chair Kellett |  |
| 3. Comments by members of the <br> public on any item of interest to <br> the public before Committee's <br> consideration of the item | Chair Kellett read the paragraph regarding <br> comments from members of the public. | No public comments | Chair Kellett |
| 4. Ratification of Minutes | Chair Kellett called for a motion to approve the <br> minutes of the August 11, 2015 meeting. Ginny <br> Carson moved to approve and Chair Kellett <br> seconded the motion. The motion was carried <br> unanimously. | Chair Kellett |  |

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| 5. Old Business |  |  |  |
| :--- | :--- | :--- | :--- |
| None |  |  | Esther Beverly |
| 6. New Business |  |  |  |
| a. Lincoln Quarterly Update | Maureen Peer, Lincoln Relationship Manager <br> presented executive summary which included <br> an update from Lincoln's quarter results. Key <br> plan statistics, plan asset growth, contributions, <br> earnings, participation rates, average deferral <br> rates and account balances where also <br> reviewed. |  | Esther Beverly |
| b. Prudent Quarterly Update | Dena' Baker presented the third quarter market <br> review. Dena' updated the committee on <br> employee participation, market summary, world <br> market performance stocks and asset classes. <br> Dena' described highlights and the growing <br> enrollment, participation rate and great <br> communication and relationship between TCHD <br> employees and Prudent investment advisors. |  |  |
| c. Lincoln Recordkeeping Services | Maureen Peer, Lincoln Relationship Manager, <br> presented a verbal quote for a 2 year fee <br> increase for Lincoln's recordkeeping services. | Chair Kellett called for a motion to <br> table Lincoln's suggested fee <br> increase. Ginny Carson moved to <br> table and Director Reno seconded <br> the motion. The motion was carried <br> unanimously. | Esther Beverly |
| 7. Comments made from the |  |  |  |
| Committee | None |  | Chair Kellett |
| 8. Date of next meeting | May 10, 2016 | Chair Kellett |  |
| 9. Adjournment | Chair Kellett adjourned the meeting at 12:30 |  | Chair Kellett |



Employee Fiduciary Retirement Plan Subcommittee

# Community Healthcare Alliance Committee <br> (No meeting held in January, 2016) 

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

| Members Present | Director James Dagostino, Director Cyril Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Marcus <br> Contardo, Dr. Frank Corona, Kathleen Mendez, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter, Tim <br> Keane |
| :--- | :--- |
| Non-Voting Members <br> Present: | Steve Dietlin, CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO, Wayne Knight, <br> Sr. VP, Medical Services |
| Others Present | Kathy Topp, Jane Dunmeyer, Ray Rivas, Ernie Mier, Charlene Carty, David Bennett, Mary Diamond, Sarah <br> Jayyousi, Tom Moore, Colleen Thompson, Monica Trudeau, Sharon Schultz, Candice Parras, Chris <br> Miechowski, Jeremy Raimo, Greta Proctor, (Procopio), Barbara Hainsworth |
| Members Absent: | Tim Moran, CEO |


| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
| 1. Call to order | Director Dagostino called the meeting to order at 12:32 pm. |  |  |
| 2. Approval of Agenda | Director Dagostino conveyed that a corrected version of write-up 6.c. and the complete Dashboard have been distributed to each committee member. | MOTION <br> It was moved by Director Nygaard, Director Kellett seconded, and it was unanimously approved to accept the agenda of January 19, 2016. |  |
| 3. Comments by members of the public on any item of interest to the public before committee's consideration of the item. | Director Dagostino read the paragraph regarding comments from members of the public. |  | Director Dagostino |
| 4. Ratification of minutes of November 17, 2015 |  | Minutes were ratified MOTION <br> It was moved by Dr. Contardo, Ms. |  |


| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
|  |  | Mendez seconded, that the minutes of November 17, 2015, be approved without any modifications requested. |  |
| 5. Old Business |  |  |  |
| 6. New Business |  |  |  |
| a. PepsiCo | Tom Moore explained that this agreement was for 3-years, with two optional years, beginning in February 2016 and ending in January 2019. It will gives this vendor exclusive pouring rights at TCHD. He further conveyed that the total estimated savings over the 3 -year term is $\$ 138,100$ from the current expenditure. | MOTION <br> Director Nygaard moved, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with PepsiCo for exclusive pouring rights for a term of 36 months with 2 additional option years, beginning February 1, 2016 and ending January 31, 2019 for an estimated annual cost of $\$ 300,000$, and a total cost not to exceed $\$ 900,000$ for the $\mathbf{3 6}$ month term. | Thomas Moore |
| b. Homecare - Homebase, LLC | Monica Trudeau presented the Homecare-Homebase, LLC <br> Agreement. She emphasized that this was a renewal of an agreement from 2013, for licensed software for electronic medical record and billing, including the following components: <br> - PointCare Manager (Point of Care) <br> - Office Administration Modules (Homecare Module) <br> - Workflow Manager <br> - Clinical Manager | MOTION <br> Mr. Harrington moved, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Homecare - Homebase, LLC for a documentation software system for a term of 6 years, beginning October 18, 2015 and ending October 18, 2021 for an annual cost of $\$ 73,002$, and a total cost for the term of $\$ 438,012$. | Monica Trudeau |


| Topic | Discussions, Conclusion Recommendations | Action Recommendations/ Conclusions | Ptison(s) Responsible |
| :---: | :---: | :---: | :---: |
| c. Physician Agreement <br> - Ruchira Densert, M.D. | Sarah Jayyousi presented the Physician Agreement for CoMedical Director for Dr. Ruchira Densert. She explained that this agreement was to increase the hours Dr. Densert will work, while reducing another physician's hours by the same amount, thus keeping the overall agreement budget neutral. | Dr. Contardo moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Densert as the Coverage Physician/Co-Medical Director for a term of 29 months beginning February 1, 2016 and ending June 30, 2018. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $\$ 125$ for an annual cost of $\$ 24,000$, and a total cost for the term of $\$ 58,000$. | Sarah Jayyousi |
| d. Physician Agreement for ED On-Call Coverage <br> - Neeta Varshney, M.D. | Kapua Conley presented the Physician Agreement for Emergency Department On-Call Ophthalmology Coverage for Dr. Neeta Varshney. He conveyed that this agreement is necessary to add another physician to the oncall Ophthalmology group of physicians, and there would be no additional expense incurred. | Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Neeta Varshney, M.D. as ED On-Call Coverage Physician for a term of 16 months beginning March 1, 2016 and ending June 30, 2017, at daily rate of $\$ 300$, for a FY 2016 cost of $\$ 36,600$, and for FY 2017 \$109,500 and a total cost for the term of $\$ 146,100$. | Kapua Conley |
| e. Emergency Department Cardiac Monitors Proposal - Nihon Kohden America | Candice Paras presented the Emergency Department's Acquisition of Cardiac Monitors proposal. She explained that this agreement would replace 39 cardiac monitors in Stations A, B, $C$ and D. The purchase would eliminate the need for the rented cardiac monitors, which would | Dr. Contardo 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 acquisition of cardiac monitors for the Emergency Department for a total cost not to exceed $\$ 448,864$. | Candice Parras |


| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
|  | subsequently render a savings of approximately $\$ 2 \mathrm{~K}$ per month. <br> Some discussion ensued, and it was further explained that the vendor for the cardiac monitors owned by TCMC and still operational, has conveyed that parts for these units will no longer available, as of 1/1/16. |  |  |
| f. Financials | Steve Dietlin presented the financials ending December 31, 2015 (dollars in thousands) <br> Fiscal Year to Date <br> By Fiscal Year <br> FY Avg. Net Patient A/R <br> (in millions) \$ 40.5 <br> FY Avg. Days in Net A/R \$ 46.6 <br> Graphs: <br> - TCMC-Net Days in Patient Accounts Receivable <br> - TCMC-Average Daily Census-Total HospitalExcluding Newborns <br> - TCMC-Adjusted Patient |  | Steve Dietlin |


| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Peison(s) Responsible |
| :---: | :---: | :---: | :---: |
|  | Days <br> - TCMC-Emergency Department Visits <br> - TCHD-EBITDA and EROE, Quarterly |  |  |
| g. Work Plan - Information Only | Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions. |  |  |
| - Construction Report | Construction Report: <br> Kapua reviewed the report detailing those projects completed, in progress, and that are pending. |  | Chris Miechowski / Kapua Conley |
| - Aionex Bed Board / Throughput | Aionex Bed Board / Thoughput: <br> Kathy Topp presented a single PowerPoint slide, detailing the status of current Patient Throughput Initiatives. |  | Kathy Topp |
| - Dashboard | Dashboard: <br> No discussion held. |  | Steve Dietlin |
| - Neuroscience Institute NSI Medical Directorships | Neuroscience Institute-NSI Medical Directorships: Jeremy Raimo gave a short PowerPoint presentation including metrics from 2015 and planned metrics for 2016 |  | Jeremy Raimo |
| - Medical Director, Surgery | Medical Director, Surgery: <br> Mary Diamond gave a brief Outcome Performance PowerPoint |  | Mary Diamond |



## FINANCE, OPERATIONS \& PLANNING COMMITTEE <br> DATE OF MEETING: January 19, 2015 <br> PepsiCo Proposal for Service

| Type of Agreement |  | Medical Directors |  | Panel | X | Other: Supply |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Status of Agreement | X | New Agreement |  | Renewal - <br> New Rates |  | Renewal - Same <br> Rates |

Vendor's Name: PepsiCo
Area of Service: $\quad$ Food \& Nutrition Services
Term of Agreement: 36 months + 2 option years, Beginning, February 2016 - Ending, January, 2019
Maximum Totals:

| Estimated <br> Monthly Cost | Estimated <br> Annual Cost | Term Cost <br> Not to Exceed |
| :---: | :---: | :---: |
| $\$ 25,000$ | $\$ 300,000$ | $\$ 900,000$ |

## Description of Services/Supplies:

- Exclusive pouring rights at TCHD with estimated savings from current spend of:
- Year 1: \$70,100
- Year 2: \$34,000
- Year 3: \$34,000
- Total value to TCHD is $\$ 138,100$ savings from current spend over 3 year term

| Document Submitted to Legal: | $X$ | Yes |  | No |  | Not Applicable |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: |
| Approved by Chief Compliance Officer: | X | Yes |  | No |  | Not Applicable |
| Is Agreement a Regulatory Requirement: |  | Yes | X | No |  | Not Applicable |

Person responsible for oversight of agreement: Thomas Moore, Director, Supply Chain Management / Steve Dietlin, Chief Financial Officer

## Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with PepsiCo for exclusive pouring rights for a term of 36 months with 2 additional option years, beginning February 1, 2016 and ending January 31, 2019 for an estimated annual cost of $\$ 300,000$, and a total cost not to exceed $\$ 900,000$ for the 36 month term.

## FINANCE, OPERATIONS \& PLANNING COMMITTEE <br> DATE OF MEETING: Month January 19, 2016 <br> Homecare - Homebase, LLC Agreement Proposal

| Type of Agreement |  | Medical Directors |  | Panel | $x$ | Other: Documentation <br> Software System |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Status of Agreement |  | New Agreement |  | Renewal - New <br> Rates | $x$ | Renewal - Same Rates |

Vendor's Name:
Homecare Homebase, LLC
Area of Service:
Term of Agreement:
Home Health
72 months, Beginning, October 18, 2015 - Ending, October 18, 2021 or until terminated in accordance with Article 10,
Termination: 30-day notice without cause.

## Maximum Totals:

| Monthly Cost | Annual Cost | Total Term Cost |
| :---: | :---: | :---: |
| $\$ 6,083.50$ | $\$ 73,002$ | $\$ 438,012$ |

## Description of Services/Supplies:

- Licensed software for electronic medical record and billing including the following components:
- PointCare Manager (Point of Care)
- Office Administration Modules (Homecare Module)
- Workflow Manager
- Clinical Manager - Intake Management System, Clinical Pathway System; Assessment/OASIS/Validation System
- Financial Manager - Billing Module
- Resource Manager - Scheduling Module, HR Module
- Report Manager - Executive Reporting Console

| Document Submitted to Legal: | X | Yes |  | No |  | Not Applicable |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: |
| Approved by Chief Compliance Officer: | X | Yes |  | No |  | Not Applicable |
| Is Agreement a Regulatory Requirement: |  | Yes | X | No |  | Not Applicable |

Person responsible for oversight of agreement: Sharon Schultz, CNE

## Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Homecare Homebase, LLC for a documentation software system for a term of 6 years, beginning October 18, 2015 and ending October 18, 2021 for an annual cost of $\$ 73,002$, and a total cost for the term of $\$ 438,012$.
Per Board Policy \# 13-013, the goods and services proposed for acquisition are the only goods and services which can meet the District's need.

FINANCE, OPERATIONS \& PLANNING COMMITTEE DATE OF MEETING: January 19, 2016
Physician Agreement for Co-Medical Director

| Type of Agreement | $x$ | Co-Medical <br> Directors | Panel | Other: Reduction <br> of hours |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Status of Agreement | $x$ | New Agreement |  | Renewal/Change <br> -New Rates | Renewal - Same <br> Rates |

Physician's Name: Ruchira Densert, M.D.
Area of Service: Outpatient Behavioral Health Services
Term of Agreement: 29 months, Beginning, February 1, 2016 - Ending, June 30, 2018
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

| Rate/Hour | Hours per Month <br> Not to Exceed | Hours per Year <br> Not to Exceed | Monthly <br> Cost | Annual <br> Cost | 29 Month (Term) Cost <br> Not to Exceed |
| :---: | :---: | :---: | :---: | :---: | :---: |
| $\$ 125$ | 16 | 192 | $\$ 2,000$ | $\$ 24,000$ | $\$ 58,000$ |

## Position Responsibilities:

- Provide professional guidance and oversight for the Outpatient Behavioral Health Services Department, including, Intensive Outpatient Program, Dual Diagnosis and afternoon program.
- Provide supervision for the clinical operation of the Department and programs.
- Provide patient and staff education and educate providers and community members on availability and efficacy of Intensive Outpatient Program services at Hospital.

| Board Approved Physician Contract Template: | X | Yes |  | No |  | Not Applicable |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Approved by Chief Compliance Officer: | X | Yes |  | No |  | Not Applicable |
| Is Agreement a Regulatory Requirement: | X | Yes |  | No |  | Not Applicable |

Person responsible for oversight of agreement: Sarah Jayyousi, MSW; Sharon Schultz, Chief Nurse Executive

## Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Densert as the Coverage Physician/Co-Medical Director for a term of 29 months beginning February 1, 2016 and ending June 30, 2018. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $\$ 125$ for an annual cost of $\$ 24,000$, and a total cost for the term of \$58,000.

## FINANCE, OPERATIONS \& PLANNING COMMITTEE <br> DATE OF MEETING: January 19, 2016 <br> PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

| Type of Agreement |  | Medical Directors | X | Panel |  | Other: |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Status of Agreement | x | New Agreement |  | Renewal - <br> New Rates |  | Renewal - Same <br> Rates |

Physicians Name: Neeta Varshney, M.D.
Area of Service: Emergency Department On-Call: Ophthalmology
Term of Agreement: 16 months, Beginning, March 1, 2016 - Ending, June 30, 2017
Within Hourly and/or Annualized Fair Market Value: Yes
Maximum Totals: For entire ED On-Call Area of Service Coverage: Yes

| Rate/Day | Days per Year | Annual Cost | 4/12 month (Term) Cost |
| :---: | :---: | :---: | :---: |
|  | FY2016: 122 | $\$ 36,600$ | $\$ 36,600$ |
|  | FY2017:365 | $\$ 109,500$ | $\$ 109,500$ |
| Total |  | $\$ 146,100$ |  |

Position Responsibilities:

- Provide 24/7 patient coverage for all 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 |  | Not Applicable |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Approved by Chief Compliance Officer: | X | Yes |  | No |  | Not Applicable |
| Is Agreement a Regulatory Requirement: |  | Yes | X | No |  | Not Applicable |

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, Chief Operating Officer

## Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Neeta Varshney, MD as ED On-Call Coverage Physician for a term of 16 months beginning March 1, 2016 and ending June 30, 2017, at daily rate of $\$ 300$, for a FY 2016 cost of $\$ 36,600$, and for FY $2017 \$ 109,500$ and a total cost for the term of $\$ 146,100$.

FINANCE, OPERATIONS \& PLANNING COMMITTEE
DATE OF MEETING: January 19, 2016
Emergency Department Acquisition of Cardiac Monitors Proposal

| Type of Agreement |  | Medical Directors |  | Panel | $x$ | Other: Capital <br> Equipment |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Status of Agreement |  | New Agreement |  | Renewal - <br> New Rates | Renewal - Same <br> Rates |  |

Vendor's Name: Nihon Kohden America
Area of Service: Emergency Department
Maximum Totals:

| Cost of Cardiac Monitors | Maximum <br> Interest Rate | Maximum 60 month (Term) <br> cost if Leased |
| :---: | :---: | :---: |
| $\$ 401,279$ | $4.5 \%$ | $\$ 448,864$ |

## Description of Services/Supplies:

- Replace 39 cardiac monitors for Stations A,B,C and D
- Central Monitoring Station and Cabling to 3Pavilion
- Training included in cost

| Document Submitted to Legal: | X | Yes |  | No |  | Not Applicable |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: |
| Approved by Chief Compliance Officer: | X | Yes |  | No |  | Not Applicable |
| Is Agreement a Regulatory Requirement: |  | Yes | X | No |  | Not Applicable |

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

## Motion:

1 move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the acquisition of cardiac monitors for the Emergency Department for a total cost not to exceed $\$ 448,864$.

| Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Dr. Marcus Contardo and Dr. James Johnson. |
| :--- |
| Non-Voting Members Present: Tim Moran, CEO, Kapua Conley, COO/ Exec. VP, Sharon Schultz, CNE/Sr. VP and Cheryle Bernard-Shaw, Chief |
| Compliance Officer. |
| Others present: Diane Racicot, General Counsel, Jami Piearson, Director of Quality and Regulatory, Marcia Cavanaugh, Sr. Director for Quality, |
| Cli. Risk Mgt. \& Patient Safety, Kathy Topp, Daniel Martinez, Lisa Mattia, Sharon Davies, Mary Diamond, Steve Sims, Priya Joshi, Patricia Guerra |
| and Karren Hertz. |
| Members absent: Director Ramona Finnila, Dr. Gene Ma and Dr. Scott Worman. |


| Topic | Discussion <br> Follow-Up Action/ <br> Recommendations | Person(s) <br> Responsible |  |
| :--- | :--- | :--- | :--- |
| 1. Call To Order | Director Mitchell called the meeting to order <br> at 12:06 p.m. in Assembly Room 1. | Director Mitchell |  |
| 2. Approval of Agenda | The group reviewed the agenda and there <br> were no additions or modifications. <br> It was noted that there were a couple of <br> changes in this committee: <br> Director Mitchell is the new PAC <br> chairman; Director Schallock <br> replaced Director Dagostino for this <br> committee. <br> Meeting frequency has now changed <br> to 2nd Thursday instead of the usual | Motion to approve the agenda <br> was made by Director Schallock <br> and seconded by Dr. Johnson. | Director Mitchell |


| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
|  | $3^{\text {rd }}$ Thursday of the month. |  |  |
| 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 |
| 4. Ratification of minutes of November 2015. | Director Mitchell called for a motion to approve the minutes from November 19, 2015. | Minutes ratified. Dr. Johnson moved and Dr. Contardo seconded the motion to approve the minutes from November 2015. Director Schallock abstained from approving the minutes. | Karren Hertz |
| 5. New Business <br> a. Quality Outcomes Dashboard | The group reviewed the current data for the ED particularly the LWOTs as well as ED arrival and ED departure times. The level of performance on some areas need improvement. Sharon Schultz mentioned that there is currently a consultant who is working with the ED staff on issues pertaining to the Emergency Department. | ACTION: Tim made a suggestion to have the Tri-City Emergency Department Management Group (TCEMG) do a presentation so that the committee can take a closer look at their metrics and how we can improve on these measures. | Administration |
|  |  |  |  |
| b. Consideration and Possible Approval of Policies and Procedures |  |  |  |
| Patient Care Policies and Procedures: |  |  |  |


| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
| 1. Fall Risk Procedure and Score Tool Procedure | It was reported that even though the primary RN should note the availability of the patient's family for safety purposes; it is still the responsibility of the RN to make sure the patient is safe from falls. This information should be documented in the rounding info in CERNER and alarms should also be installed on patients with high risk potential for falls. | ACTION: The Patient Care Services policies and procedures were approved. Dr. Contardo moved and Director Schallock seconded the motion to approve these policies moving forward for Board approval. | Patricia Guerra |
| 2. Lumbar Drains, Care of Procedure | No discussion on this policy. |  |  |
| 3. Organ Donation, Including Tissue and Eyes | There was brief discussion on the skin/ tissue differentiation. It was also identified that the procedure for organ donation should be clarified on the patients that are in custody. |  |  |
| 4. Privacy Code | There was no discussion on this policy. |  |  |
| 5. Restraints, Used for NonViolent/ Non-Self Destructive Behavior | The order on restraints should be renewed every 48 hours for non-violent patients. |  |  |
| Administrative Policies and Procedures <br> 1. Consent for Operative or Other Procedures |  |  |  |
|  | There was discussion on the status of the patient's condition when signing the anesthesia content. The emancipation issue was also mentioned in this policy. If a | ACTION: The Administrative policies and procedures were approved and are moving forward for Board approval. Dr. | Patricia Guerra |


| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
| 2. Fiscal Year End Inventory 8610-286 | patient is incapable of giving consent, the Risk Management should be called and informed. The word telegraph should be changed to "electronically transmitted'. <br> No discussion on this policy. | Contardo moved and Dr. Johnson seconded the motion to approve these policies. |  |
| 3. Patient Complaints and Grievances | It was stated that the BOD gets informed for complex cases so that they are in the loop. |  |  |
| 4. Voicemail Access 860-617 | No discussion on this policy. |  |  |
| 5. Wireless Communication Wireless Network) | No discussion on this policy. |  |  |
| Unit Specific Infection Control |  |  |  |
| 1. Aerosol Transmissible Diseases and Tuberculosis Control Plan | Sharon stated that the hospital still have negative pressure rooms (Rooms 200 and 201). | ACTION: The Infection Control policy was approved; Director Schallock moved and Dr. Johnson seconded the motion to approve this policy. | Patricia Guerra |
| Neonatal Intensive Care (NICU) <br> 1. Pulse Oximetry, NICU | There was no discussion on this policy. | ACTION: The NICU policy was approved; Dr. Contardo moved and Dr. Johnson seconded the motion to approve this policy. | Patricia Guerra |
| Rehabilitation <br> 1. Performance Evaluations | Priya Joshi reported that the pool service tehc comes in regularly for maintenance | ACTION: The Rehab policies were approved as moved by Dr. | Patricia Guerra |


| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
| 2. Pool Charges <br> 3. Pool Contamination <br> 4. Therapy Pool <br> 5. Therapy Referrals Orders and Charges <br> 6. Use of Pool by Recreation Specialists | clean-up. <br> No discussion on this policy. <br> No discussion on this policy, <br> The policy should be titled Hydroworks to differentiate it from the regular pool in the Wellness Center. <br> No discussion on this policy. <br> No discussion on this policy. | Johnson and seconded by Dr. Corona. |  |
| 6. 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 |
| 7. Return to Open Session | The Committee return to Open Session at 2:25 PM. |  | Director Mitchell |
| 8. Reports of the Chairperson of Any Action Taken in Closed Session | There were no actions taken. |  | Director Mitchell |
| 9. Comments from Members of the Committee | No Comments. |  | Director Mitchell |
| 10. Adjournment | Meeting adjourned at 2:24 PM |  | Director Mitchell |
| PAC Minutes 011416 | 5 |  |  |

## (@) Tri-City Medical Center

## PROFESSIONAL AFFAIRS COMMITTEE

## January $14^{\text {th }}, 2016$

CONTACT: Sharon Schultz, CNE

| CONTACT: Sharon Schultz, CNE |  |  |
| :---: | :---: | :---: |
| Policies and Procedures | Reason | Recommendations |
| Patient Care Services Policies \& Procedures |  |  |
| 1. Fall Risk Procedure and Score Tool Procedure | 3 year review, practice change | Forward to BOD for approval |
| 2. Lumbar Drains, Care of Procedure | 3 year review | Forward to BOD for approval |
| 3. Organ Donation, Including Tissue, and Eyes | 3 year review, practice change | Forward to BOD for approval with revisions |
| 4. Privacy Code | 3 year review, practice change | Forward to BOD for approval |
| 5. Restraints, Used for Non-Violent/Non-Self Destructive Behavior | Practice change | Forward to BOD for approval with revisions |
| Administrative Policies \& Procedures |  |  |
| 1. Consent for Operative or Other Procedures | 3 year review, practice change | Forward to BOD for approval with revisions |
| 2. Fiscal Year End Inventory 8610-286 | 3 year review, practice change | Forward to BOD for approval |
| 3. Patient Complaints and Grievances | 3 year review, practice change | Forward to BOD for approval with revisions |
| 4. Voicemail Access 8610-617 | 3 year review, practice change | Forward to BOD for approval |
| 5. Wireless Communication (Wireless Network) 8610-624 | 3 year review, practice change | Forward to BOD for approval |
| Unit Specific |  |  |
| Infection Control |  |  |
| 1. Aerosol Transmissible Diseases and Tuberculosis Control Plan | Practice change | Forward to BOD for approval with revisions |
| Neonatal Intensive Care (NICU) |  |  |
| 1. Pulse Oximetry, NICU | 3 year review, practice change | Forward to BOD for approval |
| Rehabilitation |  |  |
| 1. Performance Evaluations - 304 | DELETE | Forward to BOD for approval |
| 2. Pool Charges 1704 | DELETE | Forward to BOD for approval |
| 3. Pool Contamination 1707 | 3 year review, practice change | Forward to BOD for approval with revisions |
| 4. Therapy Pool - General Operations 1706 | 3 year review, practice change | Forward to BOD for approval with revisions |
| 5. Therapy Referrals Orders and Charges 512 | DELETE | Forward to BOD for approval |
| 6. Use of Pool by Recreation Specialists - 1708 | DELETE | Forward to BOD for approval |


| () Tri-City Medical Center | Distribution: Patient Care Services |
| :--- | :--- | :--- |
| PROCEDURE: | FALL RISK PROCEDURE AND SCORE TOOL |
| Purpose: | To provide a comprehensive fall risk assessment on all patients each shift and implement <br> appropriate fall risk interventions based upon the patient's identified fall risk factors. |
| Supportive Data: | Inclusive of all inpatient areas. Requires an Registered Nurse (RN) to evaluate and <br> identify risk factors for falls, develop an appropriate plan of care for prevention, perform a <br> comprehensive evaluation of falls that occur, and revise the plan of care as appropriate <br> for fall prevention. |
| Equipment: | Fall Risk Score Tool |

A. PROCEDURE:

1. A fall risk assessment is completed on every patient by the RN on admission or transfer and on every shift until the patient is discharged from the medical center. All patients receive the following Universal Fall Precautions as appropriate:
a. Bed in low position
b. Side rails up $\times 2$
c. Bed wheels and wheelchair brakes locked
d. Call light within easy reach
e. Assistive devices within easy reach
f. Hand rails and grab bars within easy reach
g. Non-skid slippers
h. Adequate lighting
i. Rooms free of clutter
j. Clean and dry surfaces
k. Orientation to environment
I. Patient/family fall prevention education (use the Patient Handbook and highlight the patient safety section)
2. To determine the patient's fall risk level:
a. Complete the Morse Fall Risk Assessment Tool in the electronic health record:
i. Upon admission to the hospital
1) Interview all patients to assess the risk of falls and to identify factors secondary to fall risk.
ii. Upon admission or transfer to another level of care area.
iii. After any fall occurs
iv. When there is a change in the patient's status (physiological, functional, or cognitive)
b. Review the patient's medications for any that may alter the patient's ambulatory stability.
3. The patient's primary RN shall implement an individual plan-of careInterdisciplinary Plan of Care for fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the Plan of GareInterdisciplinary Plan of Care. These include but are not limited to:
a. Low Risk Patients (= 0-35 total score):
i. Orient patients to their bed area, unit facilities, and how to get assistance.
ii. Call bell/light for patients and ensuring it is placed within reach of patient
iii. Involving family in the care of the patient
iv. Follow-up with individual caregivers
v. Stabilize beds and bedside furniture
vi. Utilize grab bars near toilets
vii. Review prescribed medications every shift
viii. Limit combinations of medications when possible
ix. Ensure the patient is able to reach necessary items (phone, water, call light/bell)

| Department Review |  <br> Procedures | Nurse Executive <br> Council | Medical Executive <br> Committee | Professional <br> Affairs Committee | Board of Directors |
| :--- | :---: | :---: | :---: | :---: | :---: |
| $6 / 06,1 / 08,6 / 09$ | $11 / 11,10 / 15$ | $11 / 11,10 / 15$ | $11 / 15$ | $2 / 12,01 / 16$ | $2 / 12$ |

x. Use safety measures in chairs and wheelchairs
xi. Use geriatric chairs
xii. Select suitable chairs with armrests that are an appropriate height for rising and sitting.
xiii. Instruct patients to rise slowly
xiv. Offer material to assess for a fall risk free home
xv. Place patients with urgency near toilets or use commodes
xvi. Instruct male patients prone to dizziness to sit while voiding.
b. $\quad$ Moderate Risk Patients ( $=$ 36-44 total score):
i. Implement Low Risk interventions
ii. Educate the patient and family about the risk of falling, safety issues and mobility limitations
iii. "Patient Safety/Preventing Slips and Falls" handout shall be provided to patient and family
iv. Offer toileting every 2 hours to patients who are receiving laxatives or diuretics
v. Ambulate patients with assistance.
vi. Teach patients to make position changes slowly
vii. Re-orient confused patients
viii. Move confused patients close to nurse's station
ix. Encourage family members to sit with confused patients
x. Use bed exit alarms
xi. Use chair alarms
xii. Teach activity limits to patient and family
xiii. Large "Yellow Stoplight Laminates" shall be placed at the head of the bed for moderate risk patients and small "Yellow Stoplight Laminates" shall be placed on the patient's medical chart.
xiv. A "stoplight" magnet shall be placed on the patient's doorframe with the designated bed indicated on the magnet using a black sharpie pen.
c. High Risk Patients ( $=45+$ total score) require:
i. Implement Low and Moderate Risk interventions
ii. Place designated color-coded wristband on patient
iii. High Risk Rounding

1) Rounds on assigned patients shall be made every hour by the RN, Licensed Vocational Nurse (LVN), or designee
2) Hourly rounding shall be documented in the electronic medical record at the end of each shift.
iv. Large "Red Stoplight Laminates" shall be placed at the head of the bed for high risk patients and small "Red Stoplight Laminates" shall be placed on the patient's medical chart.
d. Responsibilities:
i. Designated color-coded Armbands
3) The RN or LVN is responsible for placing the armbands on the wrist of patients identified as high (45+) risk
4) The RN or LVN is responsible for removing the armband upon change in Fall Risk Score or upon discharge.
ii. Large "Stoplight" Laminates
5) The RN or LVN is responsible for placing, updating, and/or removing the large "stoplight" laminates over the head of the patient's bed.
iii. Small "Stoplight" Laminates
6) The RN or LVN is responsible for placing, updating, and/or removing the small stoplight laminate on the patient's chart
iv. "Stoplight" Magnets:
7) The RN or LVN is responsible for placing, updating, and/or removing the "stoplight" magnet on the patient's doorframe with the designated bed indicated on the magnet using a black sharpie pen.
v. The charge nurse shall check for appropriateness of signage during rounds.
e. The primary RN shall reassess the patient every shift for needs and change in status. i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.
f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change or the absence of family.
g. The patient's fall risk status and family presence shall be reported during communication hand-offs.
h. If a patient falls, the Assistant Nursing Manager or designee shall conduct an immediate educational debriefing for all staff involved.
i. A Quality Review Report (QRR) and Post Fall Risk Analysis shall be completed by the Assistant Nursing Manager or designee
ii. The QRR and Post Fall Risk Analysis shall be reviewed by the Director/Manager and forwarded to Risk Management for review within 24 hours.
i. Each outpatient care area and Emergency Department will assess the risk for falls based on their own unit specific guidelines, and intervene as appropriate.
j. All patients are reassessed prior to discharge for their stability: dizziness, observe ambulation assisted and unassisted, educate on fall prevention, rescore and document.

## B. ATTACHMENTS:

1. Addendum A: Emergency Department (ED)Unit Specific Fall Precautions, Intensive-Gare Unit (ICU) Specific Fall Procautions, and
Peri-Anesthesia (PANS) Specific Fall Precautions
2. Addendum B: Tri-City Medical Center Post Fall Risk Analysis
3. Addendum C: Fall Risk Algorithm

Patient Care Services Procedure Manual
Fall Risk Procedure \& Scoring Tool
Page 4 of 7

## UNIT SPECIFIC FALL PRECAUTIONS

4 Patients-seen in the ED are-scored for falls risk based on the Morse Falls Risk Assessment Tool by an RN upon initial assessment. The following interventions shall be instituted based on the patient's risk value:

1. Low Risk $=0-35$
a. Universal-Falls Procautions
2. Moderate-Risk $=36-44$
a. Universal Falls Precautions
b. Encourage family to remain with patient
6.-Increase intervals of nursing observation
3. High Risk $=45+$
a. Universal Falls Precautions
b. Place designated color-coded armband on patient's wrist
4. Encourage family to remain with pationt
d. Increase intorvals of nursing observation
B. Stoplight magnets and overhead laminates are not required.

INTENSIVE CARE UNIT (ICU) SPECIFIC FALL PRECAUTIONS
A. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:

1. Stoplight magnets and overhead laminates are not required.
2. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
B. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team assistance with getting out of bed (requires physician order).

## PERI-ANESTHESIA (PANS) SPECIFIC FALL PRECAUTIONS

A. All patients in PANS area are considered high fall risk due to post anesthesia / sedation status.
B. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure. 1. Including call light within reach of bedside.
2. Patients shall be assisted to bathroom and ambulated wearing shoes or non slip socks.
3. RN family member in attendance behind curtain to assist out-patient while dressing prior to discharge.
C. Stoplight magnets and overhead laminates are not required.

## Post Patient Fall Huddle \& Analysis Tool

Purpose: To provide a mechanism to immediately analyze all patient falls when they occurred to evaluate potential opportunities for the immediate re-assessment of the patients falls risk indicators, to develop a plan for the prevention of additional falls, and to highlight and correct any environmental barriers that may have contributed to the initial fall.

Patient ID: $\qquad$ Date of Fall: $\qquad$ Time of Fall: Location of fall:
$\qquad$
Patient diagnosis:
$\qquad$
Incident report completed by: Room \#: $\qquad$
completed: $\qquad$
Previous Falls Risk/Lift Assessment category (circle one):
Patient Interview:
(include statement from patient about why the fall occurred):
Low Risk (0-35)
Moderate Risk (36-44)
High Risk (44 and higher)

## Check all Fall Risk Factors present

Psychotropic, analgesics, diuretics, anticoagulants or XXX medication usage within past 12 hours
Noted urinary frequency or diarrhea
Documented agitation, confusion, or disorientation
Utilization of the equipment that could contribute to ambulation problems
Call light unavailable for use
Patient incontinent
Attempting to toilet alone without assistance or equipment
atient alone, family member non present
. . oom and floor area cluttered
Patient lift assistive equipment not available or not used Shackles
| Patient Care Services Procedure Manuat
Fall Risk Procedure \& Scoring Tool
Page 6 of 7
Patient re-educated about importance of calling for assistance
amily re-educated about importance of utilizing assistance
Reinforce patient safety with patient and family through use of lift equipment Bed alarm
Chair alarm
Leave light on at all time
increase frequency of rounds to offer toileting, hydration, and assessment of condition
Obtain patient sitter
Increase utilization of lift assistive equipment (bed to chair/commode transfers, sit to stand and ambulation for toileting) Assist to floor
Unwitnessed Fall
Witnessed Fall
Appropriate Documentation Head to toe assessment Other:


To assist staff in caring for the patient with a lumbar drain. The lumbar drain is a drain inserted into the subarachnoid space of the spinal column within the levels of T-12 to L-5. The lumbar drain is placed in order to drain cerebrospinal fluid (CSF) from the spinal column.
Supportive Data: The lumbar drain is a specific procedure, which differs from any other type of neurological drain used within the care system currently and requires specific knowledge.
Equipment: $\quad$ Personal Protective Equipment (PPE)

## POLICY:

1. A lumbar drain and a comprehensive neurological assessment shall be performed every 2 hours, or per MD orders including:
a. Insertion site, including redness, skin integrity, signs/symptoms of infection, signs of CSF leakage.
b. Signs/symptoms of meningeal irritation (nuchal rigidity, photosensitivity, headache and irritability)
c. Drainage for color, clarity, and amount, hourly.
d. Dressing dry and intact and covers tubing, with no kinks.
2. Do not use bactericidal agent near insertion site, or tubing.
3. Do not allow drainage tubing to become kinked.
4. Only the physician may access the closed system drainage system.
5. Clamp the drainage tubing if drainage tubing becomes disconnected and notify physician immediately (it is recommended that physician replace drain).
6. Notify physician for signs/symptoms of infection, meningeal irritation, decrease/absence of CSF fluid drainage, damp dressing, or change in baseline neurological status (i.e., cognition, motor sensory or focal deficit.)

## B. PROCEDURE:

1. Care of patient:
a. Maintain the head of the patient's bed at the level ordered or at least 15-20 degrees.
b. Maintain the patient's head, neck and back in neutral position, avoid hyper flexion, rotation, or extension of neck or back. The patient may be turned as necessary.
c. Clamp the drain for less than (5) five minutes during care activities that require movement of the patient or change in level of the head of the bed.
d. Maintain the height of the drainage bag at the level ordered to maintain drainage at the rate physician ordered (usually $10-20 \mathrm{~mL}$ 's per hour).
e. Communicate with all patient care professionals, the presence of the drain.
f. Instruct the patient to avoid coughing, sneezing, or straining.
2. Removal of Drains (performed by the Physician/Interventional Radiologist)
a. Cover drain exit site per Physician/Interventional Radiologist order
i. If no orders, place sterile dressing over drain exit site and secure with tape
b. Verify with Physician/Interventional Radiologist that the drain is intact. If the drain is not intact collect drain, tubing and any other product associated with the drain and contact Risk Management for instruction on where to send the product for further evaluation
c. Document removal in medical record

| Revision Dates |  <br> Procedures | Nursing Executive <br> Council | Medical Executive <br> Committee | Professional <br> Affairs Committee | Board of Directors |
| :---: | :---: | :---: | :---: | :---: | :---: |
| $5 / 10$ | $07 / 11,10 / 15$ | $08 / 11.10 / 15$ | $10 / 11,11 / 15$ | $11 / 11,01 / 16$ | $12 / 11$ |

## REFERENCES:

1. American Association of Neuroscience Nurses. (2011). Care of the patient undergoing intracranial pressure monitoring/external ventricular drainage or lumbar drainage. Retrieved from www.aan.org.

## PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 1/86

REVISION DATE: $\quad 1 / 90,4 / 94,3 / 97,7 / 03,10 / 05$
7/07; 5/08; 01/11; 08/11
Clinical Policies \& Procedures Committee Approval:
Nursing Executive Council Approval:
Medical Executive Committee Approval:
Professional Affairs Committee Approval:
Board of Directors Approval:

## SUBJECT: ORGAN DONATION, INCLUDING TISSUE, AND EYES

POLICY NUMBER: IV.P. 2

06/1110/15
06/1110/15
07/1111/15
08/1101/16
08/11
A. PURPOSE:
4. Tri-City Medical Center (TCMC) is committed to ensuring every individuat or family of a potential donor, in collaboration with the Lifesharing Organ Procurement-Organization, is informed of their option to donato-organs or tissues.

1. This policy provides staff with guidance for:
a. Recognition of imminent death and provision of patient and family care needs.
2. Lifesharing and TCMG are dedicated to educating staff on-donation issues and are accountable for the organ progurement effectiveness. This policy-and procedure provides-staff with guidanee for:
a.b. The hospital's obligations for the referral of potential donors for organ, tissue, and eye donation.
b.c. Delineation of the hospital's responsibilities and the Organ Procurement Agency's Organization's responsibilities in completing the referral and donation of anatomical gift process.
e.d. The management of potential donors to include billing responsibilities.

## B. DEFINITIONS:

7. Lifesharing: Lifesharing is the federally designated-Organ Procurement Organization (OPO) for FCMG. Lifesharing has:
a. Consulted with the-San Diego Eye-Bank and developed a-protocol for identification and notification of potential eye donors.
b. Specified the San Diego-Eye Bank as an-appropriate third party for death notification on petential-ye doners.
8. Developed protocols for tissue donation.
2.1. Anatomical Gift: Donation of all or part of a human body to take effect upon or after death. Donation categories are as follows:
3.a. Organ Donor:
a-i. A brain dead individual whose cardiopulmonary function is being artificially maintained for the purpose of solid organ donation.
b.ii. An individual whose organ(s) can be recovered for transplant after the heart has stopped (Donation after Cardiac Death/DCD.)
4.b. Tissue Donor: Brain dead or cardiac dead individual who may donate their skin, heart valves, bone; or cartilage-or donor milk.
a. Human lymphetrophic virus (HTLV) testing limited to tissues that are rich in viable toukocytos.
5.c. Eye Donor: Brain dead-or circulatoryeardiag dead individual who may donate their eyes.
9. Imminent Death: Anticipated death of a patient on a ventilator or potentially brain dead. Guidance for determining imminent death include theVontilated patients at high risk for brain or cardiac death as evidenced by the following:
6.a. A ventilated patient with a devastating illness or injury who is in Intensive Care Unit or Emergency Department; and, in addition has one of the following:
a-i. Clinical findings that are consistent with a Glasgow Coma Scale (GCS) that is less than or equal to $4(\leq 4)$ without sedation or paralytics; or:
b. Neuro-insultlinjury or anoxic brain injury
c. A patient with absence of two-or more cranial nerve reflexes
d.b. A patientfor whom physicians are evaluating a diagnosis of brain death; or
c. A pationt $f$ FFor whom a physician has-orderedis considering that life-sustaining therapies be withdrawn, pursuant to the family's decision.
e-d. Reference Attachment A: patient Recognized as Imminent Death Flowchart
7.3. Brain Death: An irreversible cessation of all functions of the entire brain, including the brain stem. (Health and Safety Code Section 7180). A physician may determine an individual has sufferedis brain deathd (as defined by statute.) Law requires that a second physician independently confirm the patient's brain death. (Health \& Safety Code Section 7181.) Physicians dectaring brain death may not be a part of the transplant team.
10. Gardiac-Circulatory Death: Irreversible cessation of cardiac and respiratory functions. Declaration of death will be determined when there is no palpable pulse, no heart beat by auscultation (mechanical heart beat), and no respiratory efforts. A five minute wait period is required to confirm cessation of vital functions to declare circulatory death.
11. Designated Requestor: Staff from the Organ Procurement Agency, Lifesharing or the San Diego Eye Bank or their representative who has completed appropriate training. Training includes the methodology for approaching potential donor families and informed consent process for requesting organ, tissue and eye donation.
12. Organ Procurement Organization (Agency): Lifesharing has been designated by the United States Department of Health and Human Services (DHHS) as the organ procurement agency for San Diego and Imperial Counties within the meaning of 42 C.F.R. 486.301 et. Sew.; is a member, in good standing, of the Organ Procurement and Transplantation Network established under the Act; and is a certified member, in good standing, of the American Association of Tissue Banks.
13. CDCR: California Department of Corrections and Rehabilitation
14. SDSD: San Diego County Sheriff Department
8.C. PERSONNEL:

9-1. Care Team Members: Registered Nurses, Physicians, Social Services, Case Managers, Chaplains, or members of Spiritual Care Services.

1. Tri-City Medical Center recognizes that patients and families facing imminent death have special needs and to the extent possible, will be afforded any reasonable religious or cultural practices surrounding the issue of death. Families or next of kin will be afforded time to gather family or next of kin at the patient's bedside and understand the diagnosis and treatment options as well as the patient's right to donate or not donate organ and tissues. If there is not any source immediately available, then hospital-obligation at the time of death and imminent patient death include a reasonable-search for a document of anatomical gift or donation (i.e., advanee-directive, statement attached to driver's license, or other information specifying an-accoptance or refusal of donation).
2. Tri-City Medical Center is committed to ensuring that every individual or family of a potential donor in collaboration with Lifesharing (Organ Procurement Organization) is informed by a designated requestor of their option to donate organs or tissue or not to donate. Additionally, Lifesharing, San Diego Eye Bank and Tri-City Medical Center are dedicated to educating staff of donation issues and are accountable for the Organ Procurement Program effectiveness.
a. Lifesharing is the federally designated organ procurement agency for TCMC. Lifesharing has:
i. Consulted with the San Diego Eye Bank and developed a protocol for identification and notification of potential eye donors.
ii. Specified the San Diego Eye Bank as an appropriate third party for death notification on potential eye donors.
b. Hospital obligations at time of death and imminent patient death:
i. Make a reasonable search for a document of anatomical gift or donation, e.g. advance directive, statement attached to driver's license, or other information specifying refusal of donation, if there is not immediately available any other source of that information.
Z.ii. All potential organ donors $/ i m m i n e n t$ deaths must be referred to the donor $r$ Referfat Hinel to Lifesharing, in a timely manner, of all deaths and imminent deaths that occur in the hospital (regardless of the deceased's medical suitability for organ donation and regardless if patient is in CDCR or SDSD Forensics/Custody. (before the pationt is weaned from support medications, extubated or disconnectod from a vontilator and within 1 hour of meeting a clinical trigger.)
a-1) Any $n$ Neonatal death defined as live birth delivery requiring death certificateregardless of gestational age or weight that meets criteria as a live birth is reportable to the donor referfral line.
4-iii. Live birth defined as:
1) A live-born infant who breathes-or has any evidence of life-such as beating of the heart, pulsation of the umbilical cord, or definite movement of veluntary muscles, where-an Apgar score is given
2) Infant receives a medical record number, has-own chart that is not part of the maternal medical record
3) Subsequently dies, receives a death certificate
b.iv. Miscarriage/abortion or A stillbirth/fetal deaths are demise infant who is not issued a medical record number and does not receive a birth certificate is-not reportable to the donor referral line.
c. Lifesharing staff/representative, as Designated Requestors, are responsible for approaching potential donor families and obtaining authorization in the process of requesting organ, tissue and eye donation. If the pationt is determined to be suitable for tissueleye donation, staff from Lifesharing, San Diego-Eyo Bank, or designee shall contact the family regarding donation.
3.d. Lifesharing will ensure there is a diligent search for a legal representative or evidence of an individual's wishes regarding donation. If a search does not reveal a legal representative or documentation of wishes, a release from the Medical Examiner Office will be obtained and the Hospital Risk Manager contracted to facilitate donation authorization from hospital administration.
4-3. All healthcare providersteam members shall will display discretion and sensitivity with respect to the circumstances, views, wishes, and beliefs accommodating-special religious-or cultural requests of the families of potential donors.
a. The healtheare team shall ensure that, for the pationt who is-declared brain dead, the family/noxt of kin is provided with a reasonably brief period of accommodation prior to discontinuing cardiopulmonary-support.
b. Forensic patients as autherized through the California Department of Corrections and Rehabilitation (CDGR).
4. Lifesharing shall monitor and provide reports of eligible organ donors and organ donor conversion rates for inclusion in the hospital performance improvement activities.
D.E. PROGEDURE FOR ORGAN/TISSUE/EYE DONATIONRESPONSIBILITIES:
5. Donor-Identification:Hospital
a. Any patient who meets the-clinical triggers for-organ donation/imminent deathPrimary nurse or physician must notify Lifesharing referral service of all imminent deaths as soon as possible, and within one hour of circulatory death.
a-i. Nurse/physician is not responsible for screening potential donors. This is the responsibility of Lifesharing or its designated representatives, such as the San Diego Eye Bank..
b. Any pationt who dies.
z. Referral of potential organ/tissueteye donor:
a. The nurse caring for the patient shall call the doner referfalline at 1-888-4A-DONOR (1 888-423-6667) to refer all deaths and imminent deaths.
b. At the time of referral, provide the following information:
4.i. Patient's-Nname and medical record number;
2.ii. Age/Sex/Race;
3.iii. Height and weight;
4.iv. Time and cause of death (for cardiac death.)

3-c. Document all referrals including imminent deaths on Record the following on the Expiration Record in Cerner or if necessary on a hard copy Release of Deceased form.
(Refer to Patient Care Services Procedure Manual, Release of Deceased)
Documentation includes::
a. Referral number provided by agency
i. Date and time of referral
ii. Name of person contacted at Lifesharing;
b.iii. Referral number (when provided by Lifesharing);
iv. Determination by procurement agency
G.v. Either::

4-1) Patient was declined as donor; or
2.2) Agency shatl-will further evaluate patient as a potential donor and approach the family for donation.
4. Determination of medical suitability shall be made by the Lifesharing organ or tissue coordinator or the San Diego Eye Bank staff; not by the hospital care team members.
5.2. Ensure families are not approached regarding potential donation until:Bonation after Gardiac Death suitability:
a. Attending physician (or his/her representative) has informed family of patient's irreversible condition, brain death or imminent death. When death is imminent and medical suitability is-confirmed by Lifesharing and after the legal next of kin, surfegate, of GDCR autherity has made a decision to withdraw suppert, only then shall the OPO Lifosharing coordinator approach the family for organ donation after cardiac doath.
b. Circulatory death has occurred and patient's death has been reported via donor referral service.
3. Family Notification of Donation Options and Discussion:
a. The health care team members should not initiate the donation discussion with the family. Health care team member having a relationship with the patient or family should, when possible, collaborate with, and facilitate the discussion between the Lifesharing Designated Requestor and the family regarding options for organ and tissue donation.
6. Brain Death Documentation:
a. Two-separate licensed physicians not involved in the transplant procedure must document brain death in the Progress Notes. (California Health and Safety Code 7180 -7183.)
7. If Lifesharing has declined the patient as acceptable for organ donation, the referrallline must be gallod again by the nurse caring for the pationt at the time-of cardiac death to ensure the family has been offered the option of tissue and/or eye donation.
8. Lifesharing or San Diego Eyo-Bank shallobtain permission from the Medigal Examiner for donation(if applicable).
9. Consent:
a. Staff from Organ Procurement-Organization shall provide and complete the-consent form.
b. Consent shall be obtained from legal next of kin, CDCR-authority, Durable Power of Attorney for Healtheare-or Surrogate (Galifornia-Health and Safoty-Code 7151.)
6. When no-legal next of kin or surfegate has been-logated after- a due diligent search, the hospital Administrator may consent to organ donation in brain dead patients (Galifornia Health and Safety-Code 7151.) Clear complete documentation-of diligent-search must be notod in the medical record.
b. If the patient's family initiates discussion regarding donation, the-donor referfat lineLifesharing will shall-be notified immediately and the family informed that all their questions can be fully answered by staff from Lifesharing or the San Diego Eye Bank. Lifesharing or the San Diego Eye bank shall notify the nurse or physician of the potential donor's suitability= for -donation.
c. Upon notification by Lifesharing and/or the San Diego Eye Bank that the potential donor is found to be registered on the Donate Life California Organ and Tissue Donor Registry, collaborate with them to confirm:
i. The identity is correct per the legal decision maker
ii. Plans are consistent with any expressed wishes in a valid document pursuant the UAGA as defined in California Law (CA H\&S 7150), and the Motor Vehicle Code (CA MVC 12811), an anatomical gift, that is not revoked by the donor before death, is irrevocable and does not require authorization or concurrence of any other person after the donor's death. This includes an anatomical gift that is made by means of and/or is registered in the California Organ and Tissue Donor Registry or other State registry designated by law.
iii. In circumstances of preauthorization by the patient, support Lifesharing efforts with sensitivity and cultural consideration, to communicate to the legal decision maker, the plans to proceed with donation.
4. Physician
a. The medical management of the patient prior to brain/circulatory death remains the responsibility of TCMC attending physician. Medical Management to ensure organ viability will be continued until Lifesharing confirms suitability and options have been presented to the family.
b. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of an organ/tissue that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.
5. Lifesharing
a. Screen each referred patient based on current medical criteria for organ, tissue and eye donation. Lifesharing will refer circulatory dead patients to the appropriate agency for screening for potential eye and tissue donation.
b. The "Designated Requestor" (in collaboration with the health care team when possible) will initiate contact with family about donation options and obtain authorization from the legal decision-maker upon report of death, imminent death or brain death.
c. Collaborate with the primary physician to provide physiological maintenance while suitability for donation is being evaluated. The cost associated with a procedure required or medication given solely for the purpose of maintaining organ viability for donation will be assumed by Lifesharing.
d. Document authorization on Lifesharing Form "Authorization for Organ and Tissue Donation".
i. Authorization may be obtained via telephone utilizing recording device, a hospital staff witness or a recorded line.
ii. Provide family with a copy of the authorization form.
iii. Place original copy of the authorization form in the patient's medical record.
e. Screen all deaths for Medical Examiner criteria and obtain consent from the Medical Examiner for donation, if applicable.
f. Inform the Medical Examiner of the intent to pursue Donation by Circulatory Death.
g. Advise hospital staff of suitability for donation and subsequent steps to follow, i.e. implement corneal protective measures or provide the reason for the patient being declined as a donor.
h. Update nurses, physicians, operating room staff and others as appropriate for status of donation.
i. Document all events, procedures and donor management in the medical record.
d.j. Notify appropriate hospital staff of final outcome of referral.

## E-F <br> ORGAN DONATION MANAGEMENTPROCEDURES:

1. Primary nurse and physician shallin collaboratione with or the physician must notify Lifesharing referral service by calling 1-888-4ADONOR (1-888-423-6667) for all circulatory deaths within one hour and in the case of recognition of imminent death, as soon as possible, ideally within one hour. (Attachment A: Patient Identified as Imminent Death Flow chart)regarding status of potential donor to ensure the recovery of all possible organs.
2. Management of Brain Death Donation (Attachment C: Brain Death Donation Option Flowchart).
a. Once family is informed of brain death, assess and document in plan of care spiritual, cultural needs and accommodate as possible. Encourage family/health care decision maker to obtain as much information as possible from the clinical staff to understand the diagnosis and prognosis provide family reasonable brief period of time (generally not greater than 24 hours) to gather family/next of kin at bedside and agree to discontinuation of cardiopulmonary support.
b. Primary nurse and physician will collaborate regarding status of potential donor and confirmation of brain death diagnosis with Lifesharing.
c. Refer to the Lifesharing Catastrophic Brain Injury Guidelines at Lifesharing's website at http://www.lifesharing.org
d. Primary nurse will assist Procurement Coordinator to maintain potential internal organ donors on support systems until recovery of organs can occur in the operating room.
3. Management of the process for Donation after Circulatory Death (Attachment D: Circulatory Death Donation Option Flowchart)
a. A note by the physician, documenting the decision to withdraw life supporting therapy must be placed in the chart prior to requesting decision to withdraw life sustaining treatment or advise the family or hospital regarding medication used or procedure for withdrawal of support.
b. Lifesharing is notified to determine suitability for the purpose of establishing donation options to be offered to the family.
c. Care staff allows family time to plan end of life care decisions, autopsy, and timing of withdrawal, palliative care options, and spiritual care.
d. Lifesharing Designated Requestor advises the family of donation options. Family selects option and Lifesharing obtains all required authorizations. If the family does not select any donation option, the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
e. If the family authorizes the option of donation after circulatory death, the hospital care team will continue to provide the treatment to optimize organ viability until life sustaining measures are withdrawn. This may include line placement, laboratory testing, medications to improve organ function and reduce possibility of infection, and procedures to establish organ suitability, i.e. bronchoscope, x-rays, ultrasound, CT scan. All procedures and invasive studies and heparin will require separate authorization from the family and orders from the physician of record.
f. Plan with the family when and where life support will be discontinued and transfer patient as necessary. Consider accommodations for the family as requested. Withdrawal of life sustaining treatment will proceed as agreed upon by the family and care team.
g. Lifesharing personnel will be available to support the family and act as official time keeper for organ viability. This may include the presence of the Lifesharing Coordinator during withdrawal of life support. Lifesharing surgeons will not be present during withdrawal of life sustaining treatment.
h. After circulatory death is declared, includes a five minute wait period to confirm cessation of vital functions by a physician or nurse with validated competency (not associated with the procurement team or a hospital transplant team), organ recovery will proceed as directed by Lifesharing team.
4-i. If circulatory death does not occur within the timeframe for viable recovery, likely not to exceed two (2) hours, of the withdrawal of life support, the organ recovery plan will be terminated and the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
4. With a pationt who donates organs after brain death:
a. Once medical suitability has boen documented and Lifesharing staff has obtained informed consent, the entire medical management of the patient is transferred to the Lifesharing procurement coordinator under the direction of the Lifesharing Medicat Director and Lifesharing policies, procedures, and protocols.
5. Hospital staff shall support nursing care.
6. With a pationt who-donates organs after cardiac death:
a. The primary physician or his designee-shall withdraw-support and pronounce the patient at death (the physician or designee cannot be part of the procurement or transplant team.)
7. Management of Potential Eye Donor Alanagement:
5.a. Implement corneal integrity protective measures:
a.i. Close eyelids;
b.ii. Elevate head;
iii. Place light eye packs (a surgigal glove with crushed ice which is equal to approximately 2 regular sized ice-cubes in each glove) over closed eyelids within two (2) hours of death. Be sensitive to the family. This procedure-may be done after the family has left.)
e-5. Billing Process
a. Financial-Responsibility; No charges related to organ, tissue or eye donation will be billed to is the responsibility-of the donor, the donor's family or estate, or donor's third party payer. The appropriate recovery agency willshall assume all charges related to donation. The Hospital shall provide a copy of the pation bill within approximately ton (10) days of the-organ recovery.
8. Organ Procurement Program Effectiveness
6.a. Health Information Department will, on monthly basis or as requested, provide Lifesharing with the following data:
9. The nursing unit will notify Main-Registration-during business hours or ED Registration after hours via communication notice that the patient has consented to organ donation.
a. For brain dead patients, the notice will include:
10. "Other" admit
i. The pPatient name;
ii. MR number;
Z.iii. Admit date;
11. Sex
iv. Date of Birth;
v. Date of death;
4.vi. All ICD10 diagnoses assigned to patient during hospitalization.
12. Patient Service "DONOR"
13. Admit dateltime to equal the date and time the consent is signed

|  | 7. Admit physician |
| :---: | :---: |
|  | 8. Admit diagnosis "Organ Donation" |
|  | 9. Room number will be the room the patient is currently in |
|  | The brain dead donor's inpatient encounter will be dischargod as expired. |
|  | The donor will go to the-operating room at the designated time for the procurement. Once completed, the DONOR encounter will be-discharged by the OR |
|  | If the-patient is classified as donation after cardiag death: |
|  | 1. Follow the steps outlined in soction a. with the excoption of assigning a room number. For this, fill in "Surg Dept" as the room. |
|  | z. The pationt's DONOR-account will be-created, but the pationt's current inpationt account will stay active and present on the unit (not discharged) untill the pationt has expired. |
|  | Procurement Effectiveness: |
|  | The-Health Information Department shall provide-on a monthly basis-or as requested, the following mortality data to Lifosharing: |
|  | 1. Patient name |
|  | 2. Medical record number |
|  | 3. Admit date |
|  | 4. Dischargo/Death date |
|  | $5 . \quad$ Age |
|  | 6. Unit of discharge |
|  | 7. Medical-service |
|  | 8. AllICD-9 diagnosis codes assigned to patient's encounter |
| b. | Lifesharing shall-will review records on a monthly basis, or as needed, to evaluate monitor the referral effectiveness of $100 \%$ of imminent and actual deaths for the opportunity of organ and tissue donation. |
| c. | Lifesharing will-shall analyze data and provide organ donor conversion rates to the hospital as requested. |
| d. | Lifesharing willshall collaborate with performance improvement representatives to analyze data and identify actions to improve process where applicable. |

G. RELATED DOCUMENTS:

1. Patient Recognized as Imminent Death Flowchart
2. Donation Option: Brain Death Flowchart
d.3. Donation Option: After Circulatory Death Flowchart
H.
I. REFERENCES:
3. 42 CFR 482.45
4. American Academy of Neurology, current evidenced-based guidelines for Determining Brain Death
5. California Hospital Association, Consent Manual, Current Edition
6. California's Uniform Anatomical Gift Act (Health and Safety Code Sections 7150-7156.5, 7184. 1254/4
7. Lifesharing website: www.lifesharing.org
8. Physiologic Maintenance of Patients with Catastrophic Brain Injuries (Lifesharing)
9. San Diego Eye Bank website: www.sdeb.org
2.8. Section 9318 OBRA Hospital protocol
10. Lifesharing's-Organ and Tissue-Recovery Rosource Manual, 2001
11. Galifornia Health and Safety-Godo, Uniform Anatomical-Gift Act, 2004
12. California Health and Safety Code; Section \#7180, Uniform Determination of Death Act, 2004
13. Denation after Gardiac Death: A Reference Guide. US Dept. of Health and Human Services and UNOS, 2002
14. Lifesharing protocol for Donation after Gardiac Death. (2005, March)
15. Gritical Pathways for Organ Donation, (UNOS). 1099.

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15. California Perinatal Quality Gare-Collaborative (CPQGG) Network Database, version 1.10. (11/09/2010). Manual of definitions for infants born in 2010. Retrieved on-12/28/2010: http:///www.epgec.org/data/epgec downloads
16. Centers for Medicare and Medicaid-Services (CMS) Gonditions of Participation (GOPs), Gonditions for Coverago (GfGs): Identifigation of potential organ, tissue, and eye donors questions and answers (2004). Retrieved on-12/28/2010:
http://lifesharing.org/images/stories/rosources/medicalProfession/rulesandreg/emshospqa.pdf

Health Care Team recognizes imminent death:
Anticipated death of a patient on a ventilator or potentially brain dead. Guidance for determining imminent death include the following
A ventilated patient with a devastating illness or injury:
Who Is in an Intensive Care Unit or Emergency Department; and, in addition has one of the following:
i. Clinical findings that are consistent with a Glasgow Coma ii. For whom physicians are evaluating a diagnosis of brain death; or
iii. For whom a physician is considering that life sustaining

 Score (GCS) that is $\leq 4$ without sedation or paralytics; or therapies be withdrawn, pursuant to the family's decision.

Lifesharing


Travels to hospital and reviews case with care team for the purpose of determining donation suitability and options available to the family.

## Attachment B

## Health Care Team

# Donation Option: Brain Death 

Health Care Team explains results of brain death exam and works with family until they verbalize a clear understanding of brain death. It is important for family to know and understand that, the patient time of death is at the time the second physician confirms brain death, not the time that cardiac function ceases. As appropriate, notification of death and time is made to the Medical Examiner. (Donation options are not mentioned to family at this time)

Assess and document in plan of care, spiritual, cultural needs and accommodate as possible.
Provide family with reasonable time to gather family/next of kin at bedside. Reasonable is generally not greater than 24 hours; Provide an explanation that the body cannot be maintained for any prolonged period and should be under the care of individuals
who can provide appropriate care.

## Lifesharing

## Lifesharing Coordinator

 provides family with death diagnosis, the Health Care Team introduces Lifesharing Coordinator (Designated Requestor): "This is $\qquad$ he/she often works with families in your situation to help you make some final decisions."information about donation options in a private setting

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Attachment C


## Donation Option: After Circulatory Death



## ISSUE DATE: 1/05

REVISION DATE: 8/07, 7/10, 11/10
Clinical Policies \& Procedures Committee Approval:
Nursing Executive Committee Approval:
Operations Committee Approval:
Professional Affairs Committee Approval:
Board of Directors Approval:

SUBJECT: Privacy Code
POLICY NUMBER: IV.CC
11/1011/15
12/15
11/10
01/1101/16
01/11
A. DEFINITIONS:
A.1. Privacy Code: a code or word selected by the patient/patient's representative that contains a minimum of four (4) characters. A privacy code is used by nursing to identify patient representatives who may receive healthcare information.
B. POLICY:

1. A privacy code is a code-or word selected by the patient/pationt's representative that contains-a minimum of four (4) characters.
2. The patient/patient's representative shall be offered the option of selecting Aa privacy code shall be initiated on all-patients admitted upon admission as inpatient or observation status patient to Tri-City Medical Center (TCMC) within 24 hours of admission. (Attachments 2 and 3)
a. If the patient/patient's representative declines the option of a privacy code, document the declination in the medical record
b. If the patient is unable select a privacy code and the patient's representative (or closest available relative) is not available upon admission, a reasonable effort shall be made to obtain a privacy code during the hospital stay.
a-c. Women's and Children's Services are excluded from this policy for infant security and privacy considerations.
i. A privacy code shall be established prior to mother's discharge for the newborn infant requiring continued care/observation in the Well Born Nursery (i.e., phototherapy).
3. The patient/patient's representative on each inpatient admission shall select a privacy-code during the admission process. The registered nurse-completing the admission process shall complete the privacy-code-form. (See altachment $A$ )
4. The fRegistered $a$ Nurse completing the admission process shall ensure the privacy code option has been offered. Once the privacy code has been selected, the code shall be entered into Cerner under Nurse Orderable, "Privacy Code."
5. The patient/patient's representative shall be instructed to provide the privacy code to family members/caregivers involved in their care. The code authorizes those family members/caregivers to receive information from TCMC regarding the patient's condition.
6. When the healthcare provider receives a request for information on a patient, the staff shall ask who is calling, their relationship to the patient, and the privacy code.
a. Once the privacy code is verified, the staff may give the family member/caregiver the minimum information necessary regarding the plan of care for the patient.
7. During urgent or emergency situations when there is not time to obtain the privacy code, the TCMC staff shall verify with patient, family member, and/or patient's representative who can receive information.
8. The patient shall be asked to select a privacy code for each new admission; this can be a new code or remain the same from a previous admission.
G. ATTACHMENT:
9. Privacy-Gode Form
10. Privacy Code Education Form (English)
11. Privacy-Code Education Form (Spanish)

## Privacy Code-Form

Please place this completed form in the front of the Inpatient chart (in front of TAB 1) for all patients admitted to the nursing unit.

Patient Name: $\qquad$

Room/Bed \#: $\qquad$

Privacy Code-or word (minimum 4-characters) as selected by the Patient/Patient Representative

Gonfirmed by: $\qquad$


## DISCARD THIS FORM UPON PATIENT DISCHARGE (into "Shred-it" bin)

## Privacy-Code Patient Education

The purpose of the Privacy Code is to provide a way to protect your privacy but still give your family members/caregivers access to information needed to be involved in your care.

Upon each admission to Tri-City Medical Center, you shall be-asked to select a four (4)-digit Privacy-Code or a common word. This code shall authorize Tri-City Medical Conter to provide information to your family members/caregivers involved in your care. It-shall be required when they call the Medical-Center requesting information regarding your condition.

You-can give this Privacy Code to family members/caregivers involved in your care that you wish to receive information regarding your care.

The Privacy Code you have-selected for this admission is:
Privacy Code ___

## El propósito del CODIGO-DE PRIVACIDAD es facilitarle una

 manera-de proteger su intimidad, permitiondo el acceso-a-sus familiares o personas que usted-considere que necesitan tener información para-su cuidade.Gada vez que ingrese al centro medico Tri-City Medical Center, se le pedirá que-seleccione una-clave de-4 digitos, que pueden ser números o letras. Esta clave-sera su-código de privacidad. Esta clave sera requerida por el-Centro Medice, para poder dar información sobre su estado de-salud, por lo-cual, deberá proporcionar su clave de privacidad a sus familiares o personas cercanas-a usted.
La-clave de privacidad que usted ha seleccionado-para esta admisión es:

CLAVE DE PRIVACIDAD: $\qquad$ (Privacy Code)

## PATIENT CARE SERVICES

ISSUE DATE:
1/06

REVISION DATE: 6/07; 08/09; 10/09; 01/11 07/11; 08/12

Clinical Policies \& Procedures Committee Approval: Nursing Executive Council Approval:
Medical Executive Committee
Professional Affairs Committee Approval:
Board of Directors Approval:

## SUBJECT: Restraints, Used for Non-Violent/Non-Self-Destructive Behavior

05/1510/15
05/1510/15
06/1511/15
07/1501/16
07/15

## A. PURPOSE:

1. To provide a consistent standardized organizational-wide policy for the use of non-violent/non-self-destructive behavior restraint.

## B. PHILOSOPHY:

1. Tri-City Healthcare District acknowledges restraint may be necessary for certain patient populations.
2. Restraint shall only be used when essential to protect patients from harming themselves, other patients, or staff.
3. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event restraint of a patient becomes necessary, Tri-City Medical Center (TCMC) supports a philosophy which will protect the patient's health and safety and preserves his/her dignity, rights and well-being.
4. Restraints of any type should not be used as a punishment, retaliation, coercion, or for the convenience of staff, and should be discontinued as soon as possible.
5. All patients are given information regarding patients' rights upon admission.
6. The use of restraint is not based on a patient's restraint history or behavior history.

## C. DEFINITIONS:

1. Restraint - Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.
a. Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.
b. Hand Mitts
i. That do not allow a patient to bend all fingers and thumb, mitts that look like boxing gloves whether tied down or not
ii. That are gloves to keep a patient from scratching when tied to a bed or chair frame
a.c. Four (4) side rails in the up position if the patient cannot lower the side rails and exit the bed.
z.d. Chemical restraint or seclusion is not used for non-violent behaviors.
3.2. Physical Escort - A physical escort would include a "light" grasp to guide the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
4.3. Practitioner-Physician/Allied Health Professional (AHP) - any physician, dentist, or podiatrist who is a Medical Staff member and/or who exercises clinical privileges at TCMC as context requires, unless otherwise expressly limited.
5.4. Qualified/Specially Trained Staff - Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served.

## D. EXCLUSIONS:

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are not considered restraint:
a. Side rails
i. Used for safety or support
ii. Four (4) side rails in the up position at the same time that can be lowered by the patient to allow the patient to exit the bed
iii. During procedures for patient safety
iv. Seizure precautions with padded side rails
a.v. Patient in the Intensive Care Unit (ICU) or patient outside of the ICU placed in a bed used in the ICU
b. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure i.e., surgical positioning, intravenous (IV) arm boards, papoose, protection of surgical and treatment sites in pediatric patients.
c. Adaptive support in response to assessed patient needs i.e., orthopedic prescribed devices, postural support, table top chairs, and specialty mattress.:
d. Protective equipment such as helmets.
e. Hand mitts (gloves only) to keep from scratching self that are not secured (tied) to a bed frame or chair
i. Pinning wrists down with mitts and/or hand or fingers are immobilized are considered a restraint
f. Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm
g. Devices that permit the patient to participate in activities without the risk of physical harm
h. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes i.e., handcuffs shackles.
3. Safe transportation of patients on or off the unit for procedures or tests:
a. Patients may be secured in a transport gurney or chair with a safety device (i.e. Velcro strap, side rails) upon transport on or off the unit.
b. Patients may be secured with a safety device while obtaining a procedure or test.
c. Patients may not be left unattended.
4. Restraint use for violent or self-destructive behavior (the restraint standards for violent or selfdestructive behavior apply). See the Patient Care Services Restraints/Seclusion for Violent/SelfDestructive Behavior Policy which includes definitions for the following:
a. Chemical Restraint
b. Time-out
c. Physical Escort
d. Physical Holds
e. Qualified/Specially Trained Staff

## E. PRECAUTIONS:

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room not under continuous observation by staff is at greater risk for self-injury or adverse occurrences.

## F. ORDERS:

1. Restraint is used upon the order of a practitionerphysician/AHP.
2. Practitioner-Physican/AHP orders are valid until criteria for release is met.
3. If a practitionerphysican/AHP is not available to issue such an order, a Registered Nurse (RN) may initiate restraint use based on an appropriate assessment of the patient.
a. Once placed in restraints, a practitioner-physician/AHP shall be notified as soon as possible of the initiation of restraint, and a telephone or written order shall be obtained from that practitionerphysican/AHP and entered in the patient's medical record.
b. If the initiation of restraint is based on a significant change in the patient's condition, the RN shall immediately notify the practitionerphysician/AHP.
4. The attending physician must be consulted as soon as possible if restraint is not ordered by the patient's attending physician.
5. A written order, based on examination of the patient by a practitioner,physician/AHP is entered into the medical record on the initiation of restraint.
6. Orders for restraint are not written as standing orders or on an as needed basis i.e., PRN.
7. Orders for non-violent/non-self-destructive restraint must include: action justifying restraint, type of restraint, and criteria for release.
8. The RN shall assess the discontinuation of the use of restraints as soon as it is safely possible.
9. When restraint is discontinued and/or alternatives methods are not effective and restraint must be reapplied, a new order must be obtained.

## G. INITIATION AND DOCUMENTATION:

1. Alternatives must be considered and tried before using restraint. Refer to examples of alternative interventions on Appendix A.
2. If alternatives are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
3. The RN shall document initiation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet. The following shall be documented:
a. Restraint Reason i.e., Non-violent/ Non-Self Destructive Behavior Restraint
b. Restraint Initiation Date and Time
c. Restraint Type i.e., chair with lap table, mitts that look like boxing glovesens tied to bed, soft ankle, soft wrist, vest
d. Restraint Location i.e., left or right upper or lower extremity, torso
e. Action Justifying use of Restraint
f. Description of other behavior requiring restraint, if applicable
g. Pre-restraint alternatives attempted
h. Effectiveness of Pre-restraint alternatives
i. Education provided to patient/family education
H. ONGOING MONITORING AND DOCUMENTATION:
4. Patient in restraint may need more frequent monitoring because of age, physical or mental conditions or other needs/conditions based on clinical judgment and knowledge of the patient and their individual needs
5. If the patient is sleeping, the RN shall observe the patient to ensure a safe environment.
a. Clinical judgment and knowledge of the patient and their individual needs shall be used to determine when and what items need to be evaluated.
6. Patient Care
a. The RN or designee trained and competent in use of restraint shall address and document the following patient care needs atleast approximately -every 2 hours
i. Range of Motion (when awake)
ii. Elimination and hygiene
iii. Nutrition/Hydration
iv. Allowance for the patient to have maximum movement
7. Assessment and Reassessment
a. The RN shall reassess patients in medicat-restraint approximately every 2 hours or more frequently if necessary. induding.
b. The patient will be assessed for the following:
i. Mental status and behavior
ii. Physical/emotional well-being
iii. Respiratory status
iv. Limb circulation
v. Maintenance of the patient's rights, dignity, and security
vi. Monitoring of the correctness of the application, removal and reapplication of restraint
vii. Skin
c. Document assessment and reassessment findings in the medical record.

## I. PLAN OF CARE

1. Ensure the appropriate (IPOC) is implemented with the initiation of restraint.
a. Review and update per the IPOC policy.
2. Discontinue the restraint IPOC when restraint is discontinued

## PATIENT/FAMILY EDUCATION

1. The following education shall be provided to the patient/family:
a. Clinical reason for restraint
b. Purpose and use of restraint
c. Monitoring and care that shall be provided
d. Criteria necessary for termination of restraint
e. Additional information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. Appropriate family members shall be notified when a patient is placed in restraint when it meets with the patient's wishes and/or Health Insurance Portability and Accountability Act (HIPAA) and other regulatory standards.

## K. DISCONTINUATION

1. Restraint shall be discontinued when criteria for release are met.
2. Document discontinuation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.

## L. COMPETENCY AND EDUCATION

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the application and monitoring of restraint, and shall undergo education and training in the proper and safe use of restraint during initial orientation and annually thereafter.
2. Training requirements include but are not limited to:
a. The determination of who has authority to order restraint
b. The determination of who has authority to discontinue the use of restraint
c. The determination of who can initiate the use of restraint
d. The circumstances under which restraint is discontinued
e. The requirement that restraint is discontinued
f. A definition of restraint
g. A definition or description of what constitutes the use of medications as a restraint
h. A determination of who can assess and monitor patients in restraints
i. Time frames for assessing and monitoring patients in restraints
3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring of restraint.
a. A qualified staff member shall be assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure proper safety procedures, orders and monitoring are implemented.
4. Practitioners-Physicians/AHP's shall be educated in the use of restraint

## M. STAFFING

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, co-occurring conditions, patient acuity, age, and developmental functioning of the patient. These elements are addressed in the staffing mix of the unit.
N. NOTIFICATION
2. The hospital shall report required information to Centers for Medicare and Medicaid Services (CMS) per regulations. See the examples below:
a. Each death that occurs while a patient is in restraint or seclusion
b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
c. Each death known to the hospital that occurs within one week after restraint or seclusion was used
3. Regulatory Compliance shall document in the patient's medical record the date and time the death was reported to CMS.

## O. PERFORMANCE IMPROVEMENT

1. Data shall be collected on restraints and submitted to the Restraint Committee and reviewed by the Joint Commission Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement.
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.
P. REFERENCES
3. California Code of Regulations. Title XXII.
4. Department of Health and Human Services. Federal registry part IV. Centers for Medicare and Medicaid Services (CMS) 42CFR part 482.
5. Joint Commission (2015). Hospital accreditation standards. Retrieved from http://www.jointcommission.org

## Restraint Education/ Competency

Based Upon Scope of Practice

$\checkmark=$ Required for scope of practice

## APPENDIX A: ALTERNATIVES TO RESTRAINT

## A. Psychosocial Alternatives

- Diversion activities such as: television, soothing music, books, or folding washcloths
- Family interaction
- Orientation to day, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter
B. Environmental Alternatives
- Commode at bedside
- Decreased noise
- Music/TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings
C. Physiological Alternatives
- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values
- Pharmacy consult

Tri-City Health Care District Oceanside, California

## PATIENT CARE SERVICESAdministrative-Policy Manual

## ISSUE DATE: 11/94

## SUBJECT: Consent for Operative or Other Procedures

REVISION DATE: 9/95; 11/96; 10/97; 7/99; 6/03; 1/06; POLICY NUMBER: 8610-359 2/06; 2/07; 04/09; 09/10

| Clinical Policies and Procedures Committee Approval: | $08 / 15$ |
| :--- | :--- |
| Nurse ExecutiveOperations Team Committee Approval: | $\mathbf{1 0 1 1 0 0 9 / 1 5}$ |
| Medical Executive Committee Approval: | $11 / 15$ |
| Professional Affairs Committee Approval: | $\mathbf{1 1 / 1 0 0 1 / 1 6}$ |
| Board of Directors Approval: | $12 / 10$ |

A. PURPOSE:

1. To comply with legal and regulatory standards by defining Tri-City Healthcare District's (TCHD) process to obtain a valid consent prior to diagnostic or therapeutic invasive procedures.

## B. DEFINITIONS

1. Adult: An individual who has reached the age of 18 years, or a minor who has entered a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the United States of America, or who has been declared emancipated pursuant to Family Code section 7122et.seq. (Family Code, section 7002), or self sufficient minor (15 years or older, living apart from his/her parents, and manages his/her own financial affairs) pursuant to Family Code section 6922.
2. Consent Form: A document that verifies that thea patient has been informed of a pending diagnostic or therapeutic invasive procedure; understands the information and has given consent to the physicianphysician/Allied Health Professional.
3. Informed Consent:
a. Voluntary consent given by a person or a responsible proxy (e.g., legal guardian, responsible party) for invasive diagnostic or therapeutic procedure after being informed of:
i. -Tthe purpose, methods, benefits, and risks.
ii. The likelihood of the patient achieving their goals
iii. Any potential problems that might occur during recuperation
iv. Reasonable alternatives to the patient's proposed care, treatment, and services
v. Side effects related to alternatives
vi. Risks ratedrelated to not receiving the proposed care, treatment or services
b. The essential criteria of informed consent are that
3.i. The subject has both knowledge and comprehension. that
i.ii. Consent is freely given without duress or undue influence. and that
ii.iii. The right of withdrawal at any time is clearly communicated to the subject.-This is and documented by the physicianphysician/Allied Health Professional in the patient's medical record.
4. Emergency: A situation in which immediate services are required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required to prevent serious disability or death.
5. Minor: For minors see Patient Care Services (PCS) Policy: Consent for Minors
6. Procedures/Treatments Requiring Informed Consent/Consent forms: Informed consent and a consent form are required for any procedure or medical treatment that is considered complex and involve risks that are not commonly understood. The final determination of the "complexity" of the
procedure/treatment is the responsibility of the physicianphysician/Allied Health Professional, in accordance with the criteria listed below:
a. Any procedure that requires pre-medication for sedation/analgesia
b. Any invasive procedure which involve incision, percutaneous puncture or insertion, and requires the services of the Endoscopy Lab, Operating Room, Cardiac Gath
Catheterization Laboratory, Interventional Radiology
c. As required by law including but not limited to:
1) Blood Transfusion
2) Human Immunodeficiency Virus (HIV) Blood Tests
3) Investigational drugs or devices
4) Human Experimentation
5) Treatment for breast or prostate cancer
6) Use of psychotropic medications
7) Electroconvulsive Therapy

## C. PROCEDURE:

1. A signed consent form is required prior to invasive diagnostic or therapeutic procedures.
a. After the physician/Allied Health Professional has obtained the patient's informed consent, a consent form for a procedure must be signed by the patient.
b. The completed consent for Operative or Other Procedures shall be placed on the patient's chart under Operative/Consents.
c. A copy of the signed form may-shall be given to the patient/legal representative-upon request.
2. Consent must include:
a. Nature of the proposed care, treatment, services, medications, interventions, or procedures
b. Potential benefits, risks, or side effects of the procedure including potential problems that may occur during recuperation
c. Likelihood of achieving care, treatment, and/or service goals
d. Reasonable alternatives
e. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, or service
f. Limitations of the confidentiality of information learned from or about the patient as indicated
f.g. Any independent medical research or significant economic interests the physician/Allied Health Professional may have related to the performance of the proposed operation/procedure
3. The consent form must be signed prior to the administration of narcotics or mind-altering drugs.
a. The physicianphysician/Allied Health Professional must determine if the patient is competent to sign the consent or if the procedure must be delayed if the consent is not obtained before the administration of narcotics or mind-altering medications.
i. The decision to continue with the procedure must be documented by the physician in the medical record.
4. If, in the opinion of the physicianphysician/Allied Health Professional, the patient is permanently or temporarily incapable of giving consent, consent is obtained from one of the following, in the order listed
a. Surrogate decision maker who has been verbally designated to the physicianphysician/Allied Health Professional who has undertaken primary responsibility for the patient. This verbal designation must be documented in the medical record and is valid:
i. During the duration of the hospitalization
ii. The course of illness
iii. 60 days, whichever is shorter
b. Agent identified in an advanced directive
c. When both an agent and surrogate are appointed by the patient, the surrogate takes precedence over the agent for the limited duration previously stated.
d. Conservator, who has been authorized by the court to make health care decisions or guardian;
e. Court appointed surrogate decision maker or court order
f. Closest available relative when appropriate to rely on the consent of this person (the person has capacity, trustworthy motives, likely that patient would consent if able, no objections from close relatives). The physician/Allied Health Professional should determine appropriateness for procedures requiring informed consent.
5. The consent form must include:
a. Full terminology of the procedure (in lay terms) without the use of abbreviations.
i. The terminology is obtained from the physicianphysician/Allied Health Professional order.
ii. Right or Left shall be indicated when appropriate
b. Document the date and time when the patient signs the consent form.
c. The name of the surgeon/physicianphysician/Allied Health Professional performing the procedure and the name of the attending physicianphysician/Allied Health Professional must be listed on the consent (first and last names).
i. If there is the possibility that some in the medical group may cover for the primary-procedural physician/Allied Health Professional (i.e., call, vacation, availability, etc.) list the primary physician/Allied Health Professional and the name of the medical group or "Primary physician/Allied Health Professional and associates", whichever is applicable.
ii. When two physisianphysician/Allied Health Professionals are listed on the orders as performing the procedure together, both surgeons are listed on the consent.
d. When two physicianphysician/Allied Health Professionals are performing two different procedures on the same patient, a separate consent form shall be completed for each physisianphysician/Allied Health Professional and corresponding procedure
e. If there is the poscibility that some in the medical group may cover for the primary physician (i.e., call, vacation, availability, etc.) list the primary physician and the name of the medical-group or "Primary physician and associates", whichever is applicable.
f.e. Blank lines are not permissible on the consent form.
6. The consent form may not be altered once the patient has signed.
a. If the physicianphysician/Allied Health Professional alters the order, a new consent must be obtained.
b. In the case of a clerical error on the consent, the consent must be rewritten. The patient must sign the revised consent.
7. The consent form must be signed by a competent adult patient and witnessed by a hospital employee.
a. A mark may be placed on the consent if the patient is physically unable to sign his/her name.
i. Two hospital employees shall sign as witnesses to the mark.
b. Elective surgery/procedures shall be delayed/cancelled if the patients voluntarily indicates doubt or confusion about the indicated procedure, until the physicianphysician/Allied Health Professional obtaining informed consent has an additional opportunity to talk to the patient
8. If the patient or patient representative cannot communicate with the physicianphysician/Allied Health Professional or hospital representative due to a language barrier, interpretive services shall be obtained
a. Staff and/or family members shall only be used as interpreters in emergent situations until a GyraCom(8) medical interpreter is contacted.
i. For the complete policy governing use of interpreters, please refer to Patient Care Services Ppolicy: H.H-"Communication with the Sensory Impaired and/or Persons with Language Barriers."
b. If an interpreter is used, documentation shall include the name of the interpreter, the person's position (when appropriate) and that person's relationship to the patient.
c. When GyraCom(telephone/video translation service is used, the following must be documented on the consent form:
i. The name of the patient/legal representative receiving translation.
ii. The patient's/legal representative's primary language.
iii. The medical interpreterGyraGom(-Operator identification/Nnumber.
d. If the consent form is not available in the patient's or patient representative's primary language, the interpreter shall orally-verbally translate the form and ask the patient to sign the English form if the patient or the patient's representative agrees to the terms and conditions.
9. State and Federal regulation mandate special informed consent requirements for reproductive sterilization which is primarily for the purpose of rendering the person incapable of reproducing ("elective sterilization"), and elective sterilization may be performed only when the following conditions are met:
a. Informed consent has been obtained from the patient
b. The patient shall be able to understand the content and nature of the informed consent process
c. The patient shall not be in a condition or mental state in which judgment is significantly altered
d. The patient shall not be in labor, or less than 24 hours postpartum or post abortion
e. The patient shall not be seeking to obtain or obtaining an abortion
f. Medi-Cal or Federally funded patient shall have the following additional requirements
i. Patient shall be 21 years of age or older
ii. Patient shall not have been declared mentally incompetent by a court of competent jurisdiction, unless a limited conservator has been appointed and specific criteria have been met
iii. The patient shall not be involuntarily confined or detained in a correctional or rehabilitative facility, or confined, under a voluntary commitment in a facility for the care and treatment of mental illness
g. The sterilization consent has been signed by the necessary parties and is available on the chart prior to procedure
$h$. The required waiting period has been satisfied
i. Thirty (30) days, but not more than 180 days shall pass after the appropriate sterilization consent was signed by patient or conservator
ii. Elective sterilization shall be performed less than 30 days after the patient has signed the consent form only in the following circumstances:
1) Private (pay status) patient voluntarily requests in writing that the 30-day waiting period be waived to no less than 72 hours
2) The elective sterilization is performed at the time of emergency abdominal surgery or at the time of a premature delivery, AND the physicianphysician/Allied Health Professional certifies that informed consent was given and the sterilization consent form was signed at least 30 days before the intended date of sterilization and that at least 72 hours have actually passed since consent was given and the form was signed, and the physicianphysician/Allied Health Professionals describes the nature of the emergency, or indicates the prior expected delivery date on the sterilization consent form.
10. State regulations mandate special requirements for physicianphysician/Allied Health

Professionals regarding informed consent for hysterectomies.
a. The Authorization for and Consent to Hysterectomy shall be used to document these requirements.
i. The Hysterectomy Consent form is needed in addition to the Consent for Operative or Other Procedures form.
b. These regulations outline specific requirements for physicianphysician/Allied Health Professionals that must be documented in the medical record, including that the physicianphysician/Allied Health Professional must obtain "verbal and written" consent prior to the performance of the hysterectomy.
c. The informed consent procedure by the physicianphysician/Allied Health Professional, shall provide that at least all of the following information is given to the patient verbally and in writing:
i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.
ii. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.
iii. Advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result if the patient is not already sterile or postmenopausal.
iv. A description of the discomforts and risks that may accompany or follow the performance of the procedure.
v. A description of the benefits or advantages that may be expected as a result of the hysterectomy.
vi. Approximate length of stay in the hospital.
vii. Approximate length of time for recovery.
viii. Financial cost to the patient of the physicianphysician/Allied Health Professional's and surgeon's fees.
11. A signed consent form is in effect until the patient changes his/her mind, or the physicianphysician/Allied Health Professional alters the nature of the procedure (in which case a new consent is required).
12. Consent for a medical emergency:
a. In the case of a medical emergency where a procedure is immediately required and necessary to prevent deterioration or aggravation of the patient's condition, treatment may proceed without the patient's consent.
b. The physicianphysician/Allied Health Professional must document the determination of the medical necessity in the medical record.
c. The physicianphysician/Allied Health Professional does not sign the consent on behalf of the patient.
i. The unsigned consent is maintained in the medical record.
ii. TCHD personnel shall document on the consent "See progress notes dated $\qquad$ for physicianphysician/Allied Health Professional documentation of medical emergency indicating need to proceed with procedure."
13. Telephone/Facsimile/Email Consent
a. Informed consent may be obtained by telephone, facsimile, or email when the person having the legal capability to consent for the patient is not otherwise available.
$i$. TCHD staff must validate the person is authorized to give consent.
b. When a telephone is used, the responsible physigianphysician/Allied Health Professional must provide the patient's legal representative with the same information as would be presented to the individual in person.
c. Two individuals (either two TCHD staff personnel or the physicianphysician/Allied Health Professional and one TCHD staff member) must witness the consent conversation.
i. The patient's legal representative must be informed the conversation is being witnessed.
ii. The person(s) witnessing the conversation must sign and date documentation of the conversation on the Telephone Consent Form.
iii. The telephone consent, with the signature of the two witnesses, is placed in the medical record.
d. PhysicianPhysician/Allied Health Professional instructions may be telegraphed or emailed to the legal representative.
i. In cases of telegraph or emailconsentelectronically transmitted consent, the following occurs:

1) Specific instructions regarding where the consent will be wired or emailed shall be provided by the person who is legally able to consent for the patient
2) Written confirmation proceeding the procedure and documentation of the patient's name, secured to the cover sheet if applicable, are maintained in the medical record.
ii. Refer to APP 516 and 517 regarding facsimile transmission
e. In cases of facsimile consent:
i. Direct discussion with the legal representative giving consent must first occur.
ii. The legal representative may fax the consent after receiving full information regarding the procedure.
iii. The facsimile document(s), along with the cover sheet, is placed in the medical record.
3) Request the legal representative to send the original signed document to TCHD. This document is filed in the patient's medical record upon receipt.
14. Consent for an incompetent patient:
a. If a patient is incompetent or otherwise unable to give informed consent and does not have a conservator or holder of a durable power of attorney for healthcare decisions, the physicianphysician/Allied Health Professional may proceed by obtaining consent of the closest available relative.
b. The physiধianphysician/Allied Health Professional must document in the medical record that there is no known conservator or durable power of attorney for healthcare and that the procedure is necessary.
c. If there is no relative available, and if the procedure is not an emergency, the Director of Risk Management is contacted to assist.
D. RELATED DOCUMENTS:
15. Patient Care Services Policy: Communication with the Sensory Impaired and/or Persons with Language Barriers
16. Patient Care Services Policy: Consent for Minors
D.E. REFERENCES:
17. Comprehensive Accreditation Manual, (2015), The Joint Commission
7.2. Health \& Safety Code §1690-1691
18. California Code of Regulations (CCR) Title XXII §51305.6 \& 70707.5
2.4. California Hospital Association Consent Manual

Administrative Policy Manual


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## ). PROCEDURE:

4. Periodic inventory
a. The following hospital departments are-designated inventory locations and are-assigned responsibility for inventory:
i. Pharmacy
ii. Gentral Supply
iii. Surgery
iv. Cardias-Gatheterization Lab
$\forall$. Radielogy
$\forall$ V. Laboratory
5. Perpetual Inventory
a. Perpetual inventory will be assigned an inventory account and be titled "Stores." Perpetuat inventory processes will-consist of the issuing of products and supplies with a eorresponding transfer of expenses from Stores to departments. Such expense transfer will occur on a monthly basis.
b. The following hospital departments are designated inventory logations and are assigned responsibility for perpetual inventory: i. Linen Room

3-1. Fiscal Year-End Inventory Adjustments
a. The Finance department will adjust fiscal year end periodic inventories with gains or losses from the following departments:
i. Pharmacy
ii. Central Supply
iii. Store Inventory
iv. Linen Room
v. Surgery
vi. Cardiac Catheterization Lab
vii. Radiology
viii. Laboratory
viii.ix. Food \& Nutrition
b. The Finance department will adjust fiscal year end perpetual inventory for "Stores" with gains or losses for departments having supply stations.

## Administrative Policy ManualPATIENT CARE SERVICES

ISSUE DATE: 1/86
REVISION DATE: 12/93; 1/97; 6/97; 8/97; 11/97; 3/00; 9/00, 6/02, 4/03, 04/09, 03/11, 06/11

## SUBJECT: Patient Complaints and Grievances

POLICY NUMBER: 8610-318

Administrative-Clinical Policies \& Procedures Committee Approval: Nurse Executive Committee Approval:
Medical Executive Committee Approval:
Professional Affairs Committee Approval: Board of Directors Approval:

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05/12
A. PURPOSE:

1. To provide a process that substantively addresses grievances and complaints from patients or patient representatives as a method of improving patient care and services delivered through problem resolution; to track and analyze patient grievances and complaints; and, to identify specific issues or trends which can be improved.

## B. DEFINITIONS:

1. A"Ccomplaint" is an expressioning of displeasure or discontent about a situation (housekeeping issue, food dissatisfaction, etc.) requiring a response taken to address the concern at issue. Post hospital verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the hospital stay is typically considered a complaint.
2. A "patient gGrievance" - is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, alleged abuse or neglect, issues related to the hospital's compliance with the Centers for Medicare \& Medicaid Services Hospital Conditions of Participation, or a Medicare beneficiary billing complaint related to rights and limitations-provided by 42 CFR 489.
a. Types of complaints/grievances:
i. If a-verbal patient gare complaint cannot be resolved at the time of the-complaint by staff present, is postpened for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further-actions for resolution then the complaint is a grievance.
i. Billing issues are not usually considered grievances for the purposes of requirement unless a Medicare beneficiary billing complaint is related to rights and limitations provided by 42 CRF 489.
ii. A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with Conditions of Participation. For the purpose of the requirement an Email or fax is considered "written."
ii-1) Information obtained with patient satisfaction survey(s) does not usually meet the definition of a grievance. If an "identified" individual writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.
iii. Patient complaints that become grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding
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their patient care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more Conditions of Participation, or other Centers for Medicare \& Medicaid Services (CMS) requirements. Those post-hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.
iii.i. All verbal or written complaints regarding alleged abuse, neglect, patient harm or hospital compliance with CMS requirements, are to be considered a grievance for the purposes of these requirements.
3. Whenever the patient or the patient's representative's requests that his or her complaint be handled as formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance and all the requirements apply.

## B. POLICY:

1. The Tri -City Healthcare District Board of Director's is responsible for the effective operation of the grievance process and delegates its authority herein for the review and resolution of grievances to the grievance-Grievance committeeCommittee. The Patient Relations Specialist shall operate and maintain the hospital's grievance mechanism designed to process and resolve patient complaints and formal grievances while maintaining a comprehensive record of complaints presented to Tri-City HealthCare District (TCHD).
C. PROCEDURE: (Please-see-Attachment A-Patient-Complaint/Grievance Process Flow
2. Patient Education
a. Upon admission, patients will be provided with information summarizing the patient's right to file a formal grievance or complaint. All patients will receive a Patient's Bill of Rights upon admission. The information provided to the patient/patient representative shall contain the address and telephone number for the State agency to all patients/patient representatives, as well as The Joint Commission. Patients have the right to voice complaints or concerns freely and to voice recommended changes. Patients have the right to voice complaints and recommendation without fear of retaliation.
3. Receipt of complaints:
a. All patient/family complaints regarding medical or nursing care will be discussed first with the individuals at the lowest possible level in the organization. Every hospital employee is accountable for receiving and managing verbal complaints from patients/families.
i. Attempts to resolve patient/family concerns or complaints will be made at bedside with individuals involved. Expression of a concern or voicing a complaint regarding patient care will in no way compromise the quality of services delivered.
ii. AnyThe unresolved complaint/concern will be reported to the supervisor or designee. The supervisor or designee will attempt to resolve. If the complaint is resolved to their satisfaction, no further follow-up is required. If no resolution, the Director/Manager/designee will become involved in resolution efforts. If still no resolution, the parties may involve the Director of Risk Management or the Chief Nurse Executive in the resolution efforts.
b. Processing of verbal complaints:
i. Receipt of a verbal complaint is to be addressed promptly by the staff present ("staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaints.

## 1. If the verbal complainteompliant is resolved, no further action is required

ii. Unresolved A complaint shall be entered into RL Solutions the pationt complaint repositery immediately stating facts of the complaint and any attempts atthe resolution-provided. (A complaint/grievance is considered resolved when the patient is satisfied with the actions taken on their behalf.)
iii.1. The Patient Relations Specialist will review for completeness or needed to follow up-and for maintenance of data.
iv.2. The manager of the involved area will than-review the unsolved compliant and enter any resolution actions taken into RL Solutions the complaint repository.

## 4-3. The Patient Relations Specialist will follow-up with the patient as needed.

*iii. Patients choosing not to voice complaints to unit staff providing their care may choose to call the Patient Representative. In the absence of the Patient Representative, the Patient Relations Specialist or Administrative House Supervisor may be called.
c. Complaints not resolved on the spot by staff present are "grievances".
i.d. Grievances made about situations endangering the patient (neglect/abuse), given the seriousness of the allegations and potential to harm patients, require immediate investigation and review.
e. Grievances require written notice (response) to the patient within seven (7) days.
i. The written response shall contain the name of the hospital contact person and identify the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion.
ii. The written notice of the hospital's determination regarding the grievance must be communicated to the patient or patient's representative in a language and manner the patient or patient's legal representative understands.
iii. If the grievance is not resolved within seven (7) days and if investigation is not complete or if corrective action is still being evaluated, the hospital's response should address that the hospital is still working to resolve the complaint and that the hospital will follow-up with another written response within thirty days.
Hi.iv. Every effort will be made to resolve all grievances as soon as possible. In collaboration with the manager/director of the involved area of the grievance, the hospitals written notice (letter) to the patient will be prepared and sent by the Patient Relations Specialist and/or the Director of Risk Management for which the complaint involves.
d.f. A written complaint is always considered a grievance. To process written complaints:
i. Upon written receipt of complaint from patient or patient representative, the department receiving shall date the complaint and immediately place it into RL Solutions the Complaint-Repository. (Emails may be utilized as a method of communication of grievances only if the patient has emailed their complaint/grievance and/or are asking for a written response via email.)
ii. Once the complaint has been entered electronically, the appropriate Manager(s) of the area(s) involved will be automatically notified.
iii. An-immediate call will be placed to the patient, investigation conducted and actions thoroughly documented in RL Solutionsthe electronic-complaint repository by the Patient Relations Specialist/manager(s) of the area(s) within four days.
iv. Cases requiring immediate action or intervention may be shared directly from the Director of Risk Management or his/her designee to the Department Chairman or Chairman of Quality Assurance/Performance Improvement/Patient Safety Committee as outlined in the Medical Staff On-Going Professional Practice Evaluation/Peer Review Policy (8710-509)
v. The Patient Relations Specialist or Director of Risk Management will draft a response letter containing those findings documented in RL Solutionsthe complaint system and documented by the manager(s) of the involved areas(s). It shall contain the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion. The Patient Relations Specialist will document same and scan the letter into RL Solutions the complaint ropository and mail letter after review by the Risk Management Director's approval.
vi. Risk Management Director will provide oversight to all written-letter responses. Response letters are not to be sent by the other individuals except as named herein.
3. Patient Representative/ Patient Relations Specialist Responsibilities:
a. For each complaint received by the Patient Representative or Patient Relations Specialist Representative he/she will:
i. Enter into the complaint repositoryRL Solutions. The data collected regarding patient grievances, as well as other complaints that not defined as grievances (as determined by the hospital) maywill be incorporated into the hospital's Performance Improvement Program.
ii. Communicate with patient the projected time of response and/or resolution, immediate and/or up to 24 hours for verbal feedback and seven (7) days for written feedback. Acknowledgement letter for all grievances is to be mailed within 7248 hours by the Patient Relations Specialist.
iii. Assist appropriate leadership with complaint review, facts, and discovery upon requests.
iv. Should a patient or designated patient representative disagree with complaint findings, they will contact the Patient Relations Specialist and/or the Director of Risk Management Grievance Committee/Patient Care Conference may be offered as process for resolution. The California Department of Public Health and The Joint Commission may beare offered as an agency for complaint resolution to all patients. For premature discharge or quality of care, utilization concerns of coverage decision issues, the will atso be offered in the admissions packet given to all patients. If a patient or designated representative requests, the hospital will refer the-grievance to the state's Quality Improvement Organization(QNO).
4. Individual ancillary department' responsibilities:
a. When received by an ancillary department, a complaint specific to that department shall be formally acknowledged immediately by the manager(s) of the area(s). The complaint will be entered into the-complaint repositoryRL Solutions within 72 hours.
b. Any written documentation submitted to the department will be scanned into the somplaint repositeryRL Solutions by the department.
c. All patient complaints shall be answered promptly (e.g. within seven (7) working days with a closing statement reflecting availability of individual department, as well as the Patient Relations Specialist/Patient Representatives as a future problem resources.
5. Resolutions of the grievance:
a. When a patient communicates a grievance to the hospital via email the hospital may provide its response via email.
b. There may be situations where the hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the hospital's actions. In this situation the hospital may offer the Grievance Committee as a method for resolution. It will be necessary to maintain documentation of its efforts and demonstrate compliance with CMS requirements.
c. In written responses, the hospital is not required to include statements that could be used in legal action against the hospital, but the hospital must provide adequate information to address each item as stated in this requirement.

## D. GRIEVANCE COMMITTEE/PATIENT CARE CONFERENCE COMMITTEE:

1. The Grievance Committee shall consist of Chief Nursing Executive or his/her designee, Patient Relations Specialist, Risk Management, Performance Improvement and other departments and/or members as indicated.
2. The Grievance Committee shall meet as needed to evaluate grievances and complaints from prior month and review resolutions.
3. Reports from Grievance Committee shall be integrated into the hospital performance improvement program.
4. The governing body has the responsibility of the oversight of the grievance process and delegates the review and resolution of complaints to the Grievance Committee. The Grievance will provide to the governing body at least annually.
5. The Grievance Committee shall meet to review grievances unable to be resolved at by the involved manager, patient relations and risk management.

## E. REFERENCES:

1. Centers for Medicare \& Medicaid Services (CMS) 482.132015
2. The Joint Commission (TJC) LD.01.03.01; RI.01.07.01; MS.09.01.01 2015
2.3. California Hospital Association Consent Manual 2015
3. Galifornia Tort Claims Act
4. Attachments - Patient-Complaint/Grievance-Flow Chart
(8) Tri-City Health Care District
Administrative Policy ManualPATIENT CARE SERVICES
You can use this page to copy \& paste shapes to the following document
The ends of the arrows can be attached to the boxes at "red points" that appear on the boxes. Attached the arrow to a red point of each box you are connecting together.
On the "Home" menu tab you can also align the shapes using the "Arrange" feature in the Drawing section.
Note: Directions are applicable if using PowerPoint 2007.
Administrative, .iy ManualPatient Care Services
Tri-City HealthCare District Hospital $\quad$ _ $\quad$ Draft 1: February 9, 2012

 | $\begin{array}{l}\text { Point of Entry: } \\ \text { Billing }\end{array}$ |
| :--- | Billing Office

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Administrative, y-ManualPatient Care Services Patient Complaints and Grievances, 8610-318


Administrative Policy Manual Information Technology

ISSUE DATE: 6/03
REVISION DATE: 2/05; 5/12

SUBJECT: Voicemail Access
POLICY NUMBER: 8610-617

10/15
06/1211/15
0711201/16
07/12

## A. PURPOSE:

1. To provide Voice Mail to authorized individuals (Authorized Voice Mail Users) associated with Tri-City Healthcare District (TCHD), including employees, external case managers, authorized physicians, vendors, and other persons engaged in legitimate business at TCHD. Voice Mail Services are provided to those individuals who receive approval from a department director. Those employees who do not currently have Voice Mail capability may request it from the Information Technology Department as described below.

## B. DEFINITIONS;

1. The term Voice Mail identifies any form of voice messaging currently sanctioned for use at TCHD. It encompasses voice messaging among TCHD employees, and to/from TCHD and external organizations or individuals.

POLICY:

1. This policy addresses Voice Mail, informs Authorized Voice Mail Users of their rights and obligations, and formally notifies Authorized Voice Mail Users of usage monitoring. With advance notice, Authorized Voice Mail Users will not be put in an embarrassing situation, and are notified that TCHD:
a. Monitor, access, retrieve, download, copy, listen to, or delete anything stored in, created, received or sent via Voice Mail
b. Limit and/or restrict any authorized user's use of Voice Mail User's use of Voice Mail Services, and to inspect, copy, remove or delete any unauthorized use without notice
c. Use any information in the system
2. Authorized Voice Mail Users may communicate with each other or with outside persons or organizations via Voice Mail. Authorized Voice Mail Users should not have any expectation of personal privacy for information stored in, created, received, or sent via Voice Mail.
3. Voice Mail Services are TCHD property, with the purpose of facilitating TCHD communications. Voice Mail Services are intended for TCHD business related purposes only. TCHD encourages the use of Voice Mail to improve communications and productivity. Each Authorized Voice Mail User has a responsibility to maintain and enhance TCHD's public image and to use Voice Mail in a productive and legal manner.
4. Authorized Voice Mail Users may communicate with each other or with outside persons or organizations via Voice Mail. Authorized Voice Mail Users should not have any expectation of personal privacy for information stored in, created, received, or sent via Voice Mail.
5. Voice Mail Services are TCHD property, with the purpose of facilitating TCHD communications. Voice Mail Services are intended for TCHD business related purposes only. TCHD encourages the use of Voice Mail to improve communications and productivity. Each Authorized Voice Mail User has a responsibility to maintain and enhance TCHD's public image and to use Voice Mail in a productive and legal manner.
6. All TCHD policies and practices apply to Voice Mail Services, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality. In addition, any
communication that is sent via Voice Mail is a communication on behalf of TCHD. Therefore, any TCHD Voice Mail communication must be professional and business-related.
7. Each individual granted Voice Mailservices at TCHD is provided with a written copy of this policy. The Authorized User of Voice Mail Services must complete and sign the Voice Mail Services Agreement form that includes the following statement:
a. "I have received a written copy of TCHD's Voice Mail Services Policy. I fully understand the terms of this Policy and agree to abide by them. I know that any violation of this policy could lead to corrective action, dismissal or even criminal prosecution."
8.7. To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement annually on his/her review date.
Q-8. Appropriate security measures must be strictly followed. Each Voice Mail user is personally accountable for any action that results in a breach of TCHD security or confidentiality.
10.9. The transmission of any kind of sexually explicit information on any company system is a violation of our policy on sexual harassment. In addition, sexually explicit material may not be accessed, archived, stored, distributed, edited or recorded using our telephone resources.
14.10. TCHD's Voice Mail facilities must not be used knowingly to violate the laws and regulations of the United States or any other nation. Use of any company resources for illegal activity is grounds for corrective action or immediate dismissal, and we will cooperate with any legitimate law enforcement activity. (Administrative Policy \#8610-403, Harassment Policy)
8. An individual who believes helshe has a legitimate-need for Voice Mail Services should request it in the following manner:
a. Obtain a Voice Mail Access/Usage Agreement form from Information Technology.
b. Complete the justification section providing reasons for the request.
9. Obtain necessary signatures from the appropriate department director.
d. Submit the request to Information Technology.
e. An Information Technology representative will install the Voice Maill and will provide instructions and password information to the requestor.
13.11. Management And Administration
a. The TCHD Information Technology Department is responsible for assuring security of TCHD telephone services. The Information Technology Department provides all telephone access, and must approve all requests for Voice Mail Services.
b. Official Records
i. All messages and records of Voice Mail Services are official records and are the property of TCHD. TCHD reserves the right to access and disclose, at any time, all documentation of Voice Mail Services.
c. Passwords
i. Passwords help maintain individual accountability for Voice Mail usage. Each Authorized Voice Mail User will maintain a confidential Voice Mail password. TCHD policy prohibits the sharing of passwords.
d. Security
i. Employees should not assume that Voice Mail Messages are private. The TCHD Information Technology Department may review Voice Mail activity and analyze usage patterns, and distribute periodic reports of this data to the Executive Council and Department Directors to assure that TCHD's Voice Mail resources are devoted to maintaining the highest levels of productivity. TCHD can monitor and record all Voice Mail usage. TCHD security systems are capable of recording Voice Mail messages for each user, and TCHD reserves the right to do so at any time.
e. Violations
i. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative Policy 8610-424, Coaching and Counseling for Work Performance. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.
f. Notification of Improper Use
i. Each employee is expected to report unauthorized use or violation of this policy.

## D. FORMS:

4. Voice Mail Agreement located on the - Intranet.

## E.D. REFERENCES:

1. Administrative Policy 8610-403, Harassment Policy
2. Administrative Policy 8610-424, Coaching and Counseling for Work Performance

Administrative Policy Manual
Information Technology

## ISSUE DATE: 3/04

REVISION DATE: 2/05; 11/08; 6/12
Department Approval Date(s): Administrative Policies \& Procedures Committee Approval: Professional Affairs Committee Approval: Board of Directors Approval:

SUBJECT: Wireless Network Communication
POLICY NUMBER: 8610-624
A. PURPOSE

1. To provide Wireless Communications, while meeting audit and regulatory requirements for confidentiality and security of information, to each Authorized Wireless Communications User ("User") associated with Tri-City Healthcare District (TCHD)FCMG, including employees, internal and external case managers, authorized third parties, and authorized physicians, vendors and other persons engaged in legitimate business at Tri-City Healtheare District (TCHD).
2. The term Wireless Communications identifies all wireless connections of computer equipment to transmit voice, data, video, or images to the TCHD Network, including radio frequency, cellular technology, satellites, microwave, or any other connection that is not wired.
3. This policy outlines acceptable use of Wireless Communications, and prohibits access to the TCHD Network via unauthorized and unsecured wireless communication mechanisms. Only wireless systems that meet the criteria of this policy and have been approved by the TCHD Information Technology Department are approved for connectivity to the TCHD Network.
B. SCOPE
4. TCHD has implemented a wireless network. The TCHD Information Technology Department has implemented security methods to assure that only Authorized Users and Devices access TCHD network services via Wireless Communications. This policy covers not only wireless devices owned by TCHD and distributed by the Information Technology Department, but also wireless data communication devices (e.g. personal computers, cellular phones, Smart Devices PDAs) brought to a TCHD site by employees, visitors, physicians, or other persons.
C. POLICY
5. Wireless Communications is provided to authorized vendors, physicians, directors, managers, technical staff, or other persons who need wireless access to the TCHD Network.
6. Wireless Communications is intended for TCHD business related purposes only. Each User has a responsibility to use Wireless Communications in a productive and legal manner.
7. All TCHD policies and practices apply to Wireless Communications, including those policies regarding Network Access, Email Access, Internet Access, Cerner Access, intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.
8. Wireless Communications is provided to a User as part of another service. In most cases, the User is authorized to use a Remote or Portable Computer with wireless communications capability. No specific Agreements are associated with wireless communications. However, this Policy/Procedure outlines specific requirements for TCHD Wireless Communications.
9. Wireless Communications are defined, implemented, and supported by the TCHD Information Technology Department. Information Technology implements and supports wireless communications using technologies which will protect TCHD confidential information. These technologies (including encryption, addressable hardware, and user authentication) assure the
safety and security of the TCHD Network.
10. All wireless Access Points within TCHD are managed and controlled by the Information Technology Department. Information Technology has implemented tight security methods for wireless communications, and will conduct periodic tests and audits of the Access Points and TCHD-owned wireless devices.
11. A device with a wireless Network Interface Card (Laptop, Smart DevicePDA, and Cell Phone) brought into a TCHD facility may not be used to access the TCHD Network unless authorized and tested by the Information Technology Department. A User who attempts to access TCHD Network Services via an unapproved wireless device, or attempts to disable, defeat or circumvent any security facility, or uses a wireless device on the public wireless network for non-TCMC business use without authorization will be subject to appropriate corrective action as defined by policies.
12. While use of Wireless Communications offers significant benefits, it can also expose TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each User is personally accountable for any action that results in a breach of TCHD security or confidentiality.
13. A User must not use Wireless Communications knowingly to violate the laws and regulations of the United States or any other nation. Use of any TCHD resources for illegal activity is grounds for corrective action, immediate dismissal, or contract termination, and we will cooperate with any legitimate law enforcement activity.
14. Management And Administration
a. The TCHD Information Technology Department is responsible for assuring security of TCHD wireless communications.
b. Authorized Use
i. The Information Technology Department plans and implements security controls and management tools for wireless communications. Among the tools employed are hardware and software products to identify attempted unauthorized access to the TCHD Network through wireless communications.
ii. Wireless communications are to be used for TCHD business purposes. Authorized wireless devices, which have been configured and are supported by the Information Technology Department, meet the strict security requirements established for wireless communications.
iii. Any person who attempts to disable, defeat or circumvent any wireless communications security facility will be subject to appropriate corrective action or legal action defined by policies
c. Security
i. No patient Protected Health Information (PHI) may be transmitted outside of TCHD's Local Area Network without the approval of the Information Technology Department.
d. Violations
i. Wireless communications provide the opportunity for efficient communications of TCHD information without the constraints of cabling or fixed devices. However, this creates an opportunity for intentional or inadvertent breaching of security by patients, family members, visitors, or unauthorized persons who seek to access TCHD information. The TCHD Information Technology Department provides security controls to prevent unauthorized access to TCHD information via wireless communications. An employee, who observes any attempt by an unauthorized person to access our network via wireless communications, must immediately report that attempt to the Information Technology Department.
ii. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative Policy 424, Coaching and Counseling for Work Performance. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.
e. Legal Notice
i. California Penal Code 502 states that unauthorized use of a computer in the State of California is a felony.
f. Notification of Improper Use
i. Each employee is expected to report attempted unauthorized use or violation of this policy to the employee's manager or to the Information Technology Department.

## D. REFERENCES:

1. Administrative Policy 8610-424, Coaching and Counseling for Work Performance
2. California Penal Code 502

Tri-City Health Care District Oceanside, California<br>Infection Control Policy Manual

## ISSUE DATE: 9/95

## SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan

REVISION DATE: 9/01; 9/02; 10/03; 10/06; 10/08, 7/09; 10/09; 7/11; 7/2014 POLICY NUMBER: IG. 14

| Infection Control Department Approval: | $07 / 1410 / 15$ |
| :--- | :--- |
| Infection Control Committee Approval: | $07 / 1410 / 15$ |
| Medical Executive Committee Approval: | $07 / 1411 / 15$ |
| Professional Affairs Committee Approval Date: | $-08 / 1401 / 16$ |
| Board of Directors Approval: | $08 / 14$ |

## | A. TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration and the Centers for Disease Control and Prevention have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.
B. PURPOSE AND POLICY:
2. It is the policy of Tri-City Medical Center to provide care to patients with ATD's with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
a. Source Control Procedures including cough etiquette / respiratory hygiene.
b. Implementation of an effective triage system and early identification of suspects and active cases
c. Engineering control measures
d. Respiratory protection programs
e. Education and training of employees
f. Evaluation and treatment of employees exposed to ATD's
a.g. Protection of patients, employees and visitors from exposure to ATD's. These include: i. Pathogens requiring Airborne Precautions;
1) Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
2) Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
3) Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
4) Measles (rubeola)/Measles virus
5) Monkeypox/Monkeypox virus
6) Novel or unknown pathogens
7) Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV)
8) Smallpox (variola)/Varioloa virus (see vaccinia for management of vaccinated persons)
9) Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
a) Any other disease for which the CDC or CDHS recommends airborne infection isolation
4)ii. Diseases requiring Droplet Precautions;
10)1) Diphtheria/Corynebacterium diphtheriae - pharyngeal
11)2) Epiglottitis, due to Haemophilus influenzae type b
12)3) Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A streptococcus
13)4) Haemophilus influenzae Serotype b (Hib) disease/Haemophilus influenzae serotype b-- infants and children
44)5) Influenza, human (typical seasonal variations)/influenza viruses
15)6) Meningitis caused by the following organisms:
a) Haemophilus influenzae, type b known or suspected
b) Neisseria meningitidis (meningococcal) known or suspected
16)7) Meningococcal disease/Neisseria meningitidis: sepsis, pneumonia (see also meningitis)
17)8) Mumps (infectious parotitis)/Mumps virus
18)9) Mycoplasmal pneumonia/Mycoplasma pneumoniae
19)10) Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
10) Pertussis (whooping cough)/Bordetella pertussis
21)12) Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
22)13) Pneumonia caused by the following organisms:
a) Adenovirus
b) Chlamydia pneumoniae
c) Mycoplasma pneumoniae
i) Neisseria meningitidis
d) Streptococcus pneumoniae (use droplet precautions if evidence of transmission within a patient care unit or facility)
23)14) Pneumonic plague/Yersinia pestis
24)15) Rubella virus infection (German measles) ( also see congenital rubella)/Rubella virus
25)16) Scarlet fever in infants and young children/Group A streptococcus,
11) Serious invasive disease
12) Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses
iii. Ebola disease: Special considerations: Please refer to Tri City Medical Center Ebola Plan for management of a patient with confirmed or suspected Ebola.
13) Patients are screened at Triage and/or admission to the facility
14) place patient in negative pressure room C26
15) Patients without symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. Full face shield with surgical N 95 respirator or higher.
16) Patients with symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures or overall worsening of symptoms: must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. PAPR with full cowl or hood.
17) PAPR with extended PPE should be used prior to entering a

# patient's room with suspected or confirmed Ebola. <br> Hia) 

b. Source Control-Procedures including cough etiquette / respiratory hygiene.
e. Implementation of an effective triage-system and early identification- of suspects and active cases
d. Engineoring control measures
e. Respiratory protection programs
f. Education and training of employees
G. Evaluation and treatment of employees oxposed to ATD's
C. SCOPE:

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services
D. RESPONSIBILITY:
2. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATD's and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.
b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.
c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATD's and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling health care workers who have active ATD's. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.
d. Department Directors are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; notification of the Infection Preventionist and Facilities Management when active TB patients or patients with other ATD's are admitted to their area.
e. Administrative Supervisor is responsible for implementation of the TB control plan in the hospital during the hours of 1600-0800 and on weekends and holidays; and overseeing the reporting and discharge of suspected or confirmed cases of ATD or Tuberculosis on weekends and holidays.
f. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATD's.
g. The Director of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATD's.
h. The Facilities Director is responsible for monitoring and verifying air changes and air pressures daily on Airborne Infection isolation rooms, when in use, and reporting of air changes and air pressures to the Infection control and Safety committees annually.
i. The Director of Pulmonary Services is responsible for developing, implementing and monitoring procedures for high-hazard procedures.
j. The Director of Engineering is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.
k. Microbiology Supervisor is responsible for the notification of the local health authority according to California and Federal regulations of ATD's and TB. The Employees are responsible for early identification of suspects and active cases of ATD's and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; reporting of cases to the Infection Preventionist and/or the Public Health Nurse; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review ( $Q R$ ) report.
I. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.
i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.
ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.
iii. Treat all highly suspected tuberculosis cases with antituberculosis medications pending sputum results.
iv. Consider ATD in patients with temperature greater than 100 degrees $F$ and cough. ATD may also be considered in the presence of rash with fever.
v. Implement control measures when ATD is suspected.

## E. AVAILABILITY OF THE PLAN:

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual in every department. OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.
F. FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:
2. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a $5-10 \%$ lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
c. The final and least effective control is the use of respiratory protection.

## ง. TUBERCULOSIS RISK ASSESSMENT:

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to
evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
a. Community TB profile from public health department data
b. Number of infectious TB patients treated in outpatient and inpatient areas.
c. Drug susceptibility patterns of TB patients
d. Analysis of healthcare workers PPD test results by area
e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
f. Observation of practice and review of engineering controls.
2. Considerations for determining the hospital's risk classification will be based on the following:

| VERY LOW RISK | There are no TB patients admitted to the facility during the preceding <br> year |
| :--- | :--- |
| LOW RISK | The employee PPD conversion rate in an area is not higher than in <br> areas with increased occupation exposure to Tuberculosis <br> Fewer than 6 patients were admitted to area during the preceding year <br> There is no evidence of person-to-person transmission <br> No clusters of HCW PPD conversion |
| INTERMEDIATE RISK | Same as Low Risk with the addition of six or more TB patients <br> admitted to the area during the preceding year. |
| HIGH RISK | PPD conversion rate is higher in areas without occupational exposure <br> to Tuberculosis. <br> Clusters of HCW PPD conversion. <br> Evidence of person-to-person transmission. <br> More than 6 patients admitted to an area. |

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
b. A patient with unexplained fever, night sweats, weight loss and anorexia
c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past prison inmate, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, $>10 \%$ below body wt, chronic renal failure, diabetes mellitus, infected within past two years, or child $>5$ years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases. See Appendices A and B for a flow cart and sample questionnaire.
c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the Engineering department to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance.
Please note: The patient must be placed in an AIIR room within 5 hours of identification.
a. HCW wear N95 particulate respirators and visitors wear surgical masks when entering this area.
b. If the patient is suspected or known to have infectious TB, the room must remain vacant for one hour after the patient leaves. The door is to remain closed and the filter running.
c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection. See Page 10 for algorithm.
a. Emergency Department rooms should remain closed for 30 minutes after the patient leaves to ensure $99.9 \%$ removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
H. MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:
10. Health Care Workers who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Database screening questions.
11. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an Airborne Illness Isolation Room (AIIR) (i.e. negative pressure room: C-26, 143, 243, 443, 287, 387, 487,200 and Forensic Rooms 301, 312 and 326). The door must be closed and the HEPA filter running. Post the Airborne Precautions sign, outside the room.
a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call Engineering for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. HCW wear N95 particulate respirators and visitors wear surgical masks when entering this room.
b. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
12. Reporting:
a. The Unit Secretary notifies Engineering (by placing a worker order) and the Infection Control office that an Airborne Precautions room is in use for tuberculosis.
b. The charge or patient's nurse must notify the Infection Preventionist of the patient's name, medical record and room number. Phone call is used.
c. On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB216TBSuspectCaseReport.pdf for a copy of the report.
d. Laboratory Results: Hospitals and health care providers are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
e. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures is sent to the Public Health.
f. The Infection Preventionist or designee is responsible for reporting to public health.

Tuberculosis (TB) Program Nurses are available 8:00 a.m. to 5:00 p.m., 7 days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 p.m. and 8:00 a.m. Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610 after 8:00 a.m. on the following day.
g. Person wanting to report a case of TB after 5 P.M. should do one of the following:
i. Call pager (619) 540-0194 after 8:00 a.m. the following day to report directly to TB RN if they feel there is urgency about reporting; or
ii. Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.
h. Person requesting Discharge Approval should:
i. Contact TB RN between 8:00 a.m. and 5:00 p.m.
i. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5 P.M., should do the following:
i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.
ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB RN on phone number (619) 692-8610 after 8:00 a.m. on the following day.
j. Persons calling about patients who are leaving against medical advice (AMA):
i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
ii. Call intake RN between 8 am and 5 pm ; after hours call 8:00 a.m. the next day 1) Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB216TBSuspectCaseReport.pdf for the report form.
4. Health-care workers (fit-tested and approved for use) will wear an N-95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health section.
5. The nurse will initiate the Tuberculosis Management protocol and the Communicable Disease teaching protocol.
6. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as are adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
7. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and the areas are less crowded.
8. Limit the number of persons entering an isolation room to a minimum. All visitors (except HCW who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
9. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
10. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
a. The patient is in an Airborne Precautions room.
b. The portable air filtration system has been set-up in a regular room.
a. The Pulmonary Services Isolation Booth is used for sputum induction.
11. Health care workers must wear respiratory protection (N95 respiratorPowered Air Purifying Respirator- PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who may have infectious Tuberculosis. See high hazard procedures.
12. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until outside the hospital.
13. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Healthcare workers entering the room before the 1.5 hours are over will wear an N95 respirator (see high hazard procedures).
14. Bronchoscopy considerations
a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever a suspect case is performed. Respiratory protection will be worn. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.
2. Administration-of aerosolized Pontamidine (soe-Pulmonary Policy 6.8)
a. Patients with suspected Tuberculosis will be provided surgical masks and asked to wait in a non-communal waiting area.
b. Health care workers will wear N95 particulate respirator and use isolation booth for treatment.
6. Patients will be instructed to wear surgical masks untilout of the hospitat.
d. Room will romain closed with the filter running for 1.5 hours prior to rouse.

## ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:

1. Operating Rooms
a. Elective procedures on patients with tuberculosis should be delayed until the patient is no longer infectious.
b. If procedures must be performed, they should be done in OR rooms with anterooms with door closed and traffic at a minimum.
c. Personnel present when operative procedures are performed on patients who have infectious tuberculosis should wear respiratory protection rather than standard surgical masks alone. Valved or positive-pressure respirators are not appropriate for use during procedures requiring surgical masks.
d. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary sites.
e. A bacterial filter placed on the patient endotracheal tube or at the expiratory side of the breathing circuit of the anesthesia machine may be useful in reducing the risk of contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air when anesthesia is being administered to a patient with possible tuberculosis.
f. The pulmonary TB patient should be monitored during recovery in an individual room meeting Airborne Isolation room ventilation requirements.
g. Surgery Suites should be closed for one hour after the patient leaves to ensure 99.9\% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
2. Autopsy Rooms
a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total ACH .
b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection (see high hazard procedures).
c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
d. The autopsy room should remain closed for one hour after the patient leaves to ensure $99.9 \%$ removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the medical examiner.

## 3. Home Health Services

a. HCWs entering the home of a patient with confirmed or suspected TB or ATD should wear respiratory protection.
b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
4.e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). HCWs will wear respiratory protection during the procedure
Z.f. Specific processes and procedures pertaining to ATD's in the home are found in the Home Health Care policy manual.

## J. DIAGNOSTIC EVALUATION:

1. Diagnostic evaluation should include the following:
a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.
b. Mantoux skin test (PPD skin test) - is placed by the specially trained staff and read at 48-72 hours after injection. Results are to be documented in the Medical Record.
c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.
d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.
e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL). (See Table 1).This will assist in determining if the patient is infectious. Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.
f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.
g. Drug susceptibility should be performed on all initial isolates from patients with TB.
h. Contact Infection Control at Ext. 5696 or 7410 for the latest recommendations.
K. AIRBORNE PRECAUTIONS:
2. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
a. Airborne Precautions can be discontinued:
i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL OR when another diagnosis is confirmed
3. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

## L. DISCHARGE:

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer (This form can be accessed at http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB273TuberculosisDischargeCarePlan.pdf )
2. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.
3. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.
4. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.
5. Placement into case management (e.g. DOT) or outreach programs of the public health department.
6. The charge nurse or shift supervisor will notify the Public Health Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.
i. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194
7. Cleaning of the room after a known or suspected TB patient is moved or discharged:
a. The patient is infectious or might be infectious and was not in a negative pressure and HEPA filtered room: Post the Airborne Precautions sign and keep the door closed. Call Pulmonary ServicesEngineering for a HEPA filter. Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Pulmonary
ServicesEngineering.

| Area | Length of Time Room is Closed |
| :--- | :--- |
| Orthopedics/Rehab (1N/S) | Two hours |
| Maternal/Child | Two Hours |
| South | Two hours |
| 3 N/S | Two hours |
| Pavilion | One hour |
| E/W Tower | One hour |


| Surgery | One hour |
| :--- | :--- |
| Radiology | One hour |
| Emergency Department | 30 minutes |
| Emergency Department and <br> Bronchoscopy area | 30 minutes |

8. The patient is still infectious and was in a negative pressure room: keep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one-hour period has ended, discontinue Airborne Precautions.
9. The patient is no longer infectious or TB has been ruled out: no special precautions needed. The door may be immediately opened and the room cleaned as usual.
M. ANNUAL TUBERCULOSIS SCREENING:
10. Auxiliary and Employees: See the Employee Health section 7.1, TB Surveillance and Respiratory Protection policies.
11. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners.
N. AEROSOL TRANSMISSIBLE DISEASE CONTRO EXPOSURE DETERMINATION
12. A list of tall job classifications in which employees have occupational exposure is available in the Infection Control Manual H. 14 Employee Health Respiratory Protection Program.
O. ISOLATION PRECAUTIONS
13. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant Health Care workers (IC.5.2).

## P. HIGH HAZARD PROCEDURES:

| LOCATION | COMMON HIGH HAZARD PROCEDURES REQUIRING THE <br>  <br> USE OF: |
| :--- | :--- |
|  | AN N-95 RESPIRATOR for patients with known or suspected <br> droplet infectious disease f |
|  | POSITIVE AIR PURIFYING RESPIRATOR (PAPR) AS <br> REQURED-9/1/10) FOR PATIENTS WITH KNOWN OR <br> SUSPECTED ATD.Airborne Infectious Disease |
| ACCU, PACU, ED and <br> Bronchoscopy Suite | Intubation and Extubation <br> Sputum Induction <br> Endotracheal \& Tracheostomy Tube Care <br> Bronchoscopy |
| Medical / Surgical Units | Sputum Induction <br> Endotracheal Intubation |
| Pulmonary Services | Sputum Induction <br> Pulmonary Function Tests <br> Bronchoscopy <br> Aerosolized administration of pentamidine or other medication |
| Operating Rooms | Intubation and Extubation <br> Bronchoscopy <br> Tracheotomy |


|  | Thoracotomy <br> Lung Biopsy <br> Endotracheal \& Tracheostomy Tube Care |
| :--- | :--- |
| Recovery | Endotracheal \& Tracheostomy Tube Care <br> Intubation or Extubation |
| Pathology | Autopsy |

## Q. SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."
2. Emergency Department
a. Engineering Controls during a surge of patients with ATD is addressed in the TCMC Infection Control Policy IC15.0 Influx of Infectious Patients: Epidemic Influenza or other respiratory transmitted disease.
b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD $\mp$ and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
c. Staff wears N-95 respifators (PAPR's as required after $9 / 1 / 10$ ) during high hazard procedures (listed above) for disease spread by the airborne route.
d. N-95 respirators or PAPR's are used during patient contact for diseases spread by airborne route.
e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for Airborne Infection Isolation Room (AlIR) C-26.
g. When room C-26 is not available a private room is used.
h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
i. Patients may be cohorted in designated rooms or bays when indicated.
j. Patients suspected of having ATD's are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
m . When used for an patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
a. Patients who are admitted with airborne transmissible diseases are admitted to AllR's on nursing units.
b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions. A TB quicklook is posted outside each AIIR for step by step instructions on initiating and maintaining proper airflow.
c. Doors are kept closed.
d. Patients in Droplet precautions do not need AlIR's for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See chart above (section P) for selection on type of respiratorusing $\mathbb{N}-95$ respirators (PAPR's as required after
e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.
f. Airborne Infection Isolation rooms shall remain empty with Airborne Precautions sign posted and door closed for designated time (see LG.2.a) when a patient with Airborne transmissible disease has occupied the room.

## 4. Pulmonary AedicineServices

a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
b. N-95 respirators or PAPR's are used during Bronchoscopy.
c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The HCW should wear an N-95 or PAPR during this treatment (see high hazard procedures).
e. Bronchoscopy suite will remain closed for the designated time (see LG.2.a) when procedure is performed on a patient with and known or suspected ATD.
f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.
5. Surgical Services
a. The Surgical Suite is a positive pressure environment.
b. Patients in Airborne and Droplet Precautions should have elective procedures delayed for the duration of illiness. When this cannot be accomplished, surgery should be scheduled as the last case of the day.
c. Provide surgical mask for patients during transport.
d. Expiratory filters can be used for intubated patients during transport.
e. A portable HEPA unit should be utilized in the OR suite during intubation and extubation to supplement air cleaning but should not be used during surgery. and-HCW's shall wear N-95 respirator or PAPR- See high hazard procedures.
f. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.
g. Surgical suite shall remain empty for designated time (see LG.2.a) with door closed when a procedure has been performed on a patient with known or suspected ATD.
6. Maternal Child Health Services (MCH)
a. Neonatal Intensive Care Unit (NICU)
i. The NICU has a dedicated AIIR.
ii. Neonates born to mothers with diseases known to be spread by Airborne Route are placed in the AIIR until the neonate is found to be non-infectious.
iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
b. Labor and Delivery and Post-Partum
i. Labor rooms may have portable HEPA units installed for mothers who have suspected ADTD.
ii. Healthcare workers follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPR's for Airborne Precautions.
iii. Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.
7. Behavioral Health
i. Patients who develop symptoms of ATD will be assessed by the physician to determine the need for medical intervention.
ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.
iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.
iv. If the patient is unable to wear a mask and non compliant with containing respiratory secretions with tissues. Healthcare workers will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).
v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.
vi. Airborne precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.
vii. Patients who are identified as needing and AIIR will be transferred within five hours of identification.
8. Laboratory AledicineServices
a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
b. For respiratory protection in Laboratory Aedicine-Services: See IG. 14 Employee Health
\& Wellness Policy: Respiratory Protection Program Policy
9. Facilities Management Staff
a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
b. N-95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.
10. Personal Protective Equipment
a. The respiratory protection program policy (Employee Health and Wellness Manual) IG.14.0 describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
b. Respiratory Protection including N-95 respirators or PAPR's is required in any hospital location in the following circumstances:
i. Entering an Airborne Isolation Room occupied by a patient with an airborne transmitted ATD
ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.
iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any highhazard medical procedure.
iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.
v. Attending high hazard procedures.
c. Respirator Shortages
i. In the event of reported shortages of N-95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):

1) TCMC will maintain a cache of $\mathrm{N}-95$ respirators in accordance with the disaster plan.
2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
3) According to available stock, N-95 respirators will be prioritized for distribution to Pulmonary Services ICU, and Emergency Department for use in high hazard procedures.
4) Re-use of N-95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
5) Reuse of N-95 respirators is acceptable during the care of patients with other ATDF's under the following circumstances:
a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD (see 8.b.ii for tuberoulosis).
b) The respirator integrity remains intact
c) During the care of intubated and ventilated patients using the Puritan Bennett 840 with DX/800 filler and-(closed circuit suction systems).
ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative $\mathrm{N}-95$ ) the following steps may be considered:
6) Prioritize available $\mathrm{N}-95$ for high hazard procedures.
7) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
8) Contact Local Public Health Officer for possible acquisition of N-95 respirators from local or state stockpiles.
9) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
10) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
11) PAPR's may be used.
12) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
13) When there is no option for providing N-95 respirators, surgical masks will be provide to the employee
iii. Positive Air Purifying Respirators (PAPR's)
14) PAPR's used for bronchoscopy are maintained in Respiratory Care Department
15) SPD stores and maintains all other PAPR's
16) Units are cleaned, disinfected using a hospital approved disinfectant and tested after each use.
17) Disposable hoods are used
11. Admissions and transfers of patients with known or suspected Airborne transmissible ATD. a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use $\mathrm{N}-95$ respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
12. Influenza Season
a. From November 15 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current
influenza vaccine as recommended by the County of San Diego Public Health and
Centers for Disease Control and Prevention.
b. The enforcement dates are subject to change based on the recommendations of the
hospital's Infection Control Committee.
c. Non-compliance with this requirement is subject discipline as outlined in the hospital's
Human Resources policy.

## R. MEDICAL SERVICES

1. Vaccinations are offered to employees free of charge ((1C-14.0-Employee Health and Wellness Manual: Employee Health Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATD's.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies
S. TRAINING
5. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
6. Opportunity is provided for questions to be answered by an infection control professional.
7. Respirator Fit testing
a. Medical screening and training is performed in accordance with IG.14-Employee Health and Wellness Manual: Respiratory Protection Program.
T. REVIEW SCHEDULE
8. The ATD plan will be reviewed annually by the Infection Control Committee.
9. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected
U. RELATED DOCUMENTS:
3.1. Infection Control Manual: Infection Prevention and Control Risk assessment and Surveillance Ot Plan IC . 2
4.2. Infection Control Manual: Epidemiologic Investigation of a Suspected Outbreak IC . 3
5.3. Infection Control Manual: Healthcare Associated Infections, Facility Acquired (Nosocomial) Infections,Defined IC . 4
10. Reducing Facility Acquired Infections IC. 13
11. Employee Health and Wellness Manual: Immunization
12. Employee Health and Wellness Manual: Employee Health: Respiratory Protection 1. Participation of Staff in the Infection-Control-Program IC. 7

## U.V. REFERENCES:

1. Centers for Disease Control \& Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care FacilitiesSettings, 2005. MMWR 2005; 54 (No RR-17). 1994.
1.2. Centers for Disease Control \& Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003.
2. Centers for Disease Control \& Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance www.cdc.gov
3. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. Retrieved on September 28, 2015 from: http://www.cdph.ca.gov/programs/ohb/Documents/HCResp-ATDRespSelectGuide.pdf
2.5. California Department of Public Health (2015, January 20). Interim Guidance on Personal Protective Equipment (PPE) to be used by Healthcare Workers in the Inpatient Hospital Setting during Management of Patients with Suspected or Confirmed Ebola Virus

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\%20PPE\%20Guidance\%20for\%20Management\%20of\%20Ebola\%20Patients\%20in\%20an\% 20Inpatient\%20Setting\%20-FINAL\%201-20-2015\%20POSTED.pdf
3.6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
4.7. OSHA Directives CPL 2.106- Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis US Department of Health and Human Services. http://www.osha.gov/pls/oshaweb/owadisp.show document?p table=DIRECTIVES\&p id=1586 \&p text version=FALSE
5.8. Cal-OSHA Aerosol Transmissible Diseases Standard, August 5, 2009

6-9. New Guidelines for Purified Protein Derivative (PPD) Skin Test Interpretation and Treatment Modalities for Tuberculosis Infection. Pulmonary Perspectives, April 2001 Volume 18, Issue 1
10. APIG position paper: Responsibility for interpretation of the PPD tubereulin skin test. February 1999, Vol. 27, No. 1.
7.11. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology $4^{\text {th }}$ Ed., 95:1-20.
8-12. TB Respiratory Protection Program In Health Care Facilities Administrator's Guide U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Centers for Disease Control and Prevention National Institute for Occupational Safety and Health September 1999
9. Surveillance-QIPlan IC . 2
10. Epidemiologic Investigation of a Suspocted Outbreak IC . 3
11. Facility Acquired (Nosocomial) Infections, Defined IC . 4
12. Reducing Facility Aequired Infections IC. 13
13. Participation of Staff in the Infection Gontrol-Program IG. 7

TABLE 1
Criteria for Infectiousness and placement in high risk setting (Forensic Unit only)

| CATEGORY | SETTING | CRITERIA |
| :---: | :---: | :---: |
| TB suspect <br> - Not on treatment for suspect active TB | Forensic Unit | 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative |
| TB case or suspect on treatment for active TB -AFB smear positive -No risk factor for MDR-TB | Forensic Unit | 1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative <br> 2. At least 14 daily doses of treatment for $T B$, preferably by directly observed therapy (DOT), taken and tolerated; and <br> 3. Clinical improvement |
| TB case or suspect on treatment for TB <br> -AFB smear negative X3 -No risk factor for MDR-TB | Forensic Unit | At least 5 daily doses of treatment for TB taken and tolerated |
| TB case or suspect on treatment for TB <br> -At increased risk for MDR-TB | Forensic Unit | 1. Obtain direct genetic test, if available, for Rifampin resistance <br> 2. If direct genetic test not available, while phenotypic DST for Rifampin is pending, other criteria for patients with known MDRTB, or criteria for patients not at increased risk of MDR-TB, or criteria for patients not at increased risk of MRD-TB may be applied, at the discretion of the local TB controller |
| Known MDR-TB case | Forensic Unit | 1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative <br> 2. At least 14 daily doses of treatment for $T B$, preferably by directly observed therapy (DOT), taken and tolerated; and <br> 3. Clinical improvement <br> 4. At least 2 consecutive negative sputum cultures without a subsequent positive culture |

## Reference

CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

## EMERGENCY DEPARTMENT TUBERCULOSIS DECISION TREE APPENDIX A

Patient has signs and symptoms or chest $x$-ray compatible with TB


Unstable housing or resident in a group setting OR
Acutely ill or needing invasive diagnostic or therapeutic procedure OR
Strong likelihood that patient will not follow-up with outpatient work-up

${ }^{1}$ Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCMC Infection Control: call ext. 7410 or 5696

## Tri-City Medical Center

Nelcome to Tri-City Medical Center. Our commitment to you, our patient, is to give you the highest quality care. In order to do that, we need your help. Please answer the questions below, so that we can take better care of you. If there are any questions you do not understand, please ask for help from one of our employees.

If you are filling this out for someone else, please answer the questions as if you were that person.

Medical Record Number $\qquad$

Name $\qquad$ Date $\qquad$ (Please Print Clearly)

1. Have you had any of these problems?

Please circle your answer

| Cough longer than 10-days3 weeks? | Yes | No |
| :--- | :---: | :---: |
| Do you cough up blood? | Yes | No |
| Do you have night sweats? | Yes | No |
| Have you lost weight? | Yes | No |
| If you have lost weight- how much? |  |  |
| Have you lost your appetite? | Yes | No |
| Do you have a fever | Yes | No |

2. Have you ever had?

Please circle your answer

| A positive skin test for TB? | Yes | No |
| :--- | :---: | :---: |
| Active Tuberculosis? | Yes | No |
| Lived or worked with someone who had TB? | Yes | No |
| Have you lived outside the United States for longer than one month? | Yes | No |

3. What country were you born in?
4. Have you had?

Please circle your answer
Severe coughing spasms, that interfere with eating, drinking and breathing? Yes No
Fever with painful swollen salivary glands on one side or both sides of your face Yes No under your jaw?
Fever with chills, cough, runny nose watery eyes and unexplained diffuse rash or Yes No blister type skin rash?
Fever with headache, stiff neck, or changes in your mental status. $\quad$ Yes No

## Tri-City Medical Center

Bienvenido/a a Tri-City Medical Center. Nuestro compromiso con usted, como paciente nuestro/a, es ofrecerle ına atención médica de la más alta calidad. Para lograr esto, necesitamos su ayuda. Tenga la bondad de contestar las preguntas a continuación, y así le podremos atender mejor. Si hay preguntas que no entiende, pida ayuda a un miembro de nuestro personal.

Si está ayudando a otra persona a llenar este formulario, por favor, conteste las preguntas como si usted fuera la persona a quien ayuda.

Número de historial medico $\qquad$
Nombre $\qquad$ Fecha $\qquad$
(Escriba claramente en letra de molde)

1. ¿Ha tenido usted alguna de las condiciones siguientes?

Marque sus respuestas con un círculo
¿Tos durante más de 3 semanas 10 días? Si No
¿Ha expectorado sangre al toser? Sí No
¿Ha experimentado usted sudores nocturnos? Sí No
¿Ha experimentado pérdida de peso? Si No
Si ha perdido peso, ¿cuánto ha perdido?
¿Ha experimentado pérdida de su apetito? Si No
¿Tiene usted fiebre?
2. ¿Ha tenido usted alguna vez una de las siguientes condiciones?

Marque sus respuestas con un círculo

| ¿Una reacción positiva en la piel por una prueba de tuberculosis? | Sí | No |
| :--- | :--- | :--- |
| ¿Ha padecido activamente de tuberculosis? | Sí | No |
| ¿Ha vivido o trabajado con alguien que sufría de tuberculosis? | Sí | No |
| ¿A vivido afvera de los Estodos Unidos por mas de un mes? | Sí | No |

3. ¿En qué país nació? $\qquad$
4. ¿Ha tenido...

| Marque sus respuestas con un círculo |  |  |
| :--- | :--- | :--- |
| ¿espasmos de tos graves que le impidan comer, beber o respirar? | Sí | No |
| ¿fiebre con inflamación y dolor en glándulas salivales de uno o ambos lados <br> de su rostro debajo de la mandíbula? | Sí | No |
| ¿fiebre con escalofrios, tos, secreciones nasales, ojos llorosos y erupciones <br> difusas o erupciones con ampollas sin explicación? | Sí | No |
| ¿fiebre con dolor de cabeza, rigidez en el cuello o cambios del estado mental? | Sí | No |

## PROCEDURE: PULSE OXIMETRY, NICU

Purpose: To outline the nursing responsibilities; monitoring the infant using pulse oximetry.
Supportive Data:
Pulse oximetry is the noninvasive measurement of arterial blood oxygen saturation - the percent to which hemoglobin is filled with oxygen. A pulse oximeter is a probe with a lightemitting diode (LED) connected by a cable to an oximeter or a cardio-respiratory monitor with oximetry capabilities. Light waves emitted by the LED are absorbed and then reflected back by oxygenated and deoxygenated and hemoglobin molecules. The reflected light is processed by the oximeter, which calculates pulse oxygen saturation $\left(\mathrm{SpO}_{2}\right)$. Oxygen saturation monitoring is the most widely used method of assessing oxygenation status. The use of oximetry gan judiciously reduce the need to collect ABG-specimens for exygen saturation analysis. Pulse oximetry may be performed by a respiratory therapist or registered nurse (RN) as an acute or continuous evaluation of patient status without a direct physician's order.
Equipment: Pulse Oximeter

## A. POLICY:

1. Oxygen use requires a physician/licensed independent practitioner (LIP) order including the desired oxygen saturation (SpO2) range.
2. Oxygen saturation goals for infants less than or equal to $23-30$ weeks
a. Target saturation goals are 88-90\% with SpO2 alarm limit set low $\mathbf{8 5 \%}$ high $\mathbf{9 2 \%}$
3. Oxygen saturation goals for infants $301 / 7-35$ weeks
a. Target saturation goals are 90-94\% with SpO2 alarm limit set low 88\% high 96\%
4. Oxygen saturation goals for infants greater than 35 weeks
a. Target saturation goal are $94-98 \%$ with SpO2 alarm limits set low 92 high $100 \%$
4.B. PROCEDURE:
5. Perform hand hygiene.
6. Assemble equipment and take it to the infant's bedside. Ensure the pulse oximeter or cardiorespiratory monitor has power.- either battery or from wall outlet.
7. Choosing a site:
a. Choose a site that is well perfused.
b. Always choose a site that will completely cover the sensor's detector window.
c. Site-should be-Csleaned site of debris prior to sensor placement.
d. For infants less than 30 wooks:
a. Before taking the paper covering off the probe, determine the portion of the probe that will come into actual contact with the skin.
e. Remove the paper from the probe-and place-a transparent dressing, sticky side of drescing to sticky-side of probe, on the portion of the probe that will-come into-actuat contact with the infant's skin. Trim the transparent drossing as needed.
8. Attach the sensor to the selected site ensuring that the emitter (red light) and the photo detector are properly aligned before connecting to the pulse oximeter or cardio-respiratory monitor if possible. Cover the probe with an opaque cover. Ensure the probe is connected to the patient cable, the cable is connected to the pulse oximeter or cardio-respiratory monitor oximetry module and that the equipment's power has been activated.
9. Ensure the display window is free of alarm and system failure messages.
10. On the display, verify:
a. High and low alarm limits for $\mathrm{SpO}_{2}$ and pulse rate.
b. The reading for $\mathrm{SpO}_{2}$ and pulse rate.

| Review/ <br> Revision Date | Clinical <br>  <br> Procedures | PatientGare <br> Quality <br> Committee | Division of <br> Neonatology <br> Aledisat <br> (opartment <br> Review | Pharmacy and <br> Therapeutics | Medical <br> Executive <br> Committee | Professional <br> Affairs <br> Committee | Board of <br> Directors <br> Approvat |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| $11 / 06,05 / 08$, <br> $4 / 09,07 / 15$ | $7 / 07,4109$ | 8107,5109 | $8 / 07 ; 07 / 15$ | $n / a$ | $11 / 15$ | $9 / 07,6 / 09$, <br> $01 / 16$ | $9 / 07,6 / 09$ |

7. Wait $10-30$ seconds for $\mathrm{SpO}_{2}$ and pulse rate reading to stabilize. Motion artifact is the most common cause of inaccurate readings.
Alarm limits should be-determined in-conjunction with the physician and take into consideration the infant's-age, underlying condition, and past history of normal parameters for that infant.
b.8. Refer to the equipment's manual as needed for the setting and adjustment of alarm limits.
8. Determine with the physician when oxygen should be administered or increased based on $\mathrm{SpO}_{2}$ and/or blood gas results and the infant's clinical presentation.
9.10. Dispose of trash in the appropriate receptacle and perform hand hygiene.
10.11. When responding to alarms, assess the infant per NICU Standard of Care and for the following:
a. Pulse rate on the oximetry reading corresponds with infant's pulse rate monitor or apical heart rate.
b. Oxygen equipment is assembled and functioning properly.
c. Good connection of the sensor to the skin site.
d. Light source on the probe is functioning and oximetry cables are properly connected.
e. Opaque cover is in place over the sensor.
f. Limb being used is not being moved excessively.
g. Hypothermia.
h. Hypotension.
i. Vasoconstriction.
j. Diaphoresis.

11-12. Rotate the sensor site a minimum of once every 8 hours.
12.13. Document the $\mathrm{SpO}_{2}$ and sensor site changes in the electronic health record (EHR).patient's medical rocord.
B.C. REFERENCES:

1. Gardner. S, et al. (2011) Merenstein \& Gardner's handbook of neonatal intensive care, $7^{\text {th }}$ Ed. St. Louis, MO: Elsevier Mosby.
2. Ikuta, L. \& Beauman, S. (2011) Policies, procedures, and competencies for neonatal nursing care. National Association of Neonatal Nurses. Glenview, IL:NANN.
3. Mintz-Hittner, H., Kennedy, K. \& Chuang, A. (2011) Efficacy of intravitreal bevacizumab for stage 3+ retinopathy of prematurity. The New England Journal of Medicine. 364(7) 603-615.
Z. Bowden V.R. \&-Greenberg G.S. (2003). Pediatric nursing procedures. Philadelphia, PA: LippincottANilliams \& Wilkins, pp. 369-373.
4. Perry A.G. \& Pottor P.A. (2006). Clinicat nursing skills and techniques, $6^{\text {th }}$ Ed. St. Louis, MO: Elsivier Mosby.

## REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Performance Evaluations
ISSUE DATE: 07/91
REVISION DATE(S): 02/94, 04/95, 10/97, 9/98, 10/99, 1/06, 1/09, 3/12

Department Approval Date(s):
Department of Medicine Approval Date(s):
Pharmacy and Therapeutics Approval Date(s):
Medical Executive Committee Approval Date(s):
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

POLICY NUMBER: 304

## 07/15

n/a n/a n/a 01/16

ISSUE DATE: 7191
SUBJECT:- PERFORMANCE EVALUATIONS
REVISION DATE: $2 / 94,4 / 95,10 / 97,9 / 98,10 / 99$, STANDARD NUMBER: 304
1/06, 1/09, 3/12
REVIEW DATE: 2/03,8/03
CROSS REFERENCE: APPROVAL:

This Policy / Procedure applies to the following Rehabilitation Services' locations:
F 4002 Vista Way, Oceanside, CA
[ 2124 El Camino Real, Suite 100, Oceanside, GA
5
6250 El Gamino Real, Carlsbad CA
A. PURPOSE

1. To provide the employee with their essential job functions, pesition requirements for physical, mental, and onvironmental demands, as well as a periodic written appraisal of their performance, to develop goats, and to assess the achievement of previous yeaf's goats.

## - POLICY:

- Each omployee will be actively involved in periedic informat and annual formal appraisals of their performance with their direct supervisorthe Rehabilitation-Services Leadership-Team.
B. PROCEDURE:
1.-Informalevaluations are-completed for now-staff after the-first-90-day-period. Annually, of at the discretion of the supervisorRehabilitation Services-Leadership Team, performance-ovaluations are completed. Feedback related to performance is ongoing.
Z.- Performance standards will be utilized as an effective instrument of appraisat.

3. The-mploye has the option to complete a-self-appraisal prior to meeting with the Rehabilitation Services-Leadership-Team-supervisor for the annual performance appraisal. The omployee will-be required to complete the Annual-Competency Assessment ChecklistValidation Sheet, as applicable.
4.-The-supervisor will complete the Performance-AppraisalAppraisals will be-completed with input frem, but not-limited to, peerfoedback, observation, pationt feedback and patient satisfaction-surveys, and utilization review,reviews as appropriate.
s.- Results of the appraisal will be discussed with the employee by their supervisor. The employee shall have the opportunity to respond and contribute-during the appraisal process. The employee and manager will also disouss professional goals for the following evaluation period.

## PERFORMANCE EVALUATIONS

Page 2 of 2
Rehabilitation Services Manual
Performance Appraisals
Page 2 of 2
i- All information submitted for the peer and loadorship reviows will be maintained strictly confidential.
7. Rating levels are as follows:
a. A score of 0: Employee's performance clearly-did not meet the minimal or essential-expectations of the position.
b. Ascore of 1: Employee's performance needs significant improvement, meets fow of the performance expectations.
6. Ascore of 2: Employee meets most performance-expectations; needs improvement in one or more areas.
d. Ascore of 3: Employeo is fully proficient in performance expectations.
e. A score of 4: Employee proficient in performance expectations; frequently exceeds expectations in some areas.
f. Ascore of 5: Employee performance is exemplary in most areas. Performance is clearly exceptionat.
8.- An employee who does not meet standard and/or competency will be provided with additionat educationat opportunities and will be appropriately disciplined according to Hospital Policy \#424, General-Standards of Gonduct.
9.- Acepy of the Performance Appraisal will be placed in the employee's personnel file in the department. The employee and Human Resources will be provided with signed sopies.

- All providers-of direct patient care in the Rehabilitation Services Department are required to maintain Gurfent GPR cortification, as well as hold a valid professional license, if applicable.RELATED DOCUMENT(S):
10.A. Hespital-Policy \#424, General Standards-of Conduct

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

REHABILITATION SERVICES POLICY MANUAL

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ISSUE-DAFE: 1/09
REVISION DATE: 4/12,5/12
REVIEW- DATE:
```

SUBJECF: POOL CHARGES
STANDARD-NUMBER: 1704
EROSS REFERENGE: APPROVAL:

Department Approval Date(s): 08/15
Department of Medicine 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): 01/16
Board of Directors Approval Date(s):

This Poliey / Procedure-applies to the following Rehabilitation Services' locations:
F
4002 Vista Way, Oceanside, CA
F2124 El Camino Real, Suite 100, Oceanside, CA
N
6250 E1 Camino Real, Cartsbad-CA
A.—PURPOSE

1. Fo-outline-detail on the posting and collection of pool charges.
B._POLICY
1.-Patient treatment charges will be-done on the in-house-computer system. They will be aceurate and timely.
C.-_PROCEDURE
1.- Patient treatment charges:
ar-Each therapist will complete-charges on each patient on the-day of sefvice-
b.a. Fherapist will record-all treatment provided and eharges-submitted on the patient's flow-sheet or progress note-in the patient's record. The treating therapist will-sign each flow sheet or progress note.

## REHABILITATION SERVICES POLICY MANUAL

SUBJECT:
ISSUE DATE: 1/09
REVISION DATE(S): 5/12
Department Approval Date(s):
Department of Medicine Approval Date(s):
Pharmacy and Therapeutics Approval Date(s):
Medical Executive Committee Approval Date(s):
Board of Directors Approval Date(s):

Professional Affairs Committee Approval Date(s): 01/16
08/15
n/a
n/a
n/a

## HYDROWORX THERAPY POOL CONTAMINATION

## SUBJECT: POOL CONTAMINATION <br> STANDARD NUMBER: 1707 <br> GROSS REFERENGE: <br> APPROVAL:

This Policy / Procedure applies to the-following-Rehabilitation Services' locations:
F 4002 Vista Way, Oceanside, CA
$F_{2124 \text { El Gamino-Real, Suite-100, Oceanside, GA }}$
$F$
6250 El-Gamino Real, Carlsbad CA
A. PURPOSE

1. To outline the steps that are taken should the Hydroworx Therapy Pool become-contaminated.
B.A. POLICY:
2. The pool will be maintained in a manner consistent with manufacturer and Department of Environmental Health regulations.
4.2. The following steps are taken should the Hydroworx Therapy Pool become contaminated.
C.B. PROCEDURE:
3. Upon observation or discovery of pool contamination, the treating therapist will discretely inform patrons to immediately evacuate pool.
4. Patrons will be instructed to take a shower using soap for a minimum of 5 minutes.
5. Tri-City Medical Center engineers will be contacted at 760-940-7148 for de-contamination.
a. Immediately drain pool.
b. Clean filter and pool shell.
c. Refill pool.
d. Backwash filter.
e. Start system.
f. Balance chemicals.

Volunteer Experience for Rehabilitation Professionats
Page 2 of
Rehabilitation Services Manual
Pool Contamination
Page 2 of 3
a.g. A water contamination response log will be maintained onsite to record a contamination episode that occurs. This log will be maintained in the common binder with other maintenance logs for the Hydroworx pool.

## C. FORM(S):

1. Water Contamination Response Log

## D. REFERENCES:

1. Department of Environmental Health Food and Housing Division. (2015). Title 22 CCR Changes Effective January 1, 2015. San Diego, CA: Department of Environmental Health.

Volunteer Experience for Rehabilitation Professionats
Page 2 0f
Rehabilitation Services Manual
Pool Contamination
Page 3 of 3

| Person Conducting Contamination Response |  |  |  |
| :--- | :--- | :--- | :--- | :--- |
| Supervisor on Duty |  |  |  |
| Date (mm/dd/yyyy) of Incident Response |  |  |  |
| Time of Incident Response |  |  |  |
| Water Feature or Area Contaminated |  |  |  |
| Number of People in Water |  |  |  |
| Type/Form of Contamination in Water: <br> Fecal Accident (Formed Stool or Diarrhea), Vomit, Blood |  |  |  |
| Time that Water Feature was Closed |  |  |  |
| Stabilizer Used in Water Feature (Yes/No) |  |  |  |
|  |  |  |  |

## SUBJECT: HYDROWORX THERAPY POOL - GENERAL OPERATIONS

## ISSUE DATE:

REVISION DATE(S): 05/12

Department Approval Date(s): 08/15
Department of Medicine Approval Date(s): n/a
Pharmacy and Therapeutics Approval Date(s): n/a
Medical Executive Committee Approval Date(s):
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):
n/a
01/16

| ISSUE DATE: | SUBJECT: Therapy Pool-General Operations |
| :--- | :--- |
| REYSION DATE: $5 / 12$ | STANDARD NUMBER:-1706 |
| REYEW DATE: | CROSS REFERENCE: |
|  | APPROVAL: |

This Policy / Procedure-applies to the following Rehabilitation Services' logations:
$F_{4002}$ Vista Way, Oceanside,CA
${ }^{F}$ 2124 ElGamino Real, Suite 100, Oceanside, CA
F
6250 El Gamino Real, Carlsbad CA
A. PURPOSE

1. To provide an overviow-of operating the Hydroworx Therapy Poot.
B.A. POLICY:
2. The Weliness Center pool is operated under rules set forth in the County of San Diego Department of Environmental Health.
C.B. PROCEDURE:-
3. Water Testing
a. It is important that daily testing is done with care and accuracy. The water is tested for pH and bromineChlorine.
G-b. The readings of hand testing shall be compared to the reading of the "GAF Z000CHEMTROL." The GAT 2000CHEMTROL is an automatic chemical feeder and monitors bromineChlorine and pH
a.c. A detailed log of hand testing and GAT 2000 CHEMTROL readings are kept as a means of check and balances.
4. County of San Diego Department of Environmental Health
b-a. Daily pool testing and maintenance records are available for review.
5. Shutdowns
a. -The pool is shut down monthlyapproximately every 6 weeks.
i. The shutdowns take place at routine intervals in accordance with manufacturer guidelines for maintenance and cleaning.
ii. The shutdowns will allow appropriate cleaning and maintenance of the filter and chemical systems that ensure pH balance.
b. The pool is drained using the main drain valve. Maintenance and therapy staff that has received proper training on draining/refilling the pool will perform this taskmay perform this task. This may also be performed by a Wellness Center contracted service provider that assists with pool drainage and routine water change.
c. Maintenance and repairs are done as needed when the pool is drained.
1.4. Pool Operators
d.a. All pool operators are CPR certified and are encouraged to become certified in water safety.

## B.C. REFERENCE(S):

1. Department of Environmental Health Food and Housing Division. (2015). Title 22 CCR Changes Effective January 1, 2015. San Diego, CA: Department of Environmental Health.

REHABILITATION SERVICES POLICY MANUAL

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ISSUE-DATE: 11/88
REVISION-DATE:-1/91, 1/94,7/97, 10/00,
1/03,12/03, 2/04, 6/04, 1/06, 1/09,5/12
REVIEW-DATE:
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SUBJECT: THERAPY-REFERRALSY

ORPERS-AND-CHARGES
STANDARD-NUMBER: 512
EROSS-REFERENGEAPPROVAL:

Department Approval Date(s): Department of Medicine Approval Date(s): Pharmacy and Therapeutics Approval Date(s): Medical Executive Committee Approval Date(s):
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

## 07/15

n/a n/a 11/15 01/16

This Policy / Procedure applies to the following Rehabilitation Services' locations:
F
4002 Vista Way, Oceanside, CA
F
2124-E1 Camino Real, Suite-100, Oceanside, CA
F
6250 E1-Gamino-Real, Cartsbad CA
A.-PURPOSE
1.- To identify a system to appropriately receive and track therapy-orders.
$Z$.-To define the process and responsibilities governing the management of the billing department's exeeption reports.

B:-POLICY
1.-All therapy orders will-be received via the Tri-City Medical Center's computer system. In the event that the system is not working, refer to the "Computer Downtime Policy:"
$z_{0}$ - Respensibility of input-of charges and reviewing of those charges will be that of the Rehabilitation-Services Department.

E-PROCEDURE
1.-All therapy-orders must be initiated via a physician's referrat.
$z$. Orders are transeribed into the computer system from the physician's orders by the Unit Secretary/appropriate hospital-staff for either inpatient or outpatient Rehabilitation Services.
3.-Requisitions print out automatically on the Rehabilitation-Services Department's designated printers.
4.-Orders are taken from the-printer in the morning and throughout the day as they are printed by the Rehabilitation Services clerieal-staff and Rehabilitation Services staff, PRN. During weekends or holidays, the inpatient therapists are responsible for retrieving orders.
5.-Inpatient:
a.-The Rehabilitation Services Receptionist/assigned-staffalerts the therapy supervisor, Senior Therapist, or appropriate therapist to the new-order, and places the order in the appropriate-discipline mailbox.
6.-For-Outpatient:
a--Orders will be received via fax server or hard copy.
b. -The-clerical staff will verify insurance authorization and-contact the patient for seheduling.
7.-In the event-of printer error (i.e., paper jam) the Rehabilitation-Senvices Receptionist/assigned-staff will be respensible for aceessing the central computer to retrieve all orders.
8.-Charges
a.-Inpatient charges will be input through completion of Order Entry or Batch Charge Entry as the therapists do their chating or at the end of the day, unless alternate arrangements are made.
b.-Outpatient charges will be input through Batch Charge Entry on the day of or the next business day following the-evaluation/treatment by the appropriate staff member.
E.- Charge Viewer will be used to cheek charges.
9.-Departmental activity is monitored on a daily basis utilizing productivity reports.
-10. Exception Reports: See Rehabilitation Serviees Policy-503 (Exeeption Reports).

REHABILITATION SERVICES POLICY MANUAL

| ISSUE DATE: $1 / 09$ | SUBJECT:Use of Pool by Recreation <br> Specialists and Personal <br> Trainers |
| :--- | :--- |
| REVISION DATE: 5/12 | STANDARD NUMBER: 1708 <br> REVIEW DATE: |
|  | CROSS REFERENCE: <br> APPROVAL: |

Department Approval Date(s):
08/15
Department of Medicine 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): 01/16 Board of Directors Approval Date(s):

This Poliey / Procedure applies to the following Rehabilitation Services' locations:
F
4002 Vista Way, Oceanside, CA
$F_{z 124 \text { ElGamino Real, Suite 100,-Oceanside, CA }}$
F
6250-E1 Camino-Real, Carlsbad-CA
A. - PURPOSE
1.-Fo outline the use of the pool by personnel other than Tri-City Medical-Center Rehabilitation Serviees professionals.
B.- POLICY
1.-Recreation staff and/or personal trainers must provide proper supervision of elients at all times in pool and locker rooms. Pool-staff will-supervise all activity and programs.
Z.-No children will be allowed in the pool until-staff is ready to-supervise group in the pool.
3.-Recreation staff/Personal-Trainers will alert pool staff of -hildren requiring attention, especially children with epilepsy.
4. Recreation/Personal training staff needs to-set designated times with poot physical therapist. Changes in time need to be arranged with the pool physical therapist.

## Governance \& Legislative Committee <br> (No meeting held in January, 2016)

Tri-City ical Center
Audit, Compliance \& Ethics Committee January 21, 2016
8:30 a.m-10:30 a. m.

| Members Present: | Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community <br> Member; Barton Sharp, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community <br> Member |
| :--- | :--- |
| Non-Voting Members: | Steve Dietlin (CFO); Kapua Conley, COO; Cheryle Bernard-Shaw, CCO <br> Others Present: |
| Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director of Education and Clinical <br> Informatics; Colleen Thompson, Director of Medical Records, HIM and Privacy Officer; Jami Piearson, Director of Regulatory <br> Compliance; Glen Newhart, Chief Development Officer, Foundation; Kevin Stotmeister, Chairman, Foundation Board of <br> Trustees |  |
| Absent: | Tim Moran (CEO); Dr. Frank Corona, Medical Staff Member |


|  | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
| :---: | :---: | :---: | :---: |
| 1. Call to Order | The meeting was called to order at 8:30 a.m. in Assembly Room 3 at Tri-City Medical Center by Chairperson Finnila. |  |  |
| 2. Approval of Agenda | Chairperson Finnila requested an additional policy be added to the agenda \# 8610-278 Contract Approval Process. General Counsel Ms. Diane Racicot explained the need to take action on this policy arose after the agenda was posted. <br> It was moved by Mr. Cumming and seconded by Director Mitchell to approve the agenda as amended. The motion passed unanimously. | Amended Agenda approved. | Ms. Donnellan |
| 3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item | There were no public comments. |  |  |


|  | Discussion | Action Recommendations/ Conclusions | rerson(s) Responsible |
| :---: | :---: | :---: | :---: |
| 4. Ratification of minutes November 19, 2015 | The committee reviewed the minutes of the November $19^{\text {th }}$ meeting. Ms. Fitzwilliam requested a correction in the spelling of her name on page 1 of the minutes. With regard to Policy \#8750-538 Hiring and Employment; Screening Prospective Employees Covered Contractors Mr. Schwartz questioned if the committee had previously agreed to change the title to include the word "eligibility". The committee agreed that the name of the policy should be amended to read "Hiring and Employment; Screening Prospective Employees/Covered Contractors Eligibility". Ms. Kathy Topp stated she would ensure the name of the policy was listed correctly in MCN. <br> It was moved by Mr. Leslie Schwartz and seconded by Mr. Barton Sharp to approve the minutes as amended. The motion passed unanimously. | Amended minutes ratified | Ms. Donnellan |
| 5. Old Business |  |  |  |
| A) Review and discussion of Administrative Policies \& Procedures <br> 1. 8610-525 - Use and Disclosure of Protected Health Information (PHI) for Fundraising | Chairperson Finnila explained Policy 8610-525 Use and Disclosure of Protected Health Information (PHI) explains the policies and procedures that must be followed related to PHI for Fundraising. She introduced Mr. Glen Newhart, Chief Development Officer for the Foundation and Mr. Kevin Stotmeister, Foundation Board Chair who were in attendance today to answer any questions the committee might have related to the policy. Chairperson Finnila stated it is extremely important that the Foundation understands the importance of patient privacy. <br> Director Schallock joined the meeting at 8:55 a.m. <br> Extensive discussion was held regarding section $B$. Definitions \#8 Permissible Patient Information. Mr. Newhart explained Health Insurance Status is important for the Foundation to be able to target the appropriate patient populations. Other topics under \#8 addressed included Treating Physician, Outcome Information, Age, Gender, Date of Birth. Mr. Newhart further explained that age is also important in targeting the appropriate patient population. |  |  |
| dit, Compliance \& Ethics Committee | 2 |  | uary 21, 2016 |


|  | Discussion | Action Recommendations/ Conclusions | $\begin{gathered} \text { rerson(s) } \\ \text { Responsible } \end{gathered}$ |
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|  | General Counsel Ms. Racicot explained the language in the policy complies with HIPAA regulations. <br> Mr. Newhart provided an overview of the Foundation Department which includes four individuals. He explained the mechanisms in place to ensure patient privacy and to protect PHI. <br> Mr. Newhart also explained the process that is followed when the Foundation visits a patient. He stated the Foundation may be approached to visit the patient or the patient may be a long time donor. He stated the Foundation may provide a blanket and a meal card but does not and will not solicit funds during the visit. Mr. Newhart also discussed the fact that a patient can opt out of receiving fundraising materials on the first communication. <br> Mr. Newhart stated any changes to what HIPAA allows puts the Foundation at a disadvantage. He noted a patient's birthdate might be used simply to send a greeting card. Ms. Racicot stated that the information contained in the policy is what is allowed under HIPAA and must be used appropriately. She noted the CCO will also be conducting a training session for the Foundation staff. Mr. Newhart stated there is also a module in Net learning strictly for fundraising staff. Chairperson Finnila expressed concern that Foundation members aren't aware of the importance of restricting confidential patient information. Mr. Newhart stated that Foundations members do not have access to PHI. Ms. Fitzwilliam commented that today's discussion provided a better understanding of the Foundation's need for limited PHI but would encourage period training. Ms. Racicot commented that the Business Associate Agreement with the Foundation also ensures compliance with PHI. <br> The following revisions were suggested: <br> Revise B. f. to read Health Insurance Financial Class. |  |  |


|  | Discussion | Action Recommendations/ Conclusions | rerson(s) Responsible |
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|  | Renumber 10 a. to 11 and 11 to 12. <br> It was moved by Director Mitchell to recommend approval of Policy 8610-525 - Use and Disclosure of Protected Health Information (PHI) for Fundraising as amended. Mr. Cumming seconded the motion. The motion passed unanimously. <br> In closing Mr. Newhart presented a slide that showed the importance of relationship building. <br> Mr. Glen Newhart, Mr. Kevin Stotmeister and Mr. Jack Cumming left the meeting at 9:38 a.m. <br> It was recommended and agreed by the committee that the CCO perform random audits of the Foundation to ensure compliance and protection of patient information. | Recommendation to be sent to the Board of Directors to approve amended Policy 8610-525 Use and Disclosure of Protected Health Information (PHI) for Fundraising; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |
| 2. 8750-545 - Education \& Training - Introduction \& General Policies | Ms. Bernard-Shaw stated Policy 8750-545 - Education \& Training - Introduction \& General Policies has been deferred to allow her additional time to discuss with our volunteers and other hospital contractors. | Policy 8750-545 Education \& Training Introduction \& General Policies to be placed on the February committee agenda. | Ms. Donnellan |
| 6. New Business <br> A) Review and discussion of Administrative Policies \& Procedures <br> 1. 8610-516 - Patient Access to PHI: Patient Record | Ms. Colleen Thompson stated Policy 8610-516 - Patient Access to PHI: Patient Record and Policy 8610-517 Patient Access to Mental Health Records have been combined into one policy with the assistance of General Counsel. <br> Committee members had no recommended additions or revisions. <br> It was moved by Director Schallock to recommend approval of Policy 8610-516 - Patient Access to PHI: Patient Record as presented. Mr. Schwartz seconded the motion. The motion passed unanimously. | Recommendation to be sent to the Board of Directors to approve Policy 8610-516 Patient Access to PHI: Patient Record as presented; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |


|  | Discussion | Action Recommendations/ Conclusions | rerson(s) Responsible |
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| 2. 8610-517 - Patient Access to Mental Health Records (DELETED) | Per discussion described above, Policy 8610-517 - Patient Access to Mental Health Records has been deleted and combined with Policy 8610-516 - Patient Access to PHI: Patient Record. | Recommendation to be sent to the Board of Directors to delete Policy 8610-517 - Patient Access to Mental Health Records; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |
| 3. 8750-548 - Education \& Training: Specific Training Programs | The committee reviewed Policy 8750-548 - Education \& Training: Specific Training Programs. No additions or revisions were suggested. <br> It was moved by Director Mitchell to recommend approval of Policy 8750-548 - Education \& Training: Specific Training Programs as presented. Director Schallock seconded the motion. The motion passed unanimously. | Recommendation to be sent to the Board of Directors to approve Policy 8750-548 -Education \& Training: Specific Training Programs as presented; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |
| 4. 8750-550 - Education \& Training - Compliance Notices/Updates | The committee reviewed Policy 8750-550 - Education \& Training: Compliance Notices/Updates. No additions or revisions were suggested. <br> It was moved by Ms. Fitzwilliam to recommend approval of Policy 8750-550 - Education \& Training: Compliance Notices/Updates as presented. Director Mitchell seconded the motion. The motion passed unanimously. | Recommendation to be sent to the Board of Directors to approve Policy 8750-550 -Education \& Training: Compliance Notices/Updates as presented; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |
| 5. 8610-551 - Monitoring Compliance - Auditing \& Reporting; Introduction; General Policies | Ms. Bernard-Shaw stated Policy 8610-551 - Monitoring Compliance - Auditing \& Reporting Introduction; General Policies simply outlines the auditing and reporting function to ensure compliance with applicable laws and regulations, |  |  |


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| Process Policy | the organization was cited due to a deficiency in the organization's evaluation of contracts. She explained Policy 8610-278 has been amended to reflect the current process although additional revisions to the policy may be forthcoming. Ms. Bernard-Shaw also reviewed in detail the contract review process described in agenda item 6. C). below. <br> The committee reviewed the policy and recommended the following changes: <br> - Contract Legal Terms Checklist - for contracts less than $\mathbf{\$ 2 5 , 0 0 0}$ <br> > Reference to include Board Policy 10-013 <br> $>$ Reference to include the non-employee handbook. <br> It was moved by Director Schallock to recommend approval of Policy 8610-278 - Contract Process as amended. Director Mitchell seconded the motion. The motion passed unanimously. | Recommendation to be sent to the Board of Directors to approve Policy 8610-278 - Contract Review as amended; item to appear on Board agenda and included in agenda packet. | Ms. Donnellan |
| C) Review and discussion of contract process | Ms. Jami Piearson, Director of Regulatory Compliance reported the survey team from CDPH were concerned that our current contract process did not include a categorization of type of contract and inconsistencies in what was considered clinical or non clinical. They were also concerned that we had not clearly defined which types of contracts required the PHI review. Our process to meet the Plan of Correction included a review and revision of the contract review policy which defined criteria for clinical and non clinical contracts. Our Quality Assurance Performance Improvement (QA/PI) process also included an evaluation of the services defined in the contract and any issues we had identified. The ad-hoc committee reviewed each of the documents that were within the software system using a manual process. These contracts were classified and |  |  |


|  | Discussion | Action Recommendations/ Conclusions | rerson(s) Responsible |
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|  | identified and corrected. CareFusion Solutions was evaluated and rated with a status of "2" due to IV tubing that was found to be discolored. The vendor was contacted and the problem rectified. <br> Ms. Bernard-Shaw provided committee members with a sampling of the evaluation summary for contracts listed on the spreadsheet. <br> It was suggested the spreadsheet include an additional column to indicate if the contracts include PHI. Committee members indicated it would be important to see any evaluation summary in which the status was reflected as a "2" or above. <br> It was recommended that the spreadsheet brought forward today be viewed as an "educational dry run" and the amended spreadsheet which will include the additional column be brought back to the committee next month. <br> Ms. Kathy Topp, Ms. Colleen Thompson and Ms. Jami Piearson left the meeting at 10:25 a.m. | Amended Spreadsheet to be brought back to the committee for review of the first $1 / 3$ of non-clinical contracts. | Ms. Donnellan |
| D) Review and discussion of non-clinical contracts | Discussion of this agenda item was discussed in conjunction with item C) above. |  |  |
| B) FY2016 Audit <br> 1. Discussion of FY2016 Financial Statement Audit Proposal | Mr. Steve Dietlin stated previously the committee discussed the various options for performing the FY2016 Financial Statement Audit which included maintaining Moss Adams and rotating the managing partner per best practice or putting out an RFP and potentially selecting another firm. Mr . Dietlin further explained at that time the committee recommended that he seek a proposal from Moss Adams that would include a new managing partner. Mr. Dietlin stated Moss Adams proposed no increase in fees from the prior year, agreement to rotate partners and Senior Manager Ms. Mary Nguyen. Mr. Dietlin provided the committee with the bios of two potential partners, Mr. John Blakey and Ms. Stacy Stelzriede and verified that the previous partner, along | Committee to interview potential partner(s) for the FY2016 Financial Statement Audit process. | Committee |


|  | Discussion | Action Recommendations/ Conclusions | $\begin{gathered} \text { rerson(s) } \\ \text { Responsible } \end{gathered}$ |
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|  | with one or two new potential partners will be available to meet with the committee at the February $18^{\text {th }}$ meeting or sooner if the committee so desires. It was recommended and agreed that the committee interview one or two new potential partners at the February regular meeting. |  |  |
| 7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7) | Chairperson Finnila made an oral announcement of the item listed on the agenda to be discussed during closed session which included approval of closed session minutes. |  |  |
| 8. Motion to go Into closed session | It was moved by Director Schallock and seconded by Director Mitchell to go into closed session at 10:33 a.m. The motion passed unanimously. |  |  |
| 9. Open Session | The committee returned to open session at 10:35 a.m. with attendance as previously noted. |  |  |
| 10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) | Chairperson Finnila reported no action was taken in closed session. |  |  |
| 11. Comments from Committee Members | Ms. Bernard-Shaw reported the OIG Settlement Agreement was finalized and signed on January $14^{\text {th }}$ and includes a settlement figure in the amount of approximately $\$ 3.278$ million. Ms. Bernard-Shaw explained there were 92 physician arrangements that had technical violations when the disclosure was made in 2012. Of those 92 arrangements five were considered to be not at fair market value and involved one physician. Ms. Bernard-Shaw noted the Settlement Agreement lists the contracting parties. She explained that all issues have been resolved and did not involve any of the current executive team. She further explained that processes have been put in place to address contracts with physicians to ensure they meet legal requirements under Stark. Ms. Fitzwilliam questioned how the settlement impacted the District financially. Mr. Dietlin stated we had accounted for $\$ 1.3$ million when the Fiscal 2015 financial statement audit was issued as that was the | Information Only |  |


|  |  | Action <br> Recommendations/ <br> Conclusions |  |
| :--- | :--- | :--- | :--- |
|  | amount that was offered for settlement at the time. <br> Therefore the remaining amount will be recorded in January. <br> Chairperson Finnila made it clear that the District self- <br> disclosed and no current management staff was involved. <br> Director Schallock stated a newspaper article stated that the <br> prior CEO indicated there are other issues "still out there". <br> Director Schallock stated the Board does not believe that to <br> be true. <br> Ms. Fitzwilliam commented that it would be helpful for the <br> committee to have a complete listing of policies and dates <br> that each respective policy was reviewed. | A list of policies will be <br> included in next month's <br> meeting packet. | Ms. Donnellan |

## AUDIT, ETHICS AND COMPLIANCE COMMITTEE January 21st, 2016

| Administrative Policies \& Procedures |  |  |  |
| :---: | :---: | :---: | :---: |
| 1. Patient Access to PHI: Patient Record | 8610-516 | 3 year review, revised | Forward to BOD for approval |
| 2. Patient Access to Mental Health Records | 8610-517 | DELETE | Forward to BOD for approval |
| 3. Use and Disclosure of Protected Information for Fundraising | 8610-525 | 3 year review, revised | Forward to BOD for approval with revisions |
| 4. Education and Training; Specific Training Programs | 8750-548 | 3 year review, revised | Forward to BOD for approval |
| 5. Education \& Training Compliance Notices/Updates | 8750-550 | 3 year review, revised | Forward to BOD for approval |
| 6. Monitoring Compliance-Auditing \& Reporting; Introduction; General Policies | 8610-551 | 3 year review, revised | Forward to BOD for approval |
| 7. Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities | 8750-556 | 3 year review, revised | Forward to BOD for approval with revisions |
| 8. Contract Policy | 8610-278 | Practice Change | Forward to BOD for approval with revisions |
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Tri-City Health Care District
Oceanside, California
Administrative Policy Manual

ISSUE DATE: 12/02

SUBJECT: PATIENT AGGESSTO-PROTECTED HEALTH INFORMATION: PATIENT RECORD PATIENT ACCESS TO PROTECTED HEALTH INFORMATION IN THE DESIGNATED RECORD SET

POLICY NUMBER: 8610-516

REVISION DATE: 4/03; 9/05; 11/08

Administrative Policies \& Procedures Committee Approval: $11 / 0811 / 15$
Operations Team Committee Approval: 12108
Professional-Affairs Committee-Approval: 01109
Audit, Compliance and Ethics Committee Approval 01/16
Board of Directors Approval: 01/09
A. PURPOSE:

1. To establish policiesy and procedures for providing a Patient or his or her Personal Representative with access to, and copies of, the Patient's Protected Health Information (PHI) in a Designated Record Set. outline the conditions, limitations, and procedures for providing a patient and his/her legal representative with access to the patient's health information record as outlined in state regulation that declares persons responsible for decisions respecting health care of others have a general right to access information respecting those persons' conditions and treatments. ${ }^{4}$

## B. DEFINITIONS:

1. Alcohol and Drug Abuse Records: patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse.
2. Adult: person who has reached the age of 18, or a minor who has entered into a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the USA, or who has been declared emancipated.
3. Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for Tri-City Healthcare District (TCHD) to Use and Disclose PHI.
4. Designated Record Set: those documents, whether maintained in paper, film or electronic formats, that comprise the Individual's medical record as approved by the Medical Executive Committee, that comprise the Individual's billing records, and any documents used in whole or in part by TCHD to make decisions about individuals including copies from another health care provider's designated record set.
5. Health Care Provider: any of the following
a. Licensed health facility;
b. Licensed health clinic;
c. Licensed home health agency;
d. Licensed physician and surgeon;
e. Licensed podiatrist;
f. Licensed dentist;
g. Licensed psychologist;
h. Licensed optometrist;
i. Licensed chiropractor;
j. Licensed marriage, family, and child counselor;;-of

[^1]k. Licensed clinical social worker
6. Mental Health Records: patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a patient's mental health condition or mental disorder. "Mental Health Records" includes, but is not limited to, all Alcohol and Drug Abuse Records. "Mental Health Records" also includes, but is not limited to, all alcohol and drug abuse records.
7. Minor (emancipated): patient 14 years of age or older who has petitioned the court for emancipation. Identification (ID) card stating the minor is emancipated is issued by the Department of Motor Vehicles (a copy of this ID card is to be placed in the patient's medical record).
8. Minor (self-sufficient): patient 15 years of age or older is living separate and apart from his/her parent or legal guardian, and manages his/her own financial affairs regardless of source of income.
9. Patient: a person who is currently or was formerly a patient of Tri-City Healthcare District.
10. Personal Representative: the person who has the authority to act for the Individual in making decisions related to health care under state law (except where an unemancipated minor has the authority to act as an Individual for certain services or circumstances) or, with respect to deceased persons, the person who has the authority to act on behalf of the deceased Individual or the Individual's estate as relevant to such personal representation.
11. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in electronic or paper form that is created or received by TCHD AND:
a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
b. Relates to the provision of health care to an individual; OR
c. Relates to the past, present, or future payment AND
d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
12. PatientRecords records in any form or medium maintained by, of in the-custody-or control of, a Health-Gare-Provider relating to the health history, diagnosis, or condition of a Pationt, or relating to treatment provided or proposed to be provided to the patient.- ${ }^{z}$
a. Includes only records pertaining to the patient requesting the records or whose representative requests the records
b. Does not indude information given in confidence to a health care provider by-persen other than another health care provider or the patient. That material may be removed from any records prior to inspection or copying. ${ }^{3}$
6. Does not include information-contained in-aggregate form, such as indices, registers, of logs.
13. Patient Representative- a parent or the guardian of a miner who is a patient, or the guardian or the legal conservator of an adult Patient, or the-beneficiafy-or Personal Representative of a deceased Patient ${ }^{4}$
14. Personal Representative means-an-executor, administrator, administrator with the will annexed, specialadministrator, successor personal representative, of a person who performs substantially the same function under the law-of another jurisdiction governing the person's status.
C. POLICY:

1. It is the policy of TCMAG-TCHD to provide Patients Legat or their Personal fRepresentative (to the extent relevant to the representation) with access (to inspect and/or obtain copies) of PHI in the Designated Record Set within the time required by law.to their health
2. TCHD may deny requests to access Mental Health, Alcohol and Drug Records, and other records in the DRS as specified in this Policy but only if the requirements for denial set forth in this Policy and applicable law are met.

[^2]Z. information/medical record within a reasonable period of timeonce appropriate authorization has been Fbained
D. PROCEDURES:

1. Patient Access to Information in the Designated Record SetGenera/PatientRecords a. Right of Access to Information in the Designated Record SetPatient Records
i. Adult $\quad$ pPatients and patient-Personal fR epresentatives shall be entitled to inspect patient-records and to obtain copies of all or any portion of patient records upon presentation of a written Authorizationconsent and payment of reasonable clerical eosts incurred, exeept under certain cireumstances.
b. Responsibility for Processing Requests for Patient Access to Patient Records
i. The Medical Records/Health Information Management Department ("MRD/HIM Department") shall be primarily responsible for processing requests for ${ }^{\circ}$ Patient access to patientrecords post-discharge. However, if a patient or a patient representative chooses to personally inspect patient records, MRD/HIM Department staff shall notify the Health-Gare Provider responsible for the patient to allow him/her to be present at the inspection.
ii. MRD/HIM Department staff shall not attempt to explain or interpret anything in patient-records. If any assistance in understanding information contained within the patient-record is required, the pPatient or patientPersonal fRepresentative shall be referred to the responsible Health Care Provider.
iii. In situations in which the ${ }_{\rho}$ Patient is currently an inpatient or aHome $\epsilon$ Care $\quad$ PPatient, the MRD/HIM department will work with the nursing unit manager or case manager to ensure proper aAuthorization is obtained. The procedures set forth in D.1.c through D.1.i shall be followed. and the-physigian is notified prior to allowing pationt access to the record. Both items are to be-documented prier to inspection. The patient will be informed that the physician has been notified of their request for access. A clinical representative will need to be present during this chart review rather than a representative from Medical Records/Health Information.
c. Requirements for Requests for Patient Access to PatientRecords
i. Requests for ${ }_{\mathrm{p}}$ Patient access to $\mathrm{pPatient's}$ records must be made in writing and must provide the following information:
1) Name of the $\ddagger P$ Patient whose records are requested;
2) Name and signature of the requester;
3) A statement of the relationship to the pPatient, if the requester is a patientPersonal fRepresentative;
4) Identification of the portion of the patient-record to be inspected or copied; and
5) Date of the request;
6) Length of time the authorizationrequest is valid;
7) Date of birth of $p$ Patient;
8) Reason for ADisclosure.
d. Procedure for Processing Requests for Patient Access.
i. Records shall be reviewed by the Medical Records/Health Information Department staff prior to permitting inspection, or providing copies to ensure:
9) Integrity of the record;
10) Completeness of the record;
11) Removal of any portion of the record relating to someone-other than the patient;
12) Removal of any information furnished in confidence by someone other than the patient or another provider;
5)3) Appropriateness of requests of minor pPatients; and
6)4) Consideration of possible adverse determination on records of Mental Health Records, including Alcohol and Drug Abuse Records.
e. TCHD shall consult with legal counsel on denials of access to records that make reference to other persons or where the request is made by a Personal Representative and a licensed provider has determined, in his or her professional judgement, that access is reasonably likely to cause substantial harm to the patient or another person.
f. If a patient-record is incomplete, the requestor shall be given the option of waiting until the record is complete, or accessing the patientrecord prior to completion. When possible, completion of incomplete patient-records shall be expedited.
g. Access to patient-records shall not be denied or delayed because the Patient is still undergoing care. Such a request may signal dissatisfaction with care, therefore, the Health Care Provider shall be notified and encouraged to participate in the review personally in order to clarify any questions. The Medical Records/Health Information Department staff shall assist the nursing staff in the handling of the pPatient request form.
h. Documentation of Requests for Patient Access to Patient Records.
i. Release of any patient records shall be documented by the Medical

Records/Health Information team, who shall record the following information:

1) A copy of the written request;
2) Date the request was received;
3) Date and manner of compliance; and
4) Name of the person who released the information pursuant to the request.
i. Patient Inspection of Records
i. TCHD maintains most records in the Designated Record Set in electronic form. If a patient or Personal Representative wants to personally inspect the Patient's records, TCHD is not required to provide the Patient or Personal Representative with access to its electronic system. Instead, TCHD will print copies of the electronic record for inspection, upon proper written request. Such Patients and patient representatives shall have the right to personally inspect patient records upon proper written request. Rrecords shall be made available for inspection by pPatients or patien\#Personal fRepresentatives within five (5) working days of the hospital's receipt of a written request.
ii. Inspections may be carried out during business hours by appointment only. Inspections shall be carried out in the Medical Records/Health Information Department, and shall be under the direct visual supervision of designated MR/HIM Department staff.
iii. Reasonable efforts to establish the identity of the pPatient or the patientPersonal fRepresentative shall be made prior to the beginning of inspections. Persens requesting access as guardians or conservators of a patient must present evidence of appointment. Pursuant to applicable law, efforts to establish the identity of the pPatient or the patientPersonal fRepresentative shall not be used oppressively or discriminatorily to frustrate or delay pPatients' and patientPersonal Representatives' rights to access patient-records.
iv. One individual may accompany the pPatient or patientPersonal fRepresentative during the inspection. If the Health Care Provider elects to participate in the inspection, the p Patient or Personal Representative may choose one additional person to participate.
j. Provision of Copies of Records
i. Patients and patientPersonal fRepresentatives shall have the right to receive copies of all or a portion of Patient Rrecords in the Designated Record Set. TCHD provides electronic medical records on CDs. CDsGopies shall be provided to p Patients or patientPersonal fRepresentatives within fifteen (15) calendar days of TCHD's the hespital's-receipt of a valid written request.
ii. Reasonable efforts to establish the identity of the patient off the patientPersonal fRepresentative shall be made prior to the provision of copies in accordance with TCHD Administrative Policy No.8610-593. Persons requesting access as guardians or conservators of the patient must present-ovidence of appointment, Pursuant to applicable law, efforts to establish the identity of the $\rho$ Patient or the pationtPersonal $f$ Representative shall not be used oppressively or discriminatorily to frustrate or delay $\beta$ Patients' rights to access patient-records in the Designated Record Set.
k. Provision of Electronic copies of PHI
i. If a Patient requests access to electronic PHI, TCHD must provide an electronic PHI. TCHD is not required to provide direct access to its computer systems. TCHD will provide a copy of electronic PHI on CD.
2. Access to Patient Records of Minors
a. General Right of Access
i. Emancipated minor Patients shall have access to their health information with provision of appropriate documentation as provided in TCHD Administrative Policy No. 8610-593.
ii. Minor Patients shall have the right to access their patient records only when those records pertain to treatment to which the minor has the right to consent:
1) Pregnancy related conditions
2) Treatment for an infections, contagious, or communicable disease which must be reported to the local health officer
3) Treatment for a sexually transmitted disease
4) Treatment for rape
5) Outpatient mental health treatment
iii. When minors' patient records pertain to such treatments, parents or guardians shall not have the right to inspect or copy such records, unless the minor pPatient consents.
iv. Parents or guardians of minor aPatients shall have the general right, as patientPersonal fRepresentatives, to inspect or copy minors' pPatient records, except as noted above.
v. However, aA parent or guardian's request to access a minor's $\uparrow$ Patient records shall be denied if the Health Care Provider determines that access to pPatient records, including Mental Health Records, will have a detrimental effect on the minor's physical safety or psychological well-being, or on the Health Care Provider's professional relationship with the minor.
vi. Access to a minor's Patient's medical record and information to which the parent is otherwise entitled may not be denied to a parent solely because the parent is not the child's custodial parent.
b. Denial of Requests to Access Minors' Patient Records
i. When a parent or guardian's access to a minor's pPatient record is denied, the Health Care Provider shall make a written record, to be included with the pPatient record, noting the date of the request and explaining the Health Care Provider's reason for refusing to permit inspection or provide copies of the pPatient's record, including a description of the detrimental effect that the provider anticipates would occur if access were permitted.
c. Requests for Access to Minors' Alcohol and Drug Abuse Records
i. Requests by parents or guardians to review minor's Alcohol and Drug Abuse records shall be referred to the Director orf Operations Manager of Medical Records/Health Information.
3. Access to Suspected Child Abuse Records
a. Requests for release of suspected child abuse records to a pPatient or Personalpatient fRepresentative should be referred to the Director orf Operations Manager of Medical

Records/Health Information who will coordinate review of the request with the Case Management/Social Services Manager.
4. Access to Records of Deceased Patients
a. A pPatient's Personal fRepresentative's request to access a deceased pPatient's record willshall include verification or the identity and authority of the Personal that the patient fRepresentative in accordance with TCHD Administrative Policy No. 8610-593is the beneficiary or personal representative of the deceased patient.
b. A patientPersonal fRepresentative whose identity is verified shall have the same right to inspect or copy records as the Patientany other patient representative.
c. A request by a verified patientPersonal fRepresentative to access a deceased pPatient's records shall be processed in the same manner as a pPatient's request for access to his/her own record.
d. An abstract of Minimum Necessary documents is provided free of charge for patientPersonal fRepresentatives requesting copies of the deceaseddent's Patient's record-chart.
5. Access to Behaviora//Mental Health records-See-Administrative-Policy-8610-517.
5. Access to Mental Health Records
a. Review of Requests to Access Mental Health Records.
i. The appropriate Health Care Provider shall be notified when a patient requests access to his/her Mental Health Records. In those cases where it is difficult to determine if a record is a Mental Health Record, the request should be directed to the Director or Operations Manager of the Medical Records/Health Information Management (MR/HIM) Department. Access to such Mental Health Records shall only be denied where the Health Care Provider determines that there is a substantial risk of significant adverse or detrimental consequences to the Patient in seeing or receiving a copy of the Mental Health Records.
ii. A request by a patient to inspect or receive copies of Mental Health Records shall be honored if the MR/HIM Department has not been advised by the Health Care Provider by the fifth $\left(5^{\text {th }}\right)$ business day after notification that denial is recommended. Every effort shall be made to reach the Health Care Provider for approval and steps taken will be documented. If the Health Care Provider cannot be reached, the request for access shall be referred to the Chair of the Psychiatric Division or the Medical Director of the Behavioral Health Unit. If the Chair cannot contact the Health Care Provider, the Chair of the Psychiatric Division shall make the determination regarding release or denial of Mental Health records and the need for an alternate summary within 5 business days.
iii. Actions taken will be documented with resolution within 5 business days for access and within 14 days from receipt of request for copies.
6. Requests to Access Alcohol and Drug Abuse Records
a. Patient records specifically related to alcohol or drug abuse evaluation or treatments are considered Mental Health records under the Health and Safety Code. ${ }^{5}$ Patient requests to access adult Alcohol and Drug Abuse records shall be handled in the patient's requests to release alcohol and drug abuse records to the patient's attorney shall be treated, as a request for disclosure to a third party, and the appropriate procedure for such release shall be followed.
7. Denial of Requests to Access Mental Health Records.
a. When patient access to Mental Health records is denied, the Health Care Provider shall make a written record, to be included with the Mental Health records. The written record shall note the date of the request and explain the Health Care

[^3]Provider's reason for refusing to permit inspection or provide copies of the Mental Health records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.
b. MR/HIM Department team shall inform the patient of the Health Care Provider's refusal to permit inspection or copying of the records, and shall inform the patient that he or she has the right to permit inspection by or provide copies to the following licensed professionals as designated by the patient:

1) A licensed physician and surgeon
2) A licensed psychologist
3) A licensed marriage and family therapist;
4) A licensed clinical social worker; or
5) A licensed professional clinical counselor.
c. MR/HIM Department team shall document in the patient record that the patient was informed of his or her right to designate a licensed physician, psychologist, or social worker to review the Mental Health Record or obtain copies, and shall document whether the Patient chose to exercise this right.
d. If the patient chooses to designate a licensed physician, psychologist, social worker or clinical counselor to review the Mental Health Record or obtain copies, statutes governing access to non-patients shall apply, including the requirement of a valid written authorization from the patient for such disclosure. A reasonable effort shall be made to verify that the person named to obtain copies is, in fact, a licensed professional.

## 6.

Release of Patient Records to a Patient's Attorney
a. Right to Request Release of Patient Records to an Attorney
i. Prior to the filing of a claim or action, patientrecords shall be released to a p Patient's attorney upon receipt of a proper written aAuthorization.
ii. Requests for release of pationt records made subsequent to the filing of a claim shall require-a-subpoena-or need appropriate request from the Director of Legal Services.
b. Process for Complying with Requests for Release to an Attorney
i. A written authorization for release of patientrecords to an attorney shall contain the following items:

1) The name of the facility;
2) The name of the person or company to whom the information will be given;
3) The date of the aAuthorization; and
4) The signature of the pPatient or the patientPersonal fRepresentative
ii. Pursuant to a proper written aAuthorization, patient-records shall be released to a photocopier or agent whom the requesting attorney has employed to obtain or review the records.
iii. Presentation of the written authorization by the professional copier or agent shall be sufficient proof that the person is authorized to access the atient-records.
iv. When a requesting attorney has employed a professional photocopier or agent to access the patient records, neither the hospital nor any Health Care Provider shall make copies of the patientrecord to comply with the request.
v. If the requesting attorney has not employed a professional photocopier or agent, patientrecords may be copied by the hospital or a Health Care Provider, or be made available for inspection by the attorney or the attorney's agent.
c. Time for Providing Access to Patient's Attorneys
i. Records shall be made available to a pPatient's attorney within five (5) business days after receipt of a proper written $\begin{aligned} & \text { Authorization. }\end{aligned}$
8.9. Summaries Provided in Lieu of Patient Access to Records
a. Process for Completing Summaries

BOCS 116569-000003/2359262.1
i. A Health Care Provider may opt to provide a summary of the patient-record as an alternative to providing access to or copies of the entire patient record but only if the Patient agrees in advance, to the summary and any related fees. The patient or patientPersonal fRepresentative shall elect either to inspect or to receive a copy of such a summary.
ii. MRD/HIM staff shall oversee Health Care Providers' preparation of summaries, and shall ensure that requests for pPatients' records involving summaries are processed promptly in order to allow sufficient time for dictation and transcription of the summary.
iii. If the Health Care Provider epts-to-provides a summary in lieu of access to the entire patientrecord, the Health Care Provider may confer with the pPatient or patientPersonal fRepresentative in an attempt to clarify the purpose or goal in obtaining the $\oplus$ Patient's records. If the Patient or Personal Representative requests information only pertainings-only to certain injuries, illnesses, or episodes of care, the summary need only pertain to the specified injuries, illnesses or episodes of care.
iv. TCHD shall refer to the requirements under HIPAA and State law related to the time and manner of providing summaries and charges for summaries. $\ddagger$ the Health-Gare-Provider opts to provide a summary, the-summary shall contain the following-information for oach injury, illness, or episode included in the record. 1) Ghiefcomplaint, or complaints, including pertinent history;
2) Findings from consultations and referrals to other Health Care-Providers;
3) Diagnosis(es) where determined;
4) Treatment plan and regimen, including medications prescribed;
51) Progress of the treatment;
6) Prognosis,-ineluding significant continuing-problems-or conditions;
7) Pertinent reponts of diagnostio and operative procedures and tests performed during the episode, or episodes of gare;
8) Objective findings from the most recent physigal examination, such as blood pressure, weight, and actual values from routine laboratory tests; and
9)2) Alist of all current medications prescribed induding dosage, and any sensitivity, or allergies, to medications recorded in the-medical-record.
$v$. The Health Care Provider shallensure that each of the above items is included in the summary.

1) The-Health Gare-Provider-shall indicate that the-summary shall be provided in lieu of inspection or copying, and shall designate the summary-as satisfying criteria specified in the law.
2) If the -ummary does not include all of the above items, the actual Patient Record shall be made available to the Patient or Patient Representative for inspection-or copying.
vi. I the-Patient or Patient Representative desires to pick up the-summary, he or she shall be informed immediately once the summary is completed.
1). The requestor shall also be informed of any applicable fees due as a result of processing the summary. A receipt or billing-statement for inspection or eopying of the Patient Records, including transcription and postage fees, if applicable, shall be prepared for each summary released.
3) The Patient or Patient Representative shall receive the original of the summary. The MP/HI Department staff shall ensure that a-copy of any summary provided to a Patient or Patient Representative is included in the Patient Record.
b. Time for Providing Summaries ${ }^{6}$

[^4]1.- The-summary of the Patient Record-shall-be provided to the patient or patient representative within ten (10) calendar days of the date the hospital received the request. MRD/HIM staff shallensure that summaries are delivered to patients within the-appropriate-time-
it. If a-summary of a patient record cannet be made available within ten (10) calendar days of receipt of the request because-of extraordinarylength of the patient record or because the patient was discharged from the hospital within ten calendar days prior to receipt of the request, up to thity (30) days calendar days may elapse between the hospital's receipt of the request patient and the delivery of the summary to the patient or the patient representative.
iii. If a summary of a patient record cannot be made available within ten (10) calendar days of receipt of the request, the patient, or patient representative-shall be notified promptly that an-extension will be noeded to process the request.
iv. If the summary is not completed in a timely manner, the patient or patient representative shall be permitted to inspect or receive copies of the pationt record.
9.10. Fees for Medical Record Requests
a. Fees for Inspection or Copying by Patients/Personal Representatives
i. TCHD does not charge for making electronic records available to Patients or Personal Representatives on CDs. If Patients or Personal Representatives want a hardcopy of the full medical record, copies are charged at the rate of $\$ 0.10$ per page. Copies reproduced from microfiche/microfilm are charged at the rate of $\$ 0.20$ per pageReasonable-costs incurred in making the-record available (not to exeeed actual-costs) may be charged to the patient and may be required in advance-of inspection or obtaining copies.
ii. Patients and patientPersonal fRepresentatives shall not be charged for the processing of routine requests for inspection.
iii. Patients and Personal Representatives shall not be charged for the provision of copies of patient records being forwarded to a physician for continuing care.
iv. Patients and Personal Representatives shall not be charged for provision of aA continuing care abstract of patientinformation from the record. that meets the minimum nesessary requirements. The abstract will include the following document types:

1) All dictated reports (H\&P, CON, OP, Discharge Summary)
2) All Laboratory and Pathology reports (internal and external)
3) Cardiology reports (ECGs, invasive and non-invasive procedures)
4) Imaging reports (including interventional)
$v$. Patients shall be charged the following fees per page for copies provided in addition to the abstract ${ }^{7}$
5) Copies created from hardcopy medical record: $\$ 0.25$ per page
6) Copies reproduced from microfiche/microfilm: $\$ 0.50$ per page
7) Copies reproduced from-off-site hardcopy medical records (retrievalfee$\$ 0.25$ per page fee)
b. Fees for Attorney Requests
i. A fee not to exceed $\$ 15.00$ shall be charged to a party requesting access to a pPatient's records for inspection or copying by a professional photocopier or agent employed by an attorney.
ii. When no professional photocopier or agent is employed by a pPatient's attorney, TCHDAG may charge the reasonable cost of providing copies:
8) Copying standard documents: $\$ .1025$ per page
9) Copying microfilm/microfiche documents: $\$ .2050$ per page
10) Actual postal costs for providing records
11) Actual costs for retrieval of records held off-site.

> Fees for Summaries
> TCMAG may bill patients and patient representatives for the actual time-spent and costs incurred in preparing summaries of patient records.
> TCMC may bill patients and patient representative for the reasonable-costs incurred in transeribing and mailing summaries.
> TCMC may not bill patients and patient representatives for processing and eompleting requests for Discharge Summaries, History and Physicals, ED Department report, and/or other pertinent parts-of the patient record.

## E. DENIAL OF RIGHT TO ACCESSAD.UNGT-POHGIES:

1. Patients and Personal Representatives have a right to inspect and copy his or her records except for mental health records under specified circumstances and copies of x-rays or tracings in certain circumstances.
2. TCHD may deny a Patient's or Personal Representative's right to access the Patient's information in certain circumstances. TCHD must provide the Patient or Personal Representative, as applicable, with access to any other PHI requested after excluding the PHI for which TCHD a ground to deny access.
3. TCHD must give the Patient or Personal Representative written notice of the denial (whether in whole or in part) within five (5) working days. The notice must contain the following information:
a. An explanation of the basis for the denial;
b. A description of how the Patient or Personal Representative may complain to TCHD (including the name or title and phone number of the Privacy Officer) or to the Secretary of the Department of Health and Human Services.
c. If applicable, an explanation of the Patient's or Personal Representative's review rights and how to pursue those rights.
AP 515 "Use and Disclosure of Protected Health Information-Records"
4. AP 517 "Patient Access to Protected Health Information Behavioral Health Record."
F. REFERENCES:
5. California Health and Safety Code Section 123100 et seq.
6. 45 Code of Federal Regulations (CFR) 164.501
7. 45 CFRFederal-Register section 164.524
8. TCHD Privacy: Designated Record Set Policy \#8610-514
9. TCHD Use and Disclosure of Protected Health Information: Records Policy \#8610-515
10. TCHD Verification of Identity and Authority of Persons Requesting PHI, including Personal Representatives Policy \#8610-593

Administrative Policy Manual

DELETE - This policy has been incorporated into Policy 8610-516 Patient Access to Protected Health Information in the Designated Record Set.

ISSUE DATE: 1/03

REVISION DATE: 11/08

## SUBJECT: Patient Access to Mental Health Records

POLICY NUMBER: 8610-517
Administrative Policies \& Procedures Committee Approval: ..... 11/0811/15
Operations Team-Committee Approval: ..... 12108
Professional-Affairs-Committee Approval: ..... 01109
Audit, Compliance and Ethics Committee Approval: ..... 01/16
Board of Directors Approval: ..... 01/09

## A. PURPOSE:

4. To-stablish policy that outlines the conditions, limitations, and procedures for providing a patient and his/her logal representative with access to the pationt's Behavioral/Mental Health information record as outlined in state regulation that declares persons responsible for decisions respecting health care of others have a general right to access information respecting these persons' conditions and treatments- ${ }^{-}$

## B. DEFINITIONS:

1. Alcohol and Drug Abuso Records-patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse. ${ }^{2}$
2. Adult-person who has reached the age of 18 , or a minor who has entered into- a valid marriage (whether or not the marriage was terminated by dissolution), whe is on active duty with the armed forces of the USA, or who has been declared emancipated ${ }^{3}$
3. Health Gare Provider any of the following:
a. Licensed heallh facility;
b. Licensed health clinic;
4. Licensed home health agency;
d. Licensed physician and surgeon;
e. Ligensed podiatrist;
f. Licensed-dentist;
g. Licensed psycholegist
h. Licensed optometrist;
i. Licensed-chiropractor;
j. Licensed marriage, family, and child counselor; or
k. Licensed clinical social worker
5. Mental Health Records-patient records, or discrete pertions thereof, specifically relating to evaluation or treatment of a patient's mental health condition-or mental disorder. "Mental Health Records" includes, but is not limited to, all Alsohol and Drug Abuse-Rocords. "Mental Health Records" also includes, but is not limited to, all alcohol and drug abuse records. ${ }^{4}$
6. Patient - a person who is currontly or was formerly a patient of Tri-Gity Healtheare District ${ }^{5}$
7. Patient Records - records in any form or medium maintained by, or in the custody or control of, a Health Gare-Provider relating to the health history, diagnosis, or condition of a Patient, or relating to treatment provided or proposed to be provided to the patient. ${ }^{6}$

[^5]a. Indudes-only records pertaining to the pationt requesting the records or whose represontative requests the records
b. Does not include information given in confidence to a health care provider by a person other than another hoalth care provider or the patient (that material may be removed from any records prior to inspection or copying ${ }^{7}$
6. Does not include information contained in aggregate form, such as indices, registers, or logs.
7. Patient Representative-a parent or the guardian of a minor who is a patient, or the guardian or the legal conservator of an adult Patient, or the beneficiary or Personal Representative of a deceased Pationt ${ }^{8}$
8. Personal Represontative - means an executor, administrator, administrator with the will-annexed, special administrator, successor personal representative, or a person who performs substantially the-same function under the law of another jurisdiction governing the person's status. ${ }^{9}$

## G. POLICY:

1. It is the policy of TCAMC to provide Patient/Legal representative access (inspect and/or obtain copies) to their behavioral health information/medical record within a reasonablo period of time once appropriate-authorization has been obtained.
2. Patient Access to Mental Health Records
a. Review of Requests to Access Mental Health Records:
i. The appropriate Health Gare Provider shall- be notified when a pationt requests access to his/her Mental Health Rocords. Sometimes it is difficult to determine if a record is a Mental Health Record. In those cases, the request should be directed to the Director or Operations Manager of the Medical-Records/Health Information (MRHH) Department. Access to such Mental Health Records-shall-only be-denied where the Health Garo-Provider determines that there is a substantial risk of significant adverse-or detrimental consequences to the Pationt in seeing of receiving a copy of the Mental Health Records ${ }^{10}$ -
b. A request by a-patient to inspect or receive copies of MentalHealth Rocords shall be honored if the ARHHI Department has not been advised by the Health Gare-Provider by the fifth ( $5^{\text {th }}$ ) working day after notification that denial is recommended. Every-effort shall be made to reach the Health-Gare Provider for approval and steps taken will be documented. If the Health Care-Provider cannot be reached, the request for access-shall be referred to the-Chair of the Psychiatric Division or the Medical-Director of the Behavioral Health Unit. If the Chair cannot contact the Health Care Provider, the Chair of the Psychiatric Division shall make the determination regarding release or denial of Mentat Health records and the need for an alternato summary within 5 working days. i. Actions taken will be documented with resolution within 5 and not more than 14 days from roceipt of request.
3. Requests to Access Alcohol-and Drug Abuse Records
i. Pationt records specifically related to alcohol or drug abuse evaluation of treatments-are-considered Mental Health records under the Health and Safoty Code. ${ }^{14}$ - Patient requests to access adults' Alcohot and Drug Abuse records shall be handled in the patient's requests to release alcohol-and-drug abuse records to the patient's attornoy shall be treated, as a request for disclocure to a third party, and the appropriate procedure for such release-shall be followed.
d. Denial of Requests to Acgess Mental Health Records occurs in the same manner as requests to access Mental Health Records.

[^6]i. When patient access to Mental Health records is denied, the Health Gare-Provider shall make-a written record, to be included with the Mental Health records. The written record shall note the date of the request and explain the - Health Gare Provider's reason for refusing to permit inspection or provide copies of the Mental Health records, including a description of the specific adverse or detrimental consequences to the pationt that the provider anticipates would occur if inspection or copying were permitted.
ii. MR/HI-Department team shall inform the patient of the-Health Care Provider's refusal to permit inspection or copying of the records, and shall inform the pationt that he or she has the right to permit inspection by or provide copies to:

1) A licensed physician and surgeon
z) Alicensed psychologist
2) Alicensed marriage and family therapist; or
3) A licensed clinical-social worker
iii. MR/HH Department team shall document in the patient record that the patient was informed of his or her right to designate a licensed physician, psycholegist, of social worker to roviow the Mental Health Record or obtain copies, and shall document whother the-Patient chose to oxercise this right.
iv. If the patient chooses to designate-a licensed physician, psychologist, or social worker to review the Mental Health Record-or obtain-copies, statutes governing access to non-pationts shall apply, including the requirement of a valid written authorization from the patient for such disclosure. A reasonable effort shall be made to verify that the person named to obtain copies is, in fact, a licensed professional.
3. Release of Pationt Records to a Pationt's Attorney
a. Right to Request Release of Patient Records to an-Attorney
i. - Prior to the filing of a claim-or action, pationtrocords-shall be-released to a pationt's attorney upon receipt of a proper written authorization.
ii. Requests for release of patient records made subsequent to the filing of a-claim shall be treated as a subpeena request and processed as such.
b. Process for Complying with Requests for Release to an Attorney
i. A written authorization for release of pationt records to an attorney shall contain the following items:
1) The name of the facility;
2) The name of the person or company to whom the information will be given;
3) The date of the autherization; and
4) The-signature-of the pationt or the-patient representative
ii. - Pursuant to a proper written-autherization, pationt rocords shall be released to a photocopier or agent whom the requesting attorney has -mpleyed to obtain-or review the records.
iii. Presentation of the written autherization by the professional copier or agentshall be sufficient proof that the person is authorized to access the patient records.
iv. When a requesting attorney has employed a profossional photocopier or agent to access the patient records, neither the hospital nor any Health-Gare Provider shall make-copies of the patient record to comply with the request.
$\forall$. If the requesting attorney has not employed a professional photocopier or agent, pationt records may be-opied by the hospital or a Health Gare Provider, or be made available for inspection by the atterney or the attorney's agent.
6. Time for Providing Access to Patient's Attornoys
i. Records shall be made available to a patient's attorney within 5 business days after receipt of a proper written authorization.
7. Summaries Provided in Lieu- Pf Pationt Access to Records
a. Process for Completing Summaries


[^7]request. MRD/HIM staff shall-ensure that-summaries are delivered to pationts within the appropriate time.
ii. . If a summary of a patient record cannot be made available within ten (10) catendar days of receipt of the request because of extraordinary longth of the pationt record or because the pationt was discharged from the hospital within ten calendar days prior to receipt of the request, up to thity (30) days catendar days may-dapse between the hospital's reoeipt of the request patient and the delivery of the summary to the patient or the pationt representative.
iii. If a summary of a patient record cannot be made available within ten (10) calendar days of receipt of the request, the patient, or patient representative shall be notified promptly that an oxtension will be needed to process the request.
iv. If the summary is notcompleted in a timely manner, the patient or patient representative shall be permitted to inspect or receive copies of the patient record.

## 5. Feos for Medical Record Requests

a. Fees for Inspection or Copying
i. Reasonable costs incurred in making the record available (not to exceed actual costs) may be charged to the pationt and may be-required in advance of inspection or obtaining copies.
ii. Patients and patient representatives shall not be charged for the processing of routine-requests for inspection.
iii. Patients shall not be charged for the provision of copies of patient records being forwarded to a physician for continuing care.
iv. Patients shall not be-charged for provision of an abstract of pationt information from the record that meets the minimum necessary requirements. The abstract will includo the following document types:

1) All dictated reports (H\&P, GON, OP, Discharge Summary)
2) All Laboratory and Pathology roports-(internal and external)
3) Gardiology reports (EKGs, invasive and non-invasive procedures)
4) Imaging reports (including interventional)
$\forall$. Patients shall be charged the following fees per page for copies provided in addition to the-abstract ${ }^{15}$
5) Gopies created from hardsopy medical record: $\$ 0.25$ per page
6) Copies reproduced from microfiche/microfilm: $\$ 0.50$ per page
7) Copies-reproduced from off-site hardcopy medical rocords (retrievalfoe + $\$ 0.25$ per pagefoe)
b. Fees for Alterney Requests
i. A fee not to exceed $\$ 15.00$ shall be charged to-a party requesting access to pationt records for inspection or copying by a professional photocopier or agent employed by an attorney.
ii. When no profecsional photocopier or agent is omployed by a patient's attorney, FCMC may charge the reasonable cost of providing copies:
8) Copying-standard documents: $\$ .25$ por page
z) Copying microfilm/microfiche documents: $\$ .50$ per page
9) Actual postal costs for providing records
10) Actuat costs for retrieval of records held off-site.
6. Fees for Summaries
i. TCMG may bill patients-and patient representatives for the actual time spent and costs incurred in preparing summaries of patient records.
ii. TCMG may bill pationts and pationt representative for the reasonable costs incurred in transcribing and mailing summaries.
iii. TCMA may not bill patients and pationt ropresontatives for processing and completing requests for Dischargo Summaries, History and Physicals, ED Department report, and/or other pertinent parts of the patient record.

## D. ADJUNGT POLICIES:

1. AP 515 "Use-and Disclosure of Protected Health Information-Records"
2. AP 516 "Patient Access to Protected Health Information - Patient Record"

## E. REFERENCES:

4. Galifornia Health and Safety-Code
5. Federal Register section 164.524

Administrative Policy Manual Compliance

ISSUE DATE: 03/03

REVISION DATE: 02/06; 01/09;

SUBJECT: Use and Disclosure of Protected Health Information (PHI) for Fundraising

POLICY NUMBER: 8610-525
$\begin{array}{ll}\text { Administrative Policies \& Procedures Committee Approval: } & 06 / 15 \\ \text { Audit, Compliance and Ethics Committee Approval: } & 01 / 16 \\ \text { Board of Directors Approval: } & 04 / 09\end{array}$

## A. PURPOSE:

1. To establish policies and procedures for the Use and Disclosure of specified Tri-City Healthcare District (TCHD) patient information for fundraising including, Disclosures to the Tri-City Hospital Foundation and/or Business Associates for the purpose of TCHD fundraising in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA).

## B. DEFINITIONS:

1. Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Business Associate: a person or organization who, on behalf of the District, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclose PHI to Business Associates for the services.
3. Direct solicitation fundraising literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of TCHD.
4. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
5. Fundraising: The process of securing the financial resources necessary to support the mission and purposes of the TCHD.
6. Minimum Necessary Standard: the amount of information reasonably necessary to accomplish the purpose of the Use, Disclosure or Request.
7. Payment: includes activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.
8. Permissible Patient Information: The limited categories of PHI that TCHD may Use or Disclose to a Business Associate or to the Tri-City Hospital Foundation without a patient Authorization, for the purpose of raising funds for TCHD's own benefit and expressly limited to the following:
a. Demographic information relating to the Individual including name, address, other contact information, age, gender, and date of birth
b. Dates of health care provided to an Individual
c. Department of service (general department of transferred) information
d. Treating physician
e. Outcome information
f. Health insurance financial class
9. Protected Health Information (PHi): individually identifiable health transmitted or maintained in paper or electronic other form that is created or received by TCHD AND
a. Relates to the past, present, or future physical or mental health or condition of an

## individual; OR

b. Relates to the provision of health care to an individual; $O R$
c. Relates to the past, present, or future payment, AND
d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
10. Treatment: the provision, coordination, or management of health care and related services by one or more providers, including coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient from health care from one health care provider to another.
11. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
12. Workforce: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid for by TCHD.
C. POLICY:

1. In order to protect the privacy of a patient's information, Tri-City Hospital Foundation shall act in accordance and compliance with HIPAA and the Privacy Practices of TCHD when conducting fundraising activities for TCHD.
2. TCHD may Use or Disclose Permissible Patient Information to its Business Associates or to the Tri-City Hospital Foundation for the benefit of TCHD fundraising. Such Uses and Disclosures are subject to the minimum necessary requirements.
3. TCHD may not condition Treatment or Payment on a patient's choice with respect to fundraising communications.

## D. PROCESS:

1. Notice of Privacy Practices
a. TCHD's Notice of Privacy Practices shall indicate that TCHD may Use or Disclose a patient's PHI to its Foundation or Business Associates for fundraising purposes and that the patient has the right to opt out of receiving such communications.
b. TCHD may not Use or Disclose PHI for fundraising purposes unless the statement required by Section 1.a is included in the Notice of Privacy Practices.
2. Use of Permissible Patient Information
a. After a patient has been made aware of the TCMC's Notice of Privacy Practices, TCHD may Use or Disclose Permissible Patient information Fundraising purposes.
b. Except as provided in this Policy, TCHD may Disclose Permissible Patient Information to the Tri-City Hospital Foundation or Business Associates for fundraising purposes without first obtaining a patient's Authorization for such purpose.
c. TCHD and/or the Foundation may use Permissible Patient Information to identify patients for patient testimonials that will be Used and/or Disclosed for Fundraising purposes; however, when doing so, TCHD and/or the Foundation must follow the process for obtaining Authorizations and consents set forth in Section 3.
d. Before contacting patients (current or former) for Fundraising purposes, TCHD and the Foundation shall verify that the individuals they wish to contact have not opted out of Fundraising communications.
e. TCHD and the Foundation shall implement the Minimum Necessary Standard on Fundraising Uses and Disclosures.
f. TCHD and the Foundation must adhere to more restrictive federal and state privacy laws for certain highly sensitive health information (including mental health, substance abuse, HIVIAIDS, psychotherapy notes, abuse and other categories). This means that it may not be possible to Use and Disclose highly sensitive PHI for Fundraising purposes without a patient Authorization or even at all. TCHD Workforce members and the Foundation shall consult the Privacy Officer or Compliance Officer before Using or Disclosing any PHI, including Permissible Patient Information, involving highly sensitive PHI.
g. TCHD and the Foundation may not Use or Disclose Permissible Patient Information (or any patient PHI ) with a non-affiliated entity for purposes of that entity's Fundraising (for
example where a Medical Staff member specializes in the treatment of a specific disease and a non-profit association fundraises for research related to that specialty).
3. Patient Testimonials Used for Fundraising Purposes.
a. When Using and/or Disclosing a patient's testimonial, including the patient's PHI (e.g. hospital experience, medical treatment), for Fundraising purposes, TCHD and/or the Foundation acting as TCHD's Business Associate must obtain form the patient prior to such Use and/or Disclosure:
i. an Authorization; and
ii. Consents to videotape, photograph and/or publish the patient's testimonial, as appropriate.
b. The Authorization and Consent form shall be obtained regardless of the manner in which TCHD/Foundation learned about the patient's testimonial or whether the patient has consented either verbally or in writing (e.g. e-mail) to such Use/Disclosure.
c. The Authorization must be completed in a manner that adequately describes the categories of PHI being Used/Disclosed and the Purpose of the Use/Disclosure.
d. TCHD and the Foundation shall only Use or Disclose the patient's testimonial (and PHI)
4. Fundraising Notifications
a. Each fundraising notification shall provide the patient with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
b. The method provided to opt out of receiving further fundraising communications shall not result in a patient incurring an undue burden or more than a nominal cost. Tri-City Hospital Foundation permits patients to opt out of future fundraising communications by telephone at (760) 940-3370 or by e-mail at TCHFoundation@tcmc.com.
c. Any TCHD Workforce member or Business Associate who is advised by a patient of his/her request to opt out of receiving future Fundraising communications, must contact the Foundation to document the request.
5. Patients Who Opt Out
a. Fundraising communications will not be made to patients who have opted out of such communications.
b. Tri-City Hospital Foundation will track opt out notifications to ensure that further fundraising communications are not made to patients who have elected to opt out.
6. Opting Back In.
a. Patients who desire to opt back in to receive fundraising communications can do so by sending an e-mail with such request to TCHFoundation@tcmc.com or by opting in at an event or through the Foundation's website.
7. Direct Solicitation Fundraising Literature
a. Direct solicitation fundraising literature does not include general marketing communications to donors or prospective donors such as newsletters or other similar general communication media where TCHD does not Disclose patient PHI to Tri-City Hospital Foundation for such purposes.
8. Business Associates
a. Before the Tri-City Hospital Foundation shares any Permissible Patient information with a Business Associate, the Tri-City Hospital Foundation shall have the Business Associate sign the TCHD Business Associate Addendum.
b. If the Tri-City Hospital Foundation becomes aware of a breach of the Privacy Practices of TCHD by a Business Associate, the Tri-City Hospital Foundation shall immediately notify the Privacy Officer.

## E. REFERENCES:

1. 45 Code of Federal Regulations (CFR) Section 164.502
2. 45 CFR Section 164.514(f)
3. TCHD Notice of Privacy Practices Policy \# 518
ISSUE DATE: 03/03

SUBJECT: Use and Disclosure of Protected Health Information (PHI) for Fundraising

POLICY NUMBER: 8610-525

REVISION DATE: 02/06; 01/09;
Administrative Policies \& Procedures Committee Approval: 03/0906/15
Operations Team Gommittee Approval: 03/09-
Audit, Compliance and EthicsProfessional Affairs Committee Approval:
04/09
Board of Directors Approval:
04/0901/16

## A. PURPOSE:

3.1. To establish policiesy and procedures for the $u$ Use and Ddisclosure of specified Tri-City Healthcare District (TCHD) patient information for fundraising including, Disclosures by-to the Tri-City Hospital Foundation and/or Business Associates for the purpose of TCHD fundraising in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA).

## B. DEFINITIONS:

1. Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Business Associate: a person or organization who, on behalf of the District, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclose PHI to Business Associates for the services.
3. Direct solicitation fundraising literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of TCHD.
4. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
4.5. Fundraising: The process of securing the financial resources necessary to support the mission and purposes of the FoundationTCACHD.
5. Minimum Necessary Standard: the amount of information reasonably necessary to accomplish the purpose of the Use, Disclosure or Request.
2.7. Payment: includes activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.
6. Permissible Ppatient linformation: The limited categories of PHI that TCHDMC may Use or dDisclose to a Business Associate or to the Tri-Ccity Hospital Foundation without a patient aAuthorization, for the purpose of raising funds for TCHDMC won's own benefit and expressly limited to the following:
a. Demographic information relating to the lindividual including name, address, other contact information, age, gender, and date of birth
b. Ddates of health care provided to an lindividual
c. Ddepartment of service (general department of transferred) information
d. Ttreating physician
e. Ooutcome information
4.f. health-Health insurance statusfinancial class_(i) Name; (ii) Address; (iii) Other contact information (phone number, e-mail address, eto.); (iv) Age; (V) Gender; (vi) Insurance status; (vii) Dato(s) of service (\$164.514).
7. Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic other form that is created or received by TCMCHD AND
a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
b. Relates to the provision of health care to an individual; OR
c. Relates to the past, present, or future payment, AND Identifies the individual $O R$
d. Identifies the individual OR Wwith respect to which there is a reasonable basis to believe the information can be used to identify the individual.
8. Information relating to: (i) Diagnosis; (ii) Nature of senvices; (iii) Treatment; and (iv) place within Medical Center where patient receives treatment that identifies the treatment (i.e. Medicat-Genter Department) (§164.514).
6.10. Direct solicitation fundraising literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of the Foundation.Treatment: the provision, coordination, or management of health care and related services by one or more providers, including coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient from health care from one health care provider to another.
3.11. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
7.12. Workforce: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid for by TCHD.
9. Business Associate: Any person or entity that is not a member of the workforse of either the TriGity Hospital-Foundation or the Tri-City Medical-Center (TCMC) that provides certain functions, activities or services for the Tri-City Hospital Foundation or TCMAG.
C. POLICY:
10. In order to protect the privacy of a patient's information, the-Tri-City Hospital Foundation shall act in accordance and compliance with HIPAA and the Privacy Practices of TCMAHD when conducting fundraising activities for TCHD.
11. TCMCHD may Utse or Ddisclose Permissible Patient Information to its Bbusiness Aassociates or to the Tri-City Hospital Foundation for the benefit forof TCMCHD fundraising. Such Uuses and Ddisclosures are subject to the minimum necessary standardrequirements.
12. TCHD may not condition Treatment or Payment on a patient's choice with respect to fundraising communications.
TCHD may not condition Treatment or Payment on a patient's choice with respect to fundraising communications.
13. Such-notifications-shall provide a-clear and-conspicuous opportunity to receive any further fundraising-communications-and-shall not cause the individual to incur an undue burden or more than a nominal-cost. After a patient has been made-aware-of the TCMG's Notice of Privacy Practices, the Tri-City Hospital Foundation mayuse or disclose permissible pationt information for its fundraising purposes ( $\$ 164.514$ ). All other pationt information is PH and will not be used or disclosed by the Tri-City Hospital Foundation for its fundraising purposes without first obtaining the patient's written consent and authorization (\$164.514).
TCMC will not make fundraising communications to an individual who has-opted out of such-communication.
14. Patients who desired to opt back in to receive fundraising communications can-omail or call
language in all of its direct solicitation fundraising literature that allows its recipient's to opt out from receiving future direct solicitation fundraising literature.
15. The-Tri-City Hospital Foundation may share pationt information with its business associates provided the-Tri-City Hospital Foundation obtains satisfactory assurances that the business associate will appropriately safeguard the information( $\$ 164.502$ ).

## D. PROCESS:

1. Notice of Privacy Practices
a. TCAGHD's Notice of Privacy Practices shall indicate that TCHDTCMG "may uUse or Ddisclose" a patient's PHI to its $\mathfrak{f F o u n d a t i o n ~ o r ~ b B u s i n e s s ~ A a s s o c i a t e s ~ f o r ~}$ fundraising purposes and that the patient has the right to opt out of receiving such communications.
b. TCHD may not Use or Disclose PHI for fundraising purposes unless the statement required by Section 1.a is included in the Notice of Privacy Practices.
4.2. Use of Permissible Patient Information
12.a. After a patient has been made aware of the TCMC's Notice of Privacy Practices, the TriGity HospitalTCHD Foundation may uUse or Ddisclose ${ }_{\mathrm{p}}$ Permissible p Patient information for its $f$ Fundraising purposes $(\$ 164.514)$.
a-b. Except as provided in this Policy, TCHDUseof PH
a. Before the Foundation can use PHI for its fundraising purposes, the patient must sign the Tri-City Hospital Foundation's Consent For Use-Of Protected Health Information form. $i . \quad$ The Tri-City Hospital Foundation's Consent For Use-Of Protected Health Information form shall read as follows: "I understand that information relating to my medical diagnosis, my nature-of-services, my treatment and the place within the Tri-Gity Medical Center where I have or will receive treatment (if such place identifies the type of treatment I have or will receive) is considered Protected Health Information (PHI) and ordinarily cannot be used for fundraising purposes. I hereby voluntarily give my consent to the Tri-City-Hospital-Foundation to receive and use-such information in order for the Tri-City Hospital Foundation to raise money for the Tri-Gity Medical Center. If I decide I no longer wish to authorize the Tri-City Hospital Foundation to receive and use my Protected Heallh Information for their fundraising purposes, ishall so notify the Tri-City Medical-Center Foundation at 4002 Vista Way, Oceanside, CA 92056 in writing." All-signed Consent For Use Of Protected Health Information forms shall be kept and maintained by the Tri-Gity Hospital Foundation. The Foundation-may not-share Disclose PHPermissible Patient Information to the Tri-City Hospital Foundation or Business Associates with anyoutside ontity-for fundraising purposes without first obtainingunless thea patient's has specifically Aauthorization for such purpose.
c. TCHD and/or the Foundation may use Permissible Patient Information to identify patients for patient testimonials that will be Used and/or Disclosed for Fundraising purposes; however, when doing so, TCHD and/or the Foundation must follow the process for obtaining Authorizations and consents set forth in Section 3.
d. Before contacting patients (current or former) for Fundraising purposes, TCHD and the Foundation shall verify that the individuals they wish to contact have not opted out of Fundraising communications.
e. TCHD and the Foundation shall implement the Minimum Necessary Standard on Fundraising Uses and Disclosures.
f. TCHD and the Foundation must adhere to more restrictive federal and state privacy laws for certain highly sensitive health information (including mental health, substance abuse, HIVIAIDS, psychotherapy notes, abuse and other categories). This means that it may not be possible to Use and Disclose highly sensitive PHI for Fundraising purposes without a patient Authorization or even at all. TCHD Workforce members and the Foundation shall consult the Privacy Officer or Compliance Officer before Using or Disclosing any PHI, including Permissible Patient Information, involving highly sensitive PHI.
g. TCHD and the Foundation may not Use or Disclose Permissible Patient Information (or any patient PHI) with a non-affiliated entity for purposes of that entity's Fundraising (for example where a Medical Staff member specializes in the treatment of a specific disease and a non-profit association fundraises for research related to that specialty).
2. Patient Testimonials Used for Fundraising Purposes.
a. When Using and/or Disclosing a patient's testimonial, including the patient's PHI (e.g. hospital experience, medical treatment), for Fundraising purposes, TCHD and/or the Foundation acting as TCHD's Business Associate must obtain form the patient prior to such Use and/or Disclosure:
i. an Authorization; and
ii. Consents to videotape, photograph and/or publish the patient's testimonial, as appropriate.
b. The Authorization and Consent form shall be obtained regardless of the manner in which TCHD/Foundation learned about the patient's testimonial or whether the patient has consented either verbally or in writing (e.g. e-mail) to such Use/Disclosure.
c. The Authorization must be completed in a manner that adequately describes the categories of PHI being Used/Disclosed and the Purpose of the Use/Disclosure.
d. TCHD and the Foundation shall only Use or Disclose the patient's testimonial (and PHI)
3. Fundraising Notifications
a. Each fundraising notification shall provide the patient with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
b. The method provided to opt out of receiving further fundraising communications shall not result in a patient incurring an undue burden or more than a nominal cost. Tri-City Hospital Foundation permits patients to opt out of future fundraising communications by telephone at (760) 940-3370 or by e-mail at TCHFoundation@temc.com.
c. Any TCHD Workforce member or Business Associate who is advised by a patient of his/her request to opt out of receiving future Fundraising communications, must contact the Foundation to document the request.
4. Patients Who Opt Out
a. Fundraising communications will not be made to patients who have opted out of such communications.
b. Tri-City Hospital Foundation will track opt out notifications to ensure that further fundraising communications are not made to patients who have elected to opt out.
5. Opting Back In.
b-a. Patients who desire to opt back in to receive fundraising communications can do so by sending an e-mail with such request to TCHFoundation@tcmc.com or by opting in at an event or through the Foundation's website.ed release to the ontity.
z.7. Direct Solicitation Fundraising Literature
a. Direct solicitation fundraising literature does not include general marketing communications to donors or prospective donors such as newsletters or other similar general communication media where TCHD does not Disclose patient PHI to Tri-City Hospital Foundation for such purposes. Educational and other events that the Foundation or Medical-Center sponsors, even if those events will contain active-or passive fundraising, are not considered direct selicitations as long as the event is net primarily a fundraising ovent.
b. The following specific opt out language is required to be placed in all of its direct solicitation fundraising literature:
$i$. "Please write to us at our address if you wish to have your name removed from the Hist to receive future fundraising requests supporting Tri-City Modical Conter."
ii. If any person or entity opts out from rocoiving diroct-solicitation fundraising literature or indicates they no longer wish to receive any other literature-sent by the

Tri-City Hospital Foundation, the Tri-City Hospital-Foundation shall make the appropriate arrangements within its mailing database to provent that person or entity from receiving any future literature from the-Tri-City Hospital Foundation.
iii. The Tri-City Hospital Foundation-shall maintain a list of the names, addresses (including e-mail-addresses) and phone numbers of all persons and entities that have-opted out from receiving its direct solicitation fundraising literature or have indicated they no longer wish to receive any other literature sent by the-Tri-Gity Hospital Foundation.
iv. Before any of its literature is sent, the Tri-City Hospital-Foundation shall compare the-proposed distribution list with the list of those persons or ontities that have indicated they no-longer wish to receive -literature from the Tri-Gity Hospitat Foundation, including direct solicitation fundraising literature-and-shall remove from said distribution list any such persons or ontities and/or take any other reasonable-steps to prevent their receipt of Tri-City Hespital-Foundation literature.
38. Business Associates
a. Before the Tri-City Hospital Foundation shares any Permissible Ppatient information with a bBusiness aAssociate, the Tri-City Hospital Foundation shall have the bBusiness aAssociate sign the TCHDMG's Business Associate Agroomentddendum.
b. If the Tri-City Hospital Foundation becomes aware of a material-breach of the Privacy Practices of the-TCAAGHD by a one its bBusiness Aassociates, the Tri-City Hospital Foundation must take the appropriate stops to either correct the breach or end the relationship with the business associateshall immediately notify the Privacy Officer.

## B. ADJUNCT POLICIES:

3. Administrative Policy \#511-Business Associate Agroement
4. Administrative Policy \#518-Notice of Privacy Practices

ᄃ. REFERENCES:

1. 45 Code of Federal Regulations (CFR) Section 164.502
2. Federat-Register 45 CFR Section §164.514(f)
4.3. and §164.502TCHD Notice of Privacy Practices Policy \# 518

Administrative Policy Manual Compliance

ISSUE DATE: 05/2012
REVISION DATE(S):
SUBJECT: Education and Training; Specific Training Programs
POLICY NUMBER: 8750-548
Department Approval Date(s): ..... 11/15
Administrative Policies and Procedures Approval Date(s): ..... 11/15
Audit, Compliance and Ethics Committee Approval Date(s): ..... 01/16
Board of Directors Approval Date(s): ..... 05/12
A. PURPOSE:

1. Policy $8750-548$ provides (1)To provide a statement of the District's-Tri-City Healthcare District(TCHD) policies regarding the provision of specific education and training programs foremployees (and certain directors and Covered Contractors, as appropriate) related to theDistrict's-TCHD's Compliance Program.
B. SCHEDULE:
a. Annually, the DistrictTCHD shall provide specific compliance education and training programs ("Specific Training Programs") for DistrietTCHD employees who work in risk areas designated by the Chief Compliance Officer per Administrative Policy 8750-564 Development and Revision of Code of Conduct and Policies.
b. New hires for whom applicable annual Specific Training Programs will not occur within 30 days of their date of hire, shall receive as-needed compliance education and training pursuant to Administrative Policy 8750-549 Education and Training; As-Needed Education and Training.

## C. PARTICIPATION:

a. All District TCHD employees who work in designated risk areas are required to participate in applicable Specific Training Programs. Participation shall be documented, and will be a critical employee performance evaluation factor. Failure to participate will result in corrective and/or disciplinary action.
b. The Chief Compliance Officer shall determine whether and, if so, which Covered Contractors must participate in Specific Training Programs.
c. The Chief Compliance Officer shall recommend Specific Training Programs to Members of the Board of Directors.
D. DELIVERY:

1. Specific Training Programs may be presented in any manner the Chief Compliance Officer determines to be effective. This may include, for example, in-person training, video conference training, computerized training or telephone conference training.
E. CONTENT DEVELOPMENT, IMPLEMENTATION AND REVIEW:
a. The Chief Compliance Officer, with the assistance of the Organizational Compliance Committee and/or legal counsel (as appropriate), shall be responsible for developing, implementing, regularly reviewing (at least annually) and updating the Specific Training Programs.
b. The Chief Compliance Officer shall be responsible for selecting the topics to be covered by the Specific Training Programs. At a minimum, each program shall include, with
respect to the subject matter area in question, a discussion of (1) applicable Compliance Program Code of Conduct Policies, laws and regulations, and (2) recent legal developments related to hospitals.

## F. DOCUMENTATION:

1. The DistrictTCHD shall maintain, consistent with its document retention policies, the following in the Compliance Program files:
a. All materials used in connection with the Specific Training Programs (e.g., handouts, presentation outlines and videotapes); and
b. Sign-in sheets, attendance charts and/or any other appropriate documents used to reflect and confirm employee participation in the Specific Training Programs.

## G. REFERENCES:

1. Administrative Policy 8750-549 - Education and Training; As-Needed Education and Training
2. Administrative Policy 8750-564 - Development and Revision of Code of Conduct and Policies
ISSUE DATE: 05/12

REVISION DATE(S): 12/12
Department Approval Date(s): $\quad$ 11/15
Administrative Policies and Procedures Approval Date(s): $11 / 15$
Audit, Compliance and Ethics Committee Approval Date(s): 01/16
Board of Directors Approval Date(s): 12/12

## SUBJECT: Education and Training; Compliance Notices/Updates

POLICY NUMBER: 8750-550
A. PURPOSE:

1. This policy provides (1) a statement of the Tri-City Healthcare District's (TCHD) policies regarding the development and distribution of compliance notices and updates.

## B. PREPARATION:

1. The Chief Compliance Officer shall be responsible for developing and distributing Compliance notices and updates. Members of the Internat-Organizational Compliance Committee, as well as any other individuals and departments the Compliance Officer deems appropriate, shall provide assistance.
C. CONTENT:
2. The Compliance notices/updates shall contain, as appropriate, information regarding:
a. TCHD's commitment regarding compliance;
b. Changes to TCHD's Compliance Program;
c. Issues identified by the Chief Compliance Officer and/or the Internat-Organizational Compliance Committee as relevant to highlight or discuss;
d. Recent legal developments related to hospitals;
e. Upcoming compliance training and education programs; and
f. TCHD's compliance resources (e.g., links to the Compliance Program Policies and the number for the Confidential Reporting Line Values Line).
3. The Compliance notices/updates may contain any other information relating to compliance deemed appropriate by the Chief Compliance Officer.
D. FORM:
4. The Compliance Program notices/updates may take any form deemed appropriate by the Chief Compliance Officer.
5. The Compliance Program notices/updates may be included within other regular publications.
E. DISTRIBUTION:
6. The Compliance Program notices/updates shall be published on an as needed basis.
7. The Compliance Program notices/updates shall be distributed to all TCHD employees.
8. The Chief Compliance Officer shall determine whether and, if so, which, Covered Contractors shall receive Compliance Program notices/updates.
9. TCHD may use any appropriate format and distribution method for the Compliance Program notices/updates (e.g., paper, e-mail, intranet).
10. Archived copies of the Compliance Program notices/updates shall be available to employees, upon request.

## F. DOCUMENTATION:

1. TCHD shall maintain copies of all Compliance Program notices/updates consistent with its document retention policies.

# Tri-City Medical Center Oceanside, California <br> Administrative Policy Manual <br> Compliance 

ISSUE DATE: 05/12

## REVISION DATE(S):

Department Approval Date(s): 11/15
Administrative Policies and Procedures Approval Date(s) 11/15
Audit, Compliance and Ethics Committee Approval Date(s): 01/16
Board of Directors Approval Date(s): 05/12

## A. PURPOSE:

1. Policy 8750-551To establishes Tri-City Healthcare District's (TCHD's) commitment to actively monitor and audit its practices to ensure compliance with applicable laws and regulations, the-District's-TCHD's Code of Conduct and its Policies and Procedures.
B. INTRODUCTION:
2. Tri-City Healtheare DistrietTCHD recognizes that ongoing monitoring and auditing are critical components of a successful Compliance Program, enabling the organization to ensure that its practices are consistent with its stated Policies and Procedures. As such, Tri-GityTCHD has developed a multi-faceted approach to ensuring ongoing compliance, which includes day-to-day monitoring, and conducting regular compliance reviews, periodic audits (both upfrontprospective and retrospective), and exit interviews of departing employees and contractors. The District'sTCHD's Policies regarding monitoring and auditing are set forth in Administrative Policy 8750-552 - Monitoring Compliance Auditing \& Reporting - Annual Compliance Workplan; Administrative Policy 8750-553 - Monitoring Compliance - Auditing and Reporting - Compliance Reviews and Audits and Administrative Policy through 8750-554 Monitoring Compliance Auditing and Reporting -Exit Interviews.
C. QUESTIONSRELATING TOMONITORINGCOMPLIANCE:
3. Any questions about Administrative Policies 8750-552 through 8750-554 shall be directed to the Chief Compliance Officer.
D. AUDITANDDOCUMENTATION:
4. The DistrietTCHD shall audit and document compliance with Administrative Policies 8750-552 through 8750-554. Relevant documentation shall be maintained in the Distriet'sTCHD's compliance files, consistent with the-Distriet'sTCHD's document retention policies.
E. REFERENCES:
5. Administrative Policy 8750-552 - Monitoring Compliance Auditing \& Reporting - Annual Compliance Workplan
6. Administrative Policy 8750-553 - Monitoring Compliance Auditing \& Reporting Compliance Reviews and Audits
7. Administrative Policy 8750-554 - Monitoring Compliance Auditing \& Reporting - Exit Interviews

# Tri-City Medical Center <br> Oceanside, California 

Administrative Policy Manual Compliance

ISSUE DATE: 05/12

## SUBJECT: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities

## REVISION DATE:

POLICY NUMBER: 8750-556
Department Approval Date(s) 11/15
Administrative Policies \& Procedure Committee Approval Date(s): $11 / 15$
Audit, Compliance and Ethics Committee Approval Date(s): 06/15
Board of Directors Approval Date(s): 06/15
A. PURPOSE:

1. To setThis Policy-sets forth the commitment of Tri-City Healthcare District (TCHD) to develop and foster a culture of open communication regarding Compliance Program matters so that questions are freely asked and suspected misconduct and irregularities are reported.
B. POLICY:
2. TCHD shall develop and maintain open lines of communication regarding Compliance Program matters in an effort to prevent and detect violations of applicable laws and regulations, the Code of Conduct and the Compliance Program Policies and Procedures. Such communication shall occur without fear of retribution or retaliation. It also can be made on an anonymous basis.
3. TCHD employees have a duty to report suspected misconduct or other activity that the employee in good faith believes violates or may violate any laws, regulations, Bistrict TCHD Policies and Procedures or the TCHD Code of Conduct.
C. PROCEDURE FOR REPORTING SUSPECTED MISCONDUCT AND FOLLOW-UP ACTIONS:
4. Reporting Required:
a. TCHD employees shall report any suspected misconduct or any other activity, practice or arrangement that the employee in good faith believes violates or may violate any laws, regulations, Bistriet TCHD Policies and Procedures or its Code of Conduct.
5. To Whom.
a. Reporting of potential compliance irregularities must be made to the employee's direct supervisor or the Chief Compliance Officer or the Values Line.
b. Reporting of suspected employee misconduct should be reported to the employee's direct supervisor, Human Resources, or the Values Line.
D. FORM OF REPORT - PROCEDURE.
6. Reports of suspected misconduct or potential irregularity may be made either in writing or orally.
7. Written reports include reports made via regular mail or email. Such reports should be sent addressed to the Chief Compliance Officer at Tri-City Healthcare District, 4002 Vista Way, Oceanside, CA 92056, or to the employee's supervisor.
8. Oral reports include reports made in-person or via telephone. Oral reports may be made to District's-TCHD's Confidential Reporting Line (Values Line) at 1-800-273-8752. The confidential Reporting Line is operated by an independent third party and shall be available 24 hours per day, 7 days per week. Employees do not need to provide their names when making a report, although they are encouraged to do so to facilitate any appropriate or necessary follow up. An interview specialist will log the employees concern and assign a reference number. If the employee calls back and provides the reference number, he or she will be able to obtain an update on the status of the matter.
9. Anonymity. Reports, whether written or oral, may be made anonymously.

However, employees are encouraged to identify themselves when reporting, as it often is easier to assess the issues or concerns raised in a report when there is the ability to ask the reporting employee follow-up questions.
5. Chief Compliance Officer Actions:
a. The Chief Compliance Officer shall document follow-up action taken as a result of any written or oral reports.
b. The Chief Compliance Oefficer shall keep confidential (to the extent possible)the identity of the person(s) who report suspected misconduct.
c. The Chief Compliance Oefficer shall provide to the Chief Executive Officer (CEO), Audit, Compliance and Ethics Committee and the Board of Directors (BOD), as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.
d. The Chief Compliance Officer shall make available every report of suspected misconduct to any independent review team charged with conducting annual Compliance Reviews. An Independent review teamt shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the Compliance Officer and the CEO

## E. DOCUMENTATION:

1. The Chief Compliance Officer shall maintain, in appropriately designated Compliance Program files, copies of any written reports submitted pursuant to Policy 8750-556.
2. The Chief Compliance Officer shall document any oral reports submitted pursuant to Policy 8750-556 and shall maintain such documentation in the Compliance Program files.
3. The Chief Compliance Officer shall maintain copies of all reports submitted to the Confidential Reporting Line (Values Line) in the Compliance Program files.
4. In conformity with generally accepted compliance review procedures, final copies of work papers, notes and other documentation generated in connection with every written or oral report shall be maintained in the Compliance Program files.
5. The Chief Compliance Officer shall document follow-up action taken as a result of any written or oral reports and shall maintain such documentation in the Compliance Program files.
6. The Chief Compliance Officer shall keep confidential (to the extent possible) the identity of the person(s) who reports suspected misconduct.
7. The Chief Compliance Officer shall provide to the CEO and the BoardBOD, as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.
8. The Chief Compliance Officer shall make available every report of suspected misconduct to any independent review team charged with conducting Annual Compliance Reviews. An independent review team shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the Chief Compliance Officer and the CEO.
9. All documentation enumerated above shall be maintained consistent with the District's-TCHD's document retention policies.

## F. QUESTIONS RELATING TO MONITORING COMPLIANCE:

1. Any questions about Administrative Policyies 8750-556 - Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities and 8750-557 - Communicating and Reporting Compliance Concerns (Values Line) should be directed to the Chief Compliance Officer.
G. AUDIT AND DOCUMENTATION:
2. TCHD shall audit and document compliance with Administrative Policies 8750-556 and 8750-557, pursuant to Administrative Policy 8750-553 - Monitoring Compliance Auditing and Reporting - Compliance Reviews and Audits. Relevant documentation shall be maintained in the District's-TCHD's compliance files, consistent with the Bistrict's-TCHD's document retention policies.

## H. RELATED DOCUMENTS:

1. Administrative Policy 8750-553 Monitoring Compliance Auditing and Reporting Compliance Reviews and Audits
2. Administrative Policy 8750-556 Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities
3. Administrative Policy 8750-557 Communicating and Reporting Compliance Concerns (Values Line)
4. Board of Directors Policy \#14-008 - Records Retention and Destruction

ISSUE DATE: $11 / 02$
REVISION DATE: 05/03; 04/06; 01/11; 07/11; 04/12 09/15

## SUBJECT: CONTRACT REVIEW

POLICY NUMBER: 8610-278

Administrative Policies \& Procedures Committee Approval:
Audit, Compliance and Ethics Committee
Finance-\&-Operations-Committee-Approval:
Board of Directors Approval:

05/1512/15
01/16
09/15
09/15
A. PURPOSE:

1. To ensure all agreements executed by or on behalf of Tri-City Healthcare District or its operating units ("TCHD") have received appropriate administrative review and approval, are legally sufficient, minimize risk to TCHD and comply with legal, accreditation and TCHD requirements.
B. DEFINITION(S):
2. Clinical - to meet the intent of the contract that will require a direct patient interface (for example Physician Contracts, AlarisInfusion Pumps and Operating Room Equipment).
3. Non-Clinical - the intent of the contract is for supportive services to the organization not requiring a patient interaction (for example Coder Contract, maintenance contracts, or legal agreements)
4. Other - the intent of the information is any miscellaneous documents that do not include clinical or non-clinical information (for example Regulatory agreements, Real Estate Leases, Certificates, Non-Disclosure Agreements). Includes Confidentiality Agreements signed by physicians for trade secrets.
4.4. Protected Health Information (PHI) - individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
b. Relates to the provision of health care to an individual; OR
c. Relates to the past, present, or future payment, AND
d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
Z.5. Business Associate Agreement (BAA) - is considered a contract with PHI.
B.C. POLICY:
5. Contracts shall be categorized into:
a. Clinical with or without PHI
b. Non-clinical with or without PHI
c. Other with or without PHI
d. BAA with PHI
6. The Governing Body is responsible for all services covered under contracts at Tri-City Healthcare District (TCHD).
a. All contracts shall be assessed through the following committees to identify quality and performance problems, implement appropriate corrective or improvement activities and ensure monitoring and sustainability of those corrective actions or improvement activities.
4-i. The Organizational Compliance Committee will review all contracts initially

## and upon renewal.

ii. The Medical Executive Committee will review all Clinical contracts.
iii. The Audit, Compliance and Ethics Committee will review the Non-clinical, Other and BAA contracts.
2.3. All personnel associated with contracted services will adhere to Hospital Orientation for Non-Employees of Tri-City Healthcare District (Administrative Policy - Human Resources \#8610-451 - Non-TTCHD Worker's Orientation and Identification Badge Process, NonEmployees).
3.4. General Policy. Agreements between TCHD and other parties must be in writing, submitted by the contract requestor for appropriate administrative and/or legal review and approval and signed by the CEO or his/her authorized designee as set forth in Administrative Policy \#8610-232, Signature Authority.
4.5. Competitive Bidding and Other Procurement Procedures. TCHD has adopted policies and procedures, including competitive bidding regulations, governing the purchase of materials, supplies, equipment, services including professional services and public works, as set forth in Board Policy \#1013-013. Contract requestors must comply with TCHD procurement policies and procedures, including competitive bidding requirements when applicable, as set forth in Board Policy \#1013-013.
5.6. Fair Market Value. Compensation under an agreement, and any changes in compensation, shall compensate the contractor for the services under the agreement for the reasonable fair market value of such services.
6.7. TCHD Standard Form Agreements. A contractor must utilize TCHD standard form agreements when possible. The list of TCHD standard form agreements is attached as Exhibit A, and such lists may be amended periodically by the Contract Manager. The TCHD standard agreements may not be altered, modified, changes or amended, unless the proposed changes are approved by the Contract Manager or the Contract Manager's designee (i.e. Board counsel, or other outside legal counsel retained by TCHD.)
7.8. Legal Review. Review and approval by TCHD's legal counsel ("Legal Counsel") is required for some agreements, based on agreement type and dollar amount as set forth below.
8.9. Agreements with Physicians. All agreements between TCHD and a referring physician (and/or physician's immediate family members) require review and approval by Legal Counsel to ensure compliance with the federal Stark and Anti-kickback statutes and similar California laws_unless conforming fully to an approved form agreement. Agreements with physicians also must be approved or ratified as provided in Administrative Policy \#8610-232, Signature Authority.
9.10. Independent Contractor and Consulting Services Agreements - All consulting services agreements must be approved by the CEO and comply with IRS guidelines with respect to the status of independent contractors. All Consulting Services Agreements shall be reviewed in accordance with B.9, B. 10 and B. 11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.
10-11. Materials, Supply and Equipment. All requests to purchase or lease materials, items, equipment and supplies must be submitted by the contract requestor to Supply Chain Management. Supply Chain Management may use form agreements, or the vendor's terms and conditions, if they terms comply with the Contract Term. Supply Chain Management will submit all equipment lease requests to Finance to ensure appropriate accounting treatment of capital and/or operating leases. All materials, supplies and equipment agreements shall be reviewed in accordance with B.9, B. 10 and B. 11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.
11-12. Real Property Agreements. All requests to enter Real Property Agreements, whether via lease, acquisition, broker, or otherwise, must be submitted to the Contract Manager. The Contract Manager shall then forward the request to Legal Counsel for review and approval. All Real Property Agreements, regardless of the amount of the expenditure, shall be reviewed and approved by Legal Counsel. The contract requestor also must submit the proposal to Finance to ensure appropriate accounting treatment of capital and/or operating leases.
12.13. Agreements involving expenditures less than $\$ 25,001$. Unless otherwise expressly provided in
this policy, the responsible C-Level Executive, as set forth in Administrative Policy \#8610-232 Signature Authority, may approve the language in non-standard agreements without review by Legal Counsel, so long as the material terms comply with the Contract Check-List, as may be amended from time-to-time by Legal Counsel.
13.14. Agreements involving expenditures between $\$ 25,001$ and $\$ 100,000$. Unless otherwise expressly provided in this policy, the Contracts Manager may approve the language in non-standard agreements and/or modifications to TCHD standard form agreements that comply with the Contract Check-List or other contracting guidelines developed by Legal Counsel.
14.15. Agreements involving an expenditure in excess of $\$ 100,000$. Unless otherwise expressly provided in this policy, all agreements involving an expenditure in excess of $\$ 100,000$ shall be reviewed and approved by Legal Counsel.
G.D. PROCEDURE:

1. Contract Review and Approval. The contract review and approval process shall comply with this policy, Board Policy \#013. .
2. Procedure for Legal Review. If legal review will beis required, the contract requestor shall submit a request for legal review to TCHD's Contract Manager. The Contract Manager will then forward the request to Legal Counsel.
3. Contract Execution. The contract requestor is responsible for obtaining all appropriate signatures for approved contracts in accordance with Administrative Policy \#8610-232 Signature Authority.
4. Electronic Signatures. Contracts may be accepted in electronic form (e.g., by scanned copy of a signed document, or with an electronic or digital signature) provided that:
a. A copy of the signature is on file with the Contract Manager so that it can be determined the person to which electronic signature is attributable and
b. The contract includes a provision pursuant to which the parties agree that
i. An electronic signature by either party shall be deemed binding on that party.
ii. The parties will not contest the validity or enforceability of the contract, including under any applicable stature of frauds, because it was accepted or signed in electronic form, and
iii. The parties will not contest the validity or enforceability of a signed facsimile copy of the contact on the basis that it lacks original handwritten signature.
5. Contract Management System Compliance. All duly approved and fully executed contracts must be scanned into TCHD's contract management system, as soon as reasonably practicable following the execution of the contract, as failure to do so may result in delays in the payment process. The contract requestor shall be responsible to confirm with the Contract Manager that the executed contract has been scanned into TCHD's contract management system.
6. Approval of Invoices. The contract requestor and/or a TCHD-authorized approver will also be responsible for approving any invoices as valid and consistent with the approved contract before Accounts Payable can pay the invoice.
7. Monitoring Contract Renewal and Termination. The contract requestor for each contract as noted in TCHD's contract management system shall monitor timelines for the renewals and/or terminations of their contracts, and shall notify the Contract Manager when any change in contract terms are required.

## E. PROHIBITED CONFLICTS OF INTEREST:

D.1. Any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration are prohibited. No employee may participate in the contract process, including but not limited to the bid or other procurement process, contractor selection, negotiation, review or approval of a contract, when the employee has a relationship with a person or business entity seeking the contract that requires disqualification of the employee under the Political Reform Act or other provisions of law.

## F. COMPLIANCE WITH POLICY:

E.1. -It is the responsibility of the TCHD manager, director or other executive or employee requesting
a contract to ensure compliance with Board Policy \#130-013, the contract approval process as stated in this policy and the TCHD Handbook for Contracting, and to ensure that a fully executed agreement is obtained prior to initiating any contracted service or payment for such service.
F.G. RELATED DOCUMENTS-REFERENGED IN THS-POLICY AND LOGATED-ON THE TGHD INTRANEF:

1. Contract Categories
1.2. Contract Request Form (CRF) - for contracts greater than $\$ 25,000$
2.3. Contract Legal Terms Checklist - for contracts less than $\$ 25,0004$
H. REFERENCES:
2. Administrative Policy \#8610-232, Signature Authority
3. Administrative Policy - Human Resources \#8610-451 - Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees
4. Board of Directors Policy 13-013 - Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts
5. CMS HesptialHospital Conditions of Participation and Interpretive Guidelines, Contracted Services 482.12 (e )(1), 482.12 (e) (2)

The following is a list of types of Standard Form Agreements available from Clinical Trial Agreements (device and drug)
a. Co-Management Agreement
b. Confidentiality Agreement
c. Education Affiliation Agreements
d. Group Purchasing Organization ("GPO")_Agreements are deemed to comply with TCHD requirements when reviewed and completed by the Director of Supply Chain Management in compliance with Contract Check-list
e. Independent Contractor/Consulting Services Agreement [Non-Physician]
f. Joint Marketing Agreements
g. HIPAA Business Associate and Addendum
h. Hospice Services Agreement
i. Medical Office Lease and Sublease
j. Patient Transfer Agreement
k. Physician Agreements
i. Medical Director Agreement
ii. Medical Staff Leadership Agreement
iii. On-Call Coverage Agreement and Guidelines
iv. Physician Consulting Services Agreement
v. Physician Recruitment Agreement and associated forms.
I. Professional Services Agreement [Non-Physician]
m. Purchase Order Terms and Conditions
n. Registry Agreement
o. Request for Bids and associated forms for public works projects
p. Secured Promissory Note
q. Security Agreement
r. Travel Agency Agreement

# TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A REGULAR MEETING OF THE BOARD OF DIRECTORS 

> December 10, $2015-1: 30$ 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 December 10, 2015.

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
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.
2. Approval of Agenda

It was moved by Director Finnila to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed unanimously (7-0).
3. Public Comments - Announcement

Chairman Schallock read the Public Comments section listed on the December 10, 2015 Regular Board of Directors Meeting Agenda.

There were no public comments.
4. Oral Announcement of Items to be discussed during Closed Session

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the December 10, 2015 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; Conference with Legal Counsel regarding four matters of Potential Litigation; one report of Trade Secret, Conference with Legal Counsel regarding five matters of Existing Litigation and Approval of Closed Session Minutes.
5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into closed session. The motion passed unanimously (7-0).
6. The Board adjourned to Closed Session at 1:35 p.m.
8. At 3:40 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock 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
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent
9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.
10. Director Finnila led the Pledge of Allegiance.
11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Chairman Schallock asked that speakers be concise and adhere to the three-minute rule.
12. Community Update - None
13. Report from TCHD Auxiliary - Sandy Tucker, President

Ms. Sandy Tucker, TCHD Auxiliary President gave a brief report, highlighting the following:
$>$ As of the end of November, the Auxilians have volunteered 70,428 hours;
$>$ The Medical Center's Donor Committee, the Eye Bank and Life Sharing decorated the tree in the lobby in honor of the 2015 organ, eye and tissue donors at Tri-City Medical Center with each pink ornament representing a donor;
> The Busy Needles Ladies of La Costa Glen Retirement Community knitted 150 Christmas hats for our babies here at Tri-City. The total number of hats and blankets for this year total over 2,000;
> The Annual Cookie Extravaganza raised approximately $\$ 1,800$ which will benefit JV scholarship recipients;
> 50 Christmas Stockings were delivered to the Labor \& Delivery Department by the Workshop volunteers; and
$>$ The Auxiliary has donated $\$ 44,000$ for four Vein Finders for our nurses.
Director Finnila commented that our Tri-City Gift Shop is a great place to do some holiday shopping!

No action was taken.

## 14. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer reported we are moving forward with the Board's decision to affiliate with UC San Diego Health System and we will be signing the final affiliation agreement shortly. Mr. Moran explained our affiliation involves working together with UCSD along a number of fronts that will put us in a better position to serve our community. He stated one of the key elements of our affiliation is UCSD's desire to lease $1 / 3$ of our Medical Office Building and we are actively working on negotiating that lease. Secondly, related to our physician needs to serve the community we have approximately 35 physicians that we hope will join the TriCity Medical Staff over the next 2-3 years that span across a number of specialties. Mr. Moran stated immediate areas of focus will include Cardiovascular Services, Neurosurgery and Acute Rehab. Lastly, Mr. Moran commented on a series of joint breakfast community meetings to talk to people in the community about the affiliation and get feedback from the community as well.

Mr. Moran reported we opened escrow today for the sale of our Rady's Building in the amount of $\$ 3$ million dollars.

No action was taken.
15. Report from Chief Financial Officer

Mr. Steve Dietlin reported on the first four months of FY 2016 ending October 31, 2015 as follows:

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> Net Operating Revenue - \$111,628
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$>$ Operating Expense - \$111,818
$>$ EROE - $\$ 1,467$
$>$ EBITDA - \$6,231
Other Key Indicators for the current year driving those results included the following:

- Average Daily Census - 189
> Adjusted Patient Days - 37,674
$>$ Surgery Cases - 2,232
$>$ Deliveries - 908
$>$ ED visits $-22,490$
Mr . Dietlin also reported on the current month as follows:
$>$ Operating Revenue - $\$ 27,720$
> Operating Expense - \$28,396
$>$ EBITDA - \$1,011
$>$ EROE - $(\$ 189)$
Mr . Dietlin reported on the following indicators for FY16 Average:
$>$ Net Patient Accounts Receivable - $\$ 40.6$
$>$ Days in Net Accounts Receivable -45.8
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.

No action was taken.
16. New Business
a. Consideration and possible action to elect Board of Director Officers for calendar year 2016.

Chairman Schallock explained Directors may nominate individual Directors or a slate of Officers and the motion does not require a second.

Director Nygaard nominated the following slate of officers:
> Chairperson - Director James Dagostino
> Vice Chairperson - Director Cyril F. Kellett, M.D.
> Secretary - Director Ramona Finnila
> Treasurer - Director RoseMarie V. Reno
> Assistant Secretary - Director Laura E. Mitchell
> Assistant Treasurer - Director Julie Nygaard
> Board Member - Director Larry W. Schallock
Hearing no other nominations, the vote on the motion was follows:

AYES: Directors: Dagostino, Finnila, Kellett, Mitchell, Nygaard, Schallock
NOES: Directors: Reno
ABSTAIN: Directors: None
ABSENT: Directors: None
b. Consideration to appoint Ms. Kathy Mendez to an additional two-year term on the Finance, Operations \& Planning Committee as recommended by the committee.

It was moved by Director Dagostino to appoint Ms. Kathy Mendez to an additional two-year term on the Finance, Operations \& Planning Committee as recommended by the committee. Director Kellett seconded the motion.

Director Dagostino stated Ms. Mendez was unable to attend today's meeting however the committee unanimously supports her reappointment.

The vote on the motion was as follows:

| AYES: | Directors: | Dagostino, Kellett, Mitchell, Nygaard, Reno <br> and Schallock |
| :--- | :--- | :--- |
| NOES: | Directors: | Finnila |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | None |

c. Campus Development Plan

Presentation by Philip Soule, Cunningham Group Architecture, Inc.
Mr. Tim Moran reported the Board has authorized moving forward with the Campus Development Plan and we have engaged the Cunningham Group and McCarthy to assist us in that process. Mr. Moran stated the vision by our architects is a frugal vision that provides what the community needs and what we can afford.

Mr. Moran introduced Mr. Philip Soule and invited him to present some design concept boards to provide a visual of our future campus. Mr. Soule explained we are focusing on the needs that are highest which include our Emergency Department and parking. The new Emergency Department will have $58-60$ beds and will segregate certain populations and provide an environment that is more appealing. He noted the importance of creating good clinical functionality with this design to tie into the other services on the campus.

Mr. Wayne Hunter, also with the Huntington Group commented that the design build approach we are using allows us to manage costs as we work on implementation. He explained the biggest change we are looking at is flipping the entire orientation of the hospital to the west side of the campus which will make access more convenient for the consumer.

Mr. Robert Betz, EVP with McCarthy discussed the first phase of the project which includes a parking structure that will provide spaces for 480-500 vehicles, with a bridge to the Emergency Department and the Medical Office Building. He stated the first phase, with a budget of $\$ 150$ million is doable and economical without disrupting ongoing operations. In response to a question related to meeting space, Mr . Betz stated the roof area may be utilized for conference room, eating space, etc.

It was suggested that the design display boards be labeled draft and set up in the Cafeteria and Lobby which will generate interest and excitement in our Campus Development Plan.

Director Reno suggested the proceeds from the Rady Building sale be earmarked for our Campus Development Plan.

Directors asked several questions related to financing.
Mr. Steve Dietlin, CFO commented on the timeline for HUD financing, noting the entire process can take anywhere from 9-12 months, however we have begun the process with our preapplication. Mr. Dietlin also commented on other potential financing. He emphasized that future financing is based on our past and current financial performance.

No action taken.
17. Old Business - None
18. Chief of Staff
a. Consideration of November 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 23, 2015.

It was moved by Director Nygaard to approve the November 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 23, 2015. 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 November 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 23, 2015.

It was moved by Director Dagostino to approve the November 2015
Recredentialing Actions involving the Medical Staff as recommended by
the Medical Executive Committee at their meeting on November 23, 2015. Director Kellett 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
19. Consent Calendar

It was moved by Director Dagostino to approve the Consent Calendar. Director Kellett 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
It was moved by Director Dagostino to pull item 19 (1) E. Professional Affairs Committee minutes. Director Kellett seconded the motion

The vote on the main motion minus the item pulled was as follows:

| AYES: | Directors: | Dagostino, Finnila, Kellett, Mitchell, Nygaard, <br> Reno and Schallock |
| :--- | :--- | :--- |
| NOES: | Directors: | None |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | None |

20. Discussion of items pulled from Consent Agenda

Director Dagostino who pulled item 19 (1) E. Professional Affairs Committee minutes commented that at the Board's recent Workshop/Annual Assessment Board Members recognized that we process a voluminous amount of information each month, spending more time on these tasks than other Districts and perhaps not as much time preparing for the future. As a result, the Board is looking seriously at streamlining their workload and devoting more time to strategic planning.

Director Reno questioned if this topic would be discussed further at a Board educational workshop. Chairman Schallock stated as discussed at the Board's Workshop the Professional Affairs Committee was spending an inordinate amount of time revising policies and although the committee feels there is value in that review, General Counsel is evaluating if statutes require that the Board review all policies.
21. Reports (Discussion by exception only)

Director Mitchell reported that through her attendance at the recent Compliance Seminar she has a better understanding of the revenue cycle and believes that knowledge enhances her participation on the Audit, Compliance \& Ethics committee. In addition, Director Mitchell reported she passed the Compliance Certification exam.

Chairman Schallock reported he attended the CHA Governance Forum this past week and will submit a written report at the January meeting. He gave a brief verbal report on the Forum stating the committee discussed the closure of Southern Mono Inyo Health Care District in Lone Pine due to bankruptcy and medical care will be in Ridgecrest or Bishop, both approximately 100 miles away in either direction. Secondly, he reported San Clemente Hospital continues to be targeted for closure. A trial free-standing ER is proposed however there is opposition from ER physician groups.

Chairman Schallock stated there was a strong focus on quality of care at the Forum. He stated a volunteer organization is interested in e-mail addresses of Board members and if there is no objection we will forward the organization Board member e-mails where applicable.

Secondly, the Hospital Quality Institute holds their annual meeting each fall and historically has not been well attended by Board members in the past. The organization has expressed a willingness to meet with Board members at their convenience to discuss their role. Chairman Schallock suggested the possibility of setting up a joint meeting with Palomar Board members in the spring in North San Diego County.

Chairman Schallock stated there was also discussion at the meeting regarding the increased usage of board portals for providing information to Board members. He suggested that our new Board Chair consider appointing an Ad Hoc Committee to look at various examples and bring a recommendation to the Board.

Lastly, Chairman Schallock stated that after several years, this meeting was his last on the CHA Governance Forum committee although CHA has suggested that he consider continuing on in some sort of volunteer role.
22. Legislative Update

Chairman Schallock reported AB1300 will update parts of the " 5150 " holds for mental health patients and is significantly narrowed from last year's bill to focus solely on the Emergency Room area. He explained ER physicians would be allowed to place and remove holds and there would be immunity to ER physicians as well as ambulance drivers and paramedics. He noted there is opposition to the bill from NAMI as transitional housing is not addressed.
23. Comments by members of the Public

There were no comments by members of the public.
24. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.
25. Board Communications

Director Nygaard reported ACHD will be working on legislation for Design Build for the entire State of California public agencies. She stated that she, along with Director Dagostino will be meeting with Senator Pat Bates in support of this legislation.

Director Nygaard stated she would like to publicly thank Chairman Schallock for his time and service and stated he has truly done a "yeoman's job".

Director Nygaard also expressed her appreciation to the employees and volunteers for their hard work this past year. She stated she believes we have come a long way and are headed in the right direction.

Lastly, Director Nygaard wished everyone a very Merry Christmas and a Happy New Year.

Director Mitchell expressed her appreciation to employees and staff for all their hard work this past year. Director Mitchell also thanked Chairman Schallock for his leadership.

Director Reno expressed her appreciation to Chairman Schallock as well as all the employees, physicians and Allied Health staff for their hard work this past year.

Director Reno wished everyone a Merry Christmas and happy holidays.
Director Kelly wished everyone a Merry Christmas and a Happy New Year!
Director Finnila commented on the importance of employees receiving accurate information to their questions and concerns and encouraged them to ask questions of Board members directly to ensure the information they receive is accurate.

Director Finnila expressed her appreciation to our employees who give virtually 100\% all of the time.

Lastly, Director Finnila wished everyone a Happy New Year.
Director Dagostino shared some touching comments from a patient. He stated the letter received by the Board shined on five of our staff members along with Dr. Frank Corona. He further stated that the letter brings comfort as it demonstrates the values and the mission that drove to the building of this institution. Director Dagostino stated that he is proud to sit here and be reminded that Tri-City delivers what it promised back in 1961 -- a healthcare system operated by the community to take care of the community by professionals who live the community. Lastly Director Dagostino noted as a gesture in the spirit of the holiday season the patient also gave a generous donation.

Director Dagostino wished everyone happy holidays.
26. Report from Chairperson

Chairman Schallock commented on the Turkey Trot and recognized Ms. Sharon Schultz as a new finisher in the 3.1 mile walk.

Chairman Schallock expressed his appreciation to Ms. Donnellan for her support during his tenure as Chair. He also commented on the fact that Ms. Donnellan recently celebrated her $20^{\text {th }}$ year as a Tri-City employee.

Chairman Schallock also expressed his appreciation to his fellow Board members for their time and assistance over the past years. He stated the Guiding Light is the new partnership with UCSD as well as the potential for a new updated facility through our Campus Development Plan. Chairman Schallock stated these things have been accomplished through our team and he appreciates all that everyone has done to move us forward.

Lastly, Chairman Schallock wished everyone Happy Holidays.
27. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business
28. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 4:50 p.m.
29. Open Session

At 5:44 p.m. Chairman Schallock 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 Schallock reported no action was taken in closed session.
31. There being no further business Chairman Schallock adjourned the meeting at $5: 45$ p.m.

ATTEST:
Larry Schallock, Chairman

Ramona Finnila, Secretary

# TRI-CITY HEALTHCARE DISTRICT <br> MINUTES FOR A SPECIAL MEETING OF THE BOARD OF DIRECTORS 

January 7, 2016-10:00 o'clock a.m. Assembly Rooms 2\&3 - Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on January 7, 2016.

The following Directors constituting a quorum of the Board of Directors were present:
Director James J. Dagostino, PT, DPT
Director Ramona Finnila
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Cyril F. Kellett, MD was absent.
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 10:00 a.m. in Assembly Rooms 2\&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

It was moved by Director Reno and seconded by Director Nygaard to approve the agenda as presented. The motion passed unanimously (7-0-1) with Director Kellett absent.

Director Reno requested an item be added to the Closed Session, Hearings on Reports of the Hospital Medical, Audit or Quality Assurance Committees. Mr. Moser stated the Brown Act prohibits adding items to Special Meeting agendas, however, if the item is relative to the Hearings on Reports of the Hospital Medical, Audit or Quality Assurance Committees agenda item that is currently listed it would be permissible to discuss the item at that time.
3. Public Comments - Announcement

Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

## 4. Open Session

(a) Consideration to approve Resolution No. 776, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Application for Federal Funding under FTA Section 5310 (49 U.S.C. Section 5310) with California Department of Transportation and Delegating Authority for Title VI Compliance Program

It was moved by Director Nygaard to approve Resolution No 776, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Application for Federal Funding under FTA Section 5310 (49 U.S. C. Section 5310) with California Department of Transportation and Delegating Authority for Title VI Compliance Program. Director Reno seconded the motion.

Ms. Cheryle Bernard-Shaw, CCO explained this Resolution authorizes the CEO to act on behalf of the Board to transact business as it relates to our grant application under Title VI. She further explained that these are essentially generic duties related to making sure the grant is processed correctly and follow-up is done in acquiring the vans from CalTrans.

Chairman Dagostino referred the Board to the CalTrans Division of Mass Transportation Title VI Program Plan distributed at the Dais.

Directors requested additional background information related to the grant. Mr. Kapua Conley stated the intent is to replace two vans that we currently have with the vans acquired from CalTrans at no additional cost to the District. He explained repairs are not included nor is there a warranty on the vans.

The vote on the motion was as follows:
AYES: Directors: Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock
NOES: Directors: None
ABSTAIN: Directors: None ABSENT: Directors: Kellett
(b) Consideration of Grant Guideline Processes

Director Nygaard reported as Chairperson of the CHAC Committee she requested that the Chief Compliance Officer (CCO) review our Grant Guideline process and provide recommendations. In addition to the CCO's recommendations, Director Nygaard stated there are issues she would like feedback on from Board members.

Director Nygaard stated a major change and improvement in this year's grant process is to not accept grants unless they are filed electronically. She explained that our Web Specialist, Mr. Brian Greenwald has developed an electronic application that will alleviate a significant number of issues we had in the past. She invited Mr. Greenwald to demonstrate the on-line application process.

Mr. Greenwald explained by moving to a digital copy all applicants must answer the same questions and provide the same documentation (photos and additional material will not be accepted in fairness to all applicants). He stated applicants will have a secure log in and password. Mr. Greenwald stated a mandatory forum has been scheduled for Monday, January $11^{\text {th }}$ for all interested applicants that will review the application process and answer any questions. Discussion was held regarding the process that will be followed to ensure applicants are notified of any problems in their application. Mr. Greenwald explained all fields in the application must be filled in or the application will not be submitted successfully, similarly to other web based applications.

Secondly, Director Nygaard asked the Board's opinion on a three year time limit for applicants to submit the same grant. She stated the idea is to help organizations get started and enrich the community with our grant funds. She clarified the same organization can submit a different grant just not the exact grant as the three previous years. It was suggested a two-year limit rather than three due to the large volume of organizations in the community that would like to apply for a grant. Director Nygaard also noted grant funds not used in the current year should be rolled over to the following year.

Director Reno provided background information on the Grant process that began in the latter 1990's.

With regard to the evaluation process for grantees, Director Nygaard explained applicants must submit an evaluation for any grant received the prior year before they can apply for a new grant.

Director Nygaard stated that another important issue that the CCO addressed is the two Federally Qualified Health Centers (FQHCs) (Community Clinics). Mr. Moser stressed the importance of ensuring that we are not duplicating federal funding and we are dealing with referral sources in a consistent way.

Other topics of discussion included whether organizations that fall within the UCSD Health System zip codes would be eligible to apply for a grant and whether organizations that apply for grants should be required to have a relationship that benefits Tri-City Medical Center. It was suggested the focus of grant monies stay within North County.

The membership of the Grant Committee was also discussed and whether the Board should be involved in appointing members to the committee. Mr. Moser noted the Grant Committee is currently set up as a staff appointed committee so that it is not subject to the Brown Act.

Director Nygaard emphasized that other than the electronic filing application we cannot make any changes to the grant process for the current year however changes could be implemented next year if approved by the Board.

Director Nygaard suggested that the questions posed today remain open and be readdressed once the Grant process is completed this year.

No action was taken.
Brian Greenwald left the meeting at 11:00 a.m.
(c) Update on traffic mitigation for Medical Office Building

Mr. Kapua Conley, COO reported bids closed on Monday on the traffic mitigation project. He explained we received only one bid that was not competitive. He requested authorization to rebid the project and come forward next month with a successful bid. Mr . Moser clarified that the Board is being asked to reject the current bid. Directors asked questions that were answered by Mr. Conley.

It was moved by Director Finnila to reject the bid received for the traffic mitigation improvements for the Medical Office Building. Director Nygaard seconded the motion.

The vote on the motion was as follows:

| AYES: | Directors: | Dagostino, Finnila, Mitchell, Nygaard |
| :--- | :--- | :--- |
| NOES: | Directors: | Schallock, Reno |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | Kellett |

(d) Approval of award of contract to construct traffic mitigation improvements for Medical Office Building

The Board rejected the bid as indicated previously.
(e) Consideration to approve proposed pathway for Medical Staff Bylaw Amendments

Chairman Dagostino reviewed the proposed pathway for Medical Staff Bylaw Amendments as described in the document in today's agenda packet. He explained that this process was designed and discussed at the Joint Conference Committee and the Medical Staff is in support of this pathway which allows review and input by the Medical Staff and Board's attorney as well as the Medical Executive Committee prior to coming forward to the Governance \& Legislative Committee. Chairman Dagostino questioned if the Board would consider bypassing the Governance \& Legislative Committee as described in \#7 and bring the Bylaws directly to the Board from the Medical Executive Committee. Directors had extensive discussion regarding the Board's duty to provide oversight and whether the Governance Committee is the appropriate forum to review Medical Staff Bylaws.

## It was moved by Director Finnila to approve the pathway for Medical Staff Bylaw amendments with the omission of approval from the Governance Committee.

It was suggested the Bylaws go to the Governance Committee for information only.
Chairman Dagostino commented that the creation of the Bylaws is the Med Staff's responsibility and the Medical Staff has the right to govern themselves, however the Board is required by statute and regulation to approve the Medical Staff Bylaws.

Dr. Ma commented that he very much wants this to be a collaborative process and one that the Board is comfortable with. He did express concern with the Bylaw review process that occurred at the recent Governance \& Legislative Committee but believes the proposed pathway includes input from the appropriate parties.

It was noted the Board will significantly rely on the Board's attorney whether that occurs at the Governance \& Legislative Committee or at the Board level. Chairman Dagostino stated the Board's attorney is also involved in step \#4 along with the Medical Staff attorney and the CEO.

Mr. Moser stated in his opinion what is presented today is a significant improvement from prior practice however if we approve the motion on the table a second motion should be made to modify the Governance \& Legislative Committee Charter.

It was moved by Director Finnila to amend the motion to approve the pathway for Medical Staff Bylaw amendments by striking \#7 and omitting the refrence to the Governance Committee in \#8 and amending the Governance \& Legislative Committee Charter to reflect the current pathway. Director Nygaard seconded the motion.

The vote on the amended motion was as follows:

| AYES: | Directors: | Dagostino, Finnila, Mitchell, Nygaard |
| :--- | :--- | :--- |
| NOES: | Directors: | Schallock, Reno |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | Kellett |

Director Reno stated she wanted it to be made clear to the Medical Executive Committee that the Board is not trying to run the Medical Staff.

Diane Racicot joined the meeting at 11:20 a.m.
Mr. Moran stated he believes the pathway approved today is an excellent process that provides input and review by all appropriate individuals. Mr. Moran requested that the Medical Staff Bylaws also reflect the pathway described and approved today.
(f) Discussion and possible action to adopt new Mission, Vision \& Values Statement

Chairman Dagostino reported per discussion at the Board's recent Workshop the Mission, Vision \& Values Statement was brought forward to the Governance \& Legislative Committee for discussion and the committee recommended that the entire Board be involved in the development of the Mission, Vision \& Values Statement. Chairman Dagostino suggested forming an Ad Hoc committee that would bring forward a proposal to the full Board. Director Schallock commented that our current Mission Statement is outdated and the importance of adopting a new statement today. Directors were in support of brainstorming at today's meeting to reach conclusion and adopt a new Mission, Vision \& Values Statement.

Directors engaged in a spirited discussion and several ideas were proposed.

## Mission Statement:

Directors discussed the Mission Statement currently in place. It was suggested that the mission statement be a concise statement that is easily quotable by staff. Following extensive discussion the following Mission Statement was proposed and agreed to by all parties:

# TO ADVANCE THE HEALTH AND WELLNESS OF THE COMMUNITY WE SERVE 

## Vision Statement:

Directors discussed the Vision currently in place. Following extensive discussion, the following Vision was proposed and agreed to by all parties:

## BE RECOGNIZED AS THE HEALTHCARE SYSTEM OF CHOICE IN OUR COMMUNITY

## Values Statement:

Directors discussed the Values Statement that is currently in place which includes Quality, Caring, Innovation, Safety, Integrity and Stewardship. It was suggested the Values be limited to no more than four. Following extensive discussion the following Value Statement was proposed and agreed to by all parties:

## THE NEEDS OF OUR PATIENTS COME FIRST

It was moved by Director Nygaard to approve the Mission, Vision \& Values Statements as described. Director Schallock seconded the motion.

The vote on the motion was as follows:

| AYES: | Directors: | Dagostino, Finnila, Mitchell, Nygaard, Reno and <br> Schallock |
| :--- | :--- | :--- |
| NOES: | Directors: | None |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | Kellett |

At 12:15 p.m. Chairman Dagostino called for a lunch break.
At 12:52 p.m. the Board returned to open session with attendance as listed previously.
(g) Consideration of Legislative proposal regarding amendments to District Law

Chairman Dagostino reported the District would like to move forward with our campus redevelopment plan through the Design Build concept however currently the District does not have the permission to use the Design Build process. He explained that a recent legislative attempt to do so was unsuccessful however Senator Bates has agreed to entertain a bill that would get the Design Build concept approved and amend District Law to allow any District Hospital to use the Design Build concept. Chairman Dagostino further explained that Mr. Moser has prepared a bill that rationalizes the design build concept and Senator Bates will find a vehicle to put that legislation into play however Senator Bates would like the Board to personally support the bill in the form of a support letter. Chairman Dagostino questioned in the Board would entertain a motion in support of the Design Build bill.

It was moved by Director Finnila that the Board support legislation to amend District Law to allow any District Hospital to use the Design Build concept. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock
NOES: Directors: None
ABSTAIN: Directors: None
ABSENT: Directors: Kellett
Chairman Dagostino reported on a second piece of legislation that he created solely to amend District Law to allow for an increase in stipends or provide for a standard monthly stipend of perhaps $\$ 1,000 /$ month per Board member. Chairman Dagostino stated he recognizes that Board members have not been adequately compensated for the amount of time and work that is involved and is attempting to see if ACHD and Senator Bates will support the concept. Chairman Dagostino stated he does not recommend the Board s take action at this time but is bringing this information forward for information purposes only at this time.

Mr. Moser commented on similar legislation that water districts and other local agencies adopted several years ago that allows compensation not only up to 10 meetings a month but also a $5 \%$ increase per calendar year. Mr. Moser stated this may be a less aggressive route to explore.

Directors recommended Chairman Dagostino share both concepts with Senator Bates for her consideration.

No action taken.
(h) Consideration to appoint Ad Hoc Committee to explore electronic Board Portal

Chairman Dagostino stated per discussion at the Board's recent workshop it was suggested the Board look at ways to operate more efficiently and suggested the Board consider moving to electronic communication which is the practice of many municipalities. Chairman Dagostino recommended an Ad Hoc Committee be formed comprised of three Board members to research the market and recommend a realistic approach of what works for us. Director Schallock explained the District would continue to process a paper copy for any individual who does not want to utilize the electronic portal and the process is not intended to lock anyone out. Mr. Conley suggested an IT individual be assigned to look at the technical aspect. Dr. Ma explained the process that is now being utilized by the Medical Executive Committee and has been successful in keeping information privileged where applicable. Mr. Moser stated the Chair of the Board has the authority to form an Ad Hoc Committee with ratification from the Board.

It was moved by Director Finnila to authorize Chairman Dagostino to appoint an Ad Hoc Committee comprised of Directors Mitchell, Schallock and Nygaard to explore the electronic board portal. Director Nygaard seconded the motion.

The vote on the motion was as follows:

| AYES: | Directors: | Dagostino, Finnila, Mitchell, Nygaard, Reno and <br> Schallock |
| :--- | :--- | :--- |
| NOES: | Directors: | None |
| ABSTAIN: | Directors: | None |
| ABSENT: | Directors: | Kellett |

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 January 7, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators, two Reports Involving Trade Secrets with disclosure dates of May 31, 2016 and June 30, 2016, respectively, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees and three matters of Potential Litigation.
7. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Finnila to go into Closed Session. The motion passed (6-0-1) with Director Kellett absent.
8. Chairman Dagostino adjourned the meeting to Closed Session at 1:20 p.m.
9. The Board returned to Open Session at 4:21 p.m. All Board members were present with the exception of Director Kellett.
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 $4: 21$ p.m.

James J. Dagostino, PT, DPT
Chairman
ATTEST:

## Ramona Finnila Secretary

# Save the Date iProtean Symposium \& Workshop <br> ONLINE COURSES <br> EXPERTS <br> DEmo 

March 6-8, 2016
The Lodge at Torrey Pines
La Jolla, CA


EVENTS

This in-depth symposium focuses on the topic areas of finance, quality, mission \& strategy and governance through extended sessions with six leading healthcare experts. The workshop format offers attendees an intimate environment that allows for extensive individual interaction with the presenters.

Nationally-renowned experts will provide up-to-the-minute, detailed information on how health reform will impact not-for-profit hospitals now and in the coming years. They will provide insight into how institutions can take advantage of new opportunities and avoid potential pitfalls; how to navigate the ever-changing competitive environment; tools for creating strategic plans, and effective methods to continually update and adjust those plans; the ever-changing regulatory landscape; adjusting governance structure so that it is flexible and proactive; and many others.

The symposium features group sessions in which presenters and attendees explore information featured in the on-line courses in much greater detail. Topics will include:

## Topics for 2016 Symposium

FINANCE

- Bundled payments and how this method of payment will affect hospitals' and health systems' bottom line/finances

QUALITY

- Driving a sustained culture of quality: What works; what doesn't.
- Leading quality at the leading edge: The board's role.


## MISSION \& STRATEGY

- The role of the board in evaluating strategic alliances


## GOVERNANCE

- Governing within the arena of population health management
- How to work with physicians in an era of accountable care

Previous symposium attendees have valued the wrap-up session featuring the entire panel of experts. This is a unique opportunity to ask questions about your own organization, and gain insight into how other frustees are helping to shape the future of their institutions.

## REGISTER HERE

## Symposium Agenda

A detailed Agenda for the Symposium is available here

## Trustee Certification

Level II certification available for subscribers who have achieved Level I Certification in Finance, Quality, Mission \& Strategy and Governance. For details about certification, please go to Online Courses.

## Featured Speakers



Larry McEvoy, M.D. Practicing Excellence


Marian Jennings
M. Jennings Consuting


Daniel Grauman Veralon


James A. Rice Integrated Healthcare Strategies

## Hotel Information and Rates

For online hotel reservations, please click here


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## SUNDAY, MARCH 6, 2016

6:00 P.M. - 7:00 P.M.

MONDAY, MARCH 7, 2016

7:00 A.M. - 7:45 A.M.

8:00 A.M. -8:15 A.M.

8:15 A.M. - 9:15 A.M.
James A. Rice, Ph.D., FACHE
Managing Director and Practice Leader Governance and Leadership
Gallagher Integrated

Continental Breakfast and Registration

## Welcome \& Introduction

## Global Trends in Smart Health Sector Governance

James Rice, former Global Technical Lead Governance for the $\$ 200$ million USAID project in Asia, Africa and Latin America

15-minute break

## QUALITY

Driving a sustained culture of Quality: What works, what doesn't? Better quality, better results, more accountability. Underneath all the metrics, processes, and protocols lies the true predictor of the caliber of your results-your quality culture. There are essential tenets of a highperformance quality environment and practical tips for cultivating improvement in your quality approach at all levels of your organization.

## Leading Quality at the Leading Edge: The Board's role

Under the purview of governance and monitoring, the review of trends in metrics is a requisite board skill and obligation-but what's underneath all those metrics? What is the board's key strategic prerogative and influence on the fundamental quality culture that drives or impedes a healthcare organization's capacity to deliver optimum results and metrics, and as importantly, to sustain and constantly improve the clinical quality of every aspect of the organization?

12:45 P.M. - 2:45 P.M.
James A. Rice, Ph.D., FACHE
Managing Director and Practice Leader Governance and Leadership

Gallagher Integrated

## GOVERNANCE

## Governing within the Arena of Population Health Management

- Engaging with increasingly diverse stakeholders; collaborative governance
- Considering the social determinates of health; e.g., high risk populations, housing, schools, etc.


## How to Work with Physicians in an Era of Accountable Care

- Considering how to manage the continuum of care
- "Clinical" Governance-involving physicians in the strategic plan; governing the hospital/physician relationship wisely
- Contracting with others to provide care

15-minute break

Group Discussion and Wrap-Up

## TUESDAY, MARCH 8, 2016

7:30 A.M. - 8:30 A.M.

8:30 A.M. - 10:30 A.M.
Daniel Grauman
Managing Director \& CEO
Veralon

Continental Breakfast

## FINANCE

## Bundled Payments: Impact on Hospitals and Physicians

- Who is dealing with bundled payments now and how is it going?
- How do administration and physicians divvy up the pie?
- What will physicians be required to do to be part of the bundled payment structure?
- Are there any losers?

An Integrated Approach to Population Health Management, Accountable Care Organizations and Bundled Payments

- How do they work together in an organization?
- Which comes first?
- Do they operate in isolation of one another or are they seamlessly integrated?
- If seamlessly integrated, how does this work?
- Can an organization handle all three initiatives/reimbursement mechanisms?
- What role do physicians play?

10:30 A.M. - 10:45 A.M.

10:45 A.M. - 12:45 P.M.
Marian Jennings
President
M. Jennings Consulting

15-minute break

## MISSION \& STRATEGY

## "When Will the Dust Settle"

- Industry trends/overview and how to use scenario planning when the future is so unsettled

Beyond Payment Changes: Other Disruptors of Our Health System

Networking Luncheon

## Group Discussion - 2016 Hospital Challenges

This interactive panel will help attendees prepare for the significant challenges confronting hospitals in the coming year. Our experts will address a variety of hot-button issues, and audience members are welcome to ask questions and join in this freewheeling discussion.

## WRAP-UP \& CLOSE

## 2016 iProtean Symposium \& Workshop

iProtean
Sunday, March 6, 2016 at 6:00 PM - Tuesday, March 8, 2016 at 11:30 AM (PST) San Diego, CA

| Registration Information |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
| REGISTRATION TYPE | SALES END | PRICE | FEE | QUANTITY |
| Non-Subscriber Early Bird nore info | Ended | \$800 00 | \$3395 | N/A |
| Subscriber - Early Bird | Ended | Free | 5000 | N/A |
| Subscriber - After 1-1-2016 | Mar 6, 2016 | Free | \$0 00 | $0 \quad \mathrm{~V}$ |
| Non-Subscriber - After 1-1-16 | Mar 162016 | \$900 00 | \$36 95 | $0 \quad \vee$ |
| $\operatorname{ascivan} \text { Faxt ec VISA }$ |  |  | Register |  |
| Offline payments available |  |  |  |  |


| Who's Going |
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2016 iProtean Symposium \& Workshop

San Diego, CA Events Class

Other


December 10, 2015

Casey Fatch
Chief Operating Officer
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056-4506

Dear Mr. Fatch,
Thank you for your membership with The Governance Institute and your ongoing support of our member-driven enhancement initiatives. Member feedback is integral as we work to provide the resources you need to most effectively lead and govern your organization.

As in years past, we continue to update and improve the membership offering to remain relevant to your organizational needs. Over the next year, you can expect your Governance Institute membership to offer:

- Expert recommendations on creating and maintaining effective, well-organized board participation and performance
- Valuable insights into the challenges of today's healthcare environment and how you should address those challenges
- Cutting-edge strategies and ideas to ensure that you maintain a successful healthcare organization
- Authoritative answers and reliable guidance on a wide variety of complex topics
- An Account Manager partnering with you to best understand needs and help navigate available resources

Enclosed, please find the invoice for your next membership year. Your prompt payment will help ensure that you receive the best possible service without interruption.

Please call us at (877) 712-8778 with any questions or comments. We appreciate the opportunity to work with you to empower better healthcare.

Best regards,
Kenets Wyora
Keith Wysocki
Director, Business Development

|  | National Research Corporation |
| :--- | :--- |
|  | 1245 Q Street \|Lincoln, NE 68508 |
| Casey Fatch | $0800.388 .4264 \mid$ f 402.475 .9061 |
| Tri-City Medical Center | nationalresearch.com |
| 4002 Vista Way |  |
| Oceanside, CA $92056-4506$ |  |


| Invoice: | 36122 |
| :--- | :--- |
| Date: | 121012015 |
| Client: | HCA011 |
| Due Date: | $1 / 9 / 2016$ |


| Service/Product | Service Dates |
| :--- | :--- |
| The Governance Institute Standard Membership | Feb 2016-Jan 2017 |
|  |  |
|  | Sub Total |
|  | $\$ 22,350.00$ |

## Thank you for your business.

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## TCHD BOARD OF DIRECTORS

## COMMITTEE ASSIGNMENTS

Pursuant to Article VI of the Bylaws, the Chairperson, with the concurrence of the Board of Directors, hereby constitutes the following Committees and appoints their members; provided that the Chair of any Committee shall be authorized to appoint members designated as non-voting to serve pro tem as voting Committee members as necessary to achieve a quorum at a meeting.

## Finance, Operations \& Planning

(Meets third Tuesday of month @12:30 p.m. Agendas to be sent 72 hrs prior to meeting date)

1. Committee Chair Jim Dagostino, DPT, PT
2. Board Dr. Kellett
3. Board Julie Nygaard
4. Medical Staff Dr. John Kroener (appointed March, 2014)
5. Medical Staff Dr. Frank Corona
6. Medical Staff Dr. Contardo
7. Community Kathleen Mendez (12/10/13); renewed December 2015; expires 12/2017
8. Community Steve Harrington (3/27/14); renew March 2016
9. Community Carlo Marcuzzi (6/25/15); renew June 2017
10. Community Wayne Lingenfelter (1/29/15); renew January 2017
11. Community Tim Keane (6/25/15); renew June 2017
12. Non-Voting/ Advisory Members
13. Administration Chief Executive Officer - Tim Moran
14. Administration Chief Financial Officer - Steven Dietlin
15. Administration Chief Operations Officer - Kapua Conley
16. Administration Chief Compliance Officer - Cheryle Bernard-Shaw
17. Administration SVP Medical Services - Wayne Knight

Non-Voting Staff Members That May Observe: Carol Smyth, Contract Manager
$>$ Support Barbara Hainsworth, Senior Administrative Assistant to CFO \& Finance, ext. 7323; Board's General Counsel

## Human Resources Committee

(Meets second Tuesday of month @ 12:30 p.m. - Agendas to be sent 72 hrs. prior to meeting date)

1. Committee Chair Dr. Kellett
2. Board RoseMarie V. Reno
3. Board Laura Mitchell
4. Medical Staff Dr. Ma (appointed $7 / 12 / 2013$ )
5. Medical Staff Dr. Martin Nielsen (appointed $1 / 19 / 2012$ )
6. Medical Staff Dr. Movahhedian (appointed $3 / 26 / 09$ )
7. Community
8. Community
9. Community
10. Community
11. Administration
12. Administration
13. Administration

Gwen Sanders (8/27/2015); renew August 2017
Virginia (Ginny) Carson (1/30/2014); renew January 2016
Salvador Pilar (1/30/2014); renew January 2016
Joe Quince (8/27/2015); renew August 2017
Chief Executive Officer - Tim Moran
Chief Nurse Executive - Sharon Schultz
Vice President - Human Resources - Esther Beverly
$>$ Support Frances Carbajal, Senior Administrative Assistant, ext. 5387

## H.R. Employee Fiduciary Retirement Subcommittee

(Meets second Tuesday of month at 11:00 a.m. - Agendas to be sent 72 hrs. prior to meeting date)

1. Committee Chair Dr. Kellett
2. Board RoseMarie V. Reno
3. Community Henry Holloway (3/27/2014); renew March 2016
4. Community Virginia (Ginny) Carson (6/25/15); renew June 2017

Non-Voting Advisory Members
5. Administration Chief Executive Officer - Tim Moran
6. Administration Vice President - Human Resources - Esther Beverly
> Support Frances Carbajal, Senior Administrative Assistant, ext. 5387
(Meets first Tuesday of the month @ 12:30 p.m. - Agendas to be sent 72 hours prior to meeting date)

1. Committee Chair James Dagostino, DPT, PT
2. Board RoseMarie V. Reno
3. Board Ramona Finnila
4. Medical Staff Vacant (Bylaws Committee Chair)
5. Medical Staff Dr. Henry Showah (Medical Director, Emergency Department)
6. Medical Staff Dr. Marcus Contardo
7. Community Al Memmolo (06/26/2014); renew June 2016
8. Community Blake Kern (5/29/14); renew May 2016
9. Community Dr. Paul Slowik (12/11/14); renew December 2016
10. Non-Voting/Advisory Members
11. Administration Chief Executive Officer - Tim Moran
12. Administration Chief Compliance Officer-Cheryle Bernard-Shaw
13. Administration Chief Operating Officer - Kapua Conley

Non-voting TCMC staff members: Sherry Miller, Manager, Medical Staff Services
$\Rightarrow$ Support Teri Donnellan, Executive Assistant ext 3347-Administration; Board's General Counsel

## Professional Affairs Committee

(Meets second Thursday of the month @ Noon - Agendas to be sent 72 hours prior to meeting date)

1. Committee Chair Laura Mitchell
2. Board Larry Schallock
3. Board Ramona Finnila
4. Medical Staff Chief of Staff - (Dr. Ma)
5. Medical Staff Past Chief of Staff - (Dr. Worman)
6. Medical Staff Q.A. Chairperson - (Dr. James Johnson)
7. Medical Staff Dr. Contardo

Non-Voting/Advisory Members
8. Administration Chief Executive Officer - Tim Moran
9. Administration Chief Nurse Executive - Sharon Schultz
10. Administration Chief Compliance Officer - Cheryle Bernard-Shaw
11. Administration Chief Operations Officer - Kapua Conley
12. Administration Director, Risk Management - Marcia Cavanaugh

Non-voting TCMC staff members: Jami Piearson, Director of Regulatory Compliance
$>$ Support Karren Hertz, Senior Administrative Assistant, ext. 3353 ; Board's General Counsel

## Audit/Compliance \& Ethics Committee

(Meets third Thursday of the month @ 8:30 a.m.; Agendas to be sent 72 hours prior to meeting)

1. Committee Chair Ramona Finnila
2. Board Larry W. Schallock
3. Board Laura Mitchell
4. Medical Staff Dr. Frank Corona (appointed June 2014)
5. Community Jack Cumming (7/25/13); renewed July 2015; Expires July 2017
6. Community Leslie Schwartz (8/27/15); renew August 2017
7. Community Kathryn Fitzwilliam (11/6/14); renew November 2016
8. Community Barton Sharp (11/6/14); renew November 2016

Non-voting/Advisory Members
9. Administration Chief Executive Officer - Tim Moran
10. Administration Chief Compliance Officer - Cheryle Bernard-Shaw
11. Administration Chief Operating Officer - Kapua Conley
12. Administration Chief Financial Officer - Steven Dietlin
> Support Teri Donnellan, Executive Assistant; ext. 3347; Board's General Counsel

1. Committee Chair
2. Board
3. Board
4. District Resident O'side
5. District Resident Carlsbad
6. District Resident Vista
7. Mayor of O'side Nominee
8. Mayor of Carlsbad Nominee
9. Mayor of Vista's Nominee
10. O'side Chamber Commerce
11. Carlsbad Chamber Commerce
12. Vista Chamber Commerce
13. O'side Unified School District Nominee
14. Carlsbad Unified School District Nominee
15. Vista Unified School District Nominee
16. Senior Commission O'side Nominee
17. Senior Commission Carlsbad Nominee
18. Senior Commission Vista Nominee
19. O'side Police/Fire Nominee
20. Carlsbad Police/Fire Nominee
21. Vista Police/Fire Nominee
22. Chief of Staff or Designee
23. Community Healthcare Org.
24. Community Healthcare Org.
25. Community Healthcare Org.
26. Multicultural
27. Multicultural

## 28. Multicultural

Non-Voting/Advisory Members
29. Chief Executive Officer
30. Chief Operations Officer
31. Chief Marketing Officer
31. Manage, Marketing
> Support

Julie Nygaard
Larry Schallock
Jim Dagostino, DPT, PT
Reverend Carol Brooks (3/27/2014); renew March 2016
Linda Ledesma (9/25/14); renew September 2016

## Vacant

Gigi Gleason
Guy Roney
Mary Lou Clift
Don Reedy
Gina McBride
Bret Schazanbach
Barbara Perez
Rosemary Esheleman
Carol Herrera
Vacant
Jack Nelson
Marge Coon
Darryl Hebert
Linda Allington
Marilyn Anderson
Victor Souza, M.D.
Vista Committee Clinic (Ex-Officio Member) Fernando Sañudo
North County Health Services (Ex-Officio Member) Ramona Ferriter
City of S.D. Health \& Human Services (Ex-Officio Member) -
Audrey Lopez
Xiomara Arroyo (9/25/14); renew September 2016
Marilou dela Rosa Hruby (6/28/2012); renewed September 2014;
Expires September 2016
Vacant

Tim Moran
Kapua Conley
David Bennett
Jamie Johnson
Susan McDowell, Senior Administrative Assistant, ext. 5770

Joint Conference Committee - This is a Medical Staff Committee created and approved by the Board of Directors on 9/29/11; two Board members who are recommended by the Board Chair sit as members of this Committee. Current Board membership is:

1. James Dagostino, DPT/PT Board Chair
2. Julie Nygaard, Board Member

vivily

$\square$
$\square$
$\square$

Quality Outcomes - Page 3




| Median Time to ECS |  |
| :---: | :---: |
|  |  |
|  |  |
|  |  |
|  | Median Time from Admit Decision to ED Departure Time for Admitted ED Patients |
|  |  |



Quality Outcomes - Page 6


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.

| Description | Indication |
| :---: | :---: |
| One point is more than 3 <br> standard deviations (UCL) from <br> the mean. | One sample (two shown in this <br> case) is grossly out of control. |
| Six (or more) points in a row are <br> continually increasing (or <br> decreasing). | A trend exists. Procedures in <br> place have an effect on outcomes <br> either positive or negative. |
| 8 (or more) points in a row are on |  |
| the same side of the mean | Some prolonged bias exists. |




Quality Outcomes - Page 8

Financial Informatton

| TCMC Days in Accounts Receivable (A/R) |  |  |  |  |  |  |  |  |  |  |  |  | C/M | Goal |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Jul | Aus | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD Avs | Range |
| FY16 | 46.7 | 45.7 | 45.7 | 45.3 | 47.0 | 49.1 |  |  |  |  |  |  | 46.6 | 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 | 48.4 | 48-52 |
| TCMC Days in Accounts Payable ( $A / P$ ) |  |  |  |  |  |  |  |  |  |  |  |  | C/M | Goal |
|  | Jul | Aus | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YID AV: | Range |
| FY16 | 83.6 | 85.8 | 92.1 | 88.7 | 84.0 | 82.5 |  |  |  |  |  |  | 86.1 | 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 | 78.6 | 75-100 |
| TCHD EROE \$ in Thousands (Excess Revenue over Expenses) |  |  |  |  |  |  |  |  |  |  |  |  | C/M | C/M |
|  | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD | YTD Sudget |
| FY16 | \$862 | \$612 | \$182 | (\$189) | (\$513) | \$965 |  |  |  |  |  |  | \$1,919 | \$1,860 |
| FY15 | \$368 | (\$348) | \$112 | \$568 | \$556 | \$632 | \$198 | \$370 | \$292 | \$343 | \$1,814 | (\$471) | \$1,888 |  |
| TCHD EROE \% of Total Operating Revenue |  |  |  |  |  |  |  |  |  |  |  |  | C/M | C/M |
|  | Jul | Aus | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | Mav | Jun | YID | Yib Budges |
| FY16 | 3.03\% | 2.20\% | 0.66\% | -0.68\% | -2.00\% | 3.40\% |  |  |  |  |  |  | 1.16\% | 1.10\% |
| 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\% | 1.13\% |  |



Finenciel lmformoetion

| TC | \$ | nds | be | st, | prec | d Am | ion) |  |  |  |  |  | C/M | C/M |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Jul | Aus | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YID | YTD Budget |
| FY16 | \$2,046 | \$1,817 | \$1,357 | \$1,011 | \$644 | \$2,155 |  |  |  |  |  |  | \$9,030 | \$9,885 |
| FY15 | \$1,761 | \$988 | \$1,456 | \$1,888 | \$1,896 | \$1,983 | \$1,498 | \$1,652 | \$1,591 | \$1,620 | \$3,136 | \$724 | \$9,972 |  |


| TCHD EBITDA \% of Total Operating Revenue |  |  |  |  |  |  |  |  |  |  |  |  | C/M | c/m YTD Budget |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Yill |  |
| FY16 | 7.20\% | 6.53\% | 4.90\% | 3.65\% | 2.50\% | 7.58\% |  |  |  |  |  |  | 5.45\% | 5.84\% |
| 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\% | 5.96\% |  |


| TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed |  |  |  |  |  |  |  |  |  |  |  |  | C/M | C/M |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Jul | Aug | Sep | Oct | Nov | Dec | 3an | Feb | Mar | Apr | May | Jun | YID | VID Budget |
| FY16 | 6.13 | 6.05 | 5.91 | 5.98 | 6.11 | 6.01 |  |  |  |  |  |  | 6.03 | 6.10 |
| 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 | 6.10 |  |
| TCHD Fixed Charge Coverage Covenant Calculation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | TMM Jul | ITM Aus | TIM Sep | TrMOct | IIM Nov | TIM Dec | TrM Jan | ITM Feb | TTM Mar | ITM Apr | TIM May | TTM Iun | Covenant |  |
| FY16 | 1.88 | 1.96 | 2.15 | 2.05 | 1.85 | 1.92 |  |  |  |  |  |  | 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 | Aus | Sep | Oct | Nov |
| :--- | :---: | :---: | :---: | :---: | :---: |
| FY16 | $\$ 30.7$ | $\$ 33.4$ | $\$ 36.1$ | $\$ 35.7$ | $\$ 31.8$ |

FY16
FY15

Growth - Page 11



[^8]Deliveries

|  | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| FY16 | 21.5 | 214 | 252 | 227 | 232 | 220 |  |  |  |  |  |  | 1360 |
| FY15 | 246 | 263 | 244 | 233 | 194 | 233 | 199 | 159 | 208 | 186 | 218 | 198 | 2581 |


Performance compared to prior year:



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## Building Operating Leases

Month Ending Nov 30, 2015

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. |  | Total Rent per current month | Lease <br> Beginning | Ending | Services \& Location |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V\#81981 | $\begin{aligned} & \text { Approx } \\ & 6,200 \\ & \hline \end{aligned}$ | \$2.50 | (a) | \$18,600.00 | 02/01/15 | 10/31/18 | PCP Clinic Vista <br> 1926 Via Centre Drive, Ste A <br> Vista, CA |
| Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V\#80388 | $\begin{aligned} & \text { Approx } \\ & 87,000 \\ & \hline \end{aligned}$ | \$4.08 | (a) | 239,250.00 | 07/01/13 | 06/30/28 | Wellness Center 6250 El Camino Real Carisbad, CA 92009 |
| GCO <br> 3621 Vista Way <br> Oceanside, CA 92056 \#V81473 | 1,583 | \$1.50 | (a) | 3,398.15 | 01/01/13 | 12/31/15 | Performance Improvement 3927 Waring Road, Ste.D Oceanside, Ca 92056 |
| Golden Eagle Mgmt <br> 2775 Via De La Valle, Ste 200 <br> Del Mar, CA 92014 <br> V\#81553 | 4,307 | \$0.95 | (a) | 7,052.37 | 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) | 9,400.74 | 09/01/12 | 08/31/17 | OP Physical Therapy, OP OT \& OP Speech Therapy <br> 2124 E. El Camino Real, Ste. 100 <br> Oceanside, Ca 92054 |
| Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 1/443849 | 7,247 | \$1.22 | (a) | 10,101.01 | 07/01/11 | 07/01/16 | Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083 |
| Enterprises, LLC -u 7 Vista Way, Bldg. 5 Oceanside, Ca 92056 V\#81250 | 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 <br> DBA: Vista Town Center <br> PO Box 19068 <br> irvine, CA 92663 <br> V\#81503 | 3,307 | \$1.10 | (a) | 4,936.59 | 10/28/13 | 03/03/18 | Vacant Building <br> 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 |  | 7,749.28 | 12/19/11 | 12/18/16 | Vacant Medical Office Building <br> 4120 Waring Rd <br> Oceanside, Ca 92056 |
| Tri City Real Estate Holding \& Management Company, LLC 4002 Vista Way Oceanside, Ca 92056 | 4,295 | \$3.13 |  | 12,515.04 | 01/01/12 | 12/31/16 | Vacant Bank Building Property <br> 4000 Vista Way <br> Oceanside, Ca 92056 |
| Total |  |  |  | \$ 337,934.18 |  |  |  |

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

## (®) Tri-city Medical Center

ADVANCED HEALTH CARE FOR YOU
Building Operating Leases
Month Ending Dec 31, 2015

| Lessor | Sq. Ft. | Base Rate per <br> Sq. Ft. |  | Total Rent per current month | Lease <br> Beginning | Term Ending | Services \& Location |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V\#81981 | $\begin{array}{\|l} \text { Approx } \\ 6,200 \\ \hline \end{array}$ | \$2.50 | (a) | \$18,600.00 | 2/1/2015 | 10/31/2018 | PCP Clinic Vista <br> 1926 Via Centre Drive, Ste A <br> 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 | $\begin{array}{\|l\|} \hline \text { Approx } \\ 87,000 \\ \hline \end{array}$ | \$4.08 | (a) | 239,250.00 | 07/01/13 | 06/30/28 | Wellness Center 6250 El Camino Real Carlsbad, CA 92009 |
| GCO <br> 3621 Vista Way <br> Oceanside, CA 92056 <br> \#V81473 | 1,583 | \$1.50 | (a) | 3,398.15 | 01/01/13 | 12/31/15 | Performance Improvement 3927 Waring Road, Ste.D Oceanside, Ca 92056 |
| Golden Eagle Mgmt <br> 2775 Via De La Valle, Ste 200 <br> Del Mar, CA 92014 <br> V\#81553 | 4,307 | \$0.95 | (a) | 6,001.94 | 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 <br> 2181 El Camino Real, Ste. 206 <br> Oceanside, Ca 92054 <br> V\#81028 | 5,214 | \$1.65 | (a) | 9,400.74 | 09/01/12 | 08/31/17 | OP Physical Therapy OP OT \& OP Speech Therapy 2124 E. El Camino Real, Ste. 100 Oceanside, Ca 92054 |
| Meirose Plaza Complex, LP c/o Five K Management, Inc. <br> P O Box 2522 <br> La Jolla, CA 92038 <br> V\#43849 | 7,247 | \$1.22 | (a) | 10,101.01 | 07/01/11 | 07/01/16 | Outpatient Behavioral Health 510 West Vista Way <br> 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 }9205``` |
| Ridgeway/Bradford CA LP <br> DBA: Vista Town Center <br> PO Box 19068 <br> Irvine, CA 92663 <br> V\#81503 | 3,307 | \$1.10 | (a) | 4,936.59 | 10/28/13 | 03/03/18 | Vacant Building <br> 510 Hacienda Drive Suite 108-A <br> Vista, CA 92081 |
| Tri City Real Estate Holding \& Management Company, LLC 4002 Vista Way Oceanside, Ca 92056 | 6,123 | \$1.37 |  | 8,006.95 | 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 |  | 12,708.47 | 01/01/12 | 12/31/16 | Vacant Bank Building Property 4000 Vista Way Oceanside, Ca 92056 |
| Total |  |  |  | \$345,153.45 |  |  |  |

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Education \& Travel Expense
Month Ending 11/30/15

| Cost Centers | Description | Invoice \# | Amount | Vendor \# | Attendees |
| :---: | :---: | :---: | :---: | :---: | :---: |
| 6171 | ONS EDUCATION VOUCHERS | 112415 | 792.00 | 49112 | MEDICAL STAFF |
| 6171 | ACHSA CONFERENCE | 110215 | 804.56 | 82419 | LORI ROACH |
| 6183 | CAL NOC CONFERENCE | 102815 | 311.01 | 79284 | JENESSA FRENCH |
| 7680 | SIEMENS CLINICAL TRAINING | 91815 | 203.52 | 41552 | PETER MARTIN |
| 8390 | CSHP CONFERENCE | 90115 | 508.00 | 79349 | TORI HONG |
| 8390 | 340B COALITION WINTER CONFERENCE | 112015 | 799.00 | 80052 | TORI HONG |
| 8390 | CERNER HEALTH USER CONFERENCE | 101915 | 1,327.89 | 82547 | EVELYN SHEN |
| 8615 | DEALING WITH DIFFICULT PEOPLE | 102615 | 158.00 | 80986 | JAMIE JOHNSON |
| 8620 | COMPLIANCE ACAD | 111115 | 1,567.24 | 82269 | LAURA E MITCHELL |
| 8710 | NAMSS CONFERENCE | 102615 | 1,507.78 | 82538 | SHERRY MILLER |
| 8720 | HQI ANNUAL CONFERENCE | 1117152 | 479.06 | 59683 | MARCIA CAVENAUGH |
| 8720 | HQI ANNUAL CONFERENCE | 102015 | 566.00 | 59683 | SHARON SCHULTZ |
| 8723 | HEALTH MANAGEMENT CONFERENCE | 111615 | 182.13 | 80401 | JAY MOTOKAWA |
| 8740 | BONES SYMPOSIUM | 102915 | 100.00 | 27009 | JUDITH FARR |
| 8740 | BONES SYMPOSIUM | 102915 | 100.00 | 77871 | MING YIN |
| 8740 | BONES SYMPOSIUM | 102915 | 100.00 | 79202 | LAURA WIDMAYER |
| 8740 | BONES SYMPOSIUM | 102915 | 100.00 | 80988 | SHERRY BARTHOLOMEW |
| 8740 | ORTHOPEDIC NURSE SYMPOSIUM | 102915 | 110.00 | 79494 | DIANNE MONTIJO |
| 8740 | NEONATAL NURSES CONFERENCE | 110515 | 140.00 | 77765 | KIMBERLY GRITMAN |
| 8740 | NEONATAL NURSES CONFERENCE | 110515 | 140.00 | 82546 | SHERI HARTNETT |
| 8740 | ACLS RENEWAL | 90215 | 150.00 | 80026 | BARBARA ALCARION |
| 8740 | ACLS RENEWAL | 102615 | 150.00 | 82219 | VICTORIA BRINKLEY |
| 8740 | LEGAL \& ETHICAL ISSUES FOR PSYCHOTHERAPIST | 110515 | 158.95 | 81330 | MITCHELL COHEN |
| 8740 | CCRN CERTIFICATION | 110515 | 160.00 | 82545 | JESSICA SAGUIN |
| 8740 | ADVANCES CARDIAC LIFT SUPPORT | 111215 | 175.00 | 82555 | DANIELLE CARROLL |
| 8740 | SCASM 2015 | 102615 | 185.00 | 46582 | MAHIN NASSIM |
| 8740 | FETUS AND NEWBORN CONFERENCE | 102615 | 200.00 | 79916 | TAMARA L BOLDUC |
| 8740 | FETUS AND NEWBORN CONFERENCE | 110515 | 200.00 | 80229 | ANNETTE REED-LILLY |
| 8740 | NEONATAL TOUCH | 102915 | 200.00 | 80260 | ALISA DEYOUNG |
| 8740 | fetus and newborn conference | 102615 | 200.00 | 81979 | SUSAN AZARIAN |
| 8740 | ACLS RENEWAL | 90215 | 200.00 | 82110 | NORA PAPA |
| 8740 | BOARD OF PHARMACY EXAM | 102615 | 200.00 | 82539 | OSKA LAWRENCE |
| 8740 | NEONATAL TOUCH | 102915 | 200.00 | 82540 | JULIE ANCHESTIGUI |
| 8740 | BSN PROGRAM | 111215 | 2,000.00 | 82556 | DEONIENCE JONES |
| 8754 | HQI ANNUAL CONFERENCE | 111715 | 476.06 | 59683 | SHARON SCHULTZ |

[^9]Education \& Travel Expense
Month Ending 12/31/2015


## EVALUATION FORM

## SEMINAR: GOVERNANCE FORUM LOCATION: SACRAMENTO

DATE: DECEMBER 2, 2015

## REASON TO ATTEND: COMMITTEE MEMBER

## IMPORTANT TOPICS:

The first update for the committee was on the (1) closure of Southern Mono Inyo Health Care District hospital in Lone Pine due to bankruptcy. The SNF patients will be transferred to Ridgecrest. Medical care will be in Ridgecrest or Bishop about 100 miles away in either direction. (2) San Clemente Hospital continues to be targeted for closure. A trial free-standing ER is proposed but there is opposition from ER physician groups.

Two presentations were made to the group. One is to request all board members sign on to "Our Health California: 2016 Creative Vision". www.ourhealthcalifornia.org Health care information of concern as well as advocacy is provided once or twice monthly to registered individuals. The second presentation was by the Hospital Quality Institute for CEO and Board Governance as a Quality Work Guide. Ms. Morath stated that at the meeting in November there was almost no participation by Board members and her willingness to meet with Board members to discuss their role. (I am working on perhaps a Spring meeting in North San Diego county). The next Annual meeting will be in San Diego in the Fall, 2016.

Other topics discussed focused on Strategic Planning: specifically quality and safety, mental health/behavioral health, dealing with the transformation of managing change in healthcare and also the continued increase in usage of board portals for providing information to board members.

In the legislative arena: AB1300 which will update parts of the " 5150 " holds for mental health patients. The revision has been significantly narrowed from last year's bill to only focus on the ER area. ER physicians would be allowed to place and remove holds; immunity to ER doctors as well as ambulance drivers and paramedics. Tele-psychiatry would be allowed. HIPPA language would be adjusted. There is opposition from NAMI as transitional housing is not addressed. Prop 30 will be on the November ballot to make permanent the funding for Medi-cal. SEIU is working on a statewide ballot initiative to limit CEO salaries for non-profit hospitals/health systems.

After 7 years, this meeting was my last on this committee and I expressed my appreciation for the opportunity to be informed on the many national/statewide issues discussed.

Larry W. Schallock


# Hospital Quality Institute 

 Leadership in quality and patient safety
## CEO \& Board Governance

## Quality Work Guide



# Quality Work Guide 

For CEO \& Board Governance

From: Julie Morath, RN, MS, President/CEO

Hospital Quality Institute (HQI) is pleased to provide these materials for your review and use. These materials are intended to provide guidance in the development of a system of continued improvement for an organization, specifically focused on executive and governance oversight. The materials provide examples or a template that an organization can adapt for its use to fulfill Quality and Patient Safety requirements.

HQI Blueprint for Advancing Quality and Patient Safety

California Hospital Patient Safety Organization Membership Brochure
"Becoming a Patient Safety Organization" by Rory Jaffe, MD, MBA, Executive Director of CHPSO; Published in the AHRQ Perspective, July 2011.

HQI Improvement Pocket Guide: DMAIC

Board Leadership: A Driver of Health Care Quality

Quality as a System
Questions a Board Needs to Ask
Example: Quality and Patient Safety Committee Charter

Example: Operational Quality and Patient Safety Performance Improvement Plan (QAPI)

Example: Quality and Patient Safety Accountability and Reporting Flows

Cascade of Alignment: Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Governance and Board Readiness Assessments

We look forward to working with you as you develop your quality improvement and patient safety plan. For editable/electronic files, please contact HQI at HQIOperations@HQInstitute.org or (916) 552-7600.

## Board Leadership: A Driver of Health Care Quality

## The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

## Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions. ${ }^{1}$ Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before. ${ }^{2}$ A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality. ${ }^{3}$ Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

## Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, To Error is Human ${ }^{4}$ and Crossing the Quality Chasm ${ }^{5}$, in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $\$ 1.3$ billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points
Engaged Boards improve quality outcomes

The nation has a serious quality and patient safety problem

There are new expectations for governance oversight of quality

Quality is at the center of healthcare reform

Best practices for Boards are available
demonstrated by the infamous commercial failures, but within non-profit healthcare. These examples mark unconscionable lapses in corporate integrity and governance oversight leading to an increased scrutiny of Boards and higher standards of accountability. In 2002, Congress responded by passing the Sarbanes-Oxley legislation which introduced major changes to the regulation of corporate governance and public finance. ${ }^{6}$ While charitable organizations are largely not covered by its provisions, the law has affected and strengthened Board practices in not-for-profit organizations. Some predict, however, that a direct ". . . Sarbanes-Oxley for quality is around the corner." ${ }^{7}$ Third, while many aspects of the US healthcare system are exceptionally advanced, the care provided is too often unsafe and inefficient. Exacerbating the patient safety issues are federal forecasts that predict US healthcare spending will exceed $\$ 4.1$ billion by 2016, representing $20 \%$ of the gross national product. ${ }^{8}$ In response to the demand for better quality, patient safety, and cost efficiency, policy leaders and patient organizations have called governing Boards to enhance their oversight function on quality of care. In March 2010 Congress passed the Patient Protection and Affordable Care Act ${ }^{9}$ which addressed multiple changes to the current healthcare delivery system. Payors are moving into value-based purchasing models using financial incentives targeted at providers, consumers, or both, linked to measures of health care quality and efficiency.

These events usher in a new era of accountability for health system Boards. The change is welcomed as evidence shows that highly engaged Boards focused on quality of care can impact outcomes in very positive ways.

## Assessment

Boards face important new issues related to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, and collaboration between organizational providers and individual and group practitioners. "These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing Board." ${ }^{10}$

Historically, Boards delegated to medical staff and management the operational responsibility for safe care. Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the sole responsibility of the doctors, nurses and executives. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care. ${ }^{11}$ Training in quality principles and methods, as well as attuned organizational structures and processes are critical to enable Board effectiveness.

Recent studies show that the majority of hospital Boards are not prepared to meet the new level of expectations and accountabilities for quality of care. In a national survey of Board chairs, a study conducted by researchers at the Harvard School of Public Health found that fewer than half of the Boards rated quality of care as one of their top two priorities. Few reported receiving training in quality. Moreover, using publically reported quality data, the researchers assessed Board engagement relative to high-performing and low-performing hospitals. They identified large differences in Board activities and engagement between high-performing and low performing hospitals. Highly engaged and trained Boards who exercised active oversight of quality realized significantly higher quality performance. ${ }^{12}$

## Recommendations

Many excellent resources are available to suggest potential strategies to support Boards in meeting their oversight of quality. ${ }^{13}$ Most of these resources share common themes in their recommendations. A succinct statement of recommended Board activities was advanced in a recent study by researchers at the Johns Hopkins Quality and Safety Research Group. ${ }^{14}$ The recommendations include:

1. Boards should have a separate quality and patient safety committee that meets regularly and reports to the full Board. Evidence suggests Boards with such a committee spend more time on improvement activities, and their hospitals may have better outcomes.
2. Boards should ensure the existence and annual review of a written quality improvement and patient safety plan that reflects systems thinking, contains valid empirical measures of performance, and is consistent with national, regional, and institutional quality and safety goals.
3. Boards should have an auditing mechanism for quality and safety data, just as they do for financial data. While data quality control principles apply to clinical research and apply to financial data through generally accepted accounting principles, data quality in measuring quality and patient safety has received little to no attention in most health-care organizations.
4. Boards should routinely hear stories of harm that occurred at the hospital, putting a face on the problem of quality and patient safety. Stories may be case reviews presented by staff or interactions with patients or families who suffered harm.
5. In conjunction with the CEO and medical staff leaders, boards should identify specific, measurable, valid quality indicators consistent with strategic goals and hospital services, and review performance against the indicators no less than quarterly. Such review should include:
a. Regular quantitative measurement against benchmarks;
b. Reported compliance with rigorous data quality standards;
c. Performance transparency;
i. Weekly or monthly reports of harm;
ii. Sentinel event and claims review for quality and safety problems;
d. Methods for active intervention to improve care;
i. Survey of quality and safety culture;
ii. Use of survey results to shape improvement efforts;
iii. Routine mechanism to tap the wisdom of bedside caregivers.
${ }^{1}$ Lister E, Cameron DL. The role of the Board in assuming quality and driving major change initatives - part 1: maintaining organizational integrity. Group Practice Journal. 2001;50:13-20.
${ }^{2}$ Miller TE, Gutmann VL, "Changing expectations for Board oversight of healthcare quality: the emerging paradigm," | Health Life Sci Lazw 2009 Jul;2(4):31, 33-77.
" Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," Health Affnirs 29 (1):182-187.
${ }^{+}$To Err is Human: Building a Safer Health System (2000), Institute of Medicine
$M$ Benegas, QPS, 03.27.12
${ }^{5}$ In Crossing the Quality Chasm: A New Health System for the 221st Century (2001), the Institute of Medicine (IOM) identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable.
${ }^{6}$ Sarbanes-Oxley Act of 2002, PL 107-204, 116 Stat 745
${ }^{7}$ Nash DB, Medical Executive Post, March 9, 2008. See also, Royo MB, Nash DB. 2008. "Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects," American Journal of Medical Quality, 23(1):70-72
${ }^{8}$ Poisal JA, et al, "Health Spending Projections Through 2016: Modest Changes Obsure Part D's Impact," Health Affairs 26 (2):w242-w253 (2007)
${ }^{9}$ Patient Protection and Affordable Care Act, PL 111-148
${ }^{10}$ Callendar et al, Corporate Responsibility and Health Care Quality: A Resource for Health for Health Care Boards of Directors, American Health Lawyers Association, 2007
${ }^{11}$ National Quality Forum, Hospital Governing Boards and Quality of Care: A Call to Responsibility, 2004
${ }^{12}$ Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," Health Affairs 29 (1):182-187.
See also, Carlow DR, "Can Healthcare Boards Really Make a Difference in Quality and Safety?" Law \& Governance, 13(8) 2010;

Jaing JH, "Enhancing Board Oversight on Quality of Hospital Care: An Agency Theory Perspective," AHRQ, 2011

## ${ }^{13}$ See:

Governance Certification for Tennessee Hospital Trustees and Boards, Tennessee Hospital Association, 2006; Competency-Based Governance Enters the Health Care Boardroom, The American Hospital Association's Center for Healthcare Governance, 2010;
Hospital Governing Boards and Quality of Care: A Call to Responsibility, National Quality Forum, 2004; Great Boards: Promoting Excellence in Health Care Governance, The American Hospital Association; Reinertsen, JL, Hospital Boards and Clinical Quality: A Practical Guide, Ontario Hospital Association, 2007; Conway J, Getting Boards on Board: Engaging Governing Boards in Quality and Safety, The Joint Commission Journal on Quality and Patient Safety, Volume 34 Number 8, April 2008
${ }^{14}$ Goeschel CA, Wachter RM, Pronovost PJ, "Responsibility for Quality Improvement and Patient Safety: Hospital Board and Medical Staff Leadership Challenges," Chest 2010;138;171-178

## Quality as a System:

Escalation of Concern When Complaint or Failure is Evaluated:

1. Is this an ISOLATED Event?
2. Is there a PATTERN of failure(s) in this area?
3. Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?

A system of performance and oversight must demonstrate iterative cycles of:

Accountability
Flow and
Evidence of Action


> Pre-established Triggers


Early Identification of Opportunity

## Governance Oversight of Quality

Key Questions for Boards

1. Is there a systemic view for strategy, e.g. planning process and strategic plan?
2. Are there measures that answer whether or not strategy is advancing, i.e.: Is care getting better or worse?
3. How were the measures selected? What are the criteria?
4. Are there contexted measures and metrics? For example:

- upper/lower control limits if appropriate
- target
- actual absolute numbers, not percentages; or both
- comparison to history and targets

5. Is there a coordinated process? Is there conformance and predictability in presentations, data displays, etc.?
6. Is the focus on the core product(s) of clinical care, such as core measures, eliminating harm, other specific and relevant topics?
7. Can all staff leaders answer the following questions?

- how does "this" compare to past?
- how does "this" compare to best-of-class?
- what are we doing to improve and close the performance gap?
- what can we predict from what we know?
- what might be unintended consequences of our improvement efforts?

8. What is the relevance to the front line caregivers and providers? Where is street level example that ties "front office to front line?"

## Quality and Patient Safety Committee

[ORGANIZATION]

## Organization and Policy Statement

The Quality and Patient Safety Committee (Committee) is responsible for guiding and assisting the Executive Leaders, Medical Board, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at [ORGANIZATION]; and to meet or exceed standards and regulations that govern health care organizations.

## Responsibilities

The Committee has three broad sets of responsibilities. The first is to directly oversee that quality assurance and improvement processes are in place and operating in the hospital and clinics. The second is to enhance quality across and throughout the technical, patient care, and operations of the [ORGANIZATION]. The latter encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization. The third is to assure continual learning and skills development for risk surveillance, prevention, and continual improvement.

The committee tests all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient[/family]-centered, efficient, timely, and equitable. These aims are the drivers to the Triple Aim: Better Care, Better Health, Lower Cost.

In fulfilling these responsibilities, the committee expressly relies on the confidential protections afforded by law to review activities conducted for the purpose of reducing mortality, morbidity and improving the care provided to patients.

## A. Oversight

As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., The Joint Commission [TJC]) with insuring the quality of care rendered by hospital and clinics through its various divisions and departments. To help meet this responsibility, the Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for [ORGANIZATION], using an inclusive and data driven-process.
- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.
- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Leadership, such other activities as are required by the TJC, Centers for Medicaid and Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and other external accrediting and regulatory bodies.
- Perform such other activities as requested by the Executive Leadership of [ORGANIZATION].
- Render reports and recommendations to the Executive Leadership Committee of [ORGANIZATION], and Medical Board on its activities.
- The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved.


## B. Quality Integration

1. The Committee monitors the quality assurance and improvement activities of [ORGANIZATION]'s entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to: (List as relevant to the organization)
2. The Committee assures the coordination and alignment of quality initiatives throughout [ORGANIZATION].
3. The Committee may initiate inquiries and make suggestions for improvement.
4. The Committee conducts annual reviews of the following key areas:
a. Improvement goal achievement
b. Clinical outcomes (priorities and improvement)
c. Patient Safety/Event Analysis/Risk Trending
d. Culture of Patient Safety
e. Accreditation and Regulatory Reviews
f. Environment of Care and Disaster Management plans
5. The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.
6. The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

## Guidelines

Guidelines are designed to govern the operations of the Committee. They will be developed over time as the Committee functions and performs its responsibilities.

1. Handling of Confidential Documents

Absent a specific request, confidential documents will not be forwarded to Committee members who have indicated they will not be attending a meeting. Confidential documents will be distributed ahead of meetings with the standard agenda package. They will be separately identified, numbered and logged. They will be collected following review at meetings. A return envelope will be forwarded to Committee members unexpectedly unable to attend a meeting so they will have a convenient method of returning these materials. If sent electronically, appropriate security will be used.
2. Standard Agenda'

The standard Agenda for the council will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including: (List relevant services)
- Patient harm

[^10]- Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
- Performance to accreditation and regulatory standards and requirements
- Environmental safety and disaster management


## Rules

Authority to Act
Composition

Meeting Schedule
Recommend Size:
Quorum Requirement:
Chair
Major Staff Support
Notices Forwarded To
Non-member attendees

Yes, within charter and as directed by Executive Leadership and Board Medical and Clinical Staff Leadership appointments; Operations, Executive Staff, and Board Members Patient/ Families membership should be considered Ten meetings per year
Based on organization
Based on organization
Board Chair or Chief Executive Officer (CEO) Chief Quality and Patient Safety Officer, Quality Staff Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)
Staff resources as requested
Subject matter experts as requested

## Summary of Quality and Patient Safety Committee Roles and Responsibility

Provides the operational oversight to assess that quality and its measurement are anchored
[ORGANIZATION]'s Vision and Mission; and to assess the ability of [ORGANIZATION] to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of [ORGANIZATION] and quality of that work and is assisted by the work of the Quality and Patient Safety Committee.

The Quality and Patient Safety Committee has the following specific responsibilities:
3. Inspiring top-tier outcome performance in all clinical programs.
4. Requiring consistency of purpose in achieving best practice in clinical outcome and safety.
5. Keeping improvement as the focus against the theoretical limits of what is possible:aiming for zero defect care.
6. Evaluating whether or not processes are in place and operating to demonstrate improvement is occurring.
7. Reviewing key initiatives.
8. Requiring measures.
9. Focusing on performance results.
10. Escalating barriers to progress to appropriate forums for resolution.
11. Evaluating if community needs are met, which includes public accountability and regulatory compliance.
12. Leading celebration of gains made.
13. Improving its own methods.

# Operational Quality and Patient Safety Performance Improvement Plan 

## [Organization]

## PURPOSE

The purpose of the Quality and Patient Safety Performance Improvement Plan is to improve outcomes of care, establish reliability in delivering care, and advance patient safety, by creating a culture that facilitates:

- Recognition and acknowledgement of risks and adverse events;
- Analysis of reported risks to identify underlying causes and systems changes needed to reduce the likelihood of recurrence;
- Analysis of contributing factors to adverse events and near misses;
- Initiating actions to recover, reduce risk, and prevent recurrence;
- Reporting internally on risk reduction initiatives and their effectiveness;
- Supporting transparency of that knowledge to affect positive change in culture and behavioral changes in health care practice both internally and with other organizations;
- Focusing on processes and systems in a context of Just Culture;
- Prospective review of selected clinical programs or services before an adverse event occurs to identify system design to error proof the system;
- Organizational learning about the epidemiology of error and performance improvement principles and processes;
- Integration of Quality and Patient Safety Improvement priorities into the new design and redesign of all relevant processes, functions and services;
- Systematic planning, analysis and monitoring of performance to improve and sustain advances in processes and outcomes of patient care through interdisciplinary teamwork;
- Regular establishment and reassessment of organizational Quality and Patient Safety Improvement priorities;
- Meeting and exceeding patient / family (customer) needs and expectations;
- Research into ways to improve patient safety and quality;
- Use of evidence-based practice and decision support; and
- Public transparency of reportable performance measures.

The approach to improving quality and patient safety delineated in this plan is based on the [Organization] Quality and Patient Safety Strategy and requires a coordinated and collaborative effort to operationalize. Multiple departments and disciplines are involved in establishing the plans, processes and mechanisms that comprise health care safety and quality activities throughout [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan has been developed with broad interdisciplinary input, Quality and Patient

Safety Committees and Forums and is approved by the relevant committees, and Executive and Governance Leadership.
[Organization] endorses the six aims that the Institute of Medicine's (IOM) Advisory Commission on Consumer Protection and Quality in the Health Care Industry delineates in the report, Crossing the Quality Chasm. Specifically, health care should be:

- Safe - eliminating injuries to patients from the care that is intended to help them
- Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse, inappropriate use, and overuse)
- Patient[/family]-centered - providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide clinical decisions
- Timely - reducing waits and delays for both those who receive care and those who give care
- Efficient - avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- Equitable - providing care that does not vary in quality because of personal characteristics such as gender identity, ethnicity, sexual orientation, geographic location and socioeconomic status.


## SCOPE AND ACTIVITIES

This plan applies to all service and sites of care provided at [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience, to prevent errors and maintain and improve health care safety and quality. [ORGANIZATION] recognizes that patients, physicians and staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error/failure-free care experience. Therefore, [ORGANIZATION] commits to continuously analyzing data, and designing, monitoring, improving and sustaining performance while undertaking a proactive approach to identify and mitigate health care risk and error. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures whenever those results differ from anticipated results. [disclosure]

The Quality and Patient Safety Performance Improvement System, as described in this plan, includes the activities of relevant committees/teams, including, but not limited to:
[list as relevant to organization].
Additional program specifics include:

1. All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported via the Quality Performance Indicator Report, condition specific dashboards and other methods.
2. All departments within the organization (patient care and non-patient care departments) are responsible to report health care safety events, near-misses, risks and hazards. [ORGANIZATION] has
an event reporting system, to report unexpected events and near misses. Summary data from the event reporting system is aggregated and presented periodically to the Quality and Patient Safety Committee and other appropriate forums that determine further safety (risk reduction) activities as appropriate.
3. The organization selects at least one high-risk safety process for proactive risk assessment (FMEA) annually. This is accomplished through review of internal data reports and reports from external sources (including, but not limited to reports from evidence-based medicine, the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicaid \& Medicare Services (CMS) Hospital Compare and other federal and state organizations, The Joint Commission and Current Literature).
4. Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary health care interventions to protect and support the patient's clinical condition.
- Perform necessary health care interventions to contain the risk to others, as appropriate to the event.
- Contact the patient's attending physician and other physicians, as appropriate, to report the event, carrying out any physician orders as necessary.
- Preserve any information related to events, including physical evidence (e.g., removal and preservation of a blood unit for a suspected transfusion reaction, preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from an IV medication, preservation of any medication labels for medications administered to the incorrect patient). Preservation of information includes documenting the facts regarding the event to the immediate supervisor, and to the organization using the event reporting system, and reporting algorithm to Risk Management.

5. An effective Quality and Patient Safety Performance Improvement Plan must exist within an environment of reporting of medical/health care errors and events. [ORGANIZATION] adopts the principles of a Just Culture in management of errors and events. All physicians and staff are expected to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment. [ORGANIZATION] supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes. An accountable, Just Culture approach will be used with involved physicians and staff.
6. Quality and Patient Safety Improvement includes a periodic assessment of patients, families, physicians, and staff perceptions and suggestions for improving patient safety and clinical outcomes.
7. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ from the anticipated outcomes. Guidelines and training for disclosure are provided through the organization using expert resources.
8. New employee and leadership orientation provides initial education and training, including the need and methods to report, PDSA cycles of improvement, and Quality goals. Training, such as provision of health care through interdisciplinary teamwork, is coordinated throughout the [ORGANIZATION] educational resources. Clinical programs and workshops are identified for an emersion in quality improvement and safety science. Ongoing offerings to managers, leaders, physicians, and staff are provided as well.
9. Medical/health care events, including sentinel events, are reported in accordance with all state, federal and regulatory body rules, laws and requirements.
10. Education and orientation is provided to patients to partner for safety through the admission process and distributed materials. Patient/Family Advisory Committees are engaged to help create strategies and tools for [ORGANIZATION].
11. Systematic feedback is an aim for leaders to recognize staff when they have advanced a safety issue.

## EXAMPLE

[Organization can define its own methods]

## QUALITY IMPROVEMENT METHODOLOGY

The evaluation, monitoring, and improvement methodology utilized by [ORGANIZATION] is the DMAIC and/or PDSA process. The steps are:

- Define
- Measure
- Analyze
- Improve
- Control
- Plan the improvement and continued data collection
- Do improvement, data collection and analysis
- Study the results to inform the next test of change
- Act to hold the gain and to continue to improve the process
[ORGANIZATION] also employs tools for process improvement and/or system design that incorporate elements of Statistical Process Control, Six Sigma; and Lean Systems Thinking and Operations Engineering to reduce system variation, delays, and unnecessary complexity that are barriers to optimal patient care.


## QUALITY IMPROVEMENT PRIORITIES

Leaders plan and ensure implementation of the Quality and Patient Safety Improvement System. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Vision and Mission
- Clinical quality outcomes
- Patient safety assessments and event analysis findings
- Patient Safety Climate Survey
- Benchmarking and identification of opportunity
- Participation in improvement collaboratives
- National Patient Safety Goals and other regulatory/accrediting standards
- Customer satisfaction
- Aspirational aims for the future of health care
- IOM six aims of care that is safe, timely, efficient, effective, patient[/family]-centered, equitable

Quality improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients and communities served. Priorities are identified each year in [ORGANIZATION] quality goals and cascaded throughout the organization. Sub goals or drivers of the goals that are locally relevant, conceptually linked, and contribute to achieve the desired outcomes are identified.

Previously prioritized activities are evaluated and are incorporated into standard practice, based on positive findings from these evaluations. Further tracking and trending of these measures are continued if overall quality surveillance measures suggest that formal reevaluation is warranted.

## TOOLS TO GUIDE CLINICAL PRACTICE

Tools to improve quality of care and reduce unintended variation exist throughout [ORGANIZATION]. These tools include evidenced-based guidelines, standardized order sets, protocols and clinical pathways in addition to improvement methodologies described above. There are other activities that are not part of this Quality and Patient Safety Improvement Plan that are carried out throughout the organization where algorithmic approaches exist. Research and experimental study design oversight is conducted by the [designated review board]. Research in safety systems and improvement exists throughout [ORGANIZATION]. [optional text, based on type of organization: Medical resident quality improvement projects and a developing maintenance of certification program contribute to an enriching environment.]

## CONFIDENTIALITY

Confidentiality and peer review protections are essential to a successful quality and patient safety improvement process. Deliberations of quality committees and teams where quality and patient safety improvement issues are discussed are protected. Additionally, names of specific individuals (patients, physicians, staff, etc.) are deindentified. Quality and patient safety improvement data, reports, and other work products are maintained in secure files and databases.

## EVALUATION

The effectiveness of the Quality and Patient Safety Improvement Plan is evaluated and reported annually to the senior leaders, Medical Board, and Governance Board. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

## ACCOUNTABILITY

The executive responsibility for the Quality and Patient Safety Performance Improvement Plan is through the CEO. The Medical Board, Hospital-Clinic Systems, senior leaders, and the Quality and Patient Safety Council ensure implementation of an integrated program throughout the organization. A qualified Chief Quality and Patient Safety Officer reports to the CEO to oversee the portfolio of activity and ensure the system of improvement is operating and effective.

The office of Quality and Patient Safety, led by Chief Quality and Patient Safety Officer, is responsible for advancing strategy and guiding implementation with operations leaders.

## MEDICAL BOARD

The Medical Board has responsibility for the oversight of the safety and quality of medical and patient care rendered by the medical center. It regularly reviews and evaluates performance data and makes recommendations for further action or commissions studies when needed. The Medical Board shares responsibility with the [ORGANIZATION] Administration for developing and reviewing policies and recommending standards for other [ORGANIZATION] staff whose conduct directly influences the safety and quality of patient care.

## QUALITY AND PATIENT SAFETY COMMITTEE

The Quality and Patient Safety Committee (Committee), which represents leadership across [ORGANIZATION], is responsible and accountable for the success of the [ORGANIZATION]'s performance in quality and patient safety activities. The Committee synthesizes and coordinates quality and patient safety activities of the [ORGANIZATION]. The Committee ensures that activities throughout the organization are consistent with the priorities established by leadership. The Committee systematically reviews reports from patient safety and quality related committees and subcommittees to identify key areas of opportunities. The Committee identifies specific high volume, high risk and problem-prone aspects of care, instructing the appropriate committee(s), as delineated in the Medical Staff Bylaws, to prioritize their efforts accordingly.
Intradepartmental performance improvement activities, when appropriate, are shared with the Committee to assure coordination of efforts. The Committee evaluates progress in achieving quality qoals and recommends priorities to senior leaders for goal setting.

The Committee provides quality and patient safety improvement leadership, including but not limited to:

1. Assuring compliance with national recommendations for patient safety, including the National Patient Safety Goals.
2. Overseeing and setting/resetting priorities for [ORGANIZATION] comprehensive, interdisciplinary improvement efforts.
3. Developing an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, non-punitive manner.
4. Empowering committees to identify opportunities, design performance improvement activities and resolve issues.
5. Monitoring patient safety and quality-related functions.
6. Reviewing reports from organizational committees and making recommendations regarding safety and quality of care issues.
7. Overseeing performance measures that are required by accrediting and licensing agencies related to patient safety and quality.
8. Obtaining input for improvement opportunities from committee representatives, department heads or representatives, administrative reports including third-party reports, survey findings from professional organizations such as TJC, departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission.
9. Identifying opportunities for interdisciplinary approaches as needed to resolve problems efficiently and effectively.
10. Chartering performance improvement teams and program evaluations, addressing organizational priorities and reviewing their activities.
11. Referring issues to appropriate improvement teams, clinical services, departments or committees.
12. Facilitating dissemination, discussion and understanding of clinical Performance Improvement and Patient Safety data.
13. Reporting to the Executive Leadership and Board on significant issues.
14. Assuring compliance with accreditation standards and regulatory agency requirements.
15. Monitoring sentinel events and event analysis findings and action plans.
16. Selecting, approving, and reviewing Failure Mode and Effects Analyses (FMEA) performed by the organization.
17. The Medical Board will receive minutes and Quality Performance Indicator Reports.

## EXECUTIVE STEERING COMMITTEE

The Executive Steering Committee is composed of organizational leaders who are responsible for establishing expectations and priorities in order to manage the clinical performance and patient safety improvement system. They remove barriers and/or assign resources as needed. They ensure that processes are in place to measure, assess, and improve the hospital's patient care/safety functions. The key charge of this group is to ensure that the appropriate quality and safety priorities are identified and addressed, remove barriers to progress, and to approve strategies for quality communication inside and outside the hospital.

## STAFF RESPONSIBILITIES FOR SPECIFIC INFORMATION

- All staff from every hospital department are responsible to report patient safety events, risks, and near misses.
- Infection Control and Prevention aggregates and analyzes data related to health care associated infection, infectious disease exposure, contact tracing, and multi-drug resistant organisms.
- The Safety Officer aggregates and analyzes data related to environment of care surveillance and risks, including: safety, security, hazardous materials, and fire prevention.
- Clinical Engineering aggregates, analyzes and reports data related to medical equipment preventive maintenance, incidents, and risks.
- Pharmacy aggregates, analyzes and reports data related to pharmacist interventions, pharmaceutical inspections, and medication use.
- Risk Management aggregates, analyzes and reports data related to actual potential risk management issues and patterns.
[Refer to Organizational Quality \& Patient Safety Accountability Flow]
Example Performance Improvement Plan


## Roles and Responsibilities of Committees for Quality

[^11]Quality \& Safety Accountability \& Reporting Flows

Cascade of Alignment:
Connecting the Dots of Specific Initiatives to
Overarching Quality and Patient Safety Aims to
Move the Dial for Better Care
Continued from page 3

| Definition | Rationale | Highlights of Actions / Strategies in Place for Success |
| :---: | :---: | :---: |
| Medication Events <br> 1. Definitions remain in development | Participate in national definition through CalHEN work | Medication Events and Near Misses <br> - Medication Safety Committee <br> - High risk medication improvement focus: <br> - Opiods <br> - Vancomycin <br> - Anticoagulants <br> - Insulin <br> - Medication reconciliation <br> - Increase profile and leadership of PharmD content experts <br> - Process mapping, FMEA, of medication management system <br> - Focus on pharmacy processes and nursing administration processes <br> - Double check for high risk drugs <br> - California Association of Health System Pharmacists |
| Other areas of Preventable Harm in study / actions <br> 1. Retained surgical items (RSI) <br> 2. Air embolism <br> 3. Blood type incompatibility <br> 4. Manifestation of poor glycemic control <br> 5. DVT, VTE, or PE associated with knee or hip surgery; obstetrical care <br> Never Events are enduring areas of focus: <br> 1. Wrong site, wrong procedure, wrong patient | CMS metrics with same consequences as HAC, HAI. Publically reportable for retained objects, blood transfusion event | - Instrument and sponge count procedures <br> - Intraoperative handovers for relief in cases, and multi-surgical teams <br> - Line management <br> - Reliable system design for blood management <br> - Robust glycemic control process, informatics alert, consulting team, quality metrics and reporting <br> - DVT /VTE/PE tracking added to CaIHEN <br> - Universal Protocol / Time out expanding to outpatient procedural areas of high volume and high risk from surgical operating rooms as well as bedside procedures <br> - Surgical debriefs |

๓

| Strategic Aim: TOP PERFORMANCE IN CLINICAL CARE <br> Aim: Demonstrate top performance in clinical care, by achieving 100\% compliance to evidence-based practices |  |  |
| :---: | :---: | :---: |
| Definition | Rationale | Highlights of Actions / Strategies in Place for Success |
| Inpatient Core Process Quality <br> Metric: An aggregate score, based on compliance with multiple CMS inpatient core measures in these areas: AMI, Heart Failure, Pneumonia, Surgical Care (SCIP). Core measures. <br> Anticipate addition of chronic obstructive pulmonary disease and stroke <br> Asthma care for children | - This aggregate metric samples care quality across four important clinical areas. <br> - The individual inpatient care measures are based on CMS Proposed Rule (Issued Jan, 2011. Amended April 29, 2011) on Value Based Purchasing (VBP) for Medicare Patients; TJC for all patients. <br> - The aggregate metric ("VBP Process Domain Score") is available for monthly tracking of performance. <br> - Measures are publically reported, impacting payment (revenues and penalties) as well as ratings and reputation. <br> - This single numeric score (a percentage of achieved vs. potential) reflects both current level performance and improvement during the time interval of reporting. <br> - Note: This metric does not include the HCAHPS portion of VBC points. | - Opportunities for core measures <br> - Define issue and scope of any gaps <br> - Is Pneumonia discharge trigger and immunization protocol in place? <br> - Implement discharge advisor to deliver pneumococcal and influenza vaccines. <br> - Status of Asthma care for pediatrics <br> - SCIP opportunity is typically acute pain service and surgery service coordination in management <br> - ED to inpatient identification is operational <br> - Psychiatry/mental health emerging |



| Strategic Aim: REDUCE COSTS OF CARE <br> Through efficient, integrated systems of care that reduce the <br> Transitions of care across continuum |  |  |
| :---: | :---: | :---: |
| Definition | Rationale | Highlights of Actions / Strategies in Place for Success |
| Optimizing Care Transitions / Continuity of Care <br> Metric: Rate of Readmissions within 30 days (based on CMS definition of readmission for HF, AMI and Pneumonia). <br> All readmissions for all reasons in definition; focus on unplanned, related readmissions for AMI, HF, PN populations. <br> COPD is being added. | - Readmission rate reflects important coordination of care across inpatient / outpatient boundaries. <br> - Indicator for effectiveness in continuum of care development and partnerships <br> - Driver for differential reimbursement. <br> - Consistent with goal for Optimizing Care Transitions. <br> - Data are generated and can be reported daily, weekly, and monthly. <br> - Studies are in process for predictive models to identify and mitigate risk for readmissions. <br> - Programs for continuing care identified and in process <br> - Post-Acute Care <br> - Medical Home <br> - Skilled Nursing Facility (SNF) capacity/partnerships/access <br> - Transition clinics <br> - Home Care Services are part of care continuum <br> - Case management program and services track at risk patients/populations | - Measure in CalHEN, OCHCN <br> - Explore predictive model intended to trigger protocol for patients at high risk for readmission for more focused discharge plans and resources <br> - Optimal discharge planning teams <br> - Patient education for discharge instruction / patient - centered plan <br> - Post D/C follow up phone calls to include continuing care assessment <br> - PharmD participation in discharge process for medication reconciliations to reduce readmission through appropriate medication management <br> - Meaningful Use implications support this goal <br> - Daily, weekly, monthly readmit reports with chart reviews to understand interconnections of discharge status to reason for readmission. <br> - Readmission for psychiatry needs definition <br> - View patient flow as a value stream <br> - Work with Post-Acute care and Continuing Care agencies and facilities to effectively achieve transitions, especially access <br> - Mental health not yet well understood <br> - HSAG Readmissions collaborative <br> - Why admission in the first place? |

Advance Culture of Safety, Improvement, Reliability with a Learning and Improvement System

| Advance hospital performance to achieve high reliability to take excellence to scale with zero defect in care delivery. |  |  |
| :---: | :---: | :---: |
| Definition | Rationale | Highlights of Actions / Strategies in Place for Success |
| Just Culture provides structure and process consistent with and in support of reliable performance in care delivery. | - Aligns with NQF Safe Practice 4: "Systematically identify and mitigate patient safety risks." <br> - Leadership and reporting is foundational to a culture of safety. <br> - Knowledge, skills, tools are required for improvement at frontlines of care <br> - Leapfrog / TJC/QAPI | Patient Safety First <br> - Mobile Simulation Center Sepsis Project and Team Training <br> - TeamSTEPPS <br> CHPSO <br> - Curriculum and mentors to the programs identified and being recruited <br> - Structures: |
| AHRO/Safety culture survey results create data base for understanding and targeting improvements. | - Results can affect HCAHPS results that roll up into the Value Based Purchasing scores. | - Handovers <br> - Universal protocol and timeouts <br> - Debriefs |
| Create psychological safety for reporting and improvement. <br> Engage and align leaders, faculty, staff and residents in continual learning and improvement within defined clinical microsystems. <br> Create cultural tipping point for reliability, and resilience in frontlines of care and with clinical leaders. | - Survey is required for Leapfrog submission <br> - Handovers and reliable communication are causal variables in events of harm and near misses and central to this goal. <br> - Readiness / demand has been expressed by stakeholders <br> - Capability / capacity of frontline essential to advance habitual excellence <br> - 234 member PSO with data to inform areas of focus | - AHRQ Culture of safety survey opportunity <br> - NPSF certification program <br> - PSO feedback and engagement <br> - Attention of Leadership: fluency in performance, inquiry, recognition <br> - Alignments in HR partnerships, peer review models, mortality and morbidity review formats and conduct <br> - Codes of conduct <br> Transforming Concept from Lucian Leape Institute <br> - Through the Eyes of the Workforce-Creating Workforce and Patient Safety |

# Governance Board Readiness Assessments: 

QI and Patient Safety in Health Care Organizations

Claire Manneh, Project Manager
Hospital Quality Institute
Leadership in quality and patient safety

22 April 2014
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#### Abstract

This review is an attempt to conduct a survey of relevant board readiness instruments used to assess the work of health care organizations on quality improvement and patient safety for California hospitals and health systems. While research on the usefulness of these assessment tools is limited, adopting assessments ensures sustainability, meets patient needs, and restores the values and mission of the organizations. A copy of each these instruments are available in the appendix.


## INTRODUCTION

California is home to the most hospitals and healthcare facilities in the nation, each healthcare organization equipped with a board of directors. More than ever, hospital trustees, executives, and clinicians face a multitude of challenges. They are met with legislative pressures coupled with transformations to the healthcare system, and competition to keep up with those demands, particularly in the patient safety and quality improvement spaces. Board members' use of self-assessment tools can help the organization understand where their opportunities lie and areas of improvement.

A variety of organizations and researchers have come up with instruments for governance boards to understand how they tackle patient safety efforts. Although errors in hospitals exist, the failures in the process may be harmful to patients. Changing the culture to reduce error and improve quality in the healthcare system is an underlying goal in these assessments.

## ASSESSMENTS

## American Governance Center

In a recent study by the American Governance Center, Governance Practices in an Era of Health Care Transformation, researchers found that these tools are beneficial to both hospital and health system boards, particularly in the adoption governance practices to lead their organizations through the significant changes in care delivery. The Center's Readiness Assessment is available for free. The assessment is a high-level survey to help boards determine how their current practices compare with key transformational governance practices identified in the study. Board members have the option to complete the assessment either manually or electronically. Results can be used for discussion about board strengths and opportunities to further improve governance.

## HQLAT

In 2004, the University of lowa and the Oklahoma Foundation for Medical Quality led a major national initiative, under contract with the Centers for Medicare \& Medicaid Services (CMS), to align health care leadership with clinical performance improvement. Advisors from 96 industry organizations and over 600 supporting partners created the Hospital Leadership and Quality Assessment Tool (HLQAT), to help health care organizations identify and adopt quality-oriented leadership systems and ultimately improve clinical care processes and
outcomes. According to the research, respondent groups of hospitals (Board members, CSuite, Clinical Managers) who on average had positive perceptions on the HLQAT domains also had higher quality scores. Further, "differences in the average domain responses between Board, C-Suites and Clinical Managers were smaller for high performing hospitals than for low performing hospitals" (HLQAT). The instrument is available online and free for hospitals. At least 13 surveys per hospital are required to receive a HQLAT report: three board members, four members of the executive team, and six to ten clinical managers. (Case-by-case exceptions to the minimum threshold can be made for small hospitals). Hospitals will have access to view reports as well as evidence based resources. Earlier versions of the survey were pretested over a variety of hospitals and in 2008, Westat conducted a pilot test to determine the association between hospital leadership attributes and hospital performance by comparing the high-performing hospitals with lower performers. Their findings led to a revision based on psychometric analysis results with high reliability (WeStat).

## IFC - International Finance Corporation

An international level tool, the Self-Assessment Guide for Health Care Organizations, provides practical advice to organizations and companies that aim for international standards, including those who may wish to achieve some form of international accreditation. The guide uses a structured self-scoring methodology to lead management teams through a comprehensive assessment of their organizations. It focuses on 31 key standards based on accreditation standards of the foremost international health care accreditation body, the Joint Commission International.

The guide was developed by IFC health sector specialists with support from the Joint Commission Institute and international medical experts. It includes references to free online resources, including reputable sources of evidence-based medical practices.

## IHI

The IHI's "Protecting 5 Million Lives from Harm: Governance Leadership - Boards on Boards (2008)" report provides samples of good practice to improve quality and reduce harm. Instead of using an automated system like the HLQAT or the American Governance Center's self-evaluation tools, the IHI's approach revolves around discussions and patient narratives, recommending boards to devote a quarter of the board meeting time on quality and safety issues. Further, the IHI recommends the entire board to conduct a patient interview on an individual who has experience serious harm within the past year. Six aims the Million Lives campaign asks leadership to focus on are: setting aims; getting data and hearing stories; establishing and monitoring system-level measures; changing the environment, policies, and culture; learning, starting with the board; and establishing executive accountability. The holistic approach of the IHI instrument focuses on qualitative aspects presented at board meetings using the hospital's existing metrics or dashboard, as opposed to a measurable, survey instrument.

## The Monitor Group

Another international and UK-based level tool was created by the Monitor Group, who developed a Framework in 2010. The Framework can be relevant and translated to patient
safety and quality improvement efforts for California. Assessing themselves against this framework allows boards to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. Questions include, Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organization to achieve? Or Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership. What is your evidence for this? The tool also encourages participation from patients, such as children, older people those with mental health conditions. A good patient story will strengthen the footprint on the hospital's effort to improve quality and safety. This guidance lays out one way of gaining assurance that such requirements have been met effectively and comprehensively.

## RECOMMENDATIONS

The HQLAT will provide hospitals the opportunity to bring their Board members over a discussion on quality, identify the differing viewpoints of quality between all stakeholders, and recognize opportunities for process improvements. The benefit to using either the American Governance Center's or the HQLAT's instruments are the post-assessment resources they make available. Further, both tools are available electronically, allowing for convenient data collection and synthesis. The HQLAT also has a benchmarking tool hospitals can use to compare with other systems, a benefit the other instruments do not measure. The IFC, IHI, and Monitor tools may be used electronically if one were to enter the questions into an online survey database, such as Survey Monkey. While these resources are limited, there is a tool used for a study by Bataldan and Stoltz as well as one by Kane et al, which are both available with a PubMed subscription.

## APPENDIX

## American Governance Center Tools  <br> AHA_Governance <br> Tools for Transformat <br> HQLAT: Sample Senior Manager Survey <br>  <br> HLQAT-Senior-Mana <br> ger-Survey Final. pdf

## IFC: Promoting Standards - Quality Measurement and Improvement, Patient Safety, and After the Assessment Modules



IHI Guide


Monitor Group Guide - refer to page 38


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## EVENTLOCATIONS

## Host Hotel and Education Program

Hyatt Regency Sacramento
1209 L Street
Sacramento, CA 95814

## Government Relations/Welcome Reception

Downtown \& Vine
1200 K Street, \#8
Sacramento, CA 95814

## Breakfast Reception with Legislators

Mayahuel Restaurant
1200 K Street
Sacramento, CA 95814

## ACCOMMODATIONS

The Hyatt Regency Sacramento is the host hotel for the event. Rooms are available at a discounted rate of $\$ 229$, single and double occupancy. For reservations, call (800) 421-1442 and mention the "California Hospital Association." The deadline to reserve a room at the discounted rate is February 19.

## TRANSPORTATION

Cab fare from the Sacramento International Airport to the hotel is approximately $\$ 40$ one way and takes about 30 minutes.

## QUESTIONS

Please call the CHA Education Department at (916) 552-7637.

TUITION
This program is for executives of CHA-member hospitals only and the deadline to register is February 19. To encourage members to register by the deadline, registration fees are discounted.

Member rate, by February 19 ........................................... $\$ 245$
Member rate, after February 19 ....................................... \$345

## CONFIRMATIONS

A confirmation will be emailed to all registrants. Participants will be emailed their schedule of appointments with the legislators one week prior to the program.

## CANCELLATION POLICY

A $\$ 50$ non-refundable processing fee will be retained for each cancellation received in writing by March 8. No refunds will be made after this date. Substitutions are encouraged. Cancellation and substitution notification may be emailed to education@calhospital.org.

## AMERICANS WITH DISABILITIES ACT

If you require special accommodations pursuant to the Americans with Disabilities Act, contact CHA at (916) 552-7637.

## 1215 K Street, Suite 800

Sacramento, CA 95814
(916) 443-7401
www.calhospital.org


[^0]:    Employee Fiduciary Retirement Plan Subcommittee

[^1]:    1 California-Health-and-Safoty Code-Soction 123100.
    DOCS-146569-000003/2359262.1

[^2]:    2 Galifornia Health and Safoty Code-Section 123105(d)
    3-Gatifornia-Hoalth and Safoty-Codo-Soction 123110-or 123115
    4 California Health and Safety-Codo-Soction $123105(0)$
    DOCS 116569-000003/2359262.1

[^3]:    ${ }^{5}$ Cal. Health and Safety Code Section 123105(b)
    DOGS $116569-000032359262.1$

[^4]:    ${ }^{6}$-California Health and Safety-Codo Section- 123130
    DOCS $116569-000003 / 2359262.1$

[^5]:    Falifornia-Hoalth and Safoty-Godo-Section 123100.
    Galifornia Hoalth and Safoty Code-Section-123105(f).
    3 Farmily Code-Section 7122 .
    4-Galifornia-Health and Safety Gode Section 123105(a)
    5 California Health and-Safoty Code-Soction-1231050
    6 Galifornia-Health and Safory Codo-Section 123105(d)

[^6]:    Galifernia Health and Safety Code Section 123110-or 123115
    \& California-Health and-Safoty Code-Soction $123105(0)$
    9 Cal. Prob-Codo Soction 58
    10 California Health and Safoty Codo-Section-123115(a)
    ${ }^{\text {+1 }}$ Gal. Health and Safoy-Codo Soction 123105 (b)

[^7]:    12-California Health and Safety Code Section 123130(a)
    13-Galifornia-Health and Safoty-Code Section 123130(b)
    14 Galifornia-Health and-Safoty-Codo-Soction-123130

[^8]:    Hospital - Average Daily Census (ADC) $\qquad$ \begin{tabular}{c|c|c|c}
    \& Jul \& Aus \& Sep <br>
    \hline FY16 \& 183.9 \& 183.4 \& 199.7 <br>
    \hline

 

    FY15 \& 190.8 \& 195.0 \& 195.1 <br>
    \hline
    \end{tabular}

[^9]:    **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.

[^10]:    ${ }^{1}$ Reports are not made on each agenda item in each meeting.

[^11]:    

    Courtesy of Hospital Quality Institute

