**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**June 29, 2017 – 1:30 o'clock p.m.**
**Assembly Room 1 - Eugene L. Geil Pavilion**
**Open Session – Assembly Rooms 1, 2, 3**
**4002 Vista Way, Oceanside, CA 92056**

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 1 | Call to Order | 3 min. | Standard |
| 2 | Approval of agenda | | |
| 3 | Public Comments – Announcement<br>Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. | 3 min. | Standard |
| 4 | Oral Announcement of Items to be Discussed During Closed Session<br>(Authority: Government Code, Section 54957.7) | | |
| 5 | Motion to go into Closed Session | | |
| 6 | Closed Session | **2 Hours** | |
| | a. Conference with Labor Negotiators:<br>(Authority: Government Code, Section 54957.6)<br>Agency Negotiator: Steve Dietlin<br>Employee organization: CNA | | |
| | b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees<br>(Authority: Health & Safety Code, Section 32155) | | |
| | c. Reports Involving Trade Secrets<br>(Authority: Health and Safety Code, Section 32106)<br>Discussion Will Concern: Proposed new service or program<br>Date of Disclosure: December 31, 2017 | | |
| | d. Conference with Legal Counsel – Potential Litigation<br>(Authority: Government Code, Section 54956.9(d) (2 Matters) | | |
| | e. Approval of prior Closed Session Minutes | | |

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

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | f. Conference with Legal Counsel – Existing Litigation<br>(Authority: Government Code, Section 54956.9(d)1, (d)4<br><br>(1) Medical Acquisitions Company vs. TCHD<br>Case No: 2014-00009108<br><br>(2) TCHD vs. Medical Acquisitions Company<br>Case No: 2014-00022523<br><br>(3) Larry Anderson Employment Claims | | |
| 7 | Motion to go into Open Session | | |
| 8 | Open Session | | |
| | ***Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.*** | | |
| 9 | Report from Chairperson on any action taken in Closed Session<br>(Authority: Government Code, Section 54957.1)<br>. | | |
| 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 Recognitions –<br><br>1) Dr. Gene Ma, Chief of Staff | 5 min. | Chair |
| 13 | Introductions –<br><br>1) Anton Kushnaryov, M.D.<br><br>2) Victor L. Souza, M.D. – Incoming Chief of Staff | <br><br>5 min.<br><br>5 min. | <br><br>CSO<br><br>Dr. Ma |
| 14 | Community Update –<br><br>a) American Heart Association Awards Recognition – Luz Aguilar<br><br>b) Ceremonial Presentation and Awarding of Community Healthcare Grant Awards – Gigi Gleason, Chair of Grant Committee/Director Julie Nygaard, Chair of CHAC Committee | <br><br>15 min.<br><br>30 min. | <br><br>E. England/<br><br>J. Johnson<br>CHAC |
| 15 | Report from TCHD Foundation – Glen Newhart – Chief Development Officer | 5 min. | Standard |
| 16 | Report from Chief Executive Officer | 10 min. | Standard |
| 17 | Report from Acting Chief Financial Officer | 10 min. | Standard |
| 18 | New Business | | |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | a. Consideration to approve Resolution No. 786, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2017 and ending June 30, 2018, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California | 5 min. | CFO |
| | b. Consideration to approve a Physician Recruitment Agreement with Dr. Ashish Kabra, General Cardiology | 10 min. | Wayne Knight, CSO |
| | c. Consideration to partnership with the County on the *Live Well San Diego Program* | 10 min. | CHAC Director Nygaard |
| 19 | Old Business | | |
| | a. Consideration of Action to Direct Staff to Prepare Resolution of Application for Proposed Annexation of LAFCO-Recommended Unserved Areas (South Carlsbad and Vista) | 10 min. | General Counsel |
| | b. Update Regarding Resolution No. 785, A Resolution of the Board of Directors of the Tri-City Healthcare District Outlining Intention to Transition from At-Large to District Based Elections Pursuant to Elections Code 10010(e)(3)(A) | 10 min. | General Counsel |
| | c. Update on Board Workshop | 5 min. | Chair |
| 20 | Chief of Staff<br><br>a. Consideration of June 2017 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 26, 2017 | 5 min. | Standard |
| 21 | Consideration of Consent Calendar<br><br>(1) Board Committees<br>***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.***<br>***(2) All items listed were recommended by the Committee.***<br>***(3) Requested items to be pulled <u>require a second</u>.***<br><br>**A. Human Resources Committee**<br>Director Kellett, Committee Chair<br>Open Community Seats – 0<br>*(No meeting held in June, 2017)*<br><br>**B. Employee Fiduciary Retirement Subcommittee**<br>Director Kellett, Subcommittee Chair<br>Open Community Seats – 0<br>*(No meeting held in June, 2017)* | 5 min. | Standard<br><br>HR Comm.<br><br>Emp. Fid. Subcomm. |
| | **C. Community Healthcare Alliance Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 2<br>*(Committee minutes included in Board Agenda packets for informational purposes)* | | CHAC Comm. |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | **D. Finance, Operations & Planning Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 2<br>*(Committee minutes included in Board Agenda packets for informational purposes)*<br><br>1) **<u>Approval of Administrative Policies & Procedures</u>**<br>a) 8610-258 - Charge Description Master, New Charge Or Charge Change<br><br>b) 8610-260 – Charges/Late Charges<br><br>c) 8610-285 – Charity Care, Uncompensated Care, Community Service (English & Spanish versions_<br><br>2) Approval of an agreement with Uni-First Corporation for services to provide and launder mops/cleaning cloths and entrance floor mats for a term of 36 months, beginning July 1, 2017 through June 30, 2020, for an annual cost of $84,156 and a total cost for the term of $252,468.<br><br>3) Approval of a renewal of an agreement with Dr. Mark Yamanaka, ICU Medical Director for a term of 12 months beginning July 1, 2017 through June 30, 2018, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for annual cost of $42,000 and a total cost for the term of 42,000.<br><br>4) Approval of a renewal of an Emergency Department On Call Agreement with Drs. Frank Corona, Martin Nielsen, Mark Yamanaka and Safouh Malhis for Pulmonary and ICU ICU ED Coverage Panel for a term of 24 months, beginning July 1, 2017 through June 30, 2019, at a daily rate of $1,500, for an annual cost of $547,500 and a term cost of $1,095,000.<br><br>5) Approval of a renewal on an Emergency Department On Call Agreement with Drs. Michael Burke, Brian Goelitz, Justin Gooding, Charles McGraw, Michael Noud, Donald Ponec and Richard Saxon as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018, at a daily rate of $650 for an annual and term cost of $237,250.<br><br>6) Approval of a renewal of an Emergency Department On Call Agreement with Drs. Julie Berry, Hernan Goldsztein, Robert Jacobs, Marc Lebovists, Bruce Reisman, Ashish Wadhwa, Anton Kushnaryov, and Jennifer MacEwan for ENT ED Call Coverage Physicians a term of 24 months, beginning July 1, 2017 through June 30, 2019, at a daily rate of $550, for an annual cost of $200,750 and total term cost of $401,500.<br><br>7) Approval of a renewal of an Emergency Department On Call Agreement with Drs. Neville Alleyne, David Amory, Payam Moazzaz, Lokesh Tantuwaya, Kevin Yoo, Sunil | | FO&P Comm. |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | Jeswani, Tyrone Hardy, Thomas Marcisz, Mark Stern and Howard Tung, as the Spine ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018, at a daily rate of $400, for an annual cost of $146,000 and total term cost of $292,000.<br><br>8) Approval of a renewal of an Emergency Department On Call Agreement with Dr. Neeta Varshney, as the Ophthalmology ED-Call Coverage Physician for a term of 12 months, beginning July 1, 2017 through June 30, 2018, at a daily rate of $300 for an annual and term cost of $109,500.<br><br>9) Approval of a renewal of an Emergency Department On Call Agreement with Drs. Caroline Vilchis, Bradley Frasier, Michael Guerena, Jason Phillips, Arthur Warshawsky and Aaron Boonjindasup as the Urology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018, at a daily rate of $350, for an annual and term cost of $127,750.<br><br>10) Approval of an agreement with R. F. MacDonald Co. for the re-tube of boiler #1, for a total expected contract cost of $43,562, and a total project budget of $47,918.<br><br>11) Approval of an agreement with Kone, Inc. for Elevator Maintenance and Service for a term of 60 months, for a cost not to exceed $270,320.<br><br>12) Approval of an agreement with Anesthesia Services Medical Group (ASMG) for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019, not to exceed $49,372 per month, with a total cost for the term of $1,687,096.<br><br>13) Approval of an agreement with Dr. Yung Le, Medical Director/Covering Physician for the Specialty Care Clinic and Progressive Care Unit, for a term of 24 months, beginning July 1, 2017 through June 30, 2019, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163., for an annual cost of $39,120 and a total cost for the term of $78,240.<br><br>14) Approval of a renewal of an agreement with Registry and Traveler Vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and Allied Health for the remaining term of two years, beginning July 1m, 2017 through June 30, 2019, for a new cost for the term of $18.5M.<br><br>15) Approval of a renewal of an agreement with Tri-City Medical Center Neuroscience Institute LLC for Co-Management Services for a term of 36 months, beginning July 15, 2017 through July 14, 2020, for an annual cost of $650,004, and a total cost for the term of $1,950,012.<br><br>16) Approval of a renewal of an agreement of Drs. Jack Schim and Dr. Greg Sahagian, as the Specialty Medical | | |

| | Agenda Item | Time Allotted | Requestor |
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| | Directorship Agreements for the Neuroscience Institute, for a term of 12 months, beginning July 1, 2017 through June 30, 2018, not to exceed an average of 24 hours per month or 288 hours annually, at an hourly rate of 200, for an annual cost of $57,600, and a total cost for the term of $57,600.<br><br>17) Approval of a renewal of an agreement with Drs. Hardy, Sahagian and Yoo, as the Neuroscience Institute Operations Committee Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018, not to exceed an average of six (6) hours per month or 72 hours annually, at an hourly rate of $210, for an annual cost of $15,120, and a total cost for the term of $15,120.<br><br>18) Approval of a renewal of an agreement with Drs. Donald Ponec and Jack Schim, Coverage Physicians for the Neuroscience Institute Quality Committee, for a term of 12 months, beginning July 1, through June 30, 2018, not to exceed an average of four (4) hours per month or 48 hours annually, at an hourly rate of $210, for an annual cost of $10,080, and a total cost for the term of $10,080.<br><br>19) Approval of an extension to an Employee Leasing Agreement with Dr. Tannaz Ebrahimi Adib, for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA.<br><br>20) Approval of an agreement with Sfeir Architects and Construction Company to be named for Design, Development and Construction of an on-campus Retail Pharmacy for a total cost of $336,161.<br><br>21) Approval of a management agreement with Comprehensive Pharmacy Services to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) plus four (4) years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending four (4) years from implementation, for a total cost for the term of $1,107,242.<br><br>22) Approval of a renewal of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory Services for a term of 12 months, beginning July 1, 2017, and ending June 30, 2018, at an annual cost of $695,000 and a total cost of the term of $695,000. | | |
| E. | **Professional Affairs Committee**<br>Director Mitchell, Committee Chair<br>*(Committee minutes included in Board Agenda packets for informational purposes)*<br><br>1) **<u>Patient Care Services</u>**<br>a) Advanced Care Technician (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services<br>b) Passy-Muir Speaking Valve (PMV)<br>c) Sedation/ Analgesia Used During Therapeutics or Diagnostic Procedures | | PAC |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | d) Spontaneous Awakening Trials/ Spontaneous Breathing Trials<br>e) Surgical Attire Policy<br>f) Titrating Medications, Adult Patients Policy<br><br>**2) <u>Administrative Policies and Procedures</u>**<br>a) Equipment /Medical Device Reporting/ Sequestering<br>b) Parking Program<br>c) Paul Gann Blood Safety Act<br>d) Purpose and Responsibility of Risk Management<br>e) Security Department Incident Notification<br>f) Use of Personal Electrical Appliances<br>g) Weapons on Medical Center Campus<br><br>**3) <u>Unit Specific – Education</u>**<br><br>a) AHA TC Records Management Policy<br>b) AHA TC: Safety Guidelines / Safety for AHA Course Participants Policy<br>c) Continuing Education Course Criteria Policy<br>d) Education Documentation of Activities Policy<br>e) Library- Reference Services<br><br>**4) <u>Unit Specific – Emergency</u>**<br>a) Video Laryngscope Set-Up and Cleaning-<br><br>**5) <u>Unit Specific – Medical Staff</u>**<br>a) Discharge Planning for Pediatric and Adolescent Patient<br>b) Influenza Vaccination of Physicians and Allied Health Practitioners<br><br>**6) <u>Unit Specific - NICU</u>**<br>a) Breast Milk Management in the NICU-<br>b) Breastfeeding for the Term and Late Pre-Term Infant in the NICU<br>c) Family Centered Care, NICU<br>d) Repogle Tube Insertion and Management<br>e) Visitation in the NICU<br><br>**7) <u>Formulary Requests</u>**<br>a) 7 + 3 Chemotherapy Orders<br>b) Alemtuzumab (Lemtrada) Orders<br>c) BR for CLL Chemo Orders<br>d) BR for NHL Chemo Orders<br>e) Carbotaxol Chemo Orders<br>f) DA Epoch+ Rituximab Chemo Orders<br>g) Folfox6 + Bevacizumab Chemo Orders<br>h) R Hyper-Cvad Course A (Odd Cycles) Chemo Orders<br>i) R Hyper-Cvad Course B (Even Cycles) Chemo Orders<br>j) Intrathecal Chemo Orders<br>k) Outpatient Bronchoscopy and Needle Biopsy Orders<br>l) R-Chop Chemo Orders<br>m)R-DHAP Chemo Orders<br>n) Xelox + Bevacizumab Chemo Orders<br><br>**8)** Approval of Clinical Contracts | | |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | **F. Governance & Legislative Committee**<br>Director Dagostino, Committee Chair<br>Open Community Seats - 1<br>*(Committee minutes included in Board Agenda packets for informational purposes.)*<br><br>1) Approval of Board Policy 023 – Responsibility for Decision-making on Legal Matters<br><br>2) Approval of amended District Bylaws<br><br>3) Approval of Board Policy 042 – Duties of the Board of Directors<br><br>**G. Audit, Compliance & Ethics Committee**<br>Director Schallock, Committee Chair<br>Open Community Seats – 0<br>*(Committee minutes included in Board Agenda packets for informational purposes.)*<br><br>1) Approval of Administrative Policy 8610-280 – Unclaimed Property<br><br>2) Approval of Non-Clinical Contract Spreadsheet<br><br>(2) Minutes – Approval of:<br><br>a) Regular Board of Directors Meeting – May 25, 2017<br>b) Special Board of Directors Meeting – May 23, 2017<br>c) Special Board of Directors Meeting – June 1, 2017<br>d) Special Board of Directors Meeting – June 15, 2017<br><br>(3) Meetings and Conferences – NONE<br><br>(4) Dues and Memberships<br>1) Payers & Providers California Edition - $219.00 (Renewal – electronic publication) | | Audit, Comp. & Ethics Comm.<br><br>Standard |
| 22 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 23 | Reports (Discussion by exception only)<br>(a) Dashboard<br>(b) Construction Report – None<br>(c) Lease Report – (May, 2017)<br>(d) Reimbursement Disclosure Report – (May, 2017)<br>(e) Seminar/Conference Reports:<br><br>1) Director Schallock – AHA Meeting/Congressional Action Plan Meeting | 0-5 min. | Standard |
| 24 | Legislative Update | 5 min. | Standard |
| 25 | Comments by Members of the Public<br>NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board | 5-10 minutes | Standard |
| 26 | Additional Comments by Chief Executive Officer | 5 min. | Standard |
| 27 | Board Communications (three minutes per Board member) | 18 min. | Standard |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 28 | Report from Chairperson | 3 min. | Standard |
| | Total Time Budgeted for Open Session | 3 hours | |
| 29 | Oral Announcement of Items to be Discussed During Closed Session | | |
| 30 | Motion to Return to Closed Session (if needed) | | |
| 31 | Open Session | | |
| 32 | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed) | | |
| 33 | Adjournment | | |

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**OTOLARYNGOLOGY**
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Santa Rosa, CA 95403
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# CURRICULUM VITAE

## PROFESSIONAL EXPERIENCE

9/2015 - Present — Santa Rosa Head and Neck Surgical Group
1701 4th Street, Suite 120
Santa Rosa, CA 95404

## EDUCATION

7/2010 – 6/2015 — Residency in Otolaryngology/Head and Neck Surgery
University of California - San Diego Medical Center

7/2011 - 6/2012 — Research Fellow
Cartilage Tissue Engineering Lab
University of California - San Diego Medical Center

7/2009 - 6/2010 — Internship in General Surgery
University of California - San Diego Medical Center

8/2005 – 6/2009 — Doctor of Medicine
University of Minneapolis Medical School - Twin Cities
Minneapolis, MN
- -Clinical rotation in Oto-Rhino-Laryngology
  Karolinska Institutet
  Stockholm, Sweden 5/2009-6/2009
- -Quie-Farbstein Healthcare in Israel Program
  Baruch Padeh Medical Center
  Poriya, Israel 5/2008

8/2002 – 6/2004 — Post Baccalaureate Medical Studies
University of Wisconsin
Milwaukee, WI

8/1997 – 12/2001 — Bachelor of Science in Art, Concentration in Oil Painting
University of Wisconsin
Madison, WI

## LICENSURE AND CERTIFICATION

California State Medical License (active/current)

Controlled Substance Registration Certification (DEA) (active/current)

American Board of Otolaryngology Written Exam passed 9/2015

American Board of Otolaryngology Oral Exam pending 4/2016

## MEDICAL STAFF APPOINTMENTS

| | | |
|---|---|---|
| 9/2015 - Present | Santa Rosa Memorial Hospital<br>1165 Montgomery Drive<br>Santa Rosa, CA 95405 | Active |
| 9/2015 - Present | Sutter Medical Center of Santa Rosa<br>3325 Chanate Road<br>Santa Rosa, CA 95404 | Active |
| 9/2015 - Present | Advanced Surgery Institute<br>1739 Fourth Street<br>Santa Rosa, CA 95404 | Active |

## PROFESSIONAL MEMBERSHIPS

| | |
|---|---|
| 2015 - present | Member, Sonoma County Medical Association |
| 2010 - present | Member, American Academy of Otolaryngology-Head and Neck Surgery |
| 2008 - present | Member, Alpha Omega Alpha |
| 2011 - 2012 | Member, California Otolaryngology Society |
| 2006 - 2007 | Board Member, Community Advisory Board, Phillips Neighborhood Clinic |
| 2005 - 2009 | Member, American Medical Association |
| 2005 - 2006 | President, Surgery Interest Group, University of Minnesota Medical School |
| 2003 - 2004 | Member, American Medical Student Association |
| 2001 | Member, Wisconsin Union Directorate Art Committee |

## GRANTS, SCHOLARSHIPS & AWARDS

| | |
|---|---|
| 2012 | American Academy of Otolaryngology-Head and Neck Surgery Resident Travel Grant |
| 2011, 2012 | American Academy of Otolaryngology-Head and Neck Surgery Resident Research CORE Grant |
| 2010 - 2012 | Synthes Resident Travel Grant |
| 2012 | Stryker Resident Travel Grant |
| 2008 | Alpha Omega Alpha |
| 2008 | Maimonides Scholarship for Study in Israel |
| 2007 | Betty Ford Center Summer Institute for Medical Students Scholarship |
| 2006 | Minnesota Medical Foundation Summer Research Grant |
| 2005 | Walter and Elva Lovell Scholarship, Minnesota Medical Foundation |
| 1997,2000,2001 | Dean's List, UW-Madison |
| 2000 | UW-Madison Study Abroad Scholarship |

## SELECTED WORK EXPERIENCE

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|---|---|
| 2011 - 2012 | Examining Physician<br>Compensation and Pension Clinic<br>VA Medical Center, San Diego, CA |
| 2011 - 2012 | Physician<br>Family Health Centers of San Diego<br>Logan Heights Clinic, San Diego, CA |
| 2007 | Gross Anatomy Teaching Assistant<br>University of Minnesota Medical School<br>Minneapolis, MN |
| 2004 | Clinical Research Coordinator<br>VA Medical Center<br>Minneapolis, MN |
| 2003 | Laboratory Technologist<br>Medical College of Wisconsin<br>Milwaukee, WI |
| 2001 | Art Instructor<br>Ann Arbor Art Center<br>Ann Arbor, MI |
| 2001 - 2002 | Assistant to the Registrar<br>Madison Arts Center<br>Madison, WI |

## COMMUNITY SERVICE

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|---|---|
| 2005 - 2008<br>2006 - 2007 | Student Clinician<br>Community Advisory Board Member<br>Phillips Neighborhood Clinic, Minneapolis, MN |
| 2004 | University of Minnesota Anatomy Memorial Service Planning Committee Member<br>University of Minnesota, Minneapolis, MN |
| 2003 - 2004 | Volunteer Compassionate Companion<br>Columbia Hospital, Milwaukee, WI |
| 2003 - 2004 | Volunteer Reader for the Blind and Disabled<br>Student Accessibility Center, Milwaukee, WI |

## PUBLICATIONS & PRESENTATIONS

. Lopez, **A. Kushnaryov**, AM, Weisman, RA. Sudden Enlargement of Facial Mass. Submitted (2016)

2. Miller M, Harris JP. Illustration for Autoimmune Inner Ear Disease. In: Paparella, da Costa, Singh eds. International Textbook of Otolaryngologic Principles and Practice. Jaypee Medical Publishers. 2014.

3. **Kushnaryov AM**, Yamaguchi T, Briggs KK, Wong VW, Reuther MS, Neuman M, Lin, Sah RL, Masuda K, Watson D. "Evaluation of Autogenous Engineered Septal Cartilage Grafts in Rabbits- A Minimally Invasive Preclinical Model" Advances in Otolaryngology, vol. 2014, Article ID 415821, 7 pages, 2014. doi:10.1155/2014/415821

4. Caffrey JP, **Kushnaryov AM**, Reuther MS, Wong VW, Briggs KK, Masuda K, Sah RL, Watson D "Flexural properties of native and tissue-engineered human septal cartilage". Otolaryngol Head Neck Surg. 2013 Apr;148(4):576-81.

5. Singh JA, Mahowald ML, **Kushnaryov A**, Goelz E, Dykstra DJ "Evaluation of Repeated Intra-articular Botulinum Toxin A Injections for Sustained Pain Relief". J Clin Rheumatol. 2009; 15:35–38.

6. "Evaluation of Autogenous Engineered Septal Cartilage Grafts in Rabbits- A Minimally Invasive Preclinical Model" **Kushnaryov AM**, Yamaguchi T, Briggs KK, Wong VW, Reuther MS, Neuman M, Lin, Sah RL, Masuda K, , Watson D. Oral Presentation at the Annual meeting of the American Academy of Otolaryngology – Head and Neck Surgery, Vancouver BC. (2013)

7. "Flexural properties of native and tissue-engineered human septal cartilage" Caffrey JP, **Kushnaryov AM**, Reuther MS, Wong VW, Briggs KK, Masuda K, Sah RL, Watson D. Oral Presentation at the Annual meeting of the American Academy of Otolaryngology – Head and Neck Surgery, Washington D.C. (2012)

8. "Repeat injections of intra-articular botulinum toxin A for the treatment of chronic arthritis joint pain". Singh JA, Mahowald ML, **Kushnaryov A**, Goelz E, Dykstra D. J Clin Rheumatol. 2009 Feb;15(1):35-8. Poster Presentation at the 2007 American College of Physicians Internal Medicine Annual Conference, National Medical Student Research Poster Competition Finalist. Poster presentation at the 6th Annual Alfred E. Michael Students' Research Colloquium at University of Minnesota Medical School (2007)

## PROFESSIONAL MEETINGS & COURSES

| | |
|---|---|
| 2/2014 | ACS Thyroid and Parathyroid Ultrasound Skills- Oriented Course, Palm Springs, CA |
| 6/2012,2014 | UCSD Temporal Bone Course, San Diego, CA |
| 2/2013 | AO North America Advance Symposium: Refinements in Facial Trauma and Reconstructive Surgery, Vail, CO |
| 9/2013 | Stryker Senior Residents Temporal Bone and Skull Base Hands-on Surgical Workshop, Tampa, FL |
| 9/2012 | AO North America Craniomaxillofacial Surgery- Orbital Approaches and Fundamentals with Human Anatomic Specimens, New Orleans, LA |
| 11/2011 | 8th State of the Arts Concepts in Laryngeal Conservation Surgery Course, Loma Linda, CA |
| 11/2011 | 9th Annual Western Residents' Advanced Functional Endoscopic Sinus Surgery Course, Loma Linda, CA |
| 10/2011 | Stryker Surgical Approaches, Techniques and Fixation in Craniomaxillofacial Trauma Surgery Course, Mawah, NJ |
| 12/2010,2012 | AO North America Principles of Operative Treatment of Craniomaxillofacial Trauma and Reconstruction, Los Angeles, CA and San Diego CA |
| /2010 | Dr. Hugh Greenway's 27th Annual Superficial Anatomy and Cutaneous Surgery Course San Diego, CA |

## PAINTING EXHIBITIONS

2005 Permanent Collection, University of Minnesota Medical School
2003 Turner Hall Annual, Milwaukee, WI
2002 First Time In Awhile, Ann Arbor, MI
2002 Late., Madison, WI
2001 108 Does Conceptual Art, Madison, WI
1999 Solo Exhibition, Madison, WI
1998 The 69th Annual Student Art Show, Madison, WI

**RESOLUTION NO. 786**

**A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2017 AND ENDING JUNE 30, 2018 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA**

WHEREAS, Section 1 of Article XIII B of the Constitution of the State of California provides that the total annual appropriations of each local government shall not exceed the appropriations limit of such entity of government for the prior year, adjusted for changes in the cost of living and population, subject to certain specified exceptions in said Article; and

WHEREAS, Section 8 of Article XIII B of the Constitution of the State of California defines "Appropriations subject to limitation" of an entity of local government as "any authorization to expand during a fiscal year the proceeds of taxes levied by or for that entity and the proceeds of state subventions to that entity" (other than subventions made pursuant to new programs or services mandates by the State Legislature) "exclusive of refunds to taxes"; and

WHEREAS, Section 7910 of the Government Code of the State of California provides that each year the governing body of each local jurisdiction shall, by resolution, establish its appropriations limit for the following fiscal year pursuant to Article XIII B of the Constitution of the State of California at a regularly scheduled meeting or noticed special meeting; and

WHEREAS, the documentation used in determining the appropriations limit adopted in this resolution has been available to the public for fifteen (15) days prior to the adoption of this resolution.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT DOES HEREBY RESOLVE AND ORDER AS FOLLOWS:

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 20167and ending June 30, 2018 is, not to exceed, $14,102,482.00

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 29th day of June, 2017.

_____
James J. Dagostino, Chairperson of the
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

_____
Laura E. Mitchell, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Physician Recruitment Proposal – General Cardiology**

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

**Physician Name:** Ashish Kabra, M.D.
**Areas of Service:** General Cardiology

**Key Terms of Agreement:**

| | |
|---|---|
| Effective Date: | July 1, 2017 or the date Dr. Kabra becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff |
| Community Need: | TCHD Physician Needs Assessment shows significant community need for General Cardiology |
| Service Area: | Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients |
| Income Guarantee: | $350,000 annually ($700,000 for two years with a three-year forgiveness period) |
| Sign-on Bonus: | $25,000 |
| Incremental Start-Up: | $30,000 |
| Relocation: | $5,000 (Not part of the Loan) |
| Total Not to Exceed: | $755,000 (Loan Amount) |

**Unique Features:** Dr. Kabra will join the group practice of Blue Coast Cardiology Medical Group, with Dr. Bui and Dr. Spiegel, in Oceanside, CA.

**Requirements:**

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

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

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

***To be included in the proposed FY Budget*

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

**Motion:**

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $755,000 in order to facilitate this General Cardiology physician practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Blue Coast Cardiology Medical Group and Dr. Ashish Kabra.

# Ashish Kabra, MD MRCP (UK)

319 Allison Drive NE, Atlanta, GA 30342. **Cell: 484-254-7016, 404-805-8454**
ashkabra@gmail.com, dr.kabra2012@gmail.com

## Professional Highlights

I am an experienced physician, completing medical school in the United Kingdom and then training and practicing Internal Medicine in the UK for five years before completing specialty and sub-specialty training in the USA for another seven years. I have been in practice as a clinical cardiologist for three years.

Although I have a significant interest in cardiovascular imaging, I take pride in being a clinically orientated non invasive cardiologist, serving patients to the best of my abilities. My personal strengths are patient interaction and clinical care. I believe my Press Ganey patient scores are reflection of this (http://www.piedmont.org/find-a-doctor/doctor-profile?id=3953).

My intention is to add value to the position I join and I hope to get involved with group practice management at all levels. I believe my clinical skills, imaging focus and managing my own office based practice is applicable to several roles at attending level.

## Licenses

American Board of Internal Medicine : General Internal Medicine:
Certified American Board of Internal Medicine: Cardiovascular
Disease: Certified Certifying Board of Nuclear Cardiology: Certified
Special Competence in Echocardiography (ASCeXAM)
Certified/Testamur Certifying Board of Cardiovascular Computed
Tomography: Certified
Medical Board of California: Full unrestricted license
Medical Board of Georgia: Full unrestricted license
National Lipid Association: Masters in Lipidology

## Skills

- General and Consultative Cardiology
- Pacemaker interrogation
- ECG interpretation
- Stress testing
- Holter and event recorder interpretation
- Advanced Lipid Management
- Level III Echocardiography
- Level I Diagnostic
- Level II Nuclear Cardiology
- Level III Cardiac MRI
- Level II Cardiac CT
- Carotid IMT

## Professional Highlights

**August 2013- date**
Clinical Cardiologist and Advanced Cardiovascular Imaging
***Piedmont Heart Institute, Piedmont Healthcare, Atlanta, GA***

**July 2012 to July 2013**
Advanced Cardiovascular Imaging Fellow
***Scripps Clinic and Green Hospital, San Diego,***

**July 2009 to July 2012**
Cardiovascular Diseases Fellowship,
***Lehigh Valley Healthcare Network/University of South Florida, Allentown, PA***

**July 2006 to July 2009**
General Internal Medicine
***Lehigh Valley Healtcare Network/Penn State University, Allentown, PA***

## UK Professional Experience

Medical Registrar, General Medicine: Guys and St Thomas Hospital, London. February-May 2006 Senior House Offier, Medical Rotation: Guys and St Thomas' Hospital, London. April 2004- July 2005

Senior House Officer, Medical Rotation: Norfolk and Norwich University Hospital, Norwich. August 2002-April 2004 Senior House Officer, Acute Medicine: Guys and St Thomas' Hospital, London. August 2001-February 2002

General Medical and Surgical Internship: Manchester Deanery, UK. August 2000 to August 2001

## Education and Training

**MB ChB (MD): Medicine**, 2000

**University of Manchester School of Medicine** - Manchester, United Kingdom

## Publications

1. Global and regional extracellular volume and myocardial circumferential strain correlate significantly in a heterogeneous patient population .

Rajpurohit N, Qian Z, Liu S, Goswami R, **Kabra A**, Polsani V & Vannan M

JCMR 2016 18(Suppl 1):P260

2. Comparison of conventional echocardiographic parameters of RV systolic dysfunction with cardiac magnetic resonance imaging.

Zhou X, Liu S, Qian Z, Lee JC, Goswami R, **Kabra A**, Blanco R, Sharma J, Vannan M, Rinehart S, Polsani V

JCMR *2015,* 17*(*Suppl 1):M10 (3 February 2015*)*

3. Fatty liver disease, glucose tolerance and insulin resistance in obese adolescents.

Slyper AH, Rosenberg H, **Kabra** A, Huang WM, Blech B, Matsumura MM.

Pediatr Obes. 2015 Dec;10(6):423-7. doi: 10.1111/ijpo.279. Epub 2014 Dec 17

4. Early atherogenesis and visceral fat in obese adolescents.

Slyper AH, Rosenberg H, **Kabra A**, Weiss MJ, Blech B, Gensler S,

Matsumura M. Int J Obes (Lond). 2014 Jul;38(7):954-8. doi:

10.1038/ijo.2014.11. Epub 2014 Jan 23.

5. Carotid intima-media thickness assessment in refinement of the Framingham Risk Score: can it predict ST-elevation myocardial infarction? A pilot study.

**Kabra A**, Neri L, Weiner H, Khalil Y, Matsumura ME.

Echocardiography. 2013 Nov;3 (10):1209-13. doi: 10.1111/echo.12272. Epub 2013 Aug 13.

6. Puzzles in Practice. Ebstein's anomaly.

Shariff N, **Kabra A**, Matsumura ME, Mishriki YY.

Postgrad Med. 2011 Nov;123(6):202-4. No abstract available.

7. Anomalous right coronary artery arising from the pulmonary artery.

Kabra AN, Martinez MW, Wu JK. Published online, Case Of The Week series, Society for Cardiovascular MRI http://www.scmr.org/caseoftheweek/2010/2267.html

## Presentations

*Oral Presentations*

1. *SONECOM: Society of Mexican Echocardiography July 2016*

CMR for Heart Failure. When? Why
CMR/ Echo in chronic AI
CMR/CT for tricuspid valve disease

2. *American Heart Association Scientific Sessions, November 2015, Orlando, FL*

CMR in Heart Failure

3. *American College of Cardiology Scientific Sessions, Heart Rhythm Society Annual Scientific Sessions, American Heart Association Scientific Sessions 2013*

Determining the risk of magnetic resonance imaging in the prescence of pacemakers and implantable cardiac defibrillators: interim results from the magnasafe study.

4. *C3 Complex Cardiovascular Catheter Therapeutics, Advanced Endovascular and Coronary Intervention Summit. Orlando, Florida*

'It's a stick up' . A case of right coronary artery dissection following radial artery catheterization

*Poster Presentations*

1. *AHA Scientific Sessions. October 2013*

Can Three-Dimensional Echocardiography Replace Two-Dimenstional Biplane Simpson's Method? A Comparison of Fully Automated Three-Dimensional Transthoracic Echocardiography and Cardiac Magnetic Reasonance Imaging for Quantification of Left Ventricular Volume and Ejection Fraction. Hirsch S. Mehta, **Ashish N. Kabra**, Rajeev C. Mohan, Kristin Billick, Karoline Sato, Michael R. Smith, and David S. Rubenson.

2. *ACC Scientific Sessions 2013, PA ACC Chapter meeting 2011:* ***Ranked 3rd place runner up,*** *Lehigh Valley resident research day 2012* ***Ranked 1st Place,*** *Preventative Cardiovascular Nurses Association Annual meeting*

Carotid Intima Media Thickness in the prediction of ST elevation myocardial infarction. **Ashish Kabra MD**, Justin Roberts DO, Nitin Verma MD, Lori Neri MSN and Martin Matsumura MD.

3. *PA ACC Chapter Meeting 2011, Lehigh Valley Resident Research day:* ***Ranked 3rd Place***

Carotid Intima Media Thickness as a marker of cardiovascular disease in obese adolescents with varying glucose tolerance. **Ashish Kabra**, Benzion Blech, Stuart Gensler, Martin Matsumura and Arnold Slyper.

4. *PA ACC Chapter Meeting 2011, SCCT Annual meeting 2012 Abstract 85, Poster Session X*

Coronary CT radiation reduction: the Lehigh Valley Healthcare Network experience. Nitin Verma MD, **Ashish Kabra MD**, Justin Roberts DO, James Newcomb MD, Howard Rosenberger MD, Julie Gubernick MD and Matthew Martinez MD.

5. *Pediatric Academy Society Research 2011 meeting*

Fatty liver disease in obese dolescents, relationships toglucose tolerance. Arnold H Slyper MD, Martin Matsumura MD, Benzion Blech, Kim Kopfer and **Ashish Kabra MD**.

## Hospital/Group Commitees

Education regional director for Northern Corridor PHI group
General and Preventative COE
Office lead: Piedmont Heart in Canton

## Interests and Activities

Running, Golf, Scuba Diving, Travelling and Auto Enthusiast.
Married to: Krishna Kabra. Executive Vice President, The Value Engineers, San Diego, CA.
Two children: Shiva Lakshmi (Girl aged 9) and Om (Boy aged 7)

## Immigration Status

British Citizen
USA Green Card Holder/ Permanent Residency Status

## Professional Societies

American Heart Association
American College of Cardiology
American Society of Nuclear Cardiology
Society for Cardiovascular Computerized Tomography
Society for Cardiovascular Magnetic Resonance Imaging
American Medical Association

## References

Available on request

# LIVE WELL SAN DIEGO

## The County of San Diego's vision of a region that is **Building Better Health**, **Living Safely** and **Thriving**

### BUILDING BETTER HEALTH

Improving the health of residents and supporting healthy choices

### LIVING SAFELY

Ensuring residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies

### THRIVING

Cultivating opportunities for all people and communities to grow, connect and enjoy the highest quality of life

In 2010, the County Board of Supervisors adopted the *Live Well San Diego* vision of a region of 3.2 million residents that is Building Better Health, Living Safely and Thriving. Based upon a foundation of community involvement, *Live Well San Diego* includes three components: *Building Better Health*, adopted on July 13, 2010; *Living Safely*, adopted on October 9, 2012; and *Thriving*, adopted on October 21, 2014.

*Live Well San Diego* is built on four strategic approaches:

## 1. BUILDING A BETTER SERVICE DELIVERY SYSTEM

Improve the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities

## 2. SUPPORTING POSITIVE CHOICES

Provide information and resources to inspire county residents to take action and responsibility for their health, safety and well-being

## 3. PURSUING POLICY & ENVIRONMENTAL CHANGES

Create environments and adopt policies that make it easier for everyone to live well, and encourage individuals to get involved in improving their communities

## 4. IMPROVING THE CULTURE WITHIN

Increase understanding among County employees and providers about what it means to live well and the role that all employees play in helping county residents live well

23 Oct 2015 v5

# PROGRESS THROUGH PARTNERSHIPS

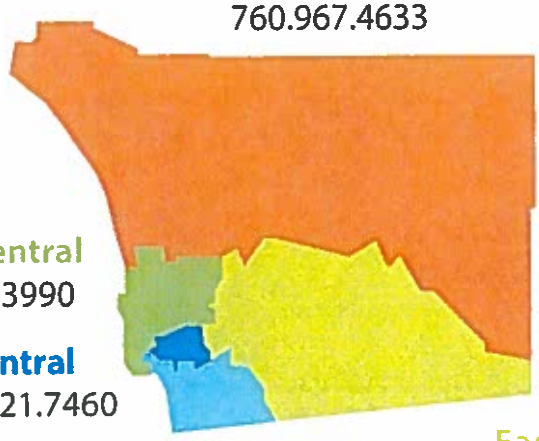
*Live Well San Diego* involves everyone. Only through collective effort can meaningful change be realized in a region as large and diverse as San Diego County. The County's partners include cities and tribal governments; diverse businesses, including healthcare and technology; military and veterans organizations; schools; and community and faith-based organizations. Most importantly, *Live Well San Diego* is about empowering residents to take positive actions for their own health, safety and well-being.

Every County department is committed to playing an active role and coordinating efforts to make the biggest impact. Annual reports highlight success stories of local communities, organizations and recognized partners who are making positive changes. These reports can be accessed on the *Live Well San Diego* website at **LiveWellSD.org/about/live-well-san-diego-materials/**. This website also includes resources for getting involved; best practice tools for organizations and recognized partners in every sector; and information about the *Live Well San Diego* Indicators, which measure our region's collective progress.

## REGIONAL LEADERSHIP TEAMS

Teams of community leaders and stakeholders are active in each of the Health and Human Services Agency (HHSA) service regions. These teams have been involved in community improvement planning and are working to address priority needs over the next few years to realize the *Live Well San Diego* vision. These teams serve as a central point for planning and prioritizing collaborative action at the local level.

Contact your team by calling the phone numbers listed on the map.




## RESULTS

How will progress be measured? The Top Ten *Live Well San Diego* Indicators have been identified to capture the overall well-being of residents in the county. These Indicators are part of a framework that allows the County to connect a wide array of programs and activities to measureable improvements in the health, safety and well-being of every resident. The complete framework is posted on the County of San Diego *Live Well San Diego* webpage: http://sdcounty.ca.gov/content/sdc/live_well_san_diego/indicators.html

**HEALTH**

Life Expectancy

Quality of Life



**KNOWLEDGE**

Education

**STANDARD OF LIVING**

Unemployment Rate

Income

**COMMUNITY**

Security

Physical Environment

Built Environment

**SOCIAL**

Vulnerable Populations

Community Involvement

# BECOMING A RECOGNIZED *LIVE WELL SAN DIEGO* PARTNER

*Live Well San Diego* involves partners in all sectors - from government, to business, to schools, to faith-based and community organizations - through a shared purpose. Working together allows for planning and implementation of innovative and creative projects to bring the *Live Well San Diego* vision of region that is Building Better Health, Living Safely and Thriving to life.

## *Live Well San Diego* Recognized Partners are:

### INFLUENTIAL

They are leaders of change in their communities, committed to setting an example and sharing knowledge and resources with other organizations to broaden collective impact.

### GOING ABOVE AND BEYOND

They are taking their activities to the next level by implementing innovative programs, policies and practices that support healthy, safe and thriving communities.

### MEASURING PROGRESS

They are developing measurable objectives and using tools to track and report their results.

### FORWARD THINKING

They are committed to sustainable change. Recognizing that this takes time, they are dedicated to supporting *Live Well San Diego's* ideals both today and in the future.

## Why become a Recognized Partner?

Designation as a *Live Well San Diego* Recognized Partner has numerous benefits, including:

- Opportunities to showcase best practice examples and success stories through online, media and events
- Support in tracking data, measuring outcomes and reporting results
- Collaboration with a growing network of champions and partners for the greatest collective impact

# Recognized Partners actively support *Live Well San Diego* in each of these 5 areas:

## 1. History

Demonstrated prior commitment to prevention activities or promoting health, safety and thriving activities consistent with *Live Well San Diego*

## 2. Partnership

Current active engagement in community health and safety efforts, such as participating in *Live Well San Diego* Regional Leadership teams or other collaborative efforts

## 3. Promotion of Positive Choices

Support programs or policies that encourage people to improve their lives in at least one of the following areas:

a. Physical activity
b. Nutrition
c. Tobacco use/exposure prevention
d. Alcohol and drug abuse prevention
e. Injury and violence prevention
f. Emergency preparedness
g. Mental health and suicide prevention
h. Other *Live Well San Diego* priority

## 4. Communication

Openly share resources, best practices, measurement tools and success stories with *Live Well San Diego* support team, County News Center and other organizations and residents

## 5. Policy, Systems or Environmental Change

Demonstrate sustained support by putting *Live Well San Diego* principles into practice in at least one of the following ways:

a. Adopting or updating policies that support public health, wellness and/or safety
b. Improving organizational and service delivery systems that support healthy, safe and thriving people
c. Promoting changes in the physical environment that make it easier for people to be healthy, safe and thriving

# WANT TO LEARN MORE?

Express interest to a Health and Human Services Agency Regional Manager or County Executive, or:

**VISIT**
LiveWellSD.org

**EMAIL**
LWSD.HHSA@sdcounty.ca.gov

**CALL**
619.338.2895

LIVE WELL

**Community & Faith-Based Organizations (179)**

1. 1to1 Movement
2. Alzheimer's San Diego
3. American Academy of Pediatrics, California Chapter 3
4. American Diabetes Association
5. American Heart Association/American Stroke Assoc.
6. America Liver Foundation – Pacific Coast Division
7. American Lung Association
8. Arthritis Foundation
9. Arts for Learning San Diego
10. BAME Community Development Organization
11. Bayside Community Center
12. Bayview Baptist Church
13. Be There San Diego
14. Borrego Community Health Foundation
15. Boys & Girls Club of Greater San Diego
16. Boys to Men Mentoring
17. Braille Institute
18. California Center for the Arts Escondido
19. California Indian Legal Services
20. California Veterans Legal Task Force
21. Casa Familiar
22. Casa de Amparo
23. Catholic Charities Diocese of San Diego
24. Center for World Music
25. Champions for Health
26. The Children's Initiative
27. Christie's Place
28. Chula Vista Community Collaborative
29. Circulate San Diego
30. Communities of Excellence 2026
31. Community Alliance for Healthy Minds
32. Community Health Group
33. Community Health Improvement Partners
34. Community Information Exchange
35. Community Research Foundation
36. Community Resource Center
37. Community, Action, Service & Advocacy
38. Consumer Advocates for RCFE Reform
39. Delta Sigma Theta Sorority, Inc.
40. DETOUR (Depositing Empowerment Through Outreach & Urban Redevelopment
41. East Region Community Collaborative
42. ElderHelp of San Diego
43. Encinitas Community Gardens
44. Escondido Community Child Development Center
45. Escondido Education COMPACT
46. Facilitating Access to Coordinated Transportation, Inc.
47. Fallbrook Healthcare District
48. Family Health Centers of San Diego
49. FAB (Fashion Art Business) Authority
50. Father Joe's Villages
51. Feeding America San Diego
52. The Fellowship Center
53. Gary & Mary West Foundation
54. George G. Glenner Alzheimer's Family Centers
55. Goodwill Industries
56. Green Oak Ranch
57. Halau Hula O Ka'eo
58. HandsOn San Diego
59. Health Center Partners of Southern California
60. Healthy Day Partners
61. Heaven's Windows
62. Helen Knoll Foundation
63. Home Start, Inc.
64. Hope through Housing Foundation
65. House of Metamorphosis
66. I Love A Clean San Diego
67. Identity Theft Resource Center
68. Imperial Beach Health Center
69. Institute for Public Strategies
70. Interfaith Community Service
71. Interfaith Shelter Network
72. Jacobs & Cushman San Diego Food Bank
73. Jewish Family Service of San Diego
74. Junior Achievement of San Diego County
75. Just in Time for Foster Youth
76. Kids' Turn San Diego
77. Kitchens for Good
78. Lake San Marcos Community Association
79. Legal Aid Society of San Diego
80. Leap to Success
81. Live Well San Diego Lions Club
82. Lux Art Institute
83. MANA de San Diego
84. Martin Luther King Jr. Community Choir
85. Meals on Wheels
86. Mental Health Systems, Inc.
87. Meridian Baptist Church
88. Miramar Federal Credit Union
89. Mission Trail Regional Park
90. Mountain Health and Community Services Inc.
91. Multicultural Health Foundation

92. National Alliance on Mental Illness, North Coastal
93. National Alliance on Mental Illness-San Diego
94. National Conflict Resolution Center
95. National Veterans Transition Services (REBOOT)
96. Neighborhood Healthcare
97. Neighborhood House Association
98. Nerds Rule Inc.
99. Nile Sisters Development Initiative
100. North County Community Action Network
101. North County Eco Alliance
102. North County Health Services
103. North County Lifeline
104. North County Philanthropy Council
105. Olivewood Gardens & Learning Center
106. Operation Engage America
107. Operation Samahan
108. Ovarian Cancer Alliance of San Diego
109. Partnerships with Industry
110. Pathways Community Services
111. Paving Great Futures
112. ProduceGood
113. Project A.W.A.R.E Enterprises, Inc.
114. Project Concern International
115. Project New Village
116. Rady Children's Hospital San Diego
117. Ramona HEART Mural Project
118. Ramona Valley Vineyard Association
119. Rancho Bernardo High School Foundation
120. Rancho Bernardo High School Friends of the Library
121. Recovery Innovations International
122. Retired Employees of San Diego County
123. ReVisions Resources
124. San Diegans for HealthCare Coverage
125. San Diego Black Health Associates
126. San Diego Black Nurses Association
127. San Diego Blood Bank
128. San Diego Center for the Blind
129. San Diego Children's Museum
130. San Diego Council on Literacy
131. San Diego County Breastfeeding Coalition
132. San Diego County Employees' Charitable Organization
133. San Diego County Farm Bureau
134. San Diego Dance Theater
135. San Diego Diplomacy Council
136. The San Diego Foundation
137. San Diego Financial Literacy Center
138. San Diego Futures Foundation
139. San Diego Health Connect
140. San Diego Hunger Coalition
141. San Diego OASIS
142. San Diego Organization of Healthcare Leaders
143. San Diego Veterans Coalition
144. San Diego Workforce Partnership
145. San Diego Youth Services
146. San Ysidro Health Center
147. Santee Community Collaborative
148. Serving Seniors
149. Social Advocates for Youth
150. Solana Center for Environmental Innovation
151. Somali Bantu Association of America
152. Somali Family Services
153. South Bay Community Services
154. Southern Caregiver Resource Center
155. Spring Valley Youth & Family Coalition
156. Straight from the Heart/No. Co. Foster Parents Assoc.
157. Surfing Madonna Oceans Project
158. Survivors of Torture, International
159. Susan G. Komen San Diego
160. Sustainable Surplus Exchange
161. Trauma Research and Education Foundation
162. Traveling Stories
163. Union of Pan Asian Communities
164. United Way of San Diego County
165. United Women of East Africa
166. University City Community Association
167. The Urban Collaborative Project
168. Urban Corps of San Diego
169. UrbanLife Ministries San Diego
170. Us for Warriors Foundation
171. VETality Corp
172. Vets' Community Connections
173. Vista Community Clinic
174. Walden Family Services
175. WILDCOAST
176. Words Alive
177. Write Out Loud
178. YMCA of San Diego County
179. Zero8Hundred

**Schools & Education** (40)

LIVE WELL

1. Access Youth Academy
2. Bonsall Unified School District
3. Cajon Valley Union School District
4. California State University – San Marcos
5. Cardiff School District
6. Carlsbad Unified School District
7. Chula Vista Elementary School District
8. The Classical Academies
9. Coronado Unified School District
10. Dehesa School District
11. Del Mar Union School District
12. Encinitas Union School District
13. Escondido Union High School District
14. Escondido Union School District
15. Fallbrook Union Elementary School District
16. Grossmont-Cuyamaca Community College District
17. Julian Union High School District
18. Julian Union School District
19. Lakeside Union School District
20. La Mesa-Spring Valley School District
21. Lemon Grove School District
22. MiraCosta College District
23. Mountain Empire Unified School District
24. Move Your Feet Before You Eat Foundation
25. National School District
26. Oceanside Unified School District
27. San Diego City College
28. San Diego County Office of Education
29. San Diego State University
30. San Diego Unified School District
31. San Dieguito Union High School District
32. San Ysidro School District
33. Santee School District
34. Solana Beach School District
35. South Bay Union School District
36. Spencer Valley Elementary School District
37. Sweetwater Union High School District
38. VIP Village Preschool
39. Vista Unified School District
40. Warner Unified School District

**Businesses & Media** (52)

1. 2-1-1 San Diego
2. A Caring Heart Home Care
3. American Cancer Society
4. Angels Foster Family Agency
5. Anthem Blue Cross
6. Biocom
7. Café Merlot
8. Cardiff 101 Main Street Association
9. Chula Vista Olympic Training Center
10. CVS Health
11. Dirty Dogs
12. Encinitas 101 MainStreet Association
13. Encinitas Chamber of Commerce
14. Everywon
15. Fashion Week San Diego
16. Fidelity Security Solutions, LLC
17. Grossmont Healthcare District
18. Hire G.I.
19. iHeartMedia Inc.
20. Jimbo's...Naturally!
21. Kaiser Permanente
22. KGTV/Azteca America TV
23. La Maestra Community Health Centers
24. Leucadia 101 Main Street Association
25. Lifestyles INFOCUS
26. Lit'l Pepper Gourmet
27. MJE Marketing Services, Inc.
28. MMA Academy
29. MusicWorx
30. National City Chamber of Commerce
31. Nordson Corporation
32. North San Diego Business Chamber
33. Northgate Gonzalez Markets
34. OptumHealth San Diego
35. Palomar Health Paradise
36. Paradise Valley Hospital
37. The Patio Playhouse
38. Real Talk San Diego
39. Resounding Joy, Inc.
40. Rural/Metro San Diego
41. San Diego County Credit Union
42. San Diego Gas & Electric
43. San Diego Regional Chamber of Commerce
44. Scripps Health
45. Sirius Fitness
46. South County Economic Development Council
47. Target
48. Terra American Bistro
49. Vista Chamber of Commerce
50. Vons
51. WD-40
52. Wyndham San Diego Bayside

**Cities & Government Agencies** (18)

1. City of Carlsbad
2. City of Chula Vista
3. City of Coronado
4. City of Del Mar
5. City of El Cajon
6. City of Encinitas
7. City of Imperial Beach
8. City of La Mesa
9. City of Lemon Grove
10. City of National City
11. City of Oceanside
12. City of San Diego
13. City of San Marcos
14. City of Solana Beach
15. Doyle Park and Recreation Council
16. In-Home Supportive Services Public Authority
17. San Diego Association of Governments
18. U.S. Border Health Commission, U.S. Section

**International Partners** (2)

1. United States-Mexico Border Health Commission (Mexico)
2. Centre for Cross Border Studies (Ireland)

**RESOLUTION NO. 785**

**RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT OUTLINING INTENTION TO TRANSITION FROM AT-LARGE TO DISTRICT-BASED ELECTIONS PURSUANT TO ELECTIONS CODE 10010(e)(3)(A)**

WHEREAS, **TRI-CITY HEALTHCARE DISTRICT** (the "District") is a California health care district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California, and more particularly, Health and Safety Code §§ 32000 *et seq*. (the "Law"); and

WHEREAS, the governing board is currently composed of seven Directors who are voted into office by an "at-large" election method, meaning one in which the voters of the entire jurisdiction elect the members to the governing body;

WHEREAS, the Board wishes to transition the method of election for the District Board of Directors from an "at-large" method to a "by-zone" or district-based" election method, meaning a method of electing members to the governing body of the District in which the candidate must reside within an election district that is a divisible part of the District's jurisdiction and is elected only by voters residing within that election district;

WHEREAS, the Board wishes to effectuate this transition from at-large to district-based elections in order to ensure the District maintains an election method that does not impair the ability of any protected class to elect candidates of its choice or its ability to influence the outcome of an election, as a result of the dilution or the abridgement of the rights of voters who are members of a protected class, as defined by Elections Code section 14026;

WHEREAS, this Resolution is expressly intended to address the requirements of Elections Code section 10010(e)(3)(A), and thereby outline the District's intention to transition from at-large to district-based elections, outline specific steps the District will undertake to facilitate this transition, and set forth an estimated time frame for doing so;

WHEREAS, the District is authorized to transition to district-based elections under the Law,

WHEREAS, under the Law, the Board of Directors must first hold a public hearing prior to adoption of a resolution moving to divisional elections, and must follow the process laid out under the Law for a transition to district-based elections;

WHEREAS, the San Diego Local Agency Formation Commission ("LAFCO") has identified, as part of a five-year sphere of influence and service review report on San Diego County healthcare services published on May 4, 2015, certain areas for potential boundary changes that LAFCO recommends that the District annex into the District's boundaries including areas within Vista and Carlsbad which would, if annexed, increase the District's population by at least an estimated 60,000 residents aged 18 and over;

WHEREAS, the Board is considering whether to annex these areas into its boundaries, and finds the annexations LAFCO has recommended would likely result in a substantial increase in the District's population;

WHEREAS, the District Board of Directors finds it is in the best interest of the District, in order to ensure the most effective expenditure of the District's resources and avoid a waste of public funds, to consider potential annexations as part of transitioning to the district-based election method;

NOW, THEREFORE, this Board of Directors of Tri-City Healthcare District does hereby resolve:

Section 1. The foregoing recitals are true and correct.

Section 2. The Chief Executive Office is hereby authorized and directed to confer with the District's General Counsel and hire independent consultants the Chief Executive Officer deems necessary and appropriate to begin the process of evaluating the LAFCO-recommended annexations.

Section 3. The Chief Executive Officer is hereby authorized and directed to confer with the District's General Counsel and hire independent consultants the Chief Executive Officer deems necessary and appropriate in order to begin the transition from at-large to district-based elections.

Section 4. The Chief Executive Officer is hereby authorized and directed to present his recommendations regarding whether to proceed with a Resolution of Application to LAFCO for the recommended annexations at a Board meeting no less than one hundred and twenty (120) days from adoption of this Resolution, or as soon thereafter as practicable.

Section 5. The Chief Executive Officer is hereby authorized and directed to coordinate and effectuate outreach to the public, including to non-English speaking communities, to explain the districting process and to encourage public participation, within ninety (90) days of action by the Board regarding adoption of the Resolution of Application to LAFCO. This public outreach may include outreach to potential annexation areas.

Section 6. The Chief Executive Officer is hereby authorized and directed to propose a schedule for no less than two public hearings pursuant to Elections Code § 10010, at which the public shall be invited to provide input regarding the composition of the districts before the District draws any draft maps of the proposed boundaries for district elections. These public hearings shall be held over a period of no more than thirty days and the first public hearing shall occur within 120 days of the Board's action regarding any Resolution of Application to LAFCO.

Section 7. In accordance with Elections Code section 10010(a)(2), the Chief Executive Officer of the District is hereby authorized and directed to confer with the District's General Counsel and any consultants, and create draft maps of the zones or districts for presentation to the Board of Directors at a Board meeting to be held no later than forty-five (45) days after the last public hearing pursuant to Section 6 above, or as soon thereafter as practicable. At this Board meeting, the District shall publish and make available for release to the public at

least one draft map and, if members of the District board of directors will be elected in their districts at different times to provide for staggered terms of office, the potential sequence of the elections.

Section 8. In accordance with Elections Code section 10010(a)(2), the District shall also hold at least two additional hearings over a period of no more than 45 days, at which the public shall be invited to provide input regarding the content of the draft map or maps and the proposed sequence of elections, if applicable. The first version of a draft map shall be published at least seven days before consideration at a public hearing. If a draft map is revised at or following a hearing, it shall be published and made available to the public for at least seven days before being adopted. The first of these two public hearings shall be no later than thirty (30) days after the Board meeting referenced in Section 7 above, or as soon thereafter as practicable.

Section 9. Pursuant to Health and Safety Code section 32100.1, the Chief Executive Officer of the District is hereby authorized and directed to subsequently coordinate and effectuate a public hearing on the proposed establishment of zones or districts for the district-based elections, at which the Board shall provide for representation in accordance with demographic, including population, and geographic factors of the entire area of the District. At this hearing, any elector of the district may present his or her views and plans in relation to the proposed zoning, but the Board shall not be bound thereby and their decision, in the resolution adopted, shall be final. This public hearing shall occur no later than forty-five (45) days after the last public hearing referenced in Section 8 above, or as soon thereafter as practicable. After this hearing, the Board of Directors will be presented with a resolution to divide the District into the zones or districts.

Section 10. If the Board elects to approve a resolution which divides the district into the zones or districts presented, the zones or districts shall be effective for the next District election after the resolution of the Board for which there is time to implement the zones and elections within the zones, or as provided for in Health & Safety Code section 32100.1

Section 11. This Resolution shall take effect immediately upon its adoption.

ADOPTED, PASSED AND APPROVED this 25th day of May, 2017, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

**AYES: DIRECTORS: DAGOSTINO, KELLETT, GRASS, MITCHELL, NYGAARD, RENO & SCHALLOCK**

**NOES: NONE**

**ABSTAIN/ABSENT: NONE**

By:_____
Chairperson, Board of Directors

ATTEST:
By: Laura C. Mitchell
Secretary, Board of Directors



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# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF INITIAL CREDENTIALS REPORT
# June 14, 2017

*Attachment A*

## INITIAL APPOINTMENTS (Effective Dates: 6/30/2017 – 5/31/2019)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 6/30/2017 through 5/31/2019:

- **BRADLEY, Joseph M.D. / Emergency Medicine (TCEMG)**
- **D'SOUZA, Gehaan M.D. / Plastic Surgery (Solo Practice)**
- **GENTILUOMO, Jesse M.D. / Emergency Medicine (TCEMG)**
- **LIU, David M. D. / Anesthesiology (ASMG)**
- **MILLER, Jessica M.D. / Emergency Medicine (TCEMG)**
- **OJHA-HAMMAD, Anita M.D. / Wound Care (TCMC Wound Center)**
- **PARK, Grace M.D. / Anesthesiology (ASMG)**
- **PATEL, Visal M.D. / Anesthesiology (ASMG)**
- **SINGH, Mandeep M.D. / Anesthesiology (ASMG)**
- **TRULLENDER, Brett M.D. / Emergency Medicine (TCEMG)**
- **YAKHNENKO, Ilya, M.D. / Internal Medicine (Bart Day, M.D.)**

## INITIAL APPLICATION FILED INCOMPLETE: (Voluntary unless otherwise specified):

- **AHAMED, Ednan M.D. / Opthalmology (Retina Center)**
- **ATMAR, Akmal, D.P.M / Podiatric Surgery (Dr's. Han & Thuen DPM)**

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
# June 14, 2017

*Attachment B*

## NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

### PRIVILEGE RELATED CHANGES

**AUTOMATIC EXPIRATION OF PRIVILEGES**

**The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 6/30/2017.**

- **HOSALKAR, Harish MD** — **Orthopedic Surgery**

**ADDITIONAL PRIVILEGE REQUEST (Effective 6/30/2017, unless otherwise specified)**

**The following practitioners requested the following privileges and meets the initial criteria for the privilege(s)**

- **BEN-HAIM, Sharona MD** — **Neurological Surgery**
- **GOELITZ, Brian MD** — **Interventional Radiology**
- **LEBOVITS, Marc J., MD** — **Otolaryngology**

**VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 6/30/2017, unless otherwise specified)**

**The following practitioners are voluntarily relinquishing the following privileges.**

- **BODDU, Navneet MD** — **Anesthesiology**
- **SHAFQAT, Jon, DDS** — **Oral & Maxillofacial Surgery**

### STAFF STATUS CHANGES

Andrade, Kristine E., MD
Ansari, Rashad A., MD/ Rheumatology
Argoud, Georges M., MD/Endocrinology

*Attachment C*

## PROCTORING RECOMMENDATIONS (Effective 6/30/17, unless otherwise specified)

- BOONJINDASUP, Aaron M.D. — Urology
- BORGSCHULTE, Gitte M.D. — Internal Medicine
- BROWN, Rica M.D. — Emergency Medicine
- BUCKLEY, Michael D.O. — Anesthesiology
- CHO, Aaron M.D. — Radiology
- KUSHNARYOV, Anton M.D. — Otolaryngology
- ONAITIS, Mark M.D. — Cardiothoracic Surgery
- POLLEMA, Travis D.O. — Cardiothoracic Surgery

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
# June 14, 2017

*Attachment B*

## BIENNIAL REAPPOINTMENTS: (Effective Dates 7/01/2017 –6/30/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 7/01/2017 through 6/30/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AFRA, Robert, MD/Orthopedic Surgery/Consulting**
- **AJIR, Mahyar, DO/Family Medicine/Affiliate**
- **BIRHANIE, Melaku, MD/Internal Medicine/Active**
- **BURKE, Michael, MD/Interventional Radiology/Active**
- **DEEMER, Andrew, MD/General and Vascular Surgery/Active**
- **DILLMAN, Ariana, MD/Emergency Medicine/Active**
- **ETEDALI, Elaheh, DO/Family Medicine/Affiliate**
- **FRAKES, Laurie, MD/Oncology/Active**
- **HODSMAN, Hugh, MD/Family Medicine/Affiliate**
- **JAMSHIDI-NEZHAD, Mohammad, DO/General and Vascular Surgery/Active**
- **JOHNSON, William, MD/Diagnostic Radiology/Active**
- **LAU, Kenneth, MD/Anesthesiology/Provisional**
- **LOZANO, Jesus, Jr., MD/Anesthesiology/Courtesy**
- **MCGRAW, Charles, Jr., MD/Interventional Radiology/Provisional**
- **NIZAMANI, Saifullah, MD/Psychiatry/Provisional**
- **NOUD, Michael, MD/Interventional Radiology/Active**
- **PAL, Joshua, MD/Pain Medicine/Provisional**
- **PATEL, Kiran, MD/Diagnostic Radiology/Active**

*Attachment B*

- PAVEGLIO, Kathleen, MD/Cardiology/Active
- PURCOTT, Kari, MD/Obstetrics & Gynecology/Active
- STARK, Erik, MD/Orthopedic Surgery/Active
- TOMANENG, Neil, MD/Emergency Medicine/Active
- WORMAN, Scott, MD/Family Medicine/Active

## RESIGNATIONS: (Effective date 6/30/2017 unless otherwise noted)

**Automatic:**

- DEPALA, Venugopal, MD/Psychiatry
- FORMAN, Michael, MD/Emergency Medicine

**Voluntary:**

- BYUN, Charlton, MD/Radiology
- IWAOKA, Ken, MD/Family Medicine
- KU, Tse-Sun, MD/Anesthesiology
- QUINTELA, Eileen, MD/Anesthesiology
- WILLIAMS, Kristin, MD/ Maternal and Fetal Medicine
- WALLACE, Aaron, MD/Anesthesiology

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

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

# Tri-City Healthcare District
# Community Healthcare Alliance Committee (CHAC)
## MEETING MINUTES
### June 15, 2017

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

**MEMBERS ABSENT:** Barbara Perez, Danielle Pearson, Guy Roney, Jack Nelson, Marilou de la Rosa Hruby, Mary Donovan, Mary Murphy

**NON-VOTING MEMBERS PRESENT:** Steve Dietlin, CEO; David Bennett, Chief Marketing Officer; Kapua Conley, COO; Fernando Sanudo

**NON-VOTING MEMBERS ABSENT:** Audrey Lopez

**OTHERS PRESENT:** Wayne Knight, CSO; Brian Greenwald, Gwen Sanders

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Call To Order** | The June 15, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:35 pm by Director and CHAC Chair Julie Nygaard. | | |
| **Approval Of Meeting Agenda** | Director Dagostino motioned to approve the June 15, 2017 meeting agenda. The motion was seconded by Ted Owen and unanimously approved. | | |
| **Public Comments & Announcements** | No public comments or announcements were made. | | |



Tri-City Medical Center
ADVANCED HEALTHCARE FOR YOU

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Ratification Of Minutes** | Sandy Tucker motioned to approve the May 18, 2017 CHAC meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved. | | |
| **Presentation: Live Well San Diego Carey Riccitelli** | Carey Riccitelli presented information about the County of San Diego's *Live Well San Diego* program.<br><br>Carey provided the following information:<br><br>• 3 key behaviors result in 4 diseases responsible for over 50% of deaths in San Diego:<br><br>**No Physical Activity / Poor Diet / Tobacco Use** — **Cancer / Heart Disease & Stroke / Type 2 Diabetes / Lung Disease** — **Over 50% of Deaths in San Diego**<br><br>• Live Well San Diego is built on three core principles – Building Better Health, Living Safely, and Thriving.<br>• Strategic approaches for community integration include – Building a better service delivery system, supporting positive choices, pursuing policy & environmental changes and improving the culture within.<br>• Alignment of strategies across all sectors will include Community & Faith-Based Organizations, Business & Media, Schools & Education, and Cities and Governments<br>• There are currently over 290 recognized partners across multiple sectors<br>• There are 5 predominant areas of influence: Health, Knowledge, Standard of Living, Community, and Social. | | |

Tri-City Healthcare District
# Community Healthcare Alliance Committee (CHAC)
## MEETING MINUTES
June 15, 2017

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Presentation: Live Well San Diego Carey Riccitelli** | Carey and her associate, Kat Casabar, addressed audience questions. Many committee members noted their agreement with this program and suggested it be brought to the attention of the TCMC Board of Directors.<br><br>Upon motion made by Linda Ledesma and seconded by Bret Schanzenbach, the CHAC Committee agreed that the program should be presented to the TCMC Board of Directors for consideration of partnership. | | |
| **CEO Update Steve Dietlin** | CEO Steve Dietlin updated the group as follows:<br><br>• Steve thanked Carey for her Live Well San Diego presentation to the Committee.<br><br>• Steve recognized Scott Ashton and the successful Oceanside Heroes event on June 14th, noting that many Oceanside community heroes were rightfully honored for their contributions.<br><br>• The Campus Redevelopment budget should be made available to the Board of Directors in the next few weeks.<br><br>• The redevelopment will include Phase 1: parking improvements and Phase 2: patient beds and earthquake guidelines.<br><br>• Steve encouraged everyone to consider participating in the upcoming Heart Walk scheduled for September 30th. | | |



Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **COO Update Kapua Conley** | Chief Operating Officer Kapua Conley reported as follows:<br>• Kapua noted that CHAC member, Dr. Victor Souza MD, will be the new incoming Chief of Staff at TCMC.<br>• Sandy Tucker requested an update on the Discharge Lounge. Kapua noted that it is going well and beginning to provide positive results concerning patient days.<br>• A comment was made about the CSU and BHU. Kapua noted that they too are making good progress and having an impactful improvement on wait times. Kapua also acknowledged the great UCSD professionals who assisted with the mental health improvements.<br>• Member Fernando Sanudo acknowledged Kapua Conley for his helpfulness with a variety of questions and issues brought to his attention.<br>Chair Julie Nygaard noted that the changes provide a caring and much improved way to continue to care for our patients. | | |
| **Chief Marketing Officer Update David Bennett** | Chief Marketing Officer David Bennett reported as follows:<br>• Marketing will continue to finalize sponsorships for the new FY. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Chief Marketing Officer Update David Bennett (con't)** | • Currently working with Jim Flores to finalize the details of the back-pac program and will share information with the committee in the near future.<br>• David supported the previous comments encouraging everyone's participation in the upcoming Heart Walk. | | |
| **Committee Vacancies** | Chair Julie Nygaard noted there remains two vacancies on the Committee that need to be filled, but one candidate has come forward for consideration for the Vista District opening. | | |
| **CHAC Grant Update** | Gigi Gleason noted that the grant recommendations were presented to the Board of Directors who approved the recommendations. Gigi thanked everyone for their support through this process. The CHAC check presentation ceremony is scheduled for June 29th. | | |
| **Public Comments** | There were no public comments. | | |
| **Committee Communications** | Dung Ngo agreed to provide information to committee members about deductions and write offs that may be available to their organizations.<br><br>Bret Schanzenbach noted that the Moonlight production season opened June 14th and encouraged everyone to check out the upcoming productions. Bret also thanked TCMC for their help in the Strawberry Festival. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Committee Communications (con't)** | Sandy Tucker noted that the Auxiliary will be holding an awards ceremony to honor volunteers with 500+ hours of service to TCMC.<br><br>Rosemary Eshelman proposed the idea that the CHAC committee members be able to tour TCMC.<br><br>Gigi Gleason reminded everyone of the July 1 Mainstreet Oceanside Independence Day parade.<br><br>Rick Robinson noted that multi-city terrorist exercises were recently performed to narrow down areas of need or vulnerability, with very good results and positive outcomes of preparedness. Rick also noted that fireworks are illegal and can result in large fines.<br><br>Scott Ashton thanked TCMC for their help with the Operation Appreciation and Oceanside Heroes events.<br><br>Carol Herrera noted that her school district recently graduated over 1700 students with $4 million in scholarships.<br><br>Linda Ledesma thanked TCMC for their exciting ads, noting they make her feel proud of her hospital.<br><br>Dr. Souza reminded the group that various doctors in the community are speaking about exciting subjects at the TC Wellness Center and encouraged attendance when possible. | | |

Tri-City Healthcare District
# Community Healthcare Alliance Committee (CHAC)
## MEETING MINUTES
June 15, 2017

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Committee Communications (con't)** | Fernando Sanudo noted that some VCC programs are currently overwhelmed, including HEP C treatment, and measures are being taken to assist this.<br><br>Guest Gwen Sanders noted that the annual NAACP event "Juneteenth" will take place on in downtown Oceanside on June 17th. | | |
| **Adjournment** | The June 15, 2017 CHAC meeting was adjourned at 1:38pm. | | |



Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

**Tri-City Medical Center**
**Finance, Operations and Planning Committee Minutes**
**June 20, 2017**

| | |
|---|---|
| **Members Present** | Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Gene Ma, Dr. Marcus Contardo, Steve Harrington, Wayne Lingenfelter, Tim Keane |
| **Non-Voting Members Present:** | Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Scott Livingstone, Interim CCO, Wayne Knight, Chief Strategy Officer |
| **Others:** | Glen Newhart, Tom Moore, Tori Hong, Kathy Topp, David Bennett, Sharon Schultz, Joni Penix, Sherry Miller, Norma Braun, Mary Diamond, Jeremy Raimo, Charlene Carty, Eva England, Chris Miechowski, Lori Roach, Jody Root (Procopio), Barbara Hainsworth |
| **Members Absent:** | Dr. John Kroener, Kathleen Mendez, Carlo Marcuzzi |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to order | Director Nygaard called the meeting to order at 12:32 p.m. | | |
| 2. Approval of Agenda | | **MOTION**<br>**It was moved by Director Kellett, Mr. Keane seconded, and it was unanimously approved to accept the agenda of June 20, 2017.** | |
| 3. Comments by members of the public on any item of interest to the public before committee's consideration of the item. | Director Nygaard read the paragraph regarding comments from members of the public. | | Director Nygaard |
| 4. Ratification of minutes of May 16, 2017 | Minutes were ratified. | Minutes were ratified.<br>**MOTION**<br>**It was moved by Mr. Keane, Director Mitchell seconded, that the minutes of May 16, 2017 are to be approved with the minor correction to the date noted on the minutes. Director Kellett and Dr. Ma abstained from the vote.** | |
| 5. Old Business | | | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 6. New Business | | | |
| a. Community Member Recognitions:<br>• Mr. Carlo Marcuzzi<br>• Mr. Tim Keane | Director Nygaard conveyed the Committee's gratitude to departing Community Members Mr. Keane who was in attendance, and Mr. Marcuzzi who was unable to attend. She also distributed a Certificate of Appreciation to Mr. Keane. Mr. Marcuzzi's certificate will be mailed. | | Chair |
| b. Policy Review<br>• Charge Description Master, New Charge or Charge Change, #8610-258<br>• Charges/Late Charges, #8610-260<br>• Charity Care, Uncompensated Care, Community Service, #8610-285<br>• Charity Care, Uncompensated Care, Community Service, #8610-285 *(Spanish Version)* | Joni Penix explained that revisions made to all policies presented were minor changes, primarily verbiage or formatting modifications. | **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve policies Charge Description Master, New Charge or Charge Change, #8610-258, Charges/Late Charges, #8610-260, Charity Care, Uncompensated Care, Community Service, #8610-285 (*English Version*), Charity Care, Uncompensated Care, Community Service, #8610-285 (*Spanish Version*).** | Joni Penix |
| c. EVS Mop / Cleaning Cloths / Entrance Floor Mat Service Agreement<br>• Uni-First Corporation | Kapua Conley explained that this contract will provide a net savings to the District of $35K a year and $105K for the term by eliminating the existing costs of in-house washing machine maintenance, purchases of mops, cloths, & entrance mats, labor to wash mops/cleaning cloths, laundry detergent, and utilities (water/sewer/electricity). It also | **<u>MOTION</u>**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Uni-First Corporation for services to provide and launder mops/cleaning cloths and entrance floor mats for a term of 36 months,** | Kapua Conley |

| Topic | Discussions, Conclusions, Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | reduces EVS employee exposure to handling soiled and heavy laundry loads, and floor mats. | **beginning July 1, 2017 and ending June 30, 2020, for an annual cost of $84,156 and a total cost for the term of $252,468.** | |
| d. Physician Agreement for ICU Medical Director<br>• Mark Yamanaka, M.D. | Mary Diamond stated that this was a renewal physician agreement with Mark Yamanaka, M.D. to remain as the ICU Medical Director for a term of 12 months, with no increase in rate. | **MOTION**<br>**It was moved by Mr. Lingenfelter, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months beginning July 1, 2017 and ending June 30, 2018. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $42,000.** | Mary Diamond |
| e. Physician Agreement for ED On-Call Coverage<br>• Adult Intensive Care / Pulmonary<br><br>• Interventional Radiology | Sherry Miller stated that this was a renewal agreement with physicians Frank Corona, M.D., Martin Nielsen, M.D., Mark Yamanaka M.D., Safouh Malhis M.D. for Pulmonary and Adult ICU ED-Call Coverage for a term of 24 months, with no increase in rate.<br><br>During the meeting it was noted that this write-up should be amended to reflect that this agreement is a renewal-same rates.<br><br>Sherry Miller conveyed that this was a renewal agreement with | **MOTION**<br>**It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize physicians Frank Corona, M.D., Martin Nielsen, M.D., Mark Yamanaka, M.D., Safouh Malhis, M.D. as the Pulmonary and ICU ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019, at a daily rate of $1,500, for an annual cost of $547,500, and a term cost of $1,095,000.**<br><br>**Barbara Hainsworth to amend the write-up**<br>**MOTION**<br>**It was moved by Director Mitchell, Mr.** | Sherry Miller |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | physicians Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; and Richard Saxon, M.D. as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 24 months, with no increase in rate.<br>The original distribution of this write-up reflected the agreement as a renewal with new rates however, the amount was inaccurate. This was subsequently amended to reflect the corrected rate, and an amended write-up was distributed at the meeting. | **Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize physicians Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; and Richard Saxon, M.D. as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $650 for an annual and term cost of $237,250.** | |
| • ENT | Sherry Miller stated that this was a renewal agreement with physicians Juile Berry, M.D., Hernan Goldsztein, M.D., Robert Jacobs, M.D., Marc Lebovits, M.D., Bruce Reisman, M.D., Ashish Wadhwa, M.D., Anton Kushnaryov, M.D. and Jennifer MacEwan, M.D. for ENT ED-Call Coverage for a term of 24 months, with an increase in rate. | **MOTION**<br>**It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize ENT physicians Juile Berry, M.D., Hernan Goldsztein, M.D., Robert Jacobs, M.D., Marc Lebovits, M.D., Bruce Reisman, M.D., Ashish Wadhwa, M.D., Anton Kushnaryov, M.D. and Jennifer MacEwan, M.D. ENT ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019 at a daily rate of $550, for an annual cost of $200,750 and total term cost of $401,500.** | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| • Spine | Sherry Miller explained that this was a renewal agreement with physicians Alleyne Neville, M.D.; David Amory, M.D.; Payam Moazzaz, M.D.; and Lokesh Tantuwaya, M.D.; Kevin Yoo, M.D., Sunil Jeswani, M.D.; Tyrone Hardy, M.D.; Thomas Marcisz, M.D, Mark Stern, M.D., and Howard Tung, M.D. for Spine ED-Call Coverage for a term of 12 months, with no increase in rate. | **MOTION**<br>**It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize spine physicians Alleyne Neville, M.D.; David Amory, M.D.; Payam Moazzaz, M.D.; and Lokesh Tantuwaya, M.D.; Kevin Yoo, M.D., Sunil Jeswani, M.D.; Tyrone Hardy, M.D.; Thomas Marcisz, M.D, Mark Stern, M.D.; Howard Tung, M.D. as the Spine ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, at a daily rate of $400, for an annual cost $146,000 and total term cost of $292,000.** | |
| • Ophthalmology – Neeta Varshney, M.D. | Sherry Miller detailed that this was a renewal agreement with physician Neeta Varshney, M.D. for Ophthalmology ED-Call Coverage for a term of 12 months, with no increase in rate. | **MOTION**<br>**It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize physician Neeta Varshney, M.D. as the Opthamology ED-Call Coverage Physician for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $300 for an annual and term cost of $109,500.** | |
| • Urology | Sherry Miller conveyed that this was a renewal agreement with | **MOTION**<br>**It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was** | |

| Topic | Discussions, Conclusi s Recommendations | Action Recommendations/ Conclusions | rson(s) Responsible |
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| | physicians Caroline J. Vilchis, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Jason Phillips, M.D.; Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D. for Urology ED-Call Coverage for a term of 12 months, with no increase in rate. | **unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Urology physicians Caroline J. Vilchis, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Jason Phillips, M.D.; Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D. as the Urology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $350, for an annual and term cost of $127,750** | |
| f. Re-Tube of Boiler #1<br>• R.F. MacDonald Co. | Kapua Conley detailed that Engineering performs an annual inspection of the boiler tubes which produce steam, heating and hot water for the hospital. During a recent inspection it was determined that we are in the time window to replace the tubes in boiler #1, and vendor R.F. MacDonald was the lowest bidder. | **MOTION**<br>**It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with R.F. MacDonald Co. for the re-tube of boiler #1, for a total expected contract cost of $43,562 and a total project budget of $47,918.** | Chris Miechowski |
| g. Elevator Maintenance & Service Agreement<br>• Kone, Inc. | Chris Miechowski explained that this agreement was for service and maintenance of the hospital's elevators. The agreement is a renegotiation of an existing contract, and is projected to save the District approximately $25,000. | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Elevator Maintenance and Service Agreement with Kone, Inc. for 60 months for a total not to exceed of $270,320.** | Chris Miechowski |
| h. Physician Agreement for Anesthesia Service | Mary Diamond reported that this is a renewal agreement for | **MOTION**<br>**It was moved by Dr. Contardo, Director** | Mary Diamond |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| • Anesthesia Services Medical Group (ASMG) | anesthesia coverage with Anesthesia Services Medical Group (ASMG) to provide on-call, on-site and unassigned anesthesia services for a term of 24 months with an increase in rate. | **Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with ASMG for Anesthesia Coverage for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019. Not to exceed $49,372 per month, with a total cost for the term of $1,687,096.** | |
| i. Physician Agreement for Specialty Care Clinic and Progressive Care Unit<br>• Yung Le, M.D. | Lori Roach detailed that this was a new physician agreement with Yung Le, M.D. as the Medical Director/Covering Physician for the Specialty Care Clinic & Progressive Care Unit for a term of 24 months, with no increase in rate from the previous medical director. | **MOTION**<br>**It was moved by Director Mitchell, Mr. Keane seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Yung Le as the Medical Director/Covering Physician for a term of 24 months beginning July 1, 2017 and ending June 30, 2019. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $ 163, for an annual cost of $39,120 and a total cost for the term of $78,240.** | Lori Roach / Sharon Schultz |
| j. Registry Contracts for Nursing and Allied Health Proposal<br>• Registry and Travel Vendors | Kathy Topp conveyed that this agreement was to increase the existing total Registry spend for the Nursing and Allied Health budget by $2M. This increased amount is to accommodate projected staffing needs; she anticipates a reduction in the use of registry and travelers costs, as more core staff members are hired. | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Registry vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and allied health for the remaining term of 2 years, beginning July 1, 2017 and** | Kathy Topp |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| | | **ending June 30, 2019 for a new cost for the term of $18.5M.** | |
| k. Neuroscience Institute<br>• Co-Management Agreement | Jeremy Raimo conveyed that this was a renewal agreement for the Co-Management of the Neuroscience Institute for a term of 36 months, with no increase in rate. | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Tri-City Medical Center Neuroscience Institute LLC for Co-Management Services for a term of 36 months, beginning July 15, 2017 and ending July 14, 2020, for an annual cost of $650,004, and a total cost for the term of $1,950,012.** | Jeremy Raimo |
| • Specialty Medical Directorship Agreement | Jeremy Raimo stated that this was a renewal agreement with physicians Jack Schim, M.D. and Greg Sahagian, M.D. to remain as Specialty Medical Directors for the Neuroscience Institute, for a term of 12 months, with no increase in rate. | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Schim and Sahagian as the Specialty Medical Directors for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 24 hours per month or 288 hours annually, at an hourly rate of $200 for an annual cost of $57,600, and a total cost for the term of $57,600** | |
| • Operations Committee | Jeremy Raimo detailed that this was a renewal agreement with physicians Tyrone Hardy, M.D., Greg Sahagian, M.D. and Kevin Yoo, M.D. to remain on the Operations | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning** | |

| Topic | Discussions, Conclusi[illegible]s Recommendations | Action Recommendations/ Conclusions | [illegible]rson(s) Responsible |
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| • Quality Committee | Committee for the Neuroscience Institute, for a term of 12 months, with no increase in rate.<br><br>Jeremy Raimo communicated that this was a renewal agreement with physicians Donald Ponec, M.D. and Jack Schim, M.D. to remain on the Quality Committee for the Neuroscience Institute, for a term of 12 months, with no increase in rate. | **Committee recommend that the TCHD Board of Directors authorize Drs. Hardy, Sahagian and Yoo as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120.**<br><br>**MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Ponec and Schim as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - ending June 30, 2018. Not to exceed an average of 4 hours per month or 48 hours annually, at an hourly rate of $210 for an annual cost of $10,080, and a total cost for the term of $10,080.** | |
| I. Physician Recruitment Proposal – General Cardiology<br>• Ashish Kabra, M.D. | Jeremy Raimo gave a brief PowerPoint presentation detailing the proposed recruitment of cardiologist Ashish Kabra, M.D. | **MOTION**<br>**It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $755,000 in order to facilitate this General Cardiology physician** | Jeremy Raimo |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| | | **practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Blue Coast Cardiology Medical Group and Dr. Ashish Kabra.** | |
| m. Employee Leasing Agreement Amendment<br>• Tannaz Ebrahimi Adib, M.D. | Jeremy Raimo detailed that this proposal was to extend the original employee leasing agreement with Dr. Tannaz Ebrahimi Adib for 3 months, in anticipation of securing the necessary TCMC staff required. | **MOTION**<br>**It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $25,000 in 3 months (90 days), in order to extend the employee leasing agreement with Tannaz Ebrahimi Adib, M.D. for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA.** | Jeremy Raimo |
| n. Retail Pharmacy Development & Build Out Proposal<br>• Sfeir Architects & a Construction Company (TBD) | Collectively Jeremy Raimo, Chris Miechowski, Tori Hong and Kapua Conley, conveyed that this proposal was for development and build-out preparations in anticipation of implementation of a strategic pharmacy initiative to expand the services at TCMC. | **MOTION**<br>**It was moved by Dr. Contardo, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Sfeir Architects and Construction Company to be named for Design, Development and Construction of an on-campus Retail Pharmacy for a total cost of $336,161.** | Kapua Conley |
| o. Retail Pharmacy Management Proposal<br>• Comprehensive Pharmacy | As a group Jeremy Raimo, Tori Hong and Kapua Conley, explained that this proposal was an effort to | **MOTION**<br>**It was moved by Dr. Contardo, Director Kellett seconded, and it was** | Kapua Conley |

| Topic | Discussions, Conclusions, Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| Services (CPS) | combine both inpatient and outpatient pharmacy management services into a single agreement with Comprehensive Pharmacy Services. | **unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Comprehensive Pharmacy Services: to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) + four years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending 4 years from implementation, for a total cost for the term of $1,107,242.** | |
| p. Physician Agreement for Clinical & Anatomic Pathology Lab<br>• Marcus Contardo, M.D., North Coast Pathology Medical Group (NCPMG) | Kapua Conley detailed that this was a renewal agreement with physician Marcus Contardo, M.D., & North Coast Pathology Medical Group for clinical and anatomic pathology lab services for a term of 12 months, with an increase in the rate.<br><br>Dr. Contardo was excused from the meeting room prior to this presentation, and did not participate in the discussion or the vote. Once the vote was accomplished, he returned to the proceedings. | **MOTION**<br>**It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 an annual cost of $695,000, and a total cost for the term of $695,000.** | Kapua Conley |
| q. Financials | Ray Rivas presented the financials ending May 31, 2017 (dollars in thousands)<br><br>**TCHD – Financial Summary**<br>**Fiscal Year to Date**<br>Operating Revenue $ 310,186<br>Operating Expense $ 312,708 | | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
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| | EBITDA $ 14,305<br>EBITDA Excl. HUD Finance Chg. $ 17,709<br>EROE $ 371<br>EROE Excl. HUD Finance Chg. $ 3,775<br>**TCMC – Key Indicators – FYTD**<br>Avg. Daily Census 180<br>Adjusted Patient Days 102,569<br>Surgery Cases 5,770<br>Deliveries 2,339<br>ED Visits 57,502<br>**TCHD-Financial Summary – Current Month**<br>Operating Revenue $ 29,880<br>Operating Expense $ 30,348<br>EBITDA $ 1,558<br>EROE $ 296<br>**TCMC – Key Indicators – Current Month**<br>Avg. Daily Census 175<br>Adjusted Patient Days 9,244<br>Surgery Cases 501<br>Deliveries 188<br>ED Visits 5,205<br>**TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year**<br>Net Patient A/R Avg. (in millions) $ 43.3<br>Days in Net A/R Avg. 49.6<br>**Graphs:**<br>• TCMC-Net Days in Patient Accounts Receivable<br>• TCMC-Acute Average Length of Stay<br>• TCMC-Emergency Department Visits | | |

| Topic | Discussions, Conclusi[illegible] Recommendations | Action Recommendations/ Conclusions | [illegible]rson(s) Responsible |
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| r. Work Plan – Information Only<br>• Physician Recruitment Tracking (annual)<br><br>• Dashboard | Jeremy Raimo gave a brief PowerPoint presentation reflecting the aggregate physicians and their respective specialties that have been recruited for TCMC since the last Work Plan physician recruitment update.<br><br>No discussion | | Jeremy Raimo<br><br>Ray Rivas |
| 7. Comments by committee members | None | | |
| 8. Date of next meeting | July 18, 2017 | | Chair |
| 9. Community Openings (none) | | | |
| 10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7) | | | Jody Root, Procopio |
| 11. Motion to go into Closed Session | | **MOTION**<br>**Dr. Contardo moved, Director Mitchell seconded, and it was unanimously approved to go into Closed Session at 1:52 pm** | |
| 15. Open Session | | | Chair |
| 16. Report from Chairperson of any action taken in Closed Session (Authority: Gov. Code, section 54957.1) | | | |
| 17. Adjournment | Prior to adjourning the meeting, Chair Nygaard welcomed Dr. Gene Ma to the Committee who has assumed the FOP Physician Member role, vacated by Dr. Corona.<br><br>Meeting adjourned 1:56 pm | | |

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

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| **ISSUE DATE:** | **07/97** | **SUBJECT:** | **CHARGE DESCRIPTION MASTER, NEW CHARGE OR CHARGE CHANGE** |
| **REVISION DATE:** | **03/00, 06/02, 12/02, 02/06, 01/09 09/10, 01/14** | **POLICY NUMBER:** | **8610-258** |

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| **Department Approval:** | **04/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~03/14~~04/17** |
| **Finance & Operations Committee Approval:** | **~~06/14~~06/17** |
| **Board of Directors Approval:** | **06/14** |

A. **PURPOSE:**

1. To implement new charges for the billing of healthcare services to third party payers and patients in compliance with Federal and State regulatory requirements.

B. **POLICY:**

1. All services provided to patients and deemed chargeable within Tri-City Medical Center will be compliant with Federal and State regulatory requirements. This policy covers all hospital charges for services and/or supplies provided to patients.

C. **CHARGEMASTER REVIEW:**

1. This policy applies to the hospital Charge Description Master (CDM). Any new charge to be added to the CDM or existing charge that requires modification to the CDM is subject to the following requirements:
   a. "Compliance" refers to (1) the proper coding inclusive of CPT-4, ICD-~~9~~**10**, and UB-04 revenue codes and/or (2) charges for supplies appropriately bundled or unbundled as required and/or permitted under the regulations, and (3) that like services are consistently priced.
   b. A new charge must be submitted to the Charge Master Specialist in the Patient Financial Services (PFS) in the format prescribed by the PFS (CDM Request for Charge Addition Packet) and/or Charge Master tool kit charge request application. This format generally requires specific cost data necessary for pricing (including routine medical supply cost indigenous to the procedure) and recommendations for CPT-4 coding and UB-04 Revenue Coding.
   c. A new charge must have a full narrative explanatory description for the new procedure attached to the new charge request form that clearly delineates the service and supply components of the new chargeable service. The description must also indicate if the new chargeable procedure or supply item is a replication of a procedure or supply in another department. There must be sufficient narrative description of the charge to validate CPT-4 coding and UB-04 revenue coding recommendations. An important component of the description will be a regulatory summary that will address such issues as FDA approval and third party coverage of the service with specific reference to coverage under Medicare and other Federal programs.
   d. The CDM should be clear and concise and should mirror as closely as possible the description used in the CPT-4 ~~codebook~~**short description**. Abbreviations are acceptable; however, they shall be standardized so that everyone using the charge master understands the terminology.

e. Departments should submit CDM requests prior to implementation of a new service/procedures or supplies.

f. Departments are not permitted to charge for any procedure that has not been approved. It is also required that departments not anticipate the approval of a procedure charge.

g. Routine medical supplies that are normally used for the setup of a room or supplies inherent to a procedure for a majority of patients should not be charged to patients. The charge for these supply items should be incorporated in the cost of the procedure or room charge. The only supplies that are chargeable are those supply items that would not be routinely used by the majority of the patient population.

i. Any new supply items must be procured and inventoried through a centralized materials distribution system. Exceptions to this process are items procured through a purchase order or special order. ~~Proposed supply items to be charged, over and above the procedure charge, must be approved by the Charge Master Analyst and/or Revenue Cycle Director.~~ It is also required that departments not anticipate the approval of a supply charge.

2. Existing charges in the CDM that department propose for change a change in pricing, description, CPT-4 coding or UB-04 revenue coding must be reviewed by the Charge Master Analyst and/or Revenue Cycle Director. All regulatory changes must be coordinated with the Charge Master Analyst and/or PFS Representative and the providing department Manager and/or Representative. Final review and approval of all regulatory changes is performed by Revenue Cycle Manager. The Manager for Revenue Integrity. The ~~Senior~~ Director for Revenue Cycle ~~Integrity~~ **or designee** will keep the Finance Department informed of regulatory changes and coordinate ~~changes~~ **any questions regarding guidelines** with the Compliance officer. Required Signature Approval and/or Notification:

a. CFO/Designee
b. Charge Maser Specialist
c. ~~Senior Director Revenue Cycle Integrity~~ **Finance Representative**
d. IT Representative
e. Revenue Cycle Director
f. **Referring Department**

**D. <u>REFERENCES:</u>**

1. **Craneware Tool Kit**
2. **Medi-Cal Provider Manual**
~~e.~~3. **CPT 2017 Professional**

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

**Administrative Policy Manual**

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**ISSUE DATE:** 07/97 **SUBJECT:** CHARGES/LATE CHARGES

**REVISION DATE:** 07/99, 12/05, 09/10, 12/13 **POLICY NUMBER:** 8610-260

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| **Department Approval:** | **05/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~12/13~~05/17** |
| **Finance & Operations Committee Approval:** | **~~06/14~~06/17** |
| **Board of Directors Approval:** | **06/14** |

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A. **PURPOSE:**
1. To define the hospital's policy regarding the posting of charges in a timely manner.

B. **DEFINITION:**
1. Late charge – any charge posted to the patient's account greater than 3 days past the service date.

C. **RESPONSIBILITY:**
1. Departments must post charges within 24 hours following the service date, on a weekday or holiday and before midnight the Monday following a weekend.
2. Departments will be audited ~~by the Charge Auditor~~ on a monthly basis to ensure compliance with the charging protocol. If any department has an error rate greater than 2% of gross audited charges they will be required to submit an action plan ~~to the Charge Auditor~~ to show improvement in the following month.
3. ~~All department managers whose late charge rate exceeds 1% of monthly department gross charges will be required to submit an action plan to the Charge Auditor to show improvement in the following month.~~

D. **BILLING HOLD PERIOD:**
1. The hospital imposed billing hold period is three days from discharge.
2. The exceptions to a bill printing within the "bill hold period" are:
   a. Diagnosis/Abstract missing
   b. Account is not in a discharge status
   c. Delinquent data/Hold (missing required billing data)

E. **AUTOMATICALLY POSTED CHARGES:**
1. Patient room charges are automatically posted each night for patients in-house.
2. ~~Charges for Outpatient Observation calculate automatically and will not calculate a charge in excess of the room charge for the assigned room and bed.~~
3. **.2.** Charges that come from **an~~the~~** order control application will post automatically.
4. **.3.** Charges that post from interfaces post automatically.

F. **MANUALLY POSTED CHARGES:**
1. Items not defined in **an~~the~~** order control application will be posted manually.
2. Charges for which the price will have an override will be posted manually.
3. Late charges/credits (items to be posted beyond the "billing hold period").
   **a.** Charges/credits, which need to be posted after the "billing hold period," will be posted through the patient accounting application. With the exception of lab pathology there should not be any charges after the "billing hold period".
   **~~a.~~4. Charges for Outpatient Observation are calculated manually and will not calculate a charge in excess of the room charge for the assigned room and bed.**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
District Operations

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**ISSUE DATE:** 09/96 **SUBJECT:** Charity Care, Uncompensated Care, Community Service

**REVISION DATE:** 08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15 **POLICY NUMBER:** 8610-285

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| **Department Approval:** | 03/17 |
| **Administrative Policies and Procedures Committee Approval:** | ~~02/15~~04/17 |
| **Finance, Operations and Planning Committee Approval:** | ~~08/15~~06/17 |
| **Board of Directors Approval:** | 08/15 |

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A. **PURPOSE:**

1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations.
2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et. seq. hereinafter referred to as the California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law.

B. **POLICY:**

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual~~;~~ , orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.

~~a.~~4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by~~,~~ or for~~,~~ the patient, will be confidential and the dignity of the patient will be maintained during this process.

~~b.~~5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage ~~g~~garnishments or a lien on the patient's primary residence~~,~~ if the patient or the patient's legal representative~~,~~ are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.

~~4.~~6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients ~~W~~with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital

C. **DEFINITIONS AND ELIGIBILITY:**

1. Charity – Health services for which the Hospital policies determine the patient is unable to pay. Charity care results from the Hospital's policy to provide health care services free of charge, or in circumstances where the patient has insurance, the self-pay balance free of charge to individuals who meet the hospital's charity criteria. Charity care is measured on the basis of revenue forgone, at full established rates. Charity care does not include contractual write-offs. **Definitions of Charity include:**
   a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost.
   b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
   c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
   d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
   e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
      i. Bankruptcy – patients who are in bankruptcy for self-pay balances.
      ii. Homeless patients – reasonable efforts have been made to locate and contact the patient and such efforts have been unsuccessful.
      iii. Deceased patients without an estate.
      ~~a)~~**iv.** MediCal/Medicaid denials – patients who qualify for MediCal/Medicaid are also ~~p~~presumed to qualify for full charity care. This includes patient's whose MediCal/Medicaid coverage is limited or restricted. This does not include Share of Cost (SOC) amounts. SOC amounts must be paid by the patient before the patient is eligible for MediCal/Medicaid.
2. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

~~a.~~**3.** High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or ~~r~~reached a lifetime limit, non-covered relating to services not medically necessary) High medical costs means:
   ~~b.~~**a.** Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceeds 10 percent of the patient's family income in the prior 12 months.
   ~~c.~~**b.** Annual out-of-pocket medical expenses by the patient that exceeds 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

~~3.~~**4.** Patient's Family and Determination of Family Income – For persons 18 years of age and older: Spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.

~~4.~~**5.** Reasonable payment formula - monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
   a. "Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

D. **PROCEDURES:**

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to

pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels:

| | ~~Income Level~~ | ~~Discount Amount~~ |
|---|---|---|
| ~~i.~~ | ~~Up to 350% of FPL~~ | ~~100% Discount~~ |
| ~~ii.~~ | ~~351% to 500% FPL~~ | ~~75% Discount~~ |
| ~~iii.~~ | ~~Over 500% of FPL,~~ | ~~Case by Case Discounts~~ |
| ~~iv.~~ | ~~High Medical Cost~~ | ~~100% Discount~~ |
| ~~v.~~ | ~~Special Circumstance~~ | ~~Case by Case Discounts~~ |

| | **Income Level** | **Discount Amount** |
|---|---|---|
| **i.** | **Up to 350% of FPL** | **100% Discount** |
| **ii.** | **351% to 500% FPL** | **75% Discount** |
| **iii.** | **Over 500% of FPL** | **Case by Case Discounts** |
| **iv.** | **High Medical Cost** | **100% Discount** |
| **v.** | **Special Circumstance** | **Case by Case Discounts** |

~~b.~~**a.** All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the ~~Confidential~~ Patient Financial **Assessment Form** ~~Statement~~ (~~CPFS~~**PFAF**) ~~(Attachment A)~~. If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre-arranged with the Hospital financial counselor. Charity determinations over $25,000 require the approval of the Chief Financial Officer or his/her designee.

~~c.~~**b.** All patients with a self -pay balance of $25 or less and an age of greater than 120 days will be written off to charity.

2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a ~~CPFS~~ **PFAF** should be completed.

   a. Family Members – Patient will be required to provide the number of family members in their household ~~(See 3.4)~~.

   ~~1)~~**b. Income Calculation – Patient will be required to provide their household's yearly gross** income. Adult patient's yearly income on the ~~CPFS~~ **PFAF** means the sum of the total yearly gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the ~~CPFS~~ **PFAF** means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.

   ~~b.~~**c.** Income verification – Patients will be required to verify the income set forth in the ~~CPFS~~**PFAF**. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, ~~telephone verification by employer of the patient's income,~~ bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.

   ~~c.~~**d.** Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:

      i. Expired patients: Expired patients may be deemed to have no income.

      ii. Written Attestation: Patient can sign the ~~CPFS~~ **PFAF** attesting to the accuracy of the income information provided.

~~i.~~iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.

3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patients will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.
4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient who is eligible for partial charity to pay over an extended period of time. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" formula to determine the payment plan.
5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or ~~c~~County-funded health coverage program.
6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.
7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt that the external agency will adhere ~~by~~ to the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. **NOTICE:**

1. Timeframe - There is no rigid limit on the time when the charity determination will be made. In some cases, a patient eligible for charity care may not be identified prior to the initiation of external collection action. The Hospital's collection agencies shall be made aware of this procedure so that the agenci~~es~~y knows to refer back to the Hospital patient accounts that may be eligible for charity care.
2. Once a full or partial charity determination has been made, a written notification will be sent to the applicant advising them of the Hospital's decision.

F. **COMMUNICATION:**

1. Information provided to patient – During registration, or as soon thereafter as practicable, the Hospital shall provide:
   a. All uninsured patients with written information regarding the Hospital's charity care policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.
   b. At the request of the patient, the Charity application will be provided.
   c. Patient statements to patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or ~~c~~County- funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications. Further, this information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, to the extent possible, these communications will be in the primary language of the patient.

d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physicians. The statement will include contact information for the emergency room physician who treated the patient.

2. Postings and Other Notices – Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

**G. FORMS/RELATED DOCUMENTS:**

**~~2.~~1. Patient Financial Assessment Form - Sample**

**~~G.~~H. REFERENCE:**

1. California Health and Safety Code, Section 127400, et. Seq
2. **ACA provisions, IRC §501(r)**

## Patient Financial Assessment Form - Sample

# PATIENT FINANCIAL ASSESSMENT REQUEST FORM

Tri-City Medical Center

Date:_____

| PATIENT NAME: LAST | FIRST | MIDDLE |
|---|---|---|
| PATIENT ADDRESS: | | MEDICAL RECORD # |
| CITY, STATE & ZIP | PATIENT SOCIAL SECURITY # | FAMILY SIZE (REQUIRED) |
| MAIDEN NAME OR OTHER: | | PHONE #: ( ) |
| NEXT OF KIN NAME: | PHONE #: ( ) | WORK PHONE ( ) |
| EMERGENCY PHONE | PATIENT DOB | CELL PHONE:# ( ) |

| RESPONSIBLE PARTY | | SPOUSE | |
|---|---|---|---|
| NAME | OCCUPATION | NAME | OCCUPATION |
| EMPLOYER (IF SELF EMPLOYED DESCRIBE) | SOCIAL SECURITY # | EMPLOYER (IF SELF EMPLOYED DESCRIBE) | SOCIAL SECURITY # |
| ADDRESS | | ADDRESS | |
| SUPERVISOR NAME | | SUPERVISOR NAME | |
| PHONE | YEARS | PHONE | YEARS |
| INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY | | INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY | |

| ASSETS | | LIABILITIES | |
|---|---|---|---|
| CASH ON HAND | $_____ | REAL ESTATE PAYMENTS | $_____ |
| CHECKING ACCOUNT | $_____ | INSURANCE PREMIUMS (AUTO/MED/HOME) | $_____ |
| SAVINGS ACCOUNT | $_____ | TAXES | $_____ |
| CREDIT UNION ACCOUNT | $_____ | UTILITIES | $_____ |
| PROPERTY OWNED VALUE | $_____ | AUTO PAYMENTS | $_____ |
| MOTOR VEHICLES OWNED | $_____ | FOOD | $_____ |
| MAKE: _____ | YEAR _____ | HOUSE PAYMENT IF RENTING | $_____ |
| MAKE: _____ | YEAR _____ | OTHER LIABILITIES: (ATTACH SEPARATE SHEET IF NECESSARY) | |
| HOME OWNER ESTIMATED VALUE | $_____ | DESCRIBE / PAYMENT / BALANCE | |
| OTHER SOURCES/ (STOCK BONDS) | $_____ | _____ / _____ / _____ | |
| | | _____ / _____ / _____ | |
| BANK BRANCH(S) & ACCOUNT NUMBERS | | | |

I/WE HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA.

_____ SIGNATURE(S) _____ DATE

## FOR PA USE ONLY

350% FPL_____ APPROVED: ☐ YES ☐ NO BY WHOM: _____

IF PARTIAL AMOUNT: $_____

Rev (310)

| | | | |
|---|---|---|---|
| **FECHA DE EMISIÓN:** | **09/96** | **ASUNTO:** | **CUIDADO DE CARIDAD, CUIDADO NO REMUNERADO, SERVICIO COMUNITARIO** |
| **FECHA DE REVISIÓN:** (mes/año) | **08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15** | **NÚMERO DE POLÍTICA:** | **8610-285** |

| | |
|---|---|
| **Aprobación Departamental:** | **03/17** |
| **Aprobado por Comité de Políticas Administrativas y Procedimientos:** | **~~02/15~~04/17** |
| **Aprobado por Comité de Finanzas y Operaciones:** | **~~08/15~~06/17** |
| **Aprobado por la Junta Directiva:** | **08/15** |

A. **PROPÓSITO:**

1. El hospital desea tener una clara, bien comunicada, y documentada política de asistencia financiera, consistente con su misión y valores, y en conformidad con las normas/estándares gubernamentales de contabilidad y reglamentos Federales y Estatales.
2. Los hospitales de atención crítica de California tienen que cumplir con el Código de Salud y Seguridad, Sección 127400 y siguientes secciones, de aquí en adelante referida como la Ley de Precios Justos de California, incluyendo requisitos de políticas por escrito proporcionando descuentos y cuidado de caridad a los pacientes que califican financieramente. Esta política tiene la intención de exceder los requisitos legales detallados en la Ley de Precios Justos de California.

B. **POLÍTICA:**

1. Como beneficio a la comunidad, es la política del Hospital el proporcionar, gratis o parcialmente gratis, servicios de salud a los miembros de la comunidad que han demostrado ser financieramente o médicamente indigentes. El Hospital da consideración a los pacientes elegibles residiendo dentro de su comunidad y a los pacientes, tengan o no seguro y sin importar el nivel de ingreso, si hay circunstancias excepcionales.
2. Los pacientes serán tratados justa y respetuosamente independientemente de su capacidad para pagar. El hospital no discrimina contra ninguna persona por motivo de raza, credo, color, origen nacional, orientación sexual o por razón de incapacidad (discapacidad) o edad.
3. El personal de la Oficina Comercial proporcionará a los pacientes interesados consejería financiera, incluyendo asistencia al aplicar para programas de salud locales, estatales y federales. Los pacientes no asegurados o insuficientemente asegurados serán informados y asistidos con su solicitud para el cuidado de caridad o cuidado con descuento.
4. Cualquier paciente o representante legal del paciente que busque asistencia financiera beberá proporcionar información relacionada con la cobertura de beneficios de salud, estado financiero (situación económica) y otra documentación pertinente que sea necesaria para tomar una determinación en cuanto a la situación del paciente concerniente a la política de cuidado de caridad del hospital, política de descuento de pago, o elegibilidad para programas locales, estatales o federales. Toda información proporcionada por o a favor del paciente será confidencial y se mantendrá la dignidad del paciente durante este proceso.
5. El Hospital y/o agentes externos trabajando en nombre del hospital no han de utilizar embargo de salario o ejercer gravamen (derecho de retención) sobre la residencia principal del paciente si el paciente o su representante legal se están comunicando y cooperando con el Hospital y se ha determinado que el paciente es elegible para el cuidado de caridad o el cuidado de descuento.

6. Como se define en la Sección 127450 del Código de Salud y Seguridad de California, Capítulo 2.5 de la División 107, a un médico de emergencia que provee servicios médicos de emergencia en un hospital, también se le requiere, por ley, proveer descuentos al paciente o a los pacientes no asegurados con altos costos médicos quienes están al nivel de o por debajo del nivel de pobreza federal de 350 por ciento. No debe interpretarse que esta declaración imponga alguna responsabilidad adicional sobre el hospital.

C. **DEFINICIONES Y ELEGIBILIDAD:**

1. Caridad – Servicios de salud por los cuales las políticas del Hospital determinan que el paciente no puede pagar. El cuidado de caridad resulta de la política del Hospital de proporcionar servicios de salud gratuitos, o, en circunstancias en las que el paciente tenga seguro, no cobrar por el saldo de la cuenta (balance de bolsillo/pago directo del paciente) a las personas que cumplan con los criterios para la caridad del hospital. El cuidado de caridad se calcula en base a los ingresos no devengados (perdidos) a precios completos establecidos. El cuidado de caridad no incluye las cancelaciones (lo incobrable) por contrato.
   Las definiciones de Caridad incluyen:
   a. Cuidado de Caridad Catastrófico - 100% cancelación de deuda del paciente para un paciente con Altos Costos Médicos.
   b. Cuidado de Caridad Completo – 100% cancelación de la responsabilidad no descontada del paciente.
   c. Cuidado de Caridad Parcial – Cancelación parcial de la responsabilidad no descontada del paciente.
   d. Cuidado de Caridad por Circunstancia Especial – Pacientes que no cumplen con otros criterios de caridad o que no son capaces de seguir los procedimientos especificados del hospital para recibir la cancelación total o parcial de cargos del cuidado de caridad.
   e. La siguiente es una lista no exhaustiva (es parcial) de algunas situaciones que podrían calificar para el cuidado de caridad por circunstancia especial:
      i. Bancarrota – pacientes que están en bancarrota por el saldo de cargos a cuenta propia.
      ii. Pacientes sin vivienda – se han realizado esfuerzos razonables para localizar y contactar al paciente y tales esfuerzos no han tenido éxito.
      iii. Pacientes fallecidos sin patrimonio (bienes).
      iv. Negación (rechazo) de Medi-Cal/Medicaid – pacientes que califican para Medi-Cal/Medicaid también se supone que califican para el cuidado de caridad total. Esto incluye a pacientes cuya cobertura de Medi-Cal/Medicaid es limitada o restringida. Esto no incluye montos (cantidades) de Su Parte del Costo (Share of Cost - SOC). Los montos de SOC los tiene que pagar el paciente antes de que el paciente sea elegible para Medi-Cal/Medicaid.
2. Nivel de Pobreza Federal (Federal Poverty Level - FPL) – Guías de pobreza, actualizadas periódicamente en el Registro Federal por el Departamento de Salud y Servicios Humanos de los Estados Unidos, bajo la autoridad de la subsección (2) de la sección 9902 del título 42 del Código de los Estados Unidos.
3. Altos Costos Médicos – Un paciente no asegurado con altos costos médicos (coaseguro, deducible y/o alcanzó el límite de por vida, no tiene cobertura relacionada con los servicios que no son médicamente necesarios). Altos costos médicos significa:
   a. Costos anuales de bolsillo (pagos directos) incurridos por el paciente, en el Hospital, que sobrepasan el 10 por ciento del ingreso familiar del paciente en los 12 meses anteriores.
   b. Gastos médicos anuales de bolsillo (pagos directos) del paciente que sobrepasan el 10 por ciento del ingreso familiar del paciente, si el paciente proporciona documentación de los gastos médicos del paciente pagados por el paciente o la familia del paciente en los 12 meses anteriores.

4. Familia del Paciente y Determinación del Ingreso Familiar – Para las personas de 18 años de edad y mayores: Cónyuge (esposo/a), pareja doméstica, y niños dependientes menores de 21 años de edad, estén o no viviendo en casa. Para las personas menores de 18 años de edad: Padre (padre/madre), parientes cuidadores, y otros niños menores de 21 años de edad del padre (padre/madre) o del pariente cuidador. La documentación de ingreso familiar deberá limitarse a talones (comprobantes) recientes de pago y de declaraciones de impuestos. Los activos (bienes) del paciente o de la familia del paciente no podrán ser considerados.
5. Formula razonable de pago – pagos mensuales que no sean más del 10 por ciento del ingreso familiar del paciente por un mes, excluyendo deducciones por gastos básicos (gastos esenciales de vida).
   a) "Gastos básicos" significa gastos por todos los siguientes: alquiler o pago de la casa y mantenimiento, comida y provisiones domésticas, gas/agua/electricidad (en inglés: utilities) y teléfono, ropa, pagos médicos y dentales, seguro (aseguranza), escuela o cuidado infantil, manutención de niño o cónyuge, transporte y gastos del carro incluyendo seguro, gasolina y reparaciones, pagos a plazo, lavandería y limpieza, y otros gastos extraordinarios.

D. **PROCEDIMIENTOS:**

1. Cualquier paciente no asegurado que indique incapacidad de pagar será evaluado para el cuidado de caridad. Además, a discreción del Hospital, cualquier paciente asegurado que indique incapacidad de pagar por lo que es su responsabilidad, después que su seguro haya pagado, será evaluado para el cuidado de caridad. El cuidado de caridad será concedido en base a los siguientes niveles sugeridos de ingreso:

| | Nivel de Ingreso | Cantidad de Descuento |
|---|---|---|
| i. | Hasta 350% del FPL | 100% de descuento |
| ii. | del 351% al 500% del FPL | 75% de descuento |
| iii | Por encima del 500% del FPL | El descuento es caso por caso |
| iv. | Altos Costos Médicos | 100% de descuento |
| v. | Circunstancias especiales | El descuento es caso por caso |

   a. Todos los pacientes que se estén registrando sin seguro serán registrados como paciente que paga por cuenta propia o paciente cuyo Medi-Cal/Medicaid está pendiente, y se debe tomar una solicitud para Medi-Cal/Medicaid. Los pacientes electivos (procedimientos opcionales) que tienen un deducible grande y/o obligación de coaseguro se reunirán con un consejero financiero y llenarán el Formulario de Evaluación Financiera del Paciente (en inglés: Patient Financial Assessment Form - PFAF). Si el paciente no califica para caridad o Medi-Cal/Medicaid, se requerirá pago por adelantado, antes del servicio. Si se determina la caridad y se requiere de pago parcial, el pago ha de efectuarse por adelantado, antes del servicio, a menos que se hayan realizado otros pre-arreglos con el consejero financiero del Hospital. Las determinaciones de caridad por encima de $25,000 requieren de la aprobación del/de la Director/a Financiero/a o de quien él/ella designe.
   b. El saldo (balance) a cuenta propia de todos los pacientes que sea de $25 o menos, con una antigüedad mayor de 120 días, será anulado por caridad.
2. Solicitud (aplicación) - Excepto en aquellos instantes en los que el Hospital haya determinado que aplican requisitos mínimos para la solicitud o la documentación a fin de calificar para el cuidado de caridad, deberá llenarse el Formulario de Evaluación Financiera del Paciente (PFAF por sus siglas en inglés).
   a. Miembros de la Familia – Se le requiere al paciente proporcionar el número de miembros de familia en sus casas (ver C.4.).

b. Cálculo de Ingreso – Se le requerirá al paciente proporcionar el ingreso bruto anual de su casa/hogar. Para un paciente adulto, el ingreso anual en el PFAF significa la suma del total del ingreso bruto (antes de deducir impuestos) del paciente y de su cónyuge o pareja doméstica. Para un paciente menor de edad, el ingreso anual en el PFAF significa el ingreso del (lo que gana el) paciente, la madre y/o el padre del paciente, y/o su pareja doméstica y/o su guardián legal.

c. Verificación de ingreso – Se le requerirá a los pacientes verificar el ingreso declarado en el PFAF. La documentación de ingresos incluirá el formulario W-2 del IRS, comprobante (recibo) de sueldo y ganancias (en inglés: wage and earnings statement), talones (comprobantes) de cheque de sueldo, declaraciones de impuestos, cuentas de bancos y otros indicadores apropiados de ingresos. Participar actualmente en un Programa de Beneficio Público, incluyendo Ingreso de Seguridad Complementario (SSI por sus siglas en inglés), Seguro Social por Incapacidad, Beneficios de Seguro de Desempleo, Medicaid, Indigente del Condado, Cupones para Alimentos, WIC, o algún otro programa similar para personas indigentes pueden utilizarse para verificar la indigencia.

d. No hay documentación disponible – Cuando el paciente sea incapaz de proporcionar documentación verificando los ingresos, los siguientes procedimientos han de seguirse:

   i. Pacientes fallecidos: Puede considerarse que los pacientes fallecidos no tengan ingreso.

   ii. Testimonio Escrito: El paciente puede firmar el PFAF atestiguando la veracidad de la información de ingreso proporcionada.

   iii. Testimonio Verbal: El consejero financiero del Hospital puede proporcionar testimonio por escrito de que el paciente verbalmente verificó el cálculo de los ingresos. Debe hacerse algún intento para documentar el ingreso anual del paciente antes de tomar un testimonio verbal.

3. Pacientes que no estén dispuestos a divulgar ninguna información como sea solicitada por el consejero financiero del Hospital – Se le advertirá al paciente que, a menos que cumplan con los requisitos y proporcionen la información, no se le dará ninguna otra consideración al proceso para el cuidado de caridad y el seguimiento estándar de Contabilidad de Deudas resultará.

4. Planes de Extensión de Pagos, sin cobro de intereses, se harán disponibles y serán negociados entre el Hospital y el paciente para permitir que el paciente que sea elegible para el cuidado de caridad parcial pague durante un periodo de tiempo prolongado. Si el Hospital y el paciente no logran ponerse de acuerdo sobre un plan de pago, el hospital utilizará la fórmula del "plan razonable de pago" para determinar el plan de pago.

5. Mercado de Beneficios de Salud de California (California Health Benefit Exchange) – El Hospital obtendrá información en cuanto a si el paciente pudiera ser elegible para el Mercado de Beneficios de Salud de California. Se le proporcionará información a un paciente que no haya mostrado prueba de tener cobertura de parte de un tercero, una declaración diciendo que el paciente podría ser elegible para cobertura a través del Mercado de Beneficios de Salud de California – u otro programa de cobertura de salud financiado por el Estado o el Condado.

6. Si el paciente presenta una solicitud (aplica), o tiene una solicitud pendiente para otro programa de cobertura de salud concurrentemente con (al mismo tiempo que) una solicitud para el cuidado de caridad o un programa de descuento de pago, ni la solicitud para el cuidado de caridad ni para el programa de descuento de pagos, ni para el programa de cobertura de salud impide (excluye) la elegibilidad para el otro programa.

7. Toda actividad de cobro (colección) interna o externa estará basada en los procedimientos escritos contenidos (expuestos) aquí. El Hospital mantendrá un acuerdo por escrito con cualquier agencia externa que colecte deuda indicando que la agencia externa cumplirá con los estándares y prácticas del Hospital. Específicamente, que la agencia externa cumplirá con la definición y solicitud del plan de pago razonable del Hospital aquí definidos.

E. **AVISO:**

1. Plazo de tiempo – No existe un límite rígido en cuanto al tiempo que tomará llegar a una determinación acerca de la caridad. En algunos casos, un paciente elegible para el cuidado de caridad podría no ser identificado antes de iniciarse la acción de cobro por agencia externa. Las agencias de cobro del Hospital deberán ser informadas acerca de este procedimiento para que sepan que han de referir al Hospital la cuenta de los pacientes que pudieran ser elegibles para el cuidado de caridad.
2. Una vez que se haya determinado si la caridad es total o parcial, se le enviará una notificación por escrito al solicitante informándole acerca de la decisión del Hospital.

F. **COMUNICACIÓN:**

1. Información proporcionada al paciente – Durante el registro, o tan pronto después como sea práctico, el Hospital proporcionará a:
   a. Todos los pacientes no asegurados información por escrito acerca de las políticas del cuidado de caridad del Hospital y la información de contacto apropiada para que el paciente obtenga información adicional acerca de estas políticas. El Hospital proporcionará al paciente una referencia a un centro local de asistencia al consumidor.
   b. A petición del paciente, se proporcionará la solicitud (aplicación) para Caridad.
   c. Las declaraciones a los paciente que no hayan proporcionado prueba de cobertura de parte de terceros incluirá información acerca del cuidado de caridad, el Mercado de Beneficios de Salud de California y otras coberturas financiadas por el Estado o el Condado, así como Medicare, Medi-Cal, Familias Sanas (Healthy Families) y Servicios para Niños de California (California Children's Services). La declaración al paciente indicará cómo el paciente podría obtener solicitudes de cobertura mediante el Mercado de Beneficios de Salud de California y otros programas de cobertura médica financiados por el Estado o por el Condado, y el Hospital proporcionará estos formularios de solicitud. Más aún, esta información tendrá lenguaje estándar informándoles a los pacientes que ellos podrían solicitar evaluación financiera para determinar elegibilidad para el cuidado de caridad. Por último, en la medida de lo posible, estas comunicaciones estarán en el idioma principal del paciente.
   d. La declaración al paciente incluirá información sobre la disponibilidad del cuidado de caridad y descuento en los pagos por parte de los médicos de la sala de emergencia. Esta declaración incluirá información de contacto del médico de la sala de emergencia que trató al paciente.
2. Anuncios y Otros Avisos – Información acerca del cuidado de caridad deberá también proporcionarse colocando avisos de manera visible en las áreas de admisión y registro.

G. **FORMULARIOS/DOCUMENTOS RELACIONADOS:**

1. Formulario de Evaluación Financiera del Paciente - Muestra

H. **REFERENCIAS:**

1. California Health and Safety Code, Section 127400, et. seq.
   Código de Salud y Seguridad de California, Sección 127400 y siguientes)
2. ACA provisions, IRC §501(r)
   Provisiones de la Ley de Reforma de Salud Integral, Código de Rentas Internas §501(r)

## Formulario de Evaluación Financiera del Paciente – Muestra

### EVALUACIÓN PARA ASISTENCIA FINANCIERA - FORMULARIO DE SOLICITUD DEL PACIENTE

Tri-City Medical Center

Fecha: _____

| | | |
|---|---|---|
| NOMBRE DEL PACIENTE: APELLIDO | 1ER NOMBRE | 2º NOMBRE |
| DIRECCIÓN DEL PACIENTE | | # DE EXPEDIENTE MÉDICO |
| CIUDAD, ESTADO, CÓDIGO POSTAL | # DE SEGURO SOCIAL DEL PACIENTE | TAMAÑO DE LA FAMILIA (REQUERIDO) |
| APELLIDO DE SOLTERA U OTRO APELLIDO | | # DE TELÉFONO ( ) |
| NOMBRE DEL PARIENTE MÁS CERCANO | # DE TELÉFONO: ( ) | # TELÉFONO DEL TRABAJO ( ) |
| TELÉFONO DE EMERGENCIA | FECHA DE NACIMIENTO DEL PACIENTE | # DE TELÉFONO MÓVIL ( ) |

| PARTE RESPONSABLE | | CONYUGE | |
|---|---|---|---|
| NOMBRE | OCUPACIÓN | NOMBRE | OCUPACIÓN |
| EMPLEADOR (DESCRIBA SI ES INDEPENDIENTE) | # DE SEGURO SOCIAL | EMPLEADOR (DESCRIBA SI ES AUTOEMPLEO) | # DE SEGURO SOCIAL |
| DIRECCIÓN | | DIRECCIÓN | |
| NOMBRE DEL SUPERVISOR | | NOMBRE DEL SUPERVISOR | |
| TELÉFONO | AÑOS EN ESE EMPLEO | TELÉFONO | AÑOS EN ESE EMPLEO |
| SUELDO (REQUERIDO) $_____ ☐ POR HORA ☐ QUINCENAL ☐ MENSUAL | | SUELDO (REQUERIDO) $_____ ☐ POR HORA ☐ QUINCENAL ☐ MENSUAL | |

| ACTIVOS/BIENES | | OBLIGACIONES/GASTOS | |
|---|---|---|---|
| DINERO EN EFECTIVO DISPONIBLE .... | $ _____ | PAGOS DE HIPOTECA ..... | $_____ |
| CUENTA DE CHEQUES ..... | $ _____ | PRIMA DE SEGUROS/ASEGURANZA (AUTO/SALUD/CASA) ..... | $_____ |
| CUENTA DE AHORROS ..... | $ _____ | | |
| CUENTA DE UNA COOPERATIVA DE CRÉDITO (CREDIT UNION ACCOUNT) ..... | $ _____ | IMPUESTOS ..... | $_____ |
| VALOR DE SUS PROPIEDADES ..... | $ _____ | SERVICIOS (GAS, ELECTRICIDAD, AGUA) ..... | $_____ |
| VEHÍCULOS DE MOTOR QUE POSEE .... | $ _____ | PAGOS DE AUTOMÓVIL ..... | $_____ |
| MARCA: _____ | AÑO _____ | COMIDA ..... | $_____ |
| MARCA: _____ | AÑO _____ | PAGO DE ALQUILER DE CASA SI ALQUILA .... | $_____ |
| DUEÑO DE CASA - VALOR ESTIMADO .. | $ _____ | OTRAS OBLIGACIONES: (INCLUYA OTRA HOJA SI ES NECESARIO) | |
| OTRAS FUENTES, (ACCIONES Y BONOS) ..... | $ _____ | DESCRÍBALAS / PAGO / BALANCE | |
| | | _____ _____ _____ | |
| | | _____ _____ _____ | |

SUCURSAL(ES) DE BANCO(S) Y NÚMERO(S) DE CUENTA

YO/NOSOTROS POR LA PRESENTE DECLARO/DECLARAMOS, BAJO PENA DE PERJURIO CONFORME A LAS LEYES DE CALIFORNIA, QUE LA INFORMACIÓN ANTERIOR ES VERDADERA.

_____ FIRMA(S) _____ FECHA

**SOLO PARA USO INTERNO • FOR PA USE ONLY**

350% FPL_____ APPROVED: ☐ YES ☐ NO BY WHOM: _____

Rev (2/17)

IF PARTIAL AMOUNT: $_____

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: JUNE 20, 2017**
**EVS MOP/CLEANING CLOTHS/ENTRANCE FLOOR MAT SERVICE AGREEMENT**

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

**Vendor's Name:** Uni-First Corporation

**Area of Service:** Environmental Services Dept.

**Term of Agreement:** 36 months, Beginning, Month July 1, 2017 – Ending, June 30, 2020

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $7,013 | $84,156 | $252,468 |

**Description of Services/Supplies:**

- Complete full services providing and laundering mops, cleaning cloths, and entrance floor mats
- This contract will provide a net savings to the District of $35K a year and $105K for the term by eliminating the existing costs of in-house washing machine maintenance, purchases of mops, cloths, & entrance mats, labor to wash mops/cleaning cloths, laundry detergent, and utilities (water/sewer/electricity).
- Ensures our cleaning supply linens are cleaned/sanitized according to Title 22 CCR § 70825.
- Reduces EVS employee exposure to handling soiled and heavy laundry loads and floor mats

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

***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Hope Chaney, Assistant Manager, Environmental Services / Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Uni-First Corporation for services to provide and launder mops/cleaning cloths and entrance floor mats for a term of 36 months, beginning July 1, 2017 and ending June 30, 2020, for an annual cost of $84,156 and a total cost for the term of $252,468.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ICU Medical Director**

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

**Physician's Name:** Mark Yamanaka, M.D.

**Area of Service:** ICU

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

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $175 | 20 | 240 | $3,500 | $42,000 | $42,000 |

**Position Responsibilities:**

- Provides Clinical Documentation
- Utilization review of program
- Evaluates and establishes policies/procedures/protocols for ICU
- Recommends, develops and implements new services
- Facilitates effective communications
- Assists with interviewing new staff
- Assists with public education
- Attend hospital meetings as requested

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Merebeth Richins, Director, ICU-PACU / Sharon Schultz, Chief Nurse Executive

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months beginning July 1, 2017 and ending June 30, 2018. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $42,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Adult Intensive Care Unit / Pulmonary**

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

**Physician's Name:** Frank Corona, M.D.; Martin Nielsen, M.D.; Mark Yamanaka, M.D.; Safouh Malhis M.D.

**Area of Service:** Emergency Department On-Call: ICU Coverage Panel / ED Pulmonary On-Call Coverage Panel

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

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

| Rate/Day | Panel Days per Year | Panel Annual Cost | 24 Month (Term) Cost |
|---|---|---|---|
| $1,500 | FY2018: 365<br>FY2019: 365 | $547,500<br>$547,500 | $1,095,000 |

**Position Responsibilities:**

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

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*
***To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physicians Frank Corona M.D., Martin Nielsen M.D., Mark Yamanaka M.D., Safouh Malhis M.D. as the Pulmonary and ICU ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019, at a daily rate of $1,500, for an annual cost of $547,500, and a term cost of $1,095,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE –Interventional Radiology (IR)**

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

**Physician's Name:** Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; and Richard Saxon, M.D.

**Area of Service:** Emergency Department On-Call: Interventional Radiology (IR)

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

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $650 | 365 | $237,250 |
| | **Total Term Cost:** | **$237,250** |

**Position Responsibilities:**

- Provide 24/7 patient coverage for all Interventional Radiology 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.
- $50 rate increase per day, over prior contract

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*
***To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physicians Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; and Richard Saxon, M.D. as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $650 for an annual and term cost of $237,250.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT**

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

**Physician's Name:** Juile Berry, M.D.; Hernan Goldsztein, M.D.; Robert Jacobs, M.D.; Marc Lebovits, M.D.; Bruce Reisman, M.D.; Ashish Wadhwa, M.D.; Anton Kushnaryov M.D., **Jennifer MacEwan, M.D.
***new physician to panel*

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

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

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $550/day | FY2018: 365<br>FY2019: 365 | $200,750<br>$200,750 |
| | **Total Term Cost:** | **$401,500** |

**Position Responsibilities:**

- Provide 24/7 patient coverage for all ENT specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.
- Rate increased from $450 (weekday rate), from prior contract

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize ENT physicians Juile Berry, M.D., Hernan Goldsztein, M.D., Robert Jacobs, M.D., Marc Lebovits, M.D., Bruce Reisman, M.D., Ashish Wadhwa, M.D., Anton Kushnaryov, M.D. and Jennifer MacEwan, M.D. ENT ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019 at a daily rate of $550, for an annual cost of $200,750 and total term cost of $401,500.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Spine**

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

**Physician's Name:** Neville Alleyne, M.D.; David Amory, M.D.; Payam Moazzaz, M.D.; Lokesh Tantuwaya, M.D.; Kevin Yoo, M.D., Sunil Jeswani, M.D.; Tyrone Hardy, M.D.; Thomas Marcisz, M.D, Mark Stern, M.D.; Howard Tung, M.D.

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

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

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $400 | FY2018: 365<br>FY2019: 365 | $146,000<br>$146,000 |
| | **Total Term Cost:** | **$292,000** |

**Position Responsibilities:**

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

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

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

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Spine physicians Alleyne Neville, M.D.; David Amory, M.D.; Payam Moazzaz, M.D.; and Lokesh Tantuwaya, M.D.; Kevin Yoo, M.D., Sunil Jeswani, M.D.; Tyrone Hardy, M.D.; Thomas Marcisz, M.D, Mark Stern, M.D.; Howard Tung, M.D. as the Spine ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, at a daily rate of $400, for an annual cost $146,000 and total term cost of $292,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Opthamology**

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

**Physician's Name:** Neeta Varshney, M.D.

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

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

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

| Rate/Day | Panel Days per Year | Total Term Cost |
|---|---|---|
| $300 | 365 | $109,500 |

**Position Responsibilities:**

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

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*
***To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physician Neeta Varshney, M.D. as the Opthamology ED-Call Coverage Physician for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $300 for an annual and term cost of $109,500.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Urology**

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

**Physician's Name:** Caroline J. Vilchis, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Jason Phillips, M.D.; Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D.

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

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

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $350 | 365 | $127,750 |

**Position Responsibilities:**

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

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*
***To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Urology physicians Caroline J. Vilchis, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Jason Phillips, M.D.; Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D. as the Urology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $350, for an annual and term cost of $127,750.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Re-Tube Hospital Boiler #1**

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

**Vendor's Name:** R.F. MacDonald Co.

**Area of Service:** Facilities

**Term of Agreement:** One Time Service

**Maximum Totals:** $43,562 + $4,356 (standard 10% contingency)

**Description of Services/Supplies:**

- Engineering performs an annual inspection of the boiler tubes. The recent inspection indicated that we are in the time window to replace the tubes.
- We have two boilers and one of them operates at a time. The boilers produce steam, heating and hot water for the hospital.
- R.F. MacDonald provides preventive maintenance for boilers and is the most qualified contractor for this job.
- R.F. Mac Donald was the lowest bidder. Below are the bid results:

| Boiler Re-Tube Bids: | Amounts: |
|---|---|
| R.F. MacDonald | $ 43,562 |
| Manley's Boiler Inc. | $ 55,928 |
| Automatic Boiler Co. | $ 66,837 |
| Trane | $ 91,611 |

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

***To be included in proposed FY Budget*

**Person responsible for oversight of agreement:** Chris Miechowski, Director of Facilities / Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with R.F. MacDonald Co. for the re-tube of boiler #1, for a total expected contract cost of $43,562 and a total project budget of $47,918.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Elevators Maintenance & Service Agreement**

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

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

**Area of Service:** Facilities

**Term of Agreement:** 60 months

**Maximum Total Not to Exceed:** $270,320

**Description of Services/Supplies:**

- Maintenance and service for the elevators at the hospital.
- This is a renegotiation to an existing contract that will save the district approximately $25,000 annually.

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

***To be included in proposed FY Budget*

**Person responsible for oversight of agreement:** Chris Miechowski, Director of Facilities / Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Elevator Maintenance and Service Agreement with Kone, Inc. for 60 months for a total not to exceed of $270,320.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for ANESTHESIA SERVICES**

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

**Physician Group:** Anesthesia Services Medical Group (ASMG)

**Area of Service:** Surgery / OB

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

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

| Coverage | Hourly Cost | Monthly Cost | Annual Cost | Total Contract Cost |
|---|---|---|---|---|
| Unassigned patients ED & OB | | $49,372 | $592,464 | $1,184,928 |
| Extra Room Coverage | Varies ($1,000) per day Monday-Thursday | | Not to exceed $200,000 | $400,000 |
| EHR Development, one-time cost | 0 | 0 | 0 | $19,800 |
| Pre Anesthesia Review (twice a week, Tuesday & Thursday), x 2 hours/day | $198 | $3,432 | $41,184 | $82,368 |
| | | **Total Term Cost:** | | **$1,687,096** |

**Description of Services/Supplies: New Service:** On-call, On-site and Unassigned Patients

**Position Responsibilities:**

- Physician Anesthesia services including on-call and designated on-site coverage
- Anesthesia Services for Unassigned Emergency Room patients
- Anesthesia Services for Unassigned Obstetrical patients
- Availability of 8th Anesthesiologist
- Comply/meet metrics outlined in Exhibit B of contract
- No change in monthly payment from prior contract

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

**Approval is recommended based on utilizing approved template. Legal review is not necessary when template is used.*
***To be included in proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with ASMG for Anesthesia Coverage for a term of 24 months, beginning July 1, 2017 and ending June 30, 2019. Not to exceed $49,372 per month, with a total cost for the term of $1,687,096.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Physician Agreement for Specialty Care Clinic & Progressive Care Unit**

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

**Physician's Name:** Yung Le, M.D.

**Area of Service:** Specialty Care Clinic and Progressive Care Unit

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

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 24 month (Term) Cost |
|---|---|---|---|---|---|
| $163 | 20 | 240 | $3,260 | $39,120 | $78,240 |

**Position Responsibilities:**

- Participates in daily UR on the inpatient unit with the CDCR patients as needed.
- Participates in risk management investigation and evaluation of events.
- Establishes and reviews policies and procedures for medical care.
- Participates in quarterly or more frequent meetings with the CDCR and Sheriff Departments.
- Communicates as needed with attending and referring physicians; provides oversight of chart audits, peer review and delinquencies in documentation.
- Assists in introducing new services/programs requested by the vendors.

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

**Approval is recommended based on utilizing approved template. Legal review is not necessary when template is used.*
***To be included in proposed FY Budget*

**Person responsible for oversight of agreement:** Lori Roach, R.N. Manager, Clinical IP Forensic Unit / Sharon Schultz, Chief Nurse Executive

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Yung Le as the Medical Director/Covering Physician for a term of 24 months beginning July 1, 2017 and ending June 30, 2019. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $ 163, for an annual cost of $39,120 and a total cost for the term of $78,240.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Registry Contracts for Nursing and Allied Health Proposal**

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

**Vendor's Name:** Registry and Traveler Vendors

**Area of Service:** Nursing and Allied Health Areas

**Term of Agreement:** 36 months, Beginning, July 1, 2016 – Ending, June 30, 2019

**Current contract approved for a total of $16.5 M**

**Maximum Totals:**

| Average Monthly Cost | Average Annual Cost | Total Term Cost |
|---|---|---|
| $514,000 | $6.1 M | $18.5 M* |

**Description of Services/Supplies:**

- *Based on current usage of Registry staff, we anticipate a $2 million increase to the currently approved amount.
- No contract changes or rate increases; current Registry and Travel Contracts are good for the next two years; this is a request for annual registry spend.
- The annual spend for the contracts vary based on availability of a provider at the time of need. Requests for registry are based on volume demands and staff vacancies; therefore there is no absolute cost figure. There may be a need to expand or delete the current Registry Agencies based on availability of providers for our needs.
- We will be able to reduce registry and traveler costs for FY 2018 as we hire on more core staff and hold additional New Grad training programs. This will allow for a decrease in overtime and double time.

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

***To be included in proposed FY Budget*

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

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Registry vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and allied health for the remaining term of 2 years, beginning July 1, 2017 and ending June 30, 2019 for a new cost for the term of $18.5M.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Neuroscience Institute - Co-Management Agreement**

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

**Vendor's Name:** Tri-City Medical Center Neuroscience Institute, LLC

**Area of Service:** Neuroscience Institute, LLC

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

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $54,167 | $650,004 | $1,950,012 |

**Description of Services/Supplies:**

- Provides structure that is consistent with the Institute's guiding principles of hospital-physician collaboration and integrated leadership; establishes an entity that is consistent with integrated delivery and provides a foundation for business and payer initiatives; the management fee and incentive fees are unchanged from the original agreement. The original agreement was established in July 2014 and structured by the law firm of Squire, Sanders and Dempsey LLP, and approved by TCHD Counsel.

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

***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Tri-City Medical Center Neuroscience Institute LLC for Co-Management Services for a term of 36 months, beginning July 15, 2017 and ending July 14, 2020, for an annual cost of $650,004, and a total cost for the term of $1,950,012.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Neuroscience Institute - Specialty Medical Directorship Agreements**

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

**Physician's Name:** Jack Schim, M.D., Stroke
Greg Sahagian, M.D., Neurology

**Area of Service:** Neuroscience Institute

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

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $200 | 24 | 288 | $4,800 | $57,600 | $57,600 |

**Position Responsibilities:**

Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed Specialty Area and the performance of the other medical administrative services as outlined in the previously approved Co-Management Agreement for the Institute.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Schim and Sahagian as the Specialty Medical Directors for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 24 hours per month or 288 hours annually, at an hourly rate of $200 for an annual cost of $57,600, and a total cost for the term of $57,600.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Neuroscience Institute - Operations Committee Agreements**

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

**Physician's Name:** Tyrone Hardy, M.D.
Greg Sahagian, M.D.
Kevin Yoo, M.D.

**Area of Service:** Neuroscience Institute

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

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $210 | 6 | 72 | $1,260 | $15,120 | $15,120 |

**Position Responsibilities:**

Physicians shall serve as Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Jeremy Raimo, Sr. Director, Business Development / Wayne Knight, Chief Strategy Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Hardy, Sahagian and Yoo as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Neuroscience Institute - Quality Committee Agreements**

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

**Physician's Name:** Donald Ponec, M.D.
Jack Schim, M.D.

**Area of Service:** Neuroscience Institute

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

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $210 | 4 | 48 | $840 | $10,080 | $10,080 |

**Position Responsibilities:**

Physicians shall serve as Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*
***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Ponec and Schim as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - ending June 30, 2018. Not to exceed an average of 4 hours per month or 48 hours annually, at an hourly rate of $210 for an annual cost of $10,080, and a total cost for the term of $10,080.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Employee Leasing Agreement Amendment**

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

**Physician Name:** Tannaz Ebrahimi Adib, M.D.
**Areas of Service:** Obstetrics/Gynecology – Venus Women's Healthcare 1206(b) Clinic

**Terms of Agreement:** 3 months (90 days)
Effective Date: April 28, 2017

| **Total Not to Exceed:** | **Total Expenditure:** |
|---|---|
| $25,000 | $25,000 |

**Unique Features**: This is an extension of the original Employee Leasing Agreement that began on January 27, 2017—the point that Venus Women's Healthcare became a Tri-City Medical Center 1206(b) clinic. The objective during this extended leased employee agreement is to secure hired Tri-City Medical Center staff by July 27, 2017.

**Requirements:**

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

***To be included in proposed FY Budget*

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

**Motion:**
I move that the Finance, Operations and Planning Committee recommend the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $25,000 in 3 months (90 days), in order to extend the employee leasing agreement with Tannaz Ebrahimi Adib, M.D. for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Retail Pharmacy Development and Build Out Proposal**

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

**Vendor's Name:** Sfeir Architects; and a Construction Company (to be determined)

**Area of Service:** Retail Pharmacy

**Maximum Totals:**

| Design Cost | Build Out Cost | Total Development Cost |
|---|---|---|
| $38,372 | $297,789 | $336,161 |

**Description of Services/Supplies:** Implementation of a strategic pharmacy initiative that expands our scope of services into the ambulatory environment. The total expense includes design and construction of an on-campus outpatient pharmacy. Benefits include:

- Decrease patient readmission rate through medication compliance and education
- Patient and Caregiver satisfaction
- Employee convenience to refill prescriptions on campus
- Reduction in employee Rx TCMC self-funded expenses
- OP expansion provides TCMC an opportunity at a new revenue stream
- Leverage 340b pricing

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

***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Sfeir Architects and Construction Company to be named for Design, Development and Construction of an on-campus Retail Pharmacy for a total cost of $336,161.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**Retail Pharmacy Management Proposal**

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

**Vendor's Name:** Comprehensive Pharmacy Services (CPS)

**Area of Service:** Retail Pharmacy

**Maximum Totals:**

| CPS Contract Cost: | OP: | IP: | Totals: |
|---|---|---|---|
| Pre-Start Implementation one-time fee | $30,000 | | $30,000 |
| Year 1 | $36,000 | $201,703 | $237,703 |
| Year 2 | $48,800 | $207,754 | $256,554 |
| Year 3 | $62,240 | $213,987 | $276,227 |
| Year 4 | $76,352 | $220,406 | $296,758 |
| Travel costs not to exceed | $10,000 | | $10,000 |
| **Total Term Cost** | **$263,392** | **$843,850** | **$1,107,242** |

**Description of Services/Supplies:** TCMC would like to leverage its existing IP Pharmacy Support agreement with CPS to provide discounted OP Retail Pharmacy Management Services. By renewing our IP contract (set to expire February 2018) TCMC will combine both IP and OP services into single agreement.

- Provide ongoing IP utilization management, policies/procedures and regulatory/compliance audits
- Provide 340 program oversight
- Additional Services: Daily management and regulatory oversight of OP pharmacy
- Additional Services: Establishment of discharge delivery services and discharge education
- Additional Services: Transition of Care counseling to reduce hospital readmissions

| Outpatient Pharmacy Management Bids: | Amounts: |
|---|---|
| Comprehensive Pharmacy Services (CPS) – 4 years | $263,392 |
| Cardinal – 3 years ($138,000/year + $50,000 implementation fee) | $464,000 |
| Visante – consultation services only to open pharmacy | $144,000 |

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

***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Kapua Conley, Chief Operating Officer

**Motion:**
Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Comprehensive Pharmacy Services: to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) + four years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending 4 years from implementation, for a total cost for the term of $1,107,242.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2017**
**PHYSICIAN AGREEMENT for Clinical & Anatomic Pathology Laboratory**

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

**Vendor's Name:** Marcus Contardo, M.D. (North Coast Pathology Medical Group, NCPMG)
**Area of Service:** Clinical & Anatomic Pathology Laboratory Services
**Term of Agreement:** 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018
**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $57,917 | $695,000 | $695,000 |

**Description of Services/Supplies:** Over the past 6 years the Pathology stipend has remained flat and below FMV.

- NCPMG will exclusively provide all anatomic pathology and clinical pathology (laboratory medicine) professional services in the Department.
- NCPMG will provide an exclusive full-time pathologist Laboratory Director for the Clinical Laboratory and Department of Pathology.
- NCPMG will ensure that there are sufficient physicians available as needed and/or on-call for the Department seven days per week, 24 hours per day.
- NCPMG will provide oversight of all professional services in the Department.
- Assist TCHD in developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program for the Department.
- Assist TCHD in establishing and evaluating policies, procedures, and protocols for patient care in Pathology and Lab.
- Assist TCHD in meeting accreditation and licensing requirements of the College of American Pathologists, the Joint Commission, the FDA and the CA DHS.
- Assist TCHD in negotiating contracts with providers of outside materials and reference services to the Clinical Laboratory.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*
***To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Kapua Conley, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 an annual cost of $695,000, and a total cost for the term of $695,000.

DRAFT

# Tri-City Medical Center
# Professional Affairs Committee Meeting
# Open Session Minutes
# June 8, 2017

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

**Non-Voting Members Present:** Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, and Scott Livingstone Interim Chief Compliance Officer.

**Others present:** Rick Barton, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Linda Sprague, Oska Lawrence, Mary Diamond, Kathy R. Topp, Nancy Myers, Patricia Guerra and Karren Hertz.

**Members Absent:** Dr. Scott Worman.

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 1. Call To Order | Director Mitchell called the meeting to order at 12:06PM in Assembly Room 1. | | Director Mitchell |
| 2. Approval of Agenda | The committee reviewed the agenda; there were no additions or modifications. | Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass. | Director Mitchell |
| 3. Comments by members of the public on any item of interest to the public before committee's consideration of the item. | Director Mitchell read the paragraph regarding comments from members of the public. | | Director Mitchell |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 4. Ratification of minutes of May 2017. | Director Mitchell called for a motion to approve the minutes from May 11, 2017 meeting.<br>There was a minor correction on the TDAP policy where in it should say that all pregnant mothers are recommended (not required) to have TDAP vaccine as they get admitted to the hospital. | The minutes were ratified and was approved by the group. Director Dagostino moved and Director Grass seconded the motion to approve the minutes from May 2017. | Karren Hertz |
| 5. New Business<br>a. Consideration and Possible Approval of Policies and Procedures<br><br>**Patient Care Policies and Procedures:**<br>1. Advanced Care Technician (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services<br><br>2. Passy-Muir Speaking Valve (PMV)<br><br>3. Sedation/ Analgesia Used Used During Therapeutics or Diagnostic Procedures<br><br>4. Spontaneous Awakening Trials/ | <br><br><br><br><br>There was no discussion on this policy.<br><br>There was no discussion on this policy.<br><br>It was noted that RNs cannot give medication intended for deep sedation. There are two provisions for deep sedation—one does it and the other one monitors it.<br><br>There was correction on the respiratory rate; it should be less than 35 per minute | **ACTION:** The Patient Care Services policies and procedures were approved. Director Leigh Anne Grass moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members. | Patricia Guerra |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| Spontaneous Breathing Trials | (the < symbol was missing). | | |
| 5. Surgical Attire Policy | Mary Diamond reported that the physicians in the OR has a high compliance for the most part when it comes to wearing surgical attire in the OR. | | |
| 6. Titrating Medications, Adult Patients Policy | There was no discussion on this policy. | | |
| **Administrative Policies and Procedures:** | | | |
| 1. Equipment/ Medical Device Reporting/ Sequestering | There was no discussion on this policy. | **ACTION:** The Administrative policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |
| 2. Parking Program | There was no discussion on this policy. | | |
| 3. Paul Gann Blood Safety Act | There was a brief discussion on this CDPH literature which is available to be printed on demand. This printout is also physically posted in some units. For patients who are Jehova's Witness believers, there is a supplement information in addition to this form. | | |
| 4. Purpose and Responsibility of Risk Management | This scope of risk management was changed to district wide (and not hospital-wide as stated); Chief of Compliance officer was added on the Operations section. | | |
| 5. Security Department Incident Notification | This policy should make use of the term medical center, and not the district because | | |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| | the incident notification is for inside the campus; outpatient areas and the Wellnes Center are not included in this policy. | | |
| 6. Use of Personal Electrical Appliances | There was no discussion on this policy. | | |
| 7. Weapons on Medical Center Campus | The last step on the process is being modified to remove the term "for the district". There was question if this policy applies to a patient or a visitor (for those who have a lawful permit for a gun); it was clarified that this applies to both as mandated by the Security Department. | | |
| **Unit Specific Education** | | | |
| 1. AHA TC Records Management Policy | There was no discussion on this policy. | **ACTION:** The Education policies were all approved. Director Grass moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval | Patricia Guerra |
| 2. AHA TC: Safety Guidelines/ Safety for AHA Course Participants Policy | There was no discussion on this policy. | | |
| 3. Continuing Education Course Criteria Policy | It was established that there is a number of CEs for other units not just nursing. Each discipline has its own different required licensure needs in regards to CEs but a lot of BRN CEs apply to other disciplines as well. | | |
| 4. Education Documentation of Activities Policy | There was no discussion on this policy. | | |
| 5. Library- Reference | | | |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| Services | There was a clarification made that the hospital has a designated person who is talking care of the literature searches for all staff and physicians and even the BOD . Her name is Monique Listion and she also manages the Net Learning Modules for the organization. | | |
| **Emergency** | | | |
| 1. Video Laryngscope Set-Up and Cleanng | There was no discussion on this policy. | **ACTION:** The ED policy and procedure was approved. Director Grass moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |
| **Medical Staff** | | | |
| 1. Discharge Planning for Pediatric and Adolescent Patient | It was noted that the team will be called in as needed (consult) and CCS blanket referrals was also briefly discussed by the group. | **ACTION:** The Medical Staff policies were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |
| 2. Influenza Vaccination of Physiciand and Allied Health Practitioners | Employees who are declining the influenza vaccination should be wearing a mask. The Employee Health process should be added as one of the related documents for this policy. | | |
| **NICU** | | | |
| 1. Breast Milk Management in the NICU | There was a short discussion on inborn errors of metabolism. | **ACTION:** The NICU policies were approved. Director | Patricia Guerra |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 2. Breastfeeding for the Term and Late Pre-term infant in the NICU | There was no discussion on this policy. | Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval. | |
| 3. Family Centered Care, NICU | There was no discussion on this policy. | | |
| 4. Repgle Tube Insertion and management | There was no discussion on this policy. | | |
| 5. Visitation in the NICU | There was no discussion on this policy. | | |
| **Formulary Requests**<br>1. 7 + 3 Chemotherapy Orders<br>2. Alemtuzumab (Lemtrada) Orders<br>3. BR for CLL Chemo Orders<br>4. BR for NHL Chemo Orders<br>5. Carbotaxol Chemo Orders<br>6. DA Epoch+ Rituximab Chemo Orders<br>7. Folfox6 + Bevacizumab Chemo Orders<br>8. R Hyper-Cvad Course A (Odd Cycles) Chemo Orders<br>9. R Hyper-Cvad Course B (Even Cycles) Chemo Orders<br>10. Intrathecal Chemo Orders<br>11. Outpatient Bronchoscopy | Oska reported that all of the chemotherapy drugs that are on this list were sanctioned by the Medical oncologists. Paper forms are essential for these drugs since most of them are very complex in nature. These drugs can be used for inpatient and outpatient. These formulary orders also provide a process for less risk of errors giving importance to patient safety.<br><br>There was a brief discussion on the old versus new agents. The Blackbox warning process was clarified to the group. | **ACTION:** The formulary requests were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval. | Patricia Guerra |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| and Needle Biopsy Orders<br>12. R-Chop Chemo Orders<br>13. R-DHAP Chemo Orders<br>14. Xelox + Bevacizumab Chemo Orders | | | |
| 6. Clinical Contracts | Scott Livingstone, who was appointed as the Interim Chief Complaince Officer, reported on the clinical contracts for the month of May.<br><br>Some vendors are listed twice since some have multiple agreements with the hospital. Scott mentioned that there will be no more numerical ratings (1-5) for this new version of reporting. It will be a straightforward process if the contract meet the requirements or not.<br><br>Meditract currently has two (2) administrators instead of the previous one so that there will be an increased ability to enter data and /or modify data as necessary. This program is very effective in maintaining accurate information for contracts if utilized correctly and efficiently. | **ACTION:** The clinical contracts were approved to move forward to go to the Board for this month. | Director Mitchell |
| 7. Closed Session | Director Mitchell asked for a motion to go into Closed Session. | Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 12:45 PM. | Director Mitchell |

| Topic | Discussion | Follow-Up Action/ Recommendations | Person(s) Responsible |
|---|---|---|---|
| 8. Return to Open Session | The Committee return to Open Session at 1:10PM. | | Director Mitchell |
| 9. Reports of the Chairperson of Any Action Taken in Closed Session | There were no actions taken. | | Director Mitchell |
| 10. Comments from Members of the Committee | No comments. | | Director Mitchell |
| 11. Adjournment | Meeting adjourned at 1:45 PM. | | Director Mitchell |

# PROFESSIONAL AFFAIRS COMMITTEE
## June 8, 2017

CONTACT: Sharon Schultz, CNE

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Patient Care Services Policies & Procedures** | | |
| 1. Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS) | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Passy-Muir Speaking Valve Procedure | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 3. Sedation Analgesia Used During Therapeutic or Diagnostic Procedures – **Tracked Changes**<br>Sedation Analgesia Used During Therapeutic or Diagnostic Procedures – **Clean Copy** | 3 Year Review, Practice Change | Forward to BOD for Approval with Revisions |
| 4. Spontaneous Awakening Trials/Spontaneous Breathing Trials | NEW | Forward to BOD for Approval with Revisions |
| 5. Surgical Attire Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 6. Titrating Medications, Adult Patients Policy | 3 Year Review | Forward to BOD for Approval |
| | | |
| **Administrative Policies & Procedures** | | |
| 1. Equipment Medical Device Reporting-Sequester 201 | 3 Year Review | Forward to BOD for Approval |
| 2. Parking Program 261 | 3 Year Review | Forward to BOD for Approval |
| 3. Paul Gann Blood Safety Act 325 | 3 Year Review | Forward to BOD for Approval |
| 4. Purpose-Responsibility for Risk Mgmt 293 | 3 Year Review | Forward to BOD for Approval with Revisions |
| 5. Security Dept Incident Notification 234 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 6. Use of Personal Electrical Appliances 212 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 7. Weapons on Medical Center Campus 284 | 3 Year Review, Practice Change | Forward to BOD for Approval with Revisions |
| **Unit Specific** | | |
| **Education** | | |
| 1. AHA TC Records Management Policy | 3 Year Review | Forward to BOD for Approval |
| 2. AHA TC Safety Guidelines & Safety for AHA Course Participants Policy | 3 Year Review | Forward to BOD for Approval |
| 3. Continuing Education Course Criteria Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 4. Education Documentation of Activities Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 5. Library - Reference Services | 3 Year Review, Practice Change | Forward to BOD for Approval with Revisions |
| **Emergency** | | |
| 1. Glide Scope Set-up and Cleaning Procedure – **Tracked Changes**<br>Glide Scope Set-up and Cleaning Procedure – **Clean Copy** | Practice Change | Forward to BOD for Approval |
| **Medical Staff** | | |
| 1. Discharge Planning for Pediatric and Adolescent Patient 8710-561 | 3 Year Review | Forward to BOD for Approval |

# PROFESSIONAL AFFAIRS COMMITTEE
## June 8, 2017

CONTACT: Sharon Schultz, CNE

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| 2. Influenza Vaccination of LIP's and Allied Health 8710-547 | 3 Year Review | Forward to BOD for Approval with Revisions |
| **NICU** | | |
| 1. Breast Milk Management and Storage – **Tracked Changes**<br>Breast Milk Management and Storage – **Clean Copy** | 3 Year Review, Practice Change | Forward to BOD for Approval with Revisions |
| 2. Breastfeeding for the Term and Late Pre-Term Infant in the NICU – **Tracked Changes**<br>Breastfeeding for the Term and Late Pre-Term Infant in the NICU – **Tracked Changes** | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 3. Family Centered Care –NICU – **Tracked Changes**<br>Family Centered Care –NICU – **Clean Copy** | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 4. Replogle Tube Insertion and Maintenance | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 5. Visitation in the NICU | Practice Change | Forward to BOD for Approval |
| **Pre-Printed Orders** | | |
| 1. 7+3 Chemotherapy Orders | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Alemtuzumab (Lemtrada) | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 3. Bendamustine + Rituximab - CLL | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 4. Bendamustine + Rituximab - NHL | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 5. CarboTaxol | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 6. DA-EPOCH + Rituximab | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 7. FOLFOX6 + Bevacizumab (Avastin) | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 8. Hyper Cvad + Rituximab: Course A (Odd Cycles) | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 9. Hyper Cvad + Rituximab: Course B (Even Cycles) | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 10. Intrathecal Chemotherapy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 11. Outpatient Bronchoscopy and Needle Biopsy Orders 8711-4006 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 12. R-CHOP | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 13. R-DHAP | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 14. XELOX + Avastin | 3 Year Review, Practice Change | Forward to BOD for Approval |

Tri-City Medical Center
Oceanside, California

**PATIENT CARE SERVICES ~~MANUAL~~**

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**ISSUE DATE:** 04/14

**SUBJECT:** Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS)

**REVISION DATE(S):** 04/14

| | |
|---|---|
| **Department Approval:** | 07/16 |
| **Clinical Policies & Procedures Committee Approval:** | ~~02/14~~~~10/15~~12/16 |
| **Nurse Executive Council Approval:** | ~~02/14~~~~10/15~~01/17 |
| **Division of Psychiatry Approval:** | n/a |
| **Pharmacy & Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~06/16~~05/17 |
| **Professional Affairs Committee Approval:** | ~~04/14~~06/17 |
| **Board of Directors Approval:** | 04/14 |

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A. **PURPOSE:**

1. To outline the Advanced Care Technician's shift assignments, routines, tasks, vital sign, intake and output, and weight assignment.
2. Acute Care Services (ACS) ACT's, Telemetry ACTs, resource ACTs, and registry Certified Nursing Assistants (CNA) shall use the Handoff Tool for their assigned unit to communicate shift handoff.

B. **POLICY:**

**1. ACTs report to Registered Nurses (RNs)**

~~1.~~**2.** ACTs shall assist with patient care needs of all patients' on their assigned units as delegated by the ~~Registered Nurse (~~RN~~)~~ and the Assistant Nurse Manager (ANM)/relief charge nurse.

~~2.~~**3.** Assignments shall be made every shift by the ANM or relief charge nurse.

~~3.~~**4.** Assignments may not be changed without the approval of the ANM/relief charge nurse

~~4.~~**5.** Breaks Telemetry & ACS

- a. One ACT shall be available on each unit at all times
- b. ACTs shall sign up for break times at the beginning of their shift.
- c. Break times will be determined by the management team and listed on the break sheet.
  - i. Sitter break coverage shall be arranged by the ACTs assigned to the unit or ANM
- d. The ACT break sheet will be posted on every unit to inform RNs of the ACT break times.
- e. ACTs are expected to take the allotted time for breaks.
  - i. ACT's must initial on the break form to confirm break time.

~~5.~~**6.** Hand-off

- a. Shift handoff is mandatory and shall be conducted for a maximum of 10 minutes from 0700-0710 and 1900-1910.
  - i. After reviewing the ACT/CNA Report Sheet, start answering call lights and phones, pass or pick up meal trays, and start A.M. or P.M. care while the nurses are completing report.
- b. Hand Off Tool
  - i. Telemetry Hand Off Tool - The Nursing Unit Census shall be used as the Telemetry ACT Hand-off tool.
  - **ii.** Acute Care Services Hand Off Tool (ACT Report) - The ACS ACT Hand Off Tool shall be used when giving and receiving report
  - **~~ii.~~iii. Progressive Care Unit (PCU) - ACTs will use PCU identified hand-off tool**
- c. Shift hand-off shall consist of a verbal hand-off and rounds on assigned patients

d. The following information shall be documented on the ACT Hand-off tool:
   i. Code Status
   ii. Isolation Status
   iii. Patient's orientation i.e. alert, confused
   iv. Oxygen requirements i.e. nasal cannula, number of liters
   v. Mobility i.e., with assist, lift team assist, turn every 2 hours
   vi. Toileting needs i.e., voids, foley catheter, rectal tube, incontinent
   vii. Hygiene needs i.e., (shower bed bath, or minimum assistance)
   viii. Oral care
   ix. Tubes, drains, and other patient care equipment
   **x.** Daily weight
   **~~x.~~xi. Daily bath**
   **~~xi.~~xii.** Diet
      1) Aspiration precautions
      2) Level of assistance required during meals
   **~~xii.~~xiii.** Intravenous (IV) type and location [i.e. peripheral (saline lock) vs. central venous catheter (CVP), or peripherally inserted central catheter (PICC)].
   **~~xiii.~~xiv.** Special considerations
      1) Hard of Hearing
      2) Legally Blind
      3) No Blood Pressure (BP) on Left or Right Arm
      4) Restraints
      5) Dialysis fistula/graft
      6) Mastectomy
   **~~xiv.~~xv.** Admitting diagnosis
   **~~xv.~~xvi.** Safety Falls Risk status
   **~~xvi.~~xvii.** Braden Scale

e. Note tasks not completed on previous shift and ensure incomplete tasks are completed prior to the end of the shift. Task not completed shall be communicated to RN and oncoming ACT.

f. After the RN (s) complete their bedside report, check for any additional patient information or changes in patient care for assigned patients.

g. Discuss with the lift team member patients needing their assistance.

**~~6.~~7.** Vitals Signs

a. Vital signs shall be taken on all patients per unit policy and as directed by the RN
   i. Telemetry vitals signs every 4 hours while patient is awake and as needed
   **ii.** ACS vital signs every 8 hours and as needed
   **iii. PCU - vital signs will be obtained as outlined for ACS and Telemetry level of care and as ordered**

b. **Neutropenic patients - if available a vital signs machine is to remain at the patient's bedside. Ensure stethoscopes are cleaned in between patient use.**

c. Vital signs shall be taken on all patients scheduled for discharge at least one hour prior to discharge per Patient Care Services Discharge of Patients – Discharge AMA Policy.

**d.** ~~The h~~**H**eart rate/pulse will be obtained **as follows:** ~~using the patient's radial pulse per Mosby's Radial Pulse Procedure.~~
   **i. Telemetry and PCU staff ACTs will use a function within the Cardiac Monitor to obtain heart rate values for patients with orders for Telemetry monitoring.**
      **1) The heart rate values will be documented as Heart Rate Monitored**
   **ii. ACTs floating to Telemetry or PCU and Registry Certified Nurse Assistants (CNA) and Nurse Assistants (NA) will:**
      **1) Contact a Monitor Technician (MT) or the primary RN to obtain heart rate values.**
         **~~d.~~a) Document the heart rate values in Cerner as "Heart Rate Monitored"**

e. Vital signs shall be initially documented on the Vital Signs Worksheet and then charted in the ~~medical record~~ **electronic health record (EHR)** after they are reviewed by the primary RN.

f. After obtaining vital signs complete the following:
   i. Make copies of the Vital Signs Worksheet for each RN
   ii. Give each RN a copy of the Vital Signs Worksheet
   iii. Document the results of the vital signs in the ~~medical record~~**EHR** after the primary RN reviews the results and provides instructions to document

g. Report the following findings to the primary RN immediately or as instructed by the primary RN:
   i. Temperature greater than 38.6 or less than 36
   ii. Heart Rate (HR) greater than 100 or less than 60
   iii. Systolic Blood Pressure (SBP) greater than 150 and less than 100
   iv. Diastolic Blood Pressure (DBP) greater than 90
   v. Respiratory Rate (RR) greater than 24 and less than 10 breaths per minute
      1) Post-op patients RR less than 14 breaths per minute
   vi. SPO2 less than 92%

~~7.~~**8.** Intake and Output (I & O)

a. Intake
   i. ACTs are responsible for measuring and documenting oral intake on all patients on their assigned unit in a timely manner
   ii. ACTs are responsible for refilling the water pitchers every 8 hours or as directed by the primary RN.

b. Output
   i. ACTs are responsible for measuring and discarding urine and stool for all patients on their assigned unit, and documenting the results in a timely manner.
      1) Check urine output every 4 hours and notify the primary RN if low or no output. Notify the primary RN if less than 240 mLs of urine is obtained within 8 hours or patient has not voided.
      2) Check stool output once a shift and notify the primary RN of any complaints of constipation or diarrhea
   ii. Output from tubes and drain is limited to Foley catheters, **ileostomies, urostomies,** rectal tubes, and colostomies canisters and will be measured and discarded at the end of the shift or as directed by RN.
   **iii. Tubes and Drains**
      **1) ACT/CNAs/NAs are responsible for measuring and discarding the output from the following throughout a shift:**
         **a) Urinary catheters i.e., Foley**
         **b) Female and male urinary device collection containers or bags (examples include but are not limited to Purewick and condom catheters)**
         **c) Rectal Tubes**
         **d) Ostomy collection bags**
            **i) ACTs, CNAs, and NAs may not change an ostomy appliance (wafer)**
      **2) ACTs/CNAs/NAs may not empty or document the output for the following. RNs only may empty the tubes and drains listed below:**
         **a) Nephrostomy tubes attached to any collection device or bag**
         **b) Jackson Pratt (JP)**
         **c) T-Tubes**
         **d) Add marking to a chest tube collection device**
         **e) Add markings to a nasogastric or gastric suction collection container**

~~iii.~~3) **Suction Canisters attached to a tube or drain may be** ~~Nasogastric canisters will~~ be emptied as directed by RN **after the RNs has obtained the drainage output.**~~.~~

c. Intake and output will be completed and documented in a timely manner-and prior to the end of each shift.

d. Intake and outputs not completed by the end of the shift shall be communicated to the oncoming ACT/CNA and primary RN.

~~8.~~**9.** Weights

a. Admission

i. All patients shall be weighed on admission

1) All patients transferred to Telemetry shall be weighed as directed by the RN.

ii. The patient's weight and the type of scale used to weigh the patient shall be documented in the ~~medical record~~**EHR**.

b. Daily

i. Nightshift ACTs shall receive a daily weight assignment from the RNs on their assigned units.

ii. All daily weights shall be completed and documented by nightshift ACTs

iii. Weights not completed shall be communicated to the RN and the oncoming shift ACT.

1) The oncoming shift ACT shall weigh the patient(s) and document the weight

c. Please review Patient Care Services Weighing Patients for additional information

~~9.~~**10.** Bath Assignments

~~a. Document bath assignments on the Bath Board. Draw a line through the assignment when the bath is completed.~~

~~i. Place the letter "R" near the assignment if the patient refuses and inform the primary RN.~~

~~b.~~**a.** ACTs are responsible for documenting completion of the baths in the ~~medical record~~**EHR**.

~~c.~~**b.** Dayshift ACTs are responsible for complete assist baths or ensuring showers are taken, if ordered, on their assigned patients.

i. Baths not completed on the dayshift shall be communicated during shift hand-off and completed by the nightshift ACT.

~~d.~~**c.** Nightshift: Each ACT is responsible to complete up to 4 baths on confused or total care patients. If these patients are not on the unit, ask each primary RN for at least two patient bath assignments.

i. Baths not completed on the nightshift shall be communicated during shift hand-off and completed by the dayshift ACT

~~e.~~**d.** Electrodes shall be replaced with each bath if needed and PRN.

~~f.~~**e.** Ventilator patients (Core Telemetry ACTs only may be assigned to these patients:

i. Ventilator patients that are not weaning shall receive a bath daily on nightshift and as directed by the RN.

ii. Ventilator patients and patients with artificial airways that are weaning shall receive their baths on the nightshift between 1800 and midnight or as directed by the primary RN.

~~g.~~**f.** Confused, disoriented, or patients that are awake shall be offered a bath during the PM and night time frames or as directed by the RN

~~10.~~**11.** Meals

a. Patients shall sit in chair for all meals unless instructed to remain in bed by the primary RN

b. Diabetic patients should not receive their trays until checking with primary RN to ensure the point of care blood glucose (finger stick) is completed

c. Distribute bedtime snacks as directed by the RN

i. Restock refrigerator when supplies are received for dietary

d. Document percentage of meal intake in the ~~medical record~~**EHR**.
e. Ensure trays are removed from patient's room after completion of the meal

~~11.~~12. Infection Control
a. Infection control manual must be followed at all times.
b. Always check with the RN if unsure of the patient's isolation status or if unclear on what isolation precautions need to be taken.
c. Infection Control Caddys or baskets must be kept stocked throughout the shift by both the day and night shift ACTs.
d. Gloves and masks must be disposed of when exiting the room of a patient that is on isolation precautions.
e. Perform hand hygiene and clean equipment use for all patients prior to leaving patient's room.
f. Do not use masks multiple times. Masks are one time use only.

~~12.~~13. Foley Care
a. Foley Care will be done on all patients with a Foley catheter once a shift, PRN and after every bowel movement using the Foley wipes.
b. Foley Care will be documented by the ACT in **the EHR**~~-Cerner~~.

**14.** Central Line Care
~~e~~**a.** All patients with a central line will have a CHG bath every 24 hours by the day shift ACT unless contraindicated or patient refuses. Patient must be educated on reason for CHG bath (to prevent infection).
~~e~~**i.** CHG baths will be documented by **the** ACT in **the EHR.**~~-Cerner~~
~~i.~~**ii.** Do not use CHG wipes on: breast feeding mothers, non-intact skin, head, face, or genitalia (clean these areas with soap and water). Can be used on buttocks. CHG wipes should be used on buttocks and inner thigh after any episodes of fecal incontinence.
~~ii.~~**iii.** Patient must be moisturized after CHG bath **is** completed and **when** skin is dry
**iv. If patient has an allergic reaction to CHG report to RN**
~~e~~**b. High touch areas will be cleaned with hospital approved disinfectant (for example sani wipes) by the night shift ACT for all central line patients once a shift.** ~~**and d**~~**Documented in the EHR.**
**i. The high touch areas to be cleaned include:**
**1) Bedside table**
**2) Remote**
**3) Call light**
**4) Phone**
**5) Bathroom door handle**
~~**c.**~~**6) Top 2 side rails**

C. **PROCEDURE:**
1. Duties and Responsibilities of all ACT's
a. Document all interventions performed.
b. Answer telephones and patient call lights during RN shift hand-off and PRN
c. Sitter relief as directed by the RN and/or ANM/relief charge nurse
d. Weights (daily, admission, transfer and as directed by the RN)
e. Pre-operative shower/baths for patients as directed by RN per PCS Pre-Operative Patient Preparation
i. Cardiovascular surgery (CVS) patients pre-operative clipper prep and showers/bath should be performed by Telemetry ACTs hired for the Telemetry Unit.
f. Distribute and assist with meal trays and bedtime snacks as directed by RN
g. Ambulate patients as directed by RN
i. Documentation should include the patient's distance and tolerance of the activity
h. Assist with passive Range of Motion (ROM) as directed by the RN

i. Assist with pressure ulcer reduction by completing the following:
   i. Assist with and/or ensure the lift team repositions patients requiring assistance every 2 (two) hours and more often as directed by the RN
   ii. Offer toileting and hygiene care to incontinent patients every hour
   iii. Offer hydration as directed by the RN
   iv. Discuss any skin abnormalities with the primary RN
j. Discontinue foley catheters and saline locks as directed by the RN and document in the ~~medical record~~**EHR**. Notify RN immediately if unable to manage bleeding, redden skin, patient complaint of pain not related to removal of tape, drainage other blood.
k. Apply Falls Risk bands as directed by RN or as indicated from the information obtained from the hand-off tool per PCS Fall Risk Procedure and Scoring Tool
l. Check and restock patient room supply baskets and remove inappropriate supplies every shift
m. Document vital signs, weights, intake and output, and Activity of Daily Living (ADL)s
n. Other duties as assigned by RN and/or ANM/relief charge nurse

2. Hourly Rounding ACT Standard Work
   a. ACTs shall round on the odd hours and as direct by RNs.
   b. Introduce yourself to patient and explain your role
   c. Inform patient of the task(s) that you plan to perform prior to performing the tasks(s)
   d. Address the four (4) P's i.e., Potty, Pain, Position and Possession
   e. Address comfort needs
   f. Ask patient prior to leaving room if there is anything else you may do for them
   g. Document completed task in the ~~medical record~~**EHR**
3. Patient Safety
   a. Prior to leaving a patient's room ensure the following:
      i. Patient's room is clean and uncluttered
      ii. Bedside tray is clean, clear of clutter and within patient's reach
      iii. Call button, television remote control and patient's other personal items are within patient's reach
      iv. Water pitcher is filled per RN instructions and/or per unit specific policy
      v. Patient's bed is in low position with upper side rails in up position
      vi. Appropriate patient signs are posted as directed by RN
      vii. Ensure each room has appropriate urine or stool graduated collection containers.
      viii. Ensure graduated container is clearly marked with patient's name and bed location. For example:
         1) Mr. Doe
         2) Room 232
   b. Assist the lift team when they are in the room turning patients or ambulating patients
4. Equipment
   a. Ensure all patient care equipment is placed or returned to the appropriate location
   b. Ensure equipment that requires charging is plugged in a socket when not in use
   c. Ensure equipment is cleaned per TCMC policy or manufacturers recommendation after each patient use
   d. Ensure remote monitoring unit and remote monitoring cables are cleaned when patient are transferred or discharged
5. Admissions and/or Transfers
   a. Assist with admission and transfers to unit by completing the following:
      i. Set up room with hygiene items, water pitcher, cup and urine collection container (label container with patient's name and room number)
      ii. Ensure chair scale is available, zeroed, and near patient room; use the chair scale to weigh ambulatory patients.
         1) If a bed with a scale is needed, ensure the bed is zeroed per unit specific policy.
      iii. Assist patient into a gown if needed.
      iv. If abnormal skin findings are observed, notify the RN.

b. Orient patient on the use of bed controls, call button, television (TV) remote, telephone, meals times, and use of light controls
c. Provide rationale for using urine collection container
d. Document patient's belongings, vital signs, admission weight, height, and ADLs in the ~~medical record~~**EHR**
   i. Notify primary RN of abnormal vital signs, patient questions, concerns, complaints, and other abnormal findings.
e. Monitored **level of care**~~units~~:
   i. Telemetry ~~Unit~~
      1) Place clean Telemetry box with batteries inserted and leadwires in room
      2) Attach patient to Telemetry box, or DASH if needed, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor
      3) Ensure Telemetry box is placed in a plastic protective cover
   ii. Medically Monitored ~~Unit~~
      1) Place clean remote monitoring unit with batteries inserted and leadwires in room
      2) Attach patient to remote monitoring unit, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor

6. Post-Operative Transfers – set-up room before patient arrives
   a. Bed available with linen pulled down and scale zeroed
   b. Equipment available:
      i. Vital sign machine
      ii. Remote monitoring device appropriate to unit
      iii. Oxygen regulator with tubing connector
      iv. Suction set-up including regulator, tubing and container
      v. Infusion pump
      vi. Sequential compression pump
      vii. Emesis basin
7. Discharges, transfers to non-monitored units, or rate monitoring discontinuation
   a. For monitored patients, remove remote Telemetry box/ remote monitoring unit immediately after notification by the RN or ANM/relief charge nurse
      i. Clean Telemetry box/remote monitoring unit and leadwires with appropriate cleaning solution and store in the appropriate location
   b. Place all patient belongings in a "Patient Belonging Bag"
      i. Check room cabinets, drawers, and bedside table for patient's belongings
      ii. Inform RN if patient/or their family reports personal items are missing, notify RN immediately.
   c. Assist patient with discharge by performing the following as directed by the RN:
      i. Removal of saline lock
      ii. Removal of foley catheter
      iii. Assist patient with applying clothing
   d. Ensure vital signs including pulse oximetry are obtained at least one hour prior to discharge. Inform RN of the results immediately.
   e. Assist with discharge transfer via wheelchair as directed by the RN

## ~~A.~~D. SPECIALTY PATIENT POPULATIONS:

~~8.~~1. Status Post Cardiac Catheterization
   a. Non-core Telemetry ACT will receive additional instructions from primary RN
   b. Do not reposition patient without instructions from the primary RN
   c. Ensure a procedure vital sign sheet is placed in patient's room
   d. Program vital sign machine to take vital signs every 15 minutes or as directed by an RN

~~9.~~2. Cardiovascular Surgery (CVS) Patients – shall be assigned to core Telemetry ACTs

a. Pre-operative Care

i. All AM showers should be completed 2 (two) hours prior to the surgery. Verify the time of AM shower with the RN.

ii. Perform the following task as outlined below and/or as directed by the RN

1) Obtain urine for urinalysis
2) Set up DVD player with the appropriate education DVD as directed
3) Assist patient with PM shower/bed bath
   a) Change linen prior to patient returning from bath or after completion of bed bath
4) Complete AM clipper prep
   a) Use surgical clippers only. Do not use disposable razors.
   b) Change clipper blade frequently as needed do not allow the clipper blades to become dull.
5) Change patient's electrodes and place patient on Telemetry box
6) Do not place electrodes on or near the sternum.
7) Notify the primary nurse of abnormal skin findings.
8) Weigh patient if more than 3 (three) days has passed since admission or as directed by the RN
9) Document shower or bed bath, clipper prep, weight and vitals in the ~~medical record~~EHR

b. Post-operative Care Prior to Shower/Bath

i. All patients must receive a shower or bed bath daily and/or as directed by the RN.

1) If a patient does not shower or receive a bed bath on the day shift, the patient shall have a shower/bed bath on the PM shift with the assistance of the ACT.
2) All CVS patients shall shower unless contraindicated, i.e., shortness of breath, attached to a pacemakers, attached to infusion pump, and/or abnormal vital signs as directed by the primary RN.

ii. Perform the following task as outlined below and/or as directed by the RN:

1) Verify with the RN patient may be escorted to shower. Remain with patient during first shower and/or until the primary RN states it is safe for the patient to be alone during their shower.
2) Report the following to the primary RN; patient complaints of dizziness, headache, light-headedness shortness of breath, increased pain, and/or drainage from incision sites.
3) Remove and discard dressing and assist patient to the shower using the necessary equipment directed by the RN
4) Do not remove the patient's oxygen during the shower unless instructed by the RN
5) Cover peripheral IV access or central line IV access with water proof barrier or glove. Secure the water proof barrier or glove with waterproof plastic tape
6) Remove ted hose, if applied prior to going to the shower
7) Report patient's refusal of shower or bath to primary RN

c. Post-operative Care After Shower/Bath

i. Assist patient back to their room, remove water proof barrier from peripheral IV site or central IV site. Notify RN immediately if the central line dressing is wet or loose

ii. Ensure incisions are dry. Do not apply lotion, ointments, betadine, iodine, or creams to incisions.

iii. Re-apply ted hose if ordered

iv. Assist patient to bed or chair

v. Document patient's bath/shower and ambulation to shower in the ~~medical record~~**EHR**.
vi. Ensure all patient equipment is within reach i.e., call button, water cup, tissue, telephone, and Incentive Spirometer (IS).

d. Post-Operative Ambulation
i. Ambulate patients as ordered or at least 3-4 times a day.
1) Examples: ambulate patient after breakfast, before lunch or dinner, and after dinner or prior to the patient's bedtime.
ii. Patient's first ambulation shall be with oxygen, if ordered, and with a nursing staff and thereafter as directed by RN.
iii. Check patient's oxygen saturation during ambulation.
iv. Notify the primary RN if patient appears short of breath, patient complains of shortness of breath, has a decrease on oxygen saturations, and/or complains of discomfort. Assist patient back to their room or to nearest chair.
v. Ambulation post-op CVS with patient pushing a wheelchair and oxygen until informed by an RN patient may ambulate independently
vi. Encourage patients with steady gaits to ambulate ad lib, or as directed by RN.
vii. Document patient's ambulation distance and tolerance in the ~~medical record~~**EHR**

~~10.~~**3.** Seizure monitored patients on Medically Monitored unit
~~1.~~**a.** Non-core 4 Pavilion ACTs will receive additional instructions from primary RN

~~11.~~**4.** Orthopedic patient population
a. Non-core 1 North ACTs will receive additional instructions from primary RN

~~12.~~**5.** Oncology patient population
a. Non-core 2 Pavilion ACTs will receive additional instructions from primary RN

**6. Progressive Care Unit**
**a. ACTs assigned to the PCU will follow the guidelines identified within the Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS) with the following exceptions:**
**i. Showers will be completed per unit practice guidelines.**
**ii. Baths (Bed Bath)**
**1) Patients will receive a bed bath only if a shower is contraindicated**
**~~2.~~2) If patient requires a bed bath, allow patient to bath self and provide assistance as needed**
**iii. Electrode Care – electrodes will be changed daily with AM vitals and scheduled baths/showers**
**~~3.~~iv. Additional task and responsibilities are outlined in the PCU~~rogressive Care~~ ACT Shift Task List**

~~D.~~**E. FORMS:**
1. Acute Care Services Hand-Off Tool (ACT Report) - **Sample**
2. ~~Telemetry~~**ACT** Hand-Off Tool - **Sample**
3. ACT Task List - **Sample**
**4.** ACT Shift Helpful Hints - **Sample**
~~4.~~**5. Progressive Care Unit ACT Shift Task - Sample**

## Acute Care Services Hand Off Tool (ACT Report) Sample

# ACT REPORT

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

| PATIENT NAME: | | | | ROOM |
|---|---|---|---|---|
| AGE: | SEX: | CODE: | FALL RISK: Y N | |
| DIAGNOSIS: | | | ALERT | OXYGEN |
| ISOLATION: | STANDARD | MRSA | ESBL | |
| | C-DIFF | AIRBORNE | VRE | |
| SITE: | | | | |
| ACTIVITY: | OUTPUT: | | V/S: | |
| DIET: | | | ACCU CHECK: Y N | |
| NOTES: | | | | |

## ~~Telemetry~~ ACT Hand-Off Tool Sample

SAMPLE

TRI-CITY MEDICAL CENTER
NURSING UNIT CENSUS
NURSING UNIT: 2E
MON Current Date

| ROOM / DIAGNOSIS / PRIMARY INSURANCE | PATIENT NAME | AGE / CORE MEAS | SEX | ADMIT DATE / ADMIT PHYSICIAN / URINARY CATHETER | LOS | MRUN / FALL RISK | TYPE / BRADEN / CENTRAL LINE | SERVICE / ACCOMMODATION |
|---|---|---|---|---|---|---|---|---|
| 227-01<br>afib flutter<br>Medicare A and B | Patient's Name<br>NPO<br>Up with assist, BPR, 2L NC, Daily WT, IV on pump Bath | 79 Y | M | Date of Admission<br>Admitting Physician | | FR: 35 | Inpatient<br>BS: 17 | DOU<br>DOU |
| 227-02<br>Sepsis Hypothermia<br>Medi-Cal | Patient's Name<br>Up Ad lib, gait steady,<br>Family at bedside | 57 Y | M | Date of Admission<br>Admitting Physician<br>Indwelling catheter RA | | FR: 85 | Inpatient<br>BS: 14<br>CL Triple | DOU<br>DOU |
| 228-01<br>pneumonia | Patient's Name<br>NO Code, 6Lt NC | 93 Y<br>CM: P | F | Date of Admission<br>Admitting Physician | | FR: 35 | Inpatient<br>BS: 15 | DOU<br>DOU |

**The following information shall be documented on the ACT Hand-off tool**

i. **Code Status**
ii. **Isolation Status**
iii. **Patient's orientation i.e. alert, confused**
iv. **Oxygen requirements**
v. **Mobility i.e. with assist, lift team assist, turn every 2 hours**
vi. **Toileting needs i.e. voids, foley catheter, rectal tube, incontinent**
vii. **Tubes and drains**
viii. **Daily weight**
ix. **Equipment in use Review the handoff tool for the information listed above and the following:**
x. **Admitting diagnosis**
xi. **Safety Falls Risk status**
xii. **Braden Scale**

## ACT Task List – Sample

### Beginning of the Shift Checklist

- ☐ Receive hand-off tool for the following:
  - ✓ Diet
  - ✓ Ambulatory needs
  - ✓ Code Status
  - ✓ Isolation Precautions
  - ✓ Special Considerations
    - ➢ Hard of Hearing
    - ➢ Legally Blind
    - ➢ No BP on Left or Right Arm
    - ➢ Restraints
    - ➢ Fall Risk
    - ➢ Pressure Ulcers
- ☐ Vitals Signs
  - ▪ Write your name and date on patient's board
  - ▪ Make sure all patients have an identification band or a risk for fall band. If the allergy band is missing, notify RN
- ☐ After completing vitals, if AM
  - ▪ Prepare patients for breakfast
  - ▪ Offer washcloth for hands and face

### Before Meal Trays Arrive

- ☐ Document vitals and assist with answering call lights and telephones
- ☐ Document bath assignments on the bath board

### Arrival of Meal Trays

- ☐ Pass trays and assist with answering lights
- ☐ Pass HS snacks as directed by RN
- ☐ Assist feeders, if no feeders, go to break or document VSS and I & O's

### Vital Signs AM Shift

- ☐ Begin AM vitals 0730-0900
- ☐ Begin Noon vitals at 1100-1200
- ☐ Begin Evening vitals at 1600 & 1930
- ☐ Begin Midnight vitals at 2200-0100
- ☐ Begin Night Shift AM vitals 0400-0600
- ☐ Documented vital signs as soon as possible

### <u>After meal times</u>

- ☐ Complete documentation
- ☐ Ambulate patients

### Intake and Output

- ☐ Document output after completing task
- ☐ Document intake as soon as possible

### Hourly Rounding

- ☐ Assist with hourly rounding as directed

### HS Snack

- ☐ Pass HS as directed by RN. Document intake in the medical record

### HS Care

- ☐ Assist patients with HS care

### End of Shift Checklist

- ☐ I/Os documented
- ☐ Vital Signs documented
- ☐ Hand-off tool updated
- ☐ Patient's room clean, call button within reach
- ☐ Upper side rails up
- ☐ Water pitcher refilled per unit policy and/or as directed by RN
- ☐ Patient information signs posted above head of bed

### Admission Checklist

- ✓ Assist ED staff by helping to transfer patient from gurney to their room
- ✓ If patient is ambulatory, use chair scale
- ✓ Ask patient for their height or estimate (verify with RN)
- ✓ Assist patient to bed
- ✓ Assist patient with removal of their clothes
- ✓ Assist patient into a hospital gown
- ✓ Obtain admission vital signs
- ✓ Provide the patient with the following:
  - ➢ Pitcher of water and cup, if not NPO
  - ➢ Box of tissue
  - ➢ Bedside trash bag
  - ➢ Toothbrush and toothpaste
  - ➢ Plastic comb
  - ➢ Slippers
  - ➢ Place a urinal or "hat" in the bathroom
  - ➢ Label urinal or hat with pt's name and room number
- ✓ Before leaving the room complete the following:
  - ➢ Instruct patient how to use the call button and place it near the patient
  - ➢ Instruct patient how to use to the bedside lights, TV remote, and bed controls
  - ➢ Place bedside table within reach of patient
- ✓ Document the patient's WT, HT, and vital signs

### Transfer /Discharge Checklist

- ✓ Assist with discharges and transfers as directed by RN and/or ANM/relief charge nurse
- ✓ Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge

Telemetry 2/08, Revised 11/10;5/11. 5/12, 3/13 PFR

## ACT Shift Helpful Hints – Sample

| TIME | TASK | HELPFUL HINTS |
|---|---|---|
| 0700-0800 | Provide/receive hand-off and round with off-going ACT.<br>Identify sitters and arrange break coverage.<br>Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water<br>Assist with answering phones and calls lights<br>Receive update from RNs<br>Offer washcloth for hand/face | Document any special task on your vital signs' worksheet<br>Ask patients the following prior to leaving their rooms:<br>1. Would you like to sit in the chair or dangle on the side of the bed for breakfast?<br>2. Can I get you anything before I leave?<br>3. Check incontinent patients |
| 0805-1100 | Prepare patients for breakfast and pass trays<br>Take vital signs, make copies of the vital signs' worksheet for the primary nurses, and receive approval of vitals before documenting.<br>Document vitals, outputs, and ADLS<br>Assist with answering phones and calls lights<br>Start AM bath assignments<br>Assist with answering call lights and answering telephone calls, reposition patients and<br>Complete oral care as needed. Pick up trays, and Document breakfast intake | Bath assignments:<br>Note the patients who will need oral care, baths, or require assistance with repositioning or ambulating.<br>Assist patients with feeding as needed<br><br>Take a few purple fall bands and keep them in your pocket. Put them on patients as needed while you are taking vital signs, answering calls lights, assisting with baths. |
| Until lunch trays arrive | Start Noon Vital signs<br>Check incontinent patients; assist patients to the bathroom, and check urine collection containers.<br>Sign falls log<br>Document vitals, output, and ADLs prior to leaving for the next unit.<br>Assist with answering call lights and answering phones.<br>Assist with passing lunch trays and assist patients with feeding as needed | Note the patients who will require assistance with repositioning or ambulating.<br>Ask patients the following prior to leaving their rooms:<br>1. Would you like to be repositioned?<br>2. Would you like to sit in the chair or dangle on the side of the bed for lunch?<br>3. Would you like to take a walk before or after lunch?<br>Can I get you anything before I leave? |
| Breaks | Take morning break as assigned.<br>Breaks shall not exceed 30 minutes | Inform ACTs and primary RNs you are leaving the floor for break |
| Until lunch trays arrive -1330 | Go to lunch after patient lunch trays are passed (Breaks shall not exceed 30 minutes)<br>Pick up lunch trays<br>Document intake and complete documentation of noon vital signs.<br>Complete AM Care and reposition patients<br>Assist with answering call lights. | Inform primary nursing that you are leaving the floor for break<br>Assist with discharges, transfers, and admissions |
| 1331-until arrival of dinner trays | Round: Check incontinent patients; assist patients to the bathroom, check urine collection containers and empty foley catheters, and other drainage collection containers.<br>Refill water pitchers<br>Assist with answering call lights and telephones<br>Complete charting.<br>Ambulate patients<br>Set up room (s) for new admissions | Assist with discharges, transfers, and admissions<br>Prepare patient's for dinner (assist to chair, raise head of bed)<br>Complete baths.<br>Inform primary nursing that you are leaving the floor for break<br>After ambulating patients offer the chair instead of returning them to bed. (This will prepare the patient for dinner).<br>Call the lift team to assist as needed.<br>Consider documenting any I & Os or ADLS that you have not completed.<br>Do not restock supply baskets before you complete your documentation.<br>Remember: an empty room will be filled and you will be expected to assist. |

| TIME | TASK | HELPFUL HINTS |
|---|---|---|
| until dinner trays arrive | Prepare for break<br>Take evening break as assigned.<br>Breaks shall not exceed 30 minutes<br>Assist with answering telephones and call lights | Inform ACTs and primary RNs you are leaving the floor for break |
| 1700-1830 (Dinner Trays Arrive) | Pass trays<br>Assist with patients as needed | Once trays are passed and you have assisted patients requiring assistance with feeding, go to break. |
| 1831-1900 | Prepare for hand-off<br>Review documentation<br>Round on all patients | Complete task as needed |
| 1901-2000 | Provide/receive hand-off, round with off-going ACT.<br>Assist with answering call lights and telephones<br>Receive update for task to perform from primary RNs | |
| 1931-2000 | Pick up dinner trays<br>Start vitals<br>Make copies of the vital signs' worksheet for the primary nurses.<br>Document vitals, intakes, outputs, and ADLS<br>Get an update and sitters you may need to relieve for breaks. Check incontinent patients<br>Place bedside table, with water pitcher, call button, and telephone within patient's reach. (Check to ensure the previous shift provided patients not NPO with a fresh pitcher of water).<br>Assist with answering phones and calls lights<br>Identify patients requiring baths, ambulation, repositioning every two hours | Consider documenting intakes before starting vitals<br>If you cannot complete your documentation, do not worry, chart as much information as you can and continue to assist as the primary nurses as needed.<br>Assist with transfers, discharges, or admissions |
| 2001-2230 | Take dinner break (breaks shall not exceed 30 minutes)<br>Assist primary RNs<br>Continue to complete charting<br>Offer PM oral and hygiene care<br>Check supply baskets and restock as needed<br>Assist with answering call lights<br>Refill water pitchers, place NPO signs as needed, document<br>I & Os and ADLs.<br>Assist with night vital signs as directed<br>Pass HS snack as directed by nursing<br>Assist with answering call lights and complete unfinished documentation.<br>Update primary nurse of any task not completed | Complete your charting before checking or restocking the supply baskets.<br>If working with weaning ventilator patients, began PM bath.<br>Complete baths assigned by RN or not completed by dayshift |
| 2231-0030 | Vital signs | |
| 0031-0400 | Complete task as assigned by RNs, Round on all patients, Check complete baths assigned by RNs | Assist with admissions,<br>Complete at least two baths on patients defined in this policy |
| 0401-0659 | Complete end of shift task i.e., vital signs, daily weights, intake and output, refill water pitchers,<br>Task assigned by primary RNs | |
| | Provide/receive hand-off and round with off-going ACT.<br>Identify sitters and arrange break coverage.<br>Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water<br>Assist with answering phones and calls lights<br>Receive update from RNs<br>Offer washcloth for hand/face | |
| 0700-0800 | Review 0700-0800 previously stated | |

## Progressive Care Unit ACT Shift Task – Sample

### Beginning of the Shift Checklist

- ☐ Print Census, receive hand-off from RNs
- ☐ Obtain the following from RNs
  - ✓ Diet
  - ✓ Ambulatory needs
  - ✓ Code Status
  - ✓ Isolation Precautions
  - ✓ Bath Assignment
    - ❖ Check with RN if patient requires a shower or assistance
  - ✓ Special Considerations
    - ➢ Hard of Hearing
    - ➢ Legally Blind
    - ➢ No BP on Left or Right Arm
    - ➢ Restraints
    - ➢ Fall Risk
    - ➢ Pressure Ulcers

### Vital Signs

- ☐ Vitals Signs
  - ▪ Complete vital signs as directed by RN
  - ▪ Document results on VSS worksheet
  - ▪ Give a copy to each RN to review prior to documenting
  - ▪ Routine VSS
    - ❖ Tele patients every 4 hours while awake
    - ❖ Med/Surg patients every 8 or once a shift as directed by RN

### Before Meal Trays Arrive

- ☐ Document vitals and assist with answering call lights and the telephone
- ☐ Perform additional duties as directed by RN

### Arrival of Meal Trays

- ☐ Ensure unapproved items are removed from tray as directed by Correctional Officers
- ☐ Pass trays and assist with answering lights
- ☐ Assist feeders as directed, if no feeders, go to break or document VSS and I & O's

### After meal times

- ☐ Complete documentation
- ☐ Ambulate patients
- ☐ Answer call lights and the telephone
- ☐ Assist RNs as directed

### Intake and Output

- ☐ Document output after completing task
- ☐ Document intake as soon as possible

### Prior to Leaving Patient Rooms

- ☐ Remove all items taken in room
- ☐ Discarded items in proper container
- ☐ Patient's room clean, call button within reach
- ☐ Upper side rails up
- ☐ Water pitcher refilled per unit policy and/or as directed by RN
- ☐ Patient information signs posted per RN

### End of Shift Checklist

- ☐ Inform RNs of task not completed as soon as possible
- ☐ I/Os documented
- ☐ Vital Signs documented
- ☐ Activity of Daily Living documented

### Admission Checklist

- ✓ Assist RN as directed
- ✓ If patient is ambulatory, use chair scale
- ✓ Ask patient for their height or estimate (verify with RN)
- ✓ Obtain admission vital signs as directed by RN
- ✓ Verify with RN or Correctional Officers items to place in patient's room (see the suggested item list below):
  - ➢ Pitcher of water and cup, if not NPO
  - ➢ Box of tissue
  - ➢ Toothbrush and toothpaste
  - ➢ Plastic comb
  - ➢ Slippers
  - ➢ Place a urinal or "hat" in the bathroom
  - ➢ Label urinal or hat with patient's name and room number, if not contraindicated
- ✓ Before leaving the room complete the following as directed by the RN:
  - ➢ Instruct patient how to use the call button and place it near the patient
  - ➢ Instruct patient how to use to the bedside lights, TV remote, and bed controls
  - ➢ Place bedside table within reach of patient
- ✓ Document the patient's WT, HT, and vital signs

### Discharge Checklist

- ✓ Do not discuss discharge plans or expected time of discharge with patient.
- ✓ Assist with discharges directed by RN, ANM, or Correctional Officers
- ✓ Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge
- ✓ Inform RN of VSS results after completing the task

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **PASSY-MUIR SPEAKING VALVE (PMV)** |
| Purpose: | Establish a standard for setting up and use of a PMV. To evaluate/assist the tracheostomized patient in possible vocalization, or as part of decannulation. |
| Supportive Data: | A. Passy-Muir Inc. Instructional Booklet<br>B. Benefits:<br>1. Allows patients to use own voice to speak<br>2. Technique is more sterile than finger occlusion<br>3. Secretion reduction<br>4. Increased sense of well being<br>5. Assists in restoration of sense of smell<br>6. Improves potential to swallow<br>7. Demonstrated to expedite weaning from the ventilator and tracheostomy tube |
| Equipment: | PMV, suction set-up and device, pulse oximeter, Personal Protective Equipment (PPE). (PMVs are stored in Sterile Processing Department [SPD].) |

A. **POLICY:**

1. Only licensed TCMC Respiratory Care Practitioners (RCP), Registered Nurses (RNs), and Speech Pathologists are authorized to perform the following procedure. RCP must be present for initial use with ventilator-dependent patients, and must be available for follow-up treatments.
2. Patient selection criteria:
   a. Tracheostomy
      ~~i. Patient must have near-normal voice articulation~~
      ~~ii. Patient needs to possess adequate language and cognitive skills~~
      ~~iii. Cardiopulmonary status must be stable~~
      ~~b.~~**i.** Tracheostomy tube can be:
         ~~i.~~**1)** Cuffed – **cuff must be deflated for use**
         ~~ii.~~**2)** Cuffless
         ~~iii.~~**3)** Fenestrated
         **4)** Metal – Jackson type ~~will need a special~~**requires a 15 mm** adapter (~~15 mm hub from plastic ETT's~~)
      ~~iv.~~**ii.** ~~**WARNING:**~~ ~~D~~do not use PMV with Bivona cuffed tracheostomy tubes.
      ~~v.~~**iii.** **Tracheostomy must be in place at least 48 hours before evaluation can be completed**
   ~~c.~~**b.** ~~Patients must be able to protect their airway from aspiration as confirmed by a Speech Therapist.~~
   **c.** Awake and responsive patients **or as ordered by physician.**
   d. **Stable cardiopulmonary status** ~~**must be stable**~~
3. Indications may include the following:
   a. Ventilator dependency
   b. Neuromuscular disease
   c. Quadriplegia
   d. Tracheomalacia
   e. Bilateral or unilateral vocal cord paralysis
   f. Sleep apnea patients who are tracheostomized ~~as an alternative to tracheal occlusion (i.e. plugging)~~ when awake
4. Contraindications may include the following:
   a. Unresponsive, unconscious, and/or comatose patients
   b. Patients who are unable to tolerate cuff deflation
   c. Inflated tracheostomy tube cuff
   d. Foam filled cuffed tracheostomy tube

| Department Review | Clinical Policies & Procedures | Nursing Executive Council | Division of Pulmonary | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 05/97, 04/08, 01/11; 09/14, 04/15 | 02/11; 09/14, **06/15** | 03/11;10/14, **07/15** | **04/17** | 04/11, **05/17** | 05/11, **06/17** | 05/97,07/03, 03/04; 02/06, 08/08, 05/11 |

e. Severe airway obstruction which may prevent sufficient exhalation
f. Thick and copious secretions
g. Severely reduced lung elasticity that may cause air trapping
h. Patients with endotracheal tubes
i. Severe tracheal and/or laryngeal stenosis
j. Laryngectomized patients

5. Physician orders must contain an order for PMV and Speech Pathology consult

B. **PROCEDURE:**

~~B.~~**1.** NOTE: The first time the PMV is used on the patient the presence of both an RCP and Speech pathologist is required.
~~1.~~**2.** Verify order and assess patient for indicators or contraindications in the use of PMV.
~~2.~~**3.** ~~Speech Therapy to A~~assess communicative potential and possible benefit of PMV **by Speech Therapy**.
~~3.~~**4.** Verify patient using two identifiers.
~~4.~~**5.** Perform hand hygiene, don gloves, identify patient, and explain procedure to the patient, family and RN, as indicated.
~~5.~~**6.** Suction patient's oral cavity and trachea to remove accumulated secretions.
~~6.~~**7.** Reposition patient for optimal breathing mechanics.
~~7.~~**8.** Ensure the inner cannula is in place and adaptable to the PMV.
~~8.~~**9.** Place patient on pulse oximeter, as indicated. Apply supplemental $O_2$ to maintain adequate saturation.
~~9.~~**10.** **Deflate the cuff slowly, ~~I~~if** patient is using a cuffed tracheostomy tube~~, slowly deflate the cuff~~. Additional suctioning may be required once cuff is fully deflated. For patients with increased secretions, consider suctioning while deflating the cuff.
~~10.~~**11.** Place PMV on tracheostomy tube with a ¼ turn twist. If forced on too hard, it may occlude the valve.
~~11.~~**12.** **Evaluate the patient for at least 15 minutes (if tolerated), ~~O~~once** the valve is in place, ~~evaluate the patient for at least 15 minutes (if tolerated)~~ for the following:
a. Respirations, heart rate
b. Respiratory distress/adequate airflow/obstructed airway
c. Vocal quality, quantity, volume
d. Oxygen saturation
e. Breath sounds
f. Overall comfort. May need to coach and re-educate patients to breathe through their upper airway.
~~12.~~**13.** Discontinue use of the PMV after 3 days if trial period fails or for patient decompensation, and await new order.
~~13.~~**14.** Discontinue speech therapy if tolerated consistently and no other communicative, cognitive, or swallowing deficits are identified.

C. **SPECIAL CONSIDERATIONS:**

1. PMV may be trialed 48 – 72 hours after insertion of a tracheostomy tube providing surgical secretions are minimal.
2. Valve can be used in some patients up to 18 – 20 hours. Do not use valve when the patient is sleeping.
3. Humidification and oxygen can be supplied through a mask or trach collar.
4. Take valve off before aerosolization of medication.
5. With proper training, patients and family members can apply and remove the valve independently.
6. Cleaning:
   ~~6.~~**a.** The PMV is designed for single patient use. It is recommended that the valve be replaced after two months.
   ~~a.~~**b.** The valve should be cleaned daily after the last usage.
      i. Swish PMV in soapy, warm water (not hot water)

ii. Rinse thoroughly with warm water (do not use hot water)
iii. Place on clean paper towel and air dry overnight. Place in storage container.

~~b.~~c. Do not clean with the following:
i. Hot water
ii. Peroxide
iii. Bleach
iv. Alcohol
v. Ethylene oxide/gas sterilization
vi. Autoclave
vii. Radiation sterilization

D. **REQUIRED DOCUMENTATION AND OBSERVATIONS:**

1. Date and time
2. PMV use, patient's tolerance, and communicative performance including duration
3. Vital signs (i.e., respiratory rate, heart rate)
4. $SpO_2$ levels
5. Adverse reactions
6. RCP shall record observations in the medical record
7. Speech pathologist shall document the PMV evaluation or Speech Therapy daily note in the medical record

E. **REFERENCES**

~~7.~~1. **Passy-Muir Inc. (2003). Passy-muir tracheostomy and ventilator speaking valve resource guide. Retrieved from http://www.passy-muir.com/sites/default/files/pdf/resource_guide.pdf**
2. **Passy-Muir Inc. (2015). Policies and procedures for passy-muir use. Retrieved from http://www.passy-muir.com/policiesandprocedures**

| PROCEDURE: | SEDATION/ANALGESIA USED DURING THERAPEUTIC OR DIAGNOSTIC PROCEDURES |
|---|---|
| Purpose: | To establish guidance for the safe administration of sedatives used specifically for a level of sedation referred to as moderate sedation/analgesia (previously referred to as "conscious sedation") and deep sedation, delineate required components of care delivery and facilitate comparability of care organization-wide in sedation/analgesia. This procedure does not apply to therapeutic/diagnostic procedures when anesthesiologist is present or NICU setting. |
| Equipment: | The following equipment/supplies are readily available and functional during sedation and recovery periods:<br>1. Emergency cart with cardiac monitor/defibrillator and airway management equipment readily available<br>2. Cardiac Monitor<br>3. Capnography Monitor<br>4. Pulse oximeter with alarm<br>5. Blood Pressure Monitor<br>6. Suction Equipment<br>7. Positive-pressure oxygen delivery system available<br>8. Reversal medications -Naloxone (Narcan) and Flumazenil (Romazicon) - readily available |

A. **DEFINITION(S):**

~~1. Ramsey Scale: Level of sedation for adults using the Ramsey Scale:~~

~~a. 1 = Patient anxious and agitated or restless or both~~

~~b. 2 = Patient cooperative, oriented and tranquil~~

~~c. 3 = Patient responds to commands only~~

~~d. 4 = A brisk response to loud auditory stimulus~~

~~e. 5 = A sluggish response to loud auditory stimulus~~

~~f. 6 = No response to loud auditory stimulus~~

~~g.~~1. **Richmond Agitation-Sedation Scale (RASS):**

| | | |
|---|---|---|
| **4** | **Combative** | **Overly combative or violent, immediate danger to staff** |
| **3** | **Very Agitated** | **Pulls on or removes tubes or catheters or has aggressive behavior toward staff** |
| **2** | **Agitated** | **Frequent non purposeful movement or patient-ventilator dyssynchrony** |
| **1** | **Restless** | **Anxious or apprehensive but movements not aggressive or vigorous** |
| **0** | **Alert and calm** | |
| **-1** | **Drowsy** | **Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice** |
| **-2** | **Light Sedation** | **Briefly, less than 10 seconds, awakening with eye contact to voice** |
| **-3** | **Moderate Sedation** | **Any movement, but no eye contact to voice** |
| **-4** | **Deep Sedation** | **No response to voice, but any to movement to physical stimulation** |
| **-5** | **Unresponsive** | **No response to voice or physical stimulation** |

2. Minimal Sedation: A drug-induced state during which patients respond normally to verbal

| Department Review | Clinical Policies & Procedures | Nurse Executive Committee | Department of Anesthesiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|
| 9/06; 10/08; 06/11; 02/12; 11/15 | 08/12; 02/16, 05/16 | 08/12, 05/16 | 03/17 | 03/17 | 10/12, 04/17 | 10/12, 06/17 | 10/12 |

commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. This level of sedation is associated with the **RASS score of - 2**~~Ramsey Sedation Scale, Level 2~~.

3. Moderate Sedation/Analgesia (Previously referred to as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Note: Reflex withdrawal from painful stimulus is not considered a purposeful response.) No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained. Moderate sedation/analgesia may only be administered during therapeutic, diagnostic or surgical procedures. This level of sedation is associated with the **RASS score of – 3**~~Ramsey Scale, Levels 3-4-5~~.
   ~~a. Minimum Staffing Requirements:~~
      ~~i. One physician~~
         ~~One RN to supervise nursing care.~~
   ~~ii.~~**a. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.**
4. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. This level of sedation is associated with the **RASS score of - 4**~~Ramsey Scale, Level 6~~.
   ~~a. Minimum Staffing Requirements:~~
      ~~i. Physician/LIP performing the procedure~~
      ~~ii. Physician/LIP to monitor the patient~~
      ~~iii. RN to assist physician/LIP~~
   ~~b.~~**a.** A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.
   **b.** Medication administration ~~and monitoring~~ for deep sedation may only be performed by a physician/~~LIP~~**AHP** who has been privileged in deep sedation.
   ~~5.~~**c. Monitoring for deep sedation may be performed by a physician/AHP.**

~~6.~~**5.** Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia.
   a. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

~~7.~~**6.** Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiological consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

~~8.~~**7. Allied Health Professional (AHP)**~~Licensed Independent Practitioner (LIP)~~: An individual credentialed/privileged to provide specified patient care, treatment and services.

~~9.~~**8.** End tidal CO2 ($EtCO_2$): The measuring of End tidal CO2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.

~~10.~~**9.** Respiratory depression: can be defined as:
   a. $EtCO_2$ values 10mmHg higher or lower than the patient's baseline with an absolute maximum of 50mmHg

b. 10% change in $EtCO_2$ values above or below a patient's baseline
c. Apnea that last for 15 seconds or longer

B. **POLICY**:

1. Tri-City Medical Center (TCMC) provides for the safe administration of sedatives, minimize clinical risks to patients, and assure comparability of care throughout the organization.
2. This policy is intended to discuss the care of patients receiving a specific level of sedation/ analgesia under the care of non-anesthesiologists privileged to administer sedation/analgesia. It has been designated to be applicable to procedures performed in a variety of settings and by various disciplines. These settings may be inpatient or outpatient and include but are not limited to:
   - **a. Moderate Sedation: Cardiac Catheterization Lab, Critical Care, Telemetry, Diagnostic Imaging, Emergency Department, Operating Room/ Endoscopy/ Bronchoscopy, Post Anesthesia Care Unit, Interventional Radiology.**
   - **b. Deep Sedation: Emergency Department**
   - ~~a. Cardiac Cath Lab~~
   - ~~b. Critical Care~~
   - ~~c. Telemetry~~
   - ~~d. Diagnostic Imaging~~
   - ~~e. Emergency Department~~
   - ~~f. Operating Room/Endoscopy/Bronchoscopy~~
   - ~~g. Post Anesthesia Care Unit (PACU)~~
   - ~~h. Interventional Radiology~~
3. This policy excludes:
   - a. Patients who are NOT undergoing therapeutic or diagnostic procedures (i.e., preoperative or postoperative sedation, pain management, sedation for insomnia, or seizure management)
   - b. Emergent procedures
   - c. Patients undergoing major regional anesthesia or general anesthesia.
   - d. Situations where it is anticipated that the required sedation analgesia will eliminate purposeful response to verbal commands or tactile stimulation accompanied by partial or complete loss of protective reflexes; such patients require a greater level of care than covered in this policy.
   - e. Otherwise healthy patients receiving peripheral nerve blocks, local or topical anesthesia.
   - ~~f. Patients with a protected airway (i.e., an intubated or trached patient on mechanical ventilation)~~
   - ~~g.~~**f.** Minimal Sedation/Anxiolytic - *note*: if patient slips into the moderate sedation level, this sedation/analgesia procedure must be implemented.
   - ~~h.~~**g.** Drug or alcohol withdrawal or prophylaxis.
   - **h.** The use of any level of sedation/analgesia in any area of the hospital where an anesthesiologist is present.
   - **i. Single doses of sedatives and narcotics (PO, IM, or IV) given in usual and customary doses for routine care of patients during procedures such as dressing changes, etc. do not require the provider to follow the sedation policy as long as the RASS score remains at a – 1 or below.**
   - ~~i.~~**j. The decision to use a single dose of medication for anxiolysis or pain control or to use the sedation policy should be based on the patient's history and planned procedure.**
4. Patient Consent:
   - a. Pre-procedural education, treatments, and services are provided according to the plan of care
   - b. Physician/**AHP**~~LIP~~s shall be responsible for discussing alternatives and risks prior to administration of medication as in any other procedure.
   - c. Procedural/Informed consents are required to be signed by all patients before any procedures.

i. Adolescent patients shall participate in the consent process as appropriate.

5. The Registered Nurse (RN) will monitor the patient for the presence of pain. Any patient undergoing a procedure who expresses concern regarding unresolved pain management has the right to request pain relief. Any patient request for temporary cessation or termination of the procedure will be honored as expeditiously as possible.
6. Medical Staff Credentialing Requirements:
   a. In order to prescribe and administer moderate or deep sedation/analgesia a physician/**AHP**~~LIP~~ must have requisite privilege (physician/**AHP**~~LIP~~ privileges available on TCMC Intranet). See Medical Staff **Policy: Criteria for Granting Moderate and Deep Sedation/Anesthesia Privileges to Non-Anesthesiologists**~~Credentialing guidelines~~.
7. **RN**~~Licensed Staff~~ Training Requirements:
   a. Moderate sedation self-study and test.
   b. Demonstrate competency in basic dysrhythmia recognition
   c. BLS, training including airway management, recognition of cardiovascular and respiratory side effects of sedatives and variability of patient responses with re-certification every 2 years is required.
   d. ACLS, PALS, ENPC, NRP staff member is readily available as appropriate.
      i. Healthcare providers shall use child CPR guidelines for children from 1 year of age to puberty.
         1) Signs of puberty include breast development on the female and underarm, chest, and facial hair on the male. Once a child reaches puberty, healthcare providers shall use adult CPR guidelines for resuscitation.
8. Administering medications:
   a. Medication administration ~~and monitoring~~ for deep sedation may only be performed by a physician/~~LIP~~**AHP** who has been privileged in deep sedation.
   b. The physician/~~LIP~~**AHP** is present prior to administering any moderate sedation/analgesia medication.
   c. Intravenous (IV) sedation analgesia drugs should be given in small incremental doses that are titrated to the desired endpoints of analgesia and sedation. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. When drugs are administered by non-IV routes (oral, rectal, intramuscular (IM), intranasal), allowance should be made for the time required for drug absorption before supplementation is considered.
   d. All medications commonly used in moderate sedation, regardless of their safety profile, produce general anesthesia and may cause cardio respiratory arrest.
   e. See resource on TCMC Intranet for the list of medications commonly used for moderate sedation/analgesia, reversal agents, and typical dosages for all ages.
   f. The RN who is directly responsible to administer medications, monitor and observe the patient's response to medications shall be with the patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure.
   g. **Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.**
   ~~f.~~**h. A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.**
9. Required Staff, Equipment and Supplies
   a. Sufficient numbers of qualified staff (in addition to the person performing the procedure) are present to evaluate the patient, assist with the procedure, provide sedation and/or anesthesia, monitor, and recover the patient.
   b. Minimum Staffing Requirements
      i. Moderate Sedation
         1) Physician/~~LIP~~**AHP** to perform procedure

2) RN to monitor patient

ii. Deep Sedation

1) Physician/~~LIP~~**AHP** to perform the procedure

2) Physician/~~LIP~~**AHP** to monitor the patient

3) RN to assist physician/~~LIP~~**AHP**

~~c. The following equipment/supplies are readily available and functional during sedation and recovery periods:~~

~~i. Emergency cart with cardiac monitor/defibrillator and airway management equipment~~

~~ii. Cardiac Monitor~~

~~iii. Capnography Monitor (trending device, not diagnostic)~~

~~iv. Pulse oximeter with alarm~~

~~v. Blood Pressure Monitor~~

~~vi. Suction Equipment~~

~~vii. Positive pressure oxygen delivery system available~~

~~viii. Reversal medications - Naloxone (Narcan) and Flumazenil (Romazicon)~~

## ~~10.~~C. PROCEDURE~~:~~ PRE-SEDATION:

**1. Pre-procedure RN:**

a. **Reviews** ~~T~~the anticipated needs of the patient are assessed to plan for the appropriate level of post procedure care.

b. **Ensures** ~~It is required that in addition to initial~~ **a** pre-anesthesia/sedation assessment **is** performed by the physician/~~LIP~~**AHP and documented in the health record**~~, completes a second pre-anesthesia assessment to be performed immediately prior to the administration of the anesthesia/sedation medications~~.

c. **Ensures** ~~A~~ **the** physician/~~LIP~~**AHP** documents patient's unchanged condition from last History **and**~~&~~ Physical or ~~is to~~ performs a pertinent pre-anesthesia/sedation assessment, to include, but not limited to:

i. Cardiac, respiratory and/or other major system abnormalities

ii. Current medications and drug allergies and/or adverse experience sedation/analgesia and anesthesia.

iii. Airway Assessment: Patient's ability to hyperextend neck, maintain airway and open mouth without difficulty and if teeth are intact.

iv. Time and nature of last oral intake. **Recommended guidelines**

1) Patients **should**~~must~~ be NPO prior to procedure time for:

a) Six (6) hours after clear liquids

b) Eight (8) hours after solids

2) Oral medications may be taken with small amounts of clear liquids.

3) Patients under 10 years of age must be NPO for a period of time as indicated below:

a) Infants 0 –1 year of age:

i) No solids the day of procedure

ii) Formula or breast milk until four (4) hours before procedure

iii) Clear liquids until 2 hours prior to procedure

iv) NPO thereafter until the procedure.

b) Ages 1 to 2 years:

i) No solids the day of procedure

ii) Full liquids until six (6) hours prior to procedure

iii) Clear liquids until three (3) hours prior to procedure

iv) NPO thereafter until the procedure

c) Ages 3 to 10 years:

i) No solids the day of procedure

ii) Clear liquids until four (4) hours prior to procedure

iii) NPO thereafter until the procedure

v. American Society of Anesthesiologists (ASA) **Physical Status Classification System** ~~Providers Class Determination~~

| ASA PS Classification | Definition | Examples, including but not limited to: |
|---|---|---|
| **ASA~~Class~~ I** | A normal healthy patient ~~with no physiologic or organic disturbance~~. | **Healthy, non-smoking, no or minimal alcohol use** |
| **ASA~~Class~~ II** | A patient with a mild systemic disease. | **Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease**<br><br>~~Cardiovascular disease with minimal restriction of activity. Hypertension, asthma, obesity, diabetes mellitus, or tobacco abuse.~~ |
| **ASA~~Class~~ III** | A patient with severe systemic disease ~~that limits activity but is not incapacitating~~. | **Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.** ~~Cardiovascular or pulmonary disease that limits activity. Severe diabetes with systemic complications. History of poorly controlled hypertension.~~ |
| **ASA~~Class~~ IV** | A patient with severe systemic disease that is a constant threat to life. | **Examples include (but not limited to): recent ( < 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis** ~~Severe cardiac, pulmonary, renal, hepatic, or endocrine dysfunction.~~ |

| | | |
|---|---|---|
| **ASA~~Class~~** V | A moribund patient who is not expected to survive ~~24 hours with or~~ without the operation. | **Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction**<br><br>~~Surgery is done as a last recourse or resuscitation effort. Cerebral trauma, ruptured aneurysm, or large pulmonary embolus.~~ |
| **ASA~~Class~~** VI | Patient declared brain dead whose organs are being removed for donor purposes. | |

d. Verify physician/~~LIP~~**AHP** orders for sedation.
e. Ensure IV access in place (as ordered by physician/~~LIP~~**AHP**):
   i. Appropriate equipment to administer intravenous fluids and drugs including blood and blood components is available.
f. Review/initiate individualized plan of care.

~~11.~~**2.** Immediate Pre-Procedure, RN monitoring or assisting ~~LIP~~**AHP** shall:
a. Check consent
b. Verify procedure with patient
c. Obtain baseline vital Signs: BP, heart rate, respiratory rate, $EtCO_2$, LOC, 02 saturation, Pain score and document on the Sedation Flowsheet or electronic medical record.
   i. For pediatric patients, include height and weight. Calculate correct dosage of reversal agent for potential administration prior to procedure.
d. Assess Level of Consciousness: Level of alertness and orientation to person/time/place/event (age appropriate).
e. Ensure a "time out" is completed before starting the procedure as described in the Patient Care Services Universal Protocol.
f. The patient is re-evaluated before moderate or deep sedation.

## ~~C.~~D. INTRA-PROCEDURE FOR PLANNED MODERATE SEDATION:

1. Measure/assess on an ongoing basis and document every 5 minutes or more often if significant changes in the patient's condition occurs during the procedure:
   a. BP
   b. Heart rate
      i. Continuous EKG rhythm is recommended for all patients receiving moderate sedation/analgesia, and REQUIRED for patients with ASA score of III or greater.
   c. Respiratory rate
   d. Adequacy of ventilation
   e. $EtCO_2$ **(except for mechanically ventilated patients)**
   f. $O_2$ Saturation
   ~~g. Level of sedation for adults using the Ramsey Scale:~~
      ~~1) 1 = Patient anxious and agitated or restless or both~~
      ~~2) 2 = Patient cooperative, oriented and tranquil~~
      ~~3) 3 = Patient responds to commands only~~
      ~~4) 4 = A brisk response to loud auditory stimulus~~

~~5) 5 = A sluggish response to loud auditory stimulus~~
~~6 = No response to loud auditory stimulus~~

g. **Level of sedation for adults using the RASS:**

| | | |
|---|---|---|
| **4** | **Combative** | **Overly combative or violent, immediate danger to staff** |
| **3** | **Very Agitated** | **Pulls on or removes tubes or catheters or has aggressive behavior toward staff** |
| **2** | **Agitated** | **Frequent non purposeful movement or patient-ventilator dyssynchrony** |
| **1** | **Restless** | **Anxious or apprehensive but movements not aggressive or vigorous** |
| **0** | **Alert and calm** | |
| **-1** | **Drowsy** | **Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice** |
| **-2** | **Light Sedation** | **Briefly, less than 10 seconds, awakening with eye contact to voice** |
| **-3** | **Moderate Sedation** | **Any movement, but no eye contact to voice** |
| **-4** | **Deep Sedation** | **No response to voice, but any to movement to physical stimulation** |
| **-5** | **Unresponsive** | **No response to voice or physical stimulation** |

h. Level of sedation for pediatrics using the Aldrete Score:

| | | |
|---|---|---|
| **Activity:** | Able to move 4 extremities voluntarily or on command | Score: 2 |
| | Able to move 2 extremities voluntarily or on command | Score: 1 |
| | Unable to move extremities voluntarily or on command | Score: 0 |
| **Respiration:** | Able to breathe deeply and cough freely | Score: 2 |
| | Dyspnea, limited breathing, or tachypnea | Score: 1 |
| | Apneic or mechanical ventilator | Score: 0 |
| **Circulation:** | BP = 20% of pre-anesthetic level | Score: 2 |
| | BP = 20% to 49% of pre-anesthetic level | Score: 1 |
| | BP = 50% of pre-anesthetic level | Score: 0 |
| **Conscious:** | Fully awake | Score: 2 |
| | Arousable on calling | Score: 1 |
| | Not responding | Score: 0 |
| Color: | Pink | Score: 2 |
| | Pale dusky blotchy, jaundiced, other | Score: 1 |
| | Cyanotic | Score: 0 |

i. Pain level

j. O2 saturation and heart rate are monitored continuously throughout the procedure. If O2 saturation is not maintained at above 90%, (unless baseline was below 90), obtain an order for supplemental oxygen and/or anesthesia consult. Supplemental oxygen is also recommended during the procedure for the following:

~~1)~~**i.** ASA class III or greater patients

~~2)~~**ii.** Patients whose O2 saturation reading is less than 90% pre-procedure while on room air

k. The measuring of End tidal CO2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.

i. If during the procedure hypoventilation or respiratory depression occurs, intervene immediately by:

1) Repositioning the patient's head to open up the airway
2) Verbally or physically stimulate the patient to breathe
3) If the patient is apneic, start bag/mask ventilation.

ii. Respiratory depression can be defined as:
1) $EtCO_2$ values 10mmHG higher or lower than the patient's baseline with an absolute maximum of 50mmHg
2) 10% change in $EtCO_2$ values above or below a patient's baseline
3) Apnea that last for 15 seconds or longer

iii. Important: Respiratory depression may occur after the procedure is complete. That is, before the patient returns to a level of consciousness. Continue to monitor the patient with $EtCO_2$ until the patient is fully awake and alert or returns to baseline.

l. Medications and fluids including drugs, dosages, route, times and personnel administering drugs are documented in the medical record.

m. Any unusual occurrences are documented.

**~~D.~~E. INTRA-PROCEDURE PLANNED FOR DEEP SEDATION:**

1. The RN shall document vital signs as requested by physician/~~LIP~~**AHP**/~~LIP~~**AHP**.

**~~E.~~F. POST PROCEDURE CARE, DOCUMENTATION AND DISCHARGE:**

1. Patients status is assessed immediately after the procedure and/or administration of moderate or deep sedation and vital signs and pain level are continuously monitored and documented every 5 - 15 minutes according to the patient's condition or until the vital signs return to the pre- procedure baseline (minimum recovery time is 30 minutes), and the following criteria are met:

a. Patient achieves a score of 7 or greater or pre-sedation baseline, on the modified Aldrete scoring system:

| | | |
|---|---|---|
| **Activity:** | Able to move 4 extremities voluntarily or on command | Score: 2 |
| | Able to move 2 extremities voluntarily or on command | Score: 1 |
| | Unable to move extremities voluntarily or on command | Score: 0 |
| **Respiration:** | Able to breathe deeply and cough freely | Score: 2 |
| | Dyspnea, limited breathing, or tachypnea | Score: 1 |
| | Apneic or mechanical ventilator | Score: 0 |
| **Circulation:** | BP = 20% of pre-anesthetic level | Score: 2 |
| | BP = 20% to 49% of pre-anesthetic level | Score: 1 |
| | BP = 50% of pre-anesthetic level | Score: 0 |
| **Conscious:** | Fully awake | Score: 2 |
| | Arousable on calling | Score: 1 |
| | Not responding | Score: 0 |

b. If the patient does not meet the above criteria, the physician/~~LIP~~**AHP** is notified for further orders.

c. If a reversal agent has been used the patient shall be recovered for an additional 90 minutes.

d. Patients must meet the following discharge criteria prior to being discharged home:
i. Pre-procedure LOC
ii. Pre-procedure Activity
iii. Vital signs within pre-procedure values
iv. Oral fluids retained
v. Pain controlled
vi. Voided
vii. Evaluate procedure site
viii. Dressing clean & dry

e. Obtain a Physician/~~LIP~~**AHP** order for discharge when all criteria are met.

f. The patient and/or designated adult receives discharge instructions if outpatient and

accompanied home by a responsible adult.

2. Monitoring Outcomes:
   ~~a. The following~~ Outcome data shall be collected in all areas where moderate or deep sedation/analgesia is performed. Data shall be aggregated by department/service and practitioner specific. The anticipated needs of the patient are assessed to the plan for the appropriate level of post procedure care. ~~including:~~
   ~~i. Airway intervention~~
   ~~ii. Allergic reaction~~
   ~~iii. Anesthesia consult~~
   ~~iv. Aspiration~~
   ~~v. Death~~
   ~~vi. Deeper than desired level of sedation~~
   ~~vii. Rise or drop in systolic BP greater than 30 mmHg~~
   ~~viii. Sustained tachycardia (greater than150 beats/min.) or bradycardia (less than50 beats/min.) or serious arrhythmia (as monitored).~~
   ~~ix. Rise or drop in respiratory rate (+/- 6/min. from baseline); dyspnea, apnea, hypoventilation or cyanosis~~
   ~~x. O2 saturation 5% below baseline~~
   ~~xi. Marked decrease in patient responsiveness to verbal/tactile stimulation~~
   ~~xii. Other complications~~
   ~~xiii. Unplanned admit to ICU or Telemetry~~
   ~~xiv. Unplanned admit to PACU~~
   ~~xv. Use of Reversal agent~~
3. Pre procedural education, treatments, and services are provided according to the plan of care, treatment, and services.
4. Patient Discharge:
   a. Patients are discharged from the recovery area and the hospital by a qualified physician/~~LIP~~**AHP** and by meeting discharge criteria.
   b. Patients who have received sedation in the outpatient setting are discharged in the company of a responsible, designated adult.

## ~~F.~~G. RELATED DOCUMENT(S)~~RESOURCES LOCATED ON THE INTRANET~~:

1. Physician Pre-Procedure/Sedation Assessment - **Sample**
2. Sedation Flow Sheet - **Sample**
3. Sedation/Analgesia Audit - **Sample**
4. Agents Commonly Used for Procedural Sedation
5. ~~: Procedural Verification Checklist~~

## ~~G.~~H. REFERENCES:

~~1. Hospital Accreditation Standards 2006 (PC13.10, 13.20, 13.30, 13.40)~~
1. **AORN 2016 Guidelines for Perioperative Practice**~~AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~
2. ***ASA Physical Status Classification System*. (2014~~, October 15th~~). Retrieved January 11th, 2016, from American Society of Anesthesiologists: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system**
3. ~~(2006).~~ **In, U. L, S. K, & L. M, (2006). *Thelan's Critical Care Nursing Diagnosis and Management* (5th Edition ed., p. 153). St. Louis, Missouri: Mosby Elsevier.**
~~2.~~**4. Rothrock, Jane C. (2015) Alexander's Care of the Patient in Surgery, 15th Edition.**~~Rothrock, Jane C. (2007), Alexander's Care of the Patient in Surgery. *Mosby, Co. 13th Edition.*~~

# PHYSICIAN PRE-PROCEDURE/ SEDATION ASSESSMENT SAMPLE

Physician: _____ Procedure: _____
Allergies _____ _____

## Immediately Prior To This Procedure

Ht: _____
Wt: _____

☐ History & Physical completed and attached. ☐Power Note: ED
History of difficulty with anesthesia/Sedation: ☐Yes ☐No
☐ Interval Change in patient's status ☐Yes ☐No since History & Physical date _____ (explain
_____

NPO Status: _____
Airway Assessment WNL (mouth opening, neck ROM, Teeth Intact) ☐Yes ☐No: _____
☐Endotracheal / Tracheostomy Tube

**Physician's verification of Informed Consent:**
☐ I have discussed the following with the patient/patient legal representative: an explanation of the procedure(s), its benefits and risks, ~~and~~ the possible alternatives and their benefits and ~~possible~~ risks **the potential problems that may occur during recuperation, the likelihood of achieving treatment goals, and any research or economic interests I may have regarding the treatment**. All questions have been answered to the patient's/Patient legal representative's satisfaction. Additional comments, if necessary: _____

## ASA Classification

☐ Class I Normal health patient.
☐ Class II A patient with mild systemic disease.
☐ Emergency medical condition
☐Class III A patient with severe systemic disease that limits activity but is not incapacitating.
☐Class IV A patient with an incapacitating systemic disease that is a constant threat to life.

## Plan for Sedation

**Plan:**
☐ Moderate Sedation/Analgesia
☐ Deep Sedation/Analgesia
☐ Supplemental Oxygen
☐ IV _____
☐ Patient is an appropriate candidate for planned sedation

☐ **Continue sedation at present level**
Medication: _____
_____
_____
_____

## Post Sedation Plan of Care

☐ PACU/OP-PACU to non-monitored bed ☐Emergency Department
☐ PACU/OP-PACU to ICU
☐ PACU/SPRA to Telemetry
☐ OP-PACU then discharge home
☐ ICU-TELE direct
☐ ACS/Non-Monitored bed ☐**Remain in ICU**

Comments: _____
_____
_____

## ~~Informed Consent~~

☐ ~~Risks, benefits, and alternatives explained and patient/surrogate accepted plan for sedation/procedure~~

## Re-evaluation

☐ Patient re-evaluated immediately prior to sedation. [See Flow Sheet]

**Signature**
**Attending Physician:** **Date:** **Time:** _____

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**PHYSICIAN PRE-PROCEDURE/ SEDATION ASSESSMENT**

(Rev. 2/10)

Affix Patient Label

# SEDATION FLOW SHEET SAMPLE

page 1 of 2

Physician _____ Procedure: _____
Allergies: _____ Date _____

| MODIFIED ALDRETE SCORING SYSTEM | | | Disc D/C | MODIFIED ALDRETE SCORING SYSTEM | | | Disc D/C |
|---|---|---|---|---|---|---|---|
| ACTIVITY | | | | CIRCULATION | | | |
| Able to move 4 extremities voluntarily or on command 2 | | | | BP = 20% of pre-anesthetic level | | | |
| Able to move 2 extremities voluntarily or on command 1 | | | | BP = 20% to 49% of pre-anesthetic level | | | |
| Unable to move extremities voluntarily or on command 0 | | | | BP = 50% of pre-anesthetic level | | | |
| RESPIRATION | | | | CONSCIOUSNESS | | | |
| Able to breathe deeply and cough freely | | | | Fully awake | | | |
| Dyspnea, limited breathing or tachypnea | | | | Arousable on calling | | | |
| Apneic or on mechanical ventilator | | | | Not responding | | | |
| Calculate TOTAL SCORE before / immediately after procedure and upon discharge or discontinuing 1:1 Monitoring | | | | | | | |

Pre Procedure Target Pain Score

| Patient Assessment | Time | BP | HR | RR | ETCO2 | O2 sat % | RASS ~~amsey (LOC)1-6~~ | Pain Level | Nursing Notes Medications / Cardiac rhythm |
|---|---|---|---|---|---|---|---|---|---|
| Immediate | | | | | | | | | |
| Intra-Procedure vitalsigns Minimally every 5 minutes based on patient's condition | | | | | | | | | |
| Immediate Post-Procedure vitalsigns | | | | | | | | | |
| Post-Procedure vitalsigns every 15 minutes until patient meets criteria for discharge or discontinue 1:1 monitoring | | | | | | | | | |

*** LOC = Level of Consciousness Score patients LOC 1-6 using the RASS ~~Ramsay~~ Scale listed**

~~1 = Patient anxious and agitated or restless or both~~
~~2 = Patient cooperative, oriented and tranquil~~
~~3 = Patient responds to commands only~~
~~4 = A brisk response to loud auditory stimulus~~
~~5 = A sluggish response to loud auditory stimulus~~
~~6 = No response to loud auditory stimulus~~

| Medication Totals |
|---|
| |
| |
| |
| |

Signature _____ Date/Time _____

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**SEDATION FLOW SHEET**

8720-1030
(Rev. 8/12)

**Sedation Flow Sheet**

| NURSING NOTES | | |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |
| IV INTAKE: | PO INTAKE | OUTPUT: |
| ▫ IV Discontinued @ _____ | ▫ Catheter | |
| **RHYTHM STRIPS** | | |

| | | | |
|---|---|---|---|
| Pre-Procedure LOC | Met | Not Met | N/A |
| Pre-Procedure Activity | Met | Not Met | N/A |
| Vital signs within pre-procedure values | Met | Not Met | N/A |
| Oral Fluids Retained | Met | Not Met | N/A |
| Pain Controlled | Met | Not Met | N/A |
| Voided | Met | Not Met | N/A |
| Evaluate procedure Site | Met | Not Met | N/A |
| Dressing Clean and dry | | No N/A | Changed X: |

Signature _____ Date/Time _____

## SEDATION / ANALGESIA AUDIT SAMPLE

Department _____ Date _____ Physician's Name _____
Medications Administered by: _____
Procedure _____
Person Auditing _____
Medication used and total dosage (Check all that apply)
D Versed _____ D Valium _____ D Demerol _____
D Fentanyl _____ D Morphine _____ D Other _____

| | Sedation/Analgesia Audit Form | YES | NO | NA |
|---|---|---|---|---|
| 1. | Consent signed for procedure | | | |
| 2. | H&P on chart | | | |
| 3. | Pre-procedure Assessment completed for: | | | |
| | a. Pre-procedure H&P completed by MD. Interval change noted | | | |
| | b. Informed consent for sedation and procedure | | | |
| | c. Airway Assessment | | | |
| | d. Previous hx. of complications with sedation/anesthesia | | | |
| | e. ASA classification | | | |
| | f. NPO status | | | |
| | g. Plan for sedation | | | |
| | h. Post procedure plan of care | | | |
| | i. RN plan of care | | | |
| 4. | Immediate pre-procedure assessment by licensed staff completed | | | |
| | a. Baseline Aldrete score | | | |
| | b. Pre-procedure VS, O2 sat, LOC and pain target and level | | | |
| 5. | Intra-procedure Assessments completed for: (every 5 min) | | | |
| | a. O2 Saturation | | | |
| | b. Blood Pressure | | | |
| | c. Respiration | | | |
| | d. End tidal CO2 | | | |
| | e. Level of Consciousness | | | |
| | f. Heartrate and Cont. EKG for ASA score of 3 or > | | | |
| 6. | Post-procedure assessment completed for: | | | |
| | a. Immediate post procedure vital signs completed | | | |
| | b. Vital signs (every 5-15 min until return to baseline) | | | |
| | c. Aldrete score | | | |
| | d. Monitoring discontinued appropriately based on Aldrete Score | | | |
| | e. Signatures present where indicated | | | |
| | f. Physician order for discharge obtained | | | |
| 7. | For patient being discharged home: | | | |
| | a. All DC criteria met | | | |

**OUTCOMES: (One selection required/Check all that apply)**

- ☐ No Complications, case completed as planned
- ☐ Unplanned escalation to moderate sedation level
- ☐ Unplanned escalation to deep sedation level
- ☐ Patient received reversal medications (i.e. Naloxone, Flumazenil)
- ☐ Unplanned respiratory support required in light or moderate sedation (i.e. Placement of nasal trumpet or oral airway, supraglottic airway, endotracheal tube, chin lift/jaw thrust, assisted ventilation with bag-valve-mask)
- ☐ Oxygen saturation <85% for greater than 3 minutes
- ☐ Hemodynamic instability requiring intervention (e.g. fluid bolus, pressor agents)
- ☐ Patient experienced a serious adverse event (e.g. perforation, anaphylaxis, aspiration, cardiac arrest, death)
- ☐ Unplanned admission/transfer to a higher level of care
- ☐ Other Comments

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7420-1020

**SEDATION / ANALGESIC AUDIT**

## AGENTS COMMONLY USED FOR PROCEDURAL SEDATION

| DRUG | CLASS & MECHANISM OF ACTION | DOSING GUIDELINES (IV ADMINSTRATION | ONSET, PEAK EFFECT, AND DURATION OF ACTION | ADVERSE DRUG REACTIONS | COMMENTS | REVERSAL |
|---|---|---|---|---|---|---|
| **Midazolam (Versed)** | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression) | IV: 0.02-0.04 mg/kg<br><br>IM: 0.02-0.1 mg/kg<br>PO: 0.5-0.8 mg/kg | Onset(IV): 1-3 min<br><br>** allow 15-30 min for effect with PO administration**<br><br>Peak Effect (IV): 5-7 min<br><br>Duration of Action(IV): 20-40 min | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Advantages include quick onset and short duration of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Lorazepam (Ativan)** | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression) | IV: 0.02-0.04 mg/kg<br>IM: 0.5-1 mg | Onset(IV): 3-7 min<br><br>Peak Effect(IV): 10-20 min<br><br>Duration of Action(IV): 6-8 hrs | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Slower onset and longer duration of action than midazolam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Diazepam (Valium)** | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression | IV: 1-5 mg<br>IM: Unreliable absorption<br>PO: 5-10 mg, | Onset(IV): 1-5 min<br><br>** allow at least 30 min for effect with PO administration**<br><br>Duration of Action(IV/PO): 6-8 hrs | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Longer duration of action than midazolam and lorazepam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Fentanyl (Sublimaze)** | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 0.5-1 mcg/kg;<br><br>*MAX: 2 mcg/kg per procedure or 250 mcg* | Onset: 1-2 min<br><br>Peak Effect: 10-15 min<br><br>Duration of Action: 30-60 min | Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | Quick onset and short duration of action. Reduce dose when combining with benzodiazepines. Less histamine release and hypotension than morphine. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |
| **Morphine** | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 2-4 mg increments;<br><br>*MAX :15-20 mg/procedure*<br>IM/SQ: not recommended due to tissue necrosis with repeat doses (0.1 mg/kg; max 4 mg/DOSE) | Onset: 2-3 min<br><br>Peak Effect: 20 min<br><br>Duration of Action: 2-4 hrs | Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | Slower onset and longer duration of activity vs. fentanyl. More histamine release and hypotension especially in under resuscitated patients vs. fentanyl. Reduce dose when combining with benzo. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Meperidine** (Demerol) | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 25-50 mg increments<br><br>*MAX: 150mg/procedure* | Onset: 5 min<br><br>Peak Effect: 1 hour<br><br>Duration of Action: 2-4 hrs | Seizures, hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | No major advantage over other opioids. Use is not recommended in the elderly due to increased risk of adverse events including seizures. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |
| **Propofol** (Diprivan) | Hypnotic/anesthetic phenolic compound<br><br>(General anesthetic and sedative properties; Structurally unrelated to opioid, barbiturate, and benzodiazepine drugs) | IV bolus: 1mg/kg<br><br>*MAX: 100 mg /procedure* | Onset: 30 seconds<br><br>Duration of Action: 10-15 min | Hypotension, heart block, asystole, and other arrhythmias, bradycardia, and possible infection from lipid based vehicle.<br><br>Allergic reactions in patients with a history of an egg allergy | Rapid onset and short duration of action. Bolus doses are restricted to patients monitored for hypotension and bradycardia (ED/ICU). No analgesic effect, caution for respiratory distress when combined with opioids. | NONE |
| **Ketamine** (Ketalar) | Dissociative general anesthetic<br><br>(Produces a cataleptic-like state in which the patient is dissociated from the surrounding environment; Produces intense analgesia and sedation without causing hypotension) | IV: 0.2-1mg/kg<br><br>IM: 2-4 mg/kg<br><br>*MAX: 2mg/kg (per procedure)* | Onset 1-2 min<br><br>Duration of Action: 15-30 min | | Can cause HYPERtension and tachycardia. Avoid in patients with aneurysms, elevated ICP, or hypertension. Produces both sedation and analgesia. SLOW IV push to avoid respiratory depression, especially when combined with opioids. | NONE |

## PEDIATRIC DOSAGES-IV
(under 12 years of age)

| Medication-Pediatric IV/IM | Dose (Pediatric) | Incremental Dose Interval | Reversal |
|---|---|---|---|
| Midazolam (Versed) | 0.05-0.1 mg/kg, max total dose 6 mg | Q 3-5 min | **Flumazenil IV:** Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg ~~whatever~~ whichever is lower. Usual total dose 0.08 to 1 mg |
| Fentanyl (Sublimaze) | 0.5-2 mcg/kg, start with 0.5 mcg/kg may repeat every 15 min up to max 3 mcg/kg total for procedure | Every 15-30 min | **Naloxone IV:** Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg. |
| Meperidine (Demerol) | 0.5-1 mg/kg, max of 150 mg per procedure | Every 5 min | **Naloxone IV:** Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg. |
| Lorazepam (Ativan) | 0.02-0.09 mg/kg (Usual 0.05 mg/dose) | Every 20 min | **Flumazenil IV:** Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg ~~whatever~~ whichever is lower. Usual total dose 0.08 to 1 mg |
| ** Etomidate (Amidate) | 0.1-0.2 mg/kg | 0.05 mg/kg every 5 min | N/A |
| Ketamine (Ketalar) | IM: 2-5 mg/kg/dose<br>IV: 0.5-1 mg/kg/dose | Every 20 min | N/A |

** Dosing information in children less than 10 years old is limited with Etomidate

## PEDIATRIC DOSEAGES-PO/RECTAL
(under 12 years of age)

| Medication-Pediatric IV/IM | Dose (Pediatric) | Comments | Reversal |
|---|---|---|---|
| Midazolam (Versed) | 0.25-1 mg/kg; PO or Rectal (usual 0.5 mg/kg) max 20 mg per procedure | Allow 20-30 minutes for effect | **Flumazenil IV:** Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg ~~whatever~~ whichever is lower. Usual total dose 0.08 to 1 mg |
| Diazepam (Valium) | 0.2-0.3 mg/kg; PO or rectal, max of 10 mg per procedure | Allow 30-60 minutes for effect | **Flumazenil IV:** Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg ~~whatever~~ whichever is lower. Usual total dose 0.08 to 1 mg |
| Ketamine (Ketalar) | 5-8 mg/kg for 1 dose, mixed in 0.2-0.3 mL/kg of cola or other beverage | Allow 30 minutes for effect | N/A |

Cautions:

(1) There is an increased risk of respiratory depression and cadiovacular depression with combinations of benzodiazepines and opioid narcotics
(2) Repiratory depression effects may last longer than analgesic; monitor for respiratory depression and apnea
(3) Use smaller (25-30% decrease) doses in elderly patients (>65 years of age)
(4) Use of nalxaone (0.4 mg dose) to reverse narcotics respiratory depression, especially if mild, can result in surge in sympathetic tone, hypertension, and ultimately pulmonary edema, in some cases

References:

~~1. Lexicomp Online ®, Lexi-Drugs ®, Hudson, Ohio: Lexi-Comp, Inc; March 22, 2017 Lacy CF, Armstrong LL, Goldman MP, Lance LL. Drug Information Handbook. 11th Edition; American Pharmaceutical Association and Lexi-Comp Inc. Hudson, Ohio, 2009-2010.~~

2. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at http://www.micromedexsolutions.com. Accessed March 22, 2017~~McArdle P. Intravenous analgesia. Crit Care Clin 1999;15(1):89-104.~~

3. Horn E, Nesbit SA. Pharmacology and pharmacokinetics of sedatives and analgesics. Gastrointestinal Clinics of North America 2004; 14(2):247-268

| PROCEDURE: | SEDATION/ANALGESIA USED DURING THERAPEUTIC OR DIAGNOSTIC PROCEDURES |
|---|---|
| Purpose: | To establish guidance for the safe administration of sedatives used specifically for a level of sedation referred to as moderate sedation/analgesia (previously referred to as "conscious sedation") and deep sedation, delineate required components of care delivery and facilitate comparability of care organization-wide in sedation/analgesia. This procedure does not apply to therapeutic/diagnostic procedures when anesthesiologist is present or NICU setting. |
| Equipment: | The following equipment/supplies are readily available and functional during sedation and recovery periods:<br>1. Emergency cart with cardiac monitor/defibrillator and airway management equipment readily available<br>2. Cardiac Monitor<br>3. Capnography Monitor<br>4. Pulse oximeter with alarm<br>5. Blood Pressure Monitor<br>6. Suction Equipment<br>7. Positive-pressure oxygen delivery system available<br>8. Reversal medications -Naloxone (Narcan) and Flumazenil (Romazicon) - readily available |

A. **DEFINITION(S):**

1. Richmond Agitation-Sedation Scale (RASS):

| | | |
|---|---|---|
| **4** | **Combative** | **Overly combative or violent, immediate danger to staff** |
| 3 | Very Agitated | Pulls on or removes tubes or catheters or has aggressive behavior toward staff |
| 2 | Agitated | Frequent non purposeful movement or patient-ventilator dyssynchrony |
| 1 | Restless | Anxious or apprehensive but movements not aggressive or vigorous |
| 0 | Alert and calm | |
| -1 | Drowsy | Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice |
| -2 | Light Sedation | Briefly, less than 10 seconds, awakening with eye contact to voice |
| -3 | Moderate Sedation | Any movement, but no eye contact to voice |
| -4 | Deep Sedation | No response to voice, but any to movement to physical stimulation |
| **-5** | **Unresponsive** | No response to voice or physical stimulation |

2. Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. This level of sedation is associated with the RASS score of - 2.
3. Moderate Sedation/Analgesia (Previously referred to as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Note: Reflex withdrawal from painful stimulus is not considered a purposeful response.) No interventions are required to maintain a

| Department Review | Clinical Policies & Procedures | Nurse Executive Committee | Department of Anesthesiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|
| 9/06; 10/08; 06/11; 02/12; 11/15 | 08/12; 02/16, 05/16 | 08/12, 05/16 | 03/17 | 03/17 | 10/12, 04/17 | 10/12, 06/17 | 10/12 |

patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained. Moderate sedation/analgesia may only be administered during therapeutic, diagnostic or surgical procedures. This level of sedation is associated with the RASS score of – 3.

a. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.

4. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. This level of sedation is associated with the RASS score of - 4.
   a. A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.
   b. Medication administration for deep sedation may only be performed by a physician who has been privileged in deep sedation.
   c. Monitoring for deep sedation may be performed by a physician/AHP.
5. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia.
   a. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
6. Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiological consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.
7. Allied Health Professional (AHP): An individual credentialed/privileged to provide specified patient care, treatment and services.
8. End tidal CO2 ($EtCO_2$): The measuring of End tidal CO2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.
9. Respiratory depression: can be defined as:
   a. $EtCO_2$ values 10mmHg higher or lower than the patient's baseline with an absolute maximum of 50mmHg
   b. 10% change in $EtCO_2$ values above or below a patient's baseline
   c. Apnea that last for 15 seconds or longer

B. **POLICY**:
1. Tri-City Medical Center (TCMC) provides for the safe administration of sedatives, minimize clinical risks to patients, and assure comparability of care throughout the organization.
2. This policy is intended to discuss the care of patients receiving a specific level of sedation/ analgesia under the care of non-anesthesiologists privileged to administer sedation/analgesia. It has been designated to be applicable to procedures performed in a variety of settings and by various disciplines. These settings may be inpatient or outpatient and include but are not limited to:
   a. Moderate Sedation: Cardiac Catheterization Lab, Critical Care, Telemetry, Diagnostic Imaging, Emergency Department, Operating Room/ Endoscopy/ Bronchoscopy, Post Anesthesia Care Unit, Interventional Radiology.
   b. Deep Sedation: Emergency Department

3. This policy excludes:
   a. Patients who are NOT undergoing therapeutic or diagnostic procedures (i.e., preoperative or postoperative sedation, pain management, sedation for insomnia, or seizure management)
   b. Emergent procedures
   c. Patients undergoing major regional anesthesia or general anesthesia.
   d. Situations where it is anticipated that the required sedation analgesia will eliminate purposeful response to verbal commands or tactile stimulation accompanied by partial or complete loss of protective reflexes; such patients require a greater level of care than covered in this policy.
   e. Otherwise healthy patients receiving peripheral nerve blocks, local or topical anesthesia.
   f. Minimal Sedation/Anxiolytic - *note*: if patient slips into the moderate sedation level, this sedation/analgesia procedure must be implemented.
   g. Drug or alcohol withdrawal or prophylaxis.
   h. The use of any level of sedation/analgesia in any area of the hospital where an anesthesiologist is present.
   i. Single doses of sedatives and narcotics (PO, IM, or IV) given in usual and customary doses for routine care of patients during procedures such as dressing changes, etc. do not require the provider to follow the sedation policy as long as the RASS score remains at a – 1 or below.
   j. The decision to use a single dose of medication for anxiolysis or pain control or to use the sedation policy should be based on the patient's history and planned procedure.
4. Patient Consent:
   a. Pre-procedural education, treatments, and services are provided according to the plan of care
   b. Physician/AHPs shall be responsible for discussing alternatives and risks prior to administration of medication as in any other procedure.
   c. Procedural/Informed consents are required to be signed by all patients before any procedures.
      i. Adolescent patients shall participate in the consent process as appropriate.
5. The Registered Nurse (RN) will monitor the patient for the presence of pain. Any patient undergoing a procedure who expresses concern regarding unresolved pain management has the right to request pain relief. Any patient request for temporary cessation or termination of the procedure will be honored as expeditiously as possible.
6. Medical Staff Credentialing Requirements:
   a. In order to prescribe and administer moderate or deep sedation/analgesia a physician/AHP must have requisite privilege (physician/AHP privileges available on TCMC Intranet). See Medical Staff Policy: Criteria for Granting Moderate and Deep Sedation/Anesthesia Privileges to Non-Anesthesiologists.
7. RN Training Requirements:
   a. Moderate sedation self-study and test.
   b. Demonstrate competency in basic dysrhythmia recognition
   c. BLS, training including airway management, recognition of cardiovascular and respiratory side effects of sedatives and variability of patient responses with re-certification every 2 years is required.
   d. ACLS, PALS, ENPC, NRP staff member is readily available as appropriate.
      i. Healthcare providers shall use child CPR guidelines for children from 1 year of age to puberty.
         1) Signs of puberty include breast development on the female and underarm, chest, and facial hair on the male. Once a child reaches puberty, healthcare providers shall use adult CPR guidelines for resuscitation.
8. Administering medications:
   a. Medication administration for deep sedation may only be performed by a physician/ who has been privileged in deep sedation.

b. The physician/AHP is present prior to administering any moderate sedation/analgesia medication.
c. Intravenous (IV) sedation analgesia drugs should be given in small incremental doses that are titrated to the desired endpoints of analgesia and sedation. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. When drugs are administered by non-IV routes (oral, rectal, intramuscular (IM), intranasal), allowance should be made for the time required for drug absorption before supplementation is considered.
d. All medications commonly used in moderate sedation, regardless of their safety profile, produce general anesthesia and may cause cardio respiratory arrest.
e. See resource on TCMC Intranet for the list of medications commonly used for moderate sedation/analgesia, reversal agents, and typical dosages for all ages.
f. The RN who is directly responsible to administer medications, monitor and observe the patient's response to medications shall be with the patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure.
g. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.
h. A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.

9. Required Staff, Equipment and Supplies
   a. Sufficient numbers of qualified staff (in addition to the person performing the procedure) are present to evaluate the patient, assist with the procedure, provide sedation and/or anesthesia, monitor, and recover the patient.
   b. Minimum Staffing Requirements
      i. Moderate Sedation
         1) Physician/AHP to perform procedure
         2) RN to monitor patient
      ii. Deep Sedation
         1) Physician/AHP to perform the procedure
         2) Physician/AHP to monitor the patient
         3) RN to assist physician/AHP

C. **PROCEDURE PRE-SEDATION:**

1. Pre-procedure RN:
   a. Reviews the anticipated needs of the patient are assessed to plan for the appropriate level of post procedure care.
   b. Ensures a pre-anesthesia/sedation assessment isperformed by the physician/AHP and documented in the health record.
   c. Ensures the physician/AHP documents patient's unchanged condition from last History and Physical or performs a pertinent pre-anesthesia/sedation assessment, to include, but not limited to:
      i. Cardiac, respiratory and/or other major system abnormalities
      ii. Current medications and drug allergies and/or adverse experience sedation/analgesia and anesthesia.
      iii. Airway Assessment: Patient's ability to hyperextend neck, maintain airway and open mouth without difficulty and if teeth are intact.
      iv. Time and nature of last oral intake. Recommended guidelines
         1) Patients should be NPO prior to procedure time for:
            a) Six (6) hours after clear liquids
            b) Eight (8) hours after solids
         2) Oral medications may be taken with small amounts of clear liquids.
         3) Patients under 10 years of age must be NPO for a period of time as indicated below:
            a) Infants 0 –1 year of age:

i) No solids the day of procedure
ii) Formula or breast milk until four (4) hours before procedure
iii) Clear liquids until 2 hours prior to procedure
iv) NPO thereafter until the procedure.

b) Ages 1 to 2 years:
i) No solids the day of procedure
ii) Full liquids until six (6) hours prior to procedure
iii) Clear liquids until three (3) hours prior to procedure
iv) NPO thereafter until the procedure

c) Ages 3 to 10 years:
i) No solids the day of procedure
ii) Clear liquids until four (4) hours prior to procedure
iii) NPO thereafter until the procedure

v. American Society of Anesthesiologists (ASA) Physical Status Classification System

| ASA PS Classification | Definition | Examples, including but not limited to: |
|---|---|---|
| ASA I | A normal healthy patient . | Healthy, non-smoking, no or minimal alcohol use |
| ASA II | A patient with a mild systemic disease. | Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease |
| ASA III | A patient with severe systemic disease. | Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents. |
| ASA IV | A patient with severe systemic disease that is a constant threat to life. | Examples include (but not limited to): recent ( < 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis |

| | | |
|---|---|---|
| ASA V | A moribund patient who is not expected to survive without the operation. | Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction |
| ASA VI | Patient declared brain dead whose organs are being removed for donor purposes. | |

d. Verify physician/AHP orders for sedation.
e. Ensure IV access in place (as ordered by physician/AHP):
   i. Appropriate equipment to administer intravenous fluids and drugs including blood and blood components is available.
f. Review/initiate individualized plan of care.

2. Immediate Pre-Procedure, RN monitoring or assisting AHP shall:
   a. Check consent
   b. Verify procedure with patient
   c. Obtain baseline vital Signs: BP, heart rate, respiratory rate, $EtCO_2$, LOC, 02 saturation, Pain score and document on the Sedation Flowsheet or electronic medical record.
      i. For pediatric patients, include height and weight. Calculate correct dosage of reversal agent for potential administration prior to procedure.
   d. Assess Level of Consciousness: Level of alertness and orientation to person/time/place/event (age appropriate).
   e. Ensure a "time out" is completed before starting the procedure as described in the Patient Care Services Universal Protocol.
   f. The patient is re-evaluated before moderate or deep sedation.

D. **INTRA-PROCEDURE FOR PLANNED MODERATE SEDATION:**

1. Measure/assess on an ongoing basis and document every 5 minutes or more often if significant changes in the patient's condition occurs during the procedure:
   a. BP
   b. Heart rate
      i. Continuous EKG rhythm is recommended for all patients receiving moderate sedation/analgesia, and REQUIRED for patients with ASA score of III or greater.
   c. Respiratory rate
   d. Adequacy of ventilation
   e. $EtCO_2$ (except for mechanically ventilated patients)
   f. $O_2$ Saturation
   g. Level of sedation for adults using the RASS:

| 4 | Combative | Overly combative or violent, immediate danger to staff |
|---|---|---|
| 3 | Very Agitated | Pulls on or removes tubes or catheters or has aggressive behavior toward staff |
| 2 | Agitated | Frequent non purposeful movement or patient-ventilator dyssynchrony |
| 1 | Restless | Anxious or apprehensive but movements not aggressive or vigorous |
| 0 | Alert and calm | |

| | | |
|---|---|---|
| -1 | Drowsy | Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice |
| -2 | Light Sedation | Briefly, less than 10 seconds, awakening with eye contact to voice |
| -3 | Moderate Sedation | Any movement, but no eye contact to voice |
| -4 | Deep Sedation | No response to voice, but any to movement to physical stimulation |
| **-5** | **Unresponsive** | No response to voice or physical stimulation |

h. Level of sedation for pediatrics using the Aldrete Score:

| | | |
|---|---|---|
| **Activity:** | Able to move 4 extremities voluntarily or on command | Score: 2 |
| | Able to move 2 extremities voluntarily or on command | Score: 1 |
| | Unable to move extremities voluntarily or on command | Score: 0 |
| **Respiration:** | Able to breathe deeply and cough freely | Score: 2 |
| | Dyspnea, limited breathing, or tachypnea | Score: 1 |
| | Apneic or mechanical ventilator | Score: 0 |
| **Circulation:** | BP = 20% of pre-anesthetic level | Score: 2 |
| | BP = 20% to 49% of pre-anesthetic level | Score: 1 |
| | BP = 50% of pre-anesthetic level | Score: 0 |
| **Conscious:** | Fully awake | Score: 2 |
| | Arousable on calling | Score: 1 |
| | Not responding | Score: 0 |
| Color: | Pink | Score: 2 |
| | Pale dusky blotchy, jaundiced, other | Score: 1 |
| | Cyanotic | Score: 0 |

i. Pain level

j. O2 saturation and heart rate are monitored continuously throughout the procedure. If O2 saturation is not maintained at above 90%, (unless baseline was below 90), obtain an order for supplemental oxygen and/or anesthesia consult. Supplemental oxygen is also recommended during the procedure for the following:
   i. ASA class III or greater patients
   ii. Patients whose O2 saturation reading is less than 90% pre-procedure while on room air

k. The measuring of End tidal CO2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.
   i. If during the procedure hypoventilation or respiratory depression occurs, intervene immediately by:
      1) Repositioning the patient's head to open up the airway
      2) Verbally or physically stimulate the patient to breathe
      3) If the patient is apneic, start bag/mask ventilation.
   ii. Respiratory depression can be defined as:
      1) $EtCO_2$ values 10mmHG higher or lower than the patient's baseline with an absolute maximum of 50mmHg
      2) 10% change in $EtCO_2$ values above or below a patient's baseline
      3) Apnea that last for 15 seconds or longer
   iii. Important: Respiratory depression may occur after the procedure is complete. That is, before the patient returns to a level of consciousness. Continue to monitor the patient with $EtCO_2$ until the patient is fully awake and alert or returns to baseline.

l. Medications and fluids including drugs, dosages, route, times and personnel administering drugs are documented in the medical record.
m. Any unusual occurrences are documented.

E. **INTRA-PROCEDURE PLANNED FOR DEEP SEDATION:**
1. The RN shall document vital signs as requested by physician/AHP/AHP.

F. **POST PROCEDURE CARE, DOCUMENTATION AND DISCHARGE:**
1. Patients status is assessed immediately after the procedure and/or administration of moderate or deep sedation and vital signs and pain level are continuously monitored and documented every 5 - 15 minutes according to the patient's condition or until the vital signs return to the pre- procedure baseline (minimum recovery time is 30 minutes), and the following criteria are met:
   a. Patient achieves a score of 7 or greater or pre-sedation baseline, on the modified Aldrete scoring system:

| | | |
|---|---|---|
| **Activity:** | Able to move 4 extremities voluntarily or on command | Score: 2 |
| | Able to move 2 extremities voluntarily or on command | Score: 1 |
| | Unable to move extremities voluntarily or on command | Score: 0 |
| **Respiration:** | Able to breathe deeply and cough freely | Score: 2 |
| | Dyspnea, limited breathing, or tachypnea | Score: 1 |
| | Apneic or mechanical ventilator | Score: 0 |
| **Circulation:** | BP = 20% of pre-anesthetic level | Score: 2 |
| | BP = 20% to 49% of pre-anesthetic level | Score: 1 |
| | BP = 50% of pre-anesthetic level | Score: 0 |
| **Conscious:** | Fully awake | Score: 2 |
| | Arousable on calling | Score: 1 |
| | Not responding | Score: 0 |

   b. If the patient does not meet the above criteria, the physician/AHP is notified for further orders.
   c. If a reversal agent has been used the patient shall be recovered for an additional 90 minutes.
   d. Patients must meet the following discharge criteria prior to being discharged home:
      i. Pre-procedure LOC
      ii. Pre-procedure Activity
      iii. Vital signs within pre-procedure values
      iv. Oral fluids retained
      v. Pain controlled
      vi. Voided
      vii. Evaluate procedure site
      viii. Dressing clean & dry
   e. Obtain a Physician/AHP order for discharge when all criteria are met.
   f. The patient and/or designated adult receives discharge instructions if outpatient and accompanied home by a responsible adult.
2. Monitoring Outcomes:
   Outcome data shall be collected in all areas where moderate or deep sedation/analgesia is performed. Data shall be aggregated by department/service and practitioner specific. The anticipated needs of the patient are assessed to the plan for the appropriate level of post procedure care.
3. Pre procedural education, treatments, and services are provided according to the plan of care, treatment, and services.
4. Patient Discharge:
   a. Patients are discharged from the recovery area and the hospital by a qualified physician/AHP and by meeting discharge criteria.
   b. Patients who have received sedation in the outpatient setting are discharged in the company of a responsible, designated adult.

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

1. Physician Pre-Procedure/Sedation Assessment - Sample
2. Sedation Flow Sheet - Sample
3. Sedation/Analgesia Audit - Sample
4. Agents Commonly Used for Procedural Sedation

H. **REFERENCES:**

1. AORN 2016 Guidelines for Perioperative Practice
2. *ASA Physical Status Classification System*. (2014). Retrieved January 11th, 2016, from American Society of Anesthesiologists: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
3. In, U. L, S. K, & L. M(2006). *Thelan's Critical Care Nursing Diagnosis and Management* (5th Edition ed., p. 153). St. Louis, Missouri: Mosby Elsevier.
4. Rothrock, Jane C. (2015) Alexander's Care of the Patient in Surgery, 15th Edition.

# PHYSICIAN PRE-PROCEDURE/ SEDATION ASSESSMENT SAMPLE

Physician: _____ Procedure: _____
Allergies _____ _____

## Immediately Prior To This Procedure

Ht: _____
Wt: _____

☐ History & Physical completed and attached. ☐Power Note: ED
History of difficulty with anesthesia/Sedation: ☐Yes ☐No
☐ Interval Change in patient's status ☐Yes ☐No since History & Physical date _____ (explain
_____

NPO Status: _____
Airway Assessment WNL (mouth opening, neck ROM, Teeth Intact) ☐Yes ☐No: _____
☐**Endotracheal / Tracheostomy Tube**

**Physician's verification of Informed Consent:**
☐ I have discussed the following with the patient/patient legal representative: an explanation of the procedure(s), its benefits and risks, ~~and~~ the possible alternatives and their benefits and ~~possible~~ risks **the potential problems that may occur during recuperation, the likelihood of achieving treatment goals, and any research or economic interests I may have regarding the treatment**. All questions have been answered to the patient's/ Patient legal representative's satisfaction. Additional comments, if necessary: _____

## ASA Classification

☐ Class I Normal health patient.
☐ Class II A patient with mild systemic disease.
☐ Emergency medical condition
☐Class III A patient with severe systemic disease that limits activity but is not incapacitating.
☐Class IV A patient with an incapacitating systemic disease that is a constant threat to life.

## Plan for Sedation

**Plan:**
☐ Moderate Sedation/Analgesia
☐ Deep Sedation/Analgesia
☐ Supplemental Oxygen
☐ IV _____
☐ Patient is an appropriate candidate for planned sedation

☐ **Continue sedation at present level**
Medication: _____
_____
_____
_____

## Post Sedation Plan of Care

☐ PACU/OP-PACU to non-monitored bed ☐Emergency Department
☐ PACU/OP-PACU to ICU
☐ PACU/SPRA to Telemetry
☐ OP-PACU then discharge home
☐ ICU-TELE direct
☐ ACS/Non-Monitored bed ☐**Remain in ICU**

Comments: _____
_____
_____

## ~~Informed Consent~~

☐ ~~Risks, benefits, and alternatives explained and patient/surrogate accepted plan for sedation/procedure~~

## Re-evaluation

☐ Patient re-evaluated immediately prior to sedation. [See Flow Sheet]

**Signature**
**Attending Physician:** **Date:** **Time:** _____

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**PHYSICIAN PRE-PROCEDURE/ SEDATION ASSESSMENT**

(Rev. 2/10)

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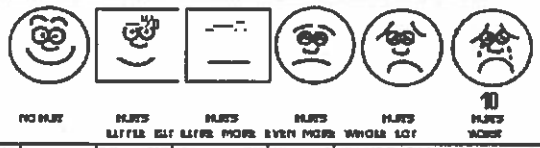
# SEDATION FLOW SHEET SAMPLE

page 1 of 2

Physician: _____ Procedure: _____
Allergies: _____ Date _____

| MODIFIED ALDRETE SCORING SYSTEM | | | Disc D/C | MODIFIED ALDRETE SCORING SYSTEM | | | Disc D/C |
|---|---|---|---|---|---|---|---|
| ACTIVITY | | | | CIRCULATION | | | |
| Able to move 4 extremities voluntarily or on command 2 | | | | BP = 20% of pre-anesthetic level | | | |
| Able to move 2 extremities voluntarily or on command 1 | | | | BP = 20% to 49% of pre-anesthetic level | | | |
| Unable to move extremities voluntarily or on command 0 | | | | BP = 50% of pre-anesthetic level 0 | | | |
| RESPIRATION | | | | CONSCIOUSNESS | | | |
| Able to breathe deeply and cough freely | | | | Fully awake | | | |
| Dyspnea, limited breathing or tachypnea | | | | Arousable on calling | | | |
| Apneic or on mechanical ventilator 0 | | | | Not responding 0 | | | |
| Calculate TOTAL SCORE before / immediately after procedure and upon discharge or discontinuing 1:1 Monitoring | | | | | | | |

Pre Procedure Target Pain Score




| Patient Assessment | Time | BP | HR | RR | ETCO2 | O2 sat % | RASS ~~amsey (LOC)1-6~~ | Pain Level | Nursing Notes Medications / Cardiac rhythm |
|---|---|---|---|---|---|---|---|---|---|
| Immediate | | | | | | | | | |
| Intra-Procedure vital signs Minimally every 5 minutes based on patient's condition | | | | | | | | | |
| Immediate Post-Procedure vital signs | | | | | | | | | |
| Post-Procedure vital signs every 15 minutes until patient meets criteria for discharge or discontinue 1:1 monitoring | | | | | | | | | |

** LOC = Level of Consciousness Score patients LOC 1-6 using the RASS ~~Ramsay~~ Scale listed
~~1 = Patient anxious and agitated or restless or both~~
~~2 = Patient cooperative, oriented and tranquil~~
~~3 = Patient responds to commands only~~
~~4 = A brisk response to loud auditory stimulus~~
~~5 = A sluggish response to loud auditory stimulus~~
~~6 = No response to loud auditory stimulus~~

| Medication Totals |
|---|
| |
| |
| |
| |

Signature _____ Date/Time _____

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8720-1030
(Rev. 8/12)

SEDATION FLOW SHEET

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**Sedation Flow Sheet**

| NURSING NOTES | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| IV INTAKE: | PO INTAKE | OUTPUT: |
| IV Discontinued @_____ | Catheter | |
| **RHYTHM STRIPS** | | |

| | | | |
|---|---|---|---|
| Pre-Procedure LOC | Met | Not Met | N/A |
| Pre-Procedure Activity | Met | Not Met | N/A |
| Vital signs within pre-procedure values | Met | Not Met | N/A |
| Oral Fluids Retained | Met | Not Met | N/A |
| Pain Controlled | Met | Not Met | N/A |
| Voided | Met | Not Met | N/A |
| Evaluate procedure Site | Met | Not Met | N/A |
| Dressing Clean and dry | | No N/A | Changed X |

Signature _____ Date/Time _____

## SEDATION / ANALGESIA AUDIT SAMPLE

Department _____ Date _____ Physician's Name _____
Medications Administered by _____
Procedure _____
Person Auditing _____
Medication used and total dosage (Check all that apply)
D Versed _____ D Valium _____ D Demerol _____
D Fentanyl _____ D Morphine _____ D Other _____

| | Sedation/Analgesia Audit Form | YES | NO | NA |
|---|---|---|---|---|
| 1. | Consent signed for procedure | | | |
| 2. | H&P on chart | | | |
| 3. | Pre-procedure Assessment completed for | | | |
| | a. Pre-procedure H&P completed by MD, Interval change noted | | | |
| | b. Informed consent for sedation and procedure | | | |
| | c. Airway Assessment | | | |
| | d. Previous hx. of complications with sedation/anesthesia | | | |
| | e. ASA classification | | | |
| | f. NPO status | | | |
| | g. Plan for sedation | | | |
| | h. Post procedure plan of care | | | |
| | i. RN plan of care | | | |
| 4. | Immediate pre-procedure assessment by licensed staff completed | | | |
| | a. Baseline Aldrete score | | | |
| | b. Pre-procedure VS, O2 sat, LOC and pain target and level | | | |
| 5. | Intra-procedure Assessments completed for: (every 5 min) | | | |
| | a. O2 Saturation | | | |
| | b. Blood Pressure | | | |
| | c. Respiration | | | |
| | d. End-tidal CO2 | | | |
| | e. Level of Consciousness | | | |
| | f. Heartrate and Cont. EKG for ASA score of 3 or > | | | |
| 6. | Post procedure assessment completed for: | | | |
| | a. Immediate post procedure vital signs completed | | | |
| | b. Vital signs (every 5-15 min until return to baseline) | | | |
| | c. Aldrete score | | | |
| | d. Monitoring discontinued appropriately based on Aldrete Score | | | |
| | e. Signatures present where indicated | | | |
| | f. Physician order for discharge obtained | | | |
| 7. | For patient being discharged home: | | | |
| | a. All DC criteria met | | | |

OUTCOMES: (One selection required/Check all that apply)

- ☐ No Complications, case completed as planned
- ☐ Unplanned escalation to moderate sedation level
- ☐ Unplanned escalation to deep sedation level
- ☐ Patient received reversal medications (i.e. Narcotine, Flumazenil)
- ☐ Unplanned respiratory support required in light or moderate sedation (i.e. Placement of nasal trumpet or oral airway, supraglottic airway, or E-tube, chin lift/jaw thrust, assisted ventilation with bag-valve-mask)
- ☐ Oxygen saturation < 85% for greater than 3 minutes
- ☐ Hemodynamic instability requiring intervention (e.g. fluid bolus, pressor agents)
- ☐ Patient experienced a serious adverse event (e.g. perforation, anaphylaxis, aspiration, cardiac arrest, death)
- ☐ Unplanned admission/transfer to a higher level of care
- ☐ Other Comments

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7426-1020
Rev. 10/10

SEDATION / ANALGESIC AUDIT

## AGENTS COMMONLY USED FOR PROCEDURAL SEDATION

| DRUG | CLASS & MECHANISM OF ACTION | DOSING GUIDELINES (IV ADMINSTRATION | ONSET, PEAK EFFECT, AND DURATION OF ACTION | ADVERSE DRUG REACTIONS | COMMENTS | REVERSAL |
|---|---|---|---|---|---|---|
| **Midazolam** (Versed) | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression) | IV: 0.02-0.04 mg/kg<br><br>IM: 0.02-0.1 mg/kg<br>PO: 0.5-0.8 mg/kg | Onset(IV): 1-3 min<br><br>** allow 15-30 min for effect with PO administration**<br><br>Peak Effect (IV): 5-7 min<br><br>Duration of Action(IV): 20-40 min | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Advantages include quick onset and short duration of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Lorazepam** (Ativan) | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression) | IV: 0.02-0.04 mg/kg<br>IM: 0.5-1 mg | Onset(IV): 3-7 min<br><br>Peak Effect(IV): 10-20 min<br><br>Duration of Action(IV): 6-8 hrs | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Slower onset and longer duration of action than midazolam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Diazepam** (Valium) | Benzodiazepine<br><br>(Binds to GABA receptor resulting in CNS depression | IV: 1-5 mg<br>IM: Unreliable absorption<br>PO: 5-10 mg, | Onset(IV): 1-5 min<br><br>** allow at least 30 min for effect with PO administration**<br><br>Duration of Action(IV/PO): 6-8 hrs | Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation. | Longer duration of action than midazolam and lorazepam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress. | Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses |
| **Fentanyl** (Sublimaze) | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 0.5-1 mcg/kg;<br><br>*MAX: 2 mcg/kg per procedure or 250 mcg* | Onset: 1-2 min<br><br>Peak Effect: 10-15 min<br><br>Duration of Action: 30-60 min | Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | Quick onset and short duration of action. Reduce dose when combining with benzodiazepines. Less histamine release and hypotension than morphine. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |
| **Morphine** | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 2-4 mg increments;<br><br>*MAX :15-20 mg/procedure*<br>IM/SQ: not recommended due to tissue necrosis with repeat doses (0.1 mg/kg; max 4 mg/DOSE) | Onset: 2-3 min<br><br>Peak Effect: 20 min<br><br>Duration of Action: 2-4 hrs | Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | Slower onset and longer duration of activity vs. fentanyl. More histamine release and hypotension especially in under resuscitated patients vs. fentanyl. Reduce dose when combining with benzo. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |

| DRUG | CLASS & MECHANISM OF ACTION | DOSING GUIDELINES (IV ADMINSTRATION | ONSET, PEAK EFFECT, AND DURATION OF ACTION | ADVERSE DRUG REACTIONS | COMMENTS | REVERSAL |
|---|---|---|---|---|---|---|
| **Meperidine** (Demerol) | Opioid narcotic<br><br>(Binds to opioid receptor in the CNS) | IV: 25-50 mg increments<br><br>*MAX: 150mg/procedure* | Onset: 5 min<br><br>Peak Effect: 1 hour<br><br>Duration of Action: 2-4 hrs | Seizures, hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash | No major advantage over other opioids. Use is not recommended in the elderly due to increased risk of adverse events including seizures. | Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed) |
| **Propofol** (Diprivan) | Hypnotic/anesthetic phenolic compound<br><br>(General anesthetic and sedative properties; Structurally unrelated to opioid, barbiturate, and benzodiazepine drugs) | IV bolus: 1mg/kg<br><br>*MAX: 100 mg /procedure* | Onset: 30 seconds<br><br>Duration of Action: 10-15 min | Hypotension, heart block, asystole, and other arrhythmias, bradycardia, and possible infection from lipid based vehicle.<br><br>Allergic reactions in patients with a history of an egg allergy | Rapid onset and short duration of action. Bolus doses are restricted to patients monitored for hypotension and bradycardia (ED/ICU). No analgesic effect, caution for respiratory distress when combined with opioids. | NONE |
| **Ketamine** (Ketalar) | Dissociative general anesthetic<br><br>(Produces a cataleptic-like state in which the patient is dissociated from the surrounding environment; Produces intense analgesia and sedation without causing hypotension) | IV: 0.2-1mg/kg<br><br>IM: 2-4 mg/kg<br><br>*MAX: 2mg/kg (per procedure)* | Onset 1-2 min<br><br>Duration of Action: 15-30 min | | Can cause HYPERtension and tachycardia. Avoid in patients with aneurysms, elevated ICP, or hypertension. Produces both sedation and analgesia. SLOW IV push to avoid respiratory depression, especially when combined with opioids. | NONE |

## PEDIATRIC DOSAGES-IV
(under 12 years of age)

| Medication-Pediatric IV/IM | Dose (Pediatric) | Incremental Dose Interval | Reversal |
|---|---|---|---|
| Midazolam (Versed) | 0.05-0.1 mg/kg, max total dose 6 mg | Q 3-5 min | Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg |
| Fentanyl (Sublimaze) | 0.5-2 mcg/kg, start with 0.5 mcg/kg may repeat every 15 min up to max 3 mcg/kg total for procedure | Every 15-30 min | Naloxone IV: Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg. |
| Meperidine (Demerol) | 0.5-1 mg/kg, max of 150 mg per procedure | Every 5 min | Naloxone IV: Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg. |
| Lorazepam (Ativan) | 0.02-0.09 mg/kg (Usual 0.05 mg/dose) | Every 20 min | Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg |
| ** Etomidate (Amidate) | 0.1-0.2 mg/kg | 0.05 mg/kg every 5 min | N/A |
| Ketamine (Ketalar) | IM: 2-5 mg/kg/dose<br>IV: 0.5-1 mg/kg/dose | Every 20 min | N/A |

** Dosing information in children less than 10 years old is limited with Etomidate

## PEDIATRIC DOSEAGES-PO/RECTAL
(under 12 years of age)

| Medication-Pediatric IV/IM | Dose (Pediatric) | Comments | Reversal |
|---|---|---|---|
| Midazolam (Versed) | 0.25-1 mg/kg; PO or Rectal (usual 0.5 mg/kg) max 20 mg per procedure | Allow 20-30 minutes for effect | Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg |
| Diazepam (Valium) | 0.2-0.3 mg/kg; PO or rectal, max of 10 mg per procedure | Allow 30-60 minutes for effect | Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose:0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg |
| Ketamine (Ketalar) | 5-8 mg/kg for 1 dose, mixed in 0.2-0.3 mL/kg of cola or other beverage | Allow 30 minutes for effect | N/A |

Cautions:

(1) There is an increased risk of respiratory depression and cadiovacular depression with combinations of benzodiazepines and opioid narcotics
(2) Repiratory depression effects may last longer than analgesic; monitor for respiratory depression and apnea
(3) Use smaller (25-30% decrease) doses in elderly patients (>65 years of age)
(4) Use of nalxaone (0.4 mg dose) to reverse narcotics respiratory depression, especially if mild, can result in surge in sympathetic tone, hypertension, and ultimately pulmonary edema, in some cases

References:

Lexicomp Online ®, Lexi-Drugs ®, Hudson, Ohio: Lexi-Comp, Inc; March 22, 2017 2. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at http://www.micromedexsolutions.com. Accessed March 22, 2017

3. Horn E, Nesbit SA. Pharmacology and pharmacokinetics of sedatives and analgesics. Gastrointestinal Clinics of North America 2004; 14(2):247-268

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **SPONTANEOUS AWAKENING TRIALS/SPONTANEOUS BREATHING TRIALS** |
| Purpose: | To provide guidelines to determine the readiness for removal of mechanical ventilator support on adult patients. These guidelines (approved by the Pulmonary physicians) are intended to guide the ICU team in providing the most efficient and effective care plan that will result in reducing the number of days a patient is on mechanical ventilation. |

A. **POLICY:**

1. Patients who are mechanically ventilated should be assessed daily for their readiness to breathe spontaneously and afforded the opportunity to do so.
2. A physicians order is not needed for the Spontaneous Awakening Trial (SAT).
3. A Physician's order is required to perform the Spontaneous Breathing Trial (SBT)
4. This order must be placed in the Computerized Physician Order Entry (CPOE) system before being initiated.
5. The procedure must be performed in collaboration between respiratory and nursing to ensure patient safety.
6. Eligibility for SAT and SBT should be determined by nursing and respiratory using the worksheet (see Appendix 1)

B. **PROCEDURE - SAT:**

1. The RN will assess all mechanically ventilated adult patients on a daily basis to determine eligibility for SAT. **Exclusion criteria for SAT is the presence of one or more of the following:**~~Patients are eligible for SAT if they meet none of the following:~~
   a. Patient on **airway pressure release ventilation (**APRV)/Bilevel ventilation
   b. PEEP ~~>~~**greater than or equal to** ~~8cmH$_2$O~~**8cmH$_2$O**
   c. Active seizures
   d. Unstable angina/myocardial ischemia in the prior 24 hours
   e. ICP ~~>~~**greater than**15mmHg
   f. Systolic blood pressure (SBP) ~~>~~**greater than**170 or ~~<~~**less than**90mmHg
   g. RASS ~~>~~**greater than**2
2. If the patient **is not eligible for SAT**~~meets any of the above,~~, ~~nursing~~ **the RN** will document "Does not meet criteria for SAT" in the electronic medical record (EHMR). DO NOT PROCEED.
3. If **no exclusion criteria is present** ~~eligibility criteria are met~~, turn sedation off completely and monitor the following parameters:
   a. RASS (-1 to 0)
   b. Respiratory rate (**less than** 35 per minute)
   c. Sp~~O~~O$_2$ (**greater than or equal to**≥ 92%)
   d. Fi~~O~~O$_2$ (**less than or equal to**≤ 45%)
   e. Cardiac rhythm (stable)
   f. Respiratory effort (~~normal)?~~ **no increase work of breathing?**
4. If the patient does not stay within the ~~parameters~~ **acceptable levels** specified above, the RN will restart the sedation at half the previous dose and rescreen in 24 hours. Nursing to document "Failed SAT" in the EHMR.
5. If parameters are maintained at the ~~levels in parenthesis~~ **acceptable levels, the** RN will keep sedation off in preparation for the weaning process. RN should contact the RCP to perform a ventilator weaning safety screen.

C. **PROCEDURE - VENTILATOR WEANING SAFETY SCREEN:**

1. RCP completes **the following** ventilator weaning safety screen:~~ as below~~:
   a. Is Sp~~O~~O$_2$ **greater than or equal to** ≥ 92%
   b. Is Fi~~O~~O$_2$ **less than or equal to**≤ 45%?

| Clinical Policies and Procedures Committee | Nurse Executive Committee | Division of Pulmonary | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|
| 01/15 | 02/15 | 04/17 | 05/17 | 06/17 | |

c. Is PEEP **<less than** 8cm$H_2$~~0~~**O**?
d. Does patient initiate respirations?
e. Is patient hemodynamically stable?
f. Is patient free of chest pain?

2. If yes to all the above the patient passes the safety screen for weaning and the RCP may perform the Rapid Shallow Breathing Index(RSBI). (The RSBI = rate divided by tidal volume: f/VT (Liters.)

D. **PROCEDURE — RSBI:**

1. **When** ~~Once~~ a patient **passes the safety screen** ~~has no contraindications to perform~~ **for** the RSBI, the RCP will perform the RSBI by placing the patient on tube compensation. Patients are placed on SBT and their treatment plans are driven by the RSBI measurement.
   2. If RSBI is **greater than or equal to ≥** 100: The RCP will place the patient back on the previous ventilator settings. The RCP may repeat the RSBI in 4-6 hours if ~~applicable; that is,~~**the** patient's condition seems more conducive to weaning.
   3. RSBI is **<less than**100: The RCP will initiate the SBT.

E. **PROCEDURE – SBT:**

1. **RCP places**~~This will consist of the RCP placing~~ the patient on Spontaneous mode with the same $Fi0_2$ and a CPAP of +5 and Pressure Support of 6-10 ~~cm$H_2$0~~**cm$H_2$O**. ~~This will~~ **C**~~c~~ontinue **spontaneous mode** for a minimum of 30 min and a maximum of 2 hours. ~~An~~ **Perform an** ABG ~~will be performed~~ at the end of the trial. Physician will be contacted for extubation orders.
2. The patient must be evaluated during the Spontaneous Breathing Trial/CPAP trial. This trial is not successful and should be stopped if:
   a. Respiratory rate is **>greater than**35 for a duration ≥ five minutes.
   b. Respiratory distress, as manifested by ~~Sp02~~ **$SpO_2$ <less than**90% with visibly increased work of breathing
   c. Systolic blood pressure **>greater than**170 or **<less than** 90mmHg
   d. There is a change of heart rate (HR) of 20% or more; or HR is ≥ 130 bpm
   e. Arrhythmias are noted
   f. Apnea
   g. Agitation, panic, diaphoresis
   h. Acidemia (acute drop in pH to **<less than** 7.33 associated with an increasing $PaCO_2$)
3. If the trial is successful, the RCP will contact the physician to request an order for extubation or extending the trials.

F. **DOCUMENTATION:**

1. The RCP and RN will document the SAT, SBT and all related monitoring parameters in the hospital wide electronic medical record.

G. **FORMS/RELATED DOCUMENT(S):**

1. Spontaneous Awakening and Spontaneous Breathing Trials Algorithm

H. **REFERENCE(S):**

1. Ely EW, Baker AM, Dunagan DP et al. Effect on the duration of mechanical ventilation of identifying patients capable of breathing spontaneously. N Engl J Med 1996; 335 (25): 1864-1869. DOI: 10.1056/N EJ M 199612193352502.
2. McConville, John F, Kress, John P. Weaning Patients from the Ventilator. Dec 6,2012. The New England Journal of Medicine, 367.23
3. SAT and SBT Protocol Definitions for CUSP for VAP, EVAP. 2013. John Hopkins University; Armstrong Institute for Patient Safety and Quality.
~~4. UCSD Ventilator STEER Protocol~~

Tri-City Medical Center
Oceanside, California

**PATIENT CARE SERVICES ~~POLICY MANUAL~~**

| | |
|---|---|
| **ISSUE DATE:** 06/10 | **SUBJECT:** Surgical Attire |
| **REVISION DATE:** ~~11/11~~02/17 | **POLICY NUMBER:** XI.K |

| | |
|---|---|
| **Department Approval:** | 02/17 |
| **Clinical Policies and Procedures Approval:** | ~~11/11~~03/17 |
| **Nurse Executive Committee Approval:** | 03/17 |
| **Operating Room Committee Approval:** | 04/17 |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~01/12~~05/17 |
| **Professional Affairs Committee Approval:** | ~~02/12~~06/17 |
| **Board of Directors Approval:** | 02/12 |

A. **PURPOSE:**

1. To provide guidelines for attire worn within the semi-restricted and restricted areas of the surgical environment **and invasive procedure areas**. The human body **and inanimate surfaces inherent in the surgical environment are**~~is a~~ major sources of microbial contamination **and transmission**~~in the surgical environment~~. Appropriate surgical attire **and personal protective equipment (PPE)** must be worn to provide **a high level of cleanliness and hygiene within the surgical/procedural area. Appropriate surgical attire and PPE provide** an effective barrier to contain bacterial shedding, promote environmental control, and prevent the dissemination of microorganisms to the surgical patient.

B. **DEFINITION(S):**

1. Restricted ~~A~~area- ~~i~~Includes the Operating Room (OR) or procedure room, the clean core and scrub sink areas.
2. Semi-~~R~~restricted ~~A~~area- ~~i~~Includes the peripheral support areas of the surgical suite**/invasive procedure area** and ~~has~~ storage areas for sterile and clean supplies, work areas for storage and processing of instruments, and corridors leading to the restricted areas.~~ of the surgical suite.~~

C. **POLICY:**

1. Scrub Garments:
   a. All individuals entering the semi-restricted and restricted areas of the surgical suite**/invasive procedure area** shall wear **clean,** hospital**-laundered**~~provided~~ scrub attire.
   b. Scrub garments shall include pants, tops and cover jackets that are maintained by the medical center through a linen service.
   c. Scrub garments shall be donned in a designated dressing area of the facility upon entry or reentry to the facility.
      i. Scrubs worn into the facility from the outside shall be changed before entering the surgical suite**/invasive procedure area** to minimize the potential for cross contamination from outside, uncontrolled environments.
   d. Scrub tops shall be tucked into pants, secured at waist, or fit close to the body.
   e. Scrub garments shall be changed daily and whenever ~~becoming~~ visibly soiled, contaminated, or wet.
      i. Worn scrub garments shall be placed in the designated "dirty" container and not hung or placed in a locker for wearing at another time.

f. Hospital-owned scrubs shall not be removed from the facility.
g. Home laundered surgical attire is not permitted.
h. Disposable, single-use scrub garments are permitted.
i. Coveralls (bunny suits) may be worn instead of hospital-laundered scrubs by individuals that must enter the semi-restricted and restricted areas of the surgical suite/**invasive procedure area for a brief time**.
   i. These individuals must not be part of the surgical team.
j. Laboratory coats shall be removed before entering the semi-restricted or restricted areas of the surgical suite/**invasive procedure area**.
k. Cover gowns are not required to be worn when leaving the surgical suite/**invasive procedure area**.
l. Non-scrubbed personnel shall wear long-sleeved cover jackets that are buttoned, tied, or snapped closed during use.
   i. Complete closure of the jacket avoids accidental contamination of the sterile field.
m. Other garments (i.e. short-sleeved undershirts) shall be completely contained or covered by the surgical attire. Clothing that cannot be covered by the surgical attire shall not be worn.

2. Identification Badges:
   a. All personnel entering the surgical/**invasive procedure** area must wear an identification badge/tag.
   b. Identification badges shall be worn pinned to scrubs; identification tags (stickers) shall be placed directly on scrubs.
   c. Identification badges/tags shall be worn above waist level.
   d. Decorative pins shall not be worn on scrubs.
3. Surgical Head Covers:
   a. All head and facial hair, including sideburns and necklines, shall be covered when entering the semi-restricted and restricted areas of the surgical suite/**invasive procedure area**.
   b. Individuals with a bald or shaved head must wear a head cover to prevent shedding of squamous cells.
   c. Disposable, bouffant and hood-style covers are preferred; skullcaps that fail to cover the side hair above the ears and hair at the nape of the neck shall not be worn.
   d. **If** ~~R~~reusable cloth head covers ~~i~~**are** worn, **they** must be covered with a disposable cap while in the semi-restricted and restricted areas.
4. Shoes / Shoe Covers:
   a. Shoes worn within the surgical suite should be clean with no visible soiling and should provide protection.
      i. Open toe shoes shall not be worn.
   b. Fluid-resistant shoe covers are considered part of personal protective equipment (PPE) and shall be worn when it can be reasonably anticipated that splashes or spills may occur.
   c. Shoe covers **are single-use and** shall be changed whenever they become torn, wet, or soiled. ~~, and they~~**Shoe covers** must be removed and discarded before leaving the surgical **suite/invasive procedure** area.
5. Masks:
   a. All personnel entering the semi-restricted or restricted areas of the surgical suite/**invasive procedure area** shall wear a mask when scrubbed personnel, open sterile supplies and/or equipment are present.
   **b.** Masks shall fully cover both the mouth and nose and be secured in a manner that prevents venting **at the sides of the mask.**
      ~~b.~~**i. Masks with ear loops may not provide secure facial fit and are not intended for use as surgical masks**.
   c. A fresh, clean surgical mask should be worn for every procedure.

d. After use, masks shall be removed by handling only the ties, and discarded immediately. **Hand hygiene should be performed after removal of masks.**
   i. Masks shall not be saved by hanging them around the neck or tucking into a pocket for future use.
   ii. The filter portion of the mask harbors bacteria collected from the nasopharyngeal airway; handling this portion of the mask poses risk for cross contamination.

6. Jewlelry:
   a. Rings shall be removed from hands before entering the semi-restricted or restricted areas of the surgical suite/**invasive procedure area**.
   **b.** Other jewelry (including, but not limited to, watches, earrings, bracelets, necklaces, and piercings) shall be removed or totally confined within the scrub attire.
      i. **Watches and bracelets should be removed prior to performing hand hygiene.**

7. Nails:
   ~~a. Fingernails are to be kept short, clean and natural.~~
   ~~b. Artificial nails may not be worn.~~
   ~~Nail polish is permitted up to three days old, with no chips or peeling.~~
   **a. Nails must be short, clean and natural.**
   ~~c.~~**b. For complete policy on nail polish and nail hygiene, refer to Administrative Policy Dress and Appearance Philosophy**~~Dress and Grooming~~**.**

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

1. **Administrative Policy: Dress and Appearance Philosophy 415**

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

1. ~~AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~**AORN Guidelines for Perioperative Practice, 2016 Edition.**

Tri-City Medical Center
Oceanside, California

**PATIENT CARE SERVICES ~~POLICY MANUAL~~**

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **04/05** | **SUBJECT:** | **Titrating Medications, Adult Patients** |
| **REVISION DATE:** | **08/07; 02/09; 12/11, 03/12** | **POLICY NUMBER:** | **IV.GG** |

| | |
|---|---|
| **Clinical Policies & Procedures Committee Approval:** | **~~03/12~~08/15** |
| **Nurse Executive Committee:** | **~~03/12~~09/15** |
| **Pharmacy & Therapeutics Committee Approval:** | **09/16** |
| **Critical Care Committee Approval:** | **03/17** |
| **Medical Executive Committee Approval:** | **~~04/12~~04/17** |
| **Professional Affairs Committee Approval:** | **~~05/12~~06/17** |
| **Board of Directors Approval:** | **05/12** |

A. **PURPOSE:**
1. To define the manner in which medications requiring titration to patient effect are utilized.

B. **POLICY:**
1. It is the policy of Tri City Medical Center to allow orders for medication titration, which is the progressive increase or decrease of the medication dose in response to the patient's clinical status.
   a. This policy pertains to the areas where titration occurs (Intensive Care Unit, Emergency Department, Post-Anesthesia Care Unit, Pain Clinic, Endoscopy, Interventional Radiology, ~~ICU,~~ **Labor and Delivery~~&D~~**).
2. Orders for medications that require titration must include the clinical effect the prescriber desires for the patient (i.e., titrate to achieve systolic blood pressure (SBP) greater than or equal to 100). Titration increments and starting dose may vary depending on the patient's clinical status, co-morbid conditions and other factors. In general, initial doses are started at the lower doses and longer intervals and titrated up to the desired patient effect.
3. Medications ordered for titration must be approved by the Pharmacy and Therapeutics Committee. Safe dose ranges for medications that are to be titrated must be reviewed and approved by that committee.
   a. A dose limit (maximum and minimum limits) at which the licensed independent practitioner must be called for each titrated medication must be set. These dose limits will correspond to the maximum and minimum dose ranges defined in the Alaris Medication Safety System Infusion pumps.
   b. If a titrated medication continues at or above the dose limit, the Registered Nurse (RN) shall contact the licensed independent practitioner ordering the titrated medication to approve the current dose at least every 24 hours by writing specific orders with a new dose limit at which he/she should be contacted.
   c. Clinical staff must assess the patient frequently when titrating mediations to detect potential problems as early as possible.
4. The attached table defines the medications currently approved for titration.

C. **RELATED DOCUMENTS:**
1. **Patient Care Services Policy: Medication Administration**
2. **Titratable Drips Reference**

~~C. **REFERENCE:**~~
3. ~~Medication Administration, Policy IV.I~~

## Titratable Drips Reference

| DRUG | STANDARD CONCENTRATION | YIELDS | CHART IN | USUAL DOSE RANGE | Titration Parameter |
|---|---|---|---|---|---|
| Argatroban | 250 mg / 250 mL NS | 1 mg/mL | mcg/kg/min | 0.25 – 10 mcg/kg/min | Titrate per Protocol |
| *Cisatracurium | 100~~400~~ mg/100~~400~~ mL NS | 1 mg/mL | mcg/kg/min | 1-10 mcg/kg/min;Start 3mcg/kg/min;titrate by 0.3mcg/kg/hr every 10 min | Goal train-of-four 2:4 or Bedside Shivering Assessment Scale Score of 0 |
| Dexmedetomidine (Precedex) | 400 mcg / 100 mL NS | 4 mcg/mL | mcg/kg/hr | 0.2 – 1.4 mcg/kg/hr; Start 0.4 mcg/kg/hr; titrate by 0.1 mcg/kg/hr every 30 minutes | To maintain RASS of 0 to -2 |
| Diltiazem (Cardizem) | 125 mg / 100 mL NS (Total volume =125 mL) | 1 mg/mL | mg/hr | 5 – 15 mg/hr Start 5mg/hr; titrate by 2.5 mg/hr every 15 min | Keep Systolic blood pressure LESS than 165 mmHg and/or keep heart rate less than 120 BPM |
| *Dobutamine (Dobutrex) (Premix) | 500 mg / 250 mL D5W | 2 mg/mL | mcg/kg/min | 2 – 20 mcg/kg/min; Start 2.5 mcg/kg/min; titrate by 0.5 mcg/kg/min every 15 min | Keep Cardiac Index GREATER than 2.2 L/min per square meter |
| *Dopamine (Premix) | 400 mg / 250 mL D5W | 1.6 mg/mL | mcg/kg/min | 2 – 20 mcg/kg/min; Start 5 mcg/kg/min; titrate by 2 mcg/kg/min every 5 min | Keep Heart Rate GREATER than 60 BPM and/or keep Mean Arterial Pressure GREATER than 65 mmHg and/or Systolic Blood Pressure GREATER than 90 mmHg |
| *Epical (Adrenalin/calcium ) | 2 mg Epinephrine, 1Gm CaCl/250 mL D5W | 8 mcg/mL | mcg/min | Based on Epi (as below) | Keep Heart Rate GREATER than 60 BPM and/or Systolic Blood Pressure GREATER than 90 mmHg |
| *Epinephrine (Adrenalin) | 4 mg / 250 mL NS | 16 mcg/mL | mcg/min | 1 – 10 mcg/min; Start 2 mcg/min; titrate by 2 mcg/min every 5 min<br><br>***Weight based for CV Surgery Patients* 0.01 – 0.5 mcg/kg/min; Start at 0.02 mcg/kg/min and titrate by 0.02 mcg/kg/min every 5 min** | Keep Heart Rate GREATER than 60 BPM and/or Systolic Blood Pressure GREATER than 90 mmHg |
| Esmolol (Brevibloc) (Premix) | 2500 mg / 250 mL D5W | 10 mg/mL | mcg/kg/min | 50 – 200 mcg/kg/min; Start 50 mcg/min; titrate by 50 mcg/kg/min every 5 min | Keep Heart rate LOWER than 120bpm and/or systolic blood pressure LOWER than 165mmHg |
| Fentanyl | 1500 mcg / 150 ml NS | 10 mcg/mL | Mcg/hr | 50-300 mcg/hr, Start 50 mcg/hr, titrate by 50 mcg every 15 minutes | Keep Goal pain scale at less than or equal to 2 or at or lower |

| DRUG | STANDARD CONCENTRATION | YIELDS | CHART IN | USUAL DOSE RANGE | Titration Parameter |
|---|---|---|---|---|---|
| | | | | | than patient reported acceptable pain level. |
| Furosemide (Lasix) | 100 mg /100 mL NS | 1mg/mL | mg/hr | 10 – 80 mg/hr; Start 10 mg/hr; titrate by 5mg/hr every hour | Keep urine output GREATER than 20ml/hr |
| Insulin | 100 units / 100 mL NS | 1 unit/mL | units/hr | 0.5 – 20 units/hr | Titrate per protocol |
| Isoproterenol (Isuprel) | 1 mg / 250 mL D5W | 4 mcg/mL | mcg/min | 2 – 10 mcg/min; Start 1 mcg/min; titrate by 1mcg/min every 10 min | Keep Heart rate GREATER than 60bpm |
| Labetalol (Normodyne) | 200 mg / 200 mL D5W | 1 mg/mL | mg/min | 0.5 – 2 mg/min; Start 2 mg/min; titrate by 0.5 mg/min every 15 min up to 300mg in 24 hours | Keep Heart rate LESS than120bpm and/or systolic blood pressure LESS than165mmHg |
| Lorazepam (Ativan) | 50mg/50 ml D5W | 0.2 mg/mL | mg/hr | 1 – 10 mg/hr; Start 2mg/hr titrate by 1 mg every 30 min | Titrate to RASS 0 to -2 |
| Midazolam (Versed) | 50 mg / 50 ml D5W | 1 mg/mL | mg/hr | 1 – 10 mg/hr; Start 2mg/hr; titrate by 1 mg every 15 min | Titrate to RASS 0 to -2 |
| Milrinone (Primacor) (Premix) | 20 mg / 100 mL D5W | 200 mcg/mL | mcg/kg/min | 0.25 - 0.75 mcg/kg/min **Start** 0.25 mcg/kg/min; **titrate** by 0.25 mcg/kg/min every hour | Keep Cardiac Index GREATER than 2.2 L/min per square meter |
| Morphine | 100 mg / 100 mL NS | 1 mg/mL | mg/hr | 1 - 20 mg/hr; Start 2 mg/hr; titrate by 0.5 mg every 30 min | Keep Goal pain scale at less than or equal to 2 or at or lower than patient reported acceptable pain level. |
| Nicardipine (Cardene) | 20mg/200 ml NS | 0.1 mg/mL | mg/hr | 2.5 – 15 mg/hr; Start 5mg/hr; titrate by 2.5 mg/hr every 15 min | Keep Systolic blood pressure LESS than 165mmHg |
| Nitroglycerin (Tridil) | 50 mg / 250 mL D5W | 200 mcg/mL | mcg/min | 5 – 400 mcg/min; Start 5 mcg/min; titrate by 5 mcg/min every 5 min up to 20 mcg/min. If no response at 20 mcg/min, may increase by 10 mcg/min every 5 min | Keep Systolic blood pressure LESS than 165mmHg and/or titrate for chest pain relief |
| *Nitroprusside (Nipride) | 50 mg / 250 mL D5W | 200 mcg/mL | mcg/kg/min | 0.25 – 10 mcg/kg/min; Start 0.25 mcg/kg/min; titrate by 0.25 mcg/kg/min every 5 min | Keep Systolic blood pressure LESS than 165 mmHg |
| *Norepinephrine (Levophed) | 4 mg / 250 mL NS | 16 mcg/mL | mcg/min | 0.5 – 30 mcg/min; Start 2 mcg/min; titrate by 2 mcg/min every 5 min | Keep Systolic blood pressure GREATER than 90mmHg and/or Mean arterial pressure GREATER than 65mmHg |
| **Oxytocin (Pitocin)** | **20 units / 1000 ml NS** | **20,000 milli units/ml** | **milliunit/min** | **1 milliunit/min-10 milliunit/min; Max dose 20 milliunit/min** | **Titrate per protocol-see Women and Newborn Services Unit Specific Procedure** |
| *Phenylephrine | 50 mg / 250 mL NS | 200 | mcg/min | 5 – 180 mcg/min; Start | Keep Systolic blood |

| DRUG | STANDARD CONCENTRATION | YIELDS | CHART IN | USUAL DOSE RANGE | Titration Parameter |
|---|---|---|---|---|---|
| (Neosynephrine) | | mcg/mL | | 10mcg/min;titrate by 20 mcg/min every 5 min | pressure GREATER than 90mmHg and/or Mean arterial pressure GREATER than 65mmHg |
| Propofol (Diprivan) | 1000 mg / 100 mL (10 mg/mL) | 10 mg/mL | mcg/kg/min | 5-80 mcg/kg/min ;Start at 10 mcg/kg/min; titrate by 5 mcg/kg/min every 10 min | Titrate to RASS 0 to -2 |
| Vecuronium (Norcuron) | 100 mg / 100 mL NS | 1 mg/mL | mcg/kg/min | Normal range 0.8 - 1.7 mcg/kg/ min; Start 0.8 mcg/kg/min; titrate by 0.1 mcg/kg/hr every 10 min | Goal train-of-four 2:4 or Bedside Shivering Assessment Scale Score of 0 |

Rev 11/2016

* Indicates that these drug infusions can be mixed in a higher concentration strength for fluid restricted patients

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
District Operations

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**ISSUE DATE:** 01/87

**SUBJECT:** EQUIPMENT/MEDICAL DEVICE REPORTING/SEQUESTERING

**REVISION DATE:** 12/91, 08/94, 05/96, 01/99, 05/02, 02/03, 04/06, 02/11, 04/14

**POLICY NUMBER:** 8610-201

| | |
|---|---|
| **Department Approval:** | 04/17 |
| **Administrative Policies & Procedures Committee Approval:** | ~~06/14~~04/17 |
| **Professional Affairs Committee Approval:** | ~~08/14~~06/17 |
| **Board of Directors Approval:** | 08/14 |

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A. **PURPOSE:**

1. To assure that safe medical device reporting/sequestering is implemented. To assure that medical devices on the market are safe and effective through user facility reporting, identification, tracking and corrective actions. For purposes of this policy, the Risk Manager is designated as the hospitals official contact for the Food and Drug Administration (FDA).

B. **DEFINITIONS:**

1. Patient – A "patient" of a facility is (1) an individual being diagnosed, or treated, or receiving medical care under the auspices of the facility, from medical personnel working in, for or who are otherwise affiliated with a device user facility; or (2) an employee of the facility who suffers death, serious illness, or serious injury from a device used at or by the facility, and, as a consequence, becomes a patient.
2. Affiliated – Affiliated is defined to include medical personnel who are associated with a device user facility and is interpreted to include physicians with admitting privileges.
3. Medical Device – An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part or accessory which is:
   - **a. Not a drug or biologic.**~~;~~
   - ~~a.~~**b.** Recognized in the official national formulary, or the USP, or any supplement to them.
   - ~~b.~~**c.** Intended for use in the diagnosis of disease or ~~*~~other conditions, or in the cure, mitigation, treatment or prevention of disease, in man or other animals, or;
   - ~~c.~~**d.** Intended to affect the structure of any function of the body, or other animals, and which does not achieve its primary intended purposes through chemical action within, or on, the body of man or other animals; and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
     - i. (Per Safe Medical Devices Act (SMDA) 1990 and Medical Device Amendments, 1992)
4. Examples of Devices – Anesthesia machines, defibrillators, pacemakers, hemodialysis machines, heart valves, catheters, thermometers, patient restraints, contact lenses, hearing aids, blood glucose monitors, x-ray machines, tampons, ventilators, wheelchairs, bedside commodes, infusion pumps, laser, electrosurgery, etc.
5. Serious Illness and Serious Injury – An illness or injury that a) is life threatening, b) results in permanent impairment of a body function or permanent damage to a body structure, c) necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

C. **POLICY:**

In compliance with Safe Medical Devices Act, all incidents that reasonably suggest that there is a probability that a medical device or user error caused or contributed to a death, serious illness or serious injury of a patient or employee of the facility, will be reported to the appropriate persons and/or organization.

D. **STAFF RESPONSIBILITY:**

1. In the event of a patient death, serious injury or illness, whether it is due to equipment/product failure or user error the staff member responsible for the patient shall follow these procedures.
   a. Immediately notify the Department Director or Supervisor of the occurrence who will then notify Administration and Risk Management.
   b. Immediately sequester the equipment/product.
   c. Preserve evidence.
   d. Maintain control settings as existed at the time of injury (if applicable), i.e., power settings, gas flow ~~(see D.b).~~
      i. Device is not to be cleaned or processed.~~,~~
      ii. Universal precautions to be used in handling all accessory components, or related equipment.~~,~~
      iii. Device will be kept intact for impoundment.
2. Sequestering the Equipment/Device (to preserve evidence):
   a. Notify Biomedical Engineering of equipment failure. Notify Risk Management of all sequestering, whether a product or equipment.
   b. Maintain the equipment/device in a secure place under the care of an individual who will be able to testify that the device has been preserved in its original condition until arrangements are made with Risk Management for further safekeeping through off-site or on-site storage as needed.
   c. When the decision to sequester is made, the equipment/supplies shall be disconnected from the patient and power supply without changing any control settings or turning the equipment off (if possible). No cleaning or processing of the equipment/supplies shall occur until the Risk Manager has identified if these processes will hinder subsequent investigation. All equipment and associated supplies shall be preserved as found. The equipment/supplies will be sequestered by the user department, biomedical engineer, or Risk Manager as appropriate.
   d. Whenever any piece of equipment is to remain sequestered, the department director will provide for replacement of the equipment and notify physicians who use this equipment.
      i. Preserve original packaging of the device if possible.
   e. Complete Quality Review Report, which includes:
      i. Name of patient
      ii. Date and time of patient injury
      iii. Description of event in detail and patient outcome
      iv. Description of malfunction and condition of device upon removal
      v. Biomed Data Control number if possible and manufacturer, model name, serial or lot number
      vi. Verification of notification to supervisor
      vii. Notations of settings as existed at the time of injury ~~(see D.C.)~~
   f. Risk Management and Biomedical Engineering (if equipment) will determine if the product/equipment is to be returned to the manufacturer (if patient injury).
   g. Equipment, instruments or supplies potentially involved in a patient's adverse occurrence are not to be returned to the manufacturer, or discarded until authorization is given by the Risk Manager.

E. **RISK MANAGEMENT DEPARTMENT REPORTING RESPONSIBILITY:**

1. Risk Management will report patient deaths, serious illness and injury or user error resulting from a medical device to the Food and Drug Administration (FDA) **within 10 work days,**

California Department of Public Health (CDPH) **within 5 days,** and to the manufacturer, if known.

2. The Risk Management Director will also notify the professional liability carrier and Administration.

F. **REPORTING SCHEDULE:**

1. A facility will be treated as first becoming aware of information when medical personnel, who are employed by or otherwise formally, affiliated with the facility, become aware of information with respect to a device in the course of their duties.
2. The Risk Manager shall determine if the event is reportable under the SMDA. Reports will be sent to:
   a. The manufacturer of the device for incidents involving serious illness, serious injury, or death.
   b. The FDA if the event resulted in death or for any serious outcome where the manufacturer is unknown.
3. If determined to be reportable, the Medwatch Form 3500A will be completed by the Risk Manager according to SMDA regulations, starting from when the hospital first became aware that the device may have caused or contributed to the event.
4. Each device user facility is required to submit to FDA, on a semiannual basis (January 1 and July 1), a summary of the reports that it has submitted to the FDA and to manufacturers. If no reports have been submitted, no summary need be sent.
5. Reporting Format: The Risk Management Director will, at a minimum, include information such as the identity of the reporting facility, product name, model, serial number, name of manufacturer, if known, and a description of the event.
6. The Risk Manager shall be responsible for maintaining a separate "File of Device Reportable Incidents." See Attachment A

G. **FDA CONTACT WITH THE HOSPITAL:**

1. If an FDA inspector visits the hospital for any purpose related to medical devices, he/she will be directed to the Risk Manager. The Risk Manager will ask for, review, and record the inspector's credentials prior to providing requested information.
2. Written or telephone inquiries from FDA representatives will be directed to the Risk Manager for response.

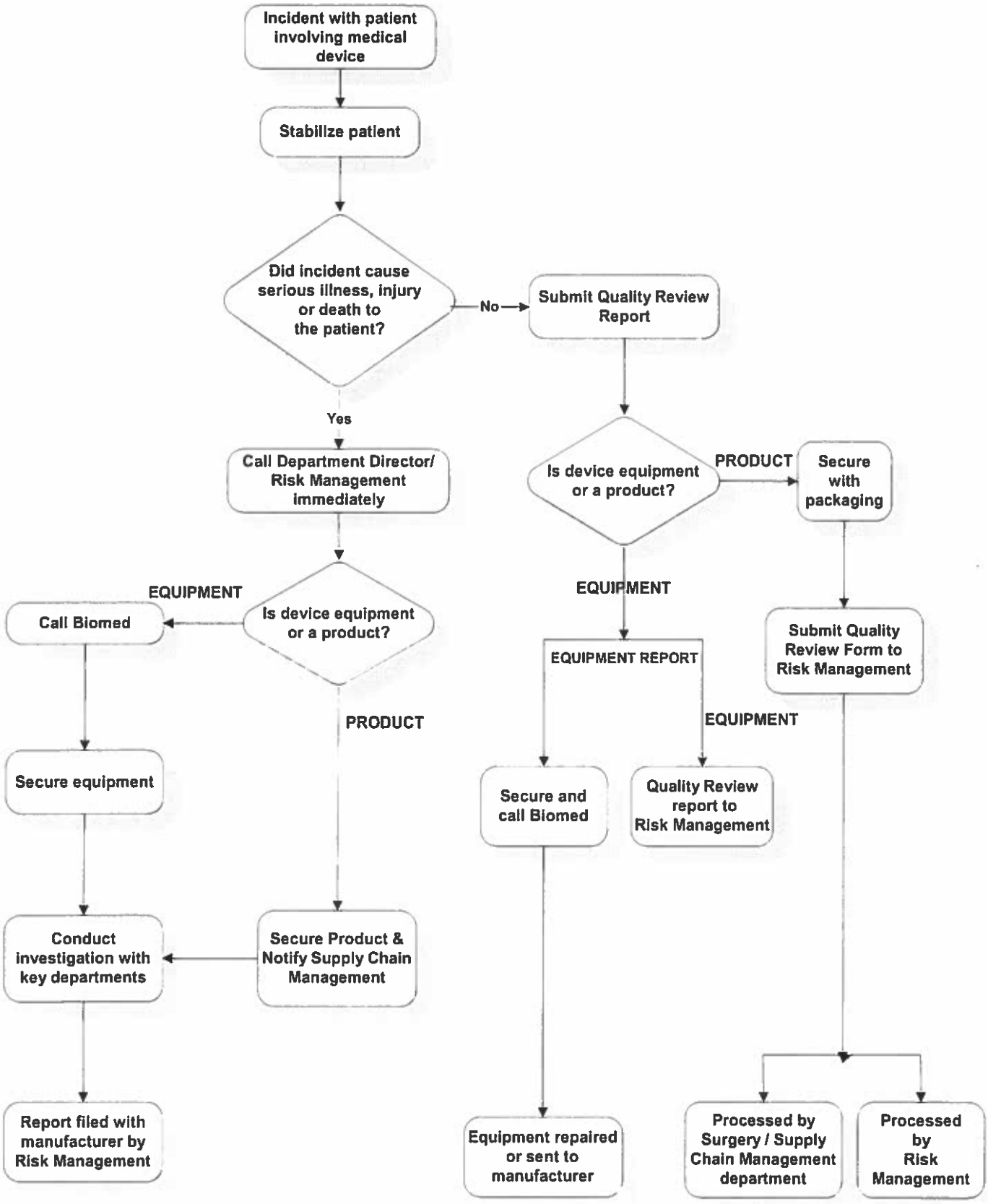
H. **ATTACHMENTS:**

1. Tri City Medical Device Incident Flow Chart

I. **REFERENCE:**

**1.** Administrative Policy #501, Adverse Events, Mandatory Reporting of
**~~1.~~2. Medical Device Amendments, 1992**
**3.** Patient Care Services Patient Owned/Supplied Equipment Brought into the Facility
**~~2.~~4. The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from: https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf**

# TRI-CITY MEDICAL CENTER
# MEDICAL DEVICE INCIDENT FLOW CHART



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

**Administrative Policy Manual**
**Environment of Care**

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**ISSUE DATE:** 06/94 **SUBJECT: PARKING PROGRAM**

**REVISION DATE:** 09/02; 03/03, 07/04; 12/05; 04/08 09/10; 01/14 **POLICY NUMBER:** 8610-261

| | |
|---|---|
| **Department Approval:** | 05/17 |
| **Administrative Policies & Procedures Committee Approval:** | ~~07/14~~05/17 |
| **Professional Affairs Committee Approval:** | ~~08/14~~06/17 |
| **Board of Directors Approval:** | 08/14 |

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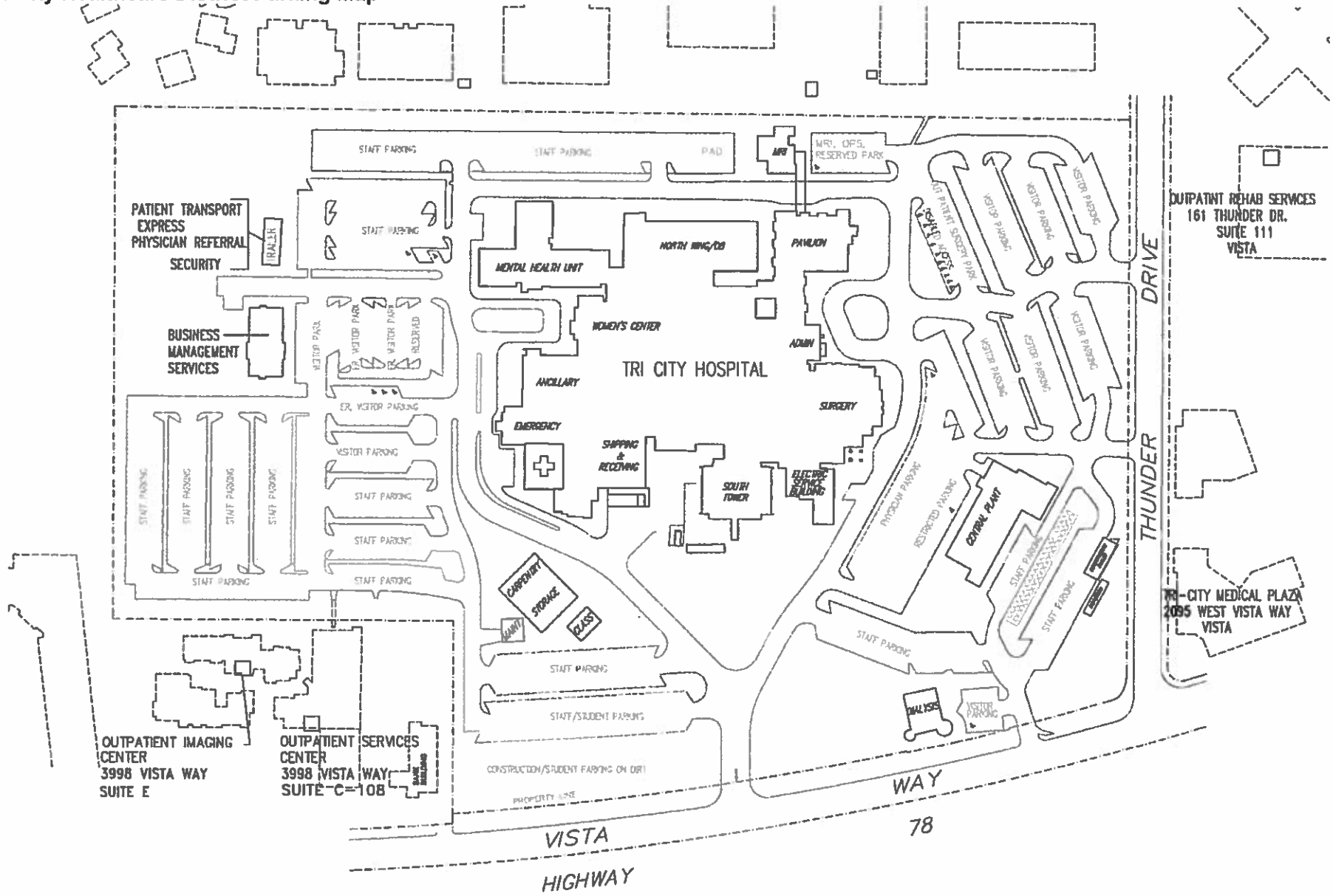
A. **PURPOSE:**
1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**
1. All employees and physicians are required to complete a parking application form.
   a. The parking application form details their mode of transportation and identifying characteristics.
      i. Employees shall submit a completed and/or revised form to Human Resources.
      ii. Physicians shall submit a completed and revised form to the Medical Staff Office.
   b. All employees and physicians are required to display the TCHD parking placard while parked on TCHD campus.
2. All TCHD Board Members, Medical staff, Executives,~~,~~ Directors and authorized administrative staff may park in the Medical Staff parking area.
3. Employees shall park in designated employee parking areas (Refer to ~~Attachment 1: "~~Tri-City Healthcare District Parking Map~~"~~).
   a. Employees or others who use a bike as their mode of transportation shall park and secure bikes in the designated bike parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.
4. Construction personnel shall receive parking instructions from the Engineering Department during their orientation.
5. Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a second parking violation. Corrective action follows Administrative Policy, Coaching and Counseling for Performance Improvement.
6. Valet services are provided to all District residents with a District benefit card. Valet services are provided Monday – Friday from 8:00 am to 4:30 pm and may be used for special events with notification one week prior to event.
7. The designated speed limit on campus is 15 MPH unless posted otherwise.

C. **RELATED DOCUMENT(S):**
1. **Tri-City Healthcare District Parking Map**

## Tri-City Healthcare District Parking Map




SITE PLAN

Tri-City Medical Center
4002 Vista Way, Oceanside Ca 92056
Hospital Campus

Tri-City Health Care District
Oceanside, California

Patient Care Services~~Administrative Policy Manual~~

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **08/91** | **SUBJECT:** | **Paul Gann Blood Safety Act** |
| **REVISION DATE:** | **10/91, 07/93, 07/97, 01/06, 01/09 02/11, 05/14** | **POLICY NUMBER:** | **8610-325** |

| | |
|---|---|
| **~~Administrative Policies & Procedures Committee Approval:~~** | **~~10/10~~** |
| **Department Approval:** | **09/16** |
| **Clinical Policies and Procedure Committee Approval:** | **10/16** |
| **Nurse Executive Council Approval:** | **~~01/11~~10/16** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Blood Utilization Review Committee Approval:** | **04/17** |
| **Medical Executive Committee Approval:** | **05/17** |
| **Professional Affairs Committee Approval:** | **~~02/11~~06/17** |
| **Board of Directors Approval:** | **02/11** |

A. **PURPOSE:**

1. To assure compliance with the Paul Gann Blood Safety Act Health and Safety Code 1645.

B. **POLICY:**

1. The Paul Gann Blood Safety Act (Health and Safety Code Section 1645) imposes specific obligations upon physicians to provide information concerning transfusions of "Autologous Blood." Autologous blood is defined to include, without being limited to presurgical-donation of blood and blood components, intraoperative and postoperative cell salvage and reinfusion, and hemodilution. This information must be provided to any patient scheduled for elective surgery or procedure, when there is the possibility that a blood transfusion may be necessary.
2. The law requires that the physician allow adequate time before elective surgery for the patient to arrange for autologous donation unless there is a life-threatening emergency, there are medical contraindications, or the patient waives the right for autologous donation.
3. The physician must give the patient a copy of the standardized written summary developed by the California Department of Public Health (CDPH) to inform the patient of the positive and negative aspects of receiving autologous blood or directed and non-directed homologous blood. The physician must use this CDPH Summary; no other information will satisfy the physician's obligation under this law.
4. The physician must document on the patient's medical record that the CDPH's information pamphlet was given to the patient.
5. The documentation must be on the Pre-Procedure Verification form.
6. This requirement will be treated consistent with other requirements indicated prior to elective surgery.
7. Exceptions to these procedures will be:
   a. Outpatient procedures, or procedures usually considered to be outpatient.
   b. All non-elective surgeries.

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

**~~8.~~1. A Patient's Guide to Blood Transfusion, California Department of Health Services June 2016**

References:


- Circular of Information for the Use of Human Blood and Blood Components. AABB. Nov 2013 (revised April 2014)
- AABB Technical Manual. 18th Edition.

This brochure was developed by the California Department of Health Services, Laboratory Field Services (850 Marina Bay Parkway, Richmond, CA 94804)

In partnership with the Medical Technical Advisory Committee of the Blood Centers of California.

For information about brochure contents, please call Laboratory Field Services 213 620-6574.

This brochure is provided as a source of information and is not considered a replacement for the Informed Consent process prior to the transfusion of blood.

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To place an order for this brochure, please FAX your request to: (916) 263-2479

This information may be obtained electronically at:

*http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx*

*Revised 06/2016*

# *A Patient's Guide to Blood Transfusion*

**California Department of Health Services**

**June 2016**

This document provides written information regarding the benefits, risks, and alternatives of transfusion of blood products (including red blood cells, plasma, platelets, or others) collected from the patient (autologous) or another person. This material serves as a supplement to the discussion you have with your physician. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your physician prior to consenting to receive a transfusion.

## ■ *Information about the treatment*

Transfusions of blood products are provided to increase the amount of blood components in your body when they are below a reasonable level for your health. The transfusion may be made up of red blood cells, plasma, platelets or other specialized products made from blood. Your physician will decide on the right amount and type of blood product based on your medical condition or diagnosis.

## ■ *Potential benefits of the treatment*

Transfusion of blood products may be necessary to correct low levels of blood components in your body, and may also make you feel better. In some cases, failure to receive transfusion(s) may result in death.

## ■ *Risks of the treatment*

Known risks of this treatment include, but are not limited to:

- Irritation, pain, or infection at the needle site
- Temporary reaction such as a fever, chills, or skin rashes.

Other rare but more serious complications include severe allergic reactions, heart failure due to fluid overload, acute pulmonary edema (fluid leaking into the lungs), hemolysis (destruction of red blood cells), shock, or death.

Transfusion of blood products carries a very small risk of transmission of infectious diseases such as HIV (about 1 in 1.5 million), Hepatitis C (about 1 in 1.2 million), and Hepatitis B (about 1 in 1 million). Other significant infections may also be transmitted by transfusion, but overall this risk is low.

## ■ *Treatment Options/Alternatives*

If you need blood you have several options. Most patients requiring transfusion receive blood products donated by volunteer community donors. These donors are extensively screened about their health history and undergo numerous blood tests as mandated by state and federal regulations in order to ensure the safest possible blood supply. Alternatives to transfusion with blood products from volunteer community donors include:

- Pre-operative autologous donation (using your own previously donated blood), see below for more information
- Directed donation (blood donated by people who you have asked to donate for you), see below for more information
- Intra-operative autologous transfusion/ Hemodilution (collecting your own blood during surgery to be given back to you)
- Medications (certain medications may increase blood volume prior to surgery or reduce active bleeding to lessen the need for transfusion)

These options may be available only if your health, time, and procedure permit. They may not be available at all locations or for all patients. You may also choose not to receive blood transfusion; however this decision may hold life-threatening consequences.

Pre-operative autologous donation is not appropriate for all patients. Autologous donation involves collecting your own blood prior to a planned surgery for storage in the hospital blood bank. It is important to discuss with your physician if it is safe for you to donate and the likelihood of needing a transfusion based on your surgery and current transfusion guidelines. Receiving your own blood may reduce, but will not eliminate, the risk of transfusion-related complications. Insurance company policies may vary regarding reimbursement for this service. Overall, although autologous donation is an option to consider for those who qualify, the number of autologous donations in the United States has significantly decreased in the last few decades mainly due to major advances in blood safety and efforts to decrease unnecessary blood transfusions.

Directed donation refers to blood collected from "directed donors" who are donating blood for a specific patient by request. Directed donors are often family and friends of the patient. Directed donors go through the same qualification process as volunteer donors. Directed donations are not considered to be safer than the general blood supply.

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

**Administrative Policy Manual**

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**ISSUE DATE:** 06/11 **SUBJECT:** **Purpose & Responsibility of Risk Management**

**REVISION DATE:** 11/14 **POLICY NUMBER:** 8610-293

| | |
|---|---|
| **Department Approval:** | **04/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~09/14~~05/17** |
| **Professional Affairs Committee Approval:** | **~~10/14~~06/17** |
| **Board of Directors Approval:** | **11/14** |

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A. **SCOPE:**

1. Risk management is a **Tri-City Healthcare District (TCHD)**~~hospital-wide~~ integrated system that encompasses all areas of patient care, visitor, employee, property and medical staff safety.
2. All employees and members of the medical staff who have authority to influence patient care outcomes directly or indirectly are actively involved in the Risk Management Program. The Risk Management Program will pursue occurrences and circumstances that may present the potential for loss.

B. **AUTHORITY:**

1. The Director of Risk Management has been authorized by the Chief Executive Officer to provide the overall coordination of the Risk Management Program. It is the Chief Executive Officer, Chief of Staff, Chief Nurse Executive, and Chief Operating Officer, who have the authority delegated by the Board of Directors to protect the interests of ~~the hospital~~**TCHD** and patients by initiating necessary corrective action when the Risk Management Program has identified potentially adverse situations.

C. **GOALS:**

1. The major goal of the Risk Management Program is to establish a joint effort of the Board of Directors, Medical Staff and Administration, and all employees to provide a safe environment and quality patient care through the risk management principles of identifying exposure to loss, evaluating, analyzing, investigating, monitoring and decreasing the risks.
2. To ensure the most advantageous method of correcting, reducing and mitigating or eliminating identifiable risks that may adversely affect our patients, visitors, employees and medical staff or the quality of care provided to patients will be selected.

D. **OBJECTIVES:**

1. To further improve the quality and safety of the care provided by ~~the hospital~~**TCHD**.
2. To reduce patient and visitor injury to the lowest possible level.
3. To maintain and improve patient satisfaction with the organization.
4. To minimize adverse effects of loss through identification and assessment of actual and potential losses, loss prevention, risk reduction and claims control.
5. To minimize the occurrences of legal claims against ~~the hospital~~**TCHD**.
6. The activity of risk management will contribute to the quality of care and a safer environment for patients, employees, visitors, medical staff and property, as well as reduce the cost of risk to the institution.

E. **RISK MANAGEMENT FUNCTIONS INCLUDE:**

1. Identifying through ongoing assessment an annual plan to manage risk and evaluate the effectiveness of the Risk Management Program. Develops/modifies goals as indicated.

2. Coordinating the development of corrective action plans to address identified risk exposures.

F. **RELATIONSHIP OF RISK MANAGEMENT TO THE ORGANIZATION:**

1. Board of Directors: Risk Management will report semi-annually to the Board of Directors. Will provide input on facility, department, and Medical Staff issues that address high-risk patient care issues, claims information, and regulatory/accreditation requirements. The Board will give input and guidance in the furtherance of Risk Management goals.
2. Medical Staff Leadership: Risk Management works with to the Medical Staff in the identification and analysis of significant risk issues affecting the clinical operations of the facility. It is expected that physicians will cooperate in the Risk Management activities. The Risk Manager will interface with staff physicians to ensure communication and cooperation in Risk Management efforts.
3. Bio-Ethics Committee: The Risk Manager participates in this multidisciplinary committee and assists in the resolution and/or advising as appropriate.
4. Quality and Safety Committees: The Risk Manager participates on these committees and contributes expertise in risk reduction as a function of patient safety.
5. Employees: The Risk Manager Counsels clinical personnel on care issues/conflicts and responds to adverse patient outcomes. The Risk Manager will act in a consulting capacity to all departments identifying and correcting unsafe conditions and practices whenever possible.

G. **ENVIRONMENTAL HEALTH AND SAFETY COMMITTEE:**

1. The Director of Risk Management is an active member of the Environmental Health and Safety Committee.
2. Risk Management will aggregate data, specific to safety indicators for submission to the Committee on a quarterly basis.
3. Risk Management will maintain risk data relating to patient or visitor occurrences and/or adverse outcomes and will present to committee members.
4. The Director of Risk Management will refer potential and actual issues related to environmental functions to the Committee.
5. Risk Management will report safety issues identified by other departments / sources to the Committee for discussion, action and if possible, for resolution.

H. **REPORTING REQUIREMENTS OF RISK MANAGEMENT:**

1. Internal:
   a. Incident Reporting and Analysis
      i. Regular review and revision of policy and procedure.
      ii. Analysis, investigation and trending of information in Quality Review Reports (QRR)/RL Solutions.
      iii. Will review each incident report entered into the electronic QRR system for follow-up, risk identification, and trend analysis.
      iv. Will compile data from the QRR and report to the appropriate committees.
   b. Sentinel Events
      i. Management and investigation of sentinel events will be according to ~~hospital~~**TCHD's** policies on mandatory reporting requirements.
2. External:
   a. Provides Medwatch reports of medical device problems to the FDA and manufacturers as required under the Safe Medical Devices Act. Will maintain files for six years.
   b. Will assist State and Federal surveyors (i.e., The Joint Commission [TJC], California Department of Public Health [CDPH]) during scheduled and unannounced regulatory surveys.
   c. Reports to CDPH will be completed as needed after consultation with Administration.

I. **ANALYSIS OF RISK DATA BY RISK MANAGEMENT:**

1. Analyzing loss data to determine appropriate loss prevention actions.

2. Analyzing incidents/occurrences and identifies patterns as evidence for decision-making.
3. Providing guidance for an evidence based risk management program for the facility.
4. Determining the appropriate investigative technique and strategies to utilize with various types of potential claims.

J. **RISK MANAGEMENT EDUCATION RESPONSIBILITIES INCLUDE:**

1. Providing an ongoing program to educate employees in risk management, safety and loss control matters, and incident reporting requirements.
2. Conducting ongoing in-service training and education with ~~hospital~~**TCHD** personnel regarding specific and general risk management related issues.
3. Develops and implements educational programs for employees, Medical Staff and Board members based on analysis or risk assessments, historical and concurrent occurrence and claims data, and national trends.

K. **CLAIMS MANAGEMENT RESPONSIBILITIES INCLUDE:**

1. Oversees investigations of incidents that could lead to professional/general liability claims.
2. Works with patients/families and visitors where appropriate to resolve outstanding issues. Complaints and grievances will be handled in accordance with policy.
3. Identifies those occurrences that are potential compensable events and reports accordingly.
4. Protects confidentiality and access to Risk Management information and files.
5. Assists defense attorneys in preparation of defense.

L. **OPERATIONS/COMPLIANCE:**

1. Works closely with the ~~Ethics &~~**Chief** Compliance Officer to ensure compliance with statutory mandates, regulatory requirements and accreditation standards (i.e., TJC).
2. Disseminates information related to changes in regulatory requirements pertinent to potential liability exposures and risk issues.
3. Helps to ensure compliance with regulatory requirements, professional standards and guidelines.
4. Formulates and implements comprehensive Risk Management program, with full responsibility for operations of the program; may include an enterprise risk management approach.
5. Directs loss control/loss prevention activities and reports results to administration.
6. Responsible for identifying and communicating regulatory requirements relating to Risk Management activities.
7. Leads development of organization-wide approach on disclosure of medical errors and obtains physician support.
8. Analyzes the risk of loss versus cost of reducing risk.
9. Answers medical/legal inquiries of physicians, nurses, and administrators regarding emergent patient care issues and loss control.
10. Maintains awareness of legislative activities that may affect Risk Management programs and participates in the legislative process.

M. **LOSS PREVENTION / PATIENT SAFETY RESPONSIBILITIES INCLUDE:**

1. Planning developing and presents, educational material to administration, medical staff, nursing personnel, and other department personnel on topics related to risk management.
2. Developing and implementing programs designed to minimize the frequency and reduce the severity of actual and potential safety hazards throughout the facility.
3. Leading or actively participating in Root Cause Analyses; makes improvement recommendations.
4. Supporting patient safety initiatives through leadership, direction, and involvement.
5. Acting as resource, internal consultant, and educator for patient safety/risk management issues.
6. Compiling with various codes, laws, rules and regulations concerning patient care, including incident reporting and those mandated by state and federal agencies; also includes investigative activities with federal, state and local enforcement authorities.

7. Leading investigations of adverse events and sentinel events.

N. **PROFESSIONAL DEVELOPMENT RESPONSIBILITIES INCLUDE:**

1. Maintaining an exchange of information with professional organizations, peers and other resources to improve and update the program.
2. Maintaining current knowledge and education in Risk Management.
3. Maintaining membership in Risk Management societies.

O. **CONFIDENTIALITY OF INFORMATION:**

1. All Risk Management record reports and other documents are privileged and protected as confidential as applicable under California Evidence Code 1156 and 1157, as well as under attorney/client privilege.
2. Protected health information is considered private and confidential and will be handled as such. This confidentiality extends to any form of disclosure, including information given over the telephone or in person. Protected privacy will include the medical record, identifiers in the record, financial statements, billing records and other information considered protected under the Health Insurance Portability and Accountability Act. Federal and State laws will be followed as applicable.

P. **REFERENCES:**

1. Administrative Policy Disclosure of Unanticipated Adverse Outcomes to Patients, 8610-275
2. Administrative Policy Mandatory Reporting Requirements, 8610-236
3. **California Evidence Code 1156 and 1157**
4. Patient Care Services Policy Incident Report – Quality Review Report (QRR), 8610-396
5. Patient Care Services Policy Patient Complaints & Grievances, 8610-318
~~5.~~6. Patient Care Services Policy Patient Rights & Responsibilities, 8610-302

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

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

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**ISSUE DATE:** 10/91 **SUBJECT:** **SECURITY DEPARTMENT INCIDENT NOTIFICATION**

**REVISION DATE:** **08/92, 10/97, 04/02, 05/03, 12/05, 01/09, 02/11, 07/14** **POLICY NUMBER:** **8610-234**

| | |
|---|---|
| **Department Review:** | **05/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~01/14~~05/17** |
| **Professional Affairs Committee Approval:** | **~~07/14~~06/17** |
| **Board of Directors Approval:** | **07/14** |

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A. **PURPOSE:**

1. To set forth a uniform Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) Security Department notification process in the event of a safety/security related incident involving ~~Medical Center~~**TCHD** personnel, visitors, and/or patients.

B. **POLICY:**

1. Upon receiving information of an alleged incident or crime, all Medical Center personnel will immediately notify the ~~TCMC~~ Security Department for a reporting and investigative follow-up.
2. It will be the responsibility of all ~~Medical Center~~**TCHD** personnel to immediately notify the Security Department of any alleged incident or crime involving staff, visitors or a patient.
3. All ~~Medical Center~~**TCHD** Staff will contact the Security Department when they learn of or witness any incident or crime that occurs on ~~the Medical Center Campus~~**TCHD property** (including ~~161 Thunder Drive,~~ **3925 Waring Rd., 3927 Waring Rd.** and 2095 Vista Way) that would require the response of a Security Officer.
   a. Examples of an incident that would require Security Department notification:
      i. Disruptive Patient or Visitor.
      ii. Theft or Damage of ~~Medical Center~~**TCHD** or Personal Property.
      iii. Assault or Battery on any person.
4. The responding Security Officer will be responsible for evaluating the incident and taking necessary action as described in the Security Department Policy and Procedure Manual.
5. All such occurrences shall be reported to the Department Director/designee and Risk Management.
6. The Security Department will make all necessary non-emergency notifications to external law enforcement agencies. Any ~~Tri City Medical Center (~~TCH~~DMC)~~ staff may contact 911 for emergency notification for law enforcement assistance.
7. Any visitor who is injured on hospital property will be offered service in the Emergency Department by a hospital staff member.
   a. Any visitor who injures themselves on hospital property will be offered service in the Emergency Department by a hospital staff member, as appropriate. It is up to the visitor to decide whether or not to go to the Emergency Department, but billing for that service will be processed as any other visit. It is not implied by the offer to take the visitor to the Emergency Department that there will be "no charge". Injured visitors that do seek treatment in the Emergency Department will follow the same admitting process as all patients.
   b. The ~~TCMC~~ Security Department must be notified for injury investigation. The ~~TCMC~~ Security Officer will complete a Security Report and take photographs of the area where the accident took place. A copy of the Security Report will be sent to Risk Management.

A Security Report will be completed whether the visitor is seen in the Emergency Department or not.

c. Hospital staff should not engage in any conversations regarding billing issues and not make any promises/offers that the hospital will pay bills.

d. Any employee who witnesses a visitor accident or has accompanied the individual to the Emergency Department will also submit a RL Solutions Report (RL). If a RL has not been submitted (i.e., in cases where the visitor goes directly to the Emergency Department unaccompanied by a staff member), the Emergency Department nurse will submit the RL.

e. If the visitor declines treatment, it will be noted in the Security Report and the RL.

f. The Emergency Department registrar will obtain insurance information following a medical screening and enter that information on the face sheet.

g. The individual will be seen by the Emergency Department physician on duty and evaluated with definitive treatment provided, as appropriate.

h. If the visitor seeks treatment but declines to submit insurance information or assume any billing responsibility, the individual will be offered treatment, regardless.

i. The visitor will be advised that issues regarding the accident and billing charges will be referred to the appropriate department for review. If the visitor declines treatment, this refusal must be documented in the RL and Security Report.

j. All visitor inquiries and accident reports will be forwarded to Risk Management. The decision on whether Emergency Department bills for visitor injuries will be paid or not is determined by the Risk Management Department.

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

**Administrative Policy Manual**

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**ISSUE DATE:** 11/87 **SUBJECT:** USE OF PERSONAL ELECTRIC APPLIANCES

**REVISION DATE:** 07/93; 10/99; 05/03; 01/09; 01/13 **POLICY NUMBER:** 8610-212

| | |
|---|---|
| **Department Approval:** | 05/17 |
| **Administrative Policies & Procedures Committee Approval:** | ~~01/13~~05/17 |
| **Professional Affairs Committee Approval:** | ~~02/13~~06/17 |
| **Board of Directors Approval:** | 02/13 |

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A. **PURPOSE:**

1. To outline a policy by which new, loaned and demonstrative equipment will be inspected upon arrival and before use within Tri-City Healthcare District (TCHD).

B. **POLICY:**

1. It is the policy (TCHD) that no electrically powered personal electric equipment be used in this institution until it has been inspected and determined to be electrically safe. That equipment deemed safe and accepted, must be suitably tagged or labeled for the area for which it will be used.
2. In accordance with Title 22 section 70837, all portable electrical equipment using 110-120 volt 60 hertz current shall be equipped with an Underwriters Laboratories approved hospital grade three-prong plug. If personal electric equipment is approved for use by physician and has only a two prong electric cord, Engineering **or Biomed** will **verify that the unit is** ~~provide for use a GFCI (Ground Fault Circuit Interrupter) adapter.~~ **a Class II or double insulated appliance.**
3. Process requirements for all inspections will be maintained and utilized by each division of the Engineering Department specified by division specialty.
4. The Clinical and Building Engineering divisions are responsible for performing inspections, labeling, and documenting inspection data, on all equipment covered under this policy.
5. All electrical equipment designated for use anywhere within ~~the Medical Center~~**TCHD** shall be inspected and tested by Clinical or Building Engineering Division before initial use.
6. All patient care equipment with direct patient connection (internal and external) designated for use anywhere within ~~the Medical Center~~**TCHD** shall be inspected and tested by the Clinical Engineering division.
7. Any equipment failing to pass the applicable electrical safety tests will not be approved for hospital use until such deficiencies have been corrected.

C. **FORM(S):**

1. **Electrical Appliance Safety Check Form- Sample**

D. **REFERENCE(S):**

1. **California Department of Public Health, Title 22 California Code of Regulations**

**Electrical Appliance Safety Check Form- Sample**

## TRI-CITY HOSPITAL DISTRICT

## ELECTRICAL APPLIANCE SAFETY CHECK

Electrical Appliance Property of _____

Room # _____ Date _____

_____

_____

The below listed electrical appliances have been found safe/unsafe for patient use during his/her hospital stay or for employee use in accordance with California and Federal Occupational Safety and Health Act requirements, with the following exceptions:

_____

_____

_____

_____

Approved Appliances:

1._____Model #_____Serial #_____

2._____Model #_____Serial #_____

3._____Model #_____Serial #_____

4._____Model #_____Serial #_____

Examined By_____
(Signature of Engineer) Date

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

**Administrative Policy Manual**

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**ISSUE DATE:** 04/91 **SUBJECT:** **WEAPONS ON MEDICAL CENTER CAMPUS**

**REVISION DATE:** 06/99; 09/05; 11/08; 03/11; 08/14 **POLICY NUMBER:** 8610-284

| | |
|---|---|
| **Department Review:** | **05/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~07/14~~05/17** |
| **Professional Affairs Committee Approval:** | **~~08/14~~06/17** |
| **Board of Directors Approval:** | **08/14** |

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A. **PURPOSE:**

1. To provide guidelines for all Security Department personnel, for insuring that patients and visitors are not permitted to bring weapons upon the **Tri-City Healthcare District** ~~Medical Center~~ **(TCHD) property**~~campus~~.

B. **DEFINITION(S):**

1. Weapons include firearms, knives, night sticks, brass knuckles, and other items defined as weapons by California and federal law.

C. **POLICY:**

1. It is the primary objective of the Security Department to provide a safe and secure environment for all Patients, Visitors, and Staff Members and free of any weapons, which could cause bodily harm or injury.

D. **PROCESS:**

1. Whenever a Security Officer discovers or is notified by staff of the presence of a weapon in the possession of a patient, visitor, or staff member, the Security Officer will immediately respond to the location of occurrence.
2. After evaluating the circumstances of the situation, the responding Security Officer, utilizing the following options, will determine the most practical and safe way to secure the weapon.
   - ~~3.~~**a.** If upon admission a patient brings a weapon into ~~the Medical Center~~**TCHD**, the weapon will be confiscated and released to a responsible family member.
   - ~~4.~~**b.** If a family member is not present, the weapon will be confiscated, made safe, placed in a proper container and locked in the Emergency Department Security Office (EDSO) for safekeeping. A ~~"~~Property Custody~~"~~ **232** ~~f~~Form will be completed with the receipt given to the patient and the department copy attached to the item. If the patient informs the Behavioral Health Liaison (BHL) that they have weapons in their possession or in their vehicle, or anywhere on TCHD~~MC~~ property, the BHL is to notify security, the patient's **Emergency Department** (ED) physician, the charge nurse, and the patient's nurse immediately. Security will ensure that the weapons are secured per security's policy. If the patient is refusing treatment is a danger to self or others, a 5150 must be initiated. If the patient agrees to voluntary treatment, she/he must be allowed to do so, but must be placed on a 5150 if they attempt to leave Against Medical Advice (AMA). **Refer to Patient Care Services: 72-Hour Hold, Evaluation and Treatment of Involuntary Patient policy.**
   - ~~5.~~**c.** If the patient is already in a patient care area, the Security Officer will confiscate the weapon and follow the procedure as stated above in a timely manner.
   - ~~6.~~**d.** If it is determined that a Visitor had entered the ~~Medical Center~~**TCHD** in possession of a weapon, the Security Officer will make contact and inform the visitor of this policy. The

visitor will then be directed to immediately remove the weapon from ~~the Medical Center campus~~**TCHD** or turn the weapon over to the Security Department for safekeeping. If the weapon is given to the Security Department for safekeeping,"Property Custody" form will be completed.

~~7.~~**e.** If a Patient or Visitor is unwilling to secure the weapon, the Security Supervisor/Shift Lead will be informed of the situation and attempt to gain cooperation with the individual.

~~8.~~**f.** If a Patient or Visitor is displaying the weapon in a reckless manner, causing a disturbance, or problem, threatening to cause a problem or disturbance, or is placing unusual/unreasonable demands on the staff, the responding Security Officer will only attempt contact if the safety and security of all involved parties will not be placed in jeopardy.

~~9.~~**g.** If the situation has escalated to the point where there is a high probability of harm or injury occurring, the responding Security Officer will **dial 911 and** immediately ensure that the Oceanside Police Department is contacted for assistance. The Security Officer will also ensure that an attempt is made to remove all persons from the immediate location safely.

~~10.~~**3.** Police Officers or Correctional Officers, who are guarding a "Police Hold"/in-custody patient, are permitted to carry weapons while discharging their duties. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.

**4.** Police Officers or Detectives questioning or interviewing a patient, employee or physician are permitted to carry weapons. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.

**5. Law Enforcement, being seen as a patient, will relinquish their weapon to a co-worker or security until discharged~~ for the District~~.**

**E. <u>RELATED DOCUMENT(S):</u>**

1. **Property Custody Form 232 – Sample**
2. **Refer to Patient Care Services: 72-Hour Hold, Evaluation and Treatment of Involuntary Patient Policy**

**Property Custody Form 232**

**Tri-City Medical Center**
**Security Department**
# Property Custody Record

**Notice to Property Owner:** Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

| Officer Receiving Property: | Date Received: | Time Received: |
|---|---|---|
| | | |

Property Received from:

- ❑ Owner: _____
- ❑ Other: _____

Location / Reason Property Obtained:

_____
_____
_____

❑ Property Received for Safekeeping

| Item # | Qty | Description / Condition: | SN / Tag # |
|---|---|---|---|
| | | | |

**Property Disposition:**

- ❑ Property Returned to Owner
- ❑ Property Returned to Other — Reason: _____
- ❑ Property Destroyed After Thirty(30) Days
- ❑ Property Destroyed Before Thirty(30) Days — Reason: _____

| Property Returned By: | | |
|---|---|---|
| Officer: | Badge: | Date: |

| Property Received By: | |
|---|---|
| Signature: | Date: |

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Tri-City Medical Center
Oceanside, California

**EDUCATION DEPARTMENT ~~MANUAL~~**

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**SUBJECT: AHA TRAINING CENTER: RECORDS MANAGEMENT**

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

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **06/17** |
| **Board of Directors Approval:** | **07/13** |
| **~~BOARD OF DIRECTORS APPROVAL DATE(S): 8/07, 4/10; 7/13~~** | |

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A. **POLICY:**

1. The **Tri-City Healthcare District** (TCHD~~MC~~) may store **American Heart Association** (AHA) records electronically or by hard copy. Electronic files must be backed up on a regular basis to protect against loss. All records must be maintained for at least three years from issue date. All electronic records must have the ability to be printed into hard copy upon request.
2. Training Center (TC) records may be stored at a Training Site as long as they are accessible during a TC review/audit at an off-site storage site (Iron Mountain)
3. An Instructor may align with only one primary TC per discipline. The primary TC is responsible for maintaining the Instructor's file and documentation of the Instructor's teaching activity.
4. The TC must maintain the following documents:
   a. An original or a copy of the current signed TC Agreement.
   b. Documentation that the TC has the appropriate minimum general liability insurance coverage or waiver as stated in the TC Agreement.
   c. Copies of training bulletins, memos, and other official correspondence from the National Center **Emergency Cardiovascular Care** (ECC) Department and Regional ~~EDD~~ **ECC** Office and evidence that these were conveyed to Training Sites and Instructors (by website, email, memo, newsletter, etc.)
   d. A current list of Training Sites and contact information
   e. Documentation of any deficiencies identified during a TC review and corrective action taken.
   f. A TC-specific outline for each type of course provided by the TC.
   g. The following written policies and procedures:
      i. Equipment/manikin maintenance and decontamination
      ii. Quality Assurance Plan (updated annually)
      iii. Internal TC dispute resolution policy
      iv. Training Site management/relations
      v. Management of Instructor communications and updates
5. Instructor and **Training Center Faculty** (TCF) Records (All Disciplines: **Advanced Cardiac Life Support** (ACLS), **Pediatric Advanced Life Support** (PALS) and **Basic Life Support** (BLS)) will include the following:
   a. Instructor/TCF Candidate Applications (Instructor/TCF Courses only) of all Instructor aligned with that TC
   b. Completed Instructor/TCF Monitor Forms
   c. Instructor/TCF Renewal Checklists
   d. Instructor/TCF Teaching Activity Notice to Primary TC
   e. Instructor/TCF Records Transfer Requests
   f. Instructor Course Completion Notice to Primary TC

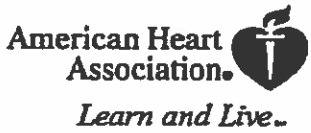
g. Documentation of administrative or disciplinary actions taken

6. Instructor Records Transfer Records Process
   a. Since a TC appoints TCF, TCF may not transfer to another TC as a TCF; they will transfer as an Instructor.
   b. Instructor/TCF member wanting to transfer to another TC must complete an Instructor Records Transfer Request.
   c. The new primary TC signs and returns the request to the Instructor/TCF member, who sends the form to his/her original primary TC.
   d. The original primary TC sends complete, up-to-date, original records to the new primary TC within 30 days of receiving the Instructor/TCF Records Transfer Request. The original primary TC will keep back-up copies of the Instructor's record for at least 30 days.
7. Files for Provider and Instructor Courses will contain the following documents:
   a. Completed (all sections) course rosters for each class.
   b. Any and all documentation related to problem resolution (attach to roster).
   c. A summary of course evaluations (used by students to rate the course and Instructor); if no problems are identified; original evaluation if there are potential problems.
   d. Students written examinations answer sheets and skills performance sheets/cards.
   e. Evidence of use of the AHA course fee disclaimer for courses in which fees are charged. See page 27 of the **Program Administrative Manual** (PAM) for wording of this disclaimer.
   f. Instructor Candidate Applications (Instructor Courses only) of all Instructors aligned with that TC may be kept in either the Instructors files or course files. Applications of Instructors not aligned with that TC should be kept in the course files.

B. **FORM(S):**
   1. AHA Instructor Records Transfer Request - **Sample**
   2. AHA Course Roster - **Sample**
   3. AHA Instructor Candidate Application - **Sample**

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

## AHA Instructor Records Transfer Request – Sample




**American Heart Association Emergency Cardiovascular Care Program**

# Instructor Records Transfer Request

1. **When a TC agrees to accept an Instructor, the TC Coordinator signs and sends this form to the Instructor.**

   Our TC is willing to accept _____ as an Instructor at our facility. We agree to keep and maintain all Instructor records in accordance with the TC Agreement.

   Signature of TC Coordinator: _____ Date
   TC address: _____
   _____
   Phone: _____ Fax: _____

2. **The Instructor completes the following information and sends it to the TC currently holding his/her Instructor records.**
   I, _____, authorize the transfer of my Instructor records from _____ TC to _____TC.

   Instructor's home address: _____
   _____
   Home phone: _____ Work phone: _____

   Check discipline(s) for which you are requesting a records transfer:
   ☐ BLS ☐ Heartsaver Instructor ☐ ACLS ☐ PALS

3. **After verifying and completing this form, the Instructor's current TC transfers the Instructor's records to the new TC. All applicable Instructor records as outlined in Chapter 5 of this manual must be transferred.**

   The transferring TC must keep copies of all transferred records for 30 days.

4. **The new TC contacts the Instructor when the transfer is complete.**

5. **The TC Coordinator from the current TC signs and dates this form when the records have been transferred.**

   Signature of TC Coordinator: _____ Date: _____
   TC Address: _____
   _____
   Phone: _____ Fax: _____

## AHA Course Roster - Sample

DATE _____ COURSE _____ ___ INSTRUCTOR _____ ___

**Course Participants**

| *NAME*<br>*Please PRINT as you wish your name to appear on your card.* | *Address* | *Telephone* | *Complete/ Incomplete* | *Exam Score* | *Expected Monitoring Date* |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

## AHA Instructor Candidate Application - Sample

American Heart Association
*Learn and Live.*

**American Heart Association Emergency Cardiovascular Care Program**

# Instructor Candidate Application

**Instructions:** To be completed by Instructor candidate with appropriate signatures. Please complete one application for *each* discipline.

Name (with credentials): _____

Mailing address: _____

Phone: _____ Fax: _____

Email _____

Type of Instructor Course: ☐ Heartsaver ☐ BLS ☐ ACLS ☐ PALS

Recommended renewal date of Provider card in discipline in which candidate is seeking Instructor status: _____

**Instructor Commitment:** As an AHA Instructor, I agree to teach at least four courses in two years in accordance with the guidelines of the American Heart Association. I also agree to strengthen and support the Chain of Survival and the mission of the American Heart Association in my community.

_____
Signature of Instructor Candidate Date

**TC Alignment:** I approve this application and grant alignment with this Training Center for this applicant. I agree to all responsibilities for this Instructor as outlined in this manual.

Name of Training Center: _____

Signature of TC Coordinator: _____ Date: _____

**Verification of Instructor Potential:** I verify that this Instructor candidate has achieved a score of 84% or higher on the Provider written examination in the discipline for which he/she is applying and has completed at least *one* of the following options:

- ☐ Has been identified as having Instructor potential during performance in a Provider Course
- ☐ Has demonstrated Instructor potential during a screening evaluation
- ☐ Has demonstrated exemplary performance of Provider skills under my direct observation

_____
Signature of TCF/Course Director/Lead Instructor (circle appropriate title) Date

Instructor Candidate Application, Revised March 2004

Tri-City Medical Center
Oceanside, California

**EDUCATION DEPARTMENT ~~MANUAL~~**

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**SUBJECT: AHA TRAINING CENTER: SAFETY GUIDELINES / SAFETY FOR AHA COURSE PARTICIPANTS**

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

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **06/17** |
| **Board of Directors Approval** | **07/13** |
| **~~BOARD OF DIRECTORS APPROVAL DATE(S): 8/07; 4/10; 7/13~~** | |

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A. **PURPOSE:**

1. To recognize the risk of potential injury and methods of reducing the chances of injury during **American Heart Association** (AHA) courses at **Tri-City Healthcare District** (TCHD~~MC~~).

B. **POLICY:**

1. The ~~TCMC~~ **TCHD** AHA **Training Center** (TC) employs decontamination policies of manikins, equipment and equipment surfaces consistent with **Centers for Disease Control and Prevention** (CDC) guidelines and **Emergency Cardiovascular Care** (ECC) recommendations to minimize the risk of infectious disease transmission
2. TC equipment is maintained in accordance with manufacture guidelines
3. Equipment is maintained in a secure locked closet
4. Equipment is monitored by **Training Center Coordinator** (TCC) and reported to ~~TCMC~~ **TCHD** maintenance department for repair in a timely fashion
5. Participants are encouraged prior to each course to notify Instructor of any physical limitations or disability which could lead to injury of self or other participant or Instructor
6. Stools, chairs, tables, gloves, tissue and hand sanitizer are available for all Instructors and course participants
7. All participants are instructed on location of emergency exits prior to each course
8. Proper rest periods for course participants are outlined and followed per AHA course agenda
9. Personal Protective equipment is available to Instructors along with proper training of procedure.
10. Safety policies are continually reviewed and updated
11. Participants have the option of reserving ahead their own manikin if they have a condition/ailment or communicable disease that could potentially harm other participants, such as a cold, Hepatitis B or **Human Immunodeficiency Virus**~~HIV~~, or a condition that could predispose self to infection
12. TCMC AHA TC upholds an anti-discrimination policy for all participants and Instructors

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

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

Tri-City Medical Center
Oceanside, California

**EDUCATION DEPARTMENT ~~MANUAL~~**

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**SUBJECT: CONTINUING EDUCATION COURSE CRITERIA**

**ISSUE DATE: 06/03**
**REVISION DATE(S): 08/07, 04/10, 07/13**

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **06/17** |
| **Board of Directors Approval:** | **07/13** |
| **~~BOARD OF DIRECTORS APPROVAL DATE(S): 8/07; 4/10, 7/13~~** | |

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A. **POLICY:**

1. Since many healthcare professionals are required to accumulate continuing education hours for re-licensure, the Education Department maintains approved continuing education provider status from the California Board of Registered Nursing **(BRN)** ~~and the California Board of Behavioral Sciences~~.
2. Continuing Education (CE) courses provided at the Medical Center meet the documentation requirements of the **BRN**~~appropriate professional board or licensing agency~~. The Education Department maintains current information on the documentation required by **the BRN**~~each professional board or licensing agency~~. Education staff **is** ~~are~~ available to assist in development of required course documentation.
3. Each contact hour is at least 50 minutes of instruction in an organized learning experience.
4. BRN Approved CE: The course file is maintained by the Education Department for **six (6) years per Board Policy, which satisfies the four** (4) years ~~according to the~~ BRN policy.
   ~~a. Packets submitted late may result in a loss of CE credits for the participants.~~
   ~~b.~~**a.** ~~Non-CE classes: Paper work will be maintained within the department course is given.~~**Class files will be retained by the Education Department.**
   ~~c.~~**b.** CE credits will appear in your NetLearning transcript as an employee of ~~TCMC~~**Tri-City Healthcare District (TCHD).**
   ~~d.~~**c.** Additional paperwork needed for paid speakers:
      ~~e.~~**i.** Submit signed contract to Director of Education and Clinical Informatiics.
      ~~f.~~**ii.** Submit completed W-9.
5. ~~Continuing Education~~**CE** course files must contain goals, objectives, handouts, course evaluations and up-to-date speaker CVs.
6. ~~Continuing Education~~**CE** credits are processed according to the **BRN**~~appropriate board or agency regulations~~, and are issued to each participant who has fulfilled course requirements. Continuing education credits are issued and tracked by the Netlearning software (refer to Netlearning documentation manual).
7. Classes offered by departments other than Education must comply with the documentation requirements of the appropriate board or licensing agency in order for ~~continuing education (~~CE~~)~~ credits to be issued.
8. Nonattendance by staff for a class in which they have registered will be tracked ~~on the attendance sheet and~~ in NetLearning. Any refunds for monies issued will be given based on the criteria established and advertised for the class.
9. If a course is cancelled, education staff will notify all registrants and every attempt will be made to reregister the individuals into a similar class. Netlearning will be updated to reflect the class cancellation.
10. Courses not completely attended by participants will not receive ~~full~~ CE credit hours.
11. Instructors can receive full ~~(~~CE~~)~~ credit for any courses they co-teach when they attend the **entire**~~whole~~ course and complete all course requirements.

B. **EXTERNAL LINK(S):**

1. California Board of Registered Nursing. Continuing Education. http://www.rn.ca.gov/

C. **REFERENCE(S):**

1. California Board of Registered Nursing Continuing Education Program -- Instructions for Providers

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

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

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT MANUAL

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**SUBJECT: EDUCATION: DOCUMENTATION OF ACTIVITIES**

**ISSUE DATE: 03/03**
**REVISION DATE(S): 06/07, 03/10, 07/13**

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **06/17** |
| **Board of Directors Approval:** | **07/13** |
| ~~**BOARD OF DIRECTOR APPROVAL DATE(S): 6/07; 3/10; 7/13**~~ | |

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A. **POLICY:**

1. The documentation system in the Education Department is designed to address two major components: document education activities provided by the Education Department and other departments/units and maintain a system of administrative record keeping that facilitates effective department function and meets the needs of regulatory agencies.
2. NetLearning is a system used to document education activities in two ways:
   a. NetLearning is used for all class registration, and mandatory training tracking. The multi-function structure of the program allows the end-user to access and print attendance rosters, individual continuing education files, and class statistic summaries.
   b. NetLearning also utilizes computer-based modules to educate staff on mandatory topics such as Fire Safety, Infection Control, Hazardous Materials, Electrical Safety, and Bloodborne Pathogens. When the learner completes the test for each module required for his/her job code, the NetLearning system automatically records the module completion and maintains a student transcript.
3. Class file folders maintained in the Education Department area are also part of the documentation system for education activities. The file folders include goals, objectives, sample handouts, instructor resume, post tests (if applicable), attendance roster and completed course/instructor evaluations.
4. The class file folders for the current year are stored in the office area of the Education Department. These are filed alphabetically according to class title.
5. At the completion of each calendar year, the continuing education files are removed from the Education Department area and stored in a closet in Assembly Room #1 or offsite for older files. These are also filed alphabetically according to class title**, and by calendar year**.
6. The class file folders are retained for ~~four (4)~~ **six (6)** years as required by the California Board of Registered Nursing and various other continuing education provider accrediting agencies. Retrieval is always available to the Education Department staff.
7. Program participants may view their own education transcript and record of scores and attendance at any time. Immediate supervisors of program participants may view their staff's records. Any other individual requesting access to the permanent educational records must demonstrate "need to know" to the satisfaction of the Director of the Education Department. All confidential records are disposed of using a locked confidential disposal bin.

~~A. **APPROVAL PROCESS**~~

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

Tri-City Medical Center
Oceanside, California

**EDUCATION DEPARTMENT ~~MANUAL~~**

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**SUBJECT: LIBRARY: REFERENCE SERVICES**

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

| | |
|---|---|
| **Department Approval:** | **02/17** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Professional Affairs Committee Approval:** | **06/17** |
| **Board of Directors Approval:** | **07/13** |
| **~~BOARD OF DIRECTORS APPROVAL DATE(S): 7/05, 8/07, 4/10, 7/13~~** | |

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A. **PURPOSE:**

1. To establish guidelines for the provision of reference services at Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)**.

B. **POLICY:**

1. Mission of Reference Services:
   a. The primary mission of the reference consulting services at ~~Tri-City Medical Center~~ **TCHD** is to provide the highest quality reference and information services in support of clinical patient care as well as the learning, and research of the physicians, staff, volunteers and students. Recognizing that modern information resources are complex and that information is a valuable commodity, the Information Specialist strives to provide appropriate advice and consultation regarding various options, **to provide useful, relevant, evidence-based information that is highly specific to the information request while ensuring that every possible resource is searched,** and to educate library users concerning resources in order to help them become effective users and consumers of all types of information.
   b. Reference Services Guidelines:
      ~~1)~~**i.** To provide the highest quality reference service ~~that all~~**to all** library users **ensuring that users** receive prompt, individualized, and complete services during every transaction. ~~A~~ **Reference services are conducted in a** courteous, helpful, and objective ~~demeanor is essential to delivering such services~~**manner in order to ensure the user feels comfortable which enables a professional exchange of information**. No reference transaction should be concluded until every possible effort has been made to meet the patron's information needs.
   c. Ethical reference work requires that all transactions be kept confidential, respecting the ~~patron's~~ **user's** privacy in accordance with HIPAA privacy practices and that equal levels of service be provided to all, without bias or discrimination of any kind.
2. Concerning medical questions, the Information Specialist must assist clients with locating the information they require, but cannot interpret or comment on the content of that information.
3. Accuracy is an important goal of reference service, but the reference service provider cannot guarantee the accuracy of any published information. However, the reference services provider should advise clients that it is their responsibility to evaluate and verify the accuracy of an information resource.
4. Every effort will be made to ensure that the patron is informed of the status of pending reference requests. Every attempt will be made to fulfill requests within deadlines.
5. Reference Collections. The electronic and print reference collection at the ~~Tri-City Medical Center~~ **TCHD** consists of materials that support the information needs of the hospital's physicians and staff. The collection development policy (~~May~~**December**, ~~2013~~**2016**) documents the content and descriptions of the collection.

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

~~D.~~C. **RELATED DOCUMENT(S)**

1. **Education Department Policy:** Library Collection Development and Organization Procedure

| Tri-City Medical Center | Patient Care ServicesEm | TRACKED CHANGES |
|---|---|---|
| PROCEDURE: | VIDEO LARYNGOSCOPEGLIDESCOPE SET-UP & CLEANIN (SATURNBIOMEDICAL) | |
| Purpose: | To establish a standard of care when setting-up and cleaning the **video laryngoscope**glide scope | |
| Supportive Data: | The Glide Scope**video laryngoscope** is an instrument used by physicians to effectively manage standard to difficult intubations. The Glide Scope**video laryngoscope** provides an unobstructed view of the vocal cords through the use of advanced video technology. The device is a non-sterile product that is reusable and requires proper cleaning between patients. | |
| Equipment: | Glide Scope Video Llaryngoscopey Ssystem and the Steris **sterilizer** wash machine (located in the Operating Room). | |

A. **AUTHORIZED TO PERFORM:**

1. Respiratory Care Practitioners (RCP) or EMT staff members trained in the usage of the Glide Scope.

B.A. **INDICATIONS FOR USE:**

1. Physicians may request the Glide Scope**Video Laryngoscope** for any intubation.

C.B. **SET-UP:**

1. **See manufacturer's recommendation for** Attach the Glide Scope**video laryngoscope system**to the monitor by inserting the cable into the port located on the side of the monitor so that the arrows on the cable and monitor are aligned.
2. Insert the other end of the connector cable into the port located on the handle of the Glide Scope. *Note:* Use the grey sleeve when connecting the connector cable.
3. Power up the Glide Scope system by pressing down the power button on the face of the monitor.

D.C. **PROCEDURE:**

1. The Glide Scope is used by physicians to intubate patients.
1. After the procedure is completed, the RCP or EMT:
   a. rRemove**s** the Glide scope**video laryngoscope** handle **(including cable if applicable)** from the **monitor**connector cable.
   b. **Ensure**Caution: Tthe Glide Scope**video laryngoscope** MUST have**has** the rubber protective cap inserted thoroughly into the handle port, **if applicable,** prior to any cleaning being done to prevent damage to the electronic connector
   2.c. **Transport** Tthe used Glide Scope**video laryngoscope** handle **to the Sterile Processing Department (SPD) in a closed biohazard container with a patient label on the outside of the container**is to be placed in a clean plastic bag and taken to the dirty utility room for initial disinfection. Do not replace the handle into the monitor cradle after use.
      i. **The scope is usually ready for pick-up within one hour.**
      i.ii. **Surgical Services will clean the video laryngoscope, and cord if attached, in the department.**
   3.d. **Wipe down** The cable is disconnected from the Glide Scope**the video laryngoscope** monitor, wiped down with a Sani-Wipe or other currently**a hospital** approved cleansing wipe and then placed back in the Airway Cart.

E. **INFECTION CONTROL:**

| Department Review | Department of Emergency Medicine | Clinical Policies & Procedure | Nurse Executive Committee | Pharmacy and Therapeutics | Infection Control Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 1/06; 02/11; 10/14 | 10/14 | 11/16 | 01/17 | n/a | 04/17 | 01/15, 05/17 | 06/17 | |

1. ~~Insert the rubber protective cap thoroughly into the connector cable port.~~
2. ~~Wipe down the exterior of the device with enzymatic detergent or equivalent for removal of all foreign material from the surface of the device.~~
3. ~~Once the Glide Scope has been wiped down and there is no foreign material left on the scope handle, it should be placed into the Steris tray, marked with "Emergency Department".~~
4. ~~The tray is then transported by an RCP or EMT to the Operating Room Central Desk.~~
5. ~~The Operating Room Central Desk representative will notify the Instrument Technician or Instrument Coordinator that a Glide Scope has been received from the Emergency Department that requires sterilization through the Steris system.~~
6. ~~The scope is ready for pick-up within an hour.~~
7. ~~If an emergency occurs that requires a Glide Scope blade handle while the Emergency Department's is being sterilized, a loaner Glide Scope blade handle from the OR Difficult Airway Cart will be provided.~~

| Tri-City Medical Center | Patient Care Services | CLEAN COPY |
|---|---|---|

| | |
|---|---|
| **PROCEDURE:** | **VIDEO LARYNGOSCOPE SET-UP & CLEANING** |
| Purpose: | To establish a standard of care when setting-up and cleaning the video laryngoscope |
| Supportive Data: | The video laryngoscope is an instrument used by physicians to effectively manage standard to difficult intubations. The video laryngoscope provides an unobstructed view of the vocal cords through the use of advanced video technology. The device is a non-sterile product that is reusable and requires proper cleaning between patients. |
| Equipment: | Video laryngoscope system and the Steris sterilizer machine (located in the Operating Room). |

A. **INDICATIONS FOR USE:**

1. Physicians may request the Video Laryngoscope for any intubation.

B. **SET-UP:**

1. See manufacturer's recommendation for the video laryngoscope system.

C. **PROCEDURE:**

1. After the procedure is completed:
   a. Remove the video laryngoscope handle (including cable if applicable) from the monitor.
   b. Ensure the video laryngoscope has the rubber protective cap inserted thoroughly into the handle port, if applicable, prior to any cleaning being done to prevent damage to the electronic connector
   c. Transport the used video laryngoscope handle to the Sterile Processing Department (SPD) in a closed biohazard container with a patient label on the outside of the container
      i. The scope is usually ready for pick-up within one hour.
      ii. Surgical Services will clean the video laryngoscope, and cord if attached, in the department.
   d. Wipe down the video laryngoscope monitor with a hospital approved cleansing wipe.

| Department Review | Clinical Policies & Procedure | Nurse Executive Committee | Pharmacy and Therapeutics | Infection Control Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|
| 1/06; 02/11; 10/14 | 11/16 | 01/17 | n/a | 04/17 | 01/15, 05/17 | 06/17 | |

Tri-City Medical Center
Oceanside, California

**MEDICAL STAFF POLICY**

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**ISSUE DATE:** 02/10

**SUBJECT:** Discharge Planning for Pediatric and Adolescent Patient

**REVISION DATE(S):**

**POLICY NUMBER:** 8710-561

| | |
|---|---|
| **Medical Staff Department Approval:** | ~~02/10~~03/17 |
| **Department of Pediatrics Approval:** | 05/17 |
| **Medical Executive Committee Approval:** | ~~02/10~~05/17 |
| **Professional Affairs Committee Approval:** | 06/17 |
| **Board of Directors Approval:** | 02/10 |

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A. **PURPOSE:**

1. To facilitate an organized discharge planning program for the timely and efficient discharge of the adolescent and pediatric patient.
2. To ensure that every patient has a comprehensive Care Management plan that strives to meet each patient's present and future needs.
3. To provide a systematic, multidisciplinary, and coordinated process that begins upon admission to the facility and continues throughout the patient's stay.

B. **POLICY:**

1. Discharge planning is an integral part of the inpatient Care Management process and serves to identify those patients who require continued healthcare services after acute hospitalization.
2. Discharge planning provides a systematic, multidisciplinary, and coordinated process for patients that are treated in the Emergency Department and require out-patient follow-up.
3. The Interdisciplinary Team is composed of the Medical Staff, Care Manager, Social Workers, Nursing, Dietary, Physical, Occupational, and Speech Therapy, Pulmonary Therapists, wound care staff, and any other staff that contribute to the development of a comprehensive discharge plan.
4. The activities and assessments of the interdisciplinary team lead to the development of an individualized treatment plan for the patient.

C. **PROCEDURE:**

1. All new admissions are initially screened at the point of entry into the system this includes the patients treated in the Emergency Department for potential discharge needs using the Care Management Initial Discharge Planning Assessment form.
2. The initial discharge screening includes an assessment of at least but not limited to the following:
   a. Reason for admit and social and financial issues affecting patient
   b. Living arrangements prior to admission (e.g., home with family)
   c. Family support system
   d. Medical condition and limitations prior to admission
   e. Services in place prior to admit (e.g., DME, Home Health, CCS)
   f. Mental Status
   g. Parents or others ability to participate in decision regarding care
   h. Recent major life events
3. All discharge materials shall be provided in the primary language of the patient/family.
   a. The Care Manager shall communicate the appropriate primary language to the post hospital health care providers/companies at the time of referrals.
4. The Care Manager and Social Worker shall:
   a. Ensure all referrals are made to CCS providers.

b. Discuss the case with the attending/consulting physician(s) to determine if the condition is CCS eligible and design the plan of care based on this information.
c. Discuss with the physician any identified specific CCS Specialty Care Centers for post-discharge referral and identify all appropriate sources of follow-up care including referral to CCS-approved providers and the CCS Medical Therapy Program. These shall also include any care provided within the Emergency Department that requires out-patient follow-up.
d. Collaborate with the attending physician to make referrals to appropriate CCS special care centers. This includes working with the local CCS program to choose the most appropriate center. CCS policy 08-0900 defines the conditions that require referral to a special care center.
e. Identify interdisciplinary services that must be provided while inpatient to ensure a timely discharge.
    i. Interdisciplinary Services shall include teaching services, dietitian consult, wound care, and any further follow-up care that is required.
f. Make referrals to the local CCS program(s).
    i. If the appointment can be made before discharge, this shall be on the discharge instruction sheet.
    ii. If the appointment cannot be made before discharge, the special care center contact number and information shall be provided to the patient/family to make their own appointment.
g. Collaborate with the PT/OT/ST for:
    i. Referrals to the local medical therapy units (MTU).
    ii. DME related to PT/OT/ST needs
h. Identify all post acute alternative levels of services (e.g., rehabilitation, LTAC). The Care Manager must develop a "best" plan as well as a back up plan.
    i. These plans shall include identification of an established CCS paneled Primary Care Physician (PCP) for follow-up care prior to discharge or if there isn't a PCP of record, work with the patient in identifying a PCP for follow-up care.
    ii. All identification and coordination shall be made for all appropriate programs/providers including CCS paneled providers that are appropriate for patient referral to include:
        1) Social Work referral to the CCS Care Manager
        2) Mental health or Regional center,
i. Collaborate with the nutritionist for special dietary needs.
j. Collaborate with the respiratory therapist for any respiratory issues, education and need for any respiratory equipment upon discharge.
k. Document the discharge plan and any additional patient/family communication in the Cerner Clinical Note system with anticipated discharge dates as soon as possible.
    i. If a delay in documentation is anticipated, communication with Care Management team must take place and/or a note placed in the progress note section of the medical record.
    ii. Documentation MUST be completed no later than the end of the shift. Additionally, this documentation shall include all CCS-referrals for adolescents needing Special Care Center referrals
l. Submit a copy of the discharge summary to the local CCS program office for CCS-eligible clients who have been referred to CCS or have authorizations for care from a CCS program.
    i. Documentation that this was provided shall be placed in the medical record.
m. Re-evaluate the plan of care and the anticipated discharge plan at least every 2 days to modify as needed and at least 24 hours before the anticipated discharge to ensure all equipment or items needed in the home are provided PRIOR to discharge.
n. Verify if an uninsured patient's condition (whether the patient is in the Emergency Department or Inpatient) is a CCS eligible condition prior to discharge and ensure

alternative arrangements for transportation, medication, or destinations have been discussed with the patient and family.
    i. If transportation is an issue, provide bus pass to community placement or a private option.
    ii. If oral medications are an issue, provide a one-week supply of medication. This service is provided to prevent further hospitalization or possible exacerbation of illness
o. Communicate to the Unit Coordinator the appropriate Discharge Disposition category for entry into the medical record.

5. Nursing shall ensure:
    a. Discharge orders are written
    b. Discharge instructions include any medication instructions on the discharge form, instructions addressing diet ,activity, equipment, other therapies, and follow up information
    c. Medications are obtained and instructions for use provided to patient/family.
        i. Instructions shall be written without medical/nursing abbreviations
    d. A written summary is available at the time of discharge, provided to the patient, and documented in the medical record.
6. The clinical dietitian shall
    a. Participate in patient care rounds
    b. Assess and reassess nutrition status
    c. Identify and address any food related issues
    d. Educate the patient and family regarding nutrition related issues.
    e. Ensure the patient/family are provided with education and literature prior to discharge and shall document in the medical record.
        i. Any ongoing outpatient nutritional referrals shall be made with collaboration between the Care Manager and the nutritionist.
            1) If the appointment can be made before discharge, this shall be on the discharge instruction sheet.
            2) If the appointment cannot be made before discharge, then the outpatient nutritionist phone number would be provided so they can make their own appointment.
7. Physical Therapy (PT) shall design a plan that addresses the patient's functional status and mobilization, including need for DME and assistive devises.
    a. If ongoing therapy shall be provided by the local MTU, the therapy staff shall call the MTU to discuss current progress with therapy in the unit as well as fax or mail a copy of the discharge therapy note.
8. Occupational Therapy (OT) shall:
    a. Evaluate activities of daily living and the patient's ability to accomplish self-care based upon assessment and medical condition
    b. Collaborate with the interdisciplinary team in identifying the patient's plan of care and post discharge needs
    c. Identify the third party payors or other CCS providers regarding durable medical equipment, home health and other referrals
        i. If ongoing therapy shall be provided by the local MTU, the therapy staff shall call the MTU to discuss current progress with therapy in the unit as well as fax or mail a copy of the discharge therapy note.

~~**Approvals:**~~
~~**Department of Pediatrics Approval: 02/10**~~
~~**Medical Executive Committee Approval: 02/10**~~
~~**Board of Directors Approval: 02/10**~~

Tri-City Medical Center
Oceanside, California

**MEDICAL STAFF POLICY ~~MANUAL~~**

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**ISSUE DATE:** 05/08

**SUBJECT:** Influenza Vaccination of ~~Licensed Independent Practitioners~~ ~~(~~Physicians and Allied Health Professionals (AHP)

**REVISION DATE:** 05/08, 08/12

**POLICY NUMBER:** 8710 – 547

| | |
|---|---|
| **Department Approval:** | 03/17 |
| **Infection Control Committee Approval:** | 04/17 |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~08/12~~05/17 |
| **Professional Affairs Committee Approval:** | 06/17 |
| **Board of Directors Approval:** | 08/12 |

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A. **PURPOSE:**

1. To increase influenza vaccination rates of healthcare workers to provide a healthier work environment and reduce adverse patient outcomes The Centers for Disease Control recommends that all health care workers receive an annual influenza vaccination to prevent transmission to patients. Influenza immunization rates among health care workers remain low, with only 36%-40% of health care workers reporting influenza vaccination each year. Influenza vaccination is an important patient safety issue because unvaccinated staff can spread influenza to patients, coworkers, and family members, leading to influenza-related illness and death. When health care workers become ill with influenza, absenteeism and disruption of care may result. When health care workers transmit influenza to patients, some of them may experience serious, even life-threatening complications or secondary pneumonias. California SB739 states the following: "Each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination." This requirement applies to all health care workers, including physicians.

B. **POLICY:**

1. All **active physicians and Allied Health Professionals (AHP)** ~~Licensed Independent Practitioners~~ at Tri-City **Healthcare District** ~~Medical Center~~**(TCHD)** will participate in the Annual Influenza Vaccination or Declination program.

C. **PROCEDURE:**

1. The program requires **physicians and AHP**~~Licensed Independent Practitioners~~ to either sign the Influenza Vaccine Declination Statement or be vaccinated by November 30 each year, unless the vaccine is unavailable.
2. **Physicians and AHP**~~Licensed Independent Practitioners~~ who begin work at TC**HD**~~MC~~ after November 30 and before April 1 will have 14 days after they begin to sign the Influenza Vaccine Declination Statement or be vaccinated.
3. If the **physicians and AHP**~~Licensed Independent Practitioner~~ fails to be vaccinated at ~~Tri-City Medical Center~~**TCHD**, or submit a signed declination pursuant to 4.6-5, the practitioner's reappointment application will be considered incomplete and the practitioner shall be deemed to have resigned membership in the medical staff within 30 days past the due date.

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

1. **Employee Health & Wellness: Immunization Policy**

## ~~3.~~2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11

~~**Approvals:**~~
~~**Infection Control Committee Approval: 07/12**~~
~~**Medical Executive Committee Approval: 08/12**~~
~~**Board of Directors Approval: 05/08; 08/12**~~

| Tri-City Medical Center | Distribution: Women & Newb | TRACKED CHANGES |
|---|---|---|

| | |
|---|---|
| **PROCEDURE:** | **BREAST MILK MANAGEMENT ~~AND STORAGE~~IN THE NICU** |
| Purpose: | To provide a standardized process for collection, storage and handling of maternal breast milk in the ~~hospital setting.~~**Neonatal Intensive Care Unit ( NICU).** |
| Supportive Data: | Mothers giving their babies pumped milk in the hospital setting is part of a wellness program that hospitals support. If circumstances such as separation of mother and baby occur, then the staff is to provide for and educate the mother in proper pumping, handling and storing of human milk. |
| Equipment: | **1. Hospital-grade electric breast pump**<br>**2. Sterile, rigid, clear plastic (BPA-free) containers with screw-on lid or plastic bags designed for human milk freezing (for collection and storage)**<br>**3. Gloves**<br>**4. Pre-stamped labels bearing two patient identifiers and bar code**<br>**5. Dedicated refrigerator**<br>**6. dedicated freezer that does not self-defrost**<br>**7. Bins in refrigerator or freezer for expressed breastmilk containers**<br>**8. BPA-free, single use, disposable bottles with disposable nipples (for feeding)**<br>**9. Additional Feeding Supplies as needed (e.g., syringe, feeding bag, feeding tube, syringe pump)**<br>**10. Breast milk scanner**<br>**~~1.~~11. Breast milk warmer** |

A. **DEFINITION(S):**

1. **Fresh/Raw Milk** – Expressed breast milk.
2. **Fresh/Frozen Milk** – Freshly expressed breast milk that has been frozen and kept at approximately less than or equal to -20°C (-4° F).
3. **Thawed Milk** – Breast milk that has been previously frozen. Thawed milk must be used within 24 hrs.
4. **Heat Processed Milk** – Fresh-raw and/or fresh frozen milk that has been heat-treated as per milk banking guidelines.

B. **POLICY:**

1. **All mothers should be instructed on the proper techniques of milk collection to minimize bacterial contamination.**
2. **Discourage breastfeeding for:**
   a. **Mothers with HIV**
   b. **Untreated active tuberculosis**
   c. **Infection with human T-cell lymphotrophic virus type I or type II**
   d. **Active herpes simplex virus (H SV) lesions on the breast**
   e. **Mothers who are taking medication that is contraindicated**
   f. **Mothers who are undergoing radiation therapy or chemotherapy with agents such as antimetabolites that interfere with DNA replication and cell division**
   g. **Mothers who are using illicit drugs.**
3. **Breastfeeding is also contraindicated when the neonate has inborn errors of metabolism (for example Galactosemia and Phenylketonuria) and must be fed non–lactose-based formula.**
4. **Do not store breast milk from mothers who are positive for hepatitis B surface antigen (HBsAg) with breast milk for other neonates because of possible contamination.**

| Department Review | ~~Clinical Policies & Procedures~~ | Perinatal Collaborative Practice | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 7/03, 5/06, 6/07, 05/08, 4/10 | ~~02/13~~ | 02/13, 04/17 | n/a | 05/13, 05/17 | 06/13, 06/17 | 06/13 |

C. **PROCEDURE:**

~~**CRITERIA FOR BREAST MILK STORAGE:**~~

1. **Storing breastmilk:**
   a. Gloves ~~should be~~are worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:
      i. **Fresh colostrum**
         1) **Colostrum containers are numbered by the RN in the order it was pumped.**
         2) **Containers are numbered for 5 days unless milk production is delayed. The RN assesses the milk for maturity and discontinues numbering once mature milk is visualized.**
         3) **Each pumping session counts as a single number.**
         4) **The colostrum is fed to the baby in chronological order.**
         5) **Chronologic order takes precedence over fresh versus frozen colostrum.**
         6) **Frozen colostrum shall be thawed and fed in chronologic order.**
         7) **Care shall be taken to keep colostrum fresh as much as possible.**
         ~~1)~~ **After 48 hours of colostrum feeds, colostrum may be alternated with fresh, mature milk.**
         ~~a. 1st two weeks of milk in chronological order~~
      ii. Fresh expressed milk
      iii. Refrigerated milk
      iv. Oldest dated frozen milk
   b. **Breast milk will be stored fresh whenever possible. Only overstock should be stored in the freezer.**
   c. At all times, all containers shall be labeled with patient identification label ~~including infant's name and medical record number.~~ **generated from the TCMC breast milk barcoding system.**
   ~~2. Syringes for feedings shall be changed every 4 hours.~~

~~B. **BREAST MILK STORAGE GUIDELINES:**~~

~~b.~~d. **Breast milk is discarded only when expired or with a physician or allied health professional's (AHP) order.**

~~c.~~e. Breast milk shall be stored as follows in a designated refrigerator/freezer:

| **Breast Milk Storage Guidelines** | | |
|---|---|---|
| Method | ~~Term Infant~~ | Pre-Term or Sick Infant |
| Room temperature less than or equal to 25° C (77° F) | ~~6-8 hours~~ | 4 hours |
| Refrigeration of Fresh Milk less than or equal to 4° C (39° F) | ~~3-5 days~~ | ~~48~~-96 hours |
| Completely Thawed & Placed in Refrigerator (plain or fortified) | ~~24 hours~~ | 24 hours |
| Deep Freezer less than or equal to -20° C (-4° F) | ~~6-12 months~~ | 6 months |
| **Freezer compartment inside refrigerator door** | | **Not Recommended** |

~~5.~~2. Collection **of Expressed Breastmilk**:
   a. Provide instruction **sheet** to ~~MOB~~ **Mother** ~~on~~ "Pumping, Storing & Transporting Breast Milk for hospitalized infants. ~~Parent information sheet given.~~
   b. **Provide *Breast Pumping & Daily Feeding Log* Book with instructions.**
   c. **Encourage mother to bring logbook to NICU. RN and LC (Lactation Consultant) review the pumping log daily, if possible, with mother to monitor progress and to look for areas of need while keeping in mind the goal of 500-1,000ml/day by the end of the first week.**
   d. **Instruct mother in hand washing before and after pumping.**
      ~~1. Direct parent to a pump rental facility and use of in-house pump when parent is at hospital with baby.~~

~~a.~~e. Instruct mother of baby in hand expression and manual pumping as alternative ways of collecting milk.

~~b.~~f. Provide individualized labels **from the TCMC breast milk barcoding system which include infant's last name/gender and medical record number and mother's last name.** ~~with the infant's name and medical record number, containers and lids.~~

**g. Instruct the mother to place expressed milk in a storage container made specifically for human milk storage.**

**h. Instruct mother to write the date and time of collection.**

~~2. When receiving breast milk from babies that are back transferred from other facilities, a TCMC patient label must be applied to all containers received.~~

~~3. Instruct mother to write the date and time of collection.~~

~~4. Instruct mother in hand washing before and after pumping.~~

~~c.~~i. Instruct mother in cleaning ~~collection bottles and flange.~~**pump parts.**

**j. Breastmilk received from infants transferred to the TCMC NICU from other facilities must be relabeled with labels generated from the TCMC breastmilk barcoding system.**

~~d.~~k. Educate mother in how to store breast milk in small volumes to minimize waste.

~~6.~~3. Hospital Pump Care:

a. Breast pumps shall be wiped down with a hospital approved germicide ~~as follows:~~ ~~P~~prior to each use in the NICU.

~~5. Prior to each new patient use in areas other than NICU.~~

~~i. If a spill occurs.~~

b. If internal contamination is noted, take the pump out of service and send to Biomed for deep cleaning.

~~7.~~4. Handling **of Breastmilk**~~:~~

**a. All milk received in the NICU must be labeled upon receipt using labels generated by the TCMC breast milk bar-coding system.**

**b. Mother will be instructed to bring in fresh milk daily.**

**c. Mother will be informed of infant's daily milk/feeding needs.**

**d. Mother will be contacted if there is insufficient milk prior to use of formula.**

~~a. Breast milk may be delivered to NICU fresh or frozen.~~

~~8.~~5. ~~To~~ ~~T~~thawing frozen breast milk:

~~a. Fill container with warm water. Place frozen milk container in warm water. Do not let the level of water in the bowl from the tap touch the mouth or top lid of the container.~~

**a. To thaw, use a hospital approved milk warmer following the manufacturer's instructions.**

~~i.~~**b. If milk warmer is not available, milk may be thawed in the refrigerator.** Do not place in boiling water or microwave.

~~b. Milk may be thawed in the refrigerator.~~

~~ii.~~**c. Once thawed,** ~~S~~swirl the container of milk to mix the cream back in, and distribute the ~~heat~~ **temperature** evenly. Do not stir ~~the milk. Do not~~ **or** shake the milk.

~~iii.~~d. Measure volume of breast milk required for feeding into appropriate feeding container. Promptly refrigerate unused portion of thawed breast milk.~~, Label as follows: Date & time thawed; date & time of expiration of thawed breast milk.~~

~~iv.~~e. ~~In the NICU, w~~When breast milk is transferred from one container to another for administration, a patient label must be affixed to ~~either~~ the new container **using the TCMC breast milk bar coding system.**~~or the warming cup it is placed in.~~

~~1) The re-labeling will be done at the preparation area and will be double-checked by two personnel.~~

**f. Once thawed, milk must be used within 24 hours. Never refreeze completely thawed breast milk.**

~~9.~~6. Warming Breast-milk:

**a. When warming breast milk, follow the same procedure as when thawing breast milk.**

~~ii. At bedside, prior to transfer of breast milk to any other feeding container (i.e., syringe, volufeed) and before administration, infant's name and medical record number shall be double checked between original container label and infant band by two personnel attending MOB and baby (LC, RN, LVN, MD).~~

~~iii. In the NICU, prior to administration, the infant's name and medical record number must be double checked between the labeled container at the bedside and the infant band, by two personnel.~~

~~iv. Breast milk may be warmed in a container of warm tap water.~~

~~v. When warming breast milk, follow the same procedure as when thawing breast milk.~~

**b.** Do not use microwave oven ~~in~~ **for** warming breast milk.

**c. Prepare the amount of milk needed for the feeding; taking care to warm only the amount of milk needed (see pump feedings).**

**d. Place the milk container or syringe in approved milk warmer following the manufacturer's directions.**

~~a.~~ **Prior to administration, the TCMC breast milk bar coding system will be utilized. In the event the system is unavailable, a two RN check will be utilized and documented in the EMR.**

**e.** Any warmed breast milk that is not used must be discarded.

~~B.~~**f. Following the infant feeding, discard the remaining milk within 1 hour after the baby is finished feeding.**

~~1.~~**7.** Transporting Breast Milk:

~~i.~~**a.** Breast milk must be kept cold **or** /frozen during transport. An insulated cooler or freezer bag with a frozen gel pack ~~or ice~~ is recommended.

~~ii.~~**b.** Liquid milk must remain cold.

~~iii.~~**c.** Frozen milk must not be allowed to thaw. If milk has thawed, do not refreeze.

~~i. Mothers shall be instructed to bring no more than 48 hours worth of breast milk at one time if possible. Extra milk can be brought in from home as needed. Mothers are educated about proper storage of milk at home.~~

~~8. Following the infant feeding, discard any unused breast milk from feeding container.~~

~~2.~~**8.** Fortification of ~~EBM~~**Breastmilk**:

a. ~~Wash hands~~**Perform hand hygeine** prior to preparing fortified breast milk.

b. Combine fortifier with ~~EBM~~ **breastmilk** according to manufacturer's recommendations.

c. The combination should be refrigerated and used within 24 hours once prepared.

~~a. Fortifiers are to be added to human milk at room temperature.~~

~~3.~~**9.** ~~Continuous Infusion~~ **Continuous and Intermittent Pump** Feedings:

~~b. Wash hands prior to preparing the feeding.~~

**a. Perform Hand Hygeine.**

**b. Breast**~~M~~**milk** that has been checked for correct milk/correct infant is placed in labeled syringes **using the TCMC breast milk bar coding system**. Gently agitate syringe to dispense fat into the solution.

**c. Draw up only the ordered feeding volume into the syringe.**

**d. Position the feeding syringe in the upright position with the tip pointed up during the feeding** ~~To minimize fat loss during gavage feedings use milk infusion systems with syringe tip pointed up.~~

**e. When the feeding is complete, push any remaining fat at the tip of the syringe plunger into the extension tubing.**

**f. Flush the extension tubing with 1-2 ml of air once the feeding is completed.**

**g.** Hang times for continuous feedings of ~~EBM~~ **breastmilk** should be limited to four hours to reduce bacterial growth.

~~c. Syringes should be changed with each feeding.~~

~~a.~~**h.** Enteral extension tubing **and syringe** ~~shall be changed~~ with each **intermittent** feeding.

~~C.~~**D.** **DOCUMENTATION:**

~~9. Document handling of breast milk (refrigeration, freezing.~~

1. Document parent education in ~~patient record~~ **patient's Electronic Medical Record (EMR).**
2. ~~Document identification of breast milk. (See handling #3)~~ **Document breastmilk identification process in EMR.**
3. **Document administration of breast milk in the EMR.**

~~10. Document administration of breast milk in the patient record.~~
~~11. Discard any expired breast milk.~~
~~12. Refrigerator and freezer temperatures are to be checked daily.~~

~~D. RELATED DOCUMENTSCROSS-REFERENCE:~~
~~7. See Breast Milk Misadministration procedure~~

~~D.~~E. **REFERENCE(S):**

1. Hoag Dann, Maureen, PNP, IBCLC;*Lactation Management, 2007. Section 111- Breastmilk Pumping, Collection, Storage & Handling. 246-248. www.lactationmanagement.com.*
2. Human Milk Banking Association of North America, Inc. Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes and Child Care Settings. 2005. Raleigh, NC: HMBANA..
3. *Infant Feedings: Guidelines for Preparation of Formula and Breast milk in Health Care Facilities*. American Dietetic Association. Copyright – 2004.
4. Lawrence, Ruth & Lawrence Robert (2005). Breastfeeding – A Guide for the Medical Profession. Elsevier Mosby. 761- 778, 1081 –1093.
5. Meier, P et al. *Breastfeeding Medicine 3;* 141-150, 2008.
6. Meirer, P.P. (1997). **Professional Guide to Breastfeeding Premature Infants**. Ross Products Division, Abbott Laboratories.
7. Pardou, A., et al. (1994) Human Milk Banking: Influence of storage process and of bacterial contamination on some milk constituents. Biol Neonate; 65; 302-309.
8. Pierce, K.Y. & Tully M.R. (1992). Mother's Won Milk: Guidelines for storage and handling. Journal of Human Lactation; 8 (3); 159-160.
9. Riordan, Jan & Wambach, Karen; 2010 *Breastfeeding and Human Lactation; 437 – 438;Jones & Bartlett, Fourth Edition.*
10. The Academy of Breastfeeding Medicine Protocol Committee; Caroline J. Cantry, MD, FABM; Cynthia R. Howard, MD, MPH, FABM. Protocol #7: Model Breastfeeding Policy. Approved 2/20/2004.

| Tri-City Medical Center | Distribution: Women & Newbo | CLEAN COPY |
|---|---|---|

| PROCEDURE: | BREAST MILK MANAGEMENT IN THE NICU |
|---|---|
| Purpose: | To provide a standardized process for collection, storage and handling of maternal breast milk in the Neonatal Intensive Care Unit ( NICU). |
| Supportive Data: | Mothers giving their babies pumped milk in the hospital setting is part of a wellness program that hospitals support. If circumstances such as separation of mother and baby occur, then the staff is to provide for and educate the mother in proper pumping, handling and storing of human milk. |
| Equipment: | 1. Hospital-grade electric breast pump<br>2. Sterile, rigid, clear plastic (BPA-free) containers with screw-on lid or plastic bags designed for human milk freezing (for collection and storage)<br>3. Gloves<br>4. Pre-stamped labels bearing two patient identifiers and bar code<br>5. Dedicated refrigerator<br>6. dedicated freezer that does not self-defrost<br>7. Bins in refrigerator or freezer for expressed breastmilk containers<br>8. BPA-free, single use, disposable bottles with disposable nipples (for feeding)<br>9. Additional Feeding Supplies as needed (e.g., syringe, feeding bag, feeding tube, syringe pump)<br>10. Breast milk scanner<br>11. Breast milk warmer |

A. **DEFINITION(S):**

1. Fresh/Raw Milk – Expressed breast milk.
2. Fresh/Frozen Milk – Freshly expressed breast milk that has been frozen and kept at approximately less than or equal to -20°C (-4° F).
3. Thawed Milk – Breast milk that has been previously frozen. Thawed milk must be used within 24 hrs.
4. Heat Processed Milk – Fresh-raw and/or fresh frozen milk that has been heat-treated as per milk banking guidelines.

B. **POLICY:**

1. All mothers should be instructed on the proper techniques of milk collection to minimize bacterial contamination.
2. Discourage breastfeeding for:
   a. Mothers with HIV
   b. Untreated active tuberculosis
   c. Infection with human T-cell lymphotrophic virus type I or type II
   d. Active herpes simplex virus (H SV) lesions on the breast
   e. Mothers who are taking medication that is contraindicated
   f. Mothers who are undergoing radiation therapy or chemotherapy with agents such as antimetabolites that interfere with DNA replication and cell division
   g. Mothers who are using illicit drugs.
3. Breastfeeding is also contraindicated when the neonate has inborn errors of metabolism (for example Galactosemia and Phenylketonuria) and must be fed non–lactose-based formula.
4. Do not store breast milk from mothers who are positive for hepatitis B surface antigen (HBsAg) with breast milk for other neonates because of possible contamination.

C. **PROCEDURE:**

1. Storing breastmilk:

| Department Review | Perinatal Collaborative Practice | Pharmacy & Therapeutics Committee | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|
| 7/03, 5/06, 6/07, 05/08, 4/10 | 02/13, 04/17 | n/a | 05/13, 05/17 | 06/13, 06/17 | 06/13 |

a. Gloves are worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:
   i. Fresh colostrum
      1) Colostrum containers are numbered by the RN in the order it was pumped.
      2) Containers are numbered for 5 days unless milk production is delayed. The RN assesses the milk for maturity and discontinues numbering once mature milk is visualized.
      3) Each pumping session counts as a single number.
      4) The colostrum is fed to the baby in chronological order.
      5) Chronologic order takes precedence over fresh versus frozen colostrum.
      6) Frozen colostrum shall be thawed and fed in chronologic order.
      7) Care shall be taken to keep colostrum fresh as much as possible.
   ii. After 48 hours of colostrum feeds, colostrum may be alternated with fresh, mature milk. Fresh expressed milk
   iii. Refrigerated milk
   iv. Oldest dated frozen milk
b. Breast milk will be stored fresh whenever possible. Only overstock should be stored in the freezer.
c. At all times, all containers shall be labeled with patient identification label generated from the TCMC breast milk barcoding system.
d. Breast milk is discarded only when expired or with a physician or allied health professional's (AHP) order.
e. Breast milk shall be stored as follows in a designated refrigerator/freezer:

| **Breast Milk Storage Guidelines** | | |
|---|---|---|
| Method | | Pre-Term or Sick Infant |
| Room temperature less than or equal to 25° C (77° F) | | 4 hours |
| Refrigeration of Fresh Milk less than or equal to 4° C (39° F) | | 96 hours |
| Completely Thawed & Placed in Refrigerator (plain or fortified) | | 24 hours |
| Deep Freezer less than or equal to -20° C (-4° F) | | 6 months |
| Freezer compartment inside refrigerator door | | Not Recommended |

2. Collection of Expressed Breastmilk:
   a. Provide instruction sheet to Mother "Pumping, Storing & Transporting Breast Milk for hospitalized infants.
   b. Provide *Breast Pumping & Daily Feeding Log* Book with instructions.
   c. Encourage mother to bring logbook to NICU. RN and LC (Lactation Consultant) review the pumping log daily, if possible, with mother to monitor progress and to look for areas of need while keeping in mind the goal of 500-1,000ml/day by the end of the first week.
   d. Instruct mother in hand washing before and after pumping.
   e. Instruct mother of baby in hand expression and manual pumping as alternative ways of collecting milk.
   f. Provide individualized labels from the TCMC breast milk barcoding system which include infant's last name/gender and medical record number and mother's last name.
   g. Instruct the mother to place expressed milk in a storage container made specifically for human milk storage.
   h. Instruct mother to write the date and time of collection.
   i. Instruct mother in cleaning pump parts.
   j. Breastmilk received from infants transferred to the TCMC NICU from other facilities must be relabeled with labels generated from the TCMC breastmilk barcoding system.
   k. Educate mother in how to store breast milk in small volumes to minimize waste.
3. Hospital Pump Care:
   a. Breast pumps shall be wiped down with a hospital approved germicide prior to each use in the NICU.

b. If internal contamination is noted, take the pump out of service and send to Biomed for deep cleaning.

4. Handling of Breastmilk
   a. All milk received in the NICU must be labeled upon receipt using labels generated by the TCMC breast milk bar-coding system.
   b. Mother will be instructed to bring in fresh milk daily.
   c. Mother will be informed of infant's daily milk/feeding needs.
   d. Mother will be contacted if there is insufficient milk prior to use of formula.
5. Thawing frozen breast milk:
   a. To thaw, use a hospital approved milk warmer following the manufacturer's instructions.
   b. If milk warmer is not available, milk may be thawed in the refrigerator. Do not place in boiling water or microwave.
   c. Once thawed, swirl the container of milk to mix the cream back in, and distribute the temperature evenly. Do not stir or shake the milk.
   d. Measure volume of breast milk required for feeding into appropriate feeding container. Promptly refrigerate unused portion of thawed breast milk.
   e. When breast milk is transferred from one container to another for administration, a patient label must be affixed to the new container using the TCMC breast milk bar coding system.
   f. Once thawed, milk must be used within 24 hours. Never refreeze completely thawed breast milk.
6. Warming Breastmilk:
   a. When warming breast milk, follow the same procedure as when thawing breast milk.
   b. Do not use microwave oven for warming breast milk.
   c. Prepare the amount of milk needed for the feeding; taking care to warm only the amount of milk needed (see pump feedings).
   d. Place the milk container or syringe in approved milk warmer following the manufacturer's directions.
   e. Prior to administration, the TCMC breast milk bar coding system will be utilized. In the event the system is unavailable, a two RN check will be utilized and documented in the EMR. Any warmed breast milk that is not used must be discarded.
   f. Following the infant feeding, discard the remaining milk within 1 hour after the baby is finished feeding.
7. Transporting Breast Milk:
   a. Breast milk must be kept cold or frozen during transport. An insulated cooler or freezer bag with a frozen gel pack is recommended.
   b. Liquid milk must remain cold.
   c. Frozen milk must not be allowed to thaw. If milk has thawed, do not refreeze.
8. Fortification of Breastmilk:
   a. Perform hand hygeine prior to preparing fortified breast milk.
   b. Combine fortifier with breastmilk according to manufacturer's recommendations.
   c. The combination should be refrigerated and used within 24 hours once prepared.
9. Continuous and Intermittent Pump Feedings:
   a. Perform Hand Hygeine.
   b. Breastmilk that has been checked for correct milk/correct infant is placed in labeled syringes using the TCMC breast milk bar coding system. Gently agitate syringe to dispense fat into the solution.
   c. Draw up only the ordered feeding volume into the syringe.
   d. Position the feeding syringe in the upright position with the tip pointed up during the feeding
   e. When the feeding is complete, push any remaining fat at the tip of the syringe plunger into the extension tubing.
   f. Flush the extension tubing with 1-2 ml of air once the feeding is completed.

g. Hang times for continuous feedings of breastmilk should be limited to four hours to reduce bacterial growth.
h. Enteral extension tubing and syringe with each intermittent feeding.

D. **DOCUMENTATION:**
1. Document parent education in patient's Electronic Medical Record (EMR).
2. Document breastmilk identification process in EMR.
3. Document administration of breast milk in the EMR.

E. **REFERENCE(S):**
1. Hoag Dann, Maureen, PNP, IBCLC;*Lactation Management, 2007. Section 111- Breastmilk Pumping, Collection, Storage & Handling. 246-248. www.lactationmanagement.com.*
2. Human Milk Banking Association of North America, Inc. Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes and Child Care Settings. 2005. Raleigh, NC: HMBANA..
3. *Infant Feedings: Guidelines for Preparation of Formula and Breast milk in Health Care Facilities*. American Dietetic Association. Copyright – 2004.
4. Lawrence, Ruth & Lawrence Robert (2005). Breastfeeding – A Guide for the Medical Profession. Elsevier Mosby. 761- 778, 1081 –1093.
5. Meier, P et al. *Breastfeeding Medicine 3;* 141-150, 2008.
6. Meirer, P.P. (1997). **Professional Guide to Breastfeeding Premature Infants**. Ross Products Division, Abbott Laboratories.
7. Pardou, A., et al. (1994) Human Milk Banking: Influence of storage process and of bacterial contamination on some milk constituents. Biol Neonate; 65; 302-309.
8. Pierce, K.Y. & Tully M.R. (1992). Mother's Won Milk: Guidelines for storage and handling. Journal of Human Lactation; 8 (3); 159-160.
9. Riordan, Jan & Wambach, Karen; 2010 *Breastfeeding and Human Lactation; 437 – 438;Jones & Bartlett, Fourth Edition.*
10. The Academy of Breastfeeding Medicine Protocol Committee; Caroline J. Cantry, MD, FABM; Cynthia R. Howard, MD, MPH, FABM. Protocol #7: Model Breastfeeding Policy. Approved 2/20/2004.

| Tri-City Medical Center | Women and Newborn Neonatal Intensive Ca | TRACKED CHANGES |
|---|---|---|
| PROCEDURE: | BREASTFEEDING FOR THE TERM AND LATE PRE-TERM INFANT IN THE NICU | |
| Purpose: | To promote and support human milk as the preferred method of providing nutrition to infants in the NICU, and to provide assistance to the mother in establishing and maintaining breastfeeding for optimal growth and development | |

A. **DEFINITION(S):**

1. LATCH (Latch, audible swallowing, type of nipple, comfort and hold): Scoring system for evaluating quality of a feeding at breast.
2. ~~SSC – skin to skin care, also called kangaroo care~~**Supplemental Nursing System (SNS): feeding tube with syringe at breast.**

B. **POLICY:**

1. To promote a philosophy of infant care that advocates breastfeeding and the feeding of breastmilk as the preferred method of infant nutrition. To assist those families choosing to breastfeed with initiating and developing a successful and satisfying experience. To facilitate the procedure of collecting breastmilk and/or breastfeeding to benefit the mother/infant dyad.
   a. Skin to skin **contact**~~care~~ (SSC)
   b. Informed Decision
   c. Attachment/LATCH-Breastfeeding Outcome
   d. Pumping and collection of mother's milk for infant nutrition
2. **This guideline pertains to healthy term and late preterm infants ≥ 35 weeks that do not have a prolonged NICU stay or extra nutritional goals including fluid restriction and/or higher protein, calorie or mineral needs.**

C. **PROCEDURE:**

1. SSC will be encouraged throughout the infant's hospitalization. (Refer to the WCS/ NICU, *Skin to Skin* ~~*Contactare*~~ *Procedure)*.
2. First oral feeding shall be at breast whenever possible.
3. Minimize use of pacifiers except for during tube-feeding, for pain relief, and for calming infants.
4. Nipple shields may be used for facilitating establishment of breastfeeding, but only after evaluation by qualified staff.
5. Whenever mother is present, assist her in breastfeeding first, before a bottle is offered. Make every effort to communicate with mother to avoid feeding her baby before she arrives.
6. Infant driven feedings will vary in duration. However, an infant actively feeding at breast for longer than 30 minutes shall be evaluated and a lactation consult ordered.
7. Infants may be offered both breasts at each feeding but may only be interested in feeding on one side in the early days.
8. Experienced hospital staff should observe mother breastfeeding to assess for position, latch, and milk transfer. A LATCH score should be documented in the EMR (electronic medical record) at least once a shift.
9. Hospital staff should make sure that mother knows what a swallow of milk sounds like.

D. **EVIDENCE OF SUCCESSFUL FEEDING:**

1. **Mother with expressible colostrum/breastmilk**
2. **Signs of milk transfer: sustained rhythmic suck/swallow pattern with occasional pauses and swallows**
3. ~~1.~~ Signs of adequate infant hydration.
   a. Voiding/Stooling- DOL 1-minimum 1 void/1 stool
      i. DOL 2- 2 void/2 stool

| NICU Department Review | Perinatal Collaborative Practice | ~~Division of Neonatology~~ | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|
| 6/14, 02/17 | 6/14, 04/17 | ~~6/14~~ | 07/14, 05/17 | 08/14, 06/17 | 08/14 |

ii. DOL 3- 3 void/3 stool
iii. DOL4 – 6-8x/day

b. <3%/day weight loss
c. <8% total weight loss

4. **Infant content for 1-3 hours after a feed**
5. **Normal blood glucose testing (if ordered)**
6. **Breastfed within 1 hour of birth and evidence of at least 3-4 effective feedings in the first 24 hours**

E. **SUPPLEMENTATION:**

1. ~~Babies~~ **Infants** whose parents have designated breastmilk as their feeding of choice will not be offered formula as an option ~~in the first 48 hours of life~~**unless medically necessary, per physician/AHP orders.**
2. ~~Informed decision:~~ Prior to formula supplementation:~~,~~
   a. **T**the parents will be informed of the risks of formula feeding.
   b. **Assess infant ability to feed: observation at breast, LATCH score, weight loss, hydration status.**
   c. **Avoid feeding by bottle if possible for supplementation for babies whose mothers intend to breast feed, evaluate the use of a SNS as appropriate.**
3. **Assess mother's breastmilk supply at least every 12 hours and prn.**
4. **Consider a pre/post weight check in order to assess milk transfer if baby > 48 hours old, mother's breasts are filling and colostrum/milk is easily expressed. Generally performing a pre/post-weight before mother appreciates significant breast changes is not useful except in the case when mother is refusing supplementation for an infant with excessive weight loss or hunger signs.**
5. **Expressed maternal breast milk (MMBM) should be used for supplementation if available; formula can be used if MBM not available, per physician/AHP orders.**
6. **If supplementing, the goal is to transition baby to breast feeding as soon as possible. It is important to give baby supplemental volumes that are appropriate for baby's day of life. Feeding babies inappropriately large volumes during first days of life, sets couplet up for breast feeding challenges when they are ready to transition to exclusive breastfeeding.**

~~2.~~7. **Mothers in the hospital who are supplementing should be double pumping every 3 hours to stimulate milk supply and empty breasts, unless infant is latching and sucking well. Mothers can also be taught hand expression for small quantities of colostrum.**

~~1. Unless medically indicated for physiologic stability, such as newborns that are at risk of hypoglycemia by virtue of impaired metabolic adaptation or increased glucose demand, provide feedings of breastmilk only.~~

~~2. If breastfeeding intake is not adequate, supplemental feeds can be given using expressed breastmilk (first choice) or an artificial milk substitute containing partially broken down protein. Supplemental feedings shall be offered after the baby goes to breast (provided mother of baby is available).~~

~~3. Neonatologist to determine need for supplementation daily, taking into account the small volume of colostrum intake expected during normal lactogenesis as well as infant's hydration needs (voiding patterns, electrolytes, course of illness). Supplementation frequency and duration to be given as ordered. Supplemental feedings are not necessary if the infant shows signs of adequate intake (voiding, stools) and electrolytes are normal.~~

Table for Supplementation Volumes

| Time (hours) | Volume (mL/feed) |
|---|---|
| 1st 24 | ~~2~~ **up to** 10 |
| 24-48 | ~~5~~ **up to** 15 |
| 48-72 | 15-30 |
| 72-96 | 30-60 |

**Based on** Academy of Breastfeeding Clinical Protocol # 3: Hospital Guidelines for the Use of Supplemental Feedings in the Healthy Term Breastfed Neonate. Revised 2009.

a. An adequately nourished infant feeds **10-12 times**~~8 or more times~~ per 24 hours.
b. A term infant shall be allowed to feed more frequently than every 3 hours.
c. Infants are expected to lose weight during the first few days of life, but should regain birth weight by two weeks of age. Excessive weight loss (>10% or >3%/day) should prompt a medical and nutritional evaluation of feeding techniques and mother's milk supply. In addition to medical evaluation of the infant, mother should be referred to a lactation evaluation and support.
d. Infants who are discharged prior to regaining birth weight should have a follow-up evaluation by the infant's primary health care provider or home health nurse within 24-48 hours of discharge to monitor weight, hydration, number of wet diapers and stools and assess for jaundice and signs of sepsis.

B. **REFERENCE LIST:**

1. **Academy of Breastfeeding Medicine Protocol Committee. (2009). ABM clinical protocol# 3: hospital guidelines for the use of supplementary feedings in the healthy term breastfed neonate, revised 2009.**~~The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in Healthy Term Breastfed Neonate, Revised 2009. Breastfeeding Medicine. 2009; Vol 4 (3)~~.
2. **ACOG Committee on Obstetric Practice. (2012). *Guidelines for perinatal care.* American Academy of Pediatrics.**~~American Academy of Pediatrics, The American College of Obstetricians & Gynecologists. Guidelines for Perinatal Care 7th ed. Washington, DC: AAP & ACOG; 2012~~.
3. **Lawrence, R. A., & Lawrence, R. M. (2010). *Breastfeeding: a guide for the medical professional.* Elsevier Health Sciences.**~~Lawrence, RA, Lawrence, RM. Breastfeeding A Guide to the Medical Professional. 7th Ed. Philadelphia, PA: Saunders; 2010~~.
4. **Nyqvist, K. H., Häggkvist, A. P., Hansen, M. N., Kylberg, E., Frandsen, A. L., Maastrup, R., & Haiek, L. N. (2013). Expansion of the baby-friendly hospital initiative ten steps to successful breastfeeding into neonatal intensive care: expert group recommendations. *Journal of Human Lactation*, *29*(3), 300-309.**~~Nyqvist, KH, Hansen, MN, Frandsen, AL, Ezeonodo, A, Hannula, L. Expansion of the Baby Friendly Hospital Initiative Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations. Journal of Human Lactation. 2013; 29(3) 300-309~~.
5. **Office of the Surgeon General (US). (2011). The Surgeon General's call to action to support breastfeeding.** ~~U. S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. 2011; Office of the Surgeon General, Washington D. C~~.
6. **Stroustrup, A., Trasande, L., & Holzman, I. R. (2012). Randomized controlled trial of restrictive fluid management in transient tachypnea of the newborn. *The Journal of pediatrics*, *160*(1), 38-43.**~~Stroustrup, A, Trasande, L., & Holzman, IR. Randomized Controlled Trial of Restrictive Fluid Management in Transient Tachypnea of the Newborn. The Journal of Pediatrics 2012;160 (1):38-43.~~
7. **University of San Diego (UCSD). (2015). Feeding Guidelines: Healthy Infants ≥35 weeks. Women and Infant Services Policy and Procedure.**
~~7.~~**8.** World Health Organization. **(2009).** Acceptable medical reasons for use of breast- milk substitutes.~~World Health Organization Website. http//whqlibdoc.who.int/hq/2009/WHO_FCH_09.01_eng.pdf/. Published 2009. Accessed April 10, 2013.~~

| Tri-City Medical Center | Women and Newborn Se CLEAN COPY<br>Neonatal Intensive Care Unit (NICU) |
|---|---|
| **PROCEDURE:** | **BREASTFEEDING FOR THE TERM AND LATE PRE-TERM INFANT IN THE NICU** |
| Purpose: | To promote and support human milk as the preferred method of providing nutrition to infants in the NICU, and to provide assistance to the mother in establishing and maintaining breastfeeding for optimal growth and development |

A. **DEFINITION(S):**
1. LATCH (Latch, audible swallowing, type of nipple, comfort and hold): Scoring system for evaluating quality of a feeding at breast.
2. Supplemental Nursing System (SNS): feeding tube with syringe at breast.

B. **POLICY:**
1. To promote a philosophy of infant care that advocates breastfeeding and the feeding of breastmilk as the preferred method of infant nutrition. To assist those families choosing to breastfeed with initiating and developing a successful and satisfying experience. To facilitate the procedure of collecting breastmilk and/or breastfeeding to benefit the mother/infant dyad.
   a. Skin to skin contact (SSC)
   b. Informed Decision
   c. Attachment/LATCH-Breastfeeding Outcome
   d. Pumping and collection of mother's milk for infant nutrition
2. This guideline pertains to healthy term and late preterm infants ≥ 35 weeks that do not have a prolonged NICU stay or extra nutritional goals including fluid restriction and/or higher protein, calorie or mineral needs.

C. **PROCEDURE:**
1. SSC will be encouraged throughout the infant's hospitalization. (Refer to the WCS/ NICU, *Skin to Skin Contact Procedure).*
2. First oral feeding shall be at breast whenever possible.
3. Minimize use of pacifiers except for during tube-feeding, for pain relief, and for calming infants.
4. Nipple shields may be used for facilitating establishment of breastfeeding, but only after evaluation by qualified staff.
5. Whenever mother is present, assist her in breastfeeding first, before a bottle is offered. Make every effort to communicate with mother to avoid feeding her baby before she arrives.
6. Infant driven feedings will vary in duration. However, an infant actively feeding at breast for longer than 30 minutes shall be evaluated and a lactation consult ordered.
7. Infants may be offered both breasts at each feeding but may only be interested in feeding on one side in the early days.
8. Experienced hospital staff should observe mother breastfeeding to assess for position, latch, and milk transfer. A LATCH score should be documented in the EMR (electronic medical record) at least once a shift.
9. Hospital staff should make sure that mother knows what a swallow of milk sounds like.

D. **EVIDENCE OF SUCCESSFUL FEEDING:**
1. Mother with expressible colostrum/breastmilk
2. Signs of milk transfer: sustained rhythmic suck/swallow pattern with occasional pauses and swallows
3. Signs of adequate infant hydration.
   a. Voiding/Stooling-
      i. DOL 1-minimum 1 void/1 stool
      ii. DOL 2- 2 void/2 stool

| NICU Department Review | Perinatal Collaborative Practice | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|
| 6/14, 02/17 | 6/14, 04/17 | 07/14, 05/17 | 08/14, 06/17 | 08/14 |

iii. DOL 3- 3 void/3 stool
iv. DOL4 – 6-8x/day

b. <3%/day weight loss
c. <8% total weight loss

4. Infant content for 1-3 hours after a feed
5. Normal blood glucose testing (if ordered)
6. Breastfed within 1 hour of birth and evidence of at least 3-4 effective feedings in the first 24 hours

E. **SUPPLEMENTATION:**

1. Infants whose parents have designated breastmilk as their feeding of choice will not be offered formula as an option unless medically necessary, per physician/AHP orders.
2. Prior to formula supplementation:
   a. The parents will be informed of the risks of formula feeding.
   b. Assess infant ability to feed: observation at breast, LATCH score, weight loss, hydration status.
   c. Avoid feeding by bottle if possible for supplementation for babies whose mothers intend to breast feed, evaluate the use of a SNS as appropriate.
3. Assess mother's breastmilk supply at least every 12 hours and prn.
4. Consider a pre/post weight check in order to assess milk transfer if baby > 48 hours old, mother's breasts are filling and colostrum/milk is easily expressed. Generally performing a pre/post-weight before mother appreciates significant breast changes is not useful except in the case when mother is refusing supplementation for an infant with excessive weight loss or hunger signs.
5. Expressed maternal breast milk (MBM) should be used for supplementation if available; formula can be used if MBM not available, per physician/AHP orders.
6. If supplementing, the goal is to transition baby to breast feeding as soon as possible. It is important to give baby supplemental volumes that are appropriate for baby's day of life. Feeding babies inappropriately large volumes during first days of life, sets couplet up for breast feeding challenges when they are ready to transition to exclusive breastfeeding.
7. Mothers in the hospital who are supplementing should be double pumping every 3 hours to stimulate milk supply and empty breasts, unless infant is latching and sucking well. Mothers can also be taught hand expression for small quantities of colostrum.

Table for Supplementation Volumes

| Time (hours) | Volume (mL/feed) |
|---|---|
| 1st 24 | up to10 |
| 24-48 | up to 15 |
| 48-72 | 15-30 |
| 72-96 | 30-60 |

Based on Academy of Breastfeeding Clinical Protocol # 3: Hospital Guidelines for the Use of Supplemental Feedings in the Healthy Term Breastfed Neonate. Revised 2009.

a. An adequately nourished infant feeds 10-12 times per 24 hours.
b. A term infant shall be allowed to feed more frequently than every 3 hours.
c. Infants are expected to lose weight during the first few days of life, but should regain birth weight by two weeks of age. Excessive weight loss (>10% or >3%/day) should prompt a medical and nutritional evaluation of feeding techniques and mother's milk supply. In addition to medical evaluation of the infant, mother should be referred to a lactation evaluation and support.
d. Infants who are discharged prior to regaining birth weight should have a follow-up evaluation by the infant's primary health care provider or home health nurse within 24-48 hours of discharge to monitor weight, hydration, number of wet diapers and stools and assess for jaundice and signs of sepsis.

B. **REFERENCE LIST:**

1. Academy of Breastfeeding Medicine Protocol Committee. (2009). ABM clinical protocol# 3: hospital guidelines for the use of supplementary feedings in the healthy term breastfed neonate, revised 2009..
2. ACOG Committee on Obstetric Practice. (2012). *Guidelines for perinatal care*. American Academy of Pediatrics..
3. Lawrence, R. A., & Lawrence, R. M. (2010). *Breastfeeding: a guide for the medical professional*. Elsevier Health Sciences..
4. Nyqvist, K. H., Häggkvist, A. P., Hansen, M. N., Kylberg, E., Frandsen, A. L., Maastrup, R., & Haiek, L. N. (2013). Expansion of the baby-friendly hospital initiative ten steps to successful breastfeeding into neonatal intensive care: expert group recommendations. *Journal of Human Lactation*, *29*(3), 300-309..
5. Office of the Surgeon General (US. (2011). The Surgeon General's call to action to support breastfeeding. .
6. Stroustrup, A., Trasande, L., & Holzman, I. R. (2012). Randomized controlled trial of restrictive fluid management in transient tachypnea of the newborn. *The Journal of pediatrics*, *160*(1), 38-43.
7. University of San Diego (UCSD). (2015). Feeding Guidelines: Healthy Infants ≥35 weeks. Women and Infant Services Policy and Procedure.
8. World Health Organization. (2009). Acceptable medical reasons for use of breast- milk substitutes.

Tri-City Medical Center
Oceanside, California

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

TRACKED CHANGES

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**SUBJECT:** FAMILY CENTERED CARE, NICU

**ISSUE DATE:** 04/09
**REVISION DATE:** 04/09, 06/11, 08/12,

| | |
|---|---|
| Department Approval: | 02/17 |
| Division of Neonatology Approval: | n/a |
| Pharmacy and Therapeutics Approval: | n/a |
| Medical Executive Committee Approval: | 05/17 |
| Professional Affairs Committee Approval: | 06/17 |
| Board of Directors Approval: | |

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A. **DEFINITION(S):**
1. Family centered care: An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.

~~A. PURPOSE:~~
~~Create a healing relationship with families at all levels of care that focus on the developmental, physical, and social needs of the patient and family.~~

~~A.~~B. **POLICY:**
1. Core Concepts of Family-Centered Care:
   a. Dignity and Respect: Health care practitioners listen to and honor family perspectives and choices. Family knowledge and values~~,~~ in addition to cultural beliefs, backgrounds are incorporated into the planning and delivery of patient care.
   b. Information Sharing: Health care practitioners communicate and share complete~~,~~ unbiased information with infants' families in an affirming and useful manner. Infants' families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
   c. Participation:~~.~~ Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
   d. Collaboration:~~.~~ Patients, families, health care practitioners, and leaders collaborate in program development, implementation, and evaluation; of health care facility design, education, and delivery of care.

~~B. Promotion of Family Centered Care in the NICU~~
~~1. Four elements to achieving family-centered care:~~
   ~~a. We will respect families and their pivotal role in promoting the well being of their babies. We will recognize families as the constant factor in the life of their infant and that the family is an intrinsic part of the health care team and the service systems and personnel as episodic. Families will partner with staff to guide decisions regarding care patterns and day-to-day activities of the NICU.~~
   ~~b. The physical and emotional environment fosters relationships between families and healthcare providers by encouraging family members to participate in the direct care of their infant and participate in decision-making regarding their infant's care.~~
   ~~c. Healthcare team members will make families feel comfortable both physically and emotionally throughout their NICU experience, and nurture their role as principal caregivers.~~

~~d. Hospital staff/personnel need to be educated on the benefits of enhanced family interaction that ensure optimal physician and emotional outcomes for our hospitalized infants and their families.~~

~~2. Collaboration and sharing information with families will be ongoing. Families will be provided with accessible support services that may include education, ethical, financial, emotional, and community resources.~~

~~C. **DEFINITIONS:**~~

~~1. **Family Centered Hospital:** Involved families are those who are empowered to care for their children's well-being. With regard to the care of the child, family centered care designates the family as the key decision-maker. To aid parents in making appropriate decisions, healthcare professionals need to collaborate and share information with families on an ongoing basis.~~

~~D. **RESPONSIBILITIES:**~~

~~1. All members of the health care team.~~

~~2. **Physical Environment:** Historically the NICU environment was designed around medical needs with less consideration of how it affected the infant and family/infant relationship. Organizational services and care delivery must be redesigned to ensure optimal responsiveness to the needs of infants and their families.~~

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

1. Physical Accommodations ~~and Family Resources.~~
   a. **A private space for families to meet with caregivers for consultation and family discussions will be available.**
   b. **A comfortable space for families and visitors to utilize during their visit will be provided. Privacy, space, and appropriate furniture will be provided to support skin-to-skin contact experiences and to promote a relaxed environment to support and facilitate breast-feeding.**
2. **Family Resources**
   a. **Social Work Consultation will be ordered on admission for coordination of family support and resource identification.**

~~3. **Provide hospital/unit orientation to include:**~~

~~4. **Printed information regarding family participation in care**~~

~~5. **Visiting policy**~~

~~6. **Telephone calls by parents when unable to be at the bedside**~~

~~7. **Support services**~~

~~8. **A private space for families to meet with caregivers for consultation and family discussions will be available.**~~

~~9. **The provision of a comfortable space for families and visitors to utilize during their visit. Effort should be made to provide reading material, television, telephone, and other amenities that provide the families with the idea that they are important to this NICU experience.**~~

~~10. **Privacy, space, and appropriate furniture must be provided to support skin-to-skin contact experiences and to promote a relaxed environment to support and facilitate breast-feeding.**~~

3. Healthcare Personnel **Responsibilities:**
   a. **Inform families of patient's/parent's rights and responsibilities. Parents are to be treated as full members of the health care team.**
   b. **Provide hospital/unit orientation which should include:**
      i. **Orientation to unit environment and practices.**
      ii. **Orientation to NIC-View camera system, Obtain signed consent prior to participation.**
      iii. **Education regarding NICU Visitation Policy.**

1) **Parents should have access to their infant 24 hours a day, including during procedures, rounds, and nursing change of shift reports. Reference NICU Visitation Policy.**
2) **Encourage parents to identify family members who may be involved in the infant's care.**
3) **Encourage Parent phone calls to the unit when they are unable to be at the bedside.**

c. **Encourage family/caregiver participation and hands-on care as appropriate to the infant's physiologic status and in preparation for discharge. Ensure parents of their role in care while infant is in the NICU.**

d. **Provide Developmentally Supportive Care to all infants in the NICU and provide education about this mode of care to the family.**

e. **-Foster continual, open, and honest communication about medical, psychosocial and ethical issues relevant to the infant and family.**

f. **Provide information on what parents can expect during certain procedures and encourage participation when possible.**

g. **Procedures for documentation and completion of forms should include information about the family's strengths, preferences, concerns, and goals specific to their infant, as well as the developmental strengths and needs of the infant.**

h. **Provide explanations and access to educational materials to foster informed decisions concerning the child's medical and nursing care.**

i. **Education provided to Parent/Caregiver(s) should be individualized to family's strengths and competencies.** ~~that is welcoming and reassuring to each family member when they visit will minimize the feeling of "being in the way". Staff should take advantage of opportunities that reinforce the importance of the family's role in the care of their infant. They should~~

ii. ~~P~~provide an opportunity for families to ask questions about their NICU experience and share concerns that may arise.

i. **Incorporate roles and activities of participating disciplines and parents/caregiver into the plan of care.**

j. **There should be a daily contact or attempt with parents to keep parent/caregiver informed of latest care developments.**

k. **As part of the care improvement process at discharge, parents shall be encouraged and informed of the process to offer feedback through a patient satisfaction survey.**

~~11. Family Involvement/Attachment~~

4. **Staffing Considerations:**

a. **Staffing assignments for physicians and nurses should promote consistency and predictability to promote continuity of care.**

b. **All possible efforts will be made so that each infant and family will have a primary team of nurses during a patient's stay.**

c. **Staff should be encouraged to seek out assistance from other staff when faced with difficult situations and recognize the individual differences of the families whose infants require NICU care.**

~~i. Encourage parents to participate in all aspects of their infant's care. Ask what they perceive the goals and needs of their infant are.~~

~~ii. Parents are to be treated as full members of the health care team rather than as a visitor.~~

~~b. Parents should have accessibility to the infant 24 hours a day including during procedures and rounds exclusive of nursing change of shift reports.~~

~~c. Foster continual, open and honest communication about medical, psychosocial and ethical issues relevant to the infant and family.~~

~~d. Family members or significant others may stay with patients involved in education and procedures as appropriate.~~

~~e. Provide information on what parents can expect during certain procedures and encourage participation when possible.~~
~~f. Inform families of patient's/parent's rights and responsibilities.~~
~~g. Healthcare staff to participate in training opportunities to increase the effective sharing of information with families and promote increased sensitivity to the feelings and experiences of families in the NICU. Staff should be encouraged to seek out the assistance of other staff when faced with difficult situations and recognize the individual differences of the families who require the NICU.~~
~~h. Encourage parents to identify family members who may be involved in the infant's care.~~
~~i. Provide explanations and access about educational materials to foster informed decisions concerning the child's medical and nursing care.~~
~~j. Staff to provide Developmentally Supportive Care to all infants in the NICU and provide education about this mode of care to the family.~~
~~k. Staffing patterns for physicians and nurses should promote consistency and predictability to promote continuity of care.~~
~~l. All possible efforts will be made so that each infant and family will have a primary team of nurses while a patient in the NICU.~~
~~m. Staff should consistently promote and support family/infant relationships as essential care practices.~~
~~n. Procedures for documentation and completion of forms should include information about the family's strengths, preferences, concerns, and goals specific to their infant as well as the development strengths and needs of the infant.~~
~~o. The roles and activities of participating disciplines and the parents should be incorporated into the plan of care.~~
~~p. There should be daily contact or attempt with parents to ensure latest development of care.~~
~~q. The language used in written and verbal communication with families should reflect each family's strengths and competencies.~~
~~r. Families should be encouraged to become actively involved in the preparation for discharge.~~
~~s. As part of the care improvement process at discharge; parents shall be encouraged and informed of the process to offer feedback through the Press Ganey survey as well as the follow-up telephone survey.~~

## ~~C.~~D. REFERENCE(S):

1. **Gardner,S.L., Voos, K., & Hills, P.. (2016). Families in Crisis: Theoretical and Practical Considerations, In Gardner, S. L., Carter, B. S. et al.(Eds.), Merenstein & Gardner's Handbook of Neonatal Intensive Care (821-864).St. Louis, Missouri: Elsevier.**
2. Institute for Family Centered Care. (2003). Collaborating with Patients and Families to Improve Quality and Patient Safety. *Advances in Family Centered Care, 9*(1), 1-3.
3. Lewandowski, L., Tesler, M. D. (2003). Family-Centered Care: Putting it into Action. *The SPN/ANA Guide to Family-Centered Care.*
4. **National Association of Nurses, American Nurses Association. (2013). Neonatal Nursing: Scope and Standards of practice (2nd Ed.). Silver Spring, Maryland. American Nurses Association.**
5. The Advisory Board. (2006).*The Family as Patient Care Partner.*

## ~~E. APPROVAL PROCESS~~

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

Tri-City Medical Center
Oceanside, California

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Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

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**SUBJECT:** FAMILY CENTERED CARE, NICU

**ISSUE DATE:** 04/09
**REVISION DATE:** 04/09, 06/11, 08/12,

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|---|---|
| **Department Approval:** | 02/17 |
| **Division of Neonatology Approval:** | n/a |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | 05/17 |
| **Professional Affairs Committee Approval:** | 06/17 |
| **Board of Directors Approval:** | |

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B. **POLICY:**
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   b. Information Sharing: Health care practitioners communicate and share complete unbiased information with infants' families in an affirming and useful manner. Infants' families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
   c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
   d. Collaboration: Patients, families, health care practitioners, and leaders collaborate in program development, implementation, and evaluation; of healthcare facility design, education, and delivery of care.

C. **PROCEDURE:**
1. Physical Accommodations
   a. A private space for families to meet with caregivers for consultation and family discussions will be available.
   b. A comfortable space for families and visitors to utilize during their visit will be provided. Privacy, space, and appropriate furniture will be provided to support skin-to-skin contact experiences and to promote a relaxed environment to support and facilitate breast-feeding.
2. Family Resources
   a. Social Work Consultation will be ordered on admission for coordination of family support and resource identification.
3. Healthcare Personnel **Responsibilities:**
   a. Inform families of patient's/parent's rights and responsibilities. Parents are to be treated as full members of the health care team.
   b. Provide hospital/unit orientation which should include:
      i. Orientation to unit environment and practices.

ii. Orientation to NIC-View camera system, Obtain signed consent prior to participation.
iii. Education regarding NICU Visitation Policy.
1) Parents should have access to their infant 24 hours a day, including during procedures, rounds, and nursing change of shift reports. Reference NICU Visitation Policy.
2) Encourage parents to identify family members who may be involved in the infant's care.
3) Encourage Parent phone calls to the unit when they are unable to be at the bedside.

c. Encourage family/caregiver participation and hands-on care as appropriate to the infant's physiologic status and in preparation for discharge. Ensure parents of their role in care while infant is in the NICU.
d. Provide Developmentally Supportive Care to all infants in the NICU and provide education about this mode of care to the family.
e. Foster continual, open, and honest communication about medical, psychosocial and ethical issues relevant to the infant and family.
f. Provide information on what parents can expect during certain procedures and encourage participation when possible.
g. Procedures for documentation and completion of forms should include information about the family's strengths, preferences, concerns, and goals specific to their infant, as well as the developmental strengths and needs of the infant.
h. Provide explanations and access to educational materials to foster informed decisions concerning the child's medical and nursing care.
i. Education provided to Parent/Caregiver(s) should be individualized to family's strengths and competencies.
ii. Provide an opportunity for families to ask questions about their NICU experience and share concerns that may arise.
i. Incorporate roles and activities of participating disciplines and parents/caregiver into the plan of care.
j. There should be a daily contact or attempt with parents to keep parent/caregiver informed of latest care developments.
k. As part of the care improvement process at discharge, parents shall be encouraged and informed of the process to offer feedback through a patient satisfaction survey.

4. Staffing Considerations:
a. Staffing assignments for physicians and nurses should promote consistency and predictability to promote continuity of care.
b. All possible efforts will be made so that each infant and family will have a primary team of nurses during a patient's stay.
c. Staff should be encouraged to seek out assistance from other staff when faced with difficult situations and recognize the individual differences of the families whose infants require NICU care.

D. **REFERENCE(S):**

1. Gardner,S.L., Voos, K., & Hills, P.. (2016). Families in Crisis: Theoretical and Practical Considerations, In Gardner, S. L., Carter, B. S. et al.(Eds.), Merenstein & Gardner's Handbook of Neonatal Intensive Care (821-864).St. Louis, Missouri: Elsevier.
2. Institute for Family Centered Care. (2003). Collaborating with Patients and Families to Improve Quality and Patient Safety. *Advances in Family Centered Care, 9*(1), 1-3.
3. Lewandowski, L., Tesler, M. D. (2003). Family-Centered Care: Putting it into Action. *The SPN/ANA Guide to Family-Centered Care.*
4. National Association of Nurses, American Nurses Association. (2013). Neonatal Nursing: Scope and Standards of practice (2nd Ed.). Silver Spring, Maryland. American Nurses Association.
5. The Advisory Board. (2006).*The Family as Patient Care Partner.*

| PROCEDURE: | REPLOGLE TUBE INSERTION AND MANAGEMENT |
|---|---|
| Purpose: | To provide gastric decompression and prevent vomiting and aspiration |
| Supportive Data: | Replogle tube insertion is used to treat a variety of gastrointestinal and multisystem disorders with gastrointestinal involvement. The largest drainage tube that can be comfortably inserted should be used to provide proper drainage and decompression of the stomach: 8-fr tube for infants <1,500 gms and a 10-fr tube for infants > 1,500 gms. Decreasing the risk of emesis and the potential for aspiration helps to prevent further complications. |
| Equipment: | 1. Dual lumen Replogle tube (8-fr or 10-fr)<br>2. Suction canister and tubing<br>3. Drainage trap<br>4. Hydrocolloid dressing<br>5. Transparent dressing<br>6. Sterile water or water-based lubricant |

A. **PROCEDURE:**

1. Insertion:
   - a. ~~RN will collaborate with attending physician regarding placement of replogle tube for purpose of gastric decompression~~**Obtain order from physician/allied health professional (AHP) for placement of replogle tube insertion.**
   - b. Perform hand hygiene and apply non-sterile gloves.
   - c. Assemble appropriate equipment.
   - d. Confirm patient identity using two-identifier system. Refer to Patient Care Services **Policy:** "Identification, Patient"~~ (IV.A) policy~~
   - e. **Immobilize the patient using developmentally appropriate containment (e.g. swaddling, facilitating tucking) and use nonpharmacologic techniques (e.g. swaddling, facilitative tucking, nonnutritive sucking) for comfort as appropriate**~~Position the patient~~:
     - ~~Patients may be swaddled.~~
     - i. ~~A second person may assist with patient containment~~.
   - f. Determine length of replogle tube to be inserted by measuring the tube from the tip of the nose to the earlobe, and from the earlobe to a space halfway between the umbilicus and the termination of the xiphoid process.
   - g. ~~Mark the measured distance on the tube with a small piece of tape or m~~Make note of the pre-printed centimeter measurement on the tubing.
   - h. Place an appropriate sized piece of hydrocolloid dressing on skin where tube is to be secured
   - i. Lubricate the distal end of the tube with sterile water or water-soluble lubricant.
   - j. Slowly and gently insert the tube through the mouth or nares, aiming down and back and advance until the pre-measured length is at the tip of the nostril or at the lip.
   - k. If there appears to be resistance, ***do not force***. Try rolling the tube gently. If still unable to pass the tube, remove it and try the other nostril. Remove tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis.
   - l. Allow the patient to stabilize and resume insertion procedure.
   - m. Verify placement of the tube in stomach by listening with a stethoscope over the epigastric area while injecting small amount (1-3 ml) of air and/or aspirate gastric contents.
   - n. Secure the replogle tube in place on top of hydrocolloid dressing with transparent dressing.

| Department Review | Perinatal Collaborative Practice | Division of Neonatology | ~~Department of OB/GYN~~ | ~~Department of Pediatrics~~ | Pharmacy & Therapeutics | Medical Executive Committee | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 7/14, 02/17 | 04/17 | n/a | ~~7/14~~ | ~~7/14~~ | n/a | 8/14, 05/17 | 10/14, 06/17 | 11/14 |

o. Connect the replogle tube to the drainage trap then connect the drainage trap to suction as ordered. Continuous or low intermittent suction should be set to 40-60mm Hg unless specified differently by the physician/**AHP**.
p. Place a small label (tape or patient label) with insertion date on replogle tubing just below the hub.
q. Discard used supplies and gloves in appropriate receptacle.
r. Perform hand hygiene.
s. Document the following in the patient's medical record:
   i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
   ii. Tolerance of procedure.

2. **M~~m~~**anagement:
   a. Ongoing proper placement is verified by:
      i. Measuring the distance from nares to the distal end of the gastrostomy tube every shift.
      ii. Verifying proper placement through auscultation or aspiration
      iii. Whenever an x-ray is obtained.
   b. Evaluate and document color and amount of aspirate and notify physician of any change in drainage color or quantity.
   c. Replogle tubes should be changed every 72hrs.
   d. If secretions are extremely thick and drainage has stopped, the replogle may be irrigated to prevent or clear plugging. Consult with the physician/**AHP** prior to irrigating the replogle tube. Irrigate with 1-5ml of normal saline. If the tube cannot be irrigated, discontinue it and insert a new tube.
   e. When charting output, subtract the amount of normal saline used as irrigant from the total output.
3. Removal:
   a. Disconnect suction (if attached) and drainage trap.
   b. Remove transparent dressing.
   c. Pinch replogle tube closed as the tube is slowly withdrawn to prevent aspiration of contents into the pharynx.
   d. Discard in appropriate receptacle.
   e. Document the procedure in the patient's medical record.

B. **REFERENCE(S) ~~LIST~~:**

1. Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. Neonatology: management, procedures, on-call problems, diseases, and drugs. 7th. New York: McGraw Hill Education Lange, 2013.
2. Ikuta, Linda M., and Sandra S. Beauman, eds. Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care, 2011.
3. Merenstein, G.G. & Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th. St. Louis, MO: Mosby.

Tri-City Medical Center
Oceanside, California

WOMEN'S & CHILDREN'S SERVICES MANUAL – NICU

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**SUBJECT:** **VISITATION IN THE NICU**

**ISSUE DATE:** **07/07**
**REVISION DATE(S): 01/09, 04/09, 06/11, 08/12**

| | |
|---|---|
| **Department Approval:** | **~~03/16~~01/17** |
| **Perinatal Collaborative Practice Approval:** | **04/17** |
| **Division of Neonatology Approval:** | **~~03/16~~ n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~09/16~~05/17** |
| **Professional Affairs Committee Approval:** | **~~10/16~~06/17** |
| **Board of Directors Approval:** | **11/16** |

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A. **POLICY ~~STATEMENT~~:**

1. The following guidelines are intended to support family visiting in the neonatal intensive care unit (NICU) embracing the Family Centered Care concept while maintaining a safe, quiet environment.
   a. "Family" is defined as any person(s) who play a significant role in an individual's life inclusive of person(s) not legally related to the individual.
   b. Members of family include spouses, domestic partners, step-parents, both different-sex and same-sex significant others, and any other persons operating in a caretaker role.
2. Only those visitors, including siblings, that are appropriate to visit in the NICU as defined in this policy, will be admitted past the first set of doors and be allowed to sit in the unit lounge.
3. These guidelines are flexible to support the diverse needs of our families.

B. **PROCEDURE:**

1. Staff shall greet family and visitors in the NICU entryway to identify who they are and whom they are visiting. Parents ID bands must be checked upon entrance. Take this opportunity to instruct families/visitors about the NICU visitation guidelines.
   a. Parents/banded individuals have 24-hour access to the NICU, inclusive of change of shift.
   b. Visitors may visit with a parent/banded individual at any time except during change of shift (0645 to 0745 and 1845 to 1945).
   c. Banded individuals who are in the unit at the beginning of change of shift may remain. Banded individuals requesting entrance into the unit during change of shift will be asked to wait in the waiting room until the conclusion of change of shift unless they have been requested to enter by the nurse for feeding purposes.
   d. Visitors who are not parents or siblings may not visit unless they are 18 years or older.
   e. Visitors are limited to two (2) visitors per patient at the bedside at any one time.
      i. One of the bedside visitors must be a banded parent/individual. (Please note this will include employees.)
         1) Foster parents as designated by Department of Health Services and with valid identification.
         2) Each multiple may have up to two visitors; only one banded individual is required per family.
   f. Siblings must be 12 years and older to visit unless they are the previously discharged sibling of a multiple. They are encouraged to visit with the following conditions:
      i. An adult must supervise siblings at all times. **Nurses are not to provide care to siblings.**

~~i.~~**ii. The discharged sibling of a multiple will be allowed to the bedside on following conditions:**
**1) Passes NICU health screening prior to admission to the unit.**

~~ii.~~**iii.** All siblings 12 years and older must show proof of up-to-date immunizations before entering the NICU.

~~iii.~~**iv.** All siblings will be health screened each time they enter.

~~iv.~~**v.** All siblings under the age of 18 will be prohibited during RSV/Flu season, inclusive of the previously discharged sibling of a multiple.

g. All Visitors will be interviewed, including but not limited to, the following for admittance to the NICU:

i. Exposures: visitors who have had exposure to chickenpox, measles, tuberculosis will not allowed to visit.

ii. Fever: No admittance will be granted to the NICU if the visitor presents with a temperature greater that 100.4 degrees Fahrenheit. Re-admittance to the NICU will be allowed when the visitor is afebrile for 24-hours.

1) Exception: Mothers that are febrile as a result of infections of non-transmissible concern may visit if:

a) The mother is afebrile times one.

b) Fever is cleared by OB as being of a non-transmissible origin.

iii. Signs of infection: visitors with signs of infection, including but not limited to, nausea, vomiting, cough, sneezing, sore throat, conjunctivitis, and draining wounds (does not include scrapes or small cuts that are scabbed over), will not be allowed to visit for the duration of the illness, e.g., the signs and symptoms are resolved.

iv. Skin Lesions/Herpes Simplex (Oral Herpes Lesion)

1) ~~No admittance will be granted to the NICU if the visitor presents with:~~ **Parents who present with** skin lesions, including open abscesses and oral herpes lesions (cold sore) that are open or draining **are to wear a surgical mask and gloves until crusted over.**~~,~~

2) ~~Re-admittance to the NICU can occur~~ **W**when ~~the neonatologist has examined the visitor and~~ the herpes lesion is completely crusted over,~~.~~ t~~T~~he visitor will be instructed to wear a mask and not to allow the sore to touch the infant.

v. Shingles

1) No admittance will be granted to the NICU of the visitor presents with shingles that are blistered or weeping.

2) Re-admittance to the NICU can occur when the shingles are dry and crusted. Visitor is instructed to not touch the affected area and not allow the lesion to touch the infant.

vi. Rashes

1) No admittance will be granted to the NICU if the visitor presents with an undiagnosed rash. Visitors with undiagnosed rash will be instructed to see their personal physician for diagnosis of origin. No admittance will be allowed until confirmation of origin is obtained and a non-contagious diagnosis is made.

2) No admittance will be granted to the NICU for visitors who have not had chicken pox or been vaccinated and have been exposed to anyone with chicken pox in the past three weeks. No admittance will be allowed from day 8 to day 21 after exposure.

3) Visitors who are diagnosed with measles or rubella will not be allowed to visit until 7 days after the onset of rash.

h. Instruct all family members/visitors to follow the hand washing procedure prior to handling the baby. ~~Refer to Hand Hygiene in the NICU Policy.~~

i. Encourage patient/family confidentiality.

j. The RN staff reserves the right to monitor and/or restrict visitation based upon unit activity and critical status of any infant.
k. At any time, the unit may close for medical purposes.
l. During seasons where there are more colds and flu, the visiting policy may be restricted further. Changes will be posted outside the NICU.

☑Inpatient ~~Cycle #~~ _____ ~~of~~ _____ ~~Cycle every~~ _____ ~~days~~

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

Prior Cumulative Dose (for agents with lifetime cumulative dose ceiling)_____

**LABORATORY STUDIES:**

- ☑ CBC with differential, CMP, Uric Acid prior to treatment on day 1
- ☑ CBC every other day
- ☑ Increase frequency of CBC's to daily when platelets reach <20,000 K/μL
- ☑ LFT's and PT, PTT q Monday and q Thursday
- ☐ Notify MD with Labs/Diagnostic test(s) prior to chemo administration
- ☐ _____

**DIAGNOSTICS:**

- ☐ Measure LVEF prior to chemo. Choose one: ☐ MUGA or ☐ ECHO
- ☐ LVEF complete. EF _____% on _____ (date)

**MEDICATIONS:**

- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**

**IV HYDRATION:**

- ☐ _____to run at _____ml/hr

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☑ **Dexamethasone** 10 mg IV on days 1, 2 and 3. Give 30 minutes prior to chemo
- ☑ ~~**Ondansetron 8**~~**Granisetron 1** mg IV on days 1, 2 and 3. Give 30 minutes prior to chemo
- ☑ **Fosaprepitant** 150 mg IV **PB over 30 minutes** on day 1 only. Give 30 minutes prior to chemo

**CHEMOTHERAPY**: Day 1 to start on _____

Choose 1 regimen with anthracycline of choice:

☐ ***Idarubicin*** + Cytarabine

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Idarubicin** | 12 mg/m2/day | _____mg | IV Push days 1-3 |
| **Cytarabine** | 100 mg/m2/day | _____mg | Given as a continuous IV infusion days 1-7 (not to be interrupted). Administer each dose over 22 hours |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**Tri-City Medical Center**

4002 Vista Way • Oceanside • CA • 92056

**7 + 3 CHEMO ORDERS**

☐ ***DAUNOrubicin*** + Cytarabine

| Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG | | | |
|---|---|---|---|
| **Drugs** | **mg/m$^2$ or AUC** | **Dose** | **SIG** |
| **DAUNOrubicin** | _____mg/m$^2$/day | _____mg | IV push days 1-3 |
| **Cytarabine** | 100 mg/m$^2$/day | _____mg | Given as a continuous IV infusion days 1-7 (not to be interrupted). Administer each dose over 22 hours |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**PROPHYLACTIC ANTIMICROBIALS:**

- ☑ ~~**Sulfamethoxazole/Trimethoprim (Bactrim) DS** 1 tablet PO BID on Saturdays and Sundays throughout therapy~~
- ☑ **Valacyclovir** 500 mg PO BID prn days when ANC < 500
- ☑ ~~**Fluconazole**~~ **Posaconazole 300 mg PO BID loading dose on day 1 then 300 mg PO daily** ~~400 mg PO daily~~ prn days when ANC < 500
- ☑ **Levofloxacin** 500 mg PO daily prn days when ANC < 500

**OTHER ORDERS:**

_____

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_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

## ALEMTUZUMAB (LEMTRADA) INSTRUCTIONS FOR TREATING DOCTORS' OFFICE

*Review attached orders and note any changes.*

**FAX COMPLETED ALEMTUZUMAB ORDERS TO:**
**Tri-City Medical Center Outpatient Infusion Center**
**Fax: (760) 721-8597 Phone: (760) 758-5770**
*3617 Vista Way Suite B, Oceanside, CA 92056*

**REMS:**

- Lemtrada is available only through the Lemtrada REMS Program to prescribers, infusion centers and pharmacies registered through the program.
- Lemtrada can only be prescribed to patients who are enrolled in and meet all the requirement of the program.
- Provide the patient with REMS program-approved patient guide.

**PRIOR TO INITIATING TREATMENT:**

- Lab orders are NOT included in this form- place orders via usual method. Lab monitoring is the responsibility of the ordering physician (neurologist).
- Baseline labs: CBC w/ differential, serum creatinine, urinalysis with urine cell counts, TSH
- Recommended: baseline PPD or quantiFERON-TB assay for latent TB; screening for JCV, HBV and HCV status
- HIV is a contraindication, screening is recommended.
- Patients should complete any necessary immunizations at least 6 weeks prior to treatment.
- Prescribe acyclovir, ranitidine and cetirizine.
    - **Cetirizine (Zyrtec)** 10 mg PO daily for 2 weeks. Start 3 days prior to first infusion.
    - **Ranitidine (Zantac)** 150 mg PO BID for 2 weeks. Start 3 days prior to first infusion.
    - **Acyclovir** 400 mg PO BID start day 1 of infusion and continuing for at least 2 months and until CD4 count >200.

**MONITORING POST TREATMENT:**

- Order and review follow-up labs per the following schedule and to continue 48 months post treatment:
    - Monthly: CBC w/ differential, serum creatinine, urinalysis with urine cell counts
    - Every 3 months: TSH
- Conduct baseline and yearly skin exams to monitor for melanoma

☑ Outpatient

**DIAGNOSIS:** ☐ Relapsing/remitting Multiple Sclerosis ☐_____

**ALLERGIES:** ☐NKA ☐Yes: _____

**HIV STATUS:**

- ☐ Patient is at low risk for HIV infection, OK to treat without screening

**NURSING ORDERS:**

- ☑ Ensure patient has acyclovir, ranitidine and cetirizine at home.
- ☑ Ensure baseline labs and screening (CBCdiff, SCr, U/A with urine cell counts, TSH, HIV screening) have been done within 30 days of initial treatment.
- ☑ Provide the patient with: *What You Need to Know about Lemtrada Treatment: A Patient Guide* prior to administering alemtuzumab (Lemtrada).
- ☑ Assess the patient 15 minutes after the infusion begins and as needed if patient is experiencing infusion reaction symptoms. Patient should be observed for 2 hours after the infusion.
- ☑ Monitor vital signs 15 minutes and 2 hours after the infusion begins and as needed throughout the infusion. Vital signs should be evaluated prior to discharging the patient.
- ☑ Complete an alemtuzumab (Lemtrada) REMS Infusion Checklist by the last day of each treatment course.

**PORT ACCESS/FLUSH ORDERS:**

☐ Access Mediport ☐Heparinize Mediport PRN ☐Infuse via Peripheral IV

☐ Other

**PRN ANTIEMETICS/PAIN:**

- ☑ **Prochlorperazine** 10mg PO q 4 hours prn N/V. Give IV if unable to take PO
- ☑ **Ondansetron** 4 mg IV q 6 h prn N/V refractory to prochlorperazine
- ☑ **Lorazepam** 0.5 mg IV q 6 h prn anticipatory N/V or N/V refractory to ondansetron
- ☑ **0.9% NS** 500 ml IV over 30 minutes x 1 for vomiting
- ☑ **Acetaminophen** 650 mg PO q 6 h prn mild pain
- ☑ **Ibuprofen** 400 mg PO q 4-6 h prn headache/mild pain not relieved by acetaminophen
- ☑ **Hydromorphone** 0.5 mg IV q 4 h prn moderate pain
- ☑ **Hydromorphone** 1 mg IV q 4 h prn severe pain

**IV HYDRATION TO PREVENT INFUSION REACTIONS:**

- ☐ BMI < 22. Give **0.9% NS** 500 ml IV over 30 minutes prior to each dose of alemtuzumab
- ☐ BMI ≥ 22. Give **0.9% NS** 1000 ml IV over 1 hour prior to each dose of alemtuzumab

**PREMEDICATIONS TO PREVENT INFUSION REACTION:**

- ☑ **Acetaminophen** 650 mg PO given 30 minutes prior to each treatment
- ☑ **Diphenhydramine** ☐ 25 mg ☐ 50 mg IV given 30 minutes prior to each treatment
- ☑ **Methylprednisolone Sodium Succinate (Solumedrol)** 1000 mg IV days 1-3 prior to treatment
- ☐ **Methylprednisolone Sodium Succinate (Solumedrol)** 500 mg IV days 4-5 prior to treatment (for first course only)

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**PREMEDICATIONS TO PREVENT NAUSEA AND VOMITING:**

☑ **Ondansetron** 8 mg IV given 30 minutes prior to each treatment

**INFUSION THERAPY:**

☐ First Course

| Drugs | Dose | SIG |
|---|---|---|
| **Alemtuzumab (Lemtrada)** | 12 mg | IV infusion over 4 hours daily x 5 days. |

☐ Second/Subsequent Course

| Drugs | Dose | SIG |
|---|---|---|
| **Alemtuzumab (Lemtrada)** | 12 mg | IV infusion over 4 hours daily x 3 days. Give 12 months after the first course. |

**ALEMTUZUMAB INFUSION REACTION:**

☑ Stop infusion immediately, increase primary infusion to wide open rate, administer PRN medications per hypersensitivity protocol, and notify MD. If anaphylaxis suspected, notify MD and call 911.

☑ **Albuterol inhaler** 2-8 inhalations PO q 20 minutes PRN shortness of breath/wheezing.

☑ **Diphenhydramine** 25 mg IV once PRN hypersensitivity, may repeat x1 for utricaria, pruritis, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ **Famotidine** 20 mg IV once PRN hypersensitivity if patient did not take morning dose of ranitidine.

☑ **Hydrocortisone sodium succinate (SOLU-CORTEF)** 100 mg IV once PRN for hypersensitivity.

**OTHER ORDERS:**

_____

_____

_____

_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every 28 days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC + diff, CMP prior to treatment on day 1
- ☑ CBC + diff on day 11
- ☑ **Uric acid prior to treatment on cycle 1 day 1**
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**MEDICATIONS:**

- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**

**IV HYDRATION:**

- ☐ _____**to run at** _____**ml/hr**

**PREMEDICATIONS TO PREVENT INFUSION REACTION**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to treatment on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to treatment on day 1

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☐ ~~Ondansetron 8~~**Granisetron** 1 mg IV 30 minutes prior to treatment on day 1 **and 2** (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to treatment on day 1 (outpatient ONLY)
- ☑ **Dexamethasone** 10 mg IV 30 minutes prior to treatment on day 1

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

☐ Cycle 1:

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Bendamustine** | 90 $mg/m^2$/day | _____mg | IVPB over 30 minutes daily on days 1 and 2 |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|

Affix Patient Label

☐ Cycle 2 and subsequent:

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 500 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Bendamustine** | 90 $mg/m^2$/day | _____mg | IVPB over 30 minutes daily on days 1 and 2 |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every 28 days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC + diff, CMP prior to treatment on day 1
- ☑ **Uric acid prior to treatment on cycle 1 day 1**
- ☑ CBC + diff on day 11
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**MEDICATIONS:**

- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**

**IV HYDRATION:**

- ☐ _____**to run at** _____**ml/hr**

**PREMEDICATIONS TO PREVENT INFUSION REACTIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to treatment on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to treatment on day 1

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☐ ~~Ondansetron 8~~**Granisetron 1** mg IV 30 minutes prior to treatment on day 1 **and 2** (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to treatment on day 1 (outpatient ONLY)
- ☑ **Dexamethasone** 10 mg IV 30 minutes prior to treatment on day 1

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Bendamustine** | 90 $mg/m^2$/day | _____mg | IVPB over 30 minutes daily on days 1 and 2 |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC diff, CMP prior to treatment on day 1
- ☑ CBC + diff on day 11
- ☐ _____

**PREMEDICATIONS TO PREVENT INFUSION REACTIONS:**

- ☑ **Dexamethasone** 20mg IV 30 minutes prior to chemotherapy
- ☑ **Famotidine** 20mg IV 30 minutes prior to chemotherapy
- ☑ **Diphenhydramine** 25mg IV 30 minutes prior to chemotherapy

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☐ **Granisetron 1 ~~Ondansetron 8~~**mg IV 30 minutes prior to chemotherapy (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to chemotherapy (outpatient ONLY)

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | mg/$m^2$, mg/kg or AUC | Dose | SIG |
|---|---|---|---|
| **Paclitaxel** | _____mg/$m^2$ | _____mg | IVPB on day (s) _____ |
| **Carboplatin** | Target AUC= _____<br>~~Scr=_____mg/dl~~<br>~~Weight Used=_____kg~~<br>~~☐ adjusted BW ☐ actual BW ☐ ideal BW~~<br>~~CICr=_____ml/min~~<br>**Scr= _____mg/dl** ☐ **Round SCr to 0.8?**<br>**Weight Used=_____kg**<br>**☐ adjusted BW ☐ actual BW ☐ ideal BW**<br>**CICr=_____ml/min** | _____mg<br>**MAX DOSE= 150 X AUC** | IVPB on day (s) _____. To be given after Paclitaxel |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

Prior Cumulative Dose (for agents with lifetime cumulative dose ceiling)_____

**LABORATORY STUDIES:**

- ☑ CBC diff, CMP prior to treatment on day 1
- ☑ **Uric acid prior to treatment on cycle 1 day 1**
- ☑ CBC diff q 4 days (ie Mon, Thurs or Tues, Fri) while on treatment.
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**DIAGNOSTICS:**

- ☐ Measure LVEF prior to chemo. Choose one: ☐ MUGA or ☐ ECHO
- ☐ LVEF complete. EF _____% on _____ (date)

**MEDICATIONS:**

- ☐ **Allopurinol** 100 mg PO TID days 1-14 ~~of cycle 1 only~~
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**
- ☑ **Trimethoprim/Sulfamethoxazole** 160/800mg (Septra DS). 1 tab PO BID on Sat/Sun throughout therapy
- ☑ **Valacyclovir** 500 mg PO BID

~~**IV HYDRATION:**~~

**IV HYDRATION:**

- ☐ _____**to run at** _____**ml/hr**
- ~~☐ **0.9% NS 1 liter IV over 1.5 hours on cycle 1 day 1 only to prevent drug induced tumor lysis syndrome, give before Rituximab**~~

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☑ **Fosaprepitant** 150 mg IV 30 minutes prior to chemo on day 1
- ☑ ~~**Ondansetron**~~ **Granisetron** ~~8~~ 1 mg IV 30 min prior to chemo given daily on days 1-5
- ☑ **Dexamethasone** 10 mg IV 30 minutes prior to chemo on days1

**PREMEDICATIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to rituximab on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to rituximab on day 1

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Etoposide** | 50 $mg/m^2$/day | _____mg | IV administered as a continuous infusion over 22 hours days 1-4 |
| **Vincristine** | 0.4 $mg/m^2$/day | _____mg | IV administered as a continuous infusion over 22 hours days 1-4 |
| **Doxorubicin** | 10 $mg/m^2$/day | _____mg | IV administered as a continuous infusion over 22 hours days 1-4 |
| **Prednisone** | 60 $mg/m^2$/day | _____mg | PO BID days 1-5 |
| **Cyclophosphamide** | 750 $mg/m^2$ | _____mg | IVPB, after completion of the infusion therapy on Day 5, give one dose only |

***Doses may change in second and subsequent cycles according to dose-adjustment paradigm. See reference.

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

**REFERENCE:**

Wilson et al, Blood, 15 April 2002, Volume 99, Number 8

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC with Diff, CMP prior to treatment on day 1
- ☑ Urine analysis for protein and blood pressure prior to bevacizumab
- ☐ _____

**PREMEDICATIONS TO PREVENT INFUSION REACTIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to first two doses of bevacizumab on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to first two doses of bevacizumab on day 1

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☐ ~~**Ondansetron 8**~~**Granisetron** 1 mg IV 30 minutes prior to treatment on day 1 **and 2** (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to treatment on day 1 (outpatient ONLY)
- ☑ **Dexamethasone** 10 mg IV 30 minutes before chemotherapy

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Bevacizumab (Avastin)** | 5 mg/kg | _____mg | IVPB on day 1. Rate per pharmacy |
| **Oxaliplatin** | 85 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Leucovorin** | 20 $mg/m^2$ | _____mg | IVPB on day 1. To infuse concurrently with oxaliplatin |
| **Fluorouracil** | 400 $mg/m^2$ | _____mg | IV Push on day 1. Give after oxaliplatin/leucovorin |
| **Fluorouracil** | 1200 $mg/m^2$/day | _____mg | IV continuous infusion over 22 hours daily on Days 1 and 2. Start after push |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

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**FOLFOX6 + BEVACIZUMAB CHEMO ORDERS**

**OTHER ORDERS:** _____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☑ Inpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

Prior Cumulative Dose (for agents with lifetime cumulative dose ceiling)_____

**LABORATORY STUDIES:**

- ☑ CBC diff, CMP, uric acid prior to treatment on day 1
- ☑ **Platelets, PT/INR and PTT prior to lumbar puncture**
- ☑☐**Transfuse 1 unit SDP for platelets < 50 K/uL prior to lumbar puncture**
- ☑ CBC diff every other day; CMP, uric acid daily
- ☑ Call oncologist with admission lab for final clearance and order to proceed with chemotherapy
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**DIAGNOSTICS:**

- ☐ Measure LVEF prior to chemo. Choose one: MUGA or ECHO
- ☐ LVEF complete. EF _____% on _____ (date)

**MEDICATIONS:**

- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**
- ~~☐ Allopurinol 300 mg PO daily~~

**IV HYDRATION:**

- ☐ **0.9% NS bolus:** give _____~~1000~~ ml IV over ~~one hour~~_____ **hour(s)** and then ~~150~~ _____ ml/hr until discharge
- ☐ _____**to run at** _____**ml/hr until discharge**
- ~~☐~~☑Hourly I & O'S
- ~~☐~~☑AM weights on all patients, call hospitalist if weight increases by > 1kg/day

**PREMEDICATIONS:**

- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to rituximab on day 1 and 11
- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to rituximab on day 1 and 11
- ☑ ~~**Ondansetron 16**~~**Granisetron 1** mg IV prior to chemotherapy given daily on days 1-4
- ☑ **Fosaprepitant** 150 mg IV 30 minutes prior to doxorubicin on day 4

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|

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**R HYPER-CVAD COURSE A (ODD CYCLES)**
**CHEMO ORDERS** **Page 1 of 3**

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | mg/m$^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 mg/m$^2$ | _____mg | IVPB on day 1 and 11 (give only if ≥ 20% of lymphoblasts are CD20 +)<br>Cycles 1 and 3 only<br>Rate per pharmacy |
| **Mesna** | 600 mg/m$^2$/day | _____mg | IV daily, given as a continuous IV infusion days 1, 2 and 3. Begin 1 hour before cyclophosphamide. Adjust rate of bags 2 & 3 to finish Mesna 12 hours after cyclophosphamide is completed |
| **Cyclophosphamide** | 300 mg/m$^2$ | _____mg | IVPB over 3 hours every 12 hours on days 1, 2 and 3 for a total of 6 doses |
| **Dexamethasone** | | 40 mg | PO daily on days 1-4 and 11-14. Give first dose 30 minutes prior to cyclophosphamide (or Rituximab, if given). Dose reduce to Dexamethasone 20 mg PO on day 4 if pt receives Fosaprepitant. May give IV if unable to tolerate PO |
| **Doxorubicin** | 50 mg/m$^2$ | _____mg | IV, given as continuous infusion on day 4. May extend duration of infusion if LVEF <50%. Start 12 hours after last Cytoxan dose |
| **Vincristine** | 1.4 mg/ m$^2$ | _____mg<br>Max dose = 2 mg | IVPB on day 4 and 11. Start 12 hours after last Cytoxan dose |
| | | | |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**INTRATHECAL CHEMOTHERAPY:**

| Drugs | Dose | SIG |
|---|---|---|
| **Methotrexate Preservative Free** | ☐ 12 mg<br>☐ 6 mg (if via Ommaya) | Intrathecal on Day 2. QS to 5 ml with sterile, preservative-free normal saline |

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

| | | |
|---|---|---|
| **Cytarabine Preservative Free** | 100 mg | Intrathecal on Day 7. QS to 5 ml with sterile, preservative-free normal saline |

**GROWTH FACTORS:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**PROPHYLACTIC ANTIMICROBIALS:**

- ☑ **Sulfamethoxazole/Trimethoprim (Bactrim) DS** 1 tablet PO BID on Saturdays and Sundays throughout therapy
- ☑ **Valacyclovir** 500 mg PO BID prn days when ANC < 500
- ☑ **Fluconazole** 400 mg PO daily prn days when ANC < 500
- ☑ **Levofloxacin** 500 mg PO daily prn days when ANC < 500

**OTHER ORDERS:**

_____
_____
_____
_____

**REFERENCE:**

Thomas, DA; J Clin Onc Volume 28 Number 24 August 20 2010

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☑ Inpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC with diff, CMP, uric acid prior to treatment on day 1
- ☑ **Platelets, PT/INR and PTT prior to lumbar puncture**
- ☑☐**Transfuse 1 unit SDP for platelets < 50 K/uL prior to lumbar puncture**
- ☑ CMP daily
- ☑ Methotrexate (MTX) levels to be drawn: at the end of the MTX infusion, 24 hours after infusion ends, 48 hours after infusion ends, **72 hours after infusion ends**.
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**IV HYDRATION:** To start before chemotherapy

- ☑ **1/2NS with 100 mEq NaHC03/Liter.** Give 1000 ml over 1 hour and then 150 mls/hr until discharge. **DO NOT STOP BICARB**

**NURSING ORDERS:**

- ☑ Hourly I and O's
- ☑ AM weights on all patients, call hospitalist if weight increases by >1kg/day.
- ☑ Check urine pH 4 hours after initiation of IV fluids, then check urine pH every 2 hours
  - ☑ Once urine pH>7 and urine output >100 mls/hour for 4 hours, begin chemotherapy.
  - ☑ If these parameters are not met within 6 hours of beginning hydration, call oncologist for modification of plan
  - ☑ **Urine pH must be maintained at greater than 7 throughout the course of treatment. Call hospitalist anytime the urine pH decreases to 7 or less.**

**MEDICATIONS:**

- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to rituximab on day 1 and 11 (only if pt is receiving rituximab)
- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to rituximab on day 1 and 11 (only if pt is receiving rituximab)
- ☑ **Dexamethasone** 0.1% eye drops, 2 drops to each eye QID days 2-7
- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**
- ☑ ~~**Allopurinol 300 mg PO daily**~~

**PREMEDICATIONS:**

- ☑ ~~**Ondansetron**~~ **Granisetron** ~~8~~ 1 mg IV prior to methotrexate and q 24 hours x 2 doses thereafter
- ☑ **Dexamethasone** 20 mg IV prior to methotrexate and q 24 hours x 2 doses thereafter

**NOTIFY PHYSICAN IF:**

- ☑ Creatinine clearance >60
- ☑ Patient on medications which decrease methotrexate clearance (Probenecid, penicillins, cephalosporins, ASA, NSAIDS)
- ☑ Any fluid collections, ascites or pleural effusions

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | mg/m$^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 mg/m$^2$ | _____mg | IVPB on Day 1 and 11 of Cycles 2 and 4 only. Rate per pharmacy. (give only if ≥ 20% of lymphoblasts are CD20 +) |
| **Methotrexate** | 1000 mg/m$^2$ | _____mg | IV on Day 1 by continuous infusion over 24 hours. Start after Rituximab, if given. |
| **Leucovorin** | | 50 mg | IVPB starting 12 hours after the end of the methotrexate infusion |
| **Leucovorin** | | 15 mg | IVPB every 6 hours x 8 doses (start 6 hours after leucovorin bolus)<br>Continue leucovorin until MTX ≤ 0.05 µmol/L.<br>Pharmacy to check levels and continue or d/c based on level. |
| **Cytarabine** | 3000 mg/m$^2$ | _____mg | IVPB over 2 hours every 12 hours x 4 doses on day 2 and 3 |
| | | | |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**INTRATHECAL CHEMOTHERAPY:**

| Drugs | Dose | SIG |
|---|---|---|
| **Methotrexate Preservative Free** | ☐ 12 mg<br>☐ 6 mg (if via Ommaya) | Intrathecal on Day 2. QS to 5 ml with sterile, preservative-free normal saline. |
| **Cytarabine Preservative Free** | 100 mg | Intrathecal on Day 7. QS to 5 ml with sterile, preservative-free normal saline. |

**GROWTH FACTORS:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**PROPHYLACTIC ANTIMICROBIALS:**

- ☑ **Sulfamethoxazole/Trimethoprim (Bactrim) DS** 1 tablet PO BID on Saturdays and Sundays throughout therapy
- ☑ **Valacyclovir** 500 mg PO BID prn days when ANC < 500
- ☑ **Fluconazole** 400 mg PO daily prn days when ANC < 500

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☑ **Levofloxacin** 500 mg PO daily prn days when ANC < 500

**OTHER ORDERS:**

**REFERENCE:**

Thomas, DA; J Clin Onc Volume 28 Number 24 August 20 2010

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ Day or Dose # _____

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

**LABORATORY STUDIES:**

- ☑ CBC with diff, **PT/INR and PTT** prior to lumbar puncture
- ☑☐**Transfuse 1 unit SDP for platelets < 50 K/uL prior to lumbar puncture**
- ☐ CSF for flow cytometry
- ☐ CSF for cytology
- ☐ CSF for protein, glucose
- ☐ CSF for cell count and diff
- ☐ _____

**CHEMOTHERAPY:** IT Chemotherapy to be given on _____

Patient has an Ommaya reservoir ☐ yes ☐ no
If yes, coordinate delivery to patient bedside for physician administration at _____ (time)

- ☐ Methotrexate preservative free _____ mg qs to 5 mL with sterile, preservative-free normal saline for intrathecal administration
- ☐ Methotrexate preservative free _____mg + hydrocortisone sodium succinate preservative free ☐ 25 mg ☐ 50 mg qs to 5 mL with sterile, preservative-free normal saline for intrathecal administration
- ☐ Cytarabine preservative free _____ mg qs to 5 mL with sterile, preservative-free normal saline for intrathecal administration
- ☐ Cytarabine preservative free _____ mg + hydrocortisone sodium succinate preservative free _____ mg qs to 5 mL with sterile, preservative-free normal saline for intrathecal administration
- ☐ Triple Therapy: Cytarabine preservative free 50 mg + Methotrexate preservative free 12 mg + hydrocortisone sodium succinate preservative free 25 mg for intrathecal administration
- ☐ Liposomal cytarabine preservative free _____ mg for intrathecal administration
- ☐ _____(drug) _____ mg qs to 5 mL with sterile, preservative-free normal saline for intrathecal administration

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
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**INTRATHECAL CHEMO ORDERS**

## PRE-PROCEDURE ORDERS

**ALLERGIES:**_____

**PRE-PROCEDURE DIAGNOSIS:**_____

- ☐ ~~See written Pre-Bronchoscopy orders~~. Schedule for _____(time) on _____ (date).
- ☑ **Ensure** Ppre-Procedure Checklist completed and present
- ☐ **Obtain** Cconsent for Bronchoscopy using moderate sedation ☐ Small scope ☐ Large scope
- ☐ **Obtain** Cconsent for Bronchoscopy with Needle Biopsy using moderate sedation
- ☐ **Ensure** NPO after MIDNIGHT
- ☐ All dentures removed
- ~~☐ Maintain current IV fluid and rate~~
- ☐ Start IV at 20 mL/hr with_____ before procedure.

~~**PRE-PROCEDURE**~~ **MEDICATIONS – to be given 30 minutes Pre-Procedure unless on-call**

- ☐ _____mg Atropine IM ☐ _____mg HydrOXYzine (Vistaril) IM
- ☐ _____mg Meperidine (Demerol) IM ~~☐ _____mg Midazolam (Versed) IV on-call~~
- ☐ _____mg Morphine Sulfate IV ~~☐ _____mcg Fentanyl (Sublimaze) IV on-call~~

**ADMINISTER TOPICAL ANESTHESIA/MEDICATIONS VIA HANDHELD NEBULIZER 15-30 MINUTES PRE-PROCEDURE:**

- ☐ **Lidocaine 5 mL 2%**
- ☐ **Lidocaine 5 mL 4%**
- ☐ **Albuterol (Proventil) 2.5 mg**
- ☐ **Ipratropium (Atrovent) 0.5 mg**
- ☐

**MEDICATIONS-on call for intra-procedural administration if needed:**

- ☐ _____**mg Midazolam (Versed) IV** ☐ **4% Lidocaine:**_____**mL** ☐ **Other:**_____
- ☐ _____**mcg Fentanyl (Sublimaze) IV** ☐ **2% Lidocaine:**_____**mL** ☐ **Other:**_____

~~**PRE-PROCEDURE**~~ **MEDICATIONS** ~~**– on-call**~~ **for post-procedurale administration if needed**

- ☑☐ ___0.4__mg Naloxone (Narcan) IV on-call
- ☑☐ __0.2__mg Flumazenil (Romazicon) IV on-call

~~**ADMINISTER TOPICAL ANESTHESIA/MEDICATIONS VIA HANDHELD NEBULIZER PRE-PROCEDURE:**~~

- ~~☐ Lidocaine 5 mL 2%~~
- ~~☐ Lidocaine 5 mL 4%~~
- ~~☐ Albuterol (Proventil) 2.5 mg~~
- ~~☐ Ipratropium (Atrovent) 0.5 mg~~

~~**MEDICATIONS GIVEN DURING BRONCHOSCOPY PROCEDURE:**~~

- ~~☐ _____mg Midazolam (Versed) IV ☐ 4% Lidocaine:_____mL ☐ Other:_____~~
- ~~☐ _____mcg Fentanyl (Sublimaze) IV ☐ 2% Lidocaine:_____mL ☐ Other:_____~~

| Nurse's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|

## POST-PROCEDURE ORDERS

- ☐ NPO for 2 hours post ☐ Chest X-ray ☐ **Remove** IV_____
- ☐ Vital Signs: Q 15 minutes X 4, then Q 30 minutes until vital signs are stable
- ☐ Oxygen for saturations:_____%
- ☐ Discharge:_____

| ~~MICROBIOLOGY SPECIMEN~~ | ~~AFB Culture/S~~ | ~~AFB Direct Smear~~ | ~~Anaerobe Culture~~ | ~~Routine Culture/S~~ | ~~Gram Stain~~ | ~~Herpes Culture~~ | ~~Legionella Culture~~ | ~~Fungus Culture/KOH~~ | ~~Viral/CMV Culture~~ |
|---|---|---|---|---|---|---|---|---|---|
| ~~Bronchial Wash~~ | | | | | | | | | |
| ~~Bartl~~ | | | | | | | | | |
| | | | | | | | | | |

☐ Read Back all T.O./V.O.orders

| Nurse's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|

Affix Patient Label

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8711-1111

**OUTPATIENT BRONCHOSCOPY AND NEEDLE BIOPSY ORDERS**

**Page 1 of 2**

| ~~PATHOLOGY SPECIMEN~~ | ~~Path Bx~~ | ~~Cytology~~ | ~~AFB/Fungi~~ | ~~Methsilver~~ | ~~Other:~~ |
|---|---|---|---|---|---|
| ~~A~~ | | | | | |
| ~~B~~ | | | | | |
| ~~C~~ | | | | | |
| ~~Assisting RCP Signature:~~ | | | | | |

8711-4010

| ☐ Read Back all T.O./V.O.orders | | | | | |
|---|---|---|---|---|---|
| Nurse's – Signature | Date | Time | Physician's – Signature | Date | Time |

Affix Patient Label

Tri-City Medical Center

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8711-1111

# OUTPATIENT BRONCHOSCOPY AND NEEDLE BIOPSY ORDERS

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every 21 days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

Prior Cumulative Dose (for agents with lifetime cumulative dose ceiling)_____

**LABORATORY STUDIES:**

- ☑ CBC + diff, CMP prior to treatment on day 1
- ☑ **Uric acid prior to treatment on cycle 1 day 1**
- ☑ CBC + diff on day 11
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**DIAGNOSTICS:**

- ☐ Measure LVEF prior to chemo. Choose one: ☐ MUGA or ☐ ECHO
- ☐ LVEF complete. EF _____% on _____ (date)

**MEDICATIONS:**

- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**

**IV HYDRATION:**

- ☐ _____**to run at** _____**ml/hr**

**PREMEDICATIONS TO PREVENT INFUSION REACTIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to treatment on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to treatment on day 1

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☑ **Dexamethasone** 10 mg IV 30 min prior to chemo
- ☐ ~~**Ondansetron**~~ **Granisetron** 18 mg IV 30 minutes prior to treatment on day 1 (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to treatment on day 1 (outpatient ONLY)
- ☑ **Fosaprepitant** 150 mg IV 30 min prior to chemo

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Rituximab** | 375 $mg/m^2$ | _____mg | IV infusion on day 1, rate per pharmacy |
| **Doxorubicin** | 50 $mg/m^2$ | _____mg | IV Push on day 1 |
| **Vincristine** | 1.4 $mg/m^2$ | _____mg<br>Max dose=2 mg | IVPB on day 1 |
| **Cyclophosphamide** | 750 $mg/m^2$ | _____mg | IVPB over 30 min on day 1 |
| **Prednisone** | | 100 mg | PO daily on days 2-5 |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☑ Inpatient Cycle # _____ of _____ Cycle every _____days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC diff, CMP prior to treatment on day 1
- ☑ **Uric acid prior to treatment on cycle 1 day 1**
- ☑ CBC diff on day 11
- ☑ Screen for HBsAg and anti-HBc prior to Rituximab (required prior to first dose only)
- ☐ HBsAg and anti-HBc complete.
  HBsAg negative/positive (circle one) on _____ (date)
  anti-HBc negative/positive (circle one) on _____ (date)
- ☐ _____

**MEDICATIONS:**

- ☑ **Prednisolone** 1% eye drops. 1 drop each eye TID starting on day 2 for 10 days total. To prevent Cytarabine induced conjunctivitis
- ☐ **Allopurinol 100 mg PO q 8 hours starting day prior to chemotherapy x 10 days**
- ☐ **Rasburicase 6 mg IV x 1 for uric acid > 8 mg/dl**
- ☑—

**IV HYDRATION:**

- ☐ _____**to run at** _____**ml/hr**
- ☑ Pre-hydration: **0.9% NS** at _____ ml IV over _____ minutes prior to cisplatin
- ☑ Post-hydration: **0.9% NS** at _____ ml IV over _____ minutes after cisplatin complete

**PREMEDICATIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to rituximab on day 1
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to rituximab on day 1
- ☑ **Fosaprepitant** 150 mg IV 30 minutes prior to chemo on day 1
- ☑ **Ondansetron** 8 mg IV 30 min prior to chemo, repeat every 12 hours for a total of 4 doses

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | $mg/m^2$ or AUC | Dose | SIG |
|---|---|---|---|
| **Dexamethasone** | | 20 mg | IVPB infused 30 minutes prior to Rituximab on day 1 |
| **Dexamethasone** | | 40 mg | IVPB daily on days 2-4 |
| **Rituximab** | 375 $mg/m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Cisplatin** | 100 $mg/m^2$ | _____mg | IV continuous infusion over 24 hours starting on day 1. Dilute in 1 liter 0.9% NS |
| **Cytarabine** | 2000 $mg/m^2$ | _____mg | IVPB over 3 hours q 12 hours x 2 doses. Start on day 2 when cisplatin infusion complete |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**GROWTH FACTORS:**

- ☐ None
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☐ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

**REFERENCE:**

Gisselbrecht et al. JCO. SEPTEMBER 20 2010, VOLUME 28, NUMBER 27

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|
| | | | Affix Patient Label | | |

☐ Inpatient ☐ Outpatient Cycle # _____ of _____ Cycle every 21 days

**DIAGNOSIS:** _____

**ALLERGIES:** ☐NKA ☐Yes: _____

Height_____(cm) CURRENT Weight _____ (kg) DOSING Weight_____ (kg) Dosing BSA_____ ($m^2$)

**LABORATORY STUDIES:**

- ☑ CBC diff, CMP prior to treatment on day 1
- ☑ CBC diff on day 11
- ☑ Urine analysis for protein and blood pressure prior to bevacizumab
- ☐ _____

**PREMEDICATIONS TO PREVENT INFUSION REACTIONS:**

- ☑ **Diphenhydramine** 25 mg IV 30 minutes prior to first two doses of bevacizumab
- ☑ **Acetaminophen** 650 mg PO 30 minutes prior to first two doses of bevacizumab

**PREMEDICATIONS TO PREVENT NAUSEA/VOMITING:**

- ☐ ~~**Ondansetron**~~ **Granisetron** 1 ~~8~~ mg IV 30 minutes prior to treatment on day 1 (inpatient)
- ☐ **Palonosetron** 0.25 mg IV 30 minutes prior to treatment on day 1 (outpatient ONLY)
- ☑ **Dexamethasone** 10 mg IV 30 minutes prior to treatment on day 1

**CHEMOTHERAPY:** Day 1 to start on _____

**Note: Diluent, volume and rate of administration per Standard of Practice unless otherwise stated in chemo SIG**

| Drugs | mg/$m^2$, mg/kg or AUC | Dose | SIG |
|---|---|---|---|
| **Bevacizumab** | 7.5 mg/kg | _____mg | IVPB on day 1. Rate per pharmacy |
| **Oxaliplatin** | _____mg/$m^2$ | _____mg | IVPB on day 1. Rate per pharmacy |
| **Capecitabine** | _____mg/$m^2$ | _____mg | PO BID on days 1-14. **Round dose to nearest tablet size.** |

**RATIONALE FOR DOSE ADJUSTMENTS:**_____

**SUPPORTIVE CARE FOR THE PROPHYLAXIS/PALLIATION OF CHEMOTHERAPY INDUCED NEUTROPENIA:**

- ☑ None
- ☑ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously on days_____
  Must start 24 hours after completion of chemotherapy.
- ☑ **Filgrastim-sndz** 5 mcg/kg (rounded to nearest vial size) subcutaneously daily starting on day _____
  Must start 24 hours after completion of chemotherapy. Stop when ANC greater than _____

**OTHER ORDERS:**

_____

_____

_____

_____

| Pharmacist's – Signature | Date | Time | Physician's – Signature | Date | Time |
|---|---|---|---|---|---|

Affix Patient Label

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

**XELOX + Bevacizumab CHEMO ORDERS**

# TRI-CITY HI HCARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

| Vendor | Contract Number | Contract Type | Responsible Party | Responsible Dept | Expiration Date | Communi cation | Date Evaluated | Renew "R"/Not Renew "NR" | PHI Req'd | PHI Rec'd | MEC Review | PAC Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Palomar Health | 1007.3286C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 3/1/2017 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Palomar Heights Post Acute Rehab | 1007.2638C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 6/30/2017 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Paratek Pharma, LLC | 1007.3473C | Clinical Study Agreement | Ingrid Stuiver | Clinical Research | 8/2/2017 | Yes | 12/5/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Pashmforoush, Mohammad MD | 1007.2962C | Physician-Recruitment Agreement | Jeremy Raimo | Business Development | 10/31/2018 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Pashmforoush, Mohammad MD | 1007.2989C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Paveglio, Kathleen A MD | 1004.2555C | Physician-Medical Director | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Paveglio, Kathleen A MD | 1004.2556C | Physician-Services Agreement | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Pendleton, Robert B MD | 1007.109C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2018 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Penvose-Yi, Jan R MD | 1007.3123C | Physician-Recruitment Agreement | Jeremy Raimo | Business Development | 8/31/2019 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Philadephia University | 1007.2706C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 1/20/2019 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Phillips, Jason MD | 1007.2882C | Physician-Recruitment Agreement | Jeremy Raimo | Strategic Services | 8/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Phillips, Jason MD | 1007.3170C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Pima Medical Institute | 1007.1466C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 1/7/2018 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

# TRI-CITY HEALTHCARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

| Vendor | Contract Number | Contract Type | Responsible Party | Responsible Dept | Expiration Date | Communication | Date Evaluated | Renew "R"/Not Renew "NR" | PHI Req'd | PHI Rec'd | MEC Review | PAC Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Platt College LLC | 1007.3179C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 10/2/2017 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Point Loma Nazarene University | 1007.1467C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 12/5/2017 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Ponec, Donald J MD | 1007.112C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Ponec, Donald J MD | 1004.2322C | Physician-Medical Director | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Ponec, Donald J MD | 1004.2553C | Physician-Services Agreement | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Ponec, Donald J MD | 1027.3221C | Physician-Services Agreement | Jeremy Raimo | Neurology | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Preiser, Kristin PA | 1007.3407C | Consulting Agreement | Sharon Schultz | Behavioral Health Unit | 6/30/2017 | No | 12/6/2016 | NR | Y | Y | 5/22/2017 | 6/8/2017 | |
| Prometheus Labratories Inc. | 1007.3187C | Laboratory Agreement | Tara Eagle | Laboratory | 11/17/2017 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rady Children's Hospital San Diego | 1007.1340C | Referral Agreement | Mary Diamond | Nursing | 1/18/2018 | No | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rady Children's Hospital San Diego | 1007.2947C | Affiliation Agreement | Mary Diamond | NICU | 1/1/2018 | No | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rady Children's Specialists | 1007.908E | Medical Provider Agreement | Mary Diamond | NICU | 12/30/2016 | No | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rady Children's Specialists of San Diego | 1007.2861E | Physician - Medical Director Agreement | Mary Diamond | Labor & Delivery | 6/30/2016 | No | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rady Children's Hospital | 1007.860E | Consulting Agreement | Mary Diamond | Mother Baby | 8/31/2016 | No | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rancho Vista | 1007.1342C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 6/5/2017 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Reisman, Bruce K MD | 1007.115C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

# TRI-CITY HE[illegible]HCARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

| Vendor | Contract Number | Contract Type | Responsible Party | Responsible Dept | Expiration Date | Communication | Date Evaluated | Renew "R"/Not Renew "NR" | PHI Req'd | PHI Rec'd | MEC Review | PAC Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Response Genetics, Inc. | 1007.3074C | Laboratory Agreement | Tara Eagle | Laboratory | 4/20/2017 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Roche Diagnostics Corporation | 1021.3395C | Supplies Agreement | Tara Eagle | Laboratory | 2/9/2017 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rosenberg, Jay H MD | 1007.117C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Rypins, Eric B MD | 1007.119C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2018 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sadoff, Mark MD | 1007.120C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sadoff, Mark MD | 1007.2240C | Physician - Medical Director Agreement | Priya Joshi | PT Acute Rehab | 6/30/2018 | Yes | 10/31/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sahagian, Gregory MD | 1007.122C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sahagian, Gregory MD | 1027.3222C | Physician-Services Agreement | Jeremy Raimo | Neurology | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sahagian, Gregory MD | 1027.3253C | Physician-Services Agreement | Jeremy Raimo | Neurology | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| San Diego Blood Bank | 1007.882C | Supplies Agreement | Tara Eagle | Laboratory | 12/31/2018 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sarkaria, Paul D MD | 1004.2801C | Physician-Services Agreement | Jeremy Raimo | Cardio Vasc Health Institute | 8/31/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| San Diego Community College District | 1007.1473C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 5/2/2018 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| San Diego Diagnostic Radiology Med Group | 1007.2015C | Physician-Services Agreement | Steve Young | Radiology | 6/30/2018 | Yes | 10/19/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| San Diego State University | 1007.1475C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 7/16/2017 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

# TRI-CITY HEALTHCARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Saxon, Richard R MD | 1007.125C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Scantibodies Clinical Laboratory, Inc. | 1007.2173C | Laboratory Agreement | Tara Eagle | Laboratory | 3/31/2017 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Schim, Jack D MD | 1007.127C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Schim, Jack D MD | 1027.3220C | Physician-Services Agreement | Jeremy Raimo | Neurology | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Schim, Jack D MD | 1027.3262C | Physician-Medical Director | Jeremy Raimo | Neuroscience Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Scripps Memorial Hospital | 1007.1948C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 3/17/2017 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Shad, Javaid A MD | 1007.129C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sheth, Manish MD | 1007.2469C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sheth, Manish MD | 1007.2403C | Physician - Medical Director Agreement | Sarah Jayyousi | OPBHU | 6/30/2017 | Yes | 10/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sheth, Manish MD | 1007.2864C | Physician-Medical Director | Sharon Schultz | Behavioral Health Unit | 6/30/2017 | | 11/5/2016 | NR | Y | Y | 5/22/2017 | 6/8/2017 | |
| Sheth, Manish MD | 1007.3491C | Physician-Medical Director | Sharon Schultz | Behavioral Health Unit | 6/30/2017 | | 11/5/2016 | NR | Y | Y | 5/22/2017 | 6/8/2017 | |
| Shim, Michael MD | 1007.132C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Siemens Healthcare Diagnostics, Inc. | 1007.2671C | Equipment: Support and Service Agreement | Tara Eagle | Laboratory | 12/20/2016 | | 11/29/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Slowik, Sharon MD | 1007.2979C | Physician - Supervision Agreement | Steve Young | Cardiac Rehab | 6/30/2017 | Yes | 10/19/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

# TRI-CITY HE ICARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Smith, Richard MD | 1007.138C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2018 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Smith, Richard MD | 1007.2016C | Physician Consultant | Tori Hong | Infection Control | 6/30/2018 | Yes | 11/4/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Smith, Richard MD | 1007.2481C | Physician-Medical Director | Sharon Schultz | Infection Control | 6/30/2019 | | 11/5/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Society of Thoracic Surgeons | 1021.904C | Participation Agreement | Jeremy Raimo | Cardio Vasc Health Institute | 12/31/2016 | No | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Southwestern University | 1007.1479C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 8/13/2018 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Souza, Victor MD | 1007.2996C | Physician-Medical Director | Sharon Schultz | OP Forens Hosp Clinic | 6/30/2017 | Yes | 11/5/2016 | NR | Y | Y | 5/22/2017 | 6/8/2017 | |
| Spiegel, David A MD | 1007.140C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Spiegel, David A MD | 1004.2353C | Physician-Medical Director | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Spiegel, David A MD | 1004.2550C | Physician-Services Agreement | Jeremy Raimo | Cardio Vasc Health Institute | 6/30/2017 | Yes | 12/6/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Stanbridge College | 1007.1481C | Clinical Affiliation Agreement | Elizabeth Fleming | Education | 5/27/2019 | Yes | 11/18/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Stern, Mark D MD | 1007.138C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical Eye Care Center | 1007.1004C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 2/17/2019 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical First Assist Nurse Practitioner - Dolores Fazzino | 1007.3124C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical First Assist Nurse Practitioner - John Cowan | 1007.3125C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

# TRI-CITY HE[illegible]ICARE DISTRICT
## CLINICAL CONTRACT EVALUATIONS 2017

| Vendor | Contract Number | Contract Type | Responsible Party | Responsible Dept | Expiration Date | Communication | Date Evaluated | Renew "R"/Not Renew "NR" | PHI Req'd | PHI Rec'd | MEC Review | PAC Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgical First Assist Nurse Practitioner - Beth Forbes | 1007.3128C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical First Assist Nurse Practitioner - Christopher Crespo | 1007.3129C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical First Assist Nurse Practitioner - James Hamilton | 1007.3470C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Surgical First Assist Nurse Practitioner - Lori Packard | 1007.3490C | Services Agreement | Mary Diamond | Nursing Admin | 6/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Tantuwaya, Lokesh MD | 1007.3304C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2018 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| The Center for Endoscopy | 1007.1003C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 8/4/2018 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| The Regents of the Univ. of California | 1007.2182C | Services Agreement | priya Joshi | Med Staff Support | 9/30/2019 | Yes | 11/7/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| The Regents of the Univ. of California | 1007.2955C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 10/23/2017 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Together We Grow | 1007.3269C | Patient Transfer Agreement | Stephen Chavez Matzel | Case Management | 5/11/2018 | Yes | 11/16/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Toosie, Katayoun MD | 1007.144C | Physician-Coverage Agreement | Sherry Miller | Emergency Room | 6/30/2018 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Translational Research Management | 1007.2500C | Clinical Study Agreement | Ingrid Stuiver | Clinical Research | 5/14/2017 | Yes | 12/5/2016 | NR | Y | Y | 5/22/2017 | 6/8/2017 | |
| Tri-City Emergency Medical Group | 1007.28C | Physician-Coverage Agreement | Sharon Schultz | Emergency Room | 12/31/2016 | | 11/5/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Tri-City Pulmonary Medical Group, APC | 1007.3112C | Physician-Medical Director | Sharon Schultz | Pulmonary Rehab | 6/30/2018 | Yes | 11/5/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |
| Tri-City Pulmonary Medical Group, APC | 1007.3295C | Physician-Panel Agreement | Sherry Miller | ICU | 6/30/2017 | | 11/1/2016 | R | Y | Y | 5/22/2017 | 6/8/2017 | |

DRAFT

# Governance & Legislative Committee Meeting Minutes
## Tri-City Healthcare District
## June 6, 2017

**Members Present:** James J. Dagostino, DPT, PT, Chairperson; Director Laura E. Mitchell; Director RoseMarie V. Reno' Dr. Paul Slowik, Community Member; Robin Iveson, Community Member; Dr. Cary Mells, Physician Member; Dr. Gene Ma, Chief of Staff; Dr. Marcus Contardo, Physician Member

**Non-Voting Members:** Steve Dietlin, CEO; Kapua Conley, COO; Scott Livingstone, Interim CCO

**Others Present:** Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Jody Root, General Counsel; David Bennett, Chief Marketing Officer; Wayne Knight, Chief Strategy Officer

**Absent:**

| | Discussion | Action Follow-up | Person(s) Responsible |
|---|---|---|---|
| 1. Call To Order | The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino. | | |
| 2. Approval of Agenda | **It was moved by Director Reno and seconded by Dr. Slowik to approve the agenda as presented. The motion passed unanimously.** | Agenda approved. | |
| 3. Comments from members of the public | Chairman Dagostino read the Public Comments announcement as listed on today's Agenda. | Information only | |
| 4. Ratification of prior Minutes | **It was moved by Dr. Contardo and seconded by Director Mitchell to ratify the minutes of the May 2, 2017 Governance & Legislative Committee. The motion passed with Director Reno, Dr. Mells and Ms. Iveson abstaining from the vote.** | Minutes ratified. | Ms. Donnellan |
| 5. Old Business<br><br>a) Review and discussion of revised Board Policy 16-023 – Responsibility for Decision-making on Legal Matters | Per discussion at last month's meeting, Board Policy 16-023 was revised to reflect the reporting structure for the Chief Compliance Officer as well as the revised Job Description for the Chief Compliance Officer. | | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
|---|---|---|---|
| | | | DRAFT |
| | In response to a question by Director Reno, General Counsel confirmed that the Board does authorize the use of all outside counsel and the Board provides oversight of General Counsel. Director Reno suggested Review of Outside Counsel be added to the Board's Work Plan.<br><br>**It was moved by Dr. Mells to recommend approval of amended Board Policy 16-023 – Responsibility for Decision-making on Legal Matters. Dr. Slowik seconded the motion. The motion passed unanimously.** | Recommendation to be sent to the Board of Directors to approve Board Policy 16-023 – Responsibility for Decision-making on Legal Matters; item to be placed on agenda and included in agenda packet.<br><br>Board Work Plan to include an annual review of outside legal counsel utilized by the District. | Ms. Donnellan<br><br>Ms. Donnellan |
| b) Review and discussion of revised District Bylaws | In follow-up to last month's meeting, revisions were made to reflect that the Compliance Officer reports directly to the CEO.<br><br>Dr. Contardo questioned the manner in which the Chief Compliance Officer is evaluated. Mr. Dietlin explained the evaluation of the Chief Compliance Officer was removed from the Bylaws as the Bylaws reflect what the Board is responsible for. Mr. Dietlin stated he would be evaluating the Chief Compliance Officer in the same manner in which he evaluates his other direct reports.<br><br>Discussion was held regarding Article VI, Section 2. Clerk of the Board of Directors. Director Reno requested clarification from General Counsel on the title. Mr. Root stated the title Clerk of the Board is widely used in governmental statutes however he does not know if the title is a statutory requirement. Director Reno questioned if the Clerk of the Board should be under the direct supervision of the Board. Dr. Contardo suggested the first section of Section 2. be revised to read: "For the purposes of statutory service, the Executive Assistant shall serve as Clerk of the Board of Directors." | | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | Dr. Ma suggested the language "Joint Commission on Accreditation of Healthcare Organizations" be struck throughout and be replaced with "The Joint Commission".<br><br>Director Reno questioned if the District has a physical Corporate Seal. Ms. Donnellan responded that the Corporate Seal is kept in the administrative offices and used as needed, from time, typically on legal documents.<br><br>**It was moved by Director Mitchell to accept the recommended changes and recommend approval of the Bylaws by the Board of Directors pending review by Mr. Moser. Dr. Contardo seconded the motion. The motion passed unanimously.** | Recommendation to be sent to the Board of Directors to approve the amended Bylaws pending review by Mr. Moser; item to be placed on Board agenda and included in agenda packet. | Ms. Donnellan |
| 6. New Business<br><br>a. Review and discussion of Board Policy 042 – Duties of the Board of Directors | Director Reno requested that the record reflect that when she submits agenda items related to succession planning and compensation philosophy, it is erroneous that she wants Mr. Dietlin to resign. Furthermore, it has never been her intention to dismiss Mr. Dietlin.<br><br>Director Reno stated that in regards to transparency and accountability, she has concerns regarding keeping the community informed. She commented on the Board's Special Meeting last week in which Quality was the topic and Dr. Johnson's role as Chairman of Quality.<br><br>Director Reno expressed concern regarding rumors of a massive layoff and how that could impact our quality.<br><br>Director Reno commented on succession planning that is needed when Mr. Dietlin is away from the Medical Center and the need to have someone in charge that the employees can trust and someone in which the physicians do not feel threatened by. It was noted that when Mr. Dietlin is away from the Medical Center the Board and C-Suite are advised and directed to the appropriate individuals as outlined in Mr. Dietlin' s recent | | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | communication to them.<br><br>With regard to Board Policy 042, it was recommended the reference to the Chief Compliance Officer be removed in the Board Policies section and policy numbers be updated as applicable.<br><br>**It was moved by Director Mitchell to recommend approval of Board Policy 042 as recommended. Dr. Contardo seconded the motion. The motion passed unanimously.**<br><br>Director Reno requested clarification on the "Responsible Officer Doctrine". Mr. Root explained the Responsible Officer Doctrine stems from a Caremark lawsuit in which Board members were going to be indicted. Mr. Root stated the compliance section of Board Policy 042 is included as a result of that action. | Recommendation to be sent to the Board of Directors to approve Board Policy 042-Duties of the Board of Directors with amendments as described; item to be listed on agenda and included in agenda packet. | Ms. Donnellan |
| 7. Discussion regarding Current Legislation | Chairman Dagostino reviewed the Key State Issues that might apply to the District, including the following:<br><br>➢ AB 43 – would levy a 10 percent tax on companies that contract to provide goods or services to state prisons, the Department of Corrections and Rehabilitation or the Department of General Services. The revenue would be used to expand programs that prevent incarceration, such as universal preschool and after-school programs.<br><br>Upon further review of AB 43 it appears the District would be exempt from the ten percent tax. General Counsel suggested ACHD track and trend the bill.<br><br>➢ SB 457 – in part, would prohibit physicians and midwives from attending certain births in a licensed alternative birth center or at home and put onerous procedures in place for those out of hospital births that would still legally be allowed. | Information only. | |

| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | It was noted that this bill would not affect the district as our midwives are hospital-based and refers to the home (lay) midwives. Discussion was held regarding problems that can arise when the lay midwife delays sending an acute patient to the Emergency Department. Dr. Ma commented that SB 457 is addressing a problem that we have already experienced in the past and if it passes the problems the district face will become worse.<br><br>➢ AB 1612 – would allow full practice authority for certified midwives.<br><br>Mr. Livingstone stated AB 1612 doesn't take away the physician back-up requirement.<br><br>It was noted CHA is supporting the AB 1612 and opposing SB 457.<br><br>➢ SB 481 – sponsored by CHA, this bill would address deficiencies identified in CANHR v. Chapman. Specifically, it would strengthen the current process of notifying skilled-nursing facility residents who lack capacity and have no legal representative of recommended medical interventions requiring informed consent.<br><br>*Ms. Iveson left the meeting at 1:24 p.m.*<br><br>➢ SB 799 –in part, would require employers to report to the BRN a registered nurse suspended, terminated or resigned for cause. "For cause" is defined to include, among other conduct, use of controlled substances or alcohol to the extent that it impairs the nurse's ability to safely practice, patient or client abuse, neglect, physical harm or sexual contact with a patient or client; and unlawful sale of controlled substance.<br><br>Director Reno questioned if the hospital's internal policy | | |

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| Topic | Discussion | Action Follow-up | Person(s) Responsible |
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| | is clear regarding action that is taken when a nurse is found to have diverted drugs. Mr. Livingstone confirmed the hospital's policy is concise and clear.<br><br>Dr. Slowik questioned what impact the single-payer healthcare care coverage bill might have on the district. Mr. Wayne Knight, CSO stated the Bill, also known as the Healthy California Act is addressed in SB 562. | | |
| 8. Review of FY2017 Committee Work Plan | The FY2017 Committee Work Plan was included in the agenda packet for information. | None | |
| 9. Committee Communications | Director Reno suggested the committee solicit applications for an additional community member.<br><br>Director Mitchell commented on her recent experience at Palomar Medical Center. | Ad to be placed for the vacancy on the committee | Ms. Donnellan |
| 10. Committee Openings – One | There is currently one opening on the committee. | | |
| 11. Confirm date and time of next meeting | The committee's next meeting is scheduled for Tuesday, August 1, 2017 at 12:30 p.m. | The next meeting of the Committee is August 1, 2017. | |
| 12. Adjournment | Chairman Dagostino adjourned the meeting at 1:50 p.m. | | |

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #16-023**

**POLICY TITLE: Responsibility for Decision-making on Legal Matters**

## 1. ROLE OF THE BOARD OF DIRECTORS

While the Board of Directors retains ultimate responsibility for the conduct of the business of the Tri-City Healthcare District, the Board has delegated implementation of its policies and day-to-day operations to the Chief Executive Officer (CEO) and management of the compliance program to the Chief Compliance Officer. Notwithstanding these general delegations or other Board policies, the Board of Directors retains responsibility for making the following decisions:

a. **General Counsel**. Hiring of General Counsel to advise the Board on any legal matter as requested by the Board or as established by policy. The Board shall approve the retainer agreement, provided that the CEO or Chief Compliance Officer may negotiate rates and approve attorneys to be assigned to legal matters over which they have authority, if not otherwise specified in the retainer agreement. Invoices shall be approved by the Chair of the Board.

b. **Chief Compliance Officer**. General oversight of the activities ~~Hiring and termination~~ of the Chief Compliance Officer in implementation of compliance programs and ~~, including~~ approval of ~~terms and conditions of employment and~~ the job description for the Chief Compliance Officer.

c. **Outside Counsel**. Authorizing the retention of any outside lawyer or law firm to represent the interests of the District and approving the terms, conditions and scope of such retention. However, the General Counsel or Chief Compliance Officer, in consultation with the CEO as appropriate, may assign such approved counsel matters, as needed, provided such matters are within the scope of work described in the retainer agreement. The General Counsel or Chief Compliance Officer shall require a matter budget for each new engagement assigned which is expected to exceed $30,000 in fees and costs. In addition, the Risk Manager, in consultation with General Counsel and the Chief Compliance Officer, shall develop and provide outside counsel with written litigation management guidelines that shall apply to all such counsel. The Board shall be provided with information on at least a quarterly basis regarding all matters projected to exceed a total of $50,000 in legal fees, costs, and damages (if applicable).

d. **Claims and Settlements**. With the exception of appeals of the denial of payment for clinical services, the Board shall approve or authorize the settlement of any legal matter exceeding $50,000 in value, whether in favor of or against the District. The Board shall authorize or approve the compromise of any claim made by the District in any litigation or other adversarial proceeding exceeding $50,000, and shall approve settlements exceeding $50,000.

e. **Initiation of litigation**. With the exception of appeals of the denial of payment for clinical services, authorizing initiation of formal arbitration or litigation shall require approval of the Board. However, in the event legal action must be taken to protect life, health or safety within or about the facilities operated by the District, the CEO, with the concurrence of the General Counsel or Chief Compliance Officer may approve the commencement of litigation seeking equitable relief. In such event, the Board shall be notified within 24 hours, and ratification of the action shall be placed on the next agenda for consideration by the Board.

## B. ROLE OF GENERAL COUNSEL

See Appendix A.

## C. ROLE OF CHIEF COMPLIANCE OFFICER

See Appendix B.

**Approved by the Board of Directors: 1/30/14**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov/Leg Committee: 5/06/14**
**Approved by the Board of Directors: 5/29/14**
**Reviewed by the Gov/Leg Committee: 6/07/16**
**Approved by the Board of Directors: 6/30/16**

*Appendix A*

**Position Description**
**General Counsel**
**Tri-City Healthcare District**

**Summary**: General Counsel is retained by and reports to the Board of Directors. General Counsel carries out legal duties as assigned by the Board, and the Chief Executive Officer acting within his or her delegated authority. General Counsel supports and coordinates with the Chief Compliance Officer and ~~other~~ in-house risk management and legal staff. General Counsel advises the District on compliance with state transparency laws, including but not limited to open meetings, public records and conflict of interest laws, as well as compliance with the Local Healthcare District Law.

**Essential Functions**:

(a) Advises the Board of Directors and District officers in all matters of law pertaining to their offices, upon request and consistent with District policies.
(b) Represents and appears for the District and any District officer in actions and proceedings in which the District or any officer or employee, in or by reason of his or her official capacity is concerned or is a party, when so directed by the Board, Chief Executive Officer, Chief Compliance Officer or Chair of the Board, as authorized.
(c) Advises on the initiation of any litigation, and provides, assists or supports the Chief Compliance Officer in, the oversight of litigation matters.
(d) Attends all regular and special meetings of the Board of Directors, and such meetings of Board committees, or other meetings as requested by the chairperson of the committee, the Chief Executive Officer or Chief Compliance Officer.
(e) Approves the form of contracts prepared by the District, and reviews the form of contracts to be made by the District as are referred by Chief Executive Officer or Chief Compliance Officer.
(f) Prepares or reviews any and all proposed ordinances or resolutions for the District and amendments thereto.
(g) Prosecutes claims or actions on behalf of the District as authorized pursuant to District policy.
(h) Devotes such time to the duties of office as may be specified by any ordinance, resolution or policy of the District.
(i) Assists in establishing compliance philosophy and guidelines in conjunction with the Chief Compliance Officer.
(j) Advises the Board and senior management on proposed and existing legislation affecting the District.

Notwithstanding the foregoing, the Board of Directors shall have control of all legal business and proceedings and may employ other attorneys to take charge of any litigation or matter or to assist the General Counsel therein.

Tri-City Medical Center

| | | | |
|---|---|---|---|
| **Position Title:** | **Chief Compliance Officer** | **Job Code Number:** | **20020** |
| Department Name/Location: | Administration | **Department Number(s):** | **8610** |
| **Status (Check one):** | **Exempt __X__ Nonexempt____** | **Position Reports To: (Title only)** | **CEO** |
| **Management Approval (VP or higher):** | **Chief Executive Officer (CEO)** | **Date Approved:** | **May 08, 2017** |
| **Compensation Approved by:** | **HR Analyst** | **Date Approved:** | **May, 2017** |

**The position characteristics reflect the most important duties, responsibilities and competencies considered necessary to perform the essential functions of the job in a fully competent manner. They should not be considered as a detailed description of all the work requirements of the position. The characteristics of the position and standards of performance may be changed by the CEO and / or District with or without prior notice based on the needs of the organization. The physical location for this position will be in the District's corporate headquarters at 4002 Vista Way, Oceanside, CA in an office designated by the CEO**

**Position Summary:**

The incumbent serves as the primary contact for the District's Compliance Program. This individual occupies a high-level position reporting directly to the Medical Center's CEO and a 'dotted line' reporting responsibility to the District's Board of Directors, and functions as an independent and objective person who directs and monitors the District's Compliance Program. Key responsibilities include: develops, initiates and ensures that policies and procedures for the operation of the Compliance Program are implemented so that the District maintains compliance with all applicable laws, regulations, standards of conduct and policies. In addition, the incumbent advises the CEO and/or his designee and the Board of Directors and all internal committees on material legal and compliance risks, mitigation and corrective actions.

**Major Position Responsibilities:**

- Develop, implement, oversee, monitor and promote the implementation and maintenance of an effective Compliance Program.
- Provide guidance to the CEO, the Board of Directors and the District's senior management regarding matters related to compliance.
- Deliver ongoing reports of Compliance Program activities to the CEO and to the Audit and Compliance Committee.
- Report on a regular basis (and no less than quarterly) to the Board of Directors on activities, changes to, and progress of, the Compliance Program.
- Develop, monitor and revise the Compliance Program, including the Code of Conduct and compliance policies and procedures, as needed and based on changes in, and needs of, the District as well as changes in applicable laws and regulations.
- Develop and coordinate timely educational and training initiatives that focus on the Compliance Program ensuring that Board members and District personnel are educated on compliance matters.
- Ensure independent contractors and agents of the District are aware of the District's Compliance Program and how it affects the services provided by contractors and agents.
- Establish, publicize and reinforce effective lines of communication throughout the organization including, reporting mechanisms, and oversee the District's compliance hotline.
- Create and enforce policies and procedures, in cooperation with Human Resources, the Procurement Department and the Medical Staff Office related to appropriate screening of the District's employees, contractors, vendors, and health care providers against state and federal health care program and agency debarment lists in accordance with District policies and procedures.
- In cooperation with Human Resources, oversee and monitor the enforcement of compliance obligations and standards through appropriate disciplinary mechanisms.
- Establish and implement systems for routine monitoring and auditing reasonably designed to detect violations of the Code of Conduct and applicable laws, regulations and policies.

- Establish an annual risk assessment process to identify key areas of compliance risk.
- Conduct timely investigations of identified potential compliance issues and consult with the District's legal counsel, as necessary and appropriate.
- Designate work groups and task forces needed to carry out investigations or initiatives of the Compliance Program.
- Develop and implement appropriate and timely corrective action plans to resolve risks and prevent similar future risks.
- Manage other resources, as appropriate, to ensure appropriate legal, compliance and risk program services are provided to the District.

Additional responsibilities may include:

- Oversight of Board approved templates and controls.
- Collector of public record requests and document production.
- Liaison with the Board of Directors and Administration regarding the Corporate Compliance program.
- Facilitate activities related to internal audit and compliance.
- Oversee all contracts in the electronic management system including alerts for deadlines, renewals and regulatory change.
- Other responsibilities assigned by the CEO.

## Qualifications:

### *ESSENTIAL COMPETENCIES, KNOWLEDGE, & EXPERIENCE*

- Knowledge of, and familiarity with, health care provider compliance programs, required.
- Knowledge of state and federal laws and regulations related to health care providers and, particularly hospitals, including fraud and abuse, reimbursement and accreditation standards.
- Demonstrated ability to communicate with management and report to boards of directors, required.
- Knowledge of healthcare risk management, claims management, and loss control, required.
- Excellent written and oral communication skills, personal initiative, organized and methodical, meticulous documentation and computer skills, prompt and reliable, thorough and consistent, and flexible and adaptable to change, required.

### Education:

- Graduate degree in Healthcare Administration or Juris Doctorate degree required.

### Experience:

- Minimum 5 years' experience in a health care compliance program, preferably in a hospital setting, with at least 2 years at an executive level, required.

### Certifications:

- Certification in Healthcare Compliance (CHC) through the Health Care Compliance Association (HCCA), California Hospital Association (CHA) or other recognized Compliance Officer Certification, preferred or obtained within 18 months of hire

### Essential Organizational Behaviors

1. Demonstrates behaviors that are consistent with the District's Mission and Values and those that reflect the "Standards of Service Excellence".
2. Performs job responsibilities in an ethical, compliant manner consistent with the District's values, policies, procedures, and Code of Conduct.
3. Works well with team members toward a common purpose. Reinforces the efforts and goals of the work group. Supports the team's decisions regardless of individual viewpoint.
4. Demonstrates flexibility in schedules and assignments in order to meet the needs of the organization. .
5. Utilizes, maintains, and allocates equipment and supplies in a cost-effective and efficient manner. Improves productivity through proper time management.
6. Seeks feedback from customers and team members in order to identify and improve processes and outcomes.

### *Equal Employment Opportunity*

Tri-City Medical Center is committed to the principle of Equal Employment Opportunity for all employees and applicants. It is our policy to ensure that both current and prospective employees are afforded equal employment opportunity without consideration of race, religious creed, color, national origin, nationality, ancestry, age, sex, marital status, sexual orientation, or present or past disability (unless the nature and extent of the disability precludes performance of the essential functions of the job with or without a

reasonable accommodation) in accordance with local, state and federal laws.

***Americans with Disabilities Act***

Applicants as well as employees who are or become disabled must be able to perform the essential job functions either unaided or with reasonable accommodation. The organization shall determine reasonable accommodation on a case-by-case basis in accordance with applicable law.

**Physical, Mental and Environmental Demands**

| Physical Requirements for Job | | |
|---|---|---|
| 1 | Sit | |
| 2 | Stand | |
| 3 | Walk | |
| 4 | Bend/stoop | |
| 5 | Squat/Crouch | |
| 6 | Climb Stairs | |
| 7 | Kneel | |
| 8 | Balance | |
| 9 | Walk on uneven surfaces | |
| 10 | Reach | |
| 11 | Twist/turn | |
| 12 | Push/pulls: | |
| | ❖ Patients | |
| | ❖ Carts | |
| | ❖ Beds/gurneys | |
| | ❖ Wheelchairs | |
| | ❖ Other: | |
| 13 | Lifts or transfers: | |
| | ❖ Up to 10 lbs. | |
| | ❖ 11-20 lbs. | |
| | ❖ 21-50 lbs. | |
| | ❖ 51-100 lbs. | |
| | ❖ Greater than 100 lbs. | |
| 14 | Lifts and carries: | |
| | ❖ Up to 10 lbs. | |
| | ❖ 11-20 lbs. | |
| | ❖ 21-50 lbs. | |
| | ❖ 51-100 lbs. | |
| | ❖ Greater than 100 lbs. | |
| **Communication/Sensory** | | |
| 1 | Speaking/hearing | |
| | ❖ In person | |
| | ❖ Phone | |
| | ❖ Call system | |
| 2 | Reading/writing | |
| | ❖ English | |
| | ❖ Other | |
| 3 | Visual acuity | |
| | ❖ Near | |
| | ❖ Far | |
| | ❖ Small figures | |
| | ❖ Color differentiation | |
| 4 | Distinguish temperatures | |
| | ❖ By touch | |
| | ❖ By proximity | |
| 5 | Hands | |
| | ❖ Repetitive motions | |
| | ❖ Fine manipulation | |
| | ❖ Finger dexterity | |
| | ❖ Gross manipulation | |
| | ❖ Grasping | |
| | ❖ Wrist - ROM | |
| **Environmental Requirements/Exposure** | | |
| 1 | Blood/body fluids | |
| 2 | Infectious diseases | |
| 3 | Radiation | |
| 4 | Antineoplastic agents | |
| 5 | Laser | |
| 6 | Solvents | |
| 7 | Chemicals | |
| 8 | Heat/cold extremes | |
| 9 | Unprotected heights | |
| 10 | Helipad | |
| 11 | Dust | |
| 12 | Fumes/gases/odors | |
| 13 | Aerosolized drugs | |
| 14 | Working with VDTs | |
| 15 | Working on moving machinery | |
| 16 | Inside | |
| 17 | Outside/changing climates | |
| 18 | Working with electrical wires | |
| 19 | Driving auto equipment | |
| 20 | Sharp objects | |
| 21 | Abusive language from patients | |
| 22 | Violent behavior from patients | |
| 23 | Confined work environment | |
| 24 | Crowded work environment | |
| **Other Factors** | | |
| 1 | Working irregular shifts | |
| 2 | Rotating shifts | |
| 3 | Working alone | |
| 4 | Independent problem-solving | |
| 5 | Working with others | |
| 6 | Exposure to public: | |
| | ❖ Patients | |
| | ❖ Staff | |
| | ❖ Physicians | |
| 7 | Fast-pace workplace | |
| 8 | Periodic education requirement | |
| 9 | Frequent change | |
| 10 | Exposure to emotional crises of others | |
| 11 | Frequent interruptions | |
| 12 | Meeting deadlines | |
| 13 | Handle multiple priorities | |
| 14 | Memory | |
| **Protective Equipment Requirements** | | |
| 1 | Gloves | |
| 2 | Goggles/face masks/shields | |
| 3 | Ear protection | |
| 4 | Gowns | |
| 5 | Aprons | |

**N = Not at all** **O = Occasionally**
**F = Frequently (34%-66%) C = Continually (67% - 100%)**

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SILICON VALLEY

# MEMORANDUM

**TO:** Board of Directors
Tri-City Healthcare District

**FILE NO:** 116569/000004

**FROM:** Greg V. Moser, General Counsel
Rachael A. Harrington

**CC:** Steve Dietlin, CEO

**DATE:** June 21, 2017

**RE:** Proposed Bylaws Amendment Defining Executive Assistant as including "Clerk"

---

The Governance and Legislative Committee took note of the recent confusion regarding the delivery of a notice of claim alleging a violation of the California Voting Rights Act under Elections Code § 10010 to the "clerk" of the District. Pursuant to Elections Code § 10010, a complainant is required to send the notice by certified mail to the *clerk* of the Board. Elec. Code § 10010(e)(1). The Board, however, has not designated any official as the clerk for these purposes. In order to clarify the matter for the future, the committee recommends that the Bylaws be revised to provide that the Executive Assistant—who is a Management Official described in the current Bylaws—be denominated as the Clerk of the district for the purposes of the Elections Code.

Therefore it is recommended that the Board amend Article VI, Section 2 of the Bylaws to read as follows:

> The Clerk of the Board of Directors shall be the Executive Assistant under the immediate supervision of the President/Chief Executive Officer. The President/Chief Executive Officer may assign other staff members as may be necessary to complete the work of the Board of Directors. The Executive Assistant shall serve as Clerk of the Board of Directors for the purposes of Elections Code section 307.

The Board is authorized "to prescribe the duties and powers of the health care facility administrator, secretary, and other officers and employees,....[and] to establish offices as may be appropriate ....." Health and Safety Code § 32121(h).

As stated above, Elections Code § 10010(e)(1) requires the complainant to provide the District "clerk" with written notice of an alleged violation of the California Voting Rights Act (CVRA) prior to filing suit. The Elections Code defines the term "clerk" as the county elections official, registrar of voters, city clerk, *or other officer or board charged with the duty of conducting any*

*election*." Elec. Code § 307 (emphasis added). Legally, then, the clerk for the purposes of Elections Code § 10010(e)(1) may be an officer of the Board or the Board itself. By amending the Bylaws, it will be clear that the Executive Assistant is the official designated to receive notices of claims against the District under the CVRA.

We note that this change is also consistent with the laws governing presentation of claims under the Government Claims Act, which provides for presentment to the clerk or secretary of the agency, which may provide clarity for some claimants. Government Code § 915.

Please find enclosed a redlined copy of the Bylaws incorporating the amendment to Article VI, Section 2 proposed above.

RNH

# TRI-CITY HEALTHCARE DISTRICT

# BYLAWS

Approved ~~July 30, 2015~~

# PREAMBLE

The name of this District shall be TRI-CITY HEALTHCARE DISTRICT, organized December 10, 1957, owning and operating TRI-CITY MEDICAL CENTER, under the terms of The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.)

The objectives of this District shall be to promote the public health and general welfare of the communities it serves.

This District shall be empowered to receive and administer funds for the attainment of these objectives, in accordance with the purposes and powers set forth in The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.) and other applicable law.

## ARTICLE I

## Purposes and Scope

Section 1. Scope of Bylaws.

These Bylaws shall be known as the "District Bylaws" and shall govern the TRI-CITY HEALTHCARE DISTRICT, its Board of Directors, and all of its affiliated and subordinate organizations and groups.

The Board of Directors may delegate certain powers to the Medical Staff and to other affiliated and subordinate organizations and groups, such powers to be exercised in accordance with the respective Bylaws of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups in the Bylaws of such other organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

The Bylaws of the Medical Staff and other affiliated and subordinate organizations and groups, and any amendments to such Bylaws, shall not be effective until they are approved by the Board of Directors of the TRI-CITY HEALTHCARE DISTRICT. In the event of any conflict between the Bylaws of the Medical Staff and any other affiliated or subordinate organization or group, and the provisions of these District Bylaws, these District Bylaws shall prevail. In the event the District Bylaws are in conflict with any statute of the State of California governing hospital and health care districts, such statute shall be controlling.

Section 2. Purposes.

The purposes of the TRI-CITY HEALTHCARE DISTRICT shall include, but not necessarily be limited to, the following:

a. Within the limits of community resources, to provide the best facilities and services possible for the acute and continued care of the injured and all, regardless of race, creed, national origin, age or disability.

b. To assure the highest level of patient care in the hospital of the District.

c. To coordinate the services of the District with community agencies and other hospitals providing health care services.

d. To conduct educational and research activities essential to the attainment of its purposes.

e. To do any and all other acts necessary to carry out the provisions of the Local Health Care District Law, other applicable law, and District Bylaws and policies.

Section 3. Profit or Gain.

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits, to any individual, under any guise whatsoever, nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. Disposition of Surplus.

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable hospital purposes, such as the establishment of free or part-free hospital beds, or for improvements in the hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Law, other applicable law, and District Bylaws and policies.

## ARTICLE II

## OFFICES

Section 1. Offices.

The principal office for the transaction for the business of the TRI-CITY HEALTHCARE DISTRICT is hereby fixed at TRI-CITY MEDICAL CENTER, 4002 Vista Way, Oceanside, California. Branch offices may at any time be established by the Board of Directors at any place within or without the boundaries of TRI-CITY HEALTHCARE DISTRICT, for the benefit of TRI-CITY HEALTHCARE DISTRICT and the people served by TRI-CITY HEALTHCARE DISTRICT.

Section 2. Mailing Address.

The mailing address of TRI-CITY HEALTHCARE DISTRICT shall be as follows:

TRI-CITY HEALTHCARE DISTRICT
c/o Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

## ARTICLE III

## DIRECTORS

Section 1. Number, Qualifications, Election or Appointment.

The Board of Directors shall consist of seven (7) members, who are elected (or appointed) in accordance with the Local Health Care District Law of the State of California, and other applicable law, each of whom shall be a registered voter, residing in the District. The members of the Board of Directors shall be elective officers of the local health care district. (H&S Code §§ 32100 and 32100.5.)

Section 2. Term.

The term of each member of the Board of Directors elected shall be four (4) years, or until his or her successor is elected and has qualified. The person receiving the highest number of votes for each office to be filled at the health care district general election shall be elected thereto. A member of the Board of Directors elected (or appointed pursuant to the provisions of the Uniform District Election Law, Elections Code §§ 10500-10556) shall take office at noon on the first Friday in December next following the District general election. (H&S Code §§ 32002, 32100 and 32100.5; Elections Code § 10554.)

Section 3. Powers and Duties.

The Board of Directors shall have and exercise all the powers of a Health Care District set forth in the Local Health Care District Law (H&S Code § 32000 et seq.), other applicable law, and District Bylaws and policies, as well as the powers listed herein:

a. To control and be responsible for the management of all operations and affairs of the District.

b. To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction.

c. To appoint the President/Chief Executive Officer and to define the powers and duties of such appointee.

~~d. To appoint the Chief Compliance Officer and to define the powers and duties of such appointee.~~

~~e.~~ d. To delegate certain powers to the Medical Staff and other affiliated or subordinate organizations in accordance with their respective bylaws. The Medical Staff shall notify the Board of Directors upon election of the Chief of the Medical Staff and of all Chairpersons of the various medical departments and services, whose powers and duties shall be defined by the Medical Staff Bylaws as approved by the Board of Directors.

~~f.~~e. To approve or disapprove all constitutions, bylaws, rules and regulations, including amendments thereto; of all affiliated or subordinate organizations.

~~g.~~f. To appoint, promote, demote and remove all members of the Medical Staff. The Medical Staff shall make recommendations in this regard.

~~h.~~g. To establish policies for the operation of this District, its Board of Directors and its facilities.

~~i.~~h. To designate by resolution persons who shall have authority to sign checks drawn on the funds of the District.

~~j.~~i. To do any and all other acts necessary to carry out the provisions of these Bylaws or the provisions of the Local Health Care District Law and other applicable law.

~~k.~~j. To negotiate and enter into agreements with independent contractors, including physicians, paramedical personnel, other agencies and other facilities within the District's jurisdiction. (H&S Code §§ 32121 and 32128.)

Along with the powers of the Board of Directors, it shall be the duty of the Board of Directors to establish rules of the hospitals and other facilities within District jurisdiction, which shall include the following:

aa. Provision for the organization of physicians and surgeons, podiatrists, and dentists, licensed to practice in the State of California who are permitted to practice in the hospitals and other facilities within District jurisdiction into a formal Medical Staff, with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

~~bb.~~ Provision for a procedure for appointment and reappointment of Medical Staff as provided by the standards of ~~the Joint Commission on Accreditation of Healthcare Organizations.~~ The Joint Commission.

~~cc.~~bb. Provision that the Medical Staff shall be self governing with respect to the professional work performed in hospitals and other facilities within District jurisdiction; that the Medical Staff shall meet in accordance with the minimum requirements of ~~the Joint Commission on Accreditation of Healthcare Organizations~~The Joint Commission; and that the medical records of the patients shall be the basis for such review and analysis.

~~dd.~~cc. Provision that accurate and complete medical records be prepared and maintained for all patients.

~~ee.~~dd. Limitations with respect to the practice of medicine and surgery in the hospitals and other facilities within District jurisdiction as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership, as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California.

Members of the Board of Directors shall also have the following duties:

aaa. Duty of Care. Directors shall exercise proper diligence in their decision-making process by acting in good faith in a manner that they reasonably believe is in the best interest of the District, and with the level of care that an ordinarily prudent person would exercise in like circumstances.

bbb. Duty of Loyalty. Directors shall discharge their duties unselfishly, in a manner designed to benefit only the District and not the Directors personally or politically, and shall disclose to the full Board of Directors situations that they believe may present a potential for conflict with the purposes of the District.

ccc. Duty of Obedience. Directors shall be faithful to the underlying purposes of the District described in Article I, section 2, herein.

If it is found, by a majority vote of all of the Board of Directors in office at that time, that a Director has violated any of his or her duties to the detriment of the District, such Director is subject to removal from office according to the procedures set forth in section 9, subdivision a, of Article IV.

The rules of the hospitals and other facilities within District jurisdiction shall, insofar as is consistent with the Local Health Care District Law and other applicable law, be in accord with and contain minimum standards not less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board of Directors may adopt other rules which could be lawfully adopted by private or voluntary hospitals. (H&S Code §§ 32121 and 32128.)

Section 4. Compensation.

a. The Board of Directors shall serve without compensation, except that the Board of Directors, by a Resolution adopted by a majority vote of the members of the Board of Directors, may authorize the payment of not to exceed One Hundred and No/100 Dollars ($100.00) per meeting not to exceed five meetings a month as compensation to each member of the Board of Directors. (H&S Code § 32103.)

b. For purposes of this provision, "meeting" shall mean the following, to the extent permitted by applicable law: (1) any congregation of a majority of the members of the Board of Directors or of a committee or other body established by the Board of Directors, at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the Board of Directors or of the committee, if the congregation is subject to the open meeting requirements of Government Code Section 54953 and other applicable law; (2) and any other occurrences described in Government Code section 53232.1, if authorized pursuant to a written Board of Directors Policy; provided that payment of compensation shall be further subject to a member's compliance with such policies as the Board of Directors may establish. A Director is eligible for compensation under this provision for attendance at a regular or special meeting of a committee or subcommittee only if the Director is a duly-appointed member of that committee or subcommittee as of the

date of attendance, or as may be authorized by Board of Directors Policy as an "occurrence" and permitted by law..

c. Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the District as approved by the Board of Directors in accordance with applicable law, including but not limited to the provisions set forth in AB 1234, as they may be revised from time to time. (H&S Code § 32103.)

Section 5. Vacancies.

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code, State of California laws and other applicable law. (H&S Code § 32100.)

Section 6. Resignations.

Any member of the Board of Directors may resign at any time by giving written notice to the Board of Directors, or to the Chairperson, or to the Secretary or to the Clerk of the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein and unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

Section 7. Absences From Meetings.

The term of any member of the Board of Directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive regular meetings of the Board of Directors, and the Board of Directors by resolution declares that a vacancy exists on the Board of Directors.

MEETINGS OF DIRECTORS

Section 8. Regular Meetings.

Regular meetings of the Board of Directors of the District shall be scheduled for the last Thursday of each calendar month at a time determined by the Board of Directors at least annually, in Assembly Room 3 of the Eugene L. Geil Pavilion, Tri-City Medical Center, 4002 Vista Way, Oceanside, California. The Board of Directors may, from time to time, change the time, the day of the month of such regular meetings and the location (provided the location is within the boundaries of the District) as dictated by holiday schedules or changing circumstances. (H&S Code § 32104; Gov. Code § 54954.)

Section 9. Special Meetings.

A special meeting of the Board of Directors may be called at any time by the presiding officer of the Board of Directors or by four (4) members of the Board of Directors, by providing written notice as specified herein to each member of the Board of Directors and to each local newspaper of general circulation, radio or television station requesting notice in writing.

The notice shall be delivered by any means to effectuate actual notice, including but not limited to, personally or by mail and shall be received at least twenty-four (24) hours before the time of the meeting as specified in the notice.

The call and notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Board of Directors.

The written notice may be dispensed with as to any Board of Directors member who at or prior to the time the meeting convenes files with the Clerk or Secretary of the Board of Directors a written waiver of notice. The waiver may be given by telegram. The written notice may also be dispensed with as to any Board of Directors member who is actually present at the meeting at the time it convenes.

The call and notice shall be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. (Gov. Code § 54956.)

Section 10. Quorum.

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business. (H&S Code § 32106.) A quorum of the Board of Directors is the number of members that must be present in order to transact business. Members of the Board of Directors who are disqualified by law from participating in a given matter may not be counted toward a quorum for that matter. Members who are entitled to vote, but who voluntarily abstain from voting on a given matter, shall be counted toward a quorum for that matter.

Section 11. Number of Votes Required for Board of Directors Action.

In order for the Board of Directors to take action, a majority of the Directors entitled to vote on the matter and who have not abstained must vote in favor of the motion, proposal or resolution.

Section 12. Adjournment.

The Board of Directors may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular or adjourned regular meeting, the Secretary or Assistant Secretary of the Board of Directors may declare the meeting adjourned to a stated time and place and he or she shall cause a written notice of the adjournment to be given in the same manner as provided for special meetings, unless such notice is waived as provided for in special meetings.

A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within twenty-four (24) hours after the time of adjournment.

When a regular or adjourned regular meeting is adjourned as herein provided, the resulting adjourned regular meeting is a regular meeting for all purposes. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified for regular meetings by these Bylaws. (Gov. Code § 54955.)

Section 13. Public Meetings.

All meetings of the Board of Directors shall be open and public, and all persons shall be permitted to attend any meeting of the Board of Directors, except as otherwise provided in the Ralph M. Brown Act, the Local Health Care District Law and other applicable law. (Gov. Code § 54953(a); H&S §§ 32106 and 32155.)

Section 14. Setting the Agenda.

At least seventy-two (72) hours before a regular meeting, the Board of Directors of Tri-City Healthcare District or its designee shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public. If requested, the agenda, shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132). In addition, the agenda shall include information regarding how, to whom, and when a request for disability related modification or accommodation, including auxiliary aids or services may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meetings. The agenda is developed by the Board of Directors' Chairperson, President/Chief Executive Officer and General Legal Counsel. Any other Board of Directors member has the right to place an item on the agenda through the Chairperson. In the absence of the Chairperson, the Vice Chairperson has the authority to place an item on the agenda, and in the absence of both the Chairperson and Vice Chairperson, the Secretary has the right to place an item on the agenda. In the absence of the Chairperson, Vice Chairperson, and Secretary, the President/Chief Executive Office or General Legal Counsel shall place an item on the agenda, as requested by any Board of Directors member. All requests by Board of Directors members regarding placement of an item on the agenda shall be in writing.

No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Board of Directors or its staff may briefly respond to statements made or questions posed by persons exercising their public testimony rights under Government Code Section 54954.3 of the Brown Act. In addition, on their own initiative or in response to questions posed by the public, a member of the Board of Directors or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of the Board of Directors or the Board of Directors itself, subject to rules or procedures of the Board of Directors, may provide a reference to staff or other resources for factual information, request staff to report back to the body at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

The Board of Directors may take action on items of business not appearing on the posted agenda under any of the conditions stated in subsection (b) of Government Code Section 54954.2 or other applicable law. Prior to discussing any item pursuant to subdivision (b) of Government Code Section 54954.2, the Board of Directors shall publicly identify the item.

There must be a determination by a majority vote of the members of the Board of Directors that an emergency situation exists, as defined in Government Code Section 54956.5, as it may be revised

from time to time, or upon a determination by a two-thirds vote of the members of the Board of Directors present at the Board of Directors meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that there is a need to take immediate action, and that the need for action came to the attention of the Board of Directors subsequent to the agenda being posted.

Section 15. Rules of Order.

The rules contained in Robert's Rules of Order on Parliamentary Procedure shall govern the meetings of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT in all cases to which they are applicable and in which they are not inconsistent with the law of the State of California, the United States, or these Bylaws and/or policies and procedures as adopted by this governing body.

Section 16. Conflicts of Interest.

The Board of Directors of TRI-CITY HEATHCARE DISTRICT shall comply with all applicable laws regarding conflicts of interest, including but not limited to the California Political Reform Act, the provisions of the California Government Code regarding Prohibited Interests in Contracts, the California Doctrine of Incompatible Offices, as these laws may be amended from time to time.

## ARTICLE IV

## OFFICERS

Section 1. Officers.

The officers of the Board of Directors shall be a Chairperson, a Vice Chairperson, a Secretary, a Treasurer, an Assistant Secretary, and an Assistant Treasurer. No person shall hold more than one office. Whenever a Board of Directors officer is authorized to execute a written instrument in his or her official capacity, other than for reimbursement of expenses, the Chairperson and Secretary shall do so.

The Board of Directors has the power to prescribe the duties and powers of the District President/Chief Executive Officer, the secretary, and other officers and employees of any health care facilities of the District, to establish offices as may be appropriate and to appoint Board of Directors members or employees to those offices, and to determine the number of and appoint all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the Board of Directors. (H&S Code §§ 32100.001 and 32121(h).)

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every calendar year by the Board of Directors at the regular December meeting. Board of Directors members who are unable to be present at the regular December meeting may attend via teleconference and vote on the election of officers provided their teleconference location meets the applicable legal requirements for participation. They shall assume office at the close of that meeting, and each officer shall hold office for one year, or until his or her successor shall be elected and qualified, or until he or she is otherwise disqualified to serve.

Section 3. Chairperson.

The Board of Directors shall elect one of their members to act as Chairperson. If at any time the Chairperson shall be unable to act, the Vice Chairperson shall take his or her place and perform his or her duties. If the Vice Chairperson shall also be unable to act, the Board of Directors may appoint some other member of the Board of Directors to do so and such person shall be vested temporarily with all the functions and duties of the office of the Chairperson.

The Chairperson, or member of the Board of Directors acting as such as above provided:

a. Shall preside over all the meetings of the Board of Directors.

b. Board of Directors Chairperson, or his or her designee, shall attend Medical Executive Committee, Joint Conference Committee meetings and other similar meetings of non-District organizations related to operations of the hospital (including those of Medical Staff committees and the hospital foundation) on behalf of the Board of Directors. Designees shall be Board of Directors members and shall at all times exclusively represent the interests of the Board of Directors. Designees may be removed at any time at the sole discretion of the Board of Directors Chairperson.

c. Shall sign as Chairperson, on behalf of the District, all instruments in writing which he or she has been specifically authorized by the Board of Directors to sign, provided that such instruments shall also be signed by the Secretary of the Board of Directors (other than for reimbursement requests).

d. Shall have, subject to the advice and control of the Board of Directors, general responsibility for management of the affairs of the District during his or her term in office. (H&S Code § 32100.001.)

Section 4. Vice Chairperson.

The Board of Directors shall elect one of their members to act as Vice Chairperson. The Vice Chairperson shall, in the event of death, absence, or other inability of the Chairperson, exercise all the powers and perform all the duties herein given to the Chairperson.

Section 5. Secretary.

The Board of Directors shall elect one of their members to act as Secretary. The Secretary of the Board of Directors shall perform ministerial duties (i.e. sign legal documents on behalf of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. (H&S Code § 32100.001.)

Section 6. Treasurer.

The Board of Directors shall elect one of their members to act as Treasurer. The Treasurer shall be required to fulfill the duties under Health and Safety Code Section 32127; provided, however, that these duties are hereby delegated to the District's Chief Financial Officer to the extent permitted by law. (H&S Code § 32127; Gov. Code § 53600 et seq.)

Section 7. Assistant Secretary.

The Board of Directors shall elect one of their members to act as Assistant Secretary. The Assistant Secretary shall in the event of death, absence or other inability of the Secretary, exercise all the powers and perform all the duties herein given to the Secretary.

Section 8. Assistant Treasurer.

The Board of Directors shall elect one of their members to act as Assistant Treasurer. The Assistant Treasurer shall in the event of death, absence or other inability of the Treasurer, exercise all the powers and perform all the duties herein given to the Treasurer.

Section 9. Removal, Resignation or Vacancy.

a. Any officer appointed or elected by the Board of Directors may be removed from that office for failure to discharge the duties of that office, for violation of any of the policies of the Board of Directors, or for any other good cause, as determined by a majority vote of all the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

b. Any officer may resign from said office at any time by giving written notice to the Chair of the Board of Directors, the Board of Directors Secretary or to the Clerk of

the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein, and, unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

c. In the event of a vacancy in the office of the Chairperson, the Vice-Chairperson shall succeed to that office for the balance of the unexpired term of the Chairperson. In the event of a vacancy in the office of the Secretary or Treasurer, the Assistant Secretary or Treasurer, as applicable, shall succeed to that office for the balance of the unexpired term of that officer. The Board of Directors may, but is not required to elect an officer to fill the vacancy in a subordinate office.

Section 10. Determination of and Sanctions for Willful or Corrupt Misconduct in Office

The following procedure may be used, in addition to any other procedures authorized by law or policy, to determine whether a Board of Directors member has engaged in willful or corrupt misconduct in office within the meaning of Government Code section 3060.

a. Any member of the Board of Directors may present an accusation in writing to the Board of Directors against another member of the Board of Directors alleging willful or corrupt misconduct in office, together with any written materials to support the accusation. "Misconduct in office" shall be broadly construed and include any willful malfeasance, misfeasance, and/or nonfeasance in office, and shall be interpreted in a manner consistent with Government Code section 3060.

b. After consideration of the accusation, the Board of Directors members present shall then vote on the question of authorizing a formal hearing on the accusation presented. A formal contempt hearing is authorized by the Board of Directors upon the concurrence of a majority of the members present, excluding the accused who shall not have a vote.

c. Within 7 days of the authorization for a formal contempt hearing, the Board of Directors shall serve upon the accused a copy of the accusation, a statement identifying the reasons for the hearing, and a notice of the date of the hearing. The date of the hearing shall not be less than 10 days from the service of the accusation. Service shall be in person, or if that fails, by leaving a copy of the accusation taped to the entry door of the accused's last known address in plain view.

d. The accused shall appear before the Board of Directors at the time and date stated in the accusation. However, if the date chosen by the Board of Directors is unacceptable to the accused for good cause as determined by the Board of Directors, another date shall be assigned, but shall not be more than 30 days beyond the original date set by the Board of Directors.

e. The accused may be represented by counsel in preparing for and/or to be present at the hearing. The cost of such counsel shall be borne by the accused. If the accused chooses to have an attorney represent him at the hearing, he must notify the Secretary of the Board of Directors in writing of that fact at least 5 days before the hearing. The Board of Directors may have a lawyer who is not the regular Board of

Directors lawyer, present at the hearing who will conduct the presentation of the Board of Directors' case and question witnesses. Formal rules of evidence shall not apply; however, witnesses and statements shall be made under oath and documentary evidence shall be authenticated. The Board of Directors may establish reasonable time limits on the duration of the hearing. Board of Directors counsel shall not participate in any way in the preparation of the accusation or presentation of evidence, but shall advise the Board of Directors on procedural matters.

f. Five days before the scheduled hearing, each party shall submit to the Secretary of the Board of Directors a witness list and outline of anticipated evidence, either oral or written, which they intend to introduce at the hearing. Upon demand by either party, this information shall be given to the opposing party by the Board of Directors Secretary on this date. A willful failure to supply this information on a timely basis may cause it to be excluded at the hearing.

g. At the hearing, the accused may introduce any oral testimony he or she feels will be helpful to the defense. The member of the Board of Directors who presented the accusation may introduce rebuttal evidence. The of Directors shall give weight to all evidence presented. The Board of Directors shall have the power to limit or exclude evidence which is repetitive, not relevant, or has little probative value. The proceeding shall be recorded.

h. The Board of Directors shall have the burden of establishing the willful or corrupt misconduct by the accused and the burden of proof shall be by a preponderance of the evidence. The Board of Directors may introduce any evidence, oral or written testimony, the Board of Directors feels will be helpful to its case.

i. If the accused fails to appear before the Board of Directors on the specified hearing date, the hearing may be held, based upon the evidence previously provided to the accused and other relevant evidence.

j. At the conclusion of presentation of evidence, the Board of Directors shall vote whether to hold the accused in contempt. The accused shall not be present during deliberation. A determination of misconduct shall be upon the concurrence of a majority of the Board of Directors members present, excluding the accused who shall not have a vote and cannot take part in deliberations.

k. Upon the determination by the Board of Directors of misconduct by the accused, the Board of Directors shall ask if the accused wishes to make a statement to the Board of Directors. Thereafter, the Board of Directors shall excuse the accused from the hearing and move to the determination of sanctions, which may include:

1. A statement of censure, identifying the misconduct;

2. Removal of the offending Board of Directors member from membership on one or more Board of Directors committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board of Directors officers;

3 Removal of the offending Board of Directors member from holding any Board of Directors office or other appointment currently held;

4. A determination that no compensation shall be earned by the offending Board of Directors member for attendance at the meeting at which the contempt occurred, or for a specified period;

5. A determination that the offending Board of Directors member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct;

6. Rendering the offending Board of Directors member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings (except those previously-approved for which expenses have been incurred prior to the time of the finding of misconduct, for a period of time or subject to conditions specified in the motion;

7. Referral of the matter to the County Grand Jury pursuant to Government Code section 3060, including the evidence adduced during the hearing.

8. Declaring a vacancy in the office of the accused. [May require legislation]

ARTICLE V

ARTICLE V

COMMITTEES

Section 1. Committees

The Chairperson, with the concurrence of the Board of Directors, may, from time to time, appoint one or more members of the Board of Directors and other persons as necessary or appropriate, to constitute committees for the investigation, study or review of specific matters. At the time of appointing and establishing the committee(s), the Chairperson, with the concurrence of the Board of Directors, shall establish the responsibilities of the committee(s).

The Chairperson, with the approval of the majority of the Board of Directors, may, from time to time, with or without cause, remove one or more members of the Board of Directors and any other persons from membership in any standing or other committee, or may temporarily discontinue, change the functions of, or combine standing or other committees.

Any committee(s) established to deliberate issues affecting the discharge of Medical Staff responsibilities shall include Medical Staff members.

No committee shall use written ballots, whether or not secret, for any purpose in its deliberations. No committee appointed shall have any power or authority to commit the Board of Directors or the District in any manner, unless the Board of Directors, by a motion duly adopted at a meeting of the Board of Directors, has specifically authorized the committee to act for and on behalf of the District.

Any advisory committee, whether permanent or temporary, which is a legislative body as defined in the Brown Act and other applicable law, shall post agendas and have meetings open to the public as provided by law.

Notices of meetings of committees which are legislative bodies shall be made in accordance with Article IV, Section 7 of these Bylaws.

Section 2. Standing Committees

Standing committees as defined by the Brown Act are open to the public and require posting of Notice of Meetings and Agendas. The following committees are the only current standing committees of the Board of Directors:

A. Finance, Operations & Planning Committee

B. Community Healthcare Alliance Committee

C. Governance & Legislative Committee

D. Human Resources Committee

E. Professional Affairs Committee

F. Audit, Compliance & Ethics Committee

The Board of Directors shall review annually the committees, their functions, and their membership.

## ARTICLE VI

## MANAGEMENT OFFICIALS

Section 1. President/Chief Executive Officer.

The Board of Directors shall select and employ a hospital administrator to be known as "President/Chief Executive Officer" who, subject to such policies as may be adopted and such orders as may be issued by the Board of Directors, or by any of its committees to which it has delegated power for such action, shall have the responsibility, as well as the authority, to function as the President/Chief Executive Officer of the institution, translating the Board of Directors' policies into actual operation. Additionally, the President/Chief Executive Officer has the authority to make recommendations to the Board of Directors on policies related to the effective ongoing operations of the District. The Chief Operating Officer/Chief Nurse Executive and/or the Chief Financial Officer are granted signing authority on behalf of the Chief Executive Officer, in order to maintain day-to-day operation of the District.

Section 2. Clerk of the Board of Directors.

The Clerk of the Board of Directors shall be the Executive Assistant under the immediate supervision of the President/Chief Executive Officer. The President/Chief Executive Officer may assign other staff members as may be necessary to complete the work of the Board of Directors. The Executive Assistant shall serve as Clerk of the Board of Directors for the purposes of Elections Code section 307.

Section 3. Chief Compliance Officer .

The Chief Compliance Officer~~, hired by the Board of Directors~~, shall advise the Board of Directors and Chief Executive Officer regarding the design and implementation of the organization's ethics and compliance programs. The Chief Compliance Officer shall report directly to the Chief Executive Officer and shall be responsible to~~advise~~ the Board of Directors to timely and periodically report to it regarding the status of the compliance programs and material legal and compliance risks and mitigation efforts.

Section 4. President/Chief Executive Officer's Evaluation.

The Board of Directors shall evaluate the President/Chief Executive Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the President/Chief Executive Officer. The President/Chief Executive Officer shall have an opportunity to reply in writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors. (Gov. Code § 54957.)

Section 5. ~~Chief Compliance Officer's Evaluation.~~

~~The Board of Directors shall evaluate the Chief Compliance Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the Compliance Officer and Vice President, Legal Affairs. The Chief Compliance Officer shall have an opportunity to reply in~~

~~writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors. (Gov. Code § 54957.)~~

ARTICLE VII

MEDICAL STAFF

Section 1. Medical Staff.

The physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in the State of California, who are permitted to practice in the hospitals and other facilities under the jurisdiction of TRI-CITY HEALTHCARE DISTRICT, shall be formed into a formal Medical Staff, in accordance with the Medical Staff Bylaws, Rules and Regulations, which have been approved by the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. The Medical Staff Bylaws shall include, but not be limited to, the following provisions:

a. Appropriate officers.

b. Staff appointments on an annual or biennial basis.

c. Procedure for appointment and reappointment of Medical Staff as provided by the Standards of ~~the Joint Commission on Accreditation of Health Care Organizations.~~The Joint Commission.

d. That the Medical Staff shall meet in accordance with the minimum requirements of ~~the Joint Commission on Accreditation of Health Care Organizations.~~The Joint Commission.

The Medical Staff shall be self-governing with respect to the professional work performed in the hospital and the medical records of the patients shall be the basis for such review and analysis of the professional work of the Medical Staff. The Medical Staff members shall be responsible for preparing and maintaining accurate and complete medical records for all patients (medical records to include, but not be limited to, identification data, personal and family history, history of present illness, physician examination, special examinations, professional or working diagnosis, treatment, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge and such other matters as the Medical Staff shall determine or as may be required by applicable law). The practice of medicine and surgery in the hospitals and other facilities under the jurisdiction of the District shall be within the limitations as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California. The Medical Staff shall be responsible for the development, adoption and annual review of the Medical Staff Bylaws and Rules and Regulations that are consistent with District policy and with any applicable law. The Medical Staff are subject to, and effective upon, appointment and reappointment by the Board of Directors in accordance with the standards of ~~the Joint Commission on Accreditation of Health Care Organizations.~~The Joint Commission (H&S Code § 32128.)

The Tri-City Healthcare District shall maintain a Quality Assurance/Performance Improvement ("QA/PI") Program developed by a committee composed of at least five (5) physicians who are members of the Medical Staff and one (1) clerical staff member. The QA/PI Program shall be implemented by the QA/PI Committee, and shall be a data-driven, quality assessment and

performance improvement program, implemented and maintained on a hospital-wide basis, in compliance with the requirements of Section 482.21 of Title 42 of the Code of Federal Regulations, and other applicable law, as it may be amended from time to time.

Section 2. Medical Staff Membership.

Membership on the Medical Staff is a privilege, not a right, which shall be extended only to physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in this State whose education, training, experience, demonstrated competence, references and professional ethics, assures, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care. Each applicant and member shall agree to abide by the District Bylaws, Medical Staff Bylaws and Rules and Regulations of the District, and applicable law. The word "Physician" when used hereafter in this Article, shall be deemed to include physicians, surgeons, dentists, and podiatrists. (H&S Code § 32128.)

Section 3. Exclusion from the Medical Staff.

a. The Board of Directors shall have the power to exclude from Medical Staff membership, to deny reappointment to the Medical Staff, or to restrict the privileges of any physician, whether a general practitioner or specialist, in any hospital operated by the District, who has not exhibited that standard of education, training, experience, and demonstrated competence, references and professional ethics which will assure, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care.

b. In the case of both general practitioners and specialists, the medical resources available in the field of his or her practice shall be considered in determining the skill and care required. No physician shall be entitled to membership on the Medical Staff, or to the enjoyment or particular privileges, merely by virtue of the fact that he or she is duly licensed to practice medicine or surgery in this or any other state, or that he or she is a member of some professional organization, or that he or she, in the past or presently, has such privileges at another hospital. The burden shall be upon the physician making an initial application for membership to establish that he or she is professionally competent and ethical. (H&S Code §§ 32128 and 32150; B&P Code § 809.3.)

Section 4. Hospital Rules.

The Bylaws of the Medical Staff shall set forth the procedure by which eligibility for Medical Staff membership and establishment of professional privileges shall be determined. Such Bylaws shall provide that the Medical Staff or a committee or committees thereof, shall study the qualifications of all applicants in the establishment of professional privileges, and shall submit to the Board of Directors recommendations thereon. Such recommendations shall be considered by the Board of Directors, but shall not be binding upon the Board of Directors. The Medical Staff shall be responsible for a process or processes designed to assure that individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to

provide such services and that the quality of patient care services provided by these individuals is reviewed as a part of the District's quality assurance programs. (H&S Code § 32150.)

Section 5. Hearings and Appeals.

The Board of Directors hereby incorporates by reference the provisions of the Medical Staff Bylaws relating to hearing procedures and appeals regarding the professional privileges of any member of, or applicant for membership on, the Medical Staff, as those Bylaws may be amended from time to time, subject to applicable law. These provisions are presently outlined in the relevant sections of the Medical Staff Bylaws.

## ARTICLE VIII

## MISCELLANEOUS

Section 1. Title to Property.

The title to all property of the District shall be vested in the District, and the signature of any officers of the Board of Directors, authorized at any meeting of the Board of Directors, shall constitute the proper authority for the purchase or sale of property or for the investment or other disposal of funds which are subject to the control of the District. (H&S Code §§ 32121(c) and 32123.)

Section 2. Seal.

The Board of Directors shall have the power to adopt a form of Corporate Seal, and to alter it at its pleasure. (H&S Code § 32121(a).)

Section 3. Amendment.

These Bylaws may be altered, amended, repealed, added to or deleted, by a majority vote of all of the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

Section 4. Annual Review of Bylaws.

The Board of Directors shall review the Bylaws annually and make any necessary changes that are necessary to be consistent with District policy, any applicable laws or other rules and regulations connected with operation of a hospital or other facility within District jurisdiction.

Section 5. Board of Directors' Evaluation Policy.

The Board of Directors shall establish a written policy and procedure for evaluation and review of the Board of Directors' performance as a group. This written copy of the Board of Directors' policy and procedures shall be reviewed by the Board of Directors, the President/Chief Executive Officer and the District Legal Counsel for the Board of Directors.

Section 6. Affiliated Organizations.

a. Auxiliary Organizations. The Board of Directors may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

b. Foundations. The Board of Directors may authorize the formation of non-profit public benefit corporations, under applicable law, to assist in the fulfillment of the purposes of the District. Each such corporation shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

CODE FOR LEGISLATIVE AUTHORITY

| | | |
|---|---|---|
| H&S | - | The Local Health Care District Law, Health and Safety Code Section 32000 et seq., State of California |
| Elections Code | - | Uniform District Election Law, Elections Code, State of California |
| Government Code | - | Government Code, State of California |
| B&P | - | Business and Professions Code, State of California |

This amendment to the TRI-CITY HEALTHCARE DISTRICT Bylaws is approved this 30th day of July, 2015.

~~Larry W. Schallock~~ James J. Dagostino
Date
Chairperson

ATTEST:

~~Julie Nygaard,~~ Laura E. Mitchell Date
Secretary

**TRICITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~15~~17-042**

**POLICY TITLE: Duties of the Board of Directors**

The purpose of this policy is to define the primary responsibilities of the Board of Directors as the governing body ultimately responsible for leadership of the organization.

**Brief Job Description**

The Board establishes the mission, vision, and goals for the organization. The Board is ultimately accountable for the quality of care rendered to its patients by both its medical and professional staffs, for its financial soundness and success, and for strategically planning its future. The Board hires the Chief Executive Officer, and approves the plans and budgets by which the CEO will accomplish the quality, financial and strategic goals of the Board. However, the Board has delegated to the CEO responsibility to run the day-to-day operations of all of the District's business enterprises; hence, the Board does not direct operations. Rather, the Board is responsible for ensuring that strategies developed by management will accomplish key goals, achieve the mission and fulfill the vision, and holding the CEO accountable for implementation of those strategies.

**Primary Duties and Responsibilities**

*Financial.*

1. Set objectives. It is the role of the Board of Directors, in cooperation with the Chief Executive Office, to specify key financial objectives which are aligned with Board-determined goals, mission and vision for the organization.

2. Oversee attainment of objectives. Through annual approval of the budget, and the ongoing activities of the Financial Operations and Planning Committee, the Board ensures that necessary financial planning activities are undertaken so that the organization's resources are effectively allocated across competing uses. The Board monitors and assesses the financial performance of the organization on an ongoing basis through review of periodic financial statements and other reports prepared and presented by the Chief Financial Officer.

3. Ensure transparency and accountability. Through the selection of independent auditors and acceptance of the annual financial audit report, together with targeted supplemental auditing activities of billing and collection activities for compliance with legal requirements, the Board ensures that appropriate accounting controls are in place and updated, as needed.

*Community needs assessment and outreach.*

The Board helps keep the organization informed about, and sensitive to, community needs and perceptions. Conversely, the Board plays a key role in keeping the community informed regarding the services, activities, and plans of the organization.

*Promote quality medical care.*

1. Under its Bylaws and those of the Medical Staff, the Board appoints, reappoints and determine privileges of physicians who practice in the institution.

2. The Board hears periodic reports on indicators of quality, utilization and outcomes, as well as quality improvement implementation plans, for each area or department of the organization. The Board holds management accountable to ensure that effective risk management systems are in place and functioning effectively. In this manner, the Board takes responsibility for ensuring the quality of nursing and medical care rendered in the hospital.

3. The Board provides opportunities for members of the medical staff to participate in governance through membership on Board-appointed committees. The Board provides the Chief of the Medical Staff an opportunity to participate in Board meetings, including providing an agenda item at each regular meeting for reports from the Medical Staff.

*Compliance oversight.*

The Board ensures compliance with requirements of regulatory and accrediting bodies by: (a) promoting an ethical, self-governing culture throughout the organization through Board and employment policies; (b) overseeing the effectiveness of the compliance program; and (c) providing the resources required to implement effective systems.

**Responsibilities Defined Elsewhere:**

*Bylaws.*

The Bylaws of the Tri-City Healthcare District Board of Directors set forth, in Article III, the legal powers and duties of the board of directors, as provided under the Healthcare District law. The Board's oversight of compliance activities is reflected in Article VI, §2 (establishing a Compliance and Audit Committee) and Article VII, §3, describing its reporting relationship with the Chief Compliance Officer. Article VIII describes the Board's relationship with the Medical Staff. Article IX, §5 requires the Board to maintain a policy regarding annual self-evaluations.

*Board Policies.*

Some of the responsibilities of the Board, including those specifically identified by the Joint Commission, are addressed by board policies. The Medical Staff provides input on equipment and services to be provided at the hospital under Policy 1014-001. Minimum liability insurance requirements required for medical staff membership are described in a policy jointly-adopted by the Medical Staff. (Policy No. 1015-038.) The Board oversees the prudent investment of excess

funds under Policy No. ~~10~~14-017, which is reviewed annually. Self-evaluations are conducted by the Board annually under Policy ~~10~~14-012. Board member orientation and training are provided for in Policies ~~10~~16-020 and ~~10~~15-039. Board responsibilities for decision making on legal matters, including hiring General Counsel ~~and the Chief Compliance Officer are~~ is described in Policy ~~11~~17-023. Other policies establish a Code of Conduct for the Board (Policy No. ~~10~~15-039) and committee members (Policy No. ~~10~~15-031), and conflict of interest rules (by resolution in accordance with the Political Reform Act). These are merely examples and are not intended to be a comprehensive list of policies describing Board responsibilities.

**Reviewed by Gov/Leg Committee: 1/12/2011**
**Approved by the Board of Directors: 1/27/2011**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by Gov/Leg Committee: 10/6/2015**
**Approved by the Board of Directors: 10/30/15**
**Reviewed by Gov/Leg Committee: 6/06/17**
**Approved by the Board of Directors:**

**Tri-City lical Center**
**Audit, Compliance & Ethics Committee**
**June 15, 2017**
**Assembly Room 1**
**8:30 a.m-10:30 a. m.**

| | |
|---|---|
| **Members Present:** | Director Larry W. Schallock(Chair); Director James Dagostino, DPT, PT; Director Leigh Anne Grass; Jack Cumming, Community Member; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member |
| **Non-Voting Members:** | Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Scott Livingstone, Interim CCO |
| **Others Present:,** | Greg Moser, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp; Director, Education, Clinical Informatics & Staffing; Charlene Carty, Director, Finance |
| **Absent:** | Cary Mells, M.D.; Physician Member; Leslie Schwartz, Community Member |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to Order | The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Schallock.<br><br>Chairman Schallock reported Ms. Bernard-Shaw began a leave a few weeks ago and Mr. Scott Livingstone has been appointed as the Interim Chief Compliance Officer.<br><br>Chairman Schallock further commented that the Board believes it would be more efficient if the Chief Compliance Officer reports directly to the CEO rather than the Board. Thus the Governance & Legislative Committee is looking at amending policies related to that change. He noted the Chief Compliance Officer would continue to have a "dotted" reporting line to the Board of Directors.<br><br>Mr. Scott Livingstone, Interim Chief Compliance Officer provided a brief summary of his background and experience both in his current role of Interim Chief Compliance Officer as well as his former role, Vice President of Hospital Transformation.<br><br>Committee members introduced themselves to Mr. | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | Livingstone. | | |
| 2. Approval of Agenda | **It was moved by Director Grass and seconded by Director Dagostino to approve the agenda as presented. The motion passed unanimously.** | **Agenda approved.** | |
| 3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item | There were no public comments. | | |
| 4. Ratification of minutes – March 16, 2017 | **It was moved by Director Dagostino and seconded by Mr. Jack Cumming to approve the minutes as presented. The motion passed unanimously.** | **Minutes ratified.** | |
| 5. Old Business | None | | |
| 6. New Business | | | |
| A) Administrative Policies & Procedures:<br><br>1) 8610-280 – Unclaimed Property | Ms. Kathy Topp stated Policy 8610-280 – Unclaimed Property has been reviewed internally as well as with Legal Counsel. Ms. Charlene Carty was in attendance to address any questions related to the policy as it is within her area of expertise. She explained that Unclaimed Property in this instance includes vendor checks, payroll checks, refunds, overpayments and credit balances.<br><br>A question was raised as to the title "Assistant Controller". General Counsel, Mr. Moser explained that Section C 3. of the policy describes the delegation by the Treasurer of authority to the Assistant Controller as provided for in Government Code sections 50050 and 50051.<br><br>Discussion was held regarding the notice that is published. Ms. Carty stated the District makes every effort to return unclaimed monies to the applicable individuals.<br><br>Mr. Cumming questioned the magnitude of the funds involved in unclaimed property. Ms. Carty stated at the | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | present time unclaimed funds total approximately $400,000.<br><br>**It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to recommend approval of Policy 8610-280 – Unclaimed Property.**<br><br>*Ms. Kathy Topp and Ms. Charlene Carty left the meeting at 8:48 a.m.* | Recommendation to be sent to the Board of Directors to approve Policy 8610-280 – Unclaimed Property; item to be placed on agenda and included in agenda packet. | Ms. Donnellan |
| 2) Audit Update | Mr. Ray Rivas reported he met with the external auditors in May and discussed the timing of the audit as well as significant items to be aware of this year. He stated the goal is to begin field work in August and have the FY 2017 Audit prepared for presentation to the Audit, Compliance & Ethics Committee and Board of Directors for acceptance at the September meetings. Mr. Rivas stated the Auditors are prepared to present their entrance report to the committee at the July 20th meeting. | **Moss Adams to present Entrance Report to the committee at the July meeting; item to be placed on agenda.** | Ms. Donnellan |
| 7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7) | Chairperson Schallock made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and two matters of Potential Litigation. | | |
| 8. Motion to go Into closed session | **It was moved by Director Dagostino and seconded by Director Grass to go into closed session at 8:50 a.m. The motion passed unanimously.** | | |
| 9. Open Session | The committee returned to open session at 9:24 a.m. with attendance as previously noted. | | |
| 10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) | Chairperson Schallock reported no action was taken in closed session. | | |
| 11. Comments from Committee Members | There were no comments from members of the public. | | |
| 12. Date of Next Meeting | Chairperson Schallock stated the Committee's next meeting will be held on July 20, 2017. | **The committee's next meeting is scheduled for** | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | | July 20, 2017. | |
| 13. Adjournment | Chairperson Schallock adjourned the meeting at 9:24 a.m. | | |

Tri-City Medical Center ADVANCE

# AUDIT COMPLIANCE AND ETHICS COMMITTEE
## June 15, 2017

| Administrative Policies & Procedures | Policy # | Reason | Recommendations |
|---|---|---|---|
| 1. Unclaimed Property - Financial | 280 | 3 year review, practice change | Forward to BOD for Approval |
| | | | |
| | | | |

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

**Administrative Policy**

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**ISSUE DATE:** 07/03 **SUBJECT:** Unclaimed Property - Financial

**REVISION DATE:** 05/09 **POLICY NUMBER:** 8610-280

| | |
|---|---|
| **Department Approval:** | **01/17** |
| **Administrative Policies & Procedures Committee Approval:** | **~~05/09~~01/17** |
| **~~Operations Team Committee Approval:~~** | **~~05/09~~** |
| **~~Finance & Operations Committee Approval:~~** | **~~06/09~~** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Audit, Ethics and Compliance Committee Approval:** | **06/17** |
| **Board of Directors Approval:** | **06/09** |

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A. **PURPOSE:**

1. **To establish the procedures by which Tri-City Healthcare District (TCHD) shall** comply with **the** ~~California's~~ unclaimed property ~~Program,~~**laws set forth in** ~~and Civil~~ **Government** Code Sections 50050 **through** 50053.

B. **DEFINITIONS OF TERMS:**

1. Unclaimed property ~~includes:~~ **has the meaning in Government Code Sections 50050-50053 and includes vendor checks, payroll checks, refunds, overpayments and credit balances.**
   ~~a. Vendor checks~~
   ~~b. Payroll checks~~
   ~~c. Patient refund checks~~
   ~~d. Credit Balances~~
2. Proper Notice – After three years, publication once a week for two successive weeks in a newspaper of general circulation published in the ~~Tri-City Hospital District (~~TCHD~~)~~ area.

C. **POLICY:**

1. **The Assistant Controller of TCHD shall cause Proper Notice of unclaimed property to be published as set forth in Government Code Sections 50050 and 50051.**
2. All unclaimed property held by TCHD that ~~remains unclaimed in its treasury or in the official custody of its officers for three years is the property of TCHD after proper notice is given.~~ **is not claimed (or no verified complaint is filed and served) within the sixty (60) day time period set forth in the Proper Notice is the property of TCHD.**
3. **Consistent with Government Code section 50056, the Treasurer of TCHD hereby delegates his/her responsibilities under this policy to the Assistant Controller, as the appropriate person within the Finance Department, which maintains the supporting records of unclaimed money initially received by or deposited with TCHD.**

D. **PROCESS FOR NOTICE PUBLICATION AND CLAIMING OF FUNDS:**

~~1. Outstanding vendor, payroll and patient refund checks:~~
   ~~a. Any outstanding checks more than six months are to be reviewed. Attempts are to be made to contact payee for checks to be cashed.~~
   ~~For checks outstanding for more than six months where the payee cannot be contacted, the checks are to be held for publication notice in the local newspaper after three years.~~

1. **Publication:**
   ~~b.~~**a. TCHD's Assistant Controller shall cause Proper Notice to be published. The notice will include: the identity of persons or entities who deposited the unclaimed property, the amount of unclaimed property, the fund in which it is held (e.g.**

**refunds, overpayments, etc.) and that it is proposed that the unclaimed property will become the property of TCHD sixty (60) days after the first publication of the notice.**

~~2. Outstanding credit balances on patient accounts are to be researched for validity on a routine basis.~~

~~a. Attempts are to be made to identify and refund to the proper entity/person. Outstanding unresolved credit balances will be considered unclaimed property and are to be held for publication notice in the local newspaper after three (3) years.~~

**2. Submission of Claims:**

**~~b.~~a. Claimants may upon or prior to publication, file a claim with the TCHD Assistant Controller c/o of the Finance Department. Claims should be submitted to the TCHD Assistant Controller, c/o TCHD Finance Department as specified in the notice on TCHD's Unclaimed Property Claim Form which includes the claimant's name, address, amount of claim, grounds on which the claim is founded and other information required by the Assistant Controller. Claimants have sixty (60) days after first publication to claim the funds.**

~~3. The Finance Department will publish in a local newspaper the names, last known address, and dollar amounts of outstanding checks and outstanding credit balances, that have been outstanding for after the expiration of three years, period per § 1531 of the Unclaimed Property Law and Regulations, October 2013.~~

**3. Proof of Ownership:**

**a. Claimants must provide appropriate documentations that demonstrate their identity and legal ownership for the unclaimed property. In the event that the party claiming the unclaimed property is not the identified owner, or if the identified owner is deceased, he or she will be required to provide documentation sufficient to demonstrate their identity and legal ownership of the unclaimed property.**

~~4. Claimant of funds has 60 days after first publication to claim funds. Claimant must prove ownership of funds by providing proper identification. If claimant is not original owner, or owner is deceased, documentation must be provided showing entitlement to property.~~

**4. Assistant Controller Determination on Claim:**

**a. The Assistant Controller will accept or reject the claim. In the event that a claim is rejected by the Assistant Controller, and the party who submitted the claim files and serves a verified complaint upon the Assistant Controller as provided in Government Code Section 50052, the Assistant Controller shall withhold release of the portion of the Unclaimed Property for which the action was filed until a decision is rendered by the court in the action.**

~~5. Unclaimed property will be transferred to the general fund of TCHD, after 60 days of first publication.~~

**5. Transfer to General Fund:**

**a. Unclaimed Property held by TCHD that remains unclaimed (or no verified complaint is filed and served) within the sixty (60) day time period set forth in the Proper Notice shall be transferred to TCHD's General Fund.**

E. **ATTACHMENTS:**

1. Public Notice Format
2. **Unclaimed Property** Claim Form

F. **REFERENCES:**

1. California Government Code, Section 50050-5005~~6~~53
~~1.~~2. **California Code of Civil Procedure Section 1502(2)(a).**
~~2. Unclaimed Property Law and Regulations, Kathleen Connell Betty T. Yee, California State Controller, January October 1999 2013~~

**Public Notice**

## PUBLIC NOTICE

Notice of Names of Persons appearing to be owners of unclaimed money being held by Tri City Hospital District.

Pursuant to Government Code sections 50050 et. Seq., ~~the Chief Financial Officer of~~ Tri City Hospital District hereby gives notice to the below listed individual(s) that it is holding, and has held for a period of three or more years, unclaimed money allegedly belonging to said individual(s). It is proposed that the money will become the property of Tri City Hospital District on the below stated date; such date not more than **sixty** (60) days after the first publication of this notice.

Date on which money shall become the property of Tri City Hospital District: ~~on~~ _____.

~~Signed: _____, CFO~~
~~Tri City Hospital District~~

TO CLAIM THESE FUNDS:

If your name or the name of your company is listed below:

1. Cut out and complete the **Unclaimed Property** Claim Form.
2. Attach one photocopy of three different pieces of current identification, i.e. driver's license or other picture ID's.
3. Mail to address listed below.
4. Allow 90)days from receipt of documents by Tri City Hospital District to receive your check or notice of denial.

Inquiries and claims should be mailed to:

Tri City Hospital District
Finance Department – **ATTN: Accounting**
4002 Vista Way
Oceanside, CA 92056

**Unclaimed Property Claim Form**

## TRI CITY HOSPITAL DISTRICT
## UNCLAIMED PROPERTY CLAIM FORM

Claim to recover monies being held by Tri City Hospital District pursuant to Government Code sections 50050 et.seq.

Name as advertised: _____ ID# _____

Address as advertised _____
(Attach proof you received mail at the advertised address)

Name of Claimant/Business: _____

Current Address of Claimant/Business _____

ATTACH PHOTOCOPY OF DRIVERS LICENSE OR OTHER PICTURE I.D. AND PROOF OF CURRENT ADDRESS.

If claimant is not the original owner or owner is deceased, attach documents supporting claim and check one of the following:

_____ 1. As heir or survivor, attach copy of death certificate and a copy of will or notarized list of heirs including address.
_____ 2. As guardian, executor, administrator or other representative capacity. (If appointment is currently in force, enclose document evidencing such authority)
_____ 3. If name of company is advertised, attach copy of articles of incorporation, etc. to identify individual having authority to sign for company.

I agree, that if for any reason it is found that I am not entitled to this payment or receive a duplicate payment, I will return the funds to Tri City Hospital District within 15 days of such finding.

Signature:_____Date_____Phone #_____

(If Joint Account, both must sign)

Signature:_____Date_____Phone #_____

R - Renew
NR - Not R ed

# TRI-CITY H THCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS - 2017

| Vendor | Contract Number | Contract Type | Responsible Party, Primary | Responsible Dept. | Expiration Date | Reviewed/ Completed | PHI REQ | PHI RCD | R / NR | ACE Review | Board Review |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Crothall Laundry Services | 1007.192C | Services Agreement | Thomas Moore | Supply Chain Management | 5/31/2017 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Currie Medical Specialties | 1007.3047 | Supplies Agreement | Thomas Moore | Supply Chain Management | 2/28/2017 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Dashboard Gear | 1007.971C | License Agreement | Anh Nguyen | Finance | Evergreen | 11/1/2016 | no | no | R | 6/15/2017 | |
| DBRS | 1007.3403A | Equipment: Rental Agreement | Steve Young | Laboratory | 11/15/2016 | 10/19/2016 | no | no | R | 6/15/2017 | |
| Deltex Medical Inc | 1007.2863C | Equipment: Purchase | Mary Diamond | Surgery | 8/1/2017 | 11/5/2016 | no | no | R | 6/15/2017 | |
| DePuy Synthese Sales | 1007.3063C | Supplies Agreement | Steve Young | Supply Chain Mana | 11/17/2017 | 10/19/2016 | no | no | R | 6/15/2017 | |
| Ecolab Inc. | 1007.3455C | Supplies Agreement | Thomas Moore | Surgery | 7/20/2018 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Edwards Lifesciences | 1007.3485C | Consignment Agreement | Thomas Moore | Supply Chain Management | 9/25/2019 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Efficient X-Ray | 1007.3482C | Services Agreement | Wayne Knight | Business Development | 8/1/2017 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Elizabeth Hospice | 1007.1742E | Services Agreement | Stephen Chavez Matzel | Case Management | 7/14/2012 | 11/16/2016 | yes | yes | R | 6/15/2017 | |
| Elsevier Inc. | 1007.602C | License Agreement | Monique Liston | Library Services | 11/14/2018 | 10/20/2016 | no | no | R | 6/15/2017 | |
| Ethicon | 1007.3145C | Business Associate Agreement | Jami Piearson | Infection Control | Evergreen | 10/25/2016 | yes | yes | R | 6/15/2017 | |
| Executive Search Associates | 1007.2942C | Professional Service Agreement | Norma Braun | Human Resources | 2/28/2017 | 12/22/2016 | no | no | R | 6/15/2017 | |
| Experian Health | 1007.1615C | License Agreement | Jessica Ruh | Finance | 9/13/2019 | 1/3/2017 | yes | yes | R | 6/15/2017 | |
| Fazzi Associates | 1007.3421C | Services Agreement | Joni Penix | Finance | 5/16/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| Fidelis Companies | 1007.2926C | Professional Services Agreement | Terry Moede | Information System | 8/29/2017 | 11/14/2016 | yes | yes | R | 6/15/2017 | |
| First Class Vending | 1007.803C | Services Agreement | Thomas Moore | Cafeteria | 12/31/2018 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Garda CL West | 1021.1604C | Services Agreement | Jessica Ruh | Administration | 6/1/2017 | 1/17/2017 | no | no | R | 6/15/2017 | |
| GE Healthcare | 1007.3462C | Services Agreement | Steve Young | Laboratory | 6/30/2021 | 10/19/2016 | yes | yes | R | 6/15/2017 | |
| GE Medical Systems | 1007.238C | Business Associate Agreement | Steve Young | Imaging Services | 4/13/2017 | 10/19/2016 | yes | yes | R | 6/15/2017 | |
| Greater TriCities IPA | 1022.653C | Services Agreement | Priya Joshi | Occupational Therapy | Evergreen | 10/31/2016 | yes | yes | R | 6/15/2017 | |
| Greater TriCities IPA | 1022.2271C | Services Agreement | Wayne Knight | OP Radiology | 12/31/2016 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Green Coast Building Services | 1007.3468C | Services Agreement | Wayne Knight | Business Development | Evergreen | 2/22/2017 | no | no | R | 6/15/2017 | |

R - Renew
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# TRI-CITY H THCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS - 2017

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Hanna, Karen MD | 1007.3387A | Services Agreement | Susan McDowell | Public Affairs Mktg | 1/17/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Happ, David | 1007.3273E | Independent Contract | Charlene Carty | Finance | 9/30/2015 | 10/26/2016 | yes | yes | R | 6/15/2017 | |
| Harbage Consulting | 1007.3448A | Consulting Agreement | Charlene Carty | Finance | 10/31/2016 | 10/26/2016 | yes | yes | R | 6/15/2017 | |
| Healing Healthcare Systems | 1007.3035C | License Agreement | Kathy Topp | Education | 9/30/2019 | 11/4/2016 | no | no | R | 6/15/2017 | |
| Healthcare Connections | 1021.3402A | Professional Service Agreement | Norma Braun | Human Resources | 1/14/2017 | 12/22/2016 | no | no | R | 6/15/2017 | |
| Healthcare Revenue Management Group | 1007.3078C | Services Agreement | Joni Penix | Finance | Evergreen | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| HealthCareSource HR | 1007.1168c | License Agreement | Monique Liston | Library Services | 3/8/2019 | 10/20/2016 | no | no | R | 6/15/2017 | |
| HealthStream, Inc. | 1007.3348C | Services Agreement | Sharon Schultz | Administration | 9/30/2018 | 11/5/2016 | yes | yes | R | 6/15/2017 | |
| HealthStream, Inc. | 1007.2212C | License Agreement | Kathy Topp | Education | 4/1/2017 | 11/4/2016 | No | No | R | 6/15/2017 | |
| HireRight, Inc. | 1007.2194C | Services Agreement | Norma Braun | Human Resources | 1/29/2017 | 12/22/2016 | no | no | R | 6/15/2017 | |
| Hirschenhofer, Nadine | 1007.2966C | Independent Contract | Colleen Thompson | Medical Records | 10/31/2017 | 10/24/2016 | yes | yes | R | 6/15/2017 | |
| Hologic | 1007.3512C | Services Agreement | Steve Young | Imaging Services | 8/31/2019 | 10/19/2016 | yes | yes | R | 6/15/2017 | |
| Howmedica Ostionics | 1007.2990A | Equipment: Purchas | Mary Diamond | Surgery | 12/29/2016 | 11/5/2016 | no | no | R | 6/15/2017 | |
| HydroWork International | 1007.2682C | Maintenance Agreement | Priya Joshi | Physical Therapy | 12/7/2017 | 10/31/2016 | no | no | R | 6/15/2017 | |
| In Motion Inc | 1007.899E | Letter of Agreement | Susan McDowell | Public Affairs Mktg | 1/31/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Intuitive Surgical | 1021.1771C | Software License & Service Agmt | Kevin McQueen | Information System | 6/29/2019 | 10/26/2016 | yes | yes | R | 6/15/2017 | |
| Investors Property Management Group | 1007.2839C | Management Agreeement | Wayne Knight | Business Development | 2/24/2017 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Iron Mountain | 1007.2512C | Services Agreement | Colleen Thompson | Medical Records | 6/30/2017 | 10/24/2016 | yes | yes | R | 6/15/2017 | |
| Karl Storz Endoscopy | 1022.2150C | Services Agreement | Mary Diamond | Surgery | 3/22/2017 | 11/5/2016 | no | no | R | 6/15/2017 | |
| Key Healthcare Consulting | 1007.1609C | Consulting Agreement | Joni Penix | Finance | 3/15/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| KPBS TV/FM | 1007.3474E | Services Agreement | Susan McDowell | Public Affairs Mktg | 11/27/2016 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Kingsbridge Healthcare | 1007.1500C | Equipment: Lease | Terry Moede | Information System | 7/15/2017 | 11/14/2016 | yes | yes | R | 6/15/2017 | |
| Kingsbridge Healthcare | 1007.2584C | Equipment: Lease | Charlene Carty | Finance | 4/1/2017 | 10/26/2016 | no | no | R | 6/15/2017 | |
| KRH Staffing | 1006.3454C | Professional Services Agreement | Susan McDowell | Wellness Center | 7/17/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| KUSI News Television | 1007.3480C | Professional Services Agreement | Susan McDowell | Public Affairs Mktg | 6/30/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |

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# TRI-CITY H HCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS - 2017

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Landreth Construction | 1007.3339C | Professional Services Agreement | Wayne Knight | Business Development | 12/31/2016 | 2/22/2017 | no | no | R | 6/15/2017 | |
| LAZ Parking Calif. | 1007.2011C | Services Agreement | Michael Parent | Security | 8/31/2019 | 10/26/2016 | no | no | R | 6/15/2017 | |
| Les Mills West Coast | 1021.444C | License Agreement | Susan McDowell | Wellness Center | 1/25/2018 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Locumtenens.com | 1007.2508C | Professional Services Agreement | Sharon Schultz | Strategic Services | 9/1/2017 | 11/5/2016 | yes | yes | R | 6/15/2017 | |
| Macro Helix | 1007.3415C | Services Agreement | Tori Hong | Pharmacy | 5/5/2021 | 11/4/2016 | yes | yes | R | 6/15/2017 | |
| Main Path | 1007.3433C | Services Agreement | Brian Greenwald | Public Affairs Mktg | 5/18/2207 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Mallinckrodt | 1007.189C | Radiology Services Agreement | Steve Young | Radiology | 4/2/2018 | 10/19/2016 | no | no | R | 6/15/2017 | |
| Managed Resources | 1007.3134C | Services Agreement | Joni Penix | Finance | 2/25/2018 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| Management Services Network | 1007.2710C | Business Associate Agreement | Steve Young | Laboratory | 2/6/2017 | 10/19/2016 | yes | yes | NR | 6/15/2017 | |
| Marquee Staffing | 1007.3476 | Professional Services Agreement | Norma Braun | Human Resources | 7/18/2017 | 1/25/2017 | no | no | R | 6/15/2017 | |
| Matheson Tri-Gas | 1007.220C | Equipment: Purchase | Thomas Moore | Supply Chain Management | 2/7/2017 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Maxim Healthcare Services | 1007.2897C | Professional Services Agreement | Colleen Thompso | Medical Records | 8/31/2017 | 10/24/2016 | yes | yes | R | 6/15/2017 | |
| Mazor Robotics | 1007.3247C | Maintenance Agreement | Mary Diamond | Surgery | 2/28/2018 | 11/5/2016 | no | no | R | 6/15/2017 | |
| McCarthy Building Companies | 1007.3372C | Professional Services Agreement | Kapua Conley | Plant Engineering | 12/27/2017 | 2/22/2017 | no | no | R | 6/15/2017 | |
| McKesson Health Solutions | 1021.1542C | Services Agreement | Stephen Chavez M | Case Management | 4/10/2017 | 11/16/2016 | no | no | R | 6/15/2017 | |
| McKesson Information | 1007.250C | Services Agreement | Steve Young | Radiology | 1/26/2017 | 10/19/2016 | yes | yes | R | 6/15/2017 | |
| MedAssets Net Revenue Systems | 1007.1623C | License Agreement | Joni Penix | Finance | 4/30/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| MedAssests Performance Mgmnt | 1007.240C | License Agreement | Charlene Carty | Finance | 6/16/2018 | 10/26/2016 | yes | yes | R | 6/15/2017 | |
| Med-Enterprise | 1007.3432C | Consulting Agreement | Joni Penix | Finance | Evergreen | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| MedHawk | 1007.3496C | Professional Services Agreement | Wayne Knight | Business Development | 10/9/2017 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Medical Consultants Network | 1007.2641C | Services Agreement | Kathy Topp | Education | 11/13/2018 | 11/4/2016 | yes | yes | R | 6/15/2017 | |
| Medical Data Exchange | 1007.1867C | Software License & Service Agmt | Joni Penix | Finance | 4/30/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| Medical Solutions | 1007.2471C | Services Agreement | Kathy Topp | Bed Control Staffin | 6/30/2019 | 11/4/2016 | yes | yes | R | 6/15/2017 | |
| MediFax EDI | 1007.2725C | License Agreement | Joni Penix | Finance | 3/25/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |

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# TRI-CITY H THCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS - 2017

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MedKeeper Inc. | 1007.2315C | License Agreement | Tori Hong | Pharmacy | 4/29/2017 | 11/4/2016 | no | no | R | 6/15/2017 | |
| Medtronic USA | 1007.3209C | Services Agreement | Mary Diamond | Supply Chain Management | 12/21/2018 | 11/5/2016 | no | no | R | 6/15/2017 | |
| Medtronic USA | 1007.3486C | Data Use Agreement | Candice Parras | Emergency Room | Evergreen | 11/10/2016 | yes | yes | R | 6/15/2017 | |
| Medtronic USA | 1007.3503C | Warranty Agreement | Eva Froyd | Cardiac Cath Lab | 1/12/2018 | 11/14/2016 | yes | yes | R | 6/15/2017 | |
| META Dynamic | 1007.2927C | Services Agreement | Mary Diamond | Supply Chain Management | 8/31/2019 | 11/5/2016 | no | no | R | 6/15/2017 | |
| MetaSource | 1007.940C | Business Associate Agreement | Terry Moede | Finance | Evergreen | 11/14/2016 | yes | yes | R | 6/15/2017 | |
| MICRUS Endovascular Corp | 1021.1897C | Consignment Agreement | Steve Young | Supply Chain Management | 12/14/2017 | 10/19/2016 | no | no | R | 6/15/2017 | |
| Midcap Funding RE Holdings, LLC | 1007.2890C | Finance Agreement | Charlene Carty | Business Development | 7/29/2038 | 10/26/2016 | no | no | R | 6/15/2017 | |
| Midwest Television | 1007.3157C | Professional Services Agreement | Susan McDowell | Public Affairs Mktg | 6/30/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| MiMedx Group | 1007.3061C | Business Associate Agreement | Kim Posten | Wound Care | Evergreen | 1/15/2017 | yes | yes | R | 6/15/2017 | |
| M-Modal Services | 1007.3064C | License Agreement | Colleen Thompson | Medical Records | 4/30/2018 | 10/24/2016 | no | no | R | 6/15/2017 | |
| M-Modal Services | 1007.3132C | Professional Services Agreement | Colleen Thompson | Medical Records | 8/10/2017 | 10/24/2016 | yes | yes | R | 6/15/2017 | |
| Modality | 1007.3317C | Staffing Agreement | Steve Young | Radiology | 9/30/2017 | 10/19/2016 | yes | yes | R | 6/15/2017 | |
| Munro, Cassendra RN | 1007.3161E | License Agreement | Ingrid Stuiver | Clinical Research | 8/10/2016 | 12/5/2016 | yes | yes | NR | 6/15/2017 | |
| National Access | 1021.1614C | Services Agreement | Joni Penix | Finance | 3/25/2017 | 11/7/2016 | yes | yes | R | 6/15/2017 | |
| Natus Medical | 1007.3464C | Equipment: Purchase | Wayne Knight | Neurology | Evergreen | 2/22/2017 | no | no | R | 6/15/2017 | |
| NBC Digital Health | 1007.2155C | Services Agreement | Mary Diamond | Mother Baby | 2/8/2017 | 11/5/2016 | no | no | R | 6/15/2017 | |
| NBC Owned Television | 1007.3379C | Professional Services Agreement | Susan McDowell | PA and Marketing | 6/30/2017 | 10/27/2016 | NO | NO | R | 6/15/2017 | |
| Nestle Healthcare Nutrition | 1007.3066C | Supplies Agreement | Thomas Moore | Food and Nutrition | 4/30/2017 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Net Health Systems, Inc | 1007.2252C | Software License & Service Agmt | Sharon Schultz | Wellness Center | 1/20/2017 | 11/5/2016 | yes | yes | R | 6/15/2017 | |
| Nihon Kohden America | 1007.3388C | Equipment: Lease | Candice Parras | Emergency Room | 3/7/20121 | 1/18/2016 | yes | yes | R | 6/15/2017 | |
| Nortel Networks | 1021.1174C | Information Svcs Agmt | Terry Moede | Information System | 2/13/2032 | 12/22/2016 | no | no | R | 6/15/2017 | |

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# TRI-CITY H HCARE DISTRICT
## NON-CLINICAL CONTRACT EVALUATIONS - 2017

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Novation, LLC | 1007.3105C | Services Agreement | Tori Hong | Pharmacy | 4/30/2020 | 1/18/2017 | no | no | R | 6/15/2017 | |
| Nuvasive | 1007.2881E | Supplies Agreement | Thomas Moore | Supply Chain Management | 7/7/2016 | 11/14/2016 | no | no | R | 6/15/2017 | |
| Oceanside Community Services (KOCT) | 1007.1801E | Services Agreement | Susan McDowell | Public Affairs Mktg | 1/31/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Origin dba Shiftwise | 1007.3174C | Software License & Service Agmt | Kathy Topp | Education | 10/15/2017 | 11/4/2016 | no | no | R | 6/15/2017 | |
| Osiris Therapeutics, Inc | 1007.3427C | Equipment: Lease | Sharon Schultz | Wound Care | 4/6/2017 | 11/5/2016 | no | no | R | 6/15/2017 | |
| Our365, Inc. | 1021.993C | Services Agreement | Mary Diamond | Mother Baby | 8/31/2019 | 11/5/2016 | no | no | R | 6/15/2017 | |
| Oxford Global Resources | 1007.2991C | Professional Services Agreement | Colleen Thompson | Medical Records | 4/30/2017 | 10/24/2016 | yes | yes | R | 6/15/2017 | |
| Pacific Cancer Fitness | 1007.3263E | Services Agreement | Susan McDowell | Wellness Center | 4/30/2016 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Pacific Registry Services | 1007.999C | Management Agreeement | Sharon Schultz | Oncology Institute | 9/30/2017 | 11/5/2016 | yes | yes | R | 6/15/2017 | |
| Pathfinders Health Search | 1007.3425C | Professional Services Agreement | Annette Morris | Human Resources | 3/2/2017 | 10/26/2016 | no | no | R | 6/15/2017 | |
| Penumbra | 1007.2931C | Consignment Agreement | Steve Young | Supply Chain Management | Evergreen | 10/19/2016 | no | no | R | 6/15/2017 | |
| Phoenix Online Media | 1007.3471C | Services Agreement | Wayne Knight | Business Development | 9/6/2017 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Philips Medical Capital | 1007.2980A | Equipment: Lease | Steve Young | Radiology | 12/9/2019 | 10/19/2016 | no | no | R | 6/15/2017 | |
| Power Search | 1007.3445C | Professional Services Agreement | Norma Braun | Human Resources | 5/30/2017 | 12/22/2016 | no | no | R | 6/15/2017 | |
| PracticeMax | 1021.3399E | Business Associate Agreement | Steve Young | Laboratory | 12/28/2016 | 10/19/2016 | yes | yes | NR | 6/15/2017 | |
| Premier Laser Services | 1007.3060C | Equipment: Lease | Mary Diamond | Surgery | 4/3/2018 | 11/5/2016 | no | no | R | 6/15/2017 | |
| Prezio Health | 1007.2401C | Services Agreement | Mary Diamond | Surgery | 3/31/2019 | 11/5/2016 | yes | yes | R | 6/15/2017 | |
| Primary Care Medical | 1007.3081C | Services Agreement | Wayne Knight | Business Developme | 11/30/2019 | 2/22/2017 | no | no | R | 6/15/2017 | |
| Professional Hospital Supply | 1007.2423C | Equipment: Purchase | Thomas Moore | Supply Chain Management | 4/15/2017 | 11/1/2016 | no | no | R | 6/15/2017 | |
| Professional Maintenance Systems | 1006.473C | Professional Services Agreement | Susan McDowell | Wellness Center | 6/30/2017 | 10/27/2016 | no | no | R | 6/15/2017 | |
| Promise Healthcare | 1007.1313C | Business Associate Agreement | Stephen Chavez Matzel | Case Management | 10/28/2017 | 11/16/2016 | yes | yes | R | 6/15/2017 | |
| Protection1 Security Solutions | 1007.919C | Equipment: Support and Services | Sarah Jayyousi | OP Behavioral Health | 8/3/2017 | 10/18/2016 | no | no | R | 6/15/2017 | |

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A REGULAR MEETING**
**OF THE BOARD OF DIRECTORS**
**May 25, 2017 – 1:30 o'clock p.m.**
**Assembly Room 1 – 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 May 25, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Financial Officer
Scott Livingstone, Interim Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Greg Moser, General Legal Counsel
Adriana Ochoa, General Legal Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Assembly Room 1 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 Nygaard to approve the agenda. Director Schallock seconded the motion. The motion passed unanimously (7-0).**

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the May 25, 2017 Regular Board of Directors Meeting Agenda.

4. Oral Announcement of Items to be discussed during Closed Session.

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the May 25, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; three (3) matters of Potential Litigation; one Report Involving Trade Secrets with a disclosure date of December 31, 2017, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; three (3) matters of Existing Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

**It was moved by Director Kellett and seconded by Director Nygaard to go into closed session. The motion passed unanimously (7-0).**

6. 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 Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Interim Chief Financial Officer
Norma Braun, Chief Human Resource Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in Closed Session.

10. Director Mitchell led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12. Special Recognitions

Nurses, Support Staff and RN Educator of the Year – 2017

a) Inpatient – Sue McCay, RN

b) Outpatient – Maria Chones, RN

c) Patient Care Support Staff – Candice Cuevas

d) RN Educator – Jennifer L. Stephenson, MSN, RN, CNOR

Ms. Sharon Schultz, CNE, reported every year in May we celebrate National Nurse's Week and recognize nurses who have gone above and beyond. These individuals are voted on by their peers. This year's winners include Sue McCay, RN, Inpatient Services, Maria Chones, RN, Outpatient Services, Candice Cuevas, Patient Care Support Staff and Jennifer Stephenson, RN Educator.

Ms. Mary Diamond, Senior Director of Nursing introduced Jennifer Stephenson, Perioperative Nurse Educator for Surgical Services. Ms. Diamond stated because of the incredible work Jennifer has done over her tenure, we can name at least 15 Registered Nurses who had the opportunity to grow and develop and become operating room nurses. Ms. Diamond stated under Jennifer's leadership the quality and value of the nursing department has increased greatly in the operating room.

Ms. Sharon Davies, Director for Women & Newborn Services introduced Sue McCay, Inpatient Nurse of the Year. Ms. Daves stated Sue has been a nurse here at Tri-City for 28 years and during that time has impacted countless lives. Ms. Davies commented on a letter she received from a patient that Sue cared for eight (8) years ago. The patient stated that the care and compassion that Sue provided had such an impact on her life that she was inspired to become a nurse.

Ms. Monica Trudeau, Director of Home Health Services introduced Maria Chones, Outpatient Nurse of the Nurse. Ms. Trudeau stated Maria is a long tenured nurse who has spent her 26 years of service here at Tri-City Home Health. Ms. Trudeau stated Maria has extreme knowledge in clinical competency, a broad depth of knowledge and expertise and is our role model in Home Health. As a patient advocate, Maria is constantly looking to improve and bring quality care to our patients. She is very deserving of this award.

Ms. Nancy Myers, Clinical Manager, NICU Nancy Myers announced the Patient Care Support Staff award was presented to Candice Cuevas, an NICU technician. Ms. Myers stated in the short amount of time that Candice has been at Tri-City she rapidly became an invaluable member of the NICU team. Ms. Myers stated Candice not only meets but she embodies the Tri-City success standard.

Board members congratulated all recipients.

Director Kellett said not all nurses can be voted number one but they are still top notch nurses and we are very fortunate to have such great nurses and support staff here at Tri-City.

Dr. Ma, Chief of Staff expressed his appreciation to all the wonderful nurses in this organization.

Dr. Ma also expressed his appreciation to Sharon Schultz, CNE for her nursing leadership and as a token of appreciation from the Medical Staff, presented her with a bouquet of flowers.

13. Community Update –

Home Health Five Star Rating Presentation – Monica Trudeau, Director of Home Health & Hospice

Ms. Monica Trudeau, Director of Home Health & Hospice reported on Tri-City Home Health's recent Five Star Rating. She explained the Five Star Quality of Patient Care Measures looks at quality outcomes in nine different individual quality metrics that are measured on Home Health Compare. Ms. Trudeau stated this is a quarterly benchmark and we have to work to sustain the Five star rating.

Ms. Trudeau reported we also just received word that we have received the Home Care Elite Status for 2016. She stated it is a national recognition program that has been in place since 2006 and looks at the top performing Medicare certified Home Health agencies throughout the country. Tri-City Home Health made the top 25% list! Ms. Trudeau stated the methodology used in defining Home Care Elite Status is the focus on improved outcomes, improved care and the patient care experience as well as Value Based Purchasing.

Ms. Trudeau stated the future of Tri-City Home Health is very bright. We deliver very high quality care and we do that while excelling in the patient care experience. We are the only agency with 5 star quality and 4 star patient satisfaction rating. In addition we are in the top 20% in local area for readmissions with a readmission rate of 12.4%. Ms. Trudeau stated Home Health is in an excellent position for Value Based Purchasing and we are prime for new contracting opportunities and renegotiation of contracts. She noted we have seen an increase in referrals since the Five Star Rating was announced.

Ms. Trudeau stated Recruitment and Retention Initiatives is an ongoing challenge for Home Health & Hospice as several nurses and therapists are nearing retirement age. She explained that Home Health needs nurses that are very strong clinically and judgment wise to see the most acute patients at home. Ms. Trudeau stated Recruitment and Retention is at the top of the priority list and is needed in order to expand and grow.

In closing, Ms. Trudeau stated it is a team effort and takes all 60 staff members on the team to achieve the highest quality patient care, patient satisfaction and patient experience.

No action taken.

15. Report from TCHD Auxiliary – Pat Morocco – Auxiliary President

Ms. Mary Gleisberg, First Vice President of the Auxiliary reported she is speaking today on behalf of Mr. Pat Morocco, Auxiliary President who could not be here today.

Ms. Gleisberg highlighted two of the major events that Tri-City has participated in in the last couple of months.

The first event Ms. Gleisberg commented on was the Annual Scholarship event. On May 4th the Auxiliary awarded $102,000 for scholarships to 122 deserving recipients to further their education. The scholarships were awarded to 100 Nursing School students, 18 Junior Volunteers (high school volunteers who are going on to college and have acceptance) and four student volunteers in college.

The second event Ms. Gleisberg commented on was the 4th Annual *Tails on the* Trails Charity Dog Walk which was held on May 20th at Mance Buchanon Municipal Park with Willie Buchanon serving as Master of Ceremonies. Ms. Gleisberg stated 140 dogs participated in the walk and all dogs were on their best behavior! Ms. Gleisberg expressed her appreciation to Tri-City Medical Center for their sponsorship of the event as well as Mr. Bennett and the Marketing Department for their support of the event.

Lastly, Ms. Gleisberg reported that Mr. Pat Morocco will be retiring at of the end of June and she will take over as President. Ms. Gleisberg stated she looks forward to working with our 500+ auxiliary volunteers and will do what she can to move our Auxiliary along to benefit the hospital and the community.

Chairman Dagostino stated the Board is extremely impressed with the Auxiliary's scholarship program.

No action taken.

16. Report from TCHD Foundation, Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer invited Tri-City Hospital Foundation Trustee Lelene Balken to join him in the presentation of checks.

Mr. Newhart and Ms. Balken presented three (3) checks as follows:

1) $59,780 – Women's Imaging Center Lobby remodel. Mr. Newhart stated the project is now complete and looks beautiful.

2) $83,550.94 - GE Logiq8 SQ Clear Ultrasound for the Women's Imaging Center that pares with the SonoCine system.

3) $137,520 - da Vinci-Trumpf Medical integrated table motion. Mr. Newhart stated this motion table for the da Vinci will be the first in North County.

Mr. Newhart reported on a couple of upcoming events, 1) the Golf Tournament scheduled for September 18th and 2) the Diamond Ball scheduled on November 18th.

Mr. Newhart announced the 2017 Legacy Award winners, Kevin & Ellen Stotmeister who will be recognized for their outstanding philanthropic contributions as well as incredible donations of time and leadership to the Foundation and San Diego Imaging for their incredible donations over many many years.

Lastly, Mr. Newhart stated the Foundation Board voted this month to focus on the Women's Imaging Center this year with the idea of creating a premier imaging center here at Tri-City. Part one will include the SonoCine Automated Whole Breast Ultrasound and part two the Hologic Selenia Dimensions 3D Tomosynthesis (3D Mammo).

Chairman Dagostino expressed his appreciation on behalf of the Board for the Foundation's contributions to our community.

No action taken.

17. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO congratulated the nurses and support staff that have been recognized today. Mr. Dietlin also acknowledged the three nurses that serve on the Board of Directors and Chief Nurse Executive, Ms. Sharon Schultz. Mr. Dietlin stated Ms. Schultz is the definition of compassion and professionalism.

Mr. Dietlin commented on the Auxiliary Scholarship event in which 122 scholarships were given to local students and volunteers totaling over $100,000. He expressed his appreciation to the Auxiliary for their outstanding efforts in putting the event together, finding the sponsors and raising the funds.

Mr. Dietlin congratulated Ms. Mary Gleisberg for taking over as the new Auxiliary President.

Mr. Dietlin acknowledged the Foundation, another group of dedicated individuals coming together to help advance the mission of Tri-City by holding events, raising money and investing in the latest equipment available. Mr. Dietlin stated that often times you will see the Foundation, Auxiliary, Board and Administration all coming together to participate in one project that may not have been able to happen on its own, such as the GE 512 scanner.

Mr. Dietlin stated the second Strategic Planning meeting of the year was held with the Board. He explained strategic planning is about aligning the Board, Administration and the Medical Staff together for our community initiatives.

Mr. Dietlin commented on some of the exciting things we have been working on which include Mental Health Initiatives, Cardiac Care, Women's Health, Orthopedics, and our affiliation with UCSD, to name a few. He stated all these things are designed around expanding quality services offered to the community right here locally so people don't have to travel for their quality healthcare. Mr. Dietlin explained these initiatives will be rolled into our upcoming FY18 budget. He stated we will be meeting with the Board to seek their approval on the budget in June and with that comes the challenges that are here for healthcare including reduced reimbursement environment. He noted the importance of being flexible in order to operate within that environment with a focus on higher quality with lower costs.

Mr. Dietlin commented on the Five Star Home Health Rating as well as our Leap Frog Patient Safety rating which is the highest in North County and one of the highest ratings in all of San Diego. Mr. Dietlin stated we have done a fairly good job of producing those excellent medical outcomes at a relatively low cost which becomes more and more challenging in today's healthcare environment. In closing, Mr. Dietlin stated with all those exciting initiatives, balancing quality, cost, growth, advanced technology, campus development we look forward to our mission to expand the health and wellness of this community that we serve.

Lastly, Mr. Dietlin commented on the recent General Acute Care Hospital Recertification Survey in which one surveyor commented that this was one of the best surveys she has seen anywhere!

No action taken.

18. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date Financials as follows (Dollars in Thousands):

- Operating Revenue – $280,306
- Operating Expense – $282,361
- EBITDA- $12,747
- EBITDA Excl. HUD Financing Charge - $16,150
- EROE - $75
- EROE Excl. HUD Financing Charge - $3,479

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 181
- Adjusted Patient Days – 93,325
- Surgery Cases – 5,269
- Deliveries – 2,151
- ED Visits – 52,297

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $28,646
- Operating Expense – $29,244
- EBITDA – $,213
- EROE – ($63)

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 181
- Adjusted Patient Days – 8,880
- Surgery Cases – 517
- Deliveries – 172
- ED Visits – 5,049

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.3
- Days in Net Accounts Receivable – 49.7

Chairman Dagostino commented that operations are down however stewardship with expenses is helping our efforts.

Director Mitchell commented that we are not the only hospital seeing a reduction in Emergency Department visits. Mr. Rivas agreed that it is a nationwide phenomenon and definitely seen in San Diego county.

Director Reno questioned how we compare with other District Hospitals in California. Mr. Rivas stated he did not have that information readily available but will follow-up.

No action was taken.

18. New Business

a. California Voting Rights Act presentation

General Counsel, Ms. Adriana Ochoa gave a detailed report on the California Voting Rights Act.

She reported the California Voting Rights Act (CVRA) was passed in 2001 after several California jurisdictions successfully defended themselves against a couple of federal voting acts lawsuits. It became effective in January of 2003 and expands on the federal Voting Rights Act of 1965. The California Voting Rights Act eliminates several key burden of proof requirements that exist under the federal voting rights act and makes it easier for minority groups to challenge agencies.

Ms. Ochoa explained the CVRA allows minority voters to compel local government agencies to eliminate an at large system which some argue impair the ability of minorities to influence elections. It applies only to these "at large "or combination election systems. Both the at large or combination would be illegal under the California Voting Rights Act if they could be shown to discriminate against minority groups.

The key element to the CVRA is racially polarized voting. A violation of the CVRA is established "if is shown that racially polarized voting occurs in elections for members of the governing body of the policy subdivision".

Ms. Ochoa stated the District received written notice by Kevin Shenkman of Shenkman & Hughes threatening to sue the District for alleged violations of the CVRA and threatened to sue unless the district voluntarily converts to district-based elections. She noted Tri-City Medical Center has 45 days from receipt of the letter to approve a resolution of intention to transition to district-based elections or be subject to CVRA lawsuit.

Ms. Ochoa explained the consequences to violating the CVRA which may include that the court may order the District to transition to district based elections. She stated the best way to be insulated from potentially costly litigation is to transition to a district-based election system which is expressly provided for under Healthcare District Law.

Ms. Ochoa stated the recommendation is to approve Resolution No. 785. to insulate ourselves from a lawsuit and protect ourselves from the cost to defend a potentially costly lawsuit.

Ms. Ochoa stated our plan in the Resolution includes a timeline that corresponds with proposed LAFCO annexation which will be discussed further at the June Board meeting. The proposed LAFCO annexation considers two areas that LAFCO is recommending Tri-City annex into its boundaries. If we do proceed with the two annexations it would increase our population in the Tri-City jurisdiction by prospectively tens of thousands of new citizens and approximately 60,000 people that are voter age citizens. Ms. Ochoa stated she believes its makes financial and practical sense to consider both

concurrently, but not draw zones or district lines until decisions are made on potential changes in population in District boundaries. She commented that it would be a waste of the District's public resources.

At Director Reno's request, Ms. Ochoa explained what the election process would look like. She noted there will be two election cycles before all seven (7) members of the Board would be entirely zone elected Board members. *(A copy of Ms. Ochoa's presentation will be attached to the file copy of these minutes for reference).*

b. Consideration to approve Resolution No. 785, A Resolution of the Tri-City Healthcare District Board of Directors Outlining Intention to Transition from At-Large to a District-Based Elections Pursuant to Elections Code 10010(E)(3)(A).

**It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve Resolution No, 785, A Resolution of the Tri-City Healthcare District Board of Directors Outlining Intention to Transition from At-Large to District Based Elections Pursuant to Elections Code 10010(E(3)(A). Director Mitchell seconded the motion.**

Chairman Dagostino recognized Molly Woods, SEIU-UHW representative. Ms. Woods commented on the union's request 18 months ago urging the Board to go to district based elections. She stated we need diverse leadership that meets both the needs of the staff and the patients we provide care for. She urged the Board to do what's best for the community and follow the law.

Chairman Dagostino recognized Ms. Jane Mitchel. Ms. Mitchell commented on the outstanding Home Health nurses and her personal experience with Home Health.

Ms. Mitchell stated Vista has performed expeditiously, transparently and inclusively where they have had public input with regard to the redistricting. She believes Vista should be represented in terms of the population they are serving. In closing Ms. Mitchell stated the people of Vista deserve a transparent, fair and expeditious solution to this issue, minimizing legal issues.

Chairman Dagostino recognized Mr. Lou Montulli. Mr. Montulli stated the Board leaves out the 48% of the Hispanic population in Vista. He urged the Board to do what's right and comply with the request to draw district lines and give Vista the representation it deserves.

Chairman Dagostino recognized Councilwoman Sanchez. Councilwoman Sanchez stated the City of Oceanside was one of the six jurisdictions that received the same letter within a very short period of time. She urged the Board to follow the City of Oceanside's plan in which four council meetings plus five community meetings were held to allow the community input. Ms. Sanchez commented that she was unaware of the potential LAFCO annexation plans.

General Counsel stated the Resolution before the Board provides for five (5) public hearings. Two before maps are drawn, two after maps are drawn and one to be considered under the Healthcare District Act.

Director Schallock called for the question.

**The vote on the motion was as follows:**

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

Director Reno questioned if the resolution is available at the able for the public. Chairman Dagostino stated it was included in the Board's agenda packet that was posted on the internet and copies can be made available as requested.

c. Consideration to approve FY2017-2018 Community Healthcare Grant Awards

Chairman Dagostino invited Ms. Gigi Gleason, Grant Chair to the podium to present information on the proposed Healthcare Grant Awards.

Chairman Dagostino stated Director Grass has indicated she would like to pull the item for discussion.

**It was moved by Director Grass to table the Community Healthcare Grant Awards. Director Kellett seconded.**

General Counsel requested that the motion state when the item will be considered. Director Grass suggested the item be tabled to the next Board meeting

Director Kellett requested that the Chair give Ms. Gleason the opportunity to speak.

Ms. Gleason stated the recommendations from the Grant Panel are included in the agenda packet.

Chairman Dagostino explained the CHAC Committee has put together a Grant Committee that has screened the applications and made recommendations based on the criteria set. .

General Counsel stated the motion on the floor is to table the grants to the next Board meeting.

Director Grass stated she knows Vista has commented that they don't have representation and takes offense to that comment and strongly disagrees with that statement. She further explained that her residence may be in Carlsbad however she looks at everything from a point of view that all three (3) cities should be equally represented.

With regard to the grants, Director Grass stated the Boys and Girls Club of Vista and Oceanside is receiving half as much money as the Boys & Girls Club of Carlsbad. In addition Vista Community Clinic was completely left out and some of the resources were allocated to other things that she would not necessarily vote for.

Ms. Gleason responded that only three applications were received from the City of Vista. Vista Community Clinic was not overlooked but were disqualified for failure to submit their end of ear report.

Chairman Dagostino requested clarification as to whether the District has a financial relationship with the Clinic. Mr. Dietlin stated we have had several financial relationships with the clinic in the past however he does not know the monetary amounts.

Director Nygaard explained the Committee is extremely careful and ensures that all grants are processed in the appropriate manner and meet the program rules.

Ms. Gleason explained in detail the application process. With regard to the Vista Boys & Girls Club of Vista, Ms. Gleason explained if the purpose of the grant is the same year after year, the committee will recommend a lesser amount. In addition, the committee looks at the impact of the grant on the community.

Director Grass stated she appreciates Ms. Gleason's comments and did not intend to show any disrespect but wanted to have more communication before approving.

Director Schallock explained the purpose is not to put "city against city" but provide funds to all three cities. Director Nygaard reiterated that the object of the grants is to benefit organizations in the District.

Director Reno requested clarification on Solutions for Change. Ms. Gleason stated the grant supports a counselor in the North County.

Director Nygaard stated the Grant Committee presented their recommendations to the CHAC committee and the CHAC committee had consensus among all members that it was a good distribution of funds across the board. She noted there are several members of the committee from Vista, as well as Oceanside and Carlsbad.

General Counsel stated the motion to table has precedence over other motions.

Director Kellett called for the question on the motion to table.

Director Reno stated if Ms. Gleason reviewed the grants individuals, perhaps action could be taken today.

Director Grass stated her motion stands.

**The vote on the motion to table approval of the grants to the June meeting was as follows:**

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

**It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the FY2017-2018 Community Healthcare Grant Awards as recommended by the Communication Healthcare & Alliance Committee. Director Schallock seconded the motion.**

Ms. Gigi Gleason stated she is happy to answer any remaining questions.

Director Grass stated in her opinion this is a poor use of District funds, she disagrees with it and will be voting no.

**The vote on the motion was as follows:**

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

d. Discussion and possible action regarding Board Workshop

Chairman Dagostino requested Board direction on how to proceed with the Board Educational Workshop. He stated personally he would like a facilitator to assess the Board and see how well it has performed since the last assessment. Director Reno requested that the Board select a new Facilitator to provide a fresh set of eyes.

Director Schallock suggested the Board provide the Chair with names of potential Board Facilitators and allow the Chair to query their availability and fees and bring that information back to Board for consideration.

Directors concurred we should be conservative and hold the Workshop onsite.

Chairman Dagostino requested that Board members send Ms. Donnellan the names of potential Facilitators and he will report back at next month's meeting.

20. Old Business

a. Board Portal Update

Director Mitchell reported the Board Portal Standing Committee will be meeting next Thursday with the webmaster to review a draft of the portal webpage.

Director Schallock stated 52% of Boards are using Board portals.

Director Kellett questioned how many of those Boards are publicly elected and are required to follow the Brown Act. Chair Dagostino surmised that the majority of those Boars are corporate type boards.

No action was taken.

21. Chief of Staff

a. Consideration of May 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals

**It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the May 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee at their meeting on May 22, 2017. Director Kellett seconded the motion.**

**The vote on the motion was as follows:**

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

22. Consideration of Consent Calendar

**It was moved by Director Nygaard that the Tri-City Healthcare Board of Directors approve the Consent Calendar. Director Reno seconded the motion.**

**Director Reno pulled item 21 (4) F. 2) Board Policy 16-037. Director Kellett seconded the motion.**

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

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

23. Discussion of items Pulled from Consent Agenda

Director Reno who pulled item 22 (4) F. 2) Board Policy 16-037 stated that she has some concerns with the language. She stated she was unable to attend the Governance Committee meeting at which the policy was discussed and therefore will be abstaining from the vote on the policy.

Director Schallock clarified the Chief Compliance Officer was struck throughout to reflect the current reporting structure and now the policy applies solely to the CEO. Director Reno questioned the process for succession in the absence of the CEO and stated Dr. Mells previously pointed out that the Board has the right to appoint a successor. Director Mitchell explained that the policy simply states the officers that would be considered for succession, rather than the order of succession. Chairman Dagostino stated the policy allows the Board to choose any one of the officers listed from the C-Suite. Based on this information, Director Reno stated she would change her vote.

**It was moved by Director Kellett to approve Board Policy 16-037 – Chief Executive Officer Succession Planning Policy as presented. Director Nygaard seconded the motion.**

**The vote on the motion was as follows:**

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

24. Reports (Discussion by exception only)

25. Legislative Update

Chairman Dagostino reported he and Director Schallock had the opportunity to attend the AHA annual meeting in Washington and Legislative Day.

Director Schallock provided an extensive report on the conference and noted a written report will be included in the June agenda packet. Director Schallock also referred to materials from the annual meeting that was provided to Board members at the Dais.

26. Comments by Members of the Public

No comments from members of the public.

27. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

28. Board Communications

Director Schallock stated he was fortunate to once again attend the annual Auxiliary Scholarships event. He stated it is commendable that the Auxilians have undertaken this event year and year.

Director Schallock commented on the recent Drug Take-Back day in which almost 11,000 pounds of pills were collected throughout the county.

Director Schallock commented that a community member has expressed her delight that the hospital has purchased a SonoCine Automated Whole Breast Ultrasound and the fact that she will no longer have to travel to Pasadena for this service.

Director Reno commended Ms. Sharon Schultz, CNE for a great celebration for Nurse's Week. She expressed her appreciation to Dr. Ma and the Medical Staff for recognizing Ms. Schultz.

Director Reno expressed her appreciation to Dr. Ma for everything he has done here for Tri-City during his tenure as Chief of Staff. She stated that Dr. Ma has done an outstanding job of helping the Board understand the workings of the Medical Staff.

Director Nygaard did not have any comments.

Director Grass stated that June 14th is World Wide Blood Donor Day. She explained the reason that day was established was to bring awareness to safe blood and safe blood products. As a recipient of safe blood products that saved her life, Director Grass encouraged everyone who is qualified to give blood to consider donating, whether it be once a year or once a quarter.

Director Mitchell commented that the Nurse's Week luncheon "totally rocked" and she enjoyed seeming many of nurses that she has worked with in the past.

Director Mitchell stated that the purpose of collective bargaining is to use the power of the group to ensure fairness to the individuals. She stated she gets concerned when

this idea is turned around with the purpose of rewarding a few at the expense of the many and is not what the spirit of collective bargaining is all about.

Director Kellett expressed his appreciation to Dr. Ma for his tenure as Chief of Staff. '

Director Reno questioned if we voted on the minutes. Chairman Dagostino clarified the minutes are included in the Consent Agenda and were approved at that time.

29. Report from Chairperson

Chairman Dagostino reported he will have the opportunity to serve as a Trustee on the Governance Committee for the California Healthcare Association. He stated that this is a position that Director Schallock has held in the past and he believes it is important to keep abreast of current legislation related to healthcare.

30. Hearing no further business, Chairman Dagostino adjourned the meeting to continue to closed session at 5:30 p.m.

31. The Board returned to Open Session at 6:15 p.m. with all Board members present.

32. Report from Chairperson on any action taken in Closed Session

Chairperson Dagostino reported no action was taken in Closed Session.

33. Adjournment

There being no further business, Chairman Dagostino adjourned the meeting at 6:15 p.m.

_____
James J Dagostino, DPT, PT
Chairman

ATTEST:

_____
Laura E. Mitchell, Secretary

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A SPECIAL MEETING**
**OF THE BOARD OF DIRECTORS**

**May 23, 2017 – 2:00 o'clock p.m.**
**Assembly Rooms 2&3 – Eugene L. Geil Pavilion**
**4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 2:00 p.m. on May 23, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Jody Root, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Interim Chief Compliance Officer
Norma Braun, Chief Human Resource Officer
Wayne Knight, Chief Strategy Officer
David Bennett, Chief Marketing Officer
Jeremy Raimo, Senior Director, Business Development
Susan Hadley, Director, Network Development
Eva England, Cardiovascular Service Line Administrator
Jenelle Lovelady, Business Development Manager
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 2:04 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

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

3. Public Comments – Announcement

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

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Root, made an oral announcement of the item listed on the May 23, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report on Trade Secrets with various disclosure dates.

5. Motion to go into Closed Session

**It was moved by Director Schallock and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).**

6. Chairman Dagostino adjourned the meeting to Closed Session at 2:05 p.m.

8. The Board returned to Open Session at 5:23 p.m. with all Board Members present.

9. Open Session

10. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session

11. There being no further business, Chairman Dagostino adjourned the meeting at 5:23 p.m.

James J. Dagostino
Chairman

ATTEST:

Laura E. Mitchell
Secretary

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A SPECIAL MEETING**
**OF THE BOARD OF DIRECTORS**

**June 1, 2017 – 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 June 1, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Cyril F. Kellett, MD

Also present were:

Greg Moser, General Legal Counsel
Kapua Conley, Chief Operating Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Wayne Knight, Chief Strategy Officer
David Bennett, Chief Marketing Officer
Glen Newhart, Chief Development Officer
Dr. Gene Ma, Chief of Staff
Dr. Victor Souza, Incoming Chief of Staff
Dr. Jamie Johnson, QA Chair
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 Nygaard led the Pledge of Allegiance.

2. Approval of agenda.

   **It was moved by Director Nygaard to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (6-0-1) with Director Kellett absent.**

3. Public Comments – Announcement

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

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser, made an oral announcement of items listed on the June 1, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

5. Motion to go into Closed Session

**It was moved by Director Grass and seconded by Director Schallock to go into Closed Session. The motion passed (6-0-1) with Director Kellett absent.**

6. Chairman Dagostino adjourned the meeting to Closed Session at 10:08 a.m.

7. The Board returned to Open Session at 2:50 p.m. with all Board members present with the exception of Directors Grass and Kellett.

8. Report from Chairperson on any action taken in Closed Session.

   Chairman Dagostino reported no action had been taken in closed session.

9. There being no further business, Chairman Dagostino adjourned the meeting at 2:51 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

**TRI-CITY HEALTHCARE DISTRICT**
**MINUTES FOR A SPECIAL MEETING**
**OF THE BOARD OF DIRECTORS**

**June 15, 2017 – 6:00 o'clock p.m.**
**Assembly Room 3 – Eugene L. Geil Pavilion**
**4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on June 15, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Leigh Anne Grass

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Interim Chief Compliance Officer
Norma Braun, Chief Human Resource Officer
Wayne Knight, Chief Strategy Officer
Jeremy Raimo, Senior Director, Business Development
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 6:10 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   **It was moved by Director Schallock to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed (6-0-1) with Director Grass absent.**

3. Public Comments – Announcement

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

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of items listed on the June 15, 2017

Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report on Trade Secrets with various disclosure dates, Conference with Labor Negotiators and three (2) matters of Existing Litigation.

5. Motion to go into Closed Session

**It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed (6-0-1) with Director Grass absent.**

6. Chairman Dagostino adjourned the meeting to Closed Session at 6:12 p.m.

8. The Board returned to Open Session at 8:45 p.m. with all Board Members present with the exception of Directors Grass and Reno.

9. Open Session

10. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session

11. There being no further business, Chairman Dagostino adjourned the meeting at 8:45 p.m.

James J. Dagostino
Chairman

ATTEST:

Laura E. Mitchell
Secretary

mcol

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| Date | Invoice # |
|---|---|
| 5/15/2017 | 011855 |

Bill To

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

| P.O. No. | Terms | Due Date | Account # |
|---|---|---|---|
| | Due on receipt | 5/15/2017 | |

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| CA Sales Tax | | 7.625% | 0.00 |

Annual Subscription Fees - Aug2017-July2018

| | |
|---|---|
| **Total** | $219.00 |
| **Payments/Credits** | $0.00 |
| **Balance Due** | $219.00 |

Stakeholder Experience

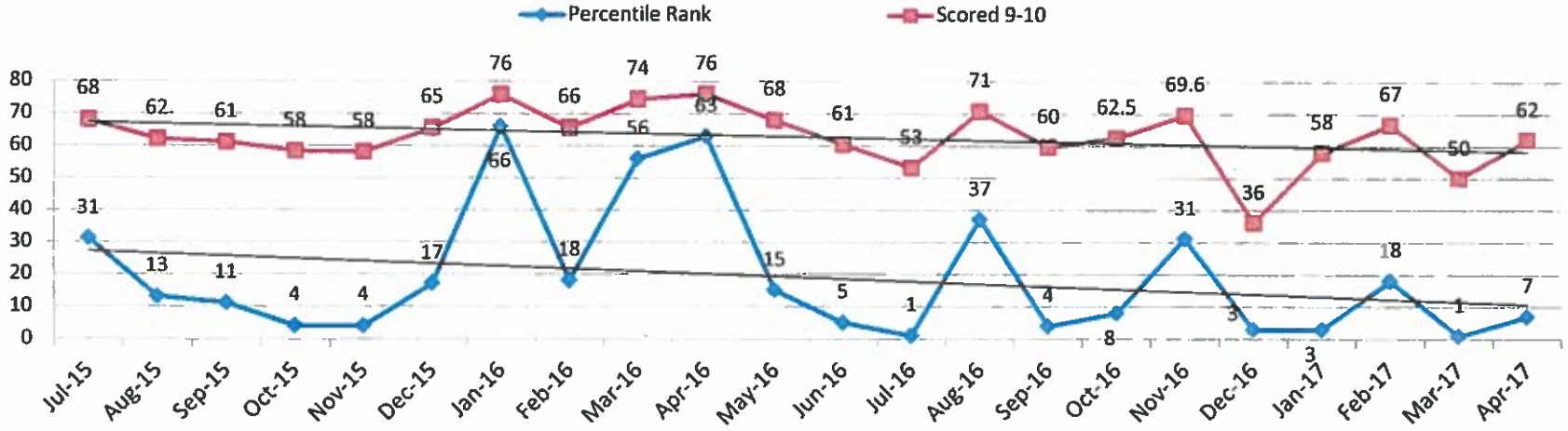
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

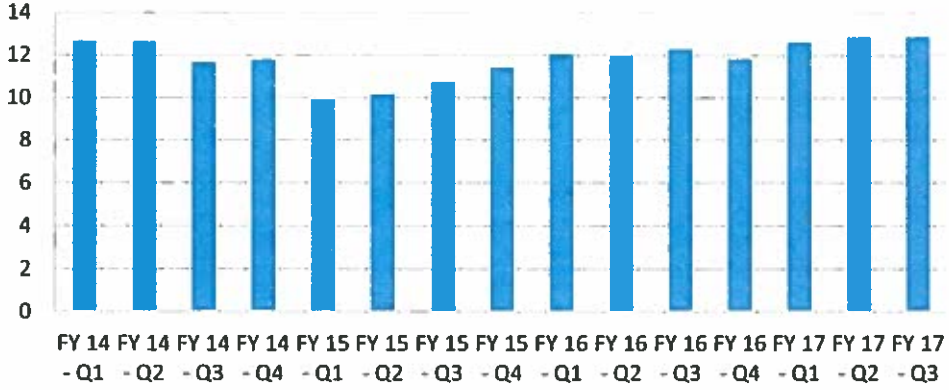
# HCAHPS (Top Box Score)

*Hospital Consumer Assessment of Healthcare Providers & Systems*

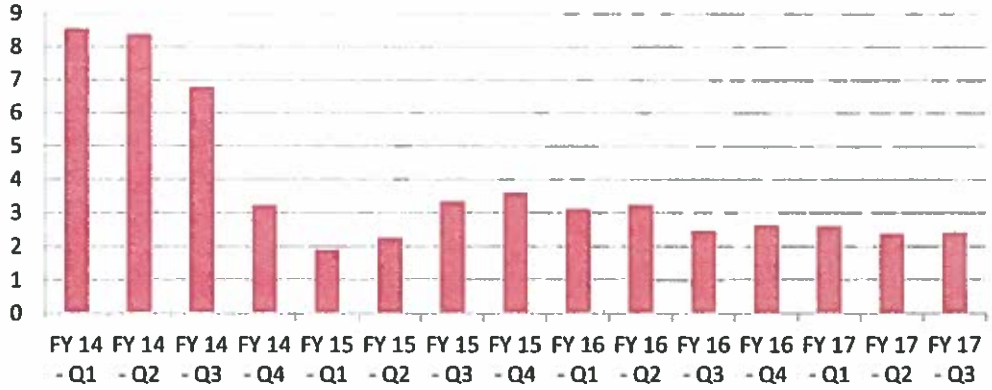
## Overall Rating of Hospital (0-10)




## Voluntary Employee Turnover Rate

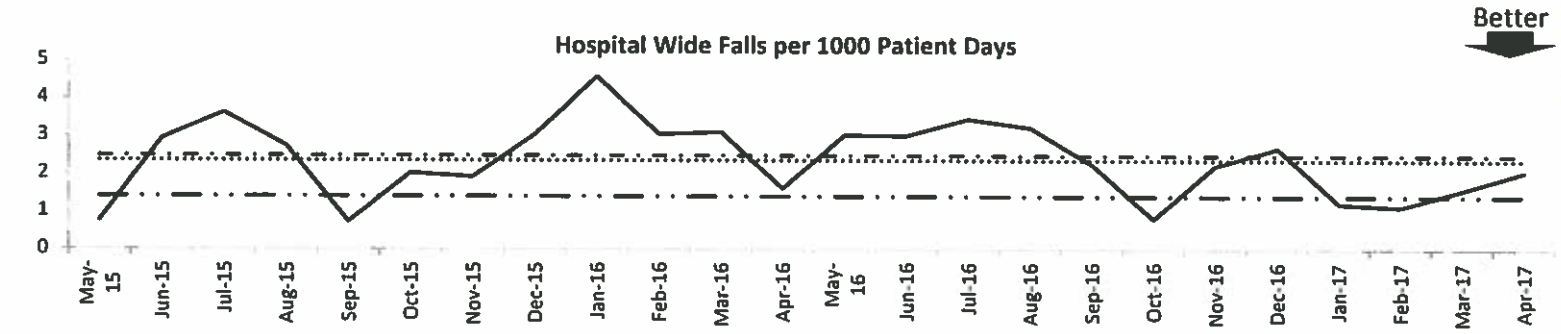



## Involuntary Employee Turnover Rate



# Current Trending Measures

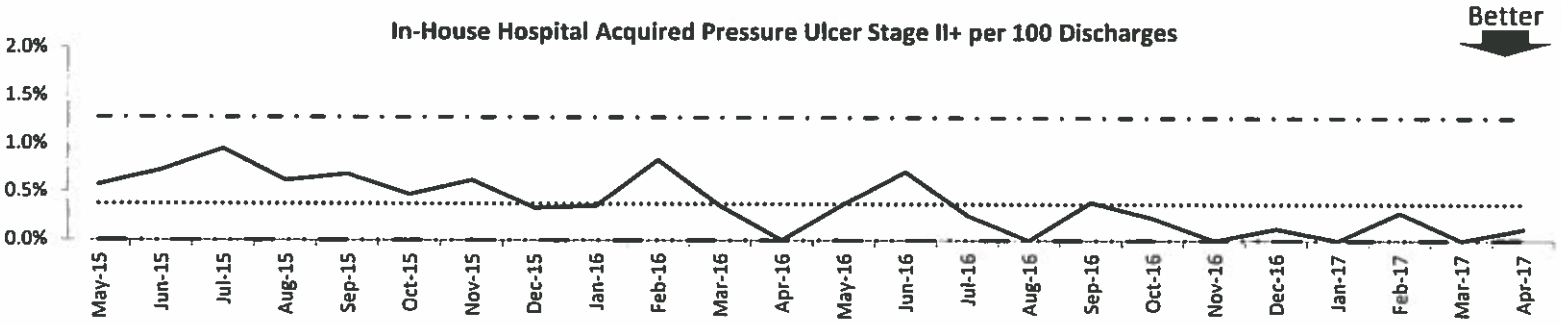
TCMC Rate — Mean — CA Mean — TCMC Target




## Action Plan

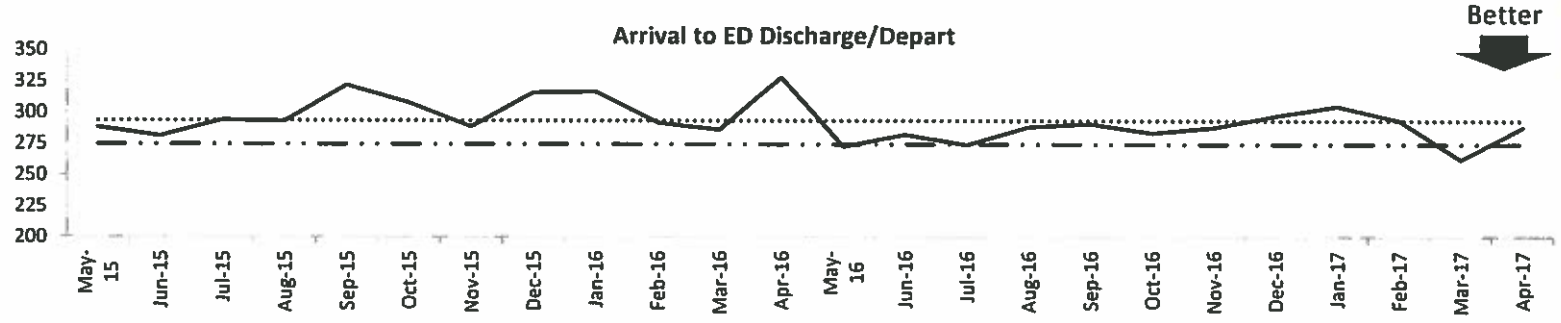
Goal to monitor & sustain improvements.
Toileting:
- Hourly rounding
- At risk assist to bathroom q. 4-6 hours.
- Remain in BR with high risk pts.
- Educate pt and family.

Redesign Fall Risk:
- "Fresh visibility"




## Action Plan

> Incr Expert Staff & create zones for focused education.
> Staff educ revised classification of pressure injuries.
> 4 Eyes in 4 hours.
> Implemented pressure injury treatment plan.
> Hardwire EHR prevention protocols.
> Implemented unit based wound champions.

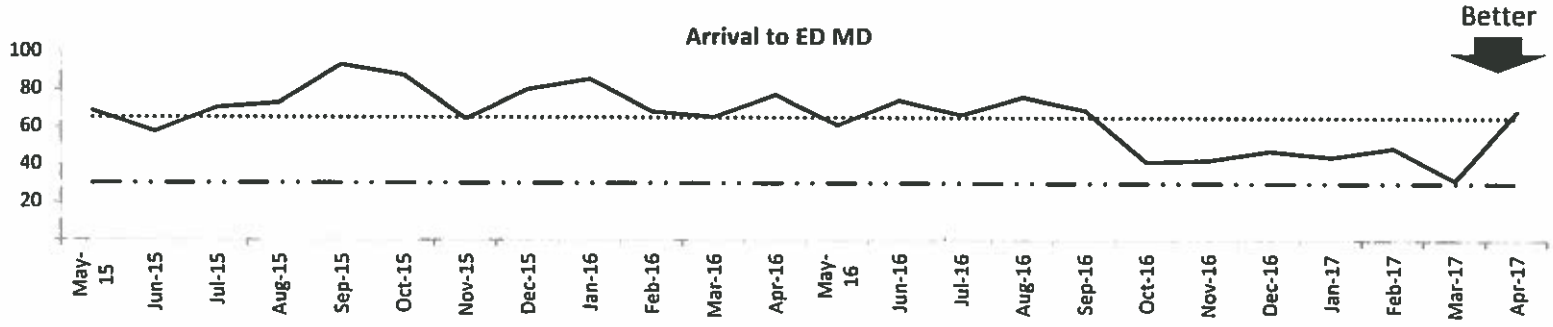



## Action Plan

Time to discharge decreased by 40 minutes after adding MD to triage. < 240 minutes

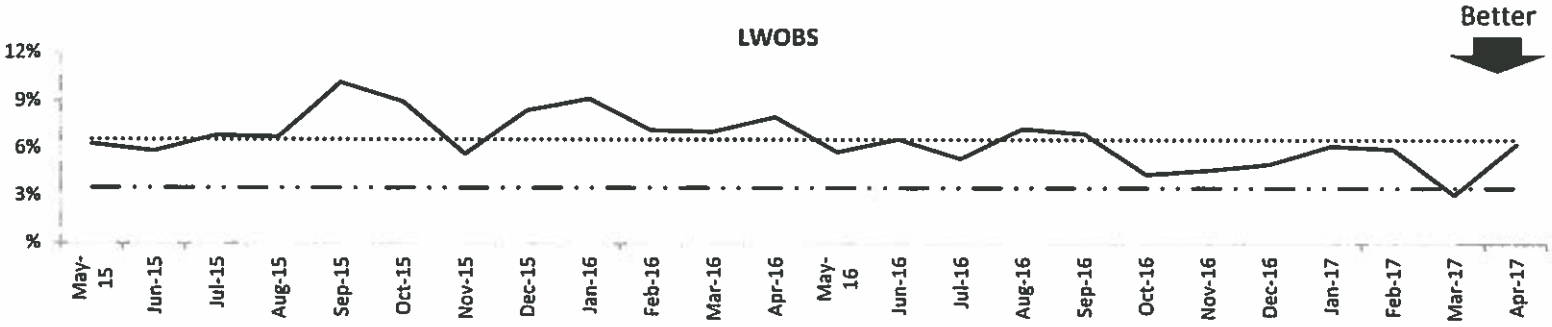
# Current Trending Measures

TCMC Rate | Mean | CA Mean | TCMC Target



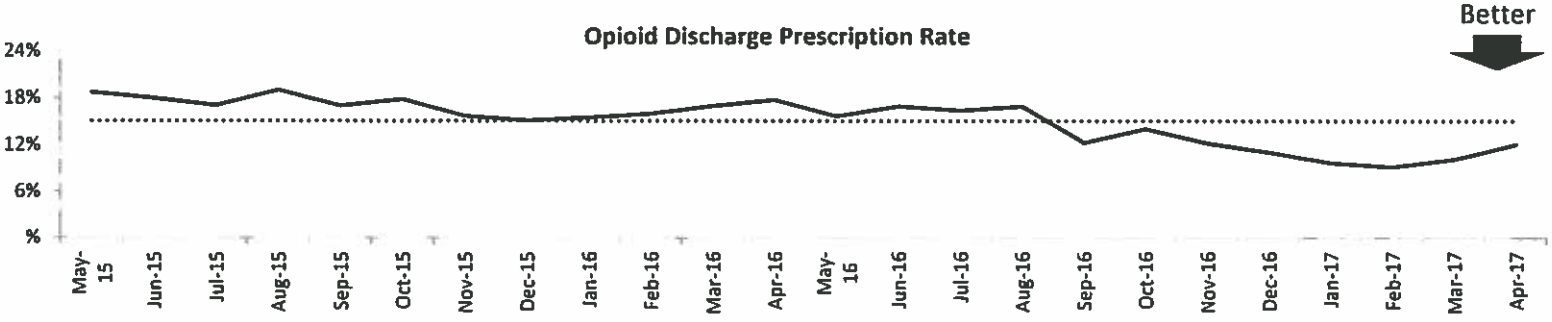

**Action Plan**

Arrival to MD/PA assessment 22 minutes




**Action Plan**

2016 LWOBS was 6.9%. Currently, LWOBS YTD 2.1% due mainly to increased MD presence in Traige.

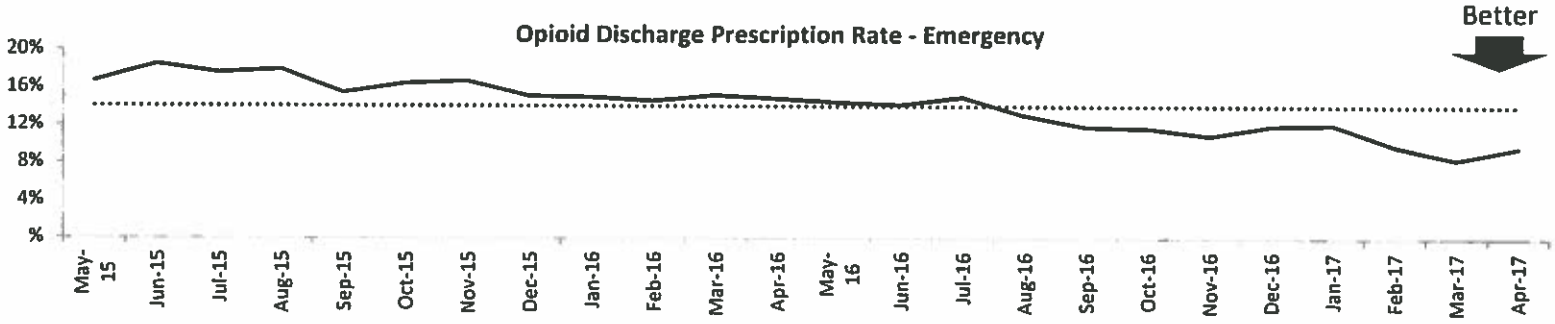



**Action Plan**

Continue to investigate the benefit of the use of CURES. Provide education to patients regarding the use of non-pharmacological methods for pain management and the risks vs benefits of opioid use. Continue to provide education to the physcians regarding opioid prescribing at time of discharge.

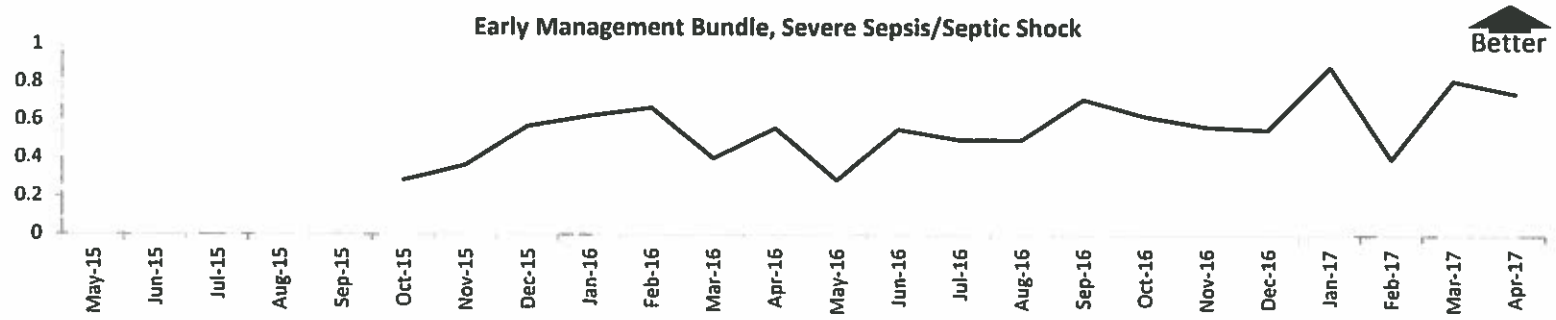
# Current Trending Measures

TCMC Rate | Mean | CA Mean | TCMC Target




## Action Plan

Continue to evaluate the process of accessing CURES. Provide education to the patients regarding the use of non-pharmacological methods for pain management and the risks vs benefits of opioid use. Continue to provide education to the physicians regarding opioid prescribing at time of discharge.




## Action Plan

Erratic results due to small sample size. 1st Quarter 2017 achieved 76% pass rate which met 70% goal. 2016 & TYD 2017 only 4 Severe Sep started after admission. None of these passed measure, current focus. Working in Cerner triggers and Code Sepsis process.

# Volume

## Spine Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 28 | 22 | 13 | 25 | 27 | 23 | 19 | 24 | 25 | 25 | 30 | | 261 |
| FY16 | 49 | 29 | 30 | 30 | 23 | 29 | 23 | 28 | 32 | 27 | 27 | 29 | 356 |

## Mazor Robotic Spine Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 9 | 9 | 5 | 13 | 12 | 11 | 10 | 8 | 15 | 8 | 12 | | 112 |
| FY16 | 20 | 19 | 15 | 23 | 12 | 13 | 16 | 15 | 15 | 17 | 8 | 15 | 188 |

## Inpatient DaVinci Robotic Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 8 | 11 | 8 | 13 | 12 | 8 | 12 | 10 | 12 | 11 | 17 | | 122 |
| FY16 | 9 | 10 | 8 | 8 | 13 | 11 | 9 | 13 | 14 | 8 | 8 | 9 | 120 |

## Outpatient DaVinci Robotic Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 18 | 18 | 17 | 14 | 20 | 22 | 20 | 16 | 18 | 13 | 17 | | 193 |
| FY16 | 16 | 19 | 13 | 4 | 7 | 9 | 15 | 20 | 15 | 13 | 17 | 15 | 163 |

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 31 | 35 | 29 | 42 | 34 | 29 | 31 | 30 | 31 | 37 | 28 | | 357 |
| FY16 | 40 | 36 | 37 | 44 | 34 | 33 | 45 | 39 | 38 | 39 | 38 | 50 | 473 |

Inpatient Behavioral Health - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 16.5 | 15.6 | 15.0 | 16.2 | 16.7 | 16.5 | 14.4 | 14.8 | 16.5 | 17.5 | 16.1 | | 16.0 |
| FY16 | 19.9 | 19.6 | 17.6 | 18.0 | 16.0 | 16.7 | 17.5 | 15.5 | 15.2 | 14.5 | 15.3 | 17.6 | 17.0 |

Acute Rehab Unit - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 6.8 | 6.8 | 6.6 | 7.0 | 5.6 | 6.2 | 5.6 | 5.9 | 4.9 | 7.0 | 8.0 | | 6.4 |
| FY16 | 7.1 | 4.9 | 5.6 | 6.9 | 7.1 | 6.7 | 6.5 | 6.6 | 5.0 | 6.5 | 5.5 | 6.3 | 6.2 |

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 14.8 | 17.4 | 17.1 | 18.6 | 13.3 | 17.0 | 15.5 | 11.7 | 10.7 | 8.8 | 10.0 | | 14.1 |
| FY16 | 13.3 | 11.1 | 14.3 | 15.1 | 16.3 | 19.0 | 20.1 | 16.3 | 13.5 | 16.0 | 17.1 | 13.4 | 15.5 |

Hospital - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 178.6 | 191.9 | 181.3 | 183.9 | 174.0 | 179.5 | 188.0 | 177.8 | 174.4 | 180.5 | 174.9 | | 180.5 |
| FY16 | 183.9 | 183.4 | 199.7 | 187.7 | 182.4 | 200.6 | 202.9 | 203.0 | 186.7 | 200.7 | 183.9 | 189.2 | 191.9 |

Performance compared to prior year: Better | Same | Worse

Deliveries

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 223 | 239 | 274 | 230 | 197 | 200 | 217 | 197 | 202 | 172 | 188 | | 2339 |
| FY16 | 215 | 214 | 252 | 227 | 232 | 220 | 216 | 183 | 209 | 189 | 208 | 200 | 2565 |

Inpatient Cardiac Interventions

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 12 | 11 | 12 | 16 | 11 | 14 | 15 | 11 | 6 | 15 | 12 | | 135 |
| FY16 | 16 | 9 | 19 | 12 | 16 | 10 | 11 | 15 | 15 | 15 | 18 | 12 | 168 |

Outpatient Cardiac Interventions

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 4 | 4 | 6 | 6 | 5 | 7 | 2 | 2 | 7 | 9 | 6 | | 58 |
| FY16 | 7 | 3 | 7 | 4 | 5 | 7 | 6 | 6 | 6 | 4 | 2 | 7 | 64 |

Open Heart Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 10 | 9 | 8 | 7 | 6 | 9 | 8 | 6 | 16 | 9 | 6 | | 94 |
| FY16 | 7 | 14 | 4 | 6 | 7 | 10 | 2 | 8 | 13 | 12 | 5 | 7 | 95 |

TCMC Adjusted Factor (Total Revenue/IP Revenue)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 1.68 | 1.71 | 1.76 | 1.72 | 1.68 | 1.70 | 1.61 | 1.73 | 1.73 | 1.64 | 1.71 | | 1.70 |
| FY16 | 1.65 | 1.63 | 1.60 | 1.62 | 1.63 | 1.56 | 1.54 | 1.63 | 1.65 | 1.60 | 1.66 | 1.68 | 1.62 |

Performance compared to prior year: Better Same Worse

# Financial Information

TCMC Days in Accounts Receivable (A/R)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD Avg | Goal Range |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 51.2 | 50.2 | 48.7 | 50.5 | 49.6 | 50.5 | 48.9 | 49.0 | 48.8 | 49.4 | 48.1 | | 49.5 | 48-52 |
| FY16 | 46.7 | 45.7 | 45.7 | 45.3 | 47.0 | 49.1 | 51.7 | 48.9 | 49.5 | 50.4 | 47.4 | 46.7 | 47.9 | 48-52 |

TCMC Days in Accounts Payable (A/P)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD Avg | Goal Range |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 78.9 | 81.6 | 86.5 | 88.1 | 91.6 | 87.9 | 84.6 | 79.9 | 74.6 | 79.9 | 81.5 | | 83.2 | 75-100 |
| FY16 | 83.6 | 85.8 | 92.1 | 88.7 | 84.0 | 82.5 | 83.6 | 81.1 | 81.4 | 81.1 | 81.1 | 80.7 | 84.1 | 75-100 |

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | $288 | $211 | $746 | $1,118 | $414 | $317 | ($226) | $181 | ($2,912) | ($63) | $296 | | $371 | $6,109 |
| FY16 | $862 | $612 | $182 | ($189) | ($513) | $965 | ($1,784) | ($411) | ($220) | $331 | $315 | ($1,842) | $149 | |

TCHD EROE % of Total Operating Revenue

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 1.04% | 0.75% | 2.69% | 3.99% | 1.51% | 1.15% | -0.79% | 0.67% | -9.92% | -0.22% | 0.99% | | 0.12% | 1.90% |
| FY16 | 3.03% | 2.20% | 0.66% | -0.68% | -2.00% | 3.40% | -6.31% | -1.53% | -0.77% | 1.13% | 1.09% | -6.82% | 0.05% | |

# Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | $1,583 | $1,496 | $2,015 | $2,365 | $1,711 | $1,556 | $1,010 | $1,428 | ($1,630) | $1,213 | $1,558 | | $14,305 | $20,431 |
| FY16 | $2,046 | $1,817 | $1,357 | $1,011 | $644 | $2,155 | ($594) | $797 | $1,019 | $1,530 | $1,598 | ($558) | $13,379 | |

TCHD EBITDA % of Total Operating Revenue

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 5.70% | 5.32% | 7.27% | 8.43% | 6.27% | 5.64% | 3.52% | 5.28% | -5.55% | 4.23% | 5.21% | | 4.61% | 6.37% |
| FY16 | 7.20% | 6.53% | 4.90% | 3.65% | 2.50% | 7.58% | -2.10% | 2.97% | 3.56% | 5.22% | 5.55% | -2.07% | 4.35% | |

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 6.04 | 5.84 | 5.74 | 5.85 | 6.43 | 6.16 | 6.26 | 6.14 | 6.25 | 6.30 | 6.18 | | 6.11 | 6.04 |
| FY16 | 6.13 | 6.05 | 5.91 | 5.98 | 6.11 | 6.01 | 5.77 | 5.43 | 6.07 | 5.86 | 6.09 | 5.99 | 5.94 | |

TCHD Fixed Charge Coverage Covenant Calculation

| | TTM Jul | TTM Aug | TTM Sep | TTM Oct | TTM Nov | TTM Dec | TTM Jan | TTM Feb | TTM Mar | TTM Apr | TTM May | TTM Jun | Covenant | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | 1.37 | 1.37 | 1.37 | 1.59 | 1.73 | 1.50 | 1.35 | 1.37 | 1.51 | 1.32 | 1.35 | | 1.10 | |
| FY16 | 1.88 | 1.96 | 2.15 | 2.05 | 1.85 | 1.92 | 1.87 | 1.73 | 1.70 | 1.82 | 1.63 | 1.47 | 1.10 | |

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY17 | $29.1 | $29.4 | $26.8 | $18.9 | $23.0 | $25.9 | $35.7 | $34.6 | $73.6 | $74.3 | $77.9 | | |
| FY16 | $30.7 | $33.4 | $36.1 | $35.7 | $31.8 | $28.0 | $26.3 | $27.5 | $24.8 | $28.0 | $37.6 | $31.7 | |

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending May 31, 2017

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. | | Total Rent per current month | LeaseTerm Beginning | LeaseTerm Ending | Services & Location |
|---|---|---|---|---|---|---|---|
| **American Health & Retirement**<br>DBA: Vista Medical Plaza<br>140 Lomas Santa Fe Dr., Ste 103<br>Solona Beach, CA 92075<br>V#82904 | 1,558 | $2.32 | (a) | 4,809.44 | 01/27/17 | 05/31/20 | **Venus OBGYN Clinic**<br>2067 W. Vista Way, Ste 160<br>Vista, CA 92083 |
| **Camelot Investments, LLC**<br>5800 Armada Dr., #200<br>Carlsbad, CA 92008<br>V#15608 | Approx 3,563 | $1.80 | (a) | 10,326.45 | 4/1/2016 | 01/31/20 | **PCP Clinic - Radiance**<br>3998 Vista Way, Ste. C<br>Oceanside, CA 92056 |
| **Creek View Medical Assoc**<br>1926 Via Centre Dr. Suite A<br>Vista, CA 92081<br>V#81981 | Approx 6,200 | $2.63 | (a) | 20,106.00 | 2/1/2015 | 01/31/20 | **PCP Clinic - Vista**<br>1926 Via Centre Drive, Ste A<br>Vista, CA |
| **Elfin Investments, LLC**<br>Clancy Medical Group<br>20136 Elfin Creek Trail<br>Escondido, CA 92029<br>V#82575 | 3,140 | $2.49 | (a) | 9,265.25 | 12/01/15 | 12/31/20 | **PCP Clinic**<br>2375 Melrose Dr. Vista<br>Vista, CA 92081 |
| **GCO**<br>3621 Vista Way<br>Oceanside, CA 92056<br>#V81473 | 1,583 | $1.92 | (a) | 3,398.15 | 01/01/13 | 05/31/17 | **Performance Improvement**<br>3927 Waring Road, Ste.D<br>Oceanside, Ca 92056 |
| **Investors Property Mgmt. Group**<br>c/o Levitt Family Trust<br>2181 El Camino Real, Ste. 206<br>Oceanside, Ca 92054<br>V#81028 | 5,214 | $1.86 | (a) | 10,062.56 | 09/01/12 | 08/31/17 | **OP Physical Therapy**<br>**OP OT & OP Speech Therapy**<br>2124 E. El Camino Real, Ste.100<br>Oceanside, Ca 92054 |
| **Melrose Plaza Complex, LP**<br>c/o Five K Management, Inc.<br>P O Box 2522<br>La Jolla, CA 92038<br>V#43849 | 7,247 | $1.35 | (a) | 10,101.01 | 07/01/16 | 06/30/21 | **Outpatient Behavioral Health**<br>510 West Vista Way<br>Vista, Ca 92083 |
| **OPS Enterprises, LLC**<br>3617 Vista Way, Bldg. 5<br>Oceanside, Ca 92056<br>#V81250 | 4,760 | $4.00 | (a) | 25,580.00 | 10/01/12 | 10/01/22 | **Chemotherapy/Infusion Oncology Center**<br>3617 Vista Way, Bldg.5<br>Oceanside, Ca 92056 |
| **Ridgeway/Bradford CA LP**<br>DBA: Vista Town Center<br>PO Box 19068<br>Irvine, CA 92663<br>V#81503 | 3,307 | $1.10 | (a) | 5,039.70 | 10/28/13 | 03/03/18 | **Vacant Building**<br>510 Hacienda Drive Suite 108-A<br>Vista, CA 92081 |
| **Total** | | | | **$ 98,688.56** | | | |

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

**Education & Travel Expense**
**Month Ending 5/31/2017**

| Cost Centers | Description | Invoice # | Amount | Vendor # | Attendees |
|---|---|---|---|---|---|
| 7420 | TRAINING NEW RN TO ENDOSCOPY | 50317 | 690.00 | 78238 | LISA FETTEROLF |
| 7500 | CASSM SUPERVISORY PROGRAM | 51617 | 1,100.00 | 40874 | WILFRED BAGUBE |
| 7770 | EXPLORING HAND THERAPY | 1387 | 462.00 | 82596 | NURSING STAFF |
| 7777 | PELVIC FLOOR CLASSES | 40317 | 846.96 | 77123 | ALONA STEIN |
| 7777 | EXPLORING HAND THERAPY | 1387 | 308.00 | 82596 | NURSING STAFF |
| 7790 | EXPLORING HAND THERAPY | 1387 | 770.00 | 82596 | NURSING STAFF |
| 8360 | CONSENT LAW SEMINAR | 41217 | 345.00 | 82956 | STEPHEN CHAVEZ MATZEL |
| 8390 | HEALTHCARE INFOMATICS | 51017 | 715.07 | 82547 | EVELYN SHEN |
| 8450 | CLEAVER BROOKS SYSTEM LEVEL 1 | 243143 | 625.00 | 48073 | DAVID THOMPSON |
| 8450 | CLEAVER BROOKS SYSTEM LEVEL 1 | 243143 | 625.00 | 48073 | TRACY WEST |
| 8510 | ERE CONFERENCE | 32217 | 1,495.00 | 82746 | ANNETTE MORRIS |
| 8510 | CAL OSA WEBINAR | 32217 | 235.00 | 82746 | NORMA BRAUN |
| 8510 | HSP SAFETY SEMINAR | 32217 | 305.00 | 82746 | NORMA BRAUN |
| 8510 | CAHR CONFERENCE | 32217 | 779.00 | 82746 | NORMA BRAUN |
| 8510 | CONNEX GRP MEETING | 32217 | 965.00 | 82746 | NORMA BRAUN |
| 8510 | PAYROLL LAW | 51017 | 515.50 | 46503 | PAYROLL STAFF |
| 8610 | CDCR MEETING | 33017 | 346.72 | 82403 | KIRKPATRICK CONLEY |
| 8610 | AHA MEETING -HOTEL | 43017 | 401.90 | 81163 | STEVE DIETLIN |
| 8610 | AHA MEETING - REGISTRATION | 43017 | 850.00 | 81163 | STEVE DIETLIN |
| 8610 | AHA MEETING- AIR FARE | 43017 | 960.40 | 81163 | STEVE DIETLIN |
| 8614 | MAZOR TRAINING | 50817 | 156.37 | 77376 | JEREMY RAIMO |
| 8631 | AFP CONFERENCE | 166 | 155.09 | 79486 | DANIELLE PORTER |
| 8631 | AFP CONFERENCE | 164 | 180.52 | 79486 | ROSELLA SAUCIER |
| 8710 | ANNUAL EDUCATION FORUM | 42417 | 650.00 | 78910 | SHIRLENE TAYLOR |
| 8720 | CONSENT LAW SEMINAR | 32917 | 345.00 | 14365 | KELLY WELLS |
| 8720 | CONSENT LAW SEMINAR | 32917 SCHULTZ | 345.00 | 14365 | SHARON SCHULTZ |
| 8720 | CARE COORDINATION SUMMIT | 51217 | 689.55 | 59683 | SHARON SCHULTZ |
| 8740 | 2017 SD ENA CONFERENCE | 50417 | 105.00 | 77941 | ALICE CATHLES |
| 8740 | SCRIPPS BRAIN INJURY CONFERENCE | 51717 | 150.00 | 81617 | CATHERINE FRAMNESS |
| 8740 | AST CE CREDIT COURSES | 51717 | 101.00 | 82973 | CELENA LUJAN SCHMIDT |
| 8740 | MSN DEGREE | 51117 | 3,395.00 | 82012 | CHRISTINA HART |
| 8740 | NPR COURSE | 51117 | 130.00 | 80156 | CHRYSTALLE BECHTOLD |
| 8740 | PALS COURSE | 42017 | 150.00 | 78473 | CRISTINA MACASPAC |
| 8740 | ADVANCED CRITIC CARE COURSE | 50417 | 200.00 | 78792 | ERIKA GUERRERO |
| 8740 | HEMOTOLOGY PHARMACY CONFERENCE | 42717 | 200.00 | 82662 | JINOO LEE |
| 8740 | ACLS RENEWAL COURSE | 42017 | 152.00 | 81376 | KIMBERLY LEMIEUX |
| 8740 | ACLS RENEWAL COURSE | 51117 | 155.00 | 55455 | LINDA PULICE |
| 8740 | ACLS RENEWAL COURSE | 42017 | 194.00 | 79144 | MARIA A BAILEY |
| 8740 | HIT COURSE | 51717 | 200.00 | 82720 | MARY G CANETE |
| 8740 | PHARMACY SPECIALTY COURSES | 51717 | 125.00 | 82539 | OSKA LAWRENCE |
| 8740 | AHA PALS COURSE | 51117 | 165.00 | 79416 | REBECCA SIMMONS |
| 8740 | ACLS RENEWAL COURSE | 51117 | 150.00 | 79449 | REINA DUDLEY |
| 8740 | MSN DEGREE | 42717 | 3,432.96 | 82852 | SHIRLEY KRUSSEL |
| 8740 | CSHE ANNUAL INSTITUTE | 42017 | 200.00 | 12307 | STEVE BERNER |
| 8740 | ACLS RENEWAL COURSE | 51117 | 150.00 | 79450 | SVJETLANA BASUROVIC |
| 8750 | HEALTHCARE COMPLIANCE CONFERENCE | 41017 | 2,664.49 | 82462 | CHERYLE BERNARD-SHAW |
| 8765 | NEW PLATFORMS TO ENGAGE DOCTORS | 51617 | 250.00 | 82728 | JENELLE LOVELADY |

**This report shows 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.

## CONFERENCE EVALUATION FORM

**TITLE: AHA ANNUAL MEETING** **DATE: MAY 7 - 10, 2017**

**LOCATION: WASHINGTON, DC**

**REASON TO ATTEND:**
With national healthcare in the forefront, an opportunity to listen to discussions on the current issues as well as for discussions with congressional staff. Also any new information as a trustee on Board governance could be of value.

**IMPORTANT TOPICS AND SPEAKERS:**

Two days prior to leaving for the conference the House of Representatives voted to make significant changes in the Affordable Care Act. With that in the forefront, the discussions and lack of compromise at this point were significant. In some of the forums, speakers from the Senate and House discussed their positions on the changes resulting in the AHCA. AHA did a good job of having both sides of the issues told. Senator Cassidy (R-La) and Senator Schumer (D-NY) provided insight on the role the Senate will play in possibly making changes in the House legislation to having no changes in the ACA at all—none of them took questions. AHA currently opposes the House bill as sent to the Senate. In addition, CHA and 4 other large state associations held a Leadership Panel for their delegations. The panel consisted of legislative staff from Minority Leader Pelosi, Majority Leader McCarthy (both from California) as well as staff from Senator Schumer and Senator Toomey (PA) to talk about the healthcare legislation. At this point, it is anyone's guess as to the final outcome.

Another forum speaker was James Comey from the FBI. He spoke on cybersecurity in healthcare and the need for constant vigilance in the IT world at our hospitals and the ability to respond quickly to attacks. In a series of events, the next day Mr. Comey was fired as head of the FBI and 2 days later there was an international cybersecurity attack on many businesses. Of concern is that hospitals in England had significant attacks for "ransom" as well as some hospitals in the US. Data breaches and theft, ransom attacks and terror attacks via the internet are all of concern.

David Shulkin, MD , the new head of the Veterans Administration, discussed the problems of care for the veterans such as long waits to schedule appointments and also to the quality of care at some facilities. He stated he would seek to expand options for treatment in the private sector to see that patients are seen and treated in a timely manner. He encouraged those interested in helping to improve this process to also become involved.

For the Congressional visits, a packet a information was provided to the staff person for each Congressperson in the San Diego delegation. That information is provided with this summary. The San Diego participants included two CEO's, 4 governmental affairs staffers and the 2 trustees from Tri-City.

The educational programs for trustees consisted of 3 sessions: (1) Effective Governance in times of Challenge and Change; (2) Leading and Engaging Boards in Improving Community Health and (3) Creating a Culture of Innovation and Safety from the Boardroom to the Bedside.
The most interesting topic from my standpoint was the changes and challenges in effective governance. A difficult part for boards is that the size, scope and complexity of healthcare is changing so rapidly that it is difficult for members to stay on top of the issues and meet the demands being placed on them. It was noted that 88% of boards receive no compensation. Because of time commitments, the majority of members are retired or have a job which gives them the time off. 52% of boards use board portals for information and agendas. Millennials do not participate because of the time constraints, the processes used and the lack of pay. In good governance, the board responsibilities need to be clearly defined and followed through. Strategic planning, finances, quality and safety need to be in the forefront, but the oversight of all areas must be continually addressed.

The session on community health focused on health, well being and innovation. One hospital addressed the community issues by "tithing" of a certain percentage based on the bottom line in the finances. For all these areas, community organizations would come to the hospital with program suggestions that the hospital can fund as part of an outreach onto the community. Sometimes those programs may have minimal costs, but in other cases it may provide the hospital with new financial streams with implementation.

The third session focused on quality and safety with the Board aware and knowledgeable about the various areas, what is being done especially when there are problems and the solutions implemented with regular reporting back to the board. There has to be transparency, accountability and effective oversight.

Larry Schallock

# Key State Issues

**Latest News on Key Bills in the State Legislature**

CALIFORNIA HOSPITAL ASSOCIATION

June 2, 2017

This week, bills that passed their respective appropriations committees went to the floor for a vote by their whole house; legislative activity consisted of all-day floor sessions. All legislation that did not pass out of the house of origin by today's deadline will become two-year bills.

For an online version of this report that can be filtered by topic, visit www.calhospital.org/key-state-issues.

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Administrative Regulations** | | | | | |
| **AB 1225** | Patterson (R-Fresno) | Would require CDPH to annually brief the Legislature on its efforts to update Title 22 regulations and would repeal the regulation requiring hospitals to publicly post their program flexibility documents. | To be heard in Senate Health Committee. | Support | Debby Rogers/ Connie Delgado |
| **Closures** | | | | | |
| **AB 651** | Muratsuchi (D-Torrance) | Would require nonprofit health facilities to, prior to selling or disposing of assets, notify the attorney general of all languages widely spoken in the county in which the facility is located. The attorney general would be required to consider whether the transaction would adversely impact the community's significant cultural interests. | To be heard in Senate Health and Judiciary committees. | Follow, Hot | Anne McLeod/ Barbara Glaser |
| **Education** | | | | | |
| **SB 15** | Leyva (D-Chino) | Would set maximum amounts for annual Cal Grant C awards for tuition and fees and for access costs. Would also require the Office of the Chancellor of the California Community Colleges to annually provide the Student Aid Commission with eligible occupational and technical training programs that meet Cal Grant C specifications. | In the Assembly. | Support | Cathy Martin/ Alex Hawthorne |
| **Emergency Services** | | | | | |
| **AB 263** | Rodriguez (D-Pomona) | Would require the Emergency Medical Services Authority to post a report on its website about violent incidents involving on-duty EMS providers. The bill would also codify the recent California Supreme Court decision on rest periods as applied to emergency services providers and add similar provisions with respect to meal periods. | In the Senate. | Follow, Hot | Gail Blanchard-Salger/ Kathryn Scott |
| **AB 583** | Wood (D-Healdsburg) | Would authorize the extension of the Emergency Medical Air Transportation Act until 2030. | Held in Assembly Appropriations Committee on May 26 | Support | BJ Bartleson/ Connie Delgado |
| **AB 820** | Gipson (D-Carson) | Sponsored by Los Angeles County, this spot bill will be amended to establish a community paramedicine program in California. | Two-year bill. | Cosponsor | BJ Bartleson/ Connie Delgado |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Emergency Services (continued)** | | | | | |
| AB 1650 | Maienschein (R-San Diego) | Would authorize the Emergency Medical Services Authority (EMSA) to develop the Community Paramedicine Program and authorize a local EMS agency (LEMSA) to develop one or more of four community paramedicine programs. EMSA would be charged with developing criteria, in conjunction with OSHPD, to participate in the program; the medical director of the LEMSA would be required to oversee the local community paramedic program. | Two-year bill. | Support | BJ Bartleson/ Connie Delgado |
| SB 432 | Pan (D-Sacramento) | Would require a hospital to, if a patient is diagnosed with a reportable disease that is transmissible orally or by bodily fluids, immediately notify any EMS pre-hospital provider who transported that patient. The pre-hospital provider would not be required to establish whether oral or bodily fluid exposure took place. Existing state and federal law already contains steps that EMS employers, local public health officers and hospitals must take to ensure that pre-hospital providers are notified if they have been exposed to a reportable communicable disease. This bill would cause duplicative, overly-expansive reporting for hospitals. | To be heard in Assembly Health Committee. | Oppose, Unless Amended | BJ Bartleson/ Connie Delgado |
| SB 443 | Hernandez (D-Azusa) | Would authorize use of an emergency automated drug delivery system for county-owned ambulance and emergency response providers to restock their vehicles. | To be heard in Assembly Business and Professions Committee. | Support | BJ Bartleson/ Alex Hawthorne |
| SB 687 | Skinner (D-Berkeley) | Would require nonprofit organizations that provide emergency services to obtain the attorney general's written consent before reducing the level of services provided. These provisions would be applied retroactively to January 2015. The bill would also prohibit the licensure of free-standing emergency rooms that are not part of a hospital. | In the Assembly. | Oppose | Anne McLeod/ Kathryn Scott |
| **Health Facilities** | | | | | |
| AB 908 | Dababneh (D-Encino) | Would require OSHPD to provide a 30-day notice to a hospital prior to revoking a seismic safety extension, and would allow the hospital to challenge the revocation. | To be heard in Senate Health Committee. | Support | Cheri Hummel/ Kathryn Scott |
| AB 1014 | Cooper (D-Elk Grove) | Would align health care facility testing and maintenance requirements related to diesel generators with the current edition of NFPA 110: Standard for Emergency and Standby Power Systems, as adopted by the Life Safety Code and CMS. Previous law expired in 2016. | To be heard in Senate Health and Environmental Quality committees. | Sponsor | Cheri Hummel/ Kathryn Scott |
| AB 1048 | Arambula (D-Fresno) | Would authorize a pharmacist to dispense a Schedule II controlled substance as a partial fill and remove the assessment of pain as a vital sign. | In the Senate. | Support | David Perrott/ Connie Delgado |
| **Labor** | | | | | |
| AB 5 | Gonzalez Fletcher (D-San Diego) | Would require an employer to offer additional hours of work to an existing employee who — in the employer's reasonable judgment — has the skills and experience to perform the work, before hiring any additional employees or subcontractors, including through a temporary employment agency, staffing agency or similar entity. The bill would not apply where it would result in payment of overtime, would require the employer to use a transparent and nondiscriminatory process to distribute the additional hours of work among existing employees, and would provide employees with a private right of action. | Two-year bill. | Oppose, Unless Amended | Gail Blanchard-Salger/ Kathryn Scott |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Labor (continued)** | | | | | |
| AB 387 | Thurmond (D-Richmond) | Would require health care entities to pay allied health students minimum wage for time spent in clinical or experiential training required to be eligible for state licensure or certification. | Placed on Assembly Inactive File. | Oppose | Cathy Martin/ Gail Blanchard-Saiger/ Kathryn Scott |
| AB 402 | Thurmond (D-Richmond) | Would require Cal/OSHA to convene, by June 1, 2018, an advisory committee to develop regulations requiring hospitals to evacuate or remove plume (noxious airborne contaminants generated as byproducts from specific devices used during surgical procedures). The proposed regulations would be required to be submitted to the Cal/OSHA Standards Board by June 1, 2019, and the board would be required to adopt regulations by July 1, 2020. | In the Senate. | Oppose, Unless Amended | Gail Blanchard-Saiger/ Kathryn Scott |
| AB 1102 | Rodriguez (D-Pomona) | As initially introduced, would have prohibited hospitals from taking adverse action against an employee who refuses an assignment on the basis that it would violate the nurse-to-patient ratio law. Recent amendments remove that provision and instead increase the fine for willful violations of whistleblower protections. CHA is now neutral. | In the Senate. | Neutral | Gail Blanchard-Saiger/ Kathryn Scott |
| SB 349 | Lara (D-Bell Gardens) | Would establish staffing ratios in dialysis clinics for nurses, technicians and social workers, as well as a 45-minute minimum transition time between patients. | In the Assembly. | Oppose | Gail Blanchard-Saiger/ Kathryn Scott |
| **Managed Care** | | | | | |
| SB 199 | Hernandez (D-Azusa) | Would require certain health care entities, including providers, to provide specified utilization and pricing information to the California Health Care Cost, Quality, and Equity Atlas. | To be heard in Assembly Health and Privacy and Consumer Protection committees. | Follow, Hot | Anne McLeod/ Barbara Glaser |
| SB 538 | Monning (D-Carmel) | Would impose numerous prohibitions on contract provisions between hospitals and payers. Among other provisions, the bill would ban binding arbitration for antitrust claims and prohibit hospitals from requiring that multiple facilities in their system be included in a contract. | In the Assembly. | Oppose | Dietmar Grellmann/ Alex Hawthorne |
| SB 562 | Lara (D-Bell Gardens)/ Atkins (D-San Diego) | Would establish the Californians for a Healthy California Act, a comprehensive universal single-payer health care coverage program and health care cost control system. As amended, the bill would cover all medical care for residents who would be required to purchase insurance, eliminate co-pays and deductibles, and allow Californians to choose their doctors. A nine-member board, appointed by the Governor and Legislature, would oversee the health system. This bill does not include a funding mechanism. | In the Assembly. | Follow, Hot | Anne McLeod/ Barbara Glaser |
| SB 647 | Pan (D-Sacramento) | As currently written, this bill would require the Department of Managed Health Care and the Department of Insurance to record and report all consumer complaints about Employee Retirement Income Security Act pensions and health plans. CHA intends to amend the bill to address deficiencies in current law, known as the Providers' Bill of Rights, which allows third-party payers to obtain the benefits of a leased network contract without adhering to all the requirements of the contract. | Two-year bill. | Support | Dietmar Grellmann/ Alex Hawthorne |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Medi-Cal** | | | | | |
| **AB 205** | Wood (D-Healdsburg) | Would implement various provisions of the federal Medicaid managed care rule related to network adequacy standards, medical loss ratio requirements, state fair hearing requirements and supplemental Medi-Cal funding for California's public health care systems. AB 205 is an identical companion bill to SB 171 (Hernandez, D-Azusa). | In the Senate. | Support | Amber Kemp/ Barbara Glaser |
| **SB 171** | Hernandez (D-Azusa) | Would implement various provisions of the federal Medicaid managed care rule related to network adequacy standards, medical loss ratio requirements, state fair hearing requirements and supplemental Medi-Cal funding for California's public health care systems. SB 171 is an identical companion bill to AB 205 (Wood, D-Healdsburg). | In the Assembly. | Support | Amber Kemp/ Barbara Glaser |
| **SB 608** | Hernandez (D-Azusa) | Would specify how grants under the Quality Assurance Fee program would be distributed to public hospitals. | In the Assembly. | Support | Amber Ott/ Barbara Glaser |
| **Medical Devices** | | | | | |
| **SB 327** | Jackson (D-Santa Barbara) | Would require manufacturers of internet-connected devices, including medical devices, to obtain user consent before collecting or transmitting specified information. The bill was originally introduced to regulate internet-connected toys that could collect information from children. | Placed on Senate Inactive File. | Pending Review | Lois Richardson/ Connie Delgado |
| **Medical Records** | | | | | |
| **SB 241** | Monning (D-Carmel) | Would harmonize state law with certain provisions of federal health information privacy regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) . | To be heard in Assembly Health and Privacy and Consumer Protection committees. | Support | Lois Richardson/ Connie Delgado |
| **Medical Staff** | | | | | |
| **AB 148** | Mathis (R-Porterville) | Would lower the eligibility threshold for rural practice settings participating in the Steven M. Thompson Physician Corps Loan Repayment Program. The program provides financial incentives, including repayment of educational loans, to a physician who practices in a medically underserved area. Currently, eligible practice settings include community clinics, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population. These settings must be located in a medically underserved area and at least 50 percent of patients must be from medically underserved populations. This bill would lower the eligibility threshold for serving the above described populations to 30 percent for practice settings located in rural areas. | To be heard in Senate Health Committee June 7. | Support | Peggy Wheeler/ Connie Delgado |
| **AB 893** | E. Garcia (D-Coachella) | Would authorize local public health agencies and others to send to OSHPD data on the number of graduate medical slots necessary to meet current and future physician needs in Imperial County and other underserved counties. The bill no longer relates to physician employment by a hospital. | To be heard in Senate Health Committee. | Follow, Hot | Peggy Wheeler/ Barbara Glaser |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Medical Staff (continued)** | | | | | |
| SB 487 | Pan (D-Sacramento) | Would prohibit a medical staff from requiring physicians to participate in a maintenance of certification program by specialty boards. For public hospitals, the bill would limit voting rights on issues affecting patient care to physicians providing "substantial" direct patient care, defined as 50 percent or more of the physician's annual practice. | Two-year bill. | Oppose | David Perrott/ Connie Delgado |
| SB 798 | Hill (D-San Mateo) | Would give licensed midwives the right to a peer review hearing; make the Board of Podiatric Medicine independent from the Medical Board; require the Medical Board and Osteopathic Board to provide information to the public about licensees on probation; require CDPH and private accreditation organizations to report peer review incidents to the Medical Board; revise the definition of reportable adverse events for outpatient settings; require outpatient settings to report comprehensive demographic, encounter, error and other data to OSHPD annually; require physicians, podiatrists, chiropractors, acupuncturists, osteopaths, and naturopaths who are on probationary status to provide written notice to patients; extend the current $100,000 penalty for failure to file required 805 reports to 805.01 reports; change educational and licensing requirements for healing arts professionals; and make numerous technical and conforming changes. | In the Assembly. | Oppose, Unless Amended | David Perrott/ Connie Delgado |
| **Mental Health** | | | | | |
| AB 191 | Wood (D-Healdsburg) | Would amend current law to authorize a licensed marriage and family therapist or professional clinical counselor to sign a notice of certification for an extended involuntary hold. This bill would require that the therapist or counselor participated in evaluating the patient, and stipulates that he or she must be the second signature (the first must be a physician or psychologist). This authority would pertain to involuntary holds exceeding 72 hours that require an additional period of intensive treatment not to exceed 14 days, or 30 days under specified conditions. | To be heard in Senate Health Committee. | Support | Sheree Lowe/ Alex Hawthorne |
| AB 451 | Arambula (D-Fresno) | Would require acute psychiatric hospitals to treat patients with an emergency psychiatric condition, regardless of whether the hospital has an emergency department. The bill would also prohibit a general acute care hospital or an acute psychiatric hospital from requiring a patient to be on an involuntary hold as a condition of transfer or admission. | To be heard in Senate Health Committee. | Oppose, Unless Amended | Sheree Lowe/ Alex Hawthorne |
| AB 477 | Ridley-Thomas (D-Los Angeles) | Would establish a Behavioral Health Stakeholder Advisory Panel to provide ongoing advice and assistance on California's behavioral health program needs and priorities, including recommending actions to improve collaboration between and processes of the multiple agencies involved in California's behavioral health delivery system. | Two-year bill. | Support | Sheree Lowe/ Alex Hawthorne |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Mental Health (continued)** | | | | | |
| **AB 1136** | Eggman (D-Stockton) | Would require the California Department of Public Health to apply for a grant to develop a real-time database showing available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential substance use disorder treatment facilities. This bill was amended to exempt state hospitals. | In the Senate. | Oppose | Sheree Lowe/ Alex Hawthorne |
| **SB 237** | Hertzberg (D-Van Nuys) | Would modify the process of arresting individuals by allowing law enforcement to, in lieu of processing them through the county jail and going before a magistrate, transport the individual to a hospital or other care setting for evaluation and treatment of co-occurring mental health and substance use disorders. | To be heard in Assembly Public Safety Committee. | Follow, Hot | Peggy Wheeler/ Barbara Glaser |
| **SB 565** | Portantino (D-La Canada Flintridge) | After the completion of a 14-day period of intensive treatment for behavioral and/or substance abuse disorders, a person may be certified for an additional period of 30 days of intensive treatment. This bill would require a hospital to, with the patient's consent, make a reasonable attempt to notify a family member or other person designated by the patient at least 36 hours prior to the certification review hearing. | To be heard in Assembly Health Committee. | Follow, Hot | Sheree Lowe/ Alex Hawthorne |
| **Nursing Services** | | | | | |
| **AB 1612** | Burke (D-Inglewood) | Would allow full practice authority for certified nurse midwives. | Two-year bill. | Support | BJ Bartleson/ Connie Delgado |
| **SB 457** | Bates (R-Laguna Niguel) | Would prohibit physicians and midwives from attending certain births in a licensed alternative birth center (ABC) or at home and put onerous procedures in place for those out-of-hospital births that would still legally be allowed. Would also require duplicative physical exams, extensive screening, additional handouts to be given to patients, and voluminous data reporting by health care providers — including complicated medical reports for a hospital to complete for each patient who attempted a planned ABC or home birth but was transferred to a hospital. Overall, this bill would prevent licensed midwives and certified nurse midwives from practicing to the full extent of their education, licensure/certification and experience. | Two-year bill. | Oppose | BJ Bartleson/ Connie Delgado |
| **SB 554** | J. Stone (R-Murrieta) | Would allow a nurse practitioner or a physician's assistant to furnish or order buprenorphine, in compliance with the Comprehensive Addiction and Recovery Act of 2016. | To be heard in Assembly Business and Professions Committee. | Support | BJ Bartleson/ Connie Delgado |
| **SB 799** | Hill (D-San Mateo) | Would require employers to report to the BRN a registered nurse suspended, terminated or resigned for cause. "For cause" is defined to include, among other conduct, use of controlled substances or alcohol to the extent that it impairs the nurse's ability to safely practice; patient or client abuse; neglect, physical harm or sexual contact with a patient or client; and unlawful sale of a controlled substance. Would impose penalties for failure to report and would provide immunity to employers for reporting. CHA has been informed that provisions in the bill related to continuing education for nurses and nurses reporting other nurses to the BRN for cause will be deleted. | In the Assembly. | Pending Review | BJ Bartleson/ Connie Delgado |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Pharmacy** | | | | | |
| SB 17 | Hernandez (D-Azusa) | Would require health plans, insurers and the pharmaceutical industry to report specified information related to prescription drug costs and prices to the state. | In the Assembly. | Support | Dietmar Grellmann/ Alex Hawthorne |
| SB 351 | Roth (D-Riverside) | Would provide additional options for hospitals to license pharmaceutical services in a satellite or approved service area located separate from the hospital's physical plant that is not under the hospital's consolidated license. | In the Assembly. | Support | BJ Bartleson/ Alex Hawthorne |
| SB 716 | Hernandez (D-Azusa) | Would increase the number of members on the California Board of Pharmacy to 14 by adding one pharmacy technician member. | To be heard in Assembly Business and Professions Committee. | Support | BJ Bartleson/ Alex Hawthorne |
| **Prison Issues** | | | | | |
| AB 43 | Thurmond (D-Richmond) | Would levy a 10 percent tax on companies that contract to provide goods or services to state prisons, the Department of Corrections and Rehabilitation or the Department of General Services. The revenue would be used to expand programs that prevent incarceration, such as universal preschool and after-school programs. | Two-year bill. | Support | BJ Bartleson/ Alex Hawthorne |
| **Public Health** | | | | | |
| SB 43 | Hill (D-San Mateo) | Would require hospitals and clinical labs, beginning July 1, 2018, to conduct and submit to the CDPH an annual antibiogram (a summary of all the antibiotic resistant infections in the previous year). Hospitals are currently creating antibiograms as part of their antibiotic stewardship programs. CDPH would be required to publish an annual report on the occurrence of antibiotic resistant infections and deaths, based on available data. The report would analyze the data by facility type, type of resistant infection and geography; facility names would not be included. | In the Assembly. | Oppose, Unless Amended | Debby Rogers/ David Perrott/ Alex Hawthorne |
| **Skilled-Nursing Facilities** | | | | | |
| AB 275 | Wood (D-Healdsburg) | Would expand notice and planning requirements that skilled-nursing and long-term care facilities must meet prior to a change in facility license or operations that may result in patient transfers. Includes a requirement that the attending physician and a licensed mental health professional, in addition to facility nursing staff, complete an assessment prior to giving the patient a written notice of transfer. | To be heard in Senate Health Committee June 7. | Follow, Hot | Patricia Blaisdell/ Barbara Glaser |
| AB 940 | Weber (D-San Diego) | Would require skilled-nursing facilities to inform the local long-term care ombudsman within 24 hours of notifying a resident in writing of a transfer or discharge from the facility. Failure to do so would constitute a class B violation. | In the Senate. | Follow, Hot | Patricia Blaisdell/ Barbara Glaser |
| AB 1335 | Kalra (D-San Jose) | Would redefine, with respect to class AA violations in skilled-nursing facilities, the causal connection that must exist between the violation and the death of a resident. It would also create a new subcategory of class A violations for situations not meeting the requirements of a class AA violation but where a resident death has occurred. | In the Senate. | Follow, Hot | Debby Rogers/ Barbara Glaser |

# California Hospital Association Key State Issues

| Bill No. | Author | | Location/Action | CHA Position | Staff Contact |
|---|---|---|---|---|---|
| **Skilled-Nursing Facilities (continued)** | | | | | |
| **SB 219** | Wiener (D-San Francisco) | Would create the Lesbian, Gay, Bisexual, and Transgender Long-Term Care Facility Resident's Bill of Rights, making it unlawful for any long-term care facility to take specified actions on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression or HIV status. | In the Assembly. | Oppose | Patricia Blaisdell/ Barbara Glaser |
| **SB 481** | Pan (D-Sacramento) | Sponsored by CHA, this bill would address deficiencies identified in *CANHR v. Chapman*. Specifically, it would strengthen the current process for notifying skilled-nursing facility residents who lack capacity and have no legal representative of recommended medical interventions requiring informed consent. | In the Assembly. | Sponsor | Patricia Blaisdell/ Lois Richardson/ Alex Hawthorne |
| **Workers' Compensation** | | | | | |
| **SB 489** | Bradford (D-Compton) | Would allow hospitals that treat injured workers who present through the emergency room up to 180 days to bill for services rendered. Existing law, which has not yet taken effect, requires billing within 30 days. | To be heard in Assembly Insurance Committee. | Support | Amber Ott/ Kathryn Scott |