TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING January 25, 2018 – 1:30 o'clock p.m. Assembly Room 1 - Eugene L. Geil Pavilion Open Session – Assembly Rooms 2&3 4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)	5.5	
5	Motion to go into Closed Session		
6	Closed Session	2 Hours	
	 a. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 1) Medical Acquisition Company vs. Tri-City Healthcare District Case No: 2014-0009108 2) Tri-City Healthcare District vs. Medical Acquisition Company Case No: 2014-00022523 3) RoseMarie Reno vs. Tri-City Healthcare District Superior Court Case No. 37-2017-00040507-CU-CR b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155) 		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: January 31, 2018		

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
	d. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: January 31, 2018		
	e. Approval of prior Closed Session Minutes		110
	f. Conference with Legal Counsel - Potential Litigation (Authority: Government Code, Section 54956.9(d) 4 Matters)		
	g. Public Employee Evaluation: Chief Executive Officer (Authority: Government Code, Section 54957)		
	h. Evaluation of Legal Counsel Services (Authority: Gov. Code section 54957)		
7	Motion to go into Open Session		
8	Open Session Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Proclamation recognizing Oceanside Mayor, Jim Wood	10 min.	Chair
13	Educational Session Introduction to IPAD and Board Portal	30 min.	Director Mitchell
14	Report from TCHD Foundation - Glen Newhart, Chief Development Officer	10 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business		
	 a. LAFCO Update b. Discussion Regarding Draft Maps for Change from At-Large to District Based Elections - Elections Code 10010(a)(2) 	10 min. 15 min.	Board Counsel Board Counsel
	Four draft maps were published on the District's website beginning October 19, 2017 and updated on November 19, 2017. Two additional maps were published on November 28, 2017. One draft map has since been revised (the original map - Orange - remains in original form, and the revised version - Orange 2, was published on January 17, 2018).		

	Agenda Item	Time Allotted	Requestor
	Pursuant to Elections Code Section 10010(a)(2), after maps are drawn, the political subdivision shall hold at least two additional hearings over a period of no more than 45 days at which the public is invited to provide input regarding the content of the draft map or maps and the proposed sequence of elections. 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 hearing was held on October 26, 2017. There were also three community-based public hearings in each of the cities within the District's boundaries on November 29 and 30. The fifth public hearing was December 7, 2017. This discussion will update the Board on the draft maps, including the minor revisions made to the Orange map, which was published on January 17, 2018 (the "Orange II" map)."		
	c. Consideration of nomination to serve as Special District Representative to the Redevelopment Oversight Board.	10 min.	Chair
	d. Consideration to approve UCSD Neurosurgical Service Agreement	10 min.	J. Raimo
	e. Consider granting temporary authority to the Board Chairperson to appoint a Director to committees, pending bylaw changes.	10 min.	Chair
18	Old Business		
	a. LAFCO Update (agendaized prior for clarity)		
19	Chief of Staff	5 min.	Standard
	 a. Consideration of January Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 22, 2018 b. Approval of NP Privilege Card NP – OB/GYN Revised 		s
	c. Approval of Proposed X Robotic Privileges Criteria		
20	Consideration of Consent Calendar (1) Board Committees (1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar. (2) All items listed were recommended by the Committee. (3) Requested items to be pulled require a second.	5 min.	Standard
	A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0 (No meeting held in January, 2018)		HR Comm.
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes)		Emp. Fid. Subcomm.

	Agenda Item	Time Allotted	Requestor
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes)	52	CHAC Comm.
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes)		FO&P Comm.
	Approval of Administrative Policy & Procedure 8610-277 – Plan to Manage and Estimate Project Cost		
	 Approval of an agreement with Oxford Coding Support for a term of 12 months, beginning May 1, 2017 through April 30, 2018 for an increased cost of \$330,000 for a total cost for the term of \$630,000. 	:	
	3) Approval of an agreement with Nova Biomedical for Nova StatStrip Glucometer and Test Strips for a term of 60 month, beginning December 2, 2017 through December 1, 2022 for an annual cost of \$55,200 and a total cost for the term of \$276,000.		
	4) Approval of an agreement with Dr. James Johnson, Physician Chairperson of MDQA/Per Review/QAPI for a term of 12 months beginning November 1, 2017 through October 31, 2018, not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of \$155 for an annual cost of \$60,000 and a total cost for the term, not to exceed \$70,000.		587
	5) Approval of an agreement with Vereco, Inc. for copier, courier, mail delivery, document shredding, copy center and print management services for a term of 60 months beginning March 1, 2018 through February 28, 2023 for an annual cost of \$1,740,000 and a total cost for the term of \$8.700,000.		
	6) Approval of an agreement with Harris Healthcare for Affinity Software Support for a term of 24 months, beginning January 1, 2018 through December 31, 2019, for an annual cost of \$451,697.62 and a total cost for the term of \$903,395.24.		
1	E. Professional Affairs Committee Director Grass, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes)		PAC
	a) Application of Lidocaine, Prilocaine Topical Cream Standardized Procedure (DELETE) b) Care for Recalcitrant Children Policy c) Documentation in the Medical Record Policy d) Family-Centered Care – Pediatrics/ Adolescents Policy e) High Level Disinfection Procedure f) 72 –Hour Hold, Evaluation and Treatment of Involuntary		

Agenda Item	Time Allotted	Requestor
Patient Policy g) Medications, High Risk/ High Alert/ Look Alike/ Sound Alike Policy h) Extended Dwell Catheter/ Midline Catheter, Adults i) Physician/ Allied Health Professionals (AHP) Inpatient Orders Policy j) Privacy Code Policy k) Pyxis Connect Scanner Procedure l) Patient Food Refrigerators/ Freezers for Temperature, Cleaning, Defrosting Responsibilities Procedure m) Release of Deceased Procedure n) Substance Abuse, Patient Policy		
2) <u>Unit Specific</u>		
Administrative a) Assignment of Medical Record Numbers and Standard Naming Guidelines b) Coverage for Employee Vehicle Insurance Deductible c) Faxing of Protected Health Information (Medical Records) d) Space and Office Allocation Standards e) Use, Security and Accuracy of Data		19
Behavioral Health Services a) Report of Firearms Prohibition		
Engineering a. Adverse Incident/ Occurrence for Post-Graduate Staff b. Credentialing Requirements for Fluoroscopy Supervisor and Operator Permit c. Credentialing Standards for Transoral Esophagogastric Fundoplication (TIF) d) Quality Review Process for Teleradiologists		
NICU a) Hand Hygiene , NICU (DELETE) b) Infection Prevention, NICU		
Pharmacy a) Automatic Dose Rounding b) Clinical Intervention/ Activity Documentation Program c) Drug Compounding for Medication Not Commercially Available d) Drug Supply Chain Security Act e) Risk Evaluation and Mitigation Strategies f) Unlabeled Uses of FDS-Approved Medications		
Rehabilitation a) Behavior Management/ Supervision Technique b) Computer Downtime/ Printer Malfunction c) Documentation Guidelines (DELETE) d) Equipment Evaluation, Dispensing and Monitoring (DELETE) e) Exception Reports (DELETE) f) Rationale for Clinical Education (DELETE)		
<u>Telemetry</u>		

	Agenda Item	Time Allotted	Requestor
	a) Opening/Closure of Telemetry Beds/ Unit (DELETE)	1	
	<u>Ultrasound and Vascular Imaging</u> a) How to Report a Critical/Stat Exam		
8	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 0 (No meeting held in January, 2018)		
	G. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes)		Audit, Comp. & Ethics Comm.
	Approval of Committee Charter		
	(2) Minutes – Approval of:		Standard
	 a) Regular Board of Directors Meeting – December 14, 2017 b) Special Board of Directors Meeting – December 7, 2017 		
	(3) Meetings and Conferences – NONE		(2)
	(4) Dues and Memberships -		
	a) The Governance Institute Limited Membership - \$24,650. b) California Special Districts Association (CSDA) Membership - \$6,842.		
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (December, 2018) (d) Reimbursement Disclosure Report – (December, 2018) (e) Seminar/Conference Reports - None	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3 hours	
28	Oral Announcement of Items to be Discussed During Closed Session		
29	Motion to Return to Closed Session (if needed)		
30	Open Session		

	Agenda item	Time Allotted	Requestor
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		



9335 Hazard Way • Suite 200 • San Diego, CA 92123 (858) 614-7755 • FAX (858) 614-7766

San Diego Local Agency Formation Commission

www.sdlafco.org

Chair

Jo MacKenzie, Director Vista Irrigation District

CALL FOR NOMINATIONS



Vice Chair

Ed Sprague, Director Olivenhain Municipal Water

Members

Catherine Blakespear, Mayor City of Encinitas

Bili Horn, Supervisor County of San Diego

Dianne Jacob, Supervisor County of San Diego

Andrew Vanderlaan Public Member

Bill Wells, Mayor City of El Cajon

Lorie Zapf, Councilmember City of San Diego

Alternate Members

Lorie Bragg, Mayor Pro Tem City of Imperial Beach

Chris Cate, Councilmember City of San Diego

Greg Cox, Supervisor County of San Diego

Judy Hanson, Director Leucadia Wastewater District

Harry Mathis
Public Member

Executive Officer

Keene Simonds

Counsel

Michael G. Colantuono

January 4, 2018

TO:

General Managers, Independent Special Districts

FROM:

Keene Simonds, Executive Officer

SUBJECT:

Start of Nomination Period

Appointment to Consolidated Redevelopment Oversight Board

This communication serves as formal notice the San Diego Local Agency Formation Commission (LAFCO) is calling an election by mail among independent special districts to appoint eligible representatives to serve on the San Diego County Consolidated Redevelopment Oversight Board. This election is ultimately tasked with appointing (a) one regular district representative and (b) one alternate district representative on the Oversight Board. Additional background information – including an outline of the policies and procedures adopted by LAFCO in implementing the statute – was previously mailed to all independent special districts on December 5, 2017 and provided as Attachment A.

With the preceding in mind, San Diego LAFCO is now commencing with the nomination period. To this end, and consistent with adopted policies, the presiding officers and/or their delegated alternates for all 60 independent special districts in San Diego County are encouraged to submit nominations using the attached form. A listing of all independent special districts allowed to participate in nominating an eligible candidate is provided in Attachment B. In considering making potential nominations please note all of the following:

- As referenced all 60 independent special districts are eligible to make one nomination through their presiding officer or authorized delegate. Nominations must be signed.
- To be eligible nominees must be an elected or appointed member of the legislative body of one of the 19 independent special districts that are enrolled in the Redevelopment Property Tax Trust Fund (RPTTF). A listing of all enrolled independent special districts is provided in Attachment C.

San Diego LAFCO

Start of the Nomination Process | Appointment to Consolidate Redevelopment Oversight Board January 4, 2018

- Nominations are for the regular voting member representative. The alternate will be determined during the subsequent voting process and based on the candidate finishing with the second most votes.
- Nominations must be received by San Diego LAFCO no later than by 5:00 p.m. on Thursday, February 15, 2018. Nominations received after this date/time will be invalid.
- Nominations may be submitted by mail, courier, or hand-delivered to the San Diego LAFCO office at 9335 Hazard Way, Suite 200 in San Diego. Additionally, and as an encouraged alternative, nominations may be submitted by e-mail and directed to Executive Assistant Tammy Luckett at tamaron.luckett@sdcounty.ca.gov. Nominations received by e-mail will be confirmed by LAFCO and taken as consent to transmit subsequent communications including ballots by e-mail unless otherwise specified.

At the close of the nomination period San Diego LAFCO will work with the Special District Advisory Committee (SDAC) in establishing additional dates and deadlines going forward in completing the appointment process ahead of the July 1, 2018 statutory deadline. This includes an expectation SDAC will consider the results of the nomination process and next steps as early as its regular meeting scheduled for Friday, February 16th.

Should you have any questions or related follow up, please do not hesitate to contact me directly via e-mail at keene.simonds@sdcounty.ca.gov) or telephone at 858.614.7755.

Thank you.

Attachments:

- A) Memorandum on Adopted Policies and Procedures in Appointing Special District Members to RDA Oversight Board
- B) List of the 60 Independent Districts Eligible to Make a Nomination
- C) List of the 19 Independent Special District Enrolled in RPTTF Whose Board Members are Eligible for Nominations
- D) Nomination Form

cc: Jon Baker, County of San Diego SDAC Members

Attuchment A

9335 Hazard Way • Suite 200 • San Diego, CA 92123 (858) 614-7755 • FAX (858) 614-7766

San Diego Local Agency Formation Commission

www.sdlafco.org

Chairman

Sam Abed, Mayor

MEMORANDUM

City of Escondido

December 5, 2017

Jo MacKenzle, Director Vista Irrigation District

Vice Chairwoman

TO:

Special Districts

Other Interested Parties

Members

Cathorine Blakespear, Mayor City of Encinitas

FROM:

Keene Simonds, Executive Officer

SUBJECT:

Notice of Approved Policy Amendments

Procedures to Appoint a Special District Representative on

Consolidated Redevelopment Oversight Board

Bill Horn, Supervisor County of San Diego

Dianne Jacob, Supervisor County of San Diego

Ed Sprague, Director Olivenhain Municipal Water

Andrew Vanderlaan Public Member

Lorie Zapf, Councilmember City of San Diego

Alternate Members

Chris Cate, Councilmember City of San Diego

Greg Cox, Supervisor County of San Diego

Judy Hanson, Director Leucadia Wastewater District

Harry Mathis Public Member

Racquel Vasquez, Mayor City of Lemon Crave

This memorandum provides notice of policy amendments approved by the San Diego Local Agency Formation Commission (LAFCO) at its December 4, 2017 meeting. The approved policy amendments address new legislation for LAFCO to oversee and conduct elections to appoint a special district representative to a consolidated oversight board tasked with winding-down redevelopment activities in San Diego County. The amendments were developed with feedback from LAFCO's Special District Advisory Committee and establish specific eligibility, allowances, and procedures in conducting an election ahead of the inaugural July 1, 2018 appointment deadline.

A summary of the policy amendments and its implementation therein is enclosed. Additional materials - including a related call for nominations will be transmitted to eligible special districts in the near future.

Should you have any questions please contact me by telephone at 858-614-7755 or by e-mail at keene.simonds@sdcounty.ca.gov.

Executive Officer

Kaana Simonds

Enclosures: as stated

Counsel

Michael G. Colantuono

San Diego Local Agency Formation Commission

Regional Service Planning | Subdivision of the State of California

Summary of Policy Amendments | Appointment of a Special District Member on Consolidated Redevelopment Oversight Board

Legislative Directive

Senate Bill 107 was passed by the Legislature with the Governor's signature in September 2015 and mandates – among other items – the consolidation of all 17 successor redevelopment agencies in San Diego County by July 1, 2018. This consolidation will be carried out through a seven-member oversight board and marks the latest and presumably final act by the Legislature in achieving the planned dissolution of redevelopment agency activities in all 58 counties. The legislation directs the oversight board to complete all remaining redevelopment projects and restore incremental property tax revenue; the latter of which presently tallies more than \$130 billion in San Diego County. The legislation also provides one of the seven seats on the oversight board shall be filled by a special district representative and through the framework of LAFCO's existing administrator role of the Independent Special Districts Selection Committee (ISDSC).

Implementing Local Policies

At its December 4, 2017 meeting San Diego LAFCO approved policy amendments to address its new responsibilities under SB 107 to administer an appointment of a special district representative to a consolidated redevelopment oversight board. The amendments were developed with feedback from LAFCO's Special District Advisory Committee and address ambiguity in the legislation with respect to appointment eligibility, standards, and procedures. Key implementing policies follow.

- All independent special districts comprising the ISDSC are eligible to participate in the process
 to appoint (nominate and vote) a representative to serve on the oversight board. However, only
 board members from those independent special districts that are also enrolled in the
 Redevelopment Property Tax Trust Fund administered by the County of San Diego Auditor
 Controller's Office are eligible to be nominated and serve on the oversight board. A list of the
 19 eligible special districts meeting this referenced criteria is attached.
- An alternate appointee to the oversight board is allowed.
- Election materials shall be transmitted from LAFCO by e-mail with prior concurrence of the presiding officer of the special district.
- So long as a voting quorum is achieved the nominee receiving the most votes will be appointed to the oversight board. The nominee with the second most votes will be the alternate.

Next Steps

LAFCO anticipates issuing a call for nominations on Thursday, January 4, 2018. (A request to transmit subsequent materials by e-mail will also be addressed.) The deadline to submit nominations will be Thursday, February 15th. Additional dates – and most notably the issuance of ballots – will be determined thereafter and in consultation with LAFCO's Special District Advisory Committee.

Attachment: as stated

Attachment B

Independent Special Districts in San Diego County

- Eligible to Make a Nomination for Appointment to Oversight Board -

Alpine Fire Protection District Bonita-Sunnyside Fire Protection Borrego Springs Fire Protection

Borrego Water District

Canebrake County Water District

Cuyamaca Water District

Deer Springs Fire Protection

Descanso Community Services District

Fairbanks Ranch Community Services District

Fallbrook Healthcare District Fallbrook Public Utility District Grossmont Healthcare District

Helix Water District

Jacumba Community Services District

Julian Community Services District

Julian-Cuyamaca Fire Protection

Lake Cuyamaca Recreation & Park

Lakeside Fire Protection District

Lakeside Water District

Leucadia Wastewater District

Lower Sweetwater Fire Protection

Majestic Pines Community Services District

Mission Resource Conservation

Mootamai Municipal Water District

Morro Hills Community Services District

North County Cemetery District

North County Fire Protection

Olivenhain Municipal Water District

Otay Water District

Padre Dam Municipal Water District

Palomar Health Care District

Pauma Municipal Water District

Pauma Valley Community Services District

Pine Valley Fire Protection District

Pomerado Cemetery District

Questhaven Municipal Water District

Rainbow Municipal Water District

Ramona Cemetery District

Ramona Municipal Water District

Rancho Santa Fe Community Services District

Rancho Santa Fe Fire Protection

Resource Conservation District of San Diego County

Rincon Del Diablo Muni Water District

Rincon Ranch Community Services District

San Luis Rey Municipal Water District

San Miguel Consolidated Fire Protection District

Santa Fe Irrigation District

South Bay Irrigation District

Tri City Hospital District

Upper San Luis Rey Resource Conservation District

Vallecitos Water District

Valley Center Cemetery District

Valley Center Parks & Recreation

Valley Center Fire Protection

Valley Center Municipal Water District

Vista Fire Protection District

Vista Irrigation District

Whispering Palms Community Services District

Wynola Water District

Yuima Municipal Water District

Attachment C

Independent Special Districts in San Diego County | Enrolled in Redevelopment Property Tax Trust Fund (RPTTF)

- Elected or Appointed Board Members are Eligible for Nomination to Oversight Board -

Grossmont Healthcare District Lakeside Fire Protection District Lakeside Water District Leucadia Wastewater District Lower Sweetwater Fire Protection District North County Cemetery District Olivenhain Municipal Water District Otay Water District Padre Dam Municipal Water District Palomar Healthcare District Pomerado Cemetery District Resource Conservation District of Greater San Diego County Rincon del Diablo Municipal Water District San Marcos Fire Protection District San Miguel Consolidated Fire Protection District Santa Fe Irrigation District Tri-City Healthcare District Vallecitos Water District

Vista Irrigation District

Attachment D

NOMINATION OF THE SPECIAL DISTRICT EPRESENTATIVE TO THE REDEVELOPMENT OVERSIGHT BOARD

The (Name of Independent Special District)	is
pleased to nominate (Name of Candidate)	as a candidate for
appointment as the SPECIAL DISTRICT REPRESENTATIVE	
As presiding officer or his/her delegated alternate as provided b certify that:	by the governing board, I hereby
 The nominee is a member of a legislative body of an i territory within the boundary of the particular RDA individual seeks appointment. 	
(Signature)	
(o.g., actai o)	
(Print Name)	(Date)
(Print Title)	

PLEASE ATTACH RESUME OR CANDIDATE STATEMENT FOR NOMINEE

- Limit two pages
- Must be submitted with Nomination Form



MEMORANDUM

PROCOPIO 525 B Street Suite 2200 San Diego, CA 92101 T. 619.238.1900 F. 619.235.0398

AUSTIN
DEL MAR HEIGHTS
PHOENIX
SAN DIEGO
SILICON VALLEY

TO:

Board of Directors

Tri-City Healthcare District

FILE NO: 116569.04

FROM:

Gregory V. Moser, Board Counsel

CC:

Steve Dietlin, CEO

DATE:

January 19, 2018

RE:

Interim Appointment of Board Members to Committees

Over the next few months, due to the expected temporary unavailability of Directors to attend Board Committees to which they have been appointed by the Chairperson, some committee meetings may be attended by only a single Director. We recommend that the Chairperson be authorized to appoint temporary replacements for such Board members, under terms and conditions approved by the Board, and reflected in amended Bylaws.

Currently, the Chairperson appoints committee members, subject to the approval of the Board of Directors per Article V, Section 1 of the Bylaws. We recommend that possible amendments to the Bylaws to allow temporary appointments by the Chairperson without Board action be referred to the Governance and Legislative Committee to consider at its April meeting.

Until then, we recommend that the Board authorize the Chairperson to make one temporary appointment of a Director to any Board Committee, without Board approval, whenever the Chairperson determines that a scheduled committee meeting would otherwise be attended by only a single Board-approved Director. This authority would expire at the regular April meeting of the Board of Directors, at which time the Board may consider the recommendations of the Governance and Legislative Committee for amendment of the Bylaws.

We recommend consideration of the following motion:

"I move that the Chairperson be authorized to make a temporary appointment of one Director to any Board Committee, without confirmation by the Board (as otherwise required by the Bylaws), if the Chairperson determines that a scheduled committee meeting will otherwise be attended by only a single Board-approved Director, provided that this authority shall expire at the conclusion of the April 2018 regular Board meeting, and that the Governance and Legislative Committee consider amendments to the Bylaws to address this issue its April 2018 meeting."

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TRI-CITY MEDICAL CENTER MEDICAL STAFF INITIAL CREDENTIALS REPORT January 10, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 1/26/2018 - 12/31/2019)

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 1/26/2018 through 12/31/2019:

- BALLAS, Jerasimos MD/Maternal & Fetal Medicine (UCSD)
- HOKE, Eileen MD/Neonatology (North County Neonatology Specialists)
- HOSSEINI, Ava MD/General Surgery (UCSD)
- KLEIN, Martina MD/Psychiatry (PsyCare)
- MALHOTRA, Kavin MD/Teleradiology (StatRad)
- VAYSER, Dean DPM/Podiatry
- WISEMAN, Stephen MD/Anesthesiology (ASMG)



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3 January 10, 2018

Attachment I

ADDITIONAL PRIVILEGE REQUEST (Effective 01/31/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

• ROHER, Alexander_M.D.

Anesthesiology

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 1/31/2018.

• DESADIER, Laura DO

Neurology

• IAMSHIDI-NEZHAD, Mohammad, DO

General and Vascular Surgery

MCGRAW, Charles, Ir., MD

Interventional Radiology

NOUD, Michael, MD

Interventional Radiology

• OH, Irene MD

Neurology

SHIN, Heamin DPM

Podiatric Surgery

STARK, Erik, MD

Orthopedic Surgery

REOUEST FOR EXTENSION OF PROCTORING REQUIREMENT

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

BURKE, Michael, MD

Interventional Radiology

• COHEN. David, MD

Cardiology

• <u>GUTIERREZ, Miguel MD</u>

Emergency Medicine

HIGGINS, Steven MD

Cardiology

• LI, Xiangli MD

Internal Medicine

• IAMSHIDI-NEZHAD, Mohammad, DO

General & Vascular Surgery

KOCH, Richard MD

Emergency Medicine



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3 January 10, 2018

• LEONARD, Lisa MD

OB/GYN

• MARQUART, Elizabeth MD

Emergency Medicine

• PREGERSON, David MD

Emergency Medicine

• VILCHIS, Caroline MD

<u>Urology</u>

ADDITIONAL EQUIPMENT USE REQUEST

The following practitioners have previously met the initial criteria for the Robotics bundle and have turned in the certificate to utilize the Xi Robotics Equipment:

• GROVE, Jay M.D.

General & Vascular Surgery

• GUERENA, Michael MD

<u>Urology</u>



TRI-CITY MEDICAL CENTER CREDENTIALS COMMITTEE REPORT – Part 3 of 3 January 10, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 1/26/18, unless otherwise specified)

• BRADLEY, Joseph DO Emergency Medicine

• GENTILUOMO, lesse MD Emergency Medicine

• GRAMIN, Daniel MD Cardiothoracic Surgery

• HAAK, Logan MD Ophthalmology

• KASED, Norbert MD Oncology

• MCGRAW, Charles MD Radiology

• MILLER, Jessica MD Emergency Medicine

• ONAITIS, Mark MD Cardiothoracic Surgery

OUESNELL, Tara DO Neurology

• RUELAZ, Robert MD Cardiology

WANG, Joyce MD Emergency Medicine



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 January 10, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 2/01/2018 -1/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 02/01/2018 through 1/31/2020, 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:

- BRION, Paul MD/ Rheumatology/Active
- BROWN, Rica MD/ Emergency Medicine/Provisional
- CHAYA, Nina/Anesthesiology/Active
- FOX. Robert MD/Anesthesiology/Active
- GUERENA, Michael MD/Urology/Active
- <u>GUPTA, Anuj MD/Pain Management/Active</u>
- HAJNIK, Christopher MD/Orthopedic Surgery/Active
- HAN. Iames_DPM/Podiatry/Active
- HEIFETZ, Susan MD/Internal Medicine/Refer and Follow
- HELGAGER, James MD/Orthopedic Surgery/Active
- MARC-AURELE, Krishnelle MD/Neonatology/Active Affiliate
- MILLER, Donald MD/Pediatrics/Active
- MORRIS. Jeffrey MD/Ophthalmology/Active
- PERIERA, Isabel MD/Internal Medicine/Active
- PERKOWSKI. David MD/Cardiothoracic Surgery/Active Affiliate
- ROTUNDA, Edward MD/Emergency Medicine/Active
- RUELAZ. Robert MD/Cardiology/Provisional
- SEBAHAR, Michael MD/Pain Medicine/Active Affiliate

TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 January 10, 2018

Attachment B

- STERN, Mark MD/Neurological Surgery/Active
- WARSHAWSKY, Arthur MD/Urology/Active
- WISNIEWSKI, Morris MD/Internal Medicine/Active
- ZIZZO, Paolo MD/Internal Medicine/Refer and Follow

<u>UPDATE TO PREVIOUS REAPPOINTMENT:</u>

- BUI, Hanh MD/Active
- PATEL, Kiran MD/Active

RESIGNATIONS: (Effective date 1/31/2018 unless otherwise noted)

Automatic Resignation:

BAHARI, Abbas MD/Neurosurgery

Voluntary:

- AMINLARI, Amv MD/Emergency Medicine
- BENTLEY, Christian, MD/Orthopedic Surgery
- CHAN, Dana MD/Ophthalmology
- DANIELS, Sara MD/Pediatrics
- GILBERT, Rebecca MD/Anesthesiology
- GOLDSZTEIN, Hernan MD/Otolaryngology
- LOBATZ, Michael MD/Neurology
- NIZAMANI. Saifullah MD/Psychiatry
- OSTRUP. Richard MD/Neurological Surgery
- PATEL, Sanketkumar MD/Internal Medicine
- WARDA. Gregory MD/Neonatology



TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT January 15, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 1/26/2018 - 12/31/2019)

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 1/26/2018 through 12/31/2019:

• HUNT. Cris Teena AUD/Audiology



TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3 January 15, 2018

Attachment B

<u>ADDITIONAL PRIVILEGE REQUEST (Effective 01/31/2018, unless otherwise specified)</u>
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

• MEMEO. Kelly NP

Allied Health Professional

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 1/31/2018.

•	ALLEN, Matthew PAC	Allied Health Professional
•	BROCKMAN, Joe PAC	Allied Health Professional
•	BUCKLEY, Alicia, Ortho Tech	Allied Health Professional
•	CARLTON, Vivian W., PAC	Allied Health Professional
•	CHASE, Nicole PAC	Allied Health Professional
•	CRESPO, Christopher PAC	Allied Health Professional
•	CHOQUETTE, Alicia, PAC	Allied Health Professional
•	ELAMPARO, Kaye L., NP	Allied Health Professional
•	GARBACZEWSKI. Stephanie PAC	Allied Health Professional
•	HERMANN, Linda, PAC	Allied Health Professional
•	KIMBER, James PAC	Allied Health Professional
•	MARTINEZ, Melinda PAC	Allied Health Professional
•	MCNALLY, Paul NP	Allied Health Professional
•	PREGERSON, Heather PAC	Allied Health Professional
•	RICE, William M., PAC	Allied Health Professional

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring



TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3 January 15, 2018

requirement by July 31, 2018 would result in these privileges automatically relinquishing.

• BROWNSBERGER, Richard PAC Allied Health Professional

• HERMANSON, Kathleen PAC Allied Health Professional

• HUANG, Stephanie, K., PAC Allied Health Professional

• INOCELDA, Andrew_PAC Allied Health Professional

ADDITIONAL EQUIPMENT USE REQUEST

The following practitioners have previously met the initial criteria for the Robotics bundle and have turned in the certificate to utilize the Xi Robotics Equipment:

• FORBES, Beth RNFA

General & Vascular Surgery

RESIGNATIONS: (Effective date 1/31/2018 unless otherwise noted)

Automatic Resignation:

• LAM. Christina NP/Allied Health Professional



TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT - Part 3 of 3 January 10, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 1/26/18, unless otherwise specified)

• AHUMADA, Alejandro AuD Allied Health Professional

• MEMEO, Kelly NP Allied Health Professional

• SCHILLINGER, Stephan PAC Allied Health Professional

• STABLER, Holly PAC Allied Health Professional

Tri-City Medical Center **Delineation of Privileges**NP - OB/GYN - 7/17

Provid	er Name:	
Request	Privilege	Action
		MSO Use Only
		Oilly
	Initial Criteria:	
	The nurse practitioner must have the following:	
	 Possession of a current California Registered Nursing license; Successfully completed a Board of Registered Nursing approved nurse practitioner program; 	
	3. Certification as a nurse practitioner by the California Board of Registered Nursing (Title	
	16, Article 8, Section 1482, Business and Professions Code); Successful completion of the Neonatal Nurse	
	Practitioner National Certification Examination within one year of initial credentialing; 4. If furnishing drugs and devices, the nurse practitioner must possess a furnishing license;	
	5. Nurse practitioners wishing to furnish Schedule II through V controlled substances are required to complete a	
	Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate	
	to prescribe Schedule II-V drugs.	
	Proctoring: Six (6) cases	
_	Provide admission orders, including a complete history and physical; diagnosis of labor and	_
	assessment of the maternal well-being and risk status under the supervising physician(s)	
	(Countersigned by supervising physician within 48 hours).	
	May prescribe medication orders in accordance with standardized procedures and approved	_
	formulary. Must have current furnishing number and DEA certificate.	
-	Routine admission orders such as laboratory and diagnostic tests as necessary	-
-	Administer local infiltration of anesthesia	_
	Care of mother after delivery, which is consistent with physician co-management defined in the standardized procedures	
	Assessment, management and discharge of normal postpartum patients	
	Evaluate and facilitate breastfeeding during the postpartum period	
_	First assist at c-section and hysterectomy (specific tasks of retraction, suction, ligation, clamping, sponging, and cutting sutures)	_
	Initial: Documentation of appropriate training/education required	
	Proctoring: Two (2) Cesarean Section assists	
	APPLICANT:	
	I agree to exercise only those services granted to me. I understand that I may perform any functions within Tri-	
	City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.	
	interdisciplinary Plactice Continuee.	
	Print Applicant Name	
	Applicant Signature	
	Date	
	*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:	
	SPONSORING PHYSICIAN:	
	As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center	

Tri-City Medical Center **Delineation of Privileges**NP - OB/GYN - 7/17

Request	Privilege	Action
	×	MSO Use Only
Print (Name of Sponsoring Physician	
Spons	soring Physician Signature	
Date		
Appro	val:	
Division	on/Department Signature	
Date		1 m

Proposed X Robotic Privileges Criteria

X Robotic surgery - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)

Initial Criteria: Must provide certificate of training for X or Xi Robotic from Intuitive prior to case.

Assist in X Robotic Surgery (da Vinci) - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)

Initial Criteria: Must provide certificate of training for X or Xi Robotic from Intuitive prior to case.

Xi Robotic Privileges - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

Assist in Xi Robotic - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

Human Resources Committee (No meeting held in January, 2018)

TRI-CITY MEDICAL CENTER EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE OF THE BOARD OF DIRECTORS January 9, 2018

Voting Members Present:

Chair Dr. Cyril Kellett, Director Rosemarie Reno, Director Leigh Anne Grass

Gwen Sanders

Non-Voting Members Present:

Steve Dietlin, CEO; Scott Livingstone, COO; Carlos Cruz, CCO; Esther Beverly, VP of HR;

Others Present:

Maureen Peer, Scott Simon, Dena Baker, Anna Lyagacheva, Frances Carbajal

Members Absent:

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 11:10 a.m.	22.50 - 2	Chair Kellett
2. Approval of Agenda	Chair Kellett called for a motion to approve the January 9, 2018 meeting agenda. Director Reno moved to approve and Gwen Sanders seconded the motion. The motion was carried unanimously.	,	Chair Kellett
3. Comments by members of the public on any item of interest to the public before Committee's consideration of the item	Chair Kellett read the paragraph regarding comments from members of the public.	-	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the September 12, 2017 meeting. Director Grass moved to approve and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
5. Old Business	None		
6. New Business			

Topic	Discussion	Action Follow-up	Person(s) Responsible
a. Lincoln Quarterly Update	Maureen Peer, Lincoln Financial Relationship Advisor presented an executive summary which included an update from Lincoln's quarterly results & an overall 2017 year to date results as of 9/30/2017. Key plan statistics, plan asset growth, contributions, earnings, participation rates, average deferral rates and account balances were also reviewed.		Esther Beverly
b. Prudent Quarterly Update	Dena Baker, Prudent Investment Advisor presented a summary of current and past participation rates. Discussed ongoing efforts to reach all employees for ideal participation. Ongoing Prudent educational sessions held and plans for upcoming sessions were discussed by Dena.		Esther Beverly
7. Comments made from the Committee	None		Chair Kellett
8. Date of next meeting	April 10, 2018		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 11:43 a.m.		Chair Kellett

MEMBERS PRESENT:

Chair Julie Nygaard; Director Jim Dagostino; Director Laura Mitchell; Dr. Victor Souza MD; Bret

Schanzenbach, Dung M. Ngo, Gigi Gleason, Guy Roney, Linda Ledesma, Marilou de la Rosa Hruby,

Rosemary Eshelman, Scott Ashton

MEMBERS ABSENT:

Barbara Perez; Carol Herrera, Danielle Pearson, Jack Nelson, Mary Donovan, Mary Lou Clift, Mary

Murphy, Rick Robinson, Roma Ferriter (maternity leave), Sandy Tucker, Ted Owen, Xiomara Arroyo

NON-VOTING MEMBERS PRESENT:

Steve Dietlin, CEO; Scott Livingstone, COO; David Bennett, CMO; Fernando Sanudo

NON-VOTING MEMBERS ABSENT:

Susan Bond, Counsel

OTHERS PRESENT:

Brian Greenwald, Jan O'Reilly

ТОРІС	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The January 18, 2018 Community Healthcare Alliance Committee meeting was called to order at 12:32pm by Chair Julie Nygaard.		
Welcome New CHAC Committee Representatives	Julie Nygaard introduced and welcomed the newest CHAC Committee representatives, Director Laura Mitchell and Scott Livingstone, COO.		



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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Approval Of Meeting Agenda	Jim Dagostino motioned to approve the January 18, 2018 meeting agenda. The motion was seconded by Gigi Gleason and unanimously approved.		
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Bret Schanzenbach noted an error in the October minutes, page 2 under Presentation. Gigi Gleason motioned to approve the October 19, 2017 CHAC meeting minutes with corrections. The motion was seconded by Jim Dagostino and unanimously approved.		
Presentation: Dr. Laura Desadier MD Stroke Management	Dr. Laura Desadier presented to the group on Stroke Management noting the following: Know the signs and symptoms of a stroke: Sudden trouble seeing in one or both eyes Sudden severe headache with no known cause Sudden numbness or weakness of the face, arm, leg (esp. one-sided) Sudden Confusion, trouble speaking or understanding Sudden trouble walking, dizziness or loss of balance		



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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Dr. Laura Desadier MD Stroke	Time = Brain. It is essential for care to be provided as quickly as possible to decrease damage and dead tissue. 3.6 years of brain age can be lost per hour.		
Management (Con't)	TCMC has been a forerunner in developing programs that greatly assist in early care for stroke victims through coordination of communication and medical procedures in transit to the hospital.		
	In 2017, TCMC treated a total of 615 cases of stroke. TCMC's treatment percentage is 33%; the national average is 13%.		99
	A-Fib causes a 5-fold increase in ischemic stroke risk, with a 2x higher rate for the stroke to be fatal. This risk is reduced by 67% in AF patients using an oral anticoagulant.		
CEO Update Steve Dietlin	Steve thanked Dr. Laura Desadier for the great presentation, noting that time does matter when an urgent situation arises. TCMC has a proven track record of the best timeframes due to our transit coordination program. Other healthcare providers in the area are trying to establish similar programs.		
	ED flu cases are way up. The average daily census has risen to 222 (generally 180-190) due to the flu.		



TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (Con't)	 Steve again noted the recent Administration change, with Scott Livingstone taking the position of COO. Campus development is progressing, with the surface lot kick-off event happening in the near future. The City of Oceanside also recently approved a <i>cut-out</i> so construction vehicles can enter and exit during construction with very little disturbance to the general traffic flow. 		
COO Update Scott Livingstone	 Scott took a moment to introduce himself to the group and share his history with TCMC. Scott noted that campus redevelopment is an event that our community residents have been looking forward to for a long time. TCMC is very excited about this opportunity for North County. Scott noted that a Retail Pharmacy is being built in the area behind the coffee station in the main lobby. It is believed that the addition of this Pharmacy will help resolve many patient medication issues such as access after discharge due to pain or inconvenience (this issue alone causes many readmissions due to the patient not having access to the medications prescribed to them at discharge). 		





DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
 The Discharge Program has been slowed a bit in an effort to prevent contamination during flu season. 		
Scott recommended that people consider getting a flu shot if they have not done so already.		
David Bennett updated the committee as follows:		
 David noted that the Carlsbad Marathon held January 12-14 was very successful. 		
TCMC has sponsored this event for 9 years now.		
6400 runners were involved in the event, 3700 from the San Diego area, 1700 from North County, 11 international. The weekend's Expo events drew over 7000 visitors.		
Many TCMC volunteers participated and media coverage was extensive.		
Marketing recently released a new A-Fib commercial with Drs. Cohen and Gramins.		
	 The Discharge Program has been slowed a bit in an effort to prevent contamination during flu season. Scott recommended that people consider getting a flu shot if they have not done so already. David Bennett updated the committee as follows: David noted that the Carlsbad Marathon held January 12-14 was very successful. TCMC has sponsored this event for 9 years now. 6400 runners were involved in the event, 3700 from the San Diego area, 1700 from North County, 11 international. The weekend's Expo events drew over 7000 visitors. Many TCMC volunteers participated and media coverage was extensive. Marketing recently released a new A-Fib commercial with Drs. Cohen 	 The Discharge Program has been slowed a bit in an effort to prevent contamination during flu season. Scott recommended that people consider getting a flu shot if they have not done so already. David Bennett updated the committee as follows: David noted that the Carlsbad Marathon held January 12-14 was very successful. TCMC has sponsored this event for 9 years now. 6400 runners were involved in the event, 3700 from the San Diego area, 1700 from North County, 11 international. The weekend's Expo events drew over 7000 visitors. Many TCMC volunteers participated and media coverage was extensive. Marketing recently released a new A-Fib commercial with Drs. Cohen



trackly to fall Wasting Minutes

Tri-City Healthcare District Community Healthcare Alliance Committee (CHAC) MEETING MINUTES January 18, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Chief Of Staff Update Dr. Victor Souza MD	 Dr. Victor Souza updated the committee as follows: During the flu season, hospital stays lengthen, as patients with the flu cannot be transported to other facilities such as SNF's. EMS wall time has decreased due to better patient placement. This is allowing the teams to return to the needs of the community faster. TCMC Doctors are using the new DaVinci XI Surgical Robot with great success. HCAHPS showed positive patient responses for OBGYN from those using the area during recent renovations. The Medical Staff meeting is tonight. The theme for 2018 is "Year of Gratitude." 		



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Tri-City Healthcare District Community Healthcare Alliance Committee (CHAC) MEETING MINUTES January 18, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Vacancies	Vista resident Jan O'Reilly petitioned the Committee to be considered a candidate for the Vista District Resident position. Jan took a few moments to speak to the group about her qualifications for this position.		
	Upon motion made by Jim Dagostino, and seconded by Dung Ngo, the Committee approved the appointment of Jan O'Reilly to fill the position of Vista District Resident.		1
	Julie Nygaard noted that the Oceanside District Resident position is still open.	81	
Public Communications	No public communications.		
Committee Communications	Scott Ashton noted that the Oceanside Chamber is presenting the State of the Community event on Monday, January 22 nd . Also, George Chamberlin will be the guest speaker at a chamber luncheon on February 1 st .		
	Guy Roney noted that he had a very heartwarming experience portraying Santa Clause to a group of Alzheimer's patients over the holidays. It was a very well-received event.		
	Rosemary Eshelman noted that she will be meeting with Cal State San Marcos to promote the Youth Resiliency Program. Also, Rosemary noted that awareness training will be taking place to help combat student use of marijuana in the school district.		
	marijuana in the school district.		



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Tri-City Healthcare District Community Healthcare Alliance Committee (CHAC) MEETING MINUTES January 18, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	Linda Ledesma noted that David Bennett will be working with MANA to help set up mentoring programs for teen girls.		
	Julie Nygaard noted that NAMI will be holding their Annual Meeting at St. Michaels in Carlsbad. Julie also noted that the North County Vista Veterans Stand Down will be held Jan 25-Jan 28.		
	Dung Ngo will provide information to the committee members about college grant programs available to the community.		
	Marilou de la Rosa Hruby noted that the Soroptimist Salad Luncheon will be taking place soon.		
Next Meeting	The next CHAC meeting is scheduled for Thursday, February 15, 2018.		
Adjournment	The January 18, 2018 CHAC meeting was adjourned at 1:35pm.		



Language and State Manager Manager

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
January 16, 2018

Members Present Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Steve Harrington, Wayne Lingenfelter

Non-Voting Members

Present: Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Carlos Cruz, CCO, Susan Bond, Director-

Legal Services

Others: Director Laura Mitchell, Colleen Thompson, David Bennett, Brent Wiest, Glen Newhart, Thomas Moore,

Mark Albright, Charlene Carty, Sherry Miller, Esther Beverly, Cristina Barrera, Steve Young, Jane Dunmeyer, Candice Parras, Chris Miechowski, Tara Eagle, Debra Fellar, Sharon Schultz, Dr. Scott

Worman, Barbara Hainsworth

Members Absent: Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:36 p.m.		
2. Approval of Agenda		MOTION It was moved by Director Kellett, Director Grass seconded, and it was unanimously approved to accept the agenda of January 16, 2018.	
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 December 7, 2017	Minutes were ratified.	Minutes were ratified. MOTION It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of December 7, 2017 are to be approved, with Director Grass abstaining from the vote.	
5. Old Business			

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
6. New Business			
a. Introduction of NewCommittee Member:Director Leigh Anne Grass	Director Nygaard welcomed Director Grass to the Finance, Operations and Planning Committee.		Chair
7. Consideration of Consent Calendar:	Mr. Harrington requested that the following items be pulled: 7.b. Coding Support Services- Contract Increase Proposal for Oxford Global Resources, LLC 7.f. Harris Healthcare (QuadraMed) Software Support Renewal Proposal.	MOTION Director Grass moved to approve the Consent Calendar minus the items pulled. Dr. Contardo seconded the motion. Members: AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter NOES: None ABSTAIN: None ABSENT: Ma, Yamanaka, Ferber	Chris Miechowski
a. Policy Review:Plan to Manage andEstimate Project Cost,#8610-277		Approved via Consent Calendar	Chris Miechowski
 b. Coding Support Services – Contract Increase Proposal Oxford Global Resources, LLC 	Colleen Thompson conveyed that this write-up is to request additional funds, as the original expenditure, approved in May 2017, had already been exceeded. She stated that continued outside service support for time sensitive coding/billing is needed, while recruitment continues of qualified coder candidates. She emphasized that the goal is to hire skilled coders, as well as implement a training plan which would assist in staff retention. It was also mentioned that HR is expanding the coder recruitment pool.	It was moved by Mr. Harrington, seconded by Dr. Contardo to approve the agreement for Coding Support Services – Contract Increase Proposal with Oxford Global Resources, LLC for Coding Support for a term of 12 months, beginning May 1, 2017 and ending April 30, 2018 for an increased cost of \$330,000, for a total cost for the term of \$630,000. Members: AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter NOES: None ABSTAIN: None ABSENT: Ma, Yamanaka, Ferber	Colleen Thompson

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
c. Nova Biomedical Glucometer Contract for Renewal for Point of Care Glucose Testing Proposal		Approved via Consent Calendar	Tara Eagle
 d. Physician Agreement for MDQA-Peer Review and QAPI Committees Dr. James L. Johnson (Manta Med) 		Approved via Consent Calendar	Sherry Miller
e. Copier and Print Management Services Proposal • Vereco, Inc.		Approved via Consent Calendar	Thomas Moore
f. Harris Healthcare (QuadraMed) Software Support Renewal Proposal	Mark Albright conveyed that this write-up was for renewal of QuadraMed software support. This agreement provides software support 7-days a week, 24-hours a day and covers break/fix issues, software enhancements and software upgrades. He emphasized this support is critical to ensure system reliability, uptime and prevent potential disruption to cash flow. Discussion ensued.	It was moved by Dr. Contardo, seconded by Director Kellett to approve the agreement with Harris Healthcare for Affinity Software Support for a term of 24 months, beginning January 1, 2018 and ending December 31, 2019 for an annual cost of \$451,697.62 and a total cost for the term of \$903,395.24. Members: AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter NOES: None ABSTAIN: None ABSENT: Ma, Yamanaka, Ferber	Mark Albright
8. Financials:	Ray Rivas presented the financials ending December 31, 2017 (dollars in thousands) TCHD – Financial Summary Fiscal Year to Date Operating Revenue \$ 178,874 Operating Expense \$ 185,591 EBITDA \$ 3,619		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EROE \$ (4,173) TCMC - Key Indicators Fiscal Year to Date Avg. Daily Census 170 Adjusted Patient Days 55,959 Surgery Cases 3,220 Deliveries 1,182 ED Visits 31,459 TCHD - Financial Summary Current Month Operating Revenue \$ 30,355 Operating Expense \$ 31,177 EBITDA \$ 908 EROE \$ (383) TCMC - Key Indicators Current Month Avg. Daily Census 173 Adjusted Patient Days 9,205 Surgery Cases 512 Deliveries 166 ED Visits 5,345 TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year Net Patient A/R Avg. (in millions) \$ 45.7 Days in Net A/R Avg. (in millions) \$ 45.7 Days in Net A/R Avg. 49.0 Graphs: • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital- Excluding Newborns • TCMC-Adjusted Patient	Conclusions	
9. Work Plan:	Days		
a. Wellness Center (quarterly)	David Bennett and Wellness Center	20.	David Bennett
a. vveimess center (quarterly)	Manager Brent Wiest went over the		David Bellilett

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
304 S	membership statistics for quarters 3		
	and 4.		
	Brent explained that operational		
	changes have been made, resulting		
	in improved customer satisfaction		
	and enhanced employee morale.		
	He emphasized that communication		
	and interaction with both members		
	and staff has had a very positive		
	effect, and that the energy level at		
	the Wellness Center has improved		
	significantly. He highlighted that the		
	employees are being encouraged to		
	provide concierge level service. In		
	addition, some equipment issues		
	have been resolved, and some		
	modifications have been made to		
	class variety and time schedules.		
	A question was raised about the		
	potential for generating revenue by		
	renting out the Wellness Center		
	conference rooms. Brent conveyed		
	that he had recently established a		
	rental fee schedule, and that one		
	rental had already been scheduled.		
	Director Nygaard conveyed that the		
	timeframe for updates on the		
	Wellness Center will be changed		
	from quarterly to bi-monthly and it		
	was also requested that the revenue		
	and expenses for the Wellness Center be included in these bi-		
o. Construction Report	monthly updates. Chris Miechowski briefly went over		Chris Miechowsk
•	the Construction Report. Several		OTHIS MIECHOWS
(quarterly)	questions were asked regarding		
	Campus Redevelopment. He		
191000	Campus Nedevelopment. Tie		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	conveyed that they are very close to		
	beginning work on paving the		
	parking area behind the Security		
	building, which is expected to		
	provide an additional 290 parking		
	stalls. Upon completion of this		
	project there are plans for two other		
	parking areas, one of which will be a		
	multi-level parking structure. Chris		
	emphasized that despite the		
	planned construction, there are no		
	plans to have less than the current		
ED Throughout (b) acceptable	number of available parking spaces.		O I'm . D
c. E.D. Throughput (bi-monthly)	Candice Parras gave a brief		Candice Parras
	PowerPoint presentation detailing		
	the ongoing efforts of to improve the		
	overall patient flow in the		
	Emergency Department. She		
	conveyed that the arrival to		
	discharge time for the E.D. had been		
	reduced by 51 minutes in 2017.		
	Candice also detailed that there had		
	been numerous changes		
	implemented, which have led to		5
	greater patient satisfaction, and a		
	significant reduction in left without		
	being seen (LWBS) patients. She		
	also updated the "No Wall Time"		
	project for paramedic patients. The		
	goal is to get patients brought in by		
	paramedic into a bed in 20 minutes,		
	which enables the ambulance and		
	crew to return to service.		
	Director Nygaard praised Candice		
	Parras and her team for the overall		
	improvements that have been		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	accomplished in the Emergency Department. She also conveyed that due to this progress all future Work Plan updates for this item would be changed from bimonthly to quarterly.		
d. I.T. Physician Liaison (semi- annual)	Mark Albright gave a brief PowerPoint presentation provided by Dr. Worman, reviewing the projects that are currently in process, as well as the strategic priorities of future projects for the full utilization of Information Technology potential. Some discussion ensued.		Mark Albright
e. Crisis Stabilization Unit (CSU) (bi-monthly)	Sharon Schultz gave a brief PowerPoint presentation detailing the statistics for the CSU, including the payer mix, the overall admissions volumes and average length of stay, as well as the Medi- Cal admission volumes and average length of stay. Additionally, a slide was included with five bullet points that reflected process improvements for the CSU. She further conveyed that Dr. Ahmed was slated to begin on February 1 st , but that he had already begun working. Sharon with confirmation from Candice Parras, described the CSU as extremely busy. Discussion ensued.		Sharon Schultz
f. Institute for Clinical Effectiveness (ICE) (semi- annual)	Scott Livingstone on behalf of Jeremy Raimo stated that although there had initially been some interest		Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	in this program, the 60 day investing period had elapsed with no packets being returned. Physician feedback reflected that concerns were expressed regarding too low of a distribution, and whether the institute could be designed around a single large metric. Further inquiry into this request would require additional funds to move forward with the initiative, but without sufficient buy-in from prospective investors this institute is currently on hold.		
g. Dashboard	No discussion		Ray Rivas
 Comments by committee members 			
11. Date of next meeting	Tuesday, February 13, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:41 p.m.		

Administrative Policy-Manual District Operations

ISSUE DATE:

10/02

SUBJECT: PLAN TO MANAGE AND ESTIMATE

PROJECT COST

REVISION DATE: 02/03, 04/06, 06/09, 07/11

POLICY NUMBER: 8610-277

Department Review

11/17

Administrative Policies & Procedures Committee Approval:

02/1511/17

Finance & Operations Committee Approval:

03/1501/18

Board of Directors Approval:

03/15

A. PURPOSE:

1. To create a policy and process for all hospital personnel to submit an accurate project cost proposal to administration for request for approval.

B. POLICY:

- Once a project has been discussed within a department, a Director/Manager will accurately
 describe the scope of the project and submit a renovation request-Form to his/her VicePresident for scope approval. Project must be reviewed by Facilities and Information
 Technology for feasibility. Upon review and approval by the Executive CouncilVice President of
 the project scope the written request will be submitted to the Facilities Department for cost
 analysis.
- 2. After receiving direction from the Vice President Executive-Council, the Facilities Department will:
 - a. Meet with all personnel involved to determine the complete construction scope of the project.
 - b. Provide an initial estimated cost and projected completion time to Administration—and to the Space Planning Committee, if needed.
- 3. If Executive CouncilVice President's decision is to approve a further investigation of the potential project, the following items will take place:
 - a. If the project scope warrants, an architect will be called in to begin design development.
 - b. If the project scope warrants, a construction manager will be called in to value engineer and put together a project budget, as well as manage the construction of the project.
- 4. Facilities will keep Administration abreast of design and budget details as the project develops.
- 5. After a complete scope and preliminary design have been established the project is completely designed, approved by the Authorities Having Jurisdiction and bid out to contractors or a professional construction estimate is completed, a project budget will be finalized, a capital purchase requisition (CPR) will be submitted by the Facilities Department with the total estimated project cost to the Capital Budget Committee for review and approval. Any necessary bidding or bidding provisions will be finalized and necessary Board approvals will be completed.
- 6. Upon Administration/Board approval, the approved CPR will be submitted by the Facilities Department to the Finance Department for approval and assignment of a budget number.
- 7. Once the project has been approved and assigned a budget number, it will be assigned a project number (CIP Number) and construction administration will begin.
- 8. If the project scope changes at any point during the project, Administration must give written approval for the additional architectural/engineering fees and construction costs associated with these changes. This supplemental CPR will follow the same process of approval as the original

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Plan to Manage and Estimate Project Costs 8610-277
Page 2 of 3

project request.

- 9. If approved, the supplemental CPR will be submitted to Administration for review and approval. Any associated costs will be added to the total project budget.
- 10. During the fiscal year budget development process, the Facilities Department will utilize both inhouse estimating resources as well as outside contractor resources to develop budget estimates Administration can depend on for the next fiscal year.
- 11. Once Administration and the Finance Department have approved a project, it is the responsibility of the area's Director/ManagerDirector of Facilities to coordinate the project's progress and schedule all project related meetings. If any other departments are affected or involved, it is the responsibility of the area's Director/Manager and Director of Facilities to keep everyone informed of progress and responsibilities.

FORM(S):

1. Request for Space/Renovations

Administrative Policy Manual- District Operations
Plan to Manage and Estimate Project Costs 8610-277
Page 3 of 3

Request-for-Space/Renovations

TRI-CITY MEDICAL CENTER

REQUEST FOR SPACE/RENOVATIONS

DELETE

INSTRUCTIONS:

Complete a separate form for each project.

Forward original to the Engineering Department <u>WITH YOUR DIRECTOR'S SIGNATURE</u> for Space Planning Committee Review.

	s for budgetary purpose only. This does not mean the project has been approved. Requisition must be filled out <u>AND</u> approved before the start of any project.
DATE SUBMITTED:	
COST CENTER NUM	BER
DEPARTMENT NAME	
DEPARTMENT DIRE	
ADMINISTRATOR'S	APPROVAL:
CONTACT PERSON:	
If this renovation is red	quired for a budgeted equipment item, please list (from Equipment Budget form):
EQUIPMENT DESCR	IPTION:
EQUIPMENT COST.	<u></u>
RENOVATION NEED	ED IN FISCAL YEAR ENDING IN 2005, 2006, OR 2007
PROJECT DESCRIPT	TON: (please provide as much information and detail as possible)
·	
Based on the descript	ions below, the priority level of this project is:
	Needed for JCAHO and/or Title 22 compliance and/or continuation of the service Needed to support growth or to upgrade services Desired to enhance departmental service
SPECIAL PROJECTS	DEPT USE ONLY
	DATE.
ESTIMATED.COST:	SIGNATURE:

Located on the Intranet under: TCMC Departments-Engineering-Electronic Forms-Request for Space/Renovations





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: January 16, 2018 Coding Support Services – Contract Increase Proposal

Type of Agreement	Medical Directors	Panel	х	Other: Increase in Term Cost
Status of Agreement	New Agreement	Renewal – New Rates		Renewal – Same Rates

Vendor's Name:

Oxford Global Resources, LLC

Area of Service:

Medical Records/Health Information

Term of Agreement:

12 months, Beginning, May 1, 2017- Ending, April 30, 2018

Maximum Totals:

Previously Approved Cost	Cost Increase	Total Term Cost
\$300,000	\$330,000	\$630,000

Description of Services/Supplies:

- Exceeded original expenditure of \$300K, approved in May 2017
- Continue to require outside service support for coding/billing in a timely manner while continuing to recruit qualified coder to address the more complex accounts for timely billing.

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:	Х	Yes		No
Is Agreement a Regulatory Requirement:		Yes	х	No
Budgeted Item: Original Cost (\$300,000)	х	Yes		No
Budgeted Item: Additional Cost (\$330,000)		Yes	х	No

Person responsible for oversight of agreement: Colleen Thompson, Director, Medical Records / Ray Rivas, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Oxford for Coding Support for a term of 12 months, beginning May 1, 2017 and ending April 30, 2018 for an increased cost of \$330,000, for a total cost for the term of \$630,000.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: January 16, 2018

Nova Biomedical Glucometer Contract Renewal for Point of Care Glucose Testing Proposal

Type of Agreement	Medical Directors		Panel	Other:
Status of Assessment New Assessment		V	Renewal –	Renewal – Same
Status of Agreement New Agre	New Agreement	^	New Rates	 Rates

Vendor's Name:

Nova Biomedical

Area of Service:

Laboratory Point of Care (Nursing)

Term of Agreement:

60 months, Beginning, December 2, 2017 - Ending, December 1, 2022

Maximum Totals:

Expected Monthly	Expected Annual	Expected Total Term
Cost .	Cost	Cost
\$4,600	\$55,200	\$276,000

Description of Services/Supplies:

- The Nova StatStrip Glucose Meter is the only FDA cleared CLIA-waived test meter to perform bedside glucose testing on critically ill patients
- The meters are currently interfaced with Cerner and the results populate within the patient EMR
- Upgrading to the next generation meter, as proposed in this contract, reduces the number of total glucometers needed due to fewer meter breakdowns/replacements
- This contract renewal represents a cost savings of \$9,025 per year over the current contract

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:	Х	Yes		No
Is Agreement a Regulatory Requirement:		Yes	х	No
Budgeted Item:	Х	Yes		No

Person responsible for oversight of agreement: Tara Eagle, Operations Manager, Laboratory / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Nova Biomedical for Nova StatStrip Glucometer and Test Strips for a term of 60 months, beginning December 2, 2017 and ending December 1, 2022 for an annual cost of \$55,200, and a total cost for the term of \$276,000.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: January 16, 2018

Physician Agreement for MDQA - Peer Review and QAPI Committees

Medical Directors		Panel	×	Other: Committee Chairperson
New Agreement	х	Renewal –		Renewal – Same Rates
			New Agreement X Renewal –	Medical Directors Panel X

Physician's Name:

Dr. James L. Johnson (Manta Med)

Area of Service:

MDQA/Peer Review/QAPI Committees

Term of Agreement:

12 months, Beginning, November 1, 2017 - Ending, October 31, 2018

Maximum Totals:

Within Hourly and/or Annualized Fair Market Value: YES

	***************************************	ing ana, or minimaniz	ca ran man	
Rate/Hour	Average Hours per Month	Hours per Year Not to Exceed	Monthly Cost	Annual / Term Cost Not to Exceed
\$155	33	400	\$5,000	\$60,000
Education H	ours & Travel Stip	end	,	\$10,000
			Total Cost	\$70,000

Position Responsibilities:

Chairperson MDQA-Peer Review and QAPI Committees:

- Promote initiatives for improving quality of patient care, and services within TCHD
 - Lead MDQA Peer Review and QAPI as Physician Chairperson
 - Provides Medical oversight for Quality/Performance Improvement regarding patient care
 - Evaluates with the MDQA-Peer Review and QAPI members effectiveness of Teams leading QA/PI initiatives
 - o Makes recommendations, with the QAPI members, for initiative interventions and outcomes
 - Identify opportunities for improvement
 - Makes recommendations to develop processes to fill in gaps in systems
 - Attends NIH annually, when able, to bring best practice recommendations to the QAPI membership

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. James L. Johnson as the Physician Chairperson of MDQA/Peer Review/QAPI for a term of 12 months beginning November 1, 2017 and ending October 31, 2018. Not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of \$155 for an annual cost of \$60,000 and a total cost for the term not to exceed \$70,000.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: January 16, 2018 COPIER AND PRINT MANAGEMENT SERVICES PROPOSAL

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

Vendor's Name:

Vereco, Inc.

Area of Service:

Supply Chain Management

Term of Agreement:

60 months, Beginning, March 1, 2018 - Ending, February 28, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$145,000	\$1,740,000	\$8,700,000

Description of Services/Supplies:

- Maintenance and repair services for TCHD's 184 copiers, 266 printers, and 2 fax machines
- Includes all copier paper, ink and toner cartridges and any necessary repair parts or new printers
- Provides 5 staff that perform mail delivery, courier services and copy center services
- Includes all of TCHD's document shredding and disposal services to protect against PHI breaches

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

Person responsible for oversight of agreement: Tom Moore, Director, Supply Chain Management / Moore / Ray Rivas, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Vereco, Inc. for copier, courier, mail delivery, document shredding, copy center and print management services for a term of 60 months beginning March 1, 2018 and ending February 28, 2023 for an annual cost of \$1,740,000, and a total cost for the term of \$8,700,000.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING January 16, 2018 Harris Healthcare (QuadraMed) Software Support Renewal Proposal

Type of Agreement	Medical Directors		Panel	l X	Other: Software Support Renewal
Status of Agreement	New Agreement	x	Renewal –		Renewal – Same
Status of Agreement	14c44 Agreement	^	New Rates		Rates

Vendor's Name:

Harris Healthcare (QuadraMed)

Area of Service:

Affinity Patient Accounting (Information System)

Term of Agreement:

24 months, Beginning, January 1, 2018 - Ending, December 31, 2019

Maximum Totals:

Annual Cost	Total Term Cost
\$451,697.62	\$903,395.24

Description of Services/Supplies:

- Affinity is the patient accounting information system used primarily for generating patient bills
 and sending them to the appropriate insurance companies for reimbursement. Additionally, it
 stores the charge master which assigns a charge to a service provided or a supply item used or
 medication given in the provision of a service. This software is a critical component of our entire
 revenue cycle management.
- This agreement/renewal provides software support 7 days per week, 24 hours per day and covers break/fix issues, software enhancements, and software upgrades. The support fees are invoiced quarterly in advance. This support is critical to ensure system reliability and uptime and prevent potential disruptions to cash flow.

Document Submitted to Legal for Review:	х	Yes		No
Approved by Chief Compliance Officer:	Х	Yes		No
Is Agreement a Regulatory Requirement:		Yes	х	No
Budgeted Item:	Х	Yes		No

Person responsible for oversight of agreement: Mark Albright, Vice President, Information Technology / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Harris Healthcare for Affinity Software Support for a term of 24 months, beginning January 1, 2018 and ending December 31, 2019 for an annual cost of \$451,697.62 and a total cost for the term of \$903,395.24

Tri-City Medical Center Professional Affairs Committee Meeting Open Session Minutes January 11, 2018

Members Present: Director Leigh Anne Grass (Chair), Director Laura Mitchell, Director Larrty Schallock, Dr. Contardo, Dr. Souza and Dr. Ma

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO, Carlos Cruz, Chief Compliance Officer, Susan Bond, Director of Legal Services Marcia Cavanaugh, Sr. Director for Risk Management and Jami Piearson, Director of Quality and Regulatory.

Others Present: Sharon Davies, Jeremy Raimo, Merebeth Richins, Stephen Chavez-Matzel, Lisa Mattia Debra mendez, Joy Melhado, Oska Lawrence, Jeff Surowiec, Dino Cinquemani, Charlene carty, Colleen Thompson, Thomas Moore, Sherry Miller, Nancy Myers, Priya Joshi, Ann Palimisano, Patricia Guerra and Karren Hertz.

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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:06 PM in Assembly Room 1. Director Grass is chairing the PAC Committee starting this month and this is her first meeting. She welcomed Director Larry Scahllock as the additional Board Member and re-inroduced Director Laura Mitchell. Scott Livingstone was also welcomed as this is his first meeting as the new COO of the hospital.		Director Grass
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Dr. Contardo and seconded by Director Schallock.	Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Grass read the paragraph regarding comments from members of the public.		Director Grass
Ratification of minutes of November 2017.	Director Grass called for a motion to approve the minutes from November 9, 2017 meeting.	The minutes were ratified and was approved by the group. Director Mitchell moved and Dr. Souza seconded the motion to approve the minutes from November 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures			
Patient Care Policies and Procedures 1. Application of Lidocaine, Prilocaine Topical Cream Standardized Procedure	There was no discussion on this policy.	ACTION: The Patient Care policies and procedures were approved. Dr. Contardo moved and Dr. Souza seconded the	Patricia Guerra
Care for Recalcitrant Children Policy	It was identified that this policy is seldom used as the hospital don't get a lot of this patient population.	motion to approve the policies moving forward for Board approval.	
Documentation in the Medical Record Policy	Dr. Souza made a clarification that all students dont have the ability to document anyting in the medical record since they are not licensed or credentialed.		

	Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4.	Family-Centered Care – Pediatrics/ Adolescents Policy	There was no discussion on this policy.		
5.	High Level Disinfection Procedure	Dr. Contardo wanted to have further clarification on the use of Cidex. The committee decided that this policy will be approved as is and will be brought back with the results of the research and further recommendations.	ACTION: Deb Feller and Dr. Contardo will sit down to meet and discuss this policy in detail.	Debra Feller/ Dr. Contardo
6.	72 –Hour Hold, Evaluation and Treatment of Involuntary Patient Policy	The term chronic alcoholism was clarified; there was also a recommendation to add the California Penal Code as a reference to this policy.		
7.	Medications, High Risk/ High Alert/ Look Alike/ Sound Alike Policy	There was no discussion on this policy.		
8.	Extended Dwell Catheter/ Midline Catheter, Adults	The term FDA was corrected to say Food and Drug Administration, and not Federal and Drug Association.		
9.	Physician/ Allied Health Professionals (AHP) Inpatient Orders Policy	Director Mitchell had asked to modify the term DMD (Doctor of Dental Medicine) on one section of the policy.		
10). Privacy Code Policy	This policy is being pulled out for further review and discussion.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Pyxis Connect Scanner Procedure	There was no discussion on this policy.		
12. Patient Food Refrigerators/ Freezers for Temperature, Cleaning, Defrosting Responsibilities Procedure	It was identified that the Patient Medication Refrigerator is being monitored by the Pharmacy Department.		
13. Release of Deceased Procedure	There was no discussion on this policy.		
14. Substance Abuse, Patient Policy	There was no discussion on this policy.		
Unit Specific Administrative Policies 1. Assignment of Medical Record Numbers and Standard Naming Guidelines	There was a grammar correction on this policy.	ACTION: The Administrative policies were approved. Director Schallock moved and Dr. Souza seconded the motion to approve the policies moving forward for	Patricia Guerra
 Coverage for Employee Vehicle Insurance Deductible 	This policy applies only to Home Health nurses and also the Marketing Department.	Board approval.	
 Designation of Authority in Temporary and Voluntary Absence of CEO 	It was noted that this policy is finished; the process just need to be streamlined.	ACTION: The notification in the absence of CEO should be posted in the Adminitsrtaion Department.	Karren Hertz/ Teri Donnellan
 Faxing of Protected Health Information (Medical Records) 	There was no discussion on this policy.	Dopartinont.	
5. Space and Office	There was no discussion on this policy.		

	Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	Allocation Standards			
6.	Use, Security and Accuracy of Data	There was no discussion on this policy.		
	vioral Health Services Report of Firearms Prohibition	There was no discussion on this policy.	ACTION: The Behavioral Health policy was approved to move forward to Board approval as moved by Director Mitchell and seconded by Dr. Souza.	Patricia Guerra
Medio	cal Staff		-fusion makes	
1.	Adverse Incident/ Occurrence for Post- Graduate Staff	There was a recommendation to add that adverse event information need to be reported to Risk Management especially if it involves a patient incident.	ACTION: The Medical Staff policies were approved. Director dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for	Patricia Guerra
2.	Credentialing Requirements for Fluoroscopy Supervisor and Operator Permit	There was no discussion on this policy.	Board approval.	
3.	Credentialing Standards for Transoral Esophagogastric Fundoplication (TIF)	There was no discussion on this policy.		
4.	Medical Record Documentation Requirements	There was no discussion on this policy.		
5.	Quality Review Process for Teleradiologists	There was no discussion on this policy.		

	Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	Hand Hygiene , NICU Infection Prevention, NICU	Both of these policies were deletions since they are included in the Infection Control Manual.	ACTION: The NICU policies were approved to move forward to Board approval as moved by Director Mitchell and seconded by Dr. Souza.	Patricia Guerra
	nacy Automatic Dose Rounding Clinical Intervention/ Activity Documentation Program	There was no discussion on this policy. There was no discussion on this policy.	ACTION: The Pharmacy policies were approved to move forward to Board approval as moved by Director Mitchell and seconded by Director Schallock.	Patricia Guerra
	Drug Compounding for Medication Not Commercially Available Drug Supply Chain	Oska explained to the committee that compounding is currently done in the Pharmacy Department for ease of use and most of them are used intra venous (IV) with syringe. Some compounding third-		
5.	Security Act Risk Evaluation and Mitigation Strategies	party companies are out of state but they are licensed to operate in California.		
6.	Unlabeled Uses of FDS- Approved Medications			
Rehal	bilitation			
	Behavior Management/ Supervision Technique	*There was no discussion on the rehabilitation policies.	ACTION: The Rehabilitation policies were approved to move forward to Board approval as	
2.	Computer Downtime/ Printer Malfunction		moved by Director Schallock and seconded by Dr. Contardo.	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Documentation Guidelines4. Equipment Evaluation,Dispensing and Monitoring			
5. Exception Reports			
Rationale for Clinical Education			
Telemetry 1. Opening/Closure of Telemetry Beds/ Unit	There was no discussion on this policy.	ACTION: The Telemetry policy was approved to move forward to Board approval as moved by Director Mitchell and seconded by Dr. Souza.	
Ultrasound and Vascular			
Imaging 1. How to Report a Critical/Stat Exam	It was clarified that McKesson is the company that deals with the the image archiving system of the hospital.	ACTION: The Ultrasound and Vascular Imaging policy was approved to move forward to Board approval as moved by Director Schallock and seconded by Dr. Contardo.	
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Schallock seconded and it was unanimously approved to go into closed session at 1:10 PM.	Director Grass
8. Return to Open Session	The Committee return to Open Session at 2:15 PM.		Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Grass
10. Comments from Members of the Committee	No comments.		Director Grass
11. Adjournment	Meeting adjourned at 2:18 PM.		Director Grass





PROFESSIONAL AFFAIRS COMMITTEE January 11, 2018

CONTACT: Sharon Schultz, CNE

		CONTACT: Sharon Schultz, CN
Policies and Procedures	Reason	Recommendations
Patient Care Services	•	
Application of Lidocaine Prilocaine Topical Cream Standardized Procedure	DELETE	Forward to BOD for Approval
2. Care for Recalcitrant Children Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Documentation in the Medical Record Policy	Practice Change	Forward to BOD for Approval
4. Family Centered Care-Peds-Adols Policy	3 Year Review, Practice Change	Forward to BOD for Approval
5. High Level Disinfection Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
7. Medications, High Risk-Alert policy	3 Year Review, Practice Change	Forward to BOD for Approval
8. Midline Catheter, Adults	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
9. Physician Provider Orders Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
10. Privacy Code Policy	Practice Change	Pulled for Further Review
11. Pyxis Connect Scanner Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
12. Refrigerator Temperature, Cleaning - Defrosting Responsibilities Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
13. Release of Deceased Procedure	Practice Change	Forward to BOD for Approval with Revisions
14. Substance Abuse, Patient Policy	3 Year Review	Forward to BOD for Approval
11.24 0 10.		
Unit Specific Administrative		
Assignment of Medical Record Numbers and	3 Year Review,	Forward to BOD for Approval with
Std Naming 390	Practice Change	Revisions
Coverage for Employee Vehicle Insurance	3 Year Review,	
Deductible 256	Practice Change	Forward to BOD for Approval
Designation of Authority in Absence of CEO 233	3 Year Review, Practice Change	Pulled for Further Review
Faxing of Protected Health Information 522	3 Year Review, Practice Change	Forward to BOD for Approval
5. Space and Office Allocation Standards 289	3 Year Review, Practice Change	Forward to BOD for Approval
6. Use, Security, and Accuracy of Data 242	3 Year Review, Practice Change	Forward to BOD for Approval
Behavioral Health Services	235	
Report of Firearms Prohibition	3 Year Review, Practice Change	Forward to BOD for Approval
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PROFESSIONAL AFFAIRS COMMITTEE January 11, 2018

			CONTACT: Sharon Schultz, CNI
	Medical Staff		
	Adverse Incident Occurrence 8710-512	3 Year Review	Forward to BOD for Approval with Revisions. Revisions to be ready by February BOD.
2.	Credentialing Requirements CA Licentiate Supervisor and Operator Permit 8710-528	3 Year Review	Forward to BOD for Approval
3.	Credentialing Standards for Transoral Esophagogastric Fundoplication (TIF) 8710- 556	3 Year Review	Forward to BOD for Approval
4.	Medical Record Documentation Requirements 8710-518	3 Year Review, Practice Change	Pulled for Further Review
5.	Quality Review for Teleradiologists 8710-525	3 Year Review	Forward to BOD for Approval
	NICU		
1.	Hand Hygiene in the NICU	DELETE	Forward to BOD for Approval
2.	Infection Prevention - NICU	Practice Change	Forward to BOD for Approval
-			
	Pharmacy	0 V B	
1.	Automatic Dose Rounding	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Clinical Intervention Activity Documentation Program	3 Year Review, Practice Change	Forward to BOD for Approval
3.	Drug Compounding for Medication Not Commercially Available	3 Year Review, Practice Change	Forward to BOD for Approval
4.	Drug Supply Chain Security Act	NEW	Forward to BOD for Approval
5.	Risk Evaluation and Mitigation Strategies (REMS) Policy	3 Year Review, Practice Change	Forward to BOD for Approval
6.	Unlabeled Uses of FDA-Approved Medications	3 Year Review	Forward to BOD for Approval
	Rehabilitation		
1.	Behavior Management - Supervision Technique 204	3 Year Review	Forward to BOD for Approval
2.	Computer Downtime Printer Malfunction 500	3 Year Review, Practice Change	Forward to BOD for Approval
3.	Documentation Guide 1000	DELETE	Forward to BOD for Approval
4.	Equipment Evaluation, Dispensing & Monitoring 502	DELETE	Forward to BOD for Approval
5.	Exception Reports 503	DELETE	Forward to BOD for Approval
6.	Rationale for Clinical Education 401	DELETE	Forward to BOD for Approval
	Telemetry		
1.		DELETE	Forward to BOD for Approval
5. 6.	Monitoring 502 Exception Reports 503 Rationale for Clinical Education 401 Telemetry	DELETE	Forward to BOD for Approva





PROFESSIONAL AFFAIRS COMMITTEE January 11, 2018

CONTACT: Sharon Schultz, CNE

Ultrasound & Vascular Imaging		
How to Report a Critical Read Stat Exam	3 Year Review, Practice Change	Forward to BOD for Approval
v notes		



PATIENT CARE SERVICES MANUAL

DELETE per Department of Emergency Medicine, physicians will order EMLA cream as needed.

STANDARDIZED PROCEDURE: APPLICATION OF LIDOCAINE 2.5% PRILOCAINE 2.5% TOPICAL CREAM (EMLA) PRIOR TO PERIPHERAL INTRAVENOUS THERAPY

POLI	CY :
Α	Function: Application of EMLA-produces local analgesia of intact-skin for peripheral intravenous
	(IV) insertion-I for infants greater than or equal to 37-weeks gestational age.
B	—Gircumstances:
	1. Setting: Emergency Department
	2. Infants who should not receive EMLA-include:
	a. Infants than<37-weeks
	b. Infants under-the-age of twelve months who-are-receiving treatments with
	methemoglobinemia-inducing agents, such as sulfonamides, sulfones,
	acetaminophen, benzocaine, phenobarbital, phenytoin, nitrates, nitrites,
	nitroglycerin, nitroprusside-and co-trimoxazole (Bactrim-and-Septra).
	3. Evaluation of the need for immediate-emergent care intervention will occur prior to EML
	application.
	4. EMLA may have a dermal analgesia effect up to three hours under the occlusive
	dressing, as well as an analgesic effect lasting one to two hours after removal of
	dressing.
	5. Care needs to be taken to ensure that doses and areas of application (Table A) are not
	exceeded (especially in children-under-the age of three months) and limit-the period of
	application to minimum required to achieve the desired anesthesia.
	6. —Efficacy of EMLA Cream for heel lancing in neonates has not been demonstrated in
	studios.
	7. EMLA is not indicated for use on mucous membranes or in the ears.
<u></u>	Instructions for Application:
•	1. To measure 1 gram-of-EMLA, the cream should be gently squeezed out of the tube as a
	narrow strip that is 1.5 inches (3.8 cm) long and 0.2 inches (5 mm) wide. The strip of
	EMLA cream should be contained within the lines of the diagram-shown below.
	=-1-Gram-strip
	1.5-x 0.2 inches
	Use the number of strips that equals your dose, like the examples in the table below.
	Ose the number of strips that equals your dose, like the examples in the table below.
	Dosing-Information
	1 strip
	2 grams - 2 strips
	2.5 grams - 2.5 strips

PROCEDURE:

- A. Refer to Table A for maximum recommended dosages, application areas and times based on age and body-weight.
- B. Apply at least 60 minutes before procedure to skin site of-procedure.
- C. Apply a thick-layer-of-EMLA to skin site.
 - 1. Do not rub cream-into-skin.
 - 2. Cover with-occlusive dressing, TegadermTM, provided-with cream.

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Department of Emergency Medicine	Pharmacy and Therapeutics Committee	Interdiscipli nary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/09,-06/11, 08/16	01/11;11/13, 09/16	01/11;11/13, 09/16, 01/17	11/16, 05/17	06/11; 11/13, 07/17	06/11;1/14, 10/17	06/11; 2/14, 11/17	01/18	06/11; 2/14

Patient Care Services-Manual
Application Of Lidocaine 2.5% Prilocaine 2.5% Topical Cream (EMLA) Prior To Peripheral Intravenous Therapy
Page 2 of 3

3. Remove occlusive dressing immediately prior-to-procedure and wipe the EMLA off the skin-with-gauze.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN-license
- B. Education
- C. Initial-Evaluation: Education and competency demonstration-of-proper-administration
- D. Ongoing Evaluation: annually during Skills Lab.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform application of Lidocaine 2.5% Prilocaine 2.5% Topical Cream EMLA prior to peripheral intravenous therapy.

VI. REFERENCES:

- A. Young, T. MD, Mangum-B, PharmD. Neofax 2008 Twenty-First-Edition, 2008.
- B. Zenk, K. PharmD, Sills, J. MD, Koeppel R., RNC Neonatal Medications and Nutrition, 3rd Edition, 2003.
- ——— Micromedex ® Healthcare Series EMLA-Cream-(lidocaine 2.5%/Prilocaine 2.5%. AstraZeneca Manufacturer's-Product Literature, 2005.Lidocaine/Priolocaine. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available
 - at: http://www.migromedexsolutions.com. Accessed September 21, 2016.
- Zempsky WT: Optimizing the management of peripheral venous access pain in children: evidence, impact, and implementation. Pediatrics Nov, 2008; 122 Suppl 3: S121-S124.
- Zempsky WT: Pharmacologic approaches for reducing venous access pain in children. Pediatrics Nov, 2008; 122 Suppl 3: S140-S153.
- C. Zenk, K. PharmD, Sills, J. MD, Koeppel R., RNC-Neonatal Medications and Nutrition, 3rd Edition, 2003.

Table-A

EMLA CREAM MAXIMUM-RECOMMENDED DOSE, APPLICATION AREA, AND APPLICATION TIME BY AGE AND WEIGHT*

For-Infants-and Children Based on Application-to-Intact Skin

Age and Body Weight Requirements	Maximum Total	Maximum	Maximum
	Dose of EMLA	Application	Application
	Cream	Area**	Time
0-up to 3 months or <5 kg	1 g	10 cm²	1-hour
3 up to 12 months and >5 kg	2 g	20-cm²	4 hours
1 to 6 years and >10 kg	10 g	100-cm²	4 hours
7 to 12 years and >20 kg	20 g	200 cm²	4 hours

Please note: If a patient greater than 3 months old-does not meet the minimum weight requirement, the maximum total dose of EMLA-Cream should be restricted to that which corresponds to the patient's weight. *There are broad guidelines for avoiding systemic toxicity in applying EMLA Cream to patients with normal intact skin and with normal renal and hepatic function.

- ** For more individualized calculation of how much lidecaine and prilocaine may be absorbed, physicians can use the following estimates of lidecaine and prilocaine absorption for children-and-adults:
 - --The-estimated mean (±SD) absorption of lidocaine is 0.045 (±0.016) mg/cm²/hr
 - The estimated-mean-(±SD) absorption of prilocaine-is-0.077-(±0.036) mg/cm²/hr

An-I.V. antiarrhythmic dose of lidocaine-is-1-mg/kg (70 mg/70 kg) and gives a-blood-level of about 1 µg/mL.

Toxicity would be expected at blood levels above 5 µg/mL. Smaller areas of treatment-are recommended in a debilitated-patient, a small child or a patient-with-impaired elimination. Decreasing the duration of application is likely-to-decrease the analgesic effect.



PATIENT CARE SERVICES POLICY-MANUAL

ISSUE DATE: 05/09 SUBJECT: Care For Recalcitrant Children

REVISION DATE: 08/12 POLICY NUMBER: IV.TT

Department Approval: 44/1609/17

Clinical Policies & Procedures Committee Approval: 07/1212/1510/17

Nurse Executive Committee: 07/1201/1610/17

Medical Executive Committee Approval: 08/1202/1611/17

Professional Affairs Committee Approval: 08/1201/18

Board of Directors Approval: 08/12

A. PURPOSE:

1. To ensure minor patients are provided with appropriate resources to identify and treat behavioral and psychological challenges.

4.2. To ensure that a minor's behavior is appropriately and consistently managed by all healthcare providers so that-the minor will receive maximum benefit from all necessary intervention.

B. **POLICYPROCEDURE:**

- Healthcare providers requiring assistance to manage the behavior of inpatients will contact a California Children's Services (CCS) paneled Social Worker.
- 1. Every patient-ages-0-to-21-years old admitted to Tri-City Healthcare DistrictMedical Center (TCMCTCHD)-shall-be evaluated for persistent behavioral and/or psychological-difficulties:
 - a. Upon admission, the Registered-Nurse (RN) will begin to document any identified problems on the patient-admission assessment or patient history form.
 - b. Every discipline-that-interacts with the minor patient is to communicate their-findings-in the patient's chart-upon-identification of difficulties.
 - i. Nursing
 - ii. Physician
 - iii. Social Work
 - iv. Ancillary Staff: Pulmonary, Rehabilitation, etc.
 - c. Each discipline will also take into account the interactions between the minor patient and their parents/guardians.
- 2. The Social Worker who is a California-Children's-Services (CCS) paneled Social Worker-will assess the situation and develop a behavior management plan.
 - a. Meet with the patient/family and advise regarding the possible eligibility for CCS benefits
 - b. Provide the patient/family with the CCS application and assist with completion of the document
 - c. Provide the family with a list of the CCS special care centers and assist in making appointments
- 3. If a child has a condition that warrants a referral to a special care center, a referral should always be made to CCS. If you can get the appointment is before discharge (if the child is eligible), then an appointment with a paneled Medical Doctor will be arranged before discharge if possible.
- 4. Nurses who have determined their minor patient is at high risk for harm to self or others, shall notify the patient's physician immediately.
 - a. A psychiatric evaluation may be ordered at any time to be completed by the psychiatric liaison staff, especially where there are:
 - i.- Threats or warnings about hurting or killing oneself
 - ii. Threats or warnings about hurting or killing someone else

- For minor patients who need to be transferred to an inpatient child-or-adelescent psychiatric facility, the psychiatric liaison and social worker will collaborate to expedite the transfer.
- 5. Persistent and recurrent behavioral and/or other psychiatric difficulties may be identified as needing further assessment and outpatient treatment such as:
 - a. General inappropriate-or-oppositional behavior
 - b.- Learning disabilities
 - Violent or dangerous behavior
 - d. Mood-changes
 - e. Depression
 - Complicated-grief
- 6. All treatment disciplines are responsible to review the patient's treatment plan and strive to assist the patient to meet their goals. When caring for minor patients with behavioral and/or psychological difficulties, it is important to remember:
 - a. Always build on the positives, give the child praise and positive reinforcement when he/she shows flexibility or cooperation.
 - b. Take a time-out break if you are about to make the conflict-with your patient worse; not better. This is good modeling.
 - c. Support your patient-if-they-decide to take a time-out to prevent everreacting.
 - d. Since some children have trouble avoiding power struggles; prioritize the things you want the child to do (choose your battles.)
 - Set up reasonable age appropriate limits, but know they will be challenged. Be united as
 a health care team in being consistent with rules and boundaries.
 - f. Manage-your own stress with patients, recognizing that you are not their parent but their health care advocate.
- 7.3. Referrals to approved facilities authorized by the patient's insurance shall be given to the parents and/or guardian for follow-up. This may include either inpatient or outpatient resources.

C. ATTACHMENTRELATED-DOCUMENT(S):

- Appendix A: Specific Behavioral and/or Psychological Problems Requiring Outpatient Referral
- ... Appendix B: Adolescent Substance Abuse Treatment Facilities
- 3. Rady Children's Hospital San-Diege: Institute of Behavioral Health

D.C. REFERENCE(S):

 The American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.W., Washington D.C. 20016-3007, www.aacap.org.

Specific Behavioral and/or Psychological Problems Requiring Outpatient Referral

Appendix A Specific Behavioral and or Psychological Problems Requiring Outpatient Referral

General inappropriate or oppositional behavior

Related to Children

- · Marked fall in school performance.
- · Poor grades in school despite trying very hard.
- Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in
 activities that are normal for the child's age.
- Hyperactivity; fidgeting; constant movement beyond regular playing.
- · Persistent nightmares.
- Persistent disobedience or aggression (longer than 6 months) and provocative opposition to authority figures.
- Frequent, unexplainable temper tantrums.

Related to Pre-Adolescents and Adolescents

- · Marked change in school performance.
- Inability to cope with problems and daily activities.
- · Marked changes in sleeping and/or cating habits.
- Frequent physical complaints.
- Sexual a
- Depressi

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panied by

- poor app
 Abuse of alcohol and/or drugs.
- Intense fear of becoming obese with no relationship to actual body weight, purging food or restricting eating.
- Persistent nightmares.
- Threats of self-harm or harm to others.
- Self-injury or self-destructive behavior.
- Frequent outbursts of anger, aggression.
- Threats to run away.
- Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism.
- Strange thoughts, beliefs, feelings, or unusual behaviors.

Oppositional Behaviors

- · Frequent temper tantrums
- Excessive arguing with adults
- · Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- · Frequent anger and resentment
- Mean and hateful talking when upset
- Seeking revenge

Learning disabilities

- Difficulty understanding and following instructions.
- · Trouble remembering what someone just told him or her.
- · Fails to master reading, spelling, writing, and/or math skills, and thus fails
- Difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").

- Lacks coordination in walking, sports, or small activities such as holding a pencil or tying a
- Easily loses or misplaces homework, schoolbooks, or other items.
- Cannot understand the concept of time; is confused by "yesterday, today, tomorrow."

Potentially violent or dangerous behavior

- Threats to run away from home
 Threats to damage or destroy property
- Past violent or aggressive behavior (including uncontrollable angry outbursts)
- Access to guns or other weapons
- Bringing a weapon to school
- Past suicide attempts or threats
- Family history of violent behavior or suicide attempts
- Blaming others and/or unwilling to accept responsibility for one's own actions
- Recent experience of humiliation, shame, loss, or rejection
- Bullying or intimidating peers or younger children
- A pattern of threats
- Being a victim of abuse or neglect (physical, sexual, or emotional)
- Witnessing abuse or violence in the home
- Themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork
- Preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and Internet sites
- Mental illness, such as depression, mania, psychosis, or bipolar disorder
- Use of alcohol or illicit drugs
- Disciplinary problems at school or in the community (delinquent behavior)
- Past destruction of property or vandalism
- Cruelty to animals
- Fire setting behavior
- Poor peer relationships and/or social isolation
- Involvement with cults or gangs
- Little or no supervision or support from parents or other caring adult

Significant mood changes in the pre-adolescent and adolescent

- Severe changes in mood-cither unusually happy or silly, or very irritable, angry, agitated or aggressive
- Unrealistic highs in self-esteem for example, a teenager who feels all powerful or like a superhero with special powers
- Great increase in energy and the ability to go with little or no sleep for days without feeling tired
- · Increase in talking the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- Distractibility the teen's attention moves constantly from one thing to the next
- Repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depression:

- Irritability, depressed mood, persistent sadness, frequent crying
- Thoughts of death or suicide
- Loss of enjoyment in favorite activities
- Frequent complaints of physical illnesses such as headaches or stomach aches
- Low energy level, fatigue, poor concentration, complaints of boredom
- Major change in cating or sleeping patterns, such as oversleeping or overcating
- Frequent sadness, tearfulness, crying

- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- · Persistent boredom; low energy
- Social isolation, poor communication
- · Low self esteem and guilt
- · Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- · Thoughts or expressions of suicide or self destructive behavior

Complicated grief:

- An extended period of depression in which the child loses interest in daily activities and events
- · Inability to sleep, loss of appetite, prolonged fear of being alone
- Acting much younger for an extended period
- · Excessively imitating the dead person
- Repeated statements of wanting to join the dead person
- · Withdrawal from friends, or
- Sharp drop in school performance or refusal to attend school

Adolescent-Substance-Abuse-Treatment-Facilities

ADOLESCENT SUBSTANCE ABUSE TREATMENT FACILITIES

PHOENIX HOUSE OF CALIFORNIA

23981 Sherilton Valley Road Descauso, CA 91916 (619) 445-0405

Both day and residential programs offer treatment, education,

family and group therapy 13 to 17 yrs of age

Variable fees, sliding scale from \$15-\$2653/mth, and private

Adolescent Day Program: 684 Requeza Street Encinitas, CA 92024 (760) 634-7610

Adolescent Residential Program 23981 Sherilton Valley Road Descanso, CA 91916 (619) 445-0405

12 to 15 months with full-time school program.

MCALISTER INSTITUTE

El Cajon and at: 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2743 Residential program up to 21 d 12 to 17 yrs of age. Appt need Sliding scale and ability to pay

AURORA SAN DIEGO HOSPITAL

11878 Avenue of Industry San Diego, CA 92128 (888) 565-4228

Programs include: Outpatient program, 3 days/week. Acute inpatient detox and Partial program offers full time school where student can earn credits.

Private insurance or private pay accepted.

CRASH SOUTH CITY

220 N. Euclid, Suites 120 & 130 San Diegn, CA 92114 (619) 263-6663 Outpatient program, county funded, and sliding scale.

SHARP MESA VISTA HOSPITAL

7850 Vista Hill Avenue San Diego, CA 92123 (858) 278-4110 Outpatient, Partial hospitalization and in-patient programs. Must call for assessment and program placement. 17 yrs and younger

Medi-cal, private insurance, military and private pay

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MITE (Affiliated with McAlister Inst.)

2964 Oceanside Blvd., Snite G Oceanside, CA 92054 (760) 754-1393

Outpatient treatment program offers treatment, education, group and individual therapy. They also offer screening for residential program. Program is 3 to 6 months long for youth

between 12-17 yrs of age.
Call ahead for appt. Orientation held 2x/week. Program fees vary and also based on sliding scale.

AA TEEN MEETINGS (adolescents to early 20's)

Young Peoples 1430 N. Hwy 101 Leucadia, CA 7:30 pm on Fridays

Young Peoples 839 2 Street Encinitas, CA 4pm on Sundays Tri-City Medical Center

4002 Vista Way Oceanside, CA 7:30 pm on Saturdays Assembly Rm. 2 & 3

YOUTH TO YOUTH HELPLINE

General Youth Resources (866) 222-1886 Open Mon-Fri from 3pm-9pm (858) 626-4403 for Intake (800) 382-4357 for information

The outpatient program is a 12-week course of treatment. They meet three days (nine hours) per week. Sessions are conducted after school during the academic year and throughout the day during summer vacation. Program offers education and support to families.

Age: Adolescents to 18 yrs of age. Please call for program fees.

MIRA MUSA TEEN CENTER

10737 Camino Ruiz, Suite 114 San Diego, CA 92126 (858) 578-2492 Outpatient program for 12-17 yr olds. Appt required.
Sliding scale and ability to pay.

SAN DIEGO YOUTH & COMMUNITY SERVICES/TEEN RECOVERY CENTER

3660 Fairmount Avenue San Diego, CA 92105 (619) 521-2250

Day treatment program with case management and counseling.

14 to 21 yr olds. Phone and walk-ins accepted. Variable fee for other services. Med-cal accepted.

Rady-Children's Hospital - San Diego: Institute of Behavioral-Health

Rady Children's Hospital - San Diego 3020 Children's Way San Diego, CA 92123 (858) 576-1700

Institute of Behavioral Health

The Rady Children's Institute of Behavioral Health is unique because it provides comprehensive mental health and psychosocial services to children and their families within a full-service pediatric medical facility. Its state-of-the-art, cost-effective clinical programs also are available at outpatient clinics throughout the county. Call (858) 966-5832 for more information.

The Institute features:

Therapy/Outpatient Psychiatry

Outpatient psychiatric services at multiple sites including including diagnostic evaluations, medication evaluations and treatment including play therapy, group therapy, family therapy, and parent intervention. The staff is bilingual and bicultural. Emergency and crisis intervention is available 24 hours a day through Rady Children's Emergency Department.

Chemical Dependency and Eating Disorders

Special programs are available for adolescents in areas such as chemical dependency, eating disorders and phobias.

Learning	Disabilities	nd Developmental Delays

The Institute has extens

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for: to

 Autism -- provid appropriate priv

through a parent group.

- Learning Disabilities -- evaluation of children for problems contributing to poor school
 performance and helps parents access appropriate education support. Also assesses kindergarten
 readiness.
- Developmental Delays -- evaluates infants and children for significance of developmental delays and helps parents access specific and appropriate intervention services.
- Attention Deficit Hyperactivity Disorder assesses attentional problems such as inattention, impulsivity, and overactivity as it relates to school difficulties and family stress. Referrals for medical/behavioral management and special school programs when indicated. For more information on ADHD, please see the San Diego ADHD Website.

Mental Health

Mental health services are available at our <u>neighborhood centers</u> in Serra Mesa, Oceanside, El Cajon, San Diego, La Mesa and through the San Diego School System.



PATIENT CARE SERVICES

ISSUE DATE: 12/01 SUBJECT: DOCUMENTATION IN THE

MEDICAL RECORD

07/1602/17

REVISION DATE: 06/03, 12/03, 02/04, 08/04, 01/05, POLICY NUMBER: IX.I

02/07, 07/10, 08/12

Department Approval:

Clinical Policies & Procedures Committee Approval: 07/1610/17

Nursing Executive Committee Approval: 07/1610/17

Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval:

08/4611/17

Professional Affairs Committee Approval:

09/4601/17

Board of Directors Approval: 09/16

A. PURPOSE:

1. To maintain documented information for each patient that is accurate, timely, legible, readily accessible, and is performed by authorized personnel.

 To ensure the medical record contains sufficient information to identify the patient, support the diagnosis, plan of care, continuity of care justify treatment and document the course and outcome of treatment.

B. DEFINITION(S):

- Activity View: A set of clinical data elements related to a specific activity that may include required documentation elements.
- 2. Annotation: Ability to add a comment to documentation.
- 3. Authentication: Review process of documentation completed by a student or other caregiver requiring review by a licensed staff or instructor.
- 4. Carry forward functionality: fields which bring forward the last charted data.
- 5. Clinical Range Bar: Indicates the date range of displayed information.
- 6. CPOE: Computerized Provider Order Entry.
- 7. Duplicate Results: Allows clinician in Iview to copy and paste data to a different time column for review and signing.
- 8. Edit Fields: The ability to modify or delete documented fields.
- 9. EHR: Electronic Health Record
- 10. Encounter: Each patient visit/admission is assigned a Financial (FIN)/encounter number.
- 11. Erasing fields: To delete or "unchart" information placed in a current field currently or from a carry forward function.
- 12. Iview: An interactive view for clinical documentation that allows direct charting.
- 13. MAR: Medication Administration Record.
- 14. Patient Access List (PAL)/Care Compass: An interactive screen available to the nursing staff to view and perform patient care tasks by selecting icons, which launch a form or screen for completion of the task.
- 15. PowerForm: Electronic forms with one or many sections. Each section provides data entry options for documenting assessments, procedures, and other patient care events.
- 16. Task List: An electronic list of tasks or reminders within a specified time frame that may be attached to a form or activity.

C. POLICY:

- 1. Documentation is the primary communication medium. Each practitioner is responsible for accurate documentation of care provided. All entries manual or computerized are permanent.
- 2. Documentation will be complete and reflect patient specific care, support the medical diagnosis, course of treatment, and Plan of Care.
- Documentation shall be efficient with minimal to no duplication of charting.
- 4. Documented patient information must be readily accessible to all providers rendering care.
 - a. For management of patient's medications information includes:
 - i. Age
 - ii. Sex
 - iii. Diagnosis
 - iv. Sensitivities
 - v. Current medications
 - vi. Height and weight
 - vii. Pregnancy and lactation information (as applicable)
 - 4.viii. Lab results
- 5. Documentation in the Medical Record shall include key components such as:
 - a. The patient's initial admission information, transfer information, and discharge summary, with a full and accurate description of the patient's condition and responses at the time.
 - b. Any change in the patient's condition.
 - c. A record of communication with physicians, patient or family.
 - d. Upon discharge, clear documentation of understanding of all discharge education and instructions to patient/responsible party.
 - e. When an unexpected event occurs, complete the following:
 - Document the facts of occurrence in the Medical Record and complete an incident report/quality review report.
 - ii. Do not document or reference that an incident report/quality review report has been completed in the medical record (See Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275).
- 6. Documentation in the patient's record shall be complete, factual, accurate, and legible.
 - a. When charting on paper, do not pre-date or back date patient information. (See Late Entry into the Medical Record).
 - i. In the manual record, document on the next available space.
 - Do not skip lines
- 7. Tri-City Healthcare District (TCHD) care providers shall document in Cerner when online documentation forms/screens/IView bands are available.
 - a. Exceptions to the practices are areas using paper flow sheets or other hard chart forms. Refer to unit specific policies and procedures.
 - b. Powerforms shall be accessed from the task or Care Compass when available. If not available on the task list or via Care Compass, access the forms from AdHoc. Some of the Powerform titles may vary slightly to indicate a patient or area specific document.
 - c. All access and documentation in Cerner shall be reflected by the user identification.
 - d. Each user must define/update an encounter relationship to access a patient's chart.
 - i. Some positions are assigned a default relationship.
- e. Users are required to use only their log-on to document in the patient's record.
- 8. Documentation shall be timed and dated to reflect the actual time events occurred.
 - a. It is recommended that all shift assessments, reassessments, as the occasion arises (PRN) assessments, and/or care provided be documented after completion of the care in a timely manner.
 - b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity document the patient care and assessment as soon as reasonably able to do so.

- c. Activity Views in IView will be used to help guide required data documentation for key assessments and reassessments.
- d. Reasonable and timely manner may be defined as within **four (4)** hours after completion of assessments or care provided or as defined in unit specific policies and/or procedures.
- e. Discharge documentation must be completed within four hours of discharging the inpatient.
- 9. Documentation in the patient record shall not include:
 - Issues affecting credibility, including inconsistency in documentation, contradiction or blaming of other practitioners.
 - b. Issues affecting professionalism, including intentional documentation of inadequate care, unprofessional verbal communications among practitioner, judgment or emotional statements about patients or their families, or "sloppy" charting practices in the manual chart (squeezing in an entry where there is not adequate space, or charting in advance of an intervention or treatment).
 - c. Issues which imply information or events are being hidden (i.e., obliterating a chart entry [{in the manual chart}], or failure to document an untoward event, such as a fall or change in vital signs).
 - d. Duplication of results in IView.
- 10. Late entry into the Medical Record (See: Patient Care Services (PCS) Procedure: Medical Record, Making Corrections in Documentation).
 - a. When a pertinent entry is missed or not written/entered into the electronic health record (EHR) in a timely manner, a late entry shall be documented in the Medical Record.
- 11. If an entry is made for another practitioner (by proxy), the entry must include the original practitioner's name and reason for proxy entry.
 - a. Name of person making revision, date and time of entry and practitioner's (proxy's) unique log-on will be tracked by the system.
- 12. Refer to departmental specific documentation procedures for unit or departmental documentation requirements.
- 13. Refer to Patient Care Services Policy: Cerner Downtime for specific downtime documentation requirements.
- 14. Authenticating documentation is a process for authenticating the person, identified by name and relationship (discipline), who is responsible for ordering, providing or evaluating a clinical service rendered to a patient.
 - a. The TCHD health care provider shall authenticate information entered into a powernote, powerform, IView or clinical note by students.
- 15. The following are authorized to document in the Medical Record:
 - a. Advanced Care Technician (ACT)
 - b. Audiologist
 - c. Behavioral Health Liaison (BHL)
 - d. Case Managers
 - e. Certified Nurse Midwife (CNM)
 - f. Chaplain
 - g. Clinical Nurse Specialist (CNS)
 - h. Dentist
 - i. Department Specific Technologist (i.e., Cath Lab, Cardiology, Radiology, etc.)
 - i. Dietician
 - k. Doctor of Osteopathic Medicine (DO)
 - I. Dosimetrist
 - m. Technician
 - n. Interpreter
 - o. Lactation Consultant
 - p. Licensed Vocational Nurse (LVN)

p.q. Lift Team

q.r. Marriage Family Therapist (MFT)

F.s. Marriage Family Therapist Intern

e.t. Medical Assistant

t.u. Doctor of Medicine (MD)

u.v. Medical Physicist

₩.w. Mental Health Worker (MHW)

w-x. Monitor Technicians (MT) per unit specific policy

x.y. Neurophysiologist

y.z. Nursing Instructor

z.aa. Nurse Practitioner (NP)

aa.bb. Nursing Assistant (NA)/Certified Nursing Assistants (CNA)/Student Nurse Technician

bb.cc. Organ Procurement Representative

cc.dd. Orthopedic Assistant

dd.ee. Ophthalmologist

ee.ff. Pharmacist

ff.gg. Physical/Occupational/Speech/Recreational Therapist (PT/OT/ST/RT)

gg.hh. Physician's Assistant (PA)

hh.ii. Podiatrist

ii-jj. Psychologistjj-kk. Respiratory Care Practitioner (RCP)

kk. Recreational Therapist (duplicate of ff above)

II. Registered Nurse (RN)

mm. Research Coordinator (credentialed by TCMCHD Medical Staff)

nn. Resident Physician

oo. Social Worker

pp. Student in approved clinical rotation.

qq. Transcriptionist

qq.rr. Transporter

rr.ss. Unit Secretary

se.tt. Contracted services that have completed the process as outlined in the Administrative Policy: Non-TCHD Workers' Orientation and Identification Badge Process 8610-451.

D. <u>RELATED DOCUMENT(S):</u>

- Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275
- 2. Administrative Policy: Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees 8610-451
- 3. Patient Care Service: Cerner Downtime Policy
- 4. Patient Care Services: Medical Record Making Corrections to Documentation Procedure



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 08/07 SUBJECT: Family Centered Care –

Pediatrics/Adolescents

REVISION DATE: 01/08, 04/09; 06/11; 087/14 POLICY NUMBER: IV.MM

Department Approval: 06/17

Clinical Policies & Procedures Committee Approval: 07/1407/17

Nursing Executive Council Approval: 07/1407/17

Department of Pediatrics Approval: 07/1411/17

Professional Affairs Committee Approval: 08/1401/18

Board of Directors Approval: 08/14

A. PURPOSE:

1. Create a healing relationship with families at all levels of care that focuses on the developmental, physical, and social needs of the patient and family.

B. **DEFINITION(S)**:

- 1. Family Centered Hospital: Families are involved in and empowered to care for their children's well-being. Family-centered care designates the family as the key decision-maker. To aid parents in making appropriate decisions, healthcare professionals collaborate and share information with families on an ongoing basis.
- 2. Adolescent population is defined as ages 14 through 20.

B.C. POLICY:

- 1. All members of the health care team are responsible for the promotion of family centered care.
- To achieve family-centered care:
 - Tri-City Healthcare District (TCHD)We respects families and their pivotal role in promoting the well-being of their children.
 - b. We-TCHD recognizes families as the constant factor in the life of the child and the family as an intrinsic part of the health care team.
 - c. We-TCHD recognizes that service systems and personnel are episodic.
 - d. Families may collaborate with staff to guide decisions regarding care patterns and day-to-day activities.
- Relationships between families and healthcare providers are fostered by encouraging family
 members to participate in the direct care of the child and participate in decision-making
 regarding the child's care.
- 4. Healthcare team members make families feel comfortable both physically and emotionally throughout their Pediatric/Adolescent experience, and nurture their role as principal caregivers.
- 5. Hospital staff/personnel are educated on the benefits of enhanced family interaction to ensure optimal physical care and emotional outcomes for our hospitalized children and their families.

C. DEFINITIONS:

- 1. Family Centered Hospital: Families are involved in and empowered to care for their children's well-being. Family-centered care designates the family as the key decision maker. To aid parents in making appropriate decisions, healthcare professionals collaborate and share information with families on an engoing basis.
- Adolescent population is defined as age 14 through age 20.

D. FAMILY INVOLVEMENT:

 Collaboration and sharing information with families is ongoing. Families will be provided with accessible support services that may include educational, ethical, financial, and community resources.

E. PROCEDURE:

- 1. Physical Accommodations and Family Resources:
 - a. Provide maps with directions to hospital and information about alternative transportation options, parking provisions, and hospital entry access to facilitate visitation-te.
- 2. Provide hospital/unit orientation as appropriate to include:
 - a. Printed information regarding family participation in care
 - b. Visiting policy
 - c. Telephone calls by parents if unable to be at the bedside
 - d. Support services
 - e. Food service
 - f. Automated Teller Machine
 - g. Family library/resource center with a variety of textbooks, articles, videotapes and internet access.
- 3. A private space shall be provided for families to meet with caregivers for consultation or family discussions.
- 4. Healthcare personnel are welcoming and reassuring to each family member that visits.

 Opportunities that reinforce the importance of the family's role in the care of their child/adolescent are encouraged and provided. Opportunities are provided for families to ask questions about their pediatric/adolescent experience and share concerns that may arise.

F. FAMILY INVOLVEMENT/ATTACHMENT:

- 1. Encourage parents to participate in all aspects of the patient's care. Elicit their perception of goals and needs.
- Parents are treated as full members of the health care team.
- 3. Parents have accessibility to the child/adolescent 24 hours a day including during procedures, rounds, and end-of shift-reports.
- 4. Continual, open and honest communication about medical, psychosocial and ethical issues relevant to the child and family are fostered.
- 5. Family members may stay with patients as appropriate.
- 6. Provide information on what parents may expect during procedures and encourage participation when possible.
- 7. Inform families of patient's/parent's rights and responsibilities.
- 8. Provide explanations and access to educational materials concerning the child's medical and nursing care.
- 9. The roles and activities of participating disciplines and the parents are incorporated into the plan of care.
- 10. Staff shall encourage families to read and educate themselves regarding their child's medical condition.
- 11. Families are encouraged to become actively involved in the preparation for discharge.
 - a. Parents are encouraged and informed of the process available to provide feedback through hospital survey as well as the follow-up telephone survey.

G. FORMS WHICH CAN BE FOUND ON IN THE INTRANET:

- 1. Bill of Rights for Children and Teens
- 2. Bill of Rights for Parents
- 3. Family Responsibilities

H.G. REFERENCE(S):

- 1. Advances in Family-Centered Care. (2003). Collaborating with Patients and Families to Improve Quality and Patient Safety. Vol. 9 No.1
- 4.2. Byczkowski, Terri, et al. (2016). Family-Centered Pediatric Emergency Care. *Academic Pediatrics*, 16 (4) pp. 327-35.
- 2.3. The Advisory Board. (2003). The Family As Patient Care Partner.
- 4. Lewandowski, L., Tesler, Mary D. (2003). Family-Centered Care: Putting It Into Action. The SPN/ANA Guide to Family -Centered Care.
- 3.5. Smith, Joanna, et al. (2015). Involving Parents in Managing Their Child's Long-Term Condition A Concept Synthesis of Family-Centered Care and Partnership-In-Care. *Journal of Pediatric Nursing*, 30 (1), pp. 143-59.

Tri-City Medical Center		Patient Care Services	
PROCEDURE:	HIGH LEVEL DISINFECTION		
Purpose:	To disinfect semi-critical patient ca	re equipment between uses	
Equipment:	Personal protective equipment (glo simple surgical mask) Container with enzymatic detergen Sponge or soft, lint-free cloth Brush Cidex ortho-phthalaldehyde (OPA) Tap Water Sterile Water 70% isopropyl alcohol or equivalen		

A. DEFINITION(S):

- 1. Critical equipment: items that enter sterile tissue or the vascular system and must be sterile when used (i.e., surgical instruments, implants and needles).
- Semi-critical equipment; items that come in contact with non-intact skin or mucous membranes, should receive a minimum of high-level disinfection (i.e. vaginal and rectal probes, respiratory therapy equipment, bronchoscopes, gastrointestinal endoscopes and accessories).
- 3. Non-critical equipment: items that come into contact only with intact skin and should receive intermediate level disinfection, low-level disinfection or cleaning (i.e. tourniquets, blood pressure cuffs).
- 4. High Level Disinfection (HLD):
 - a. The destruction of all forms of microbial life, except large numbers of spores
 - b. Used for reprocessing semi-critical patient care items
 - Can be done on lumuned and other submersible-items in an automated reprocessor
 - c. Manual soaking must be done on items that cannot be totally submersedMay be accomplished via an automated reprocessor or manual soaking in a high level disinfecting agent. The method of HLD for each piece of equipment shall be selected based on manufacturer's instructions for use (IFU).
- 3.5. Pre-Cleaning: Pre-cleaning is the first and most important step in removing the microbial burden from an item. Retained debris may inactivate or interfere with the capability of the active ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.

B. POLICY:

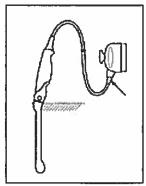
- The department manager has the responsibility to oversee the High-Level Disinfection (HLD) process in his/her department with consultation from Infection Prevention.
- 2.1. High level disinfection:
 - a. The destruction of all forms of microbial life, except large-numbers-of-spores
 - b.a. Used for reprocessing semi-critical patient care items
 - ca. Can be done on lumuned and other-submersible items in an automated represessor
 - Manual soaking must be done on items that cannot be totally submersed.
- 2. The following staff are authorized to perform high-level disinfectionHLD-outside of the Sterile Processing area including but not limited to:
 - 3.a. Sterile Processing Technicians
 - a.b. Endoscopy Registered Nurses (RN's)
 - c. Respiratory Therapists.

Department Approval	Clinical Policies & Procedures	Nurse Executive Council	Medical Staff Department/Divici en Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
02/06, 05/07, 06/09, 09/11, 08/12, 04/15, 06/17	08/12, 06/15, 12/16, 07/17	08/12, 07/15, 01/17, 07/17	07/15, 04/17, 10/17	10/12, 07/15, 05/17, 11/17	11/12, 08/15, 01/18	12/12, 08/15

- b.d. Equipment Respiratory Technician
- e.e. Ultrasound Technicians
- d.f. Cardiology Technicians
- e. Anesthesia Technicians
- f.g. Endoscopy Technicians
- g.h. Surgical RN's
- h. Surgical Technicians-
- 4.3. Education, Training, and Competency Validation:
 - a. Initial:
 - i. An orientation and training program will be provided to all staff prior to performing High-Level-DisinfectionHLD. Clinical educators, clinical managers, or any other competent staff member will provide this training. Competency Validation of eempetence-will be accomplished through individual return demonstration of skills. Competency records will be maintained in unit specific staff files.
 - b. Annual:
 - All staff performing HLD will complete an annual Computer Based Learning (CBL) module.
 - ii. Staff who perform HLD will complete an annual competency.
 - 1) Additional training will be provided on an as needed basis

C. PROCEDURE:

- 1. Pre-cleaning equipment according to manufacturer's instructionsiFU. General guidelines for pre-cleaning include:
 - a. Don personal protective equipment
 - b. Remove the item from the patient, immediately wipe the insertion tube with the wet cloth or sponge soaked in an enzymatic or detergent solution (commercially packaged or freshly prepared). Discard the cloth/sponge after use.
 - i. Pre-cleaning is the first and most important step in removing the microbial-burden from an item. Retained debris may inactivate or interfere with the capability of the active-ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.
 - c. Suction the enzymatic/detergent solution through the all channels.
 - d. Transport the item to the reprocessing area in an enclosed container with a Biohazard label. Reprocessing should occur in a room separate from the procedure room.
- 2. Cleaning equipment according to manufacturer's instructionsIFU. General guidelines for cleaning include:
 - a. Follow manufacturer's instructions.
 - b.a. Don personal protective equipment
 - e.b. Fill a sink or basin with freshly made-prepared solution of water and a low-sudsing enzymatic detergent compatible with the item.
 - Dilute and use according to the detergent manufacturer's instructionsIFU.
 - ii. Fresh detergent solution should be used for each item to prevent crosscontamination.
 - iii. Low-sudsing detergents are recommended such that the device can be clearly visualized during the cleaning process to preclude personnel injury and to allow for complete cleaning of surfaces. Excessive sudsing can inhibit good fluid contact with the device surfaces.
 - d.c. Leak test equipment according to manufacturer's instructionsIFU.
 - e. Perform manual-cleaning-of-equipment-according to manufacturer's instructions.
 - i.d. Immerse the item.
 - 4)i. EXCEPTION: Non-immersible probes shall only be immersed up to the connector (for example see diagram below)



- ii.e. Wash all debris from the exterior of the item by brushing and wiping the instrument while submerged in the detergent solution. Whenever practical, leave the item submerged in the detergent solution when performing all subsequent cleaning steps. Note that the item should be left under water during the cleaning process to prevent splashing of contaminated fluid.
- iii.f. Use a small, soft brush to clean all removable parts. Use non-abrasive and lint-free cleaning tools to prevent damage to the item.
- iv.g. Clean all non-removable, non-submersible parts according to manufacturer's instructionsIFU.
- v-h. Continue brushing until there is no debris visible on the brush-as-needed.

 1)i. Dispose of single-use brushes after each use.
- vi.i. Soak the item for the period of time specified by the label of the enzymatic detergent. If, due to time constraints, it is not possible to complete the reprocessing immediately, the item should be brushed and allowed to soak in a detergent solution until it can be thoroughly reprocessed. Follow manufacturer's recommendationsIFU for the maximum liquid exposure time.
- f.3. Rinse equipment after cleaning, according to manufacturer's instructionsIFU.
 - i-a. Thoroughly rinse the item with clean water to remove residual debris and detergent.
 - ii.b. Dry the exterior of the item with a clean soft, lint-free cloth to prevent dilution of the liquid chemical germicide-HLD agent used in subsequent steps.
- g. Follow manufacturer's instructions for High Level Disinfection using an Automated-Endoscope Reprocessor (AER), or perform manual High-Level Disinfection.
- 3.4. Manual-High-Lovel-DisinfectionPerform HLD according to manufacturer's instructionsIFU. HLD may be performed by the following methods:
 - a. Automated Endoscope Reprocessor (AER)
 - i. Follow manufacturer's instructions IFU for HLD and AER operation.
 - b. Hydrogen Peroxide-Based HLD Agent (i.e., Trophon) for endocavity probes:
 - i. Don personal protective equipment.

Pre clean the probe by using an enzamatic cleaner

One gallon of water, push button on enzamatic cleaner that is premeasured, soak for one minute

Rinse-probe

Ensure that the probe is clean and free of all visible debris, gel or other soil Dry-the probe

- ii. Load the clean and dry probe into the Trophon Endocavity Probe Reprocessor (EPR)
- iii. Ensure that the probe is secured high in the chamber with tip of probe above the embossed line
- iv. Place the new red-Trophon Chemical indicator into the indicator holder with red side facing up
- v. Close the chamber door
- vi. Confirm that the probe is both clean and dry, if YES, press start

- vii. At the end of the seven minute HLD cycle, Trophon screen will state "cycle complete remove and wipe the probe"
- viii. Wear newDon clean gloves
- ix. Open the chamber door
- x. Remove the chemical indicator and check the chemical indicator chart on the chemical indicator carton. Discard the chemical indicator after verifying a positive reading.
- xi. Remove and wipe the probe using a dry single use cloth
- xii. Close the chamber door
- xiii. Record the HLD cycle on the log
- c. Manual HLD:
 - e.i. Use Cidex OPA directly from the manufacturer's original container, and no activation is required.
 - i.ii. Expiration Dating:
 - 1) Cidex OPA has a <u>14 day reuse life</u> once it has been poured into a secondary container (soaking basin/tray).
 - a) Record the date Cidex OPA was poured into the secondary container and the expiration date on: the lid(s) of the basin(s)/tray(s) and on the Cidex OPA Log Sheet for each basin/tray used.
 - 2) Any Cidex OPA that remains unused in the manufacturer's original container is good for 75 days from the date the that-its-container is opened. Record the date that-the container was opened directly on the container.
 - ii-iii. Temperature Recording:
 - 1) When the Cidex OPA has been poured into a secondary container, record (on Cidex OPA Log Sheet) the temperature each time the Cidex OPA is used. Temperature must be 68° F or higher for manual disinfection.
 - iii.iv. Minimum Effective Concentration (MEC) Testing:
 - Cidex OPA must be tested prior to <u>each</u> use (test each time a new set of instruments / devices is placed in soaking basin / tray) for appropriate concentration using Cidex OPA Test Strips.
 - 1)a) Test each time a new set of instruments / devices is placed in soaking basin / tray.
 - 2) Cidex OPA Test Strips are good forexpire 90 days after the test strip container is opened.
 - a) Label test strip container with date opened and expiration date.
 - b) Tightly re-cap test strip bottle after each use.
 - 3) Completely submerge the indicating pad of the test strip in the Cidex OPA.
 - 4) Hold the test strip in the solution for 1 second, and then remove the test strip.
 - a) Do not swirl the strip.
 - 5) Remove excess solution from the test strip by standing the strip upright on a paper towel.
 - 6) Read the results in 90 seconds. Do not read past 90 seconds. Pad will be completely purple to indicate effective solution.
 - 7) If any blue remains on the indicator pad apart from the top line, solution is ineffective and must be discarded.
 - 8) Record results (Pass or Fail), on the Log Sheet.
 - iv.v. Quality Control of Test Strips:
 - 1) Cidex OPA test strips must be tested for efficacy each time a new container of test strips is opened. Repeat the quality control testing of the

test strips at 30 days and 60 days, if the container is still in use. Results must be recorded on the Cidex OPA Log. Testing is earried eutcompleted as follows:

- a) Open new bottle of test strips and record lot # on Cidex OPA Log Sheet.
- b) Open a container of Cidex OPA.
- c) Dilute one part Cidex OPA solution with one part tap water.
 e)i) Example: one ounce Cidex OPA to one ounce tap water.
- d) Submerge 3 Cidex OPA test strips in undiluted Cidex OPA solution and 3 Cidex OPA test strips in the diluted Cidex OPA solution for 1 second. Remove the test strips and read the results in 90 seconds.
- e) The test strips that were placed in the full strength Cidex OPA should turn purple. The test strips in the diluted Cidex OPA will either remain the same or have an incomplete color change. Refer to the color chart.
- f) Record the test results on the Cidex OPA log sheet.
- g) If the test strips fail the test, repeat the test with fresh Cidex OPA solution and test strips from another bottle. If they fail, notify Materials Management. Return the test strips to Materials Management and re-order test strips.
- d.vi. Immerse the item in a container of Cidex OPA.
 - **EXCEPTION:** Non-Immersable probes shall only be immersed up to the connector.
 - ii.2) The container must be of a size to accommodate the item without overflowing, and must be used in conjunction with a device to contain the chemical vapors.
 - To prevent damage to the item, the item should not be soaked with other sharp instruments that could potentially damage the item.
 - iv.4) Complete microbial destruction cannot occur unless all surfaces are in complete contact with the chemical.
 - **4.5)** Use the Cidex OPA in a device used to minimize chemical vapor exposure. Note that:
 - 4)a) Exposure to chemical vapors may present a health hazard.
 - 2)b) The reprocessing area should have engineering controls to ensure good air quality.
 - vi.6) Soak the item in the Cidex OPA for the time/temperature required to achieve HLD. Use a timer to verify soaking time. Document device and time. Cidex OPA requires 12 minutes minimum at room temperature.
- e-vii. Rinse After Disinfection:
 - i-1) Thoroughly rinse all surfaces of the item with copious amounts of clean water (2 gallons per rinse). Repeat rinsing with fresh rinse water for a total of 3 times.
 - 4)a) Tap water is acceptable for non-endoscopic devices.
 - 2)b) Use sterile water or filtered potable water for endoscopic devices.
 - 3)c) Rinsing prevents exposure and potential injury of skin and mucous membranes from chemical residue.
 - 4)d) Fresh water should be used for each item and each rinse.
 - 5)e) The device should be totally immersed for a minimum of 1 minute with each rinse.
 - 6)f) Discard rinse water for each rinse. Do not reuse water for any other purpose.

- a. Wipe item with clean cloth to remove residual moisture and flush channels with pressurized air.
 - i. Bacteria such as *Pseudomonas aeruginosa* have been identified in both tap and filtered water, and may multiply in a moist environment.
 - ii. Wipe item with alcohol per manufacturer's instructionsIFU for use
 - 1) 70% isopropyl alcohol is used to assist in drying of surfaces.
 - Use alcohol that has been properly stored in a closed container between uses. Alcohol rapidly evaporates when exposed to air, and cannot be relied upon to assist in the drying process if below the recommended percentage level.
 - 3) AER may automatically perform alcohol flush; refer to AER manufacturer's instructionsIFU for use.
 - Alcohol wipe should be used even when sterile water is used for rinsing.
 - iv. Dry the exterior of the item with a soft, clean lint-free cloth.

5.6. Storage:

- a. Store the item in a well-ventilated, dust-free area.
 - i. A storage area with good ventilation will encourage continued air-drying of the surfaces, and prevent undue moisture build-up, thus discouraging any microbial contamination.
 - ii. Use storage cabinets that are made of a material that can be disinfected.
 - iii. Wipe down storage cabinets with a hospital-approved disinfectant at least every 14 days.
 - iv. Correct storage of the item will prevent damage to the exterior of the instrument by protecting it from physical impact.-Padding may be used.
- b. Storage of endoscopes:
 - i. Hang endoscopes in a vertical position, with all caps, valves, and other detachable components removed to prevent moisture accumulation and microbial growth.
 - ii. Ensure scopes hang freely so they are not damaged by contact with one another.
 - iii. Reusable buttons and valves shall be reprocessed and stored together with the endoscope as a unique set for tracking purposes.
 - iv. Endoscopes may be stored for up to 7 days if they have been reprocessed according to manufacturer's instructionsIFU and they are stored in a way that keeps them completely dry and free from environmental and human contamination.
 - ii.1) On the 7th day of storage, endoscopes must be reprocessed.
- 6.7. Disposal of Cidex OPA:
 - a. Add a neutralizing agent to Cidex OPA in accordance with the manufacturer's recommendations prior to disposal.
- a-8. Follow manufacturer's recommendations for maximum time to elapse between steps of pre-cleaning, cleaning, and HLD/sterilization. If the maximum allowable time is exceeded between steps, follow manufactures recommendations for delayed reprocessing steps.

D. RELATED DOCUMENT(S):

Olympus Dual Scope Disinfector (DSD) Sample Log

E. <u>REFERENCE(S):</u>

- AORN Perioperative Guidelines for Practice, 20156 Edition.
- Cidex OPA manufacturer's instructions for use.
- Multi-Society Guideline on Reprocessing Flexible Gastrointestinal Endoscopes. Vol73, No 6: 2011.

Patient Care Services High Level Disinfection Page 7 of 8

- Standards of Infection ControlPrevention in Reprocessing of Flexible Gastrointestinal Endoscopes. SGNA Society of Gastroenterology Nurses and Associates, Inc, 2009.2016. W. A. Rutala, PhD, MPH, D.J. Weber, MD, MPH (2014). Cleaning, disinfection, and sterilization
- 5. in healthcare facilities. APIC Text of Infection Control & Epidemiology, Chapter 31.

Olympus Dual Scope Disinfector (DSD) Sample Log



OLYMPUS DUAL SCOPE DISINFECTOR (DSD) SAMPLE LOG

QC OF TEST STRIPS TO BE COMPLETED WHEN OPENING A NEW VIAL OF TEST STRIPS, 30 DAYS, 60 DAYS DISCARD TESTS STRIPS AT 90 DAYS						
TEST STRIP LOT NUMBER TEST STRIP DATE DATE EXPIRATION DATE		QC PERFORMED (CIRCLE ONE) TEST RESULT PASS OR FAIL		TESTED BY (INITIALS)		
			INITIAL			
			30 DAY			
			60 DAY	2		

INSTRUCTIONS FOR USE

Pre-Disinfection:

- 1. Leak test, brush, and clean endoscope
- 2. Place scope into tray and begin cycle following DSD instructions
- 3. Record required items in boxes below

Post-Disinfection:

- 1. Confirm the cycle met parameters per manufacturer's recommendations.
- 2. Parameters not met require repeating the load in another station.
- 3. Failure to meet parameters- Notify Engineering Department

Patient Sticker Procedure & Physician	Time	Temperature	Cidex OPA Test Strip (Pass or Fail)	Leak Test (Pass or Fail)	Alcohol Rinse Complete (Yes/No)	Item Description or Scope #	Operator's Initials
			*:				



PATIENT CARE SERVICES

ISSUE DATE: 11/07 SUBJECT: 72–Hour Hold, Evaluation and

Treatment of Involuntary Patient

REVISION DATE: 12/08, 05/11 POLICY NUMBER: II.B

Department Approval: 09/1511/16
Clinical Policies & Procedures Committee Approval: 11/1512/16

Clinical Policies & Procedures Committee Approval: 41/1512/16

Nurse Executive Council Approval: 42/1501/17

Division of Psychiatry Approval: 06/17
Pharmacy and Therapeutics Approval: n/a

Medical Executive Committee Approval: 04/4107/17
Professional Affairs Committee Approval: 05/4110/4701/18

Board of Directors Approval: 05/11

A. PURPOSE:

- To ensure individuals presenting to Tri-City Healthcare DistrictMedical Center (TCHDMC) with symptoms that put them at high risk for danger to themselves or others or who meet criteria for being considered gravely disabled are evaluated and treated in accordance with the procedural requirements set forth in the Lanterman-Petris-Short (LPS) Act.
- 2. To ensure patient rights are respected for those patients receiving behavioral health services at TEMETCHD.
- 3. To clarify the process and each staff member's legal responsibilities for 5150s, 5151s, and 5152s.

B. SCOPE AND APPLICABILITY:

1. This policy applies to all patients evaluated and treated on an involuntary basis for an emotional or behavioral disorder in the Emergency Department (ED) as well as inpatient and outpatient settings of TCMCTCHD.

C. **DEFINITION(S)**:

- Lanterman-Petris-Short (LPS) Act: This act establishes procedural requirements under which
 persons found to be dangerous to themselves or others or are gravely disabled due to mental
 disorder, inebriation, or the use of narcotics or restricted dangerous drugs may be involuntarily
 detained for specified periods for evaluation and treatment. These periods include:
 - a. An initial 72-hour hold for evaluation and treatment.
 - b. An additional 14-day intensive treatment period.
 - c. An additional 30-day intensive treatment period after the 14-day period of treatment has ended.
 - d. Further confinement depending on the patient's condition
 - i. A second 14-day intensive treatment period for persons who are imminently suicidal.
 - ii. An additional 180-day confinement for persons who present a demonstrated danger to others.
 - iii. Confinement pursuant to a conservatorship for persons who are gravely disabled.
- 2. Gravely disabled:

- A condition in which a person, due to mental disorder or, in some cases, chronic alcoholism, is unable to provide for his/her basic personal needs for food, clothing, or shelter.
- b. A condition in which a person has been found mentally incompetent under California Welfare and Institutions Code §5008(h)(1)Penal Code.
 - i. Mental retardation, by itself, does not constitute a grave disability
- California Welfare and Institutions Code Section 5150:
 - a. When a person, due to mental disorder, is a danger to self or others or is gravely disabled, the person may be taken into custody by authorized persons and placed in a facility designated and approved by the county and the Department of Mental Health as a facility for 72-hour evaluation and treatment.
 - b. A 5150 gives the issuing party the authority to only detain and transport the patient until a 5151 has been completed. A 5150 may be released only under the following two circumstances:
 - The 5150 issuing party obtains further information that the patient does not meet criteria and discontinues the 5150 or
 - ii. The 5151 (Psychiatric Assessment) is complete and the 5151 designee determines through assessment that the patient does not meet 5150 criteria.
- 4. California Welfare and Institutions Code Section 5151:
 - a. Prior to admitting a person for 72-hour treatment and evaluation, a professional person in charge of the facility or his/her designee shall assess the individual in person to determine the appropriateness of the involuntary detention (5150). This designation has been placed with the Psychiatric Liaison (PL)/Crisis Stabilization Unit (CSU) Psychiatric RN to complete the 5151 face-to-face assessments.
 - It is to be determined by the PL/CSU-Psychiatric RN whether to drop the 5150 or proceed with a 5152.
 - ii. The PL/CSU-Psychiatric RN has the authority designated upon them to discontinue any 5150s placed on individuals. 5150's initiated by TCMCTCHD emergency physicians do not need a psychiatrist to discontinue them, but may be discontinued by the PL/CSU Psychiatric RN upon completion of the 5151 face-to-face assessment.
- California Welfare and Institutions Code Section 5152:
 - a. Once admitted the individual is now detained under a 5152, which gives authority to the LPS facility to admit, observe and treat individuals for a period of 72 hours. Individuals may be released before 72 hours has elapsed only under the direction of a Psychiatrist's personal evaluation.

D. POLICY:

- 1. Individuals who are able to initiate a 72-hour hold include:
 - a. Peace officers
 - b. Members of the Psychiatric Emergency Response Team (PERT)
 - Members of the attending staff who are authorized to admit a person to the facility and who have been designated by San Diego County to do so, specifically at Tri-City Medical CenterTCHD.
 - d. Other professional persons designated by the county including registered nurses and/or psychiatric liaisonPL personnel
- 2. Designated personnel initiating a 72-hour evaluation (5150) are required to complete a written application which states the following:
 - a. Circumstance under which the individual's condition was called to his/her attention
 - b. Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled.
- 3. The written application must be completed for individuals brought to the ED as well as for those patients already being treated in the ED.

- a. When determining if probable cause exists to detain a person pursuant to Welfare and Institutions Section 5150 and California AB 1424, all available relevant information about the historical course of the person's mental disorder shall be considered if it has reasonable bearing on the determination.
- 4. Behavioral Health patients brought in by law enforcement agencies:
 - Health and Welfare Code 5150.1 and 5150.2 restrict mental health professionals from interfering with peace officers who may be transporting a person to TCMCTCHD for assessment.
 - i. The officer(s) shall not be detained unreasonably when presenting with a patient to the ED.
 - ii. Once on Tri-City Medical Center's campus, the officers may not be directed to transport the patient to another facility nor asked to wait outside the ED.
 - iii. The ED clinical staff shall expeditiously process the patient into the ED and place the patient in the safest available space as quickly as possible.
 - iv. When a patient brought into the ED for evaluation by law enforcement is not admitted pursuant to the 5150 hold, and declines alternative mental health services, that person will have their custody transferred to the law enforcement agency when there is a criminal detention pending.
 - b. All efforts shall be made to ensure the peace officers are relieved of their responsibility for the patient within one (1) hour of arrival.
 - i. During Emergency DepartmentED saturation, Emergency DepartmentED Staff may not be immediately available to relieve the peace officer. The peace officer shall be asked to remain with the patient for safety reasons. Every effort shall be made to minimize the time a peace officer is needed to monitor the patient.

E. PROCEDURE FOR EMERGENCY DEPARTMENT (ED):

- 1. ED Clinical staff shall
 - a. Notify the Security Department when an individual is admitted to the ED pursuant to the initiation of a 5150.
 - b. For patients identified as a high risk for elopement, the clinical staff shall:
 - Place the patient in a secure room with only one exit that facilitates close observation and monitoring.
 - ii. Offer a nicotine patch for those patients requesting to smoke; they are not allowed to leave the ED for this purpose.
 - iii. Arrange for a sitter to remain in direct observation of patient. Refer to Patient Care Services:-Policy, Sitter Policy, VIII.C.
 - iv. Assist the patient with removing his/her clothing including all undergarments, shoes and socks, and place the patient in a hospital gown.
 - 1) Secure all the patient's personal belongings in a locked cabinet and out of reach of the patient.
 - v. Place the wandering bracelet on the patient's wrist after activation.
 - vi. Perform an initial assessment of the patient and implement necessary interventions to ensure the patient's immediate safety and the safety of the environment.
 - vii. Communicate the patient's status to the ED Assistant Nurse Manager (ANM)/designee, the Physician, and Security.
 - c. Facilitate an evaluation by the PL/-CSU Psychiatric RN as soon as possible and whenever possible before the patient has been given medications that may be sedating or restrict his/her ability to participate in a mental status evaluation.
 - Maintain ongoing communication with the PL/ CSU-Psychiatric RN regarding the plan for treatment.
 - e. Monitor the patient at regular intervals, as clinically indicated to provide safe and effective nursing care.
 - f. Ensure that the patient's rights are respected including:

- The right to refuse medications unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment
- ii. The right to be free from restraint or seclusion and to be treated in the least restrictive environment unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment
- iii. The right to be treated with dignity and respect.
- g. Complete all necessary documentation in accordance with TCMCTCHD policy, including documentation associated with the use of restraint or seclusion.
- 2. The PL/CSU Psychiatric-RN shall:
 - a. Perform a mental status examination and other assessments for individuals referred for a psychiatric evaluation, including:
 - i. Suicide Risk Assessment
 - ii. Elopement Risk Assessment
 - b. Maintain availability for 1st hour evaluations of patients placed in restraints for violent/self-destructive behavior, if ED physician unable to evaluate patient. Only specially trained RN's can do a First Hour Assessment.
 - c. Act as a resource for Emergency-DepartmentED personnel caring for the patient.
 - d. Ensure patient rights are preserved during the course of evaluation and care.
 - e. Assist the ED staff with evaluation, assessment, care planning, and implementation of care for the patient.
 - ED psychiatric patient evaluations shall be documented on the Behavioral Health Liaison (BHL) tracking log.
 - f. Relay medication and diagnostic recommendations from the on-call Psychiatrist to the ED physician within the PL scope of professional practice (RN PL only).
 - g. Collaborate with ED registration staff to identify funding resources and benefit status.
 - i. Pre-authorization is required for all psychiatric patients admitted to Behavioral Health Unit (BHU) and shall be documented in the medical record.
 - h. Determine and recommend the level of psychiatric care as indicated by the patient's presenting problem(s).
 - Ascertain if/when following procedures for using the hospital gown or wandering bracelet may increase a patient's agitation or escalate a situation and communicate the determination to staff.
 - i. The PL/CSU-Psychiatric RN shall reassess patient frequently. If the patient does not have the capacity to participate in the 5151assessment, the PL/CSU Psychiatric-RN is to document every effort made to interview the patient in the BHU Liaison Assessment.
 - 1) Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.
 - j. Provide for expeditious patient disposition utilizing all available community resources and communicate the status of discharge planning with the Emergency DepartmentED clinical staff at regular intervals.
 - i. The BHU ANM or designee shall be notified by the PL/-CSU Psychiatric RN when a determination is made regarding the patient's admission to the unit.
 - The PL/-CSU-Psychiatric RN shall facilitate transfers to the BHU or to another psychiatric facility.
 - iii. The PL/ CSU Psychiatric-RN is responsible to obtain the pre-authorization on any patient transferred to the BHU or other psychiatric hospital from a TCMCTCHD medical unit.
 - k. Collaborate with the ED physician when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as possible.

- I. Once the 5151 assessment is completed and it is determined to proceed to a 5152, in collaboration with the on-call Psychiatrist, the PL/-CSU-Psychiatric RN shall complete an Involuntary Patient Advisement form.
 - i. The patient shall receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed, the 72-hour hold may not be discontinued, except by a psychiatrist after personal evaluation.
- m. Collaborate with the Security Officer to communicate changes in the patient condition that may require more frequent surveillance or concerns about the patient's imminent safety or safety of the environment.
- n. Provide direction to ED clinical staff and Security Officer(s) in the management of situations requiring de-escalation or physical management.
- o. Participate in debriefing with ED clinical staff and Security Officer(s) following incidents requiring physical management or restraint application to determine opportunities for process improvement.
- p. Complete all necessary documentation in accordance with established policy.
- 3. The assigned Security Officer notified when a patient is being evaluated and cared for in the Emergency-DepartmentED shall:
 - a. Make his/her presence known to the PL and ED clinical staff as soon as possible.
 - b. Communicate with staff to ascertain the patient's current condition as it relates to the safety and security of the patient and the immediate environment.
 - c. Assist in episodes of verbal de-escalation and/or restraint application in accordance with TCMCTCHD policy at the direction of the PL, ED Physician, or ED clinical staff (depending upon who is at the scene and designated as the team leader of the situation).
 - d. Ensure the patients who are at high risk for elopement are not permitted to leave the treatment area of the ED until an evaluation has been completed, a disposition for treatment is completed, or a determination has been met indicating the individual does not meet criteria for further treatment pursuant to the evaluation.
 - i. The security officer shall assist with transporting the patient from the ED to admitting unit (usually BHU) ensuring the patient is wearing a gown and all items that may cause harm to self or others are not in the patient's possession.
 - e. Communicate observed changes in the patient's behavior that may indicate a change in safety risk to the designated clinical staff member on the scene.
 - f. Advocate for the patient to ensure all patient rights are preserved during the course of treatment while maintaining the safety of the patient and the immediate environment.
 - g. Participate with clinical staff in debriefing following all episodes of physical management and/or restraint application in accordance with TCMCTCHD policy.

F. PROCEDURE FOR CRISIS STABILIZATION UNIT (CSU) OF TCMCTCHD:

- 1. When a patient on a 72 hour hold arrives at the CSU, security will assist with the patient's belongings to ensure there are no contraband, and locked the belongings in the appropriate, assigned patient locker.
- 1.2. The PL shall reassess the patient frequently. If the patient does not have the capacity to participate in the 5151 assessment, the PL is to document every effort made to interview the patient in the BHUL-Liaison Assessment.
 - a. Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.
- 2.3. The PL will Collaborate with the CSU NP and or psychiatrist or Allied Health Professional (AHP) when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as possible.

- 3.4. Once the 5151 assessment is completed and it is determined to proceed to a 5152, in collaboration with the on-call Psychiatrist or AHP, the PL shall complete an Involuntary Patient Advisement form.
 - a. The patient shall receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed, the 72-hour hold may not be discontinued, except by a psychiatrist after personal valuation.
- 4.5. Ifn case the patient is not admitted to an acute inpatient setting pursuant to the 5150, CSU staff will-make adhere to sure the following steps-adhered-to:
 - Make sure the patient understands and agrees with the discharge plan
 - b. Assure the patient has sufficient medications and/or prescriptions for medication to fill at local pharmacy (sufficient to bridge the gap until the patient is able to be seen by the outpatient provider)
 - c. Coordinate for pick up and or transportation needs
 - d. Review the appropriate outpatient resources and referrals with the patient and family or friend, as indicated. All minors will have discharge plans reviewed with legal parent or guardian
 - e. Develop a safety plan, if indicated, and document in medical record
 - f. Encourage patient to ask for help from support and professional providers when in crisis immediately
 - g. All patients will be provided the San Diego County Access and Crisis Line phone number 1888-724-7240

G. PROCEDURE FOR INPATIENT UNITS of TCMCTCHD:

- There are occasions when an individual is hospitalized pursuant to a 5151 assessment on an
 inpatient unit because a co-existing medical condition requires stabilization. If the patient does
 not have the capacity required to complete a 5151 assessment in the ED and it is unknown
 when medical clearance or capacity can be obtained, the 5150 may be discontinued.
- 2. In circumstances when a patient is hospitalized on the inpatient units on a 72-hour hold, pursuant to a 5151 assessment the clinical staff shall:
 - a. Notify the attending physician.
 - b. The attending physician shall order a PL consult.
 - Unit Secretary or clinical staff will contact the PL directly or notify Inpatient BHU of request for PL consult.
 - d. Inform the PL when the patient's medical condition allows an adequate assessment to be conducted, i.e., patient is conscious, extubated, awake, and able to participate in an assessment.
 - e. Assign a sitter to remain with the patient if it is determined the patient is at risk for self-harm or elopement until they are medically cleared.
 - f. Collaborate with the PL in their provision of care, treatment, and disposition of the individual.
 - g. Notify the Security Department.
- The PL shall:
 - a. Contact the nursing unit to acknowledge receipt of consultation request, and discuss the patient's medical and psychiatric condition.
 - i. If the patient is able, communicate a time frame to complete the assessment.
 - ii. If the patient does not have the capacity to participate in the 5151 assessment the PL is to document every effort made to interview the patient in the BHU Liaison Assessment. Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.
 - b. Determine and recommend the level of psychiatric care as indicated by the patient's presenting problem(s).
 - c. Collaborate with the attending physician when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and

- Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as practicable.
- d. Once the 5151 assessment is completed and it is determined to proceed to 5152, the PL is to complete an Involuntary Patient Advisement form. The patient is to receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed the 72-hour hold cannot be discontinued except by a psychiatrist after a personal evaluation.
- e. Inform the on-call psychiatrist there is a patient who meets 5150 criteria and the 5151 assessment has been completed on the medical floor to collaborate for psychiatric admission of the patient to the TCMCTCHD BHU, or another psychiatric hospital, as indicated.
- f. Collaborate with the clinical staff to ensure pre-authorization from insurance is obtained prior to all transfers to the BHU.
- g. Ensure patient rights are preserved during the course of evaluation and care.
- h. Assist the Inpatient clinical staff with assessment, care planning, and implementation of care for the patient.
- Collaborate with the Security Department to communicate changes in the patient condition that may require more frequent surveillance or concerns about the patient's imminent safety or safety of the environment.
- 4. Notify the on-call psychiatrist to:
 - a. Assess the patient, if the PL has completed the 5151 assessment and Involuntary Patient Advisement process. These shall occur within 24 hours of the patient's arrival on the medical unit, or as soon as the patient is responsive enough for a psychiatric evaluation, but in all cases before the expiration of the 72-hour hold to determine if the patient continues to meet criteria for the hold.
 - The on-call psychiatrist is the only clinical staff that may discontinue a hold at this point in the treatment episode.
 - b. Initiate the paperwork for a 14-day hold if in his/her assessment it is clinically appropriate and shall ensure the patient receives all necessary advisements in accordance with hospital policy.
 - c. Act as a resource to the staff providing on-going care to the patient.
- 5. When a patient has been hospitalized, the assigned security officer shall:
 - a. Respond to requests for assistance from clinical staff in the event the patient's behavior constitutes a threat to self or others.
 - b. Collaborate with unit-based clinical staff and/or the BHU clinical staff representative to ensure on-going evaluation and care of the patient is conducted in a safe manner while ensuring all patient rights are upheld.

H. PROCEDURE FOR BEHAVIORAL HEALTH-UNIT-(BHU):

- When individuals are admitted to the BHU pursuant to a 72-hour hold they shall be assigned a
 bed in the Inpatient Behavior Health Unit. The BHU ANM or Charge RN will assign bed based
 on presenting symptoms of patient upon admission.
- 2. The nursing staff shall document on the Information Board, the patient's legal status and the date and time the 72-hour evaluation was initiated as well as the date and time it expires.
 - This information shall be communicated in all change of shift reports.
- 3. The patient may be released from the involuntary 5150 hold before 72 hours have elapsed only if the psychiatrist directly responsible for the person's treatment believes, as a result of his/her personal observations, that the person no longer requires evaluation or treatment. However, should there be a situation in which both a psychiatrist and psychologist have personally evaluated or examined a person who is placed under a 72-hour hold and there is a collaborative treatment relationship between them, either may authorize the release but only after they have consulted with each other.
 - a. In the event of a clinical or professional disagreement the hold will be maintained unless the medical director overrules the decision of one or the other.

- b. In this event, both the psychiatrist and the psychologist must enter their findings, concerns, or objections into the patient's medical record.
- 4. The attending psychiatrist shall be kept informed of the patient's legal status as well, to ensure an application for an additional 14-day hold may be initiated in a timely manner if it is clinically indicated.
- 5. The level of observation shall be determined by the attending psychiatrist in collaboration with the nursing staff, based on assessment data.
- 6. The involvement of the Security Department shall be solely dependent upon the patient's behavior as it relates to imminent danger to self or others.
 - a. When a Security Officer(s) is called to the BHU to assist in the containment of imminently dangerous behavior, the Officer shall wait for and follow direction from the nursing staff.
 - b. The Security Officer(s) shall participate in all scheduled debriefing sessions related to physical management occurrences including seclusion and/or restraint.

I. RELATED DOCUMENT(S):

- Behavioral Health Services Unit-(BHU) Inpatient Policy: Exclusionary Criteria
- 4.2. Patient Care Services: Sitter Policy

J. REFERENCE(S):

- 1. Detention of Mentally Disordered Persons for Evaluation and Treatment, CA Welfare and Institution Code § 5150 (1969)
- 2. Certification for Intensive Treatment, CA Welfare and Institution Code § 5250 (1982)
- Lanterman-Petris-Short Act, CA Welfare and Institution Code § 5000 (1967)
- 2.4. CA Welfare and Institution Code § 5008, 5150, 5150.1, 51510.2, 5151, 5152



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 03/03 SUBJECT: Medications, High Risk/High

Alert/Look Alike Sound Alike

REVISION DATE: 06/03, 02/04, 05/05, 04/06, 04/09,

12/09, 06/13

POLICY NUMBER: IV.I.8

Department Review:

09/17

Clinical Policies & Procedures Committee Approval:

11/1310/17

Nursing Executive Committee:

44/4310/17 44/4311/17

Pharmacy & Therapeutics Committee:
Medical Executive Committee Approval:

02/1411/17

Professional Affairs Committee Approval:

02/1401/18

Board of Directors Approval:

02/14

A. PURPOSE:

 To identify medications with high risk to patients, and provide a process to safely deliver the highest quality pharmaceutical care with the minimum number of medication errors and the lowest potential for patient risk.

B. **DEFINITION(S)**:

- 1. High Risk/High Alert medications are drugs that have a heightened risk of causing significant patient harm when they are used in error.
- 2. High Risk/High Alert medications have a higher risk of causing injury, either as a result of a narrow therapeutic range or due to a high incidence of reported serious errors.
- Methods to reduce error include strategies such as:
 - a. Improving access to information about these drugs.
 - b. Limiting access to High Risk/High Alert medications
 - c. Using Tallman lettering for lookalike sound alike meds
 - d. Using auxiliary labels and automated alerts on the electronic Medication Administration Record (eMAR) and Automated Dispensing Machine (ADM)
 - e. Standardizing the ordering, storage, preparation and administration of these products
 - f. Employing redundancies such as automated or independent double checks when necessary
- 4. New formulary medications and additional relevant safety information will be reviewed for inclusion on the High Risk/High Alert Medication list by the Medication Safety Committee and Pharmacy & and Therapeutics Committee.
- 5. Medications that have deemed to be High Risk or High Alert include the following:
 - a. Chemotherapy agents
 - b. Therapeutic Anti-Coagulants (infusions of heparin, argatroban, lepirudin)
 - c. Insulin both continuous infusions and subcutaneous doses
 - d. Epidural/Intrathecal infusions, Patient-Controlled Analgesias (PCAs)
 - e. Continuous Thrombolytic Infusions (alteplase)
 - f. Concentrated Electrolytes
 - g. Neuromuscular Blocking Agents (NMBA)
 - h. Fentanyl patch and transmucosal products
 - i. Glycoprotein IIb/IIIa inhibitors (eptifibatide, abciximab)
 - j. Inotropic medications (dopamine, dobutamine, milrinone)
 - k. Intravenous (IV) Adrenergic Agonists (epinephrine, norepinephrine, phenylephrine)

10% Magnesium Sulfate

C. POLICY:

- High Risk/High Alert Medication Verification & ADM Alert List medications requiring verification by a second practitioner.
 - a. Chemotherapy (refer OncololyOncologyPatient Care Services (PCS) Procedure: Chemotherapy Administration—Procedure)
 - b. Therapeutic Anti-Coagulants:
 - Heparin (refer to PCSPatient-Gare-Services Policy: Therapeutic Anticoagulation Management-Policy)
 - ii. Argatroban: & Lepirudin
 - 1) Standardized dosing nomograms and orders are in place.
 - 2) All infusions will be administered by a programmable infusion pump with "smart pump" technology.
 - 3) Independent double checking of dose ordered, dose prepared, initial infusion rate and any changes in infusion rate shall be verified and documented by another nurse.
 - c. Insulin:
 - i. Continuous Infusions:
 - 1) Standard concentration of an insulin infusion is 1 unit/mL.
 - 2) Standardized dosing protocol for insulin infusions.
 - 3) All Insulin infusions will be administered by a programmable infusion pump with "smart pump" technology.
 - 4) Independent double checking of dose ordered, dose prepared, initial infusion rate and any changes in infusion rate shall be verified and documented by a second nurse.
 - ii. Subcutaneous:
 - Insulin vials opened on nursing units will have an expiration date of 28 days per the PCSPatient Care Services Policy: Medication Administration-Pelicy.
 - 2) Insulin vials are separated by type in labeled bin dividers in the refrigerators.
 - 3) Prior-to-administration, the amount ordered and prepared shall be verified by a second nurse.
 - d. Epidural/Intrathecal/PCA Infusions:
 - i. All infusions will be administered by a programmable infusion pump with "smart pump" technology.
 - Independent double checking of dose ordered, dose prepared, initial infusion rate and any changes in infusion rate shall be verified and documented by another nurse.
 - e. Continuous Thrombolytic Infusions (alteplase):
 - i. All infusions will be administered by a programmable infusion pump with "smart pump" technology.
 - ii. Independent double checking of dose ordered, dose prepared, initial infusion rate and any changes in infusion rate shall be verified and documented by another nurse.
 - iii. An ADM alert will identify this agent with the warning "1 BOTTLE Maximum for Stroke. Maximum dose of 90mg"
 - f. Concentrated Electrolytes (refer to Pharmacy: General and Concentrated Electrolyte Policy).
 - g. Neuromuscular Blocking Agents (NMBA):
 - NMBA continuous infusions require an independent double checking of dose ordered, dose prepared, initial infusion rate and any changes in infusion rate shall be verified and documented by another nurse.

Patient Care Services Medications, High-Risk IV.1.8 Page 3 of 4

- ii. All infusions will be administered by a programmable infusion pump with "smart pump" technology.
- iii. Standard concentrations for NMBA infusions are used.
- iv. Use of NMBA are limited to Operating Room (OR), Intensive Care Unit (ICU), Neonatal Intensive Care Unit (NICU) and procedural areas.
- v. A paralytic warning label is applied to all NMBA prior to distribution.
- vi. An ADM alert will identify these agents with a warning upon removal "Paralyzing agent high risk/high alert requires Patient to be on mechanical ventilation or Physician in attendance" and requires nurse to indicate which condition applies prior to removal.
- 2. High Risk/High Alert Medication ADM Alert List:
 - a. ADM alert is defined as a reminder message that appears prior to obtaining a medication from the ADM machine and is designed to notify staff that the medication is High Risk/High Alert.
- 3. Look Alike Sound Alike Medications (LASA):
 - The LASA list will be annually updated.
 - LASA meds in Talyst are bar coded in and out, and bins are not labeled with drug names.
 - c. Medications in Talyst and CII Safe are not stored in any order enhancing patient safety with lookalike sound alike medications in pharmacy.
 - d. A current list of LASA can be found on the TCMC-Tri-City Intranet.
 - e. Tall man lettering shall be utilized as appropriate.

D. RELATED DOCUMENT(S):

- 1. Look Alike sound Alike (LASA) Medication List
- Oncology-Patient Care Services Procedure: Chemotherapy Administration-Procedure
- 3. Patient Care Services Policy: Medication Administration
- 3.4. Patient Care Services Policy: Therapeutic Anticoagulation Management-Policy
- Pharmacy Policy: General and Concentrated Electrolyte-Policy

Look Alike sound Alike (LASA) Medication List

** MEDICATION SAFETY ALERT **

Look Alike Sound Alike
MEDICATION LIST

KEPPra/ketaMINE

ePHEDrine/EPINEPHrine

HYDROmorphone/morphine
hydrOXYzine/hydrALAZINE

DAUNOorubicin/DOXOrubicin/IDArubicin
oxyCONTIN/oxyCODONE
vinBLAStine/vinCRIStine
celeBREX(celeCOXib)/celeXA/ceReBYX
cloNIDine/clonazePAM
ceFAZolin/cefTRIAXone
NIFEdipine/niMODipine/niCARdipine
leveMIR/lanTUS/lisPRO (HumaLOG)/HumuLIN/novoLIN
levETIRAcetam/levofloxacin
pyridOXINE/pyridOSTIGMINE

What does Tri-City do to help avoid LASA medication errors?

- Use tall man lettering seen on Pyxis removals and eMAR
- Store medications in Talyst carousel (non-alphabetically)
- Barcoding upon receipt in pharmacy, during Pyxis fills and at the bedside

	dical Center	Patient Care Services					
PROCEDURE:	EXTENDED DWELL CATHETER	/MIDLINE CATHETER, ADULTS					
Purpose:	To outline the following nursing responsibilities for patients with or requiring midline catheter placement:						
	1. Assisting with the insertion of	a midline catheter					
	1. Patient selection						
	2. Placement of catheter						
	4.3. Assessment						
	2.4. Maintenance						
	3.5. Documentation						
	4.6. Flushing						
	5.7. Blood specimen collection						
	6-8. Dressing changes						
	7.9. Removal						
Supportive Data:	1. Infusion Nursing Standards of	Practice					
	Standards of Care for Adults						
	Central Venous Access Proce	dure					
	4. Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10)						
Equipment:	1. Extended Dwell Catheter Ins	sertion Kit (3 French or 4 French)					
	2. Sterile gloves						
	3. Microclave (green or yellow						
		n as SorbaView SHIELD Contour)					
	5. Swabcap port protector						
	4-6. Central Line Change Kit						
	2.7. Saline-Flush-Syringes						
	3.8. Port protector©						

A. <u>DEFINITION(S):</u>

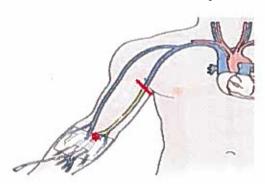
- 1. Extended Dwell Catheter (EDC):
 - a. An Extended Dwell Catheter (EDC) is a peripheral intravenous (IV) catheter 2.4 inches in length, power-injectable and approved by the Federal Food and Drug Administration (FDA) for use up to 29 days.
 - b. The most favorable site for EDC insertion is mid-forearm. However, placement can be in any vein deemed appropriate by the inserting Registered Nurse, including hand veins.
 - EDC catheters shall not traverse flexion surfaces, such as the wrist or antecubital fossa.
 - ii. An EDC catheter is not a Midline, unless inserted above the antecubital fossa and the catheter tip terminates distal to the axillary line.
 - iii. An EDC catheter is not a Peripherally Inserted Central Catheter (PICC).
 - iv. An EDC catheter is not a centrally inserted catheter, i.e. central line.

4-2. Midline Catheter:

- a. A-short term-peripheral venous-access catheter for selected IV therapies and blood sampling
- b. A midline catheter is typically-8 inches (range 3 -10 inches) long
- a. A Midline catheter is an EDC peripheral IV catheter 3.1 to 3.9 inches in length, power-injectable and FDA cleared for use up to 29 days, that is inserted into the upper arm via the deeper basilica, cephalic, or brachial veins, with the internal tip located level at or near the level of the axilla and distal to the shoulder. See illustration below.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/17	06/14 , 07/17	06/14, 07/17	09/14, 10/17	09/14, 11/17	10/14, 11/17	05/15, 01/18	05/15

- e-b. Midlines catheters do not extend beyond the axillary line and do not extend into the vena cava; see illustration below.
 - A midline catheter is not a Peripherally Inserted Central Catheter (PICC).
 - ii. A Midline catheter is not a centrally inserted catheter, i.e. central line.



B. POLICY:

- In the absence of a clear indication for a central line, an EDC or Midline catheter should be considered for all patients requiring access for up to twenty-nine (29) days, as well as difficult access or "hard stick" patients and patients requiring frequent phlebotomy.
- 2. Contraindications to EDC or Midline use: A EDC or Midline catheter should not be used for the following indications:
 - a. Continuous vesicant therapy
 - b. Total parenteral nutrition
 - c. Any intravenous medication requiring central venous access for administration
 - Patients with known allergy to the components of the EDC
- 3. EDC and Midline catheters may be inserted in the patient's room by a Physician/Allied Health Professional (AHP), Physician Assistant (PA), or a Registered Nurse (RN) trained to insert EDC and Midline catheters for patients meeting one or more of the following criterion:
 - Patient has poor or limited peripheral access.
 - b. Two unsuccessful attempts to insert a peripheral catheter by one RN and a reassessment by a 2nd RN who is also unable to insert a peripheral catheter after two attempts.
 - c. Patient requires minimum of one (1) week to twenty-eight (28) days of intravenous (IV) therapy for hydration solutions, isotonic or near isotonic drugs and solutions, pain medications, antibiotics, blood products, or frequent blood sampling.
- 4. EDC and Midline catheters shall be labeled with an EDC catheter sticker.
- 1.5. A Physician or a Physician Assistant (PA) will determine if a single or double lumen midline catheter is required.
 - a: The primary RN will consult with a Physician or a PA-to-identify the need for a midline catheter-versus a PICC
- 2.6. Midline-cathoters may be inserted by a Physician or a PA in the patient's room-when-one-or more of the following criterion is mot:
 - a. Patient-has-poor or limited peripheral access
 - b. Patient-skin-condition-and-voin-integrity limits insertion of a peripheral catheter by nursing
 - e. Physician order may be obtained after consulting with a Physician or a PA
 - d. Two unsuccessful attempts to insert a peripheral catheter by one Registered Nurse (RN) and a reassessment by a 2nd-RN who is also unable to insert a peripheral catheter
 - e. Patient requires minimum of one (1) week to 28 days of intravenous (IV) therapy for hydration solutions, isotonic or near isotonic drugs and solutions, pain medications, antibiotics compatible to a midline catheter, blood products, or frequent blood sampling
- 3.7. Midline-catheters shall be labeled with a midline catheter sticker.

- 4.8. Midline catheters are contraindicated:
 - Presence of device-related-infection, bacteremia, or septicemia is known or suspected
 - b. Post irradiation of prospective site
 - c. High powered injection unless the catheter is labeled as high-powered
 - d. W solutions that may be only infused using a centrally inserted-line
 - e. Vesicants or caustic intravenous (IV) solutions i.e., IV chemotherapy
 - f. Total-Parenteral Nutrition (TPN)
 - g. IV solutions with:
 - i. pH-less than-5-or-greater-than-9
 - ii. Greater than 10% dextrose
 - iii. Greater than 5% protein
 - h. IV medications: administration of dopamine, vancomycin, nafeillin/exacillin and phenytion through a midline catheter should be avoided when possible and is contraindicated based on the pH of the drug.
 - i. Consider Central Line-placement
 - ii. The list is not inclusive, contact-pharmacy-for assistance with identifying IV solutions and medications appropriate for a midline-catheter
- 5.9. X-rays are not required for placement confirmation

C. PROCEDURE FOR BEDSIDE INSERTION:

- 1. Verify Physician order for peripheral IV.
- 2. Verify patient per Patient Care Services: Identification, Patient Policy.
- 3. Gather equipment.
- 4. Aseptic or sterile technique shall be used during EDC or Midline catheter insertion.
- 5. Lidocaine 1% without epinephrine may be used during EDC or Midline insertion per Patient Care Services: Standardized Procedure: Local Anesthetic Prior to Intravenous Insertions Standardized Procedure.
- 6. Skin preparation shall-be-done Prepare skin at insertion site with 2% chlorhexidine scrub. Allow to dry thoroughly.
- 7. Insert EDC or Midline catheter according to manufacturer's directions-for useinstructions.
- 8. Ultrasound guidance may be used, but is not required, for insertion of EDC or Midline catheter.
- 9. Use Biopatch disk or equivalent around insertion site. Cover using acceptable-sterile dressing.
- 10. EDC and Midline catheters shall be secured using a hospital-approved peripheral-IV occlusive dressing.
- 11. Ensure all connections are tight and free from leakage.
- 12. Unless continuously infusing, place a neutral displacement connector and instill flush solution flush with at least 10 mL preservative-free normal saline.
- 13. The inserting RN shall document the insertion of the EDC or Midline catheter in the Electronic Health Record (EHR), i.e. catheter location, site condition, dressing, date and time of insertion etc.
 - a. If a Midline is placed by a physician or PA, the primary RN shall document the insertion in the EHR
- 14. Ensure EDC or Midline catheter is labeled with an EDC catheter sticker.
- 1.15. Verify-Physician order
- 2.16. Verify patient per Patient Care Services (PCS), Identification, Patient
- 3.17. Assist Physician or PA as directed
- 4.18. The primary-RN-shall document the insertion of the midline catheter in the Electronic Health Record (EHR) i.e., catheter location, site-condition, dressing, date and time of insertion etc.
- 5.19. Ensure midline catheter is labeled with a midline catheter sticker.

D. ASSESSMENT:

- Monitor site and catheter position after insertion for the following:
 - a. Minor bleeding is anticipated within the first 24 hours of insertion.
 - b. If excessive bleeding occurs, do not remove existing dressing as this can dislodge any clot that has begun to form. Instead, apply pressure and notify the PA-consult with the Rapid Response Team.
 - i. Notify the physician or PA for excessive bleeding from a Midline.
- 2. Monitor IV and catheter position every four hours for the first 24 hours, if no minor or excessive bleeding observed, continue to assess per the Patient Care Services: Standards of Care, Adult.
 - a. Peripheral IV site shall be assessed on admission, ongoing, and transfer from other nursing unit.
- 3. Document assessment findings in the EHR.

E. CARE AND MAINTENANCE:

- Assess site every shift, with flushing, prior to and after the administration of medications and PRN.
 - a. Always flush using positive pressure, push/pause technique.
 - b. Flush EDC or Midline catheter with at least 10mL of preservative-free normal saline at least every 8-12 hours.
 - c. Assess blood flow before and after administration of medications.
 - d. Flush EDC or Midline catheter immediately before and after administration of medications with at least 10 mL preservative-free normal saline.
 - e. Flush EDC or Midline catheter after infusing blood products with 20 mL of preservative-free normal saline.
 - f. For saline locked EDC or Midline catheters, always clamp tubing after instilling flush solution.
- 2. Review the Patient Care Services: Standards of Care Adult Procedure:- Infusion Therapy for detailed information on the following:
 - a. Port protector:
 - Do not reuse the port protector, a new one should be used each time it is removed, every 8 hours with routine IV flushing, and PRN.
 - b. Neutral Displacement Connector (i.e. MicroClave).
 - c. Tubing changes.
 - d. Infusion Therapy: Nursing Interventions.
- 3. Dressing changes shall be performed every seven days in accordance with Patient Care Services: Central Venous Access Devices, Adults Procedure for central line dressing changes using central line dressing change kit.
 - Assess blood flow before and after administration of medications
- 2.4. Use 10 mL syringe for flushing and medication administration
- 3.5. Review the Standards of Care: Infusion Therapy for detailed information on the following:
 - a. Port-protector
 - i- Do not reuse the port protector, a-new one should be used-each-time it is removed, every 8 hours with routine-IV-flushing and PRN.
 - b. Neutral-Displacement Connector (MicroClave)
 - c. Tubing-changes
 - d. Infusion Therapy: Nursing Interventions
- 4.6. Flush with minimum of 10-mL syringe of normal saline:
 - a. Before and after medication administration
 - b. After IV fluids
 - e. For-maintenance
 - d. Befere-and-after blood draws
 - e. After-blood backs up in the tubing

F. BLOOD SPECIMEN COLLECTION:

- 1. Diagnostic blood draws ("LABS") may be performed through an EDC or Midline catheter as follows:
- 4.2. Maintain a closed system by drawing-blood-directly from the neutral displacement-connector when possible; except when drawing blood cultures.
- 2.3. Use-aseptic-technique (with sterile gloves, mask-and-sterile field) if the neutral displacement connector is removed-for-a-blood-draw.
- 3.4. Precedure
 - a. Identify patient per Tri-City Healthcare District (TCHDMC) policy.
 - b. Turn off any continuous infusions, disconnect as needed, and ensure all clamps are open.
 - c. Perform hand hygiene and don clean non-sterile gloves.
 - d. Remove port protector from the neutral displacement connector (Microclave) if used.
 - If a port protector is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time.
 - e. Allow injection port to dry, do not fan or blow on port to speed drying.
 - f. Flush with 10 mL normal saline; wait 2 minutes.
 - g. Place a light venous tourniquet proximal to the catheter tip.
 - f-h. Position arm in gravity dependent position with palm up. Allow 30-60 seconds for venous pooling.
 - e-i. Draw off and discard 5 mL of blood.
 - Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect discard-blood for discard.
 - ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Reconnect tubing or replace with a new neutral displacement connector
 - iii. Tip: gentle traction on the catheter hub or on the securement device may draw catheter tip away from vessel wall and allow for free flow.
 - ii-1) If no blood returns, remove neutral displacement connector (with clamp in place), access extension set directly and attempt to aspirate.
 - h.j. Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating
 - i.k. Allow to dry, do not fan or blow-on-site to speed drying
 - 4.I. For Direct Transfer Method:
 - a.i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.
 - b-ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.
 - 5.m. For Indirect Transfer Method:
 - a.i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.
 - i-ii. A safety transfer device must be used to fill the vacuum tube from a syringe.
 - b.iii. Remove device or syringe and wipe away blood residual.
 - e.n. Flush with normal saline and reconnect to infusions, if required-Upon completion, flush with 20 mL preservative-free normal saline.
 - o. Re-clamp lines as appropriate-Reconnect tubing or replace with a new neutral displacement connector being careful not to contaminate the end of the hub.
 - d.i. Remove gloves, perform hand hygiene, and don a second pair of gloves.
 - e.ii. Document your Corner logon, date and time of lab draw on the specimen label(s)
 Labeling: refer to Patient Care Services: Specimen Labeling, Nurse
 Collectibles Procedure.

- f.iii. Place label(s) on specimen collection tube(s) at patient's bedside.
- g-iv. Place specimen collection bag in the designated area for lab to pick up or use tubing system.

G. DRESSING CHANGES:

- 1. Change the original dressing one day after insertion if newly inserted midline catheter has a gauze dressing.
- 2. Change transparent dressings with Biopatch disk every 7 days.
 - Gauze dressings (including transparent dressings with gauze underneath) shall be changed every two days.
- 3. Change dressings as needed if they become loose, soiled, or moist.
- 4. Use the Central Line dressing change kit; the kit has the supplies required for changing an EDC or midline catheter dressing.
- 5. Explain the procedure to patient.
- 6. Use Standard Precautions during dressing change (refer to Infection Control: Standard and Transmission- Based Precautions Policy IC.5).
- 7. Avoid talking over site and have the patient turn away from the site to prevent contamination.
- 8. Perform hand hygiene, don clean non-sterile gloves, and remove the dressing and discard.
- 9. Assess insertion site for:
 - a. Signs of infection, i.e. redness, er-purulent drainage.
 - Ensure the securement device and/or sutures are intact.
 - Ensure the catheter is not kinked, leaking, or otherwise compromised.
- 10. Remove non-sterile gloves and perform hand hygiene.
- 11. Open sterile supplies and don sterile gloves and sterile mask.
- 12. Perform hand hygiene and don sterile gloves.
- 13. Apply chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds.
- 14. Cleanse catheter tubing from exit site to distal end.
- 15. Allow antiseptic to air dry (do not blow on or fan site) before redressing.
- 16. Replace securement-device if needed per manufacturer's guidelines.
- 47.16. Apply transparent dressing with Biopatch.
 - a. Place Biopatch disk around catheter with blue side up and white foam side next to skin at exit site.
 - b. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.
 - c. Center transparent dressing over exit site and the Biopatch disk.
 - d. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.

H. DOCUMENTATION:

- 1. Document assessments, care and maintenance, and dressing changes in the EHR per the **Patient Care Services:** Standards of Care, **Adults.**
- Document patient education provided and patient and/or caregiver responses in the EHR.

I. REMOVAL:

- Removal of the catheter requires a Physician order
- 2. Perform hand hygiene per Infection Control: Hand Hygiene IC 8 per TCMC policy.
- Assemble equipment and supplies.
- 4. Remove dressing and discard.
- Remove sutures, if present
- 6.5. Grasp catheter near insertion site.
- **7.6.** Remove slowly, do not use excessive force.
- 8-7. If resistance is felt, stop removal, and notify PA or ordering physician and document interventions in the EHR.

9.8. Document removal of catheter and patient's tolerance in the EHR.

J. POTENTIAL COMPLICATIONS

- 1. Notify the ordering Physician/AHP for any sign and symptoms of catheter related complications, which may include one or more of the following:
 - a. Infection:
 - i. Fever
 - ii. Chills
 - iii. Swelling, erythema or drainage at insertion site
 - b. Phlebitis:
 - i. Warmth, tenderness, erythema, palpable venous cord
 - c. Thrombosis:
 - i. Leakage from the site
 - ii. Decreased flow rate of infusion pump inability to draw or infuse
 - iii. Edema in areas distal or proximal to the site
 - iv. Swelling in shoulder and neck area or jaw, shoulder or chest pain
 - d. Malposition catheter:
 - Lack of blood return
 - ii. Complaints of pain or discomfort in the arm or jaw during infusion
 - iii. Leaking at catheter site
 - iv. Complaints of hearing a swishing sound during infusion
 - e. Catheter breakage:
 - Leakage of IV fluid from catheter, hole in the catheter, catheter fracture.
 - 1) In the event of catheter breakage, a tourniquet shall be placed high on the upper arm so that venous flow (not arterial flow) is obstructed.
 - 2) Check vital signs and radial pulse every 5 minutes while the tourniquet is in place.
 - Any distress or change in condition should be immediately brought to the attention of the physician.

K. RELATED DOCUMENT(S):

- 1. Infection Control: Hand Hygiene IC 8 Policy
- 4.2. Infection Control: Pelicy IC.5-Standard and Transmission- Based Precautions IC.5 Policy
- 3. Patient Care Services: Central Venous Access Devices Procedure
- 4. Patient Care Services: Identification, Patient Policy
- 5. Patient Care Services: Local Anesthetic Prior to Intravenous Insertions Standardized Procedure

PCS: Midline Catheter. Adults

- 6. Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure
- 7. Patient Care Services: Standards of Care, Adults Procedure

L. REFERENCE(S):

 Gorski, L. A. (2016). The 2016 infusion therapy standards of practice. (2016) Journal of Infusion Nursing.



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 12/01 SUBJECT: Physician/Allied Health

Professionals (AHP)Provider

Inpatient Orders

REVISION DATE: 10/02, 05/03, 06/03, 06/05, 06/06,

04/09, 06/11, 07/12, 01/13

POLICY NUMBER: IV.M.

Department Approval: 10/17

Clinical Policies & Procedures Committee Approval: 02/1410/17 **Nursing Executive Council Approval:** 02/1410/17

Pharmacy & Therapeutics Committee Approval: 11/17

Medical Executive Committee Approval: 03/1411/17 **Professional Affairs Committee Approval:** 04/1401/18 04/14

Board of Directors Approval:

A. **PURPOSE:**

To define the parameters for the receipt, validation, and follow through of Medical Staff orders to increase patient safety and reduce physician/previder-Allied Health Professional (AHP) order errors.

B. **DEFINITION(S):**

- Chart Check:— Chart checks ensure transcribed orders from the previous shift are current, accurate, appropriate for the nursing unit, and have been entered into Cerner.
- 2. Electronically Transmitted Order:— an order that has been written by the prescriber and electronically transmitted to authorized hospital personnel.
- 3. Medical Staff orders:— therapeutic interventions that are written, verbal, electronically transmitted, or dictated by telephone by a member of the Medical Staff or an Allied Health Professional (AHP).
- 4. Range Dosing:— orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status.
- 5. Standardized Procedure Order:— an order written in the medication record as a result of implementation of a standardized procedure.
- 6. Telephone Order (T.O.): order communicated by telephone when the prescriber is not physically present (face-to-face) with the authorized personnel.
 - On the paper chart as T.O. a.
 - Texting orders via electronic portable devices are prohibited.
- 7. Verbal Order (V.O.): order communicated by oral, spoken, or face-to-face communication between prescriber and authorized hospital personnel within their scope of practice.
 - On the paper chart is noted as V.O.
- 8. Read Back Process: All telephone/verbal orders shall be read back to the prescriber in their entirety from the primary source.
- 9. Titrating Orders: orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services: Titrating Medications, Adult Patients Policy.
- 10. Taper Orders: orders in which the dose is decreased by a specified amount with each dosing interval.
- 11. Hold Orders: order for discontinuation of the medication (refer to Patient Care Services: Automatic Stop Orders Policy).

C. POLICY:

- 1. Authorized personnel may accept orders from:
 - a. Members of the Tri-City Hospital DistrictMedical Center (TCHDCMC) Medical Staff and AHPs for inpatient/outpatient treatment and diagnosis:
 - i. A Physician's Assistant who has been appropriately credentialed through the Medical Staff may transmit orders from the physician/AHP given verbally, via telephone, or in writing. Orders must be co-signed by the Physician's Assistant and supervising physician or attending physician/AHP within 48 hours for medication orders and fourteen (14) days post discharge for all other orders.
 - b. The following categories of practitioners who are not TCHDCMC Medical Staff members or AHPs for outpatient diagnostic tests and services:
 - i. Doctors of Medicine (M.D.)
 - ii. Doctors of Osteopathic Medicine (D.O.)
 - iii. Doctors of Podiatric Medicine (D.P.M.)
 - iv. Doctors of Dentistry (D.D.S.)/ Doctor of Dental Medicine (D.M.D.)
 - v. Nurse Practitioner (NP)
 - vi. Physician Assistant (PA)
 - vii. Chiropractor (D.C.)
 - viii. Licensed Acupuncturist (L.AC.)
 - c. It is the responsibility of the unit/department accepting the order to verify the **physician/AHP**practitioner is authorized to order (i.e., **Mm**aintains the appropriate license).
 - d. Registered Nurses (RN) may accept verbal orders from the Lifesharing RN on brain dead potential organ donors whose care has transferred to Lifesharing, under the direction of their Medical Director.
 - d.e. RNs or other designated personnel may accept and implement a medication order which is transmitted by a designee of the Medical Staff member to the RN after determining that the order is being transmitted and not initiated by the Medical Staff member's designee, that the order is appropriate for the patient's condition and is in his or her best interest, and that the order is in compliance with applicable statutes, regulations, and hospital policies.
- 2. All orders shall be recorded (written) legibly or entered electronically into the patient's record in a timely manner.
 - a. Order(s) shall include name of physician/AHPprovider giving order, date and time, name of person receiving order if other than physician/AHP.
 - b. A licensed practitioner, within their scope of practice, may receive orders.
 - c. Orders that do not contain the required elements shall be considered incomplete and shall not be implemented until clarified. If the prescriber cannot be reached and the intervention is urgently needed, the appropriate on-call physician/previder-AHP shall be contacted to clarify the order.
 - e.d. If the refusal order icon appears, the order shall be clarified with attending physician/providerAHP.
 - d.e. "Blanket orders" for medication, treatments, procedures, and laboratory tests (i.e. "continue previous medications," "resume all pre-op medication, labs or treatments," "resume all physical therapy ([PT]) therapy," or "discharge on current medications") will not be accepted.
 - e-f. Telephone orders/verbal orders shall be decumented-immediately on the physician's order-sheet-or-entered directly into the electronic health record (EHR). When it is not possible to enter a telephone order, document the order immediately on the Physician's Order sheet and ensure it is signed, dated, and timed by the individual who received the order.
 - i. The complete order(s) shall be clearly read back to the physician/provider directly from the primary source.

- If oOrders are entered directly into the EHRelectronic record, shall be entered using the correct Communication Type. the correct Verbal Order/Read Back or Telephene-Order/Read-Back communication type must be selected. A message will be sent to ordering physician/provider message-center-for-signature.
- 2) If orders written on the Physician's Order sheet, the Read Back box shall be check-marked (✓) to document orders were read back.
- ii. Orders must be signed within 48 hours for medication orders and fourteen (14) days post discharge for all other orders.
 - 3)1) Medical Staff members covering for another may sign his/her order. Telephone orders for antineoplastic agents are not permitted.
 - 1) Exceptions: See Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation PolicyThe-pPharmacyist-may clarify antineoplastic orders via the telephone.
- iii.iv. Emergency telephone orders/verbal orders will not be accepted for withdrawing life support, (i.e., mechanical ventilation).
- iv.v. Telephone or Verbal orders are to be used infrequently, only to meet the care needs of the patient when it is impossible or impractical for the ordering physician/provider-AHP to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician/provider-AHP to enter orders into Cerner or in writing when they are on the unit.
 - Verbal orders given during patient procedures are to be recorded and signed by the ordering physician/previder-AHP immediately following the procedure.
- f.g. Medication orders:

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- i. Only medications needed to treat the patient's condition are ordered.
 - 1) Diagnosis, condition, or indication for use must be documented for each medication ordered.
- i-ii. An acceptable medication order contains the following information:
 - 1) Drug name (brand or generic)
 - 2) Dose
 - 3) Strength and concentration
 - 4) Frequency
 - 5) Route of administration
 - 5)6) Duration (see Patient Care Services: Automatic Stop Orders Policy)
 - 6)7) Indication if PRN
- ii.iii. Physician/AHPprevider "PRN" medication orders shall specify an indication or symptom unless only one indication exists for the medication.
 - 1) If an order is written without an indication, the use of the "PRN Medication Default Reasons" will auto populate for select medications on the medication administration record (MAR).
 - 2) Multiple orders for the same PRN reason will not be accepted unless one of the following criteria are met:
 - a) Order clarifies the sequence of administration. Example: Percocet 5/325 1 tab PO Q4H PRN severe pain (7-10) Morphine 2 mg IV Q4H PRN severe pain not relieved by Percocet
 - Order specifies different, non-overlapping ranges for the symptoms. Example: Percocet 5/325 1 tab PO Q4H PRN moderate pain (scale)
 - Morphine 4 mg IV Q4H PRN severe pain (scale)
 - 3) Any order with the same PRN reason as a previous order will supersede the previous order. The pharmacist will automatically discontinue the previous order.

- 4) If the indication entered does not reflect the patient's condition or if there are any questions concerning the appropriate indication the physician/AHPprovider shall be contacted for clarification.
- iv. Range Orders:— orders may only contain one set of ranges (dose or frequency). If orders are received with more than one set of ranges, then the healthcare provider must contact the physician/provider-AHP to change the order unless a policy or protocol is in place for interpretation of range orders (i.e. sliding scale insulin order, Post Anesthesia Nursing Unit opiate orders). See Patient Care Services-IV-I: Medication Administration Policy-for Administration of Medications Policy.
- v. Range orders for a dosage that is more the double than smallest dose, shall not be accepted by pharmacy and shall be clarified with the physician/AHP by pharmacy
 - 1) Example: Morphine 2-8 mg IV every 4 hours PRN will be clarified by pharmacy.
 - 2) Acceptable orders include: Morphine 2-4 mg IV every 4 hours PRN or Morphine 4-8 mg IV every 4 hours PRN after speaking with the physician/AHP.
- vi. Pediatric Orders:
 - 1) Physician/AHP orders for pediatric populations shall contain weight based dosing (i.e. mg/kg), calculated dose, and the patients current weight except for the following defined medication classes:
 - a) Medications not determined by the patient's weight (i.e., iron sulfate).
 - b) Vaccines:
 - i) Ensure the weight-based dose does not exceed the recommended adult dose.
- iii.vii. A pharmacist shall check all medication orders for appropriateness before access is granted through the Pyxis to licensed staff, unless a physician/AHPprevider is administering the medication or overseeing the administration of the medication, er (i.e. "Non-Profile" Pyxis areas).
 - 1) See Patient Care Services: Medication Administration Policy if a nurse needs to obtain medications not yet reviewed by a pharmacist.
- viii. Orders that do not contain the required elements or entered incorrectly, shall be considered incomplete and shall not be implemented until clarified. If the prescriber cannot be reached and the intervention is urgently needed, the appropriate on-call physician/AHP shall be contacted to clarify the order.
- ix. Titration medication orders must include the rate of infusion and instructions for titration with goal parameters, unless part of an approved protocol. See Patient Care Services: Titrating Medications, Adult Patients Policy.
- x. Taper orders must include a detailed taper/wean schedule, including specific dose reductions per specified dosing intervals, unless they are part of an approved protocol specified by the prescribing physician/AHP.
- xi. Any medications put on "hold" by the physician/AHP shall automatically be discontinued by the nurse and Pharmacy and must be reordered by the physician/AHP if and when the medication is resumed.
- xii. Medication orders will be renewed in a timely manner and in accordance to Patient Care Services: Automatic Stop Order Policy.
- iv-xiii. Preprinted orders will be accepted if they have been approved by the Pharmacy and Therapeutics Committee.
- Transfer Process:

- a. When a patient is transferred from one level of care to another the physician/AHPprovider updates the orders and completes medication reconciliation per medical staff policy. The nurse will review the orders and contact the physician/AHPprovider for any clarification of orders.
- b. When a patient undergoes one of the following minor procedures and returns to the same level of care the physician/previder-AHP is not required to rewrite orders:
 - i. Heart catheterization
 - ii. Interventional procedures including PICC line placement
 - iii. Endoscopy including bronchoscopy
 - iv. Inpatient dialysis
 - v. Pain management
 - vi. Insertion of feeding tube, radiologic, GI or surgical
 - vii. Tracheostomy
- c. When a patient undergoes a surgical procedure, all previous orders shall be discontinued and post-operative orders implemented.
- e.d. Discharge Medication Orders: See Pharmacy Policy: Discharge Prescriptions.
- Reviewing Orders on Inpatient Units:
 - All orders entered electronically or written on the Physician Order sheet must be reviewed for correctness and clarity and acknowledged in a timely manner before being implemented.
 - i. Notify the physician/provider-AHP if needed for clarification of any orders.
 - ii. Orders entered electronically:
 - 1) Complete Nurse Review
 - iii. Orders written on Physician Order Sheet:
 - 1) Scan the Physician's Order sheet to the pharmacy.
 - A RN will compare medication orders from the physician/provider's AHP's order(s) with the information entered electronically by the pharmacist and complete Nurse Review.
 - 3) A RN will compare non-medication orders with the information entered electronically.
 - 4) A RN will note (sign) the orders by writing name, title, date, and time in the Nurse's Signature Box on the Physician's Order sheet.
 - b. If the mComplete an occurreance report/quality review report for medications are entered incorrectly. For such orders with one or all of the following: wrong dose, route, time, frequency, or spelled incorrectly by:
 - i. If-pPhysician order entry error, the pharmacist/nurse will clarify with the ordering physician.
 - ii. If pPharmacist order entry error, then nursing will not review/note (sign) the orders until the corrections are made by pharmacy on Nurse Review.
 - iii. Complete-an-occurrence-report/quality-review report.
- 5. Chart Checks:
 - a. Chart checks shall be implemented every shift.
 - b. Chart checks shall include:
 - i. Orders entered electronically:
 - Review orders and ensure Nurse Review has been completed.
 - 2) Orders should be completed or discontinued as applicable.
 - 3) Orders should be reviewed for duplicate orders which should be corrected to reflect most current order.
 - ii. Orders written on Physician Order sheet:
 - 1) Review for written orders. Ensure medications have been scanned to Pharmacy and all orders have been correctly entered electronically and noted (signed).
 - c. Process for chart checks:

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Physician Orders – IV.M.
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- i. Review Physician Order sheets for new orders within the last **twelve** (12) hours or since last chart check.
- ii. Review electronic orders for new orders within the last **twelve** (12) hours or since the last chart check.
- iii. Validate completed chart checks by documenting on **twelve** (12) hour chart check power form ensuring both paper and electronic orders have been reviewed.

1. Podiatric Orders:

- a. Physician/provider orders for pediatric populations-shall-contain weight based dosing (i.e. mg/kg), calculated dose, and the patients current weight-except-for the following defined-medication classes:
 - i. Medications not determined by the patient's weight (i.e., iron sulfate)
 - ii. Vaccines
- b. Ensure the weight-based dose does not-exceed the recommended adult dose and a pharmacist has checked all medication orders for appropriateness.
- c. Resources available on the Intranet under Electronic Forms; Patient Care Services
- d. Electronic Transfer-Process

D. RELATED DOCUMENT(S):

- 1. Patient Care Services: Automatic Stop Orders Policy
- 2. Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation Policy
- 3. Patient Care Services: Medication Administration Policy
- 4. Patient Care Services: Titrating Medications, Adult Patients Policy
- 5. Pharmacy Policy: Discharge Prescriptions Policy

D. RESOURCES AVAILABLE ON THE INTRANET UNDER ELECTRONIC FORMS; Patient Care Services

1. Electronic Transfer Process

* In-City Medical Center		Patient Care Services			
PROCEDURE:	PYXIS CONNECT SCANNER				
Purpose:	To optimize the consistent and efficiency orders.	cient use of the Pyxis Connect Scanners for written			

A. PROCEDURE:

- 1. Processing Orders: Nursing Responsibilities:
 - Nursing personnel will scan the original Physicians Order Form as soon as possible after the order is written.
 - All Physician Order Forms will be scanned into the Pyxis Connect System.
 - c. After scanning the original Physician Order, the letter (s) (meaning scanned) will be stamped on the scanned orders. Additional orders may not be added to the section with scanned orders.
 - d. Immediate (STAT) orders:
 - i. When scanning a "STAT" order, select the "STAT" option from the scanner menu screen. The scan will appear in red with a priority level of "STAT" in Pyxis Connect.
 - i. Place a Pyxis-STAT-barcode sticker in the middle of the page regardless of where the order is written. The scan-will-appear in-red-for the pharmacist indicating that it contains a stat-order.
 - ii. The STAT Bar Code Sticker will be lined through-on-multiple-section order sheets after-scanning-to-prevent false STATs.
 - iii. Any other-bar codes placed inside the blue box area will cause the STAT barcode sticker-to-fail. (Avoid placing the patient sticker in this area for STATs).
 - iv. Pyxis STAT-barcode-stickers are available from the Copy Center.
 - e. If the order is unclear or unreadable, nursing personnel will clarify the order before scanning.
 - i. If the Pharmacist receives a scanned order that needs clarification, the Pharmacist will sean-the-order-back tocontact the nursing unit from which the scanned document was received and request clarification as needed.neting on the order-what kind of clarification is needed.
 - ii. Once the order is clarified by nursing personnel, the order will then be rescanned through the Pyxis Connect System.
- Processing Orders: Pharmacy Responsibility
 - Scanned orders will automatically route to specific workstations such that specific pharmacist personnel will be responsible for physician order processing occurring in the hospital.
 - b. Scanned orders queue up similar to e-mail, with the first order scanned listed at the top of the queue for processing by Pharmacy personnel.
 - c. Each scanned order is electronically stamped with the location and the time it was scanned.
 - d. If orders in a particular areas queue for longer than twenty (20) minutes, the Pharmacist will ask for assistance as available.
 - e. If the pharmacist clarifies or changes the order, -The clarified or changed ordercorresponding annotations will be written by the pharmacist andmarked on the scanned order intewithin Pyxis Connect. Pharmacy will deliver the original order to the nursing unit. Nursing personnel will place the order in the patient's chart. The pharmacist will then place a new medication order in Cerner as a telephone or verbal order per the Physician Orders policy. The pharmacist will call thenotify nursing floor to alert of the new order and inform them if the order is STAT or urgent.
- 3. Downtime Procedures:

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/05, 08/07, 05/10, 02/14, 10/17	05/10, 02/14, 11/17	05/10, 02/14, 12/17	n/a	n/a	06/10, 03/14, 01/18	06/10, 03/14

Patient Care Services-Procedure Manual Pyxis Connect Scanner Page 2 of 3

- a. When the scanner is down, nursing personnel will notify the Pharmacy Department.
- b. Nursing personnel will fax Physicians Order Form to (760) 940-3786.
- c. When the scanner system returns to normal status, the Pharmacist will scan the orders into the system.
 - i. An S would be stamped on the order before scanning occurs by the Pharmacist if the order has been entered.
 - ii. For Stat-STAT orders during down time, nursing will notify the pharmacist by phone.

B. FORM(S):

iii.1. Physicians Order Form

+

Physicians Order Form - Sample

Unapproved Abbreviation	Preferred Term	KNOWN ALLERGIES TO BE LISTED WITH EACH ADMISSION: Admit status:	_					
C.C.	'mL'	May interrupt Telemetry monitoring for transport to tests/procedures without nurse						
U	"Units"		_					
IU	"International Units"		_					
QÐ.	"Daily"		_					
QO.D.	"every other day"	Read Back all T.O.N.O.orders Nurse's - Signature Date Time Physician's - Signature Date Time						
Indrigzero (X O my)	Noverwije azero by tod diera dvanid priet (King)	May interrupt Telemetry monitoring for transport to tests/procedures without nurse.	_ _					
Leckoffeeding zisu (X mg)	/Negsuze azoro belore adecinal paet (D X mg)		<u>-</u>					
MS MSO4	"morphine sulfale"		_ _					
MgSO ₄	"magnesium sulfate"	□ Read Back all T.O.V.O.orders Nurse's - Signature Data Time Physician's - Signature Date Time May interrupt Telemetry monitoring for transport to tests/procedures without nurse.	_					
S.C. or S.Q.	"Sub-Q", or "subQ"	3	_ _ _					
μg	"mog" ar "micrograms"		_					
DO NOT use abbreviations for chemotherapeutic agents		Read Back all T.O.N.O.orders Nurse's - Signature Date Time Physician's - Signature Date Time	_ _					

STAT: If STAT Pharmacy order, place X in box





PHYSICIAN'S ORDERS

Affix Patient Label

Tri-City Me	dical Center	Patient Care Services
PROCEDURE:	PATIENT FOOD REFRIGERATO CLEANING/DEFROSTING RES	ORS/FREEZERS TEMPERATURE PONSIBILITIES
Purpose:	To ensure patient care refrigerate and cleaned.	ors for food and medication a re monitored, defrosted,

A. PROCEDURE:

B. Patient Food Refrigerators—Temperature-Monitoring and Log Documentation:

- All patient food refrigerators shall be cleaned/defrosted as neededat least monthly by Food & Nutrition-personnel.
 - a. The patient food refrigerators/freezers will be checked when inventoried/stocked by Food & Autrition personnel.
 - 1.i. Nursing will be responsible for refrigerators not routinely stocked.
 - b. Food &and Nutrition personnol-shall-documentis responsible for cleaning and defresting of patient food refrigerators on the refrigerator- cleaning log.
 - a.c. Engineering is responsible for defrosting.
- **1-2.** Temperature range for patient food stored in refrigerators should range from 30 to— 40 degrees Fahrenheit (F).
- 3. The patient food refrigerators have an Awarepoint probe monitoring the temperature-every 10 minutes, 24 hours a day, seven (7) days a week. Access the Awarepoint website from the Tri-City TCMC-Intranet.
 - 2.a. Awarepoint will send an initial emailtext-message to the Food &and Nutrition supervisors from 0500 to- 2100 and to Engineering from 2100 to- 0500assistant nurse manager (ANM) or designee, either-via-text-page, a-text-to-a cellular telephone, or an email.
- a.4. If the temperature falls outside the correct range, the ANM-supervisor/Engineering shall:
 - i.a. Check the freezer compartment for over icing. If the freezer requires defrosting alert the Food and Nutrition supervisor/Engineering to arrange for defrosting.
 - ii.b. If the freezer is not the problem, the supervisor/Engineering will contact nursing personnel to shall-adjust the thermostat. The supervisor/Engineering willand monitor results in one hour.
- iii.5. If the temperature is not corrected one (1) hour after adjusting the thermostat, a work order will be placed to Engineeringnursing personnel shall notify Engineering at Ext 7148.
 - iv.a. In addition, nursing personnel shall notify-Food &and Nutrition supervisors will evaluate the need to aid in-relocateing appropriate food items until temperature is corrected.
 - v.b. Corrective actions shall be documented in the Awarepoint system.

B. Patient Medication Refrigerators - Temperature Monitoring and Log Documentation:

- 1.——All-patient medication refrigerators shall be cleaned/defrested at least-monthly-by Food & Nutrition personnel.
 - a. Food-&-Nutrition personnel shall enlist the RN in the area to open-the-medication refrigerator, supervise cleaning and relock refrigerator at the completion-of-the cleaning/defresting.
 - b. Food-&-Nutrition-personnel-shall-document cleaning and defresting of patient medication refrigerators on the Cleaning and Defresting-Log-
- Temperature range for patient medications requiring refrigeration should be greater than 36°F and less than 46°F.
- 3. The medication refrigorators have an Awarepoint probe monitoring the temperature every 10 minutes, 24 hours a day, 7 days a week. Access the Awarepoint website from the TCMC intranet. Awarepoint will send an initial text message to the pharmacy Courier between 0700-2400 or the night pharmacy technician between 2400-0700. If there is no response from the initial alert, the system will-send a second text message to the pharmacist A Cart phone (760-908-3918).

Department Review	Clinical Policies & Procedures	Nurse Executive Operations Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/00, 06/03, 07/07, 11/10 , 10/17	11/10, 11/17	11/10, 12/17	n/a	01/11, 01/18	01/11

Patient Care Services
Refrigerator Temperature, Cleaning-Defrosting Responsibilities Procedure
Page 2 of 3

- a. When the Pharmacy personnel is notified by Awarepoint that the temperature is outside the correct range, they shall:

 i. Check the freezer compartment for over icing.

 1) If the freezer requires defresting, the Food & Nutrition Department shall be notified.

 ii. If the freezer is not the problem, pharmacy personnel shall adjust the thermostat and monitor results in one hour.

 1) If the temperature is not corrected one hour after adjusting the thermostat, Engineering shall be notified at Ext 7148.

 a) In addition, Pharmacy personnel aid in relocating medications until temperature is corrected.

 iii. Corrective actions shall be documented in Awarepoint.
- C. FORM/GUIDE REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:
 - 1. Cleaning & Defrosting Logs -Food-and-Medication
 - 2. Awarepoint Refrigerator-Monitoring-Guide

Tri-City Medical Center

Refrigerator Cleaning Log

Refrigerators used for patients' food must be cleaned by Food and Nutrition Services Personnel. Cleaned/Defrosted by: (Print Name) Date Completed	Location:				
Month of:	Refrigerator Number:				
Refrigerators used for patients' food must be ci	leaned by Food and Nutrition Services Personnel.				
Cleaned/Defrosted by: (Print Name)	Date Completed				
	<u> </u>				
DELET	E Log				
Comments:					

Tri-City Medical Center		Patient Care Services			
PROCEDURE:	RELEASE OF DECEASED				
Purpose:	To care for and release remains of deceased to Medical Examiner's Office, appropriate mortuary/crematory or Lifesharing				
Supportive-Data:	Patient Care Services Medical E Procedure-Deceased-Patient-Ca	rgan Donation, Including Tissues and Eyes, and xaminer Notification, Patient Care Services re and Disposition, Security Department policy # Deceased Form and Consent of Anatomical			

A. AFTER A PATIENT'S DEATH, THE STAFF NURSE WILL:

- Notify physician/Allied Health Professional (AHP) to pronounce the patient or to obtain physician's order for the Administrative Supervisor (AS) or specially-trainedauthorized Registered Nurse (RN) to pronounce patient dead.
 - a. Notification of the family of the patient's death is the responsibility of the physician/AHP.
 - i. Provide next of kin's name and phone number to physician/AHP.
 - ii. Ask the physician/AHP who will be responsible for signing the death certificate and complete the Expiration Record in Cerner with this information.
 - For neonatal deaths see Patient Care Services Procedure: Miscarriage and Stillbirth Identification and Disposition Process and Patient Care Services Procedure:
 Miscarriages and Stillbirth Identification and Disposition ProcedureDeceased Newborn/Stillborn, Care of.
 - c. For in-custody deaths see In-CustodyProgressive Care Unit Procedure: Release of a Deceased of an-IncarceratedJustice Involved Patient.
- Notify the Medical Examiner of reportable deaths within one (1) hour of death and do not remove any lines unless this is waived by the Medical Examiner. (Refer to Patient Care Services Policy: Medical Examiner Notification for criteria for reportable deaths and process for reporting). Explain procedures involved to family.
- 3. Indicate in the Expiration Record in Cerner if the Medical Examiner is notified or not.
 - a. If the Medical Examiner is notified and waives the case make sure to enter the waive number in the Expiration record.
 - b. If the Medical Examiner accepts the case document in Cerner the Medical Examiner accepts case.
 - The Medical Examiner's office will pick up decedent.
- 4. Notify the donor referral line (Lifesharing) as soon as possible and within one (1) hour of the death at 1-888-423-6667 (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes **Donation Option Brain Death**). Note the date and time of this call and name of the referral line staff on the Expiration Record in Cerner.
 - a. If LifeSharing identifies the patient as a candidate for eye, bone or tissue procurement, a Lifesharing Representative shall contact the family regarding donation options (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes Donation Option Brain Death) for referral, obtaining consent, and recovery process. If the representative calls back with donation information for consent purposes, the additional information on donation in the Expiration Record in Cerner needs to be completed.
 - b. Only a Lifesharing Procurement Coordinator shall approach the family regarding donation option for organs.
 - Verify that the family consent or refusal for donation option is documented in the Expiration Record in Cerner along with time of death.
 - ii. Provide eye care for corneal / eye donation patients (close eyes, place light ice bags over the eyes). Corneas can be utilized up to twelve (12) hours.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/94, 04/07, 03/10, 06/13,12/13 , 10/17	07/06, 04/07, 03/10, 06/13,12/13, 03/16, 10/17	08/06, 07/07, 04/10, 06/13,12/13, 03/16, 10/17	08/06, 07/07, 04/10, 07/13, 01/14, 04/16, 11/17	09/06, 08/07, 05/10, 09/13, 02/14, 06/16, 01/18	09/06, 08/07, 05/10, 09/13, 02/14, 06/16

- iii. Document consent for donation in the "Expiration Record" in Cerner and place signed consent form in the front of the medical record. Leave the chart in the Nursing area at the main nursing desk on the floor in which the patient expired for the Procurement Coordinator to review. Document recovery procedure completion if done at bedside in the expiration record in the "other" comment box of "Organ Donation Approval" section.
- Notify AS /specially trained RN 760-644-6968 immediately after death.
 - a. If the AS is not available, Security will be point of contact, until AS is available.
- 6. Solicit assistance from Chaplain, Social Services and/or patient's Hospice Nurse as needed for family support.
 - a. If hospice is involved, they do not notify the mortuary to pick up the deceased, only the AS makes this call.
 - b. In the Emergency Room, Social Services and Trauma Interventional Program (TIP) is available for family support.
- 7. Verify that the time of death is recorded in the Expiration Record in Cerner by the AS or by the physician/AHP who pronounced the death. If the AS or specially trained RN pronounces, the time will be entered into the note of pronouncement and expiration record, otherwise the time will be noted in the Physician's Progress Note.
- 8. Provide family information regarding funeral arrangements and support services.
- 9. Release patient belongings and valuables after recording inventory of all valuables and patient belongings in the Expiration Report in Cerner and then print Authority for Release of Deceased Report and place a patient label where indicated. Release belongings to family and obtain their signature on Authority for Release of Deceased Report.
 - a. Any unclaimed valuables will be secured in valuables envelope and then the RN notifies Security to pick up the valuables. All unclaimed valuables will be placed in the hospital safe per Patient Care Services Policy: Patient Valuables, Liability and Control and the receipt forwarded to the AS. Security is to be contacted to provide patient valuables to family members when requested after a patient's death.
 - b. If family is not present to take patient belongings, then the RN notifies Security to pick up the belongings and place them in a secure designated location. Security is to be contacted to provide patient belongings to family members when requested after a patient's death.
- 10. Print Cerner report Authority for Release of Deceased Report for signatures.
 - If Authority for Release of Deceased Report is signed by a legal representative, attach a copy of the documentation of legal representation, e.g. Power of Attorney.
- 11. Forward the following to the AS:
 - a. A completed electronic Authority for Release of Deceased Report.
 - b. Facesheet 1 copy.
 - c. 1 copy of documentation of legal representation of patient, i.e. Power of Attorney;
 Conservator, if applicable.
 - d. Valuables receipt.
 - e. Gensent-Authorization for Autopsy (if requested by family or physician and financial arrangements have been confirmed with Department of Pathology).
 - f. Consent for Anatomical Donation, for Tissue and/or Eye Donation (when procurement is complete).
 - g. Body donation program acceptance letter/forms.
- 12. After patient is properly identified and placed in body bag, notify Lift Team to transport the body from the patient care area to the morgue for temporary storage.
- 13. May also release patients to Medical Examiner's office or mortuary from the patient's room following the above process and sign off appropriately on the Authority for Release of Deceased Report.

B. THE ADMINISTRATIVE SUPERVISOR WILL:

1. Call the mortuary when the body is ready for release from Tri-City Healthcare District

(TCMCHD) and provide them with the information requested from the completed Authority for Release of Deceased Report. Refuse release of body to any agency or transport service before hearing from next of kin and having authorization signed. Exceptions to this are as follows:

- a. The Medical Examiner will pick up the deceased on their authority.
- b. If the patient has made prior arrangements (pre needs), a copy of this document from the mortuary is acceptable.
- 2. Send the Authority for Release of Deceased Report and additional paperwork to the AS office, even if patient is to be picked up from room or other areas of the Medical Center.
- 3. Notify Engineering when morgue bay is full to adjust temperature.
- 4. Respond to call from Private Branch Exchange (PBX) when a security officer is unavailable to release deceased from TCMCHD.
- 5. Notify Public Administrator if:
 - a. Next of Kin of patient is unidentified and there is no identified court appointed Power of Attorney or Conservator/Guardian.
 - i. Holding A Body Pending Disposition: The body of any person whose death occurs in this State, or whose body is found in the State, or which is brought in from outside the State, shall not be temporarily held pending disposition more than eight (8) calendar days after death, unless a permit for disposition is issued by the local registrar of the registration district in which the death occurred or the body was found.
 - b. Parents or family of fetal demise have made no mortuary arrangements after eight (8) days.
 - If parents or families are unable to financially te-obtain mortuary services, they
 may contact the Public Administrator for assistance. This is done by the family
 placing the call to the San Diego County Public Administrator (858) 694-3500.
 - ii. The Medical CenterTCHD staff is prohibited from making mortuary referrals or financial arrangements for families.
- 6. Serve as a resource to the staff nurse regarding consent for tissue, organs, and eye donation, (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes **Donation Option Brain Death**). The determination of donor suitability will be done by Lifesharing.
- 7. Contact Anatomical Gift Program to verify donation when patient has applied or been accepted into the anatomical gift program for body donation.
 - a. If available, attach a copy of the acceptance forms and letter, from the University Medical Center or school to the Authority for Release of Deceased Report. If not available from the family, call the Program Office at the School or University for a copy to be faxed to TCMCHD and attached to the Authority for Release of Deceased Report.
- 8. In the case of an autopsy:
 - a. Autopsies may be requested on any deceased patient by the attending physician/AHP or immediate family/legal guardian who has legal standing, in order to determine the cause(s) of death, but only with a signed written consent, i.e., a formal Autopsy Permit, sometimes referred to as Authorization for Autopsy.
 - b. Ensure family understanding that the attending physician/AHP's request for an autopsy does not make TCMGHD financially responsible for the autopsy, and does not obligate the TCMGHD Pathologist. There is a professional fee from the Pathologist for the service, and the Family must make financial arrangements for the autopsy with the TCMGHD Pathologists prior to the start of the autopsy. The AS will assist the family in meeting with a representative of the Pathology Department to make such arrangements.
 - **c.** The TCMCHD Pathologist reserves the right to evaluate the indications for the autopsy, and may decline the request if it is deemed inappropriate.
 - i. If the autopsy is so declined by the TCMCHD Pathologist, the family may then elect to commission the S.D. County Medical Examiner's office (M.E.) to perform a private autopsy, if that office agrees to do so. Those private arrangements must be made directly between the next-of-kin with legal standing and the M.E.'s office. The Family will be financially responsible for the M.E.'s fees in these

- circumstances also. The M.E. would be expected to charge a fee if that office does <u>not</u> exert it legal jurisdiction and convert the case to a "Medical Examiner's Case".
- b. TCMC Pathologist-reserves the right to honor the request based on written-consent from the physician; no payment. If-declined at TCMC, the family may request the ME or independent Pathology to perform at their request. In those cases the family is responsible for payment.
- c. Ensure family-understanding that a physician's order for autopsy-does-not-make-TCMC financially-responsible for the autopsy. The Family must make financial arrangements for autopsy with the Department of Pathology prior to start of autopsy. The AS will assist the family in meeting with a representative of Pathology department to make such arrangements.
- d. When a family requests an autopsy be performed at TCMGHD:
 - i. The patient's physician/AHP, Pathology and Medical Records are notified.
 - ii. All forms are signed.
 - iii. The chart is sent to Medical Records for processing and is forwarded to Pathology Department the same day for the autopsy.
 - iv. The canary copy of the autopsy consent is kept by the AS with the Authority for Release of Deceased Report copies.
- e. The Secretary for the Department of Pathology notifies the AS when the autopsy is complete. The original Authorization for Autopsy form stays with the chart, a carbon copy remains in the Laboratory. Upon notification of autopsy completion, the body may be released to the mortuary.
- f. For autopsies to be completed at outside facilities (e.g. UCSD Medical Center or the Medical Examiner's office), the body will be released and signed copies of the Authority for Release of Deceased Report in the space provided for such agencies and Autopsy Consent (pink copies) provided. The Authority for Release of Deceased Report will remain on the board for return of body if known. Remaining forms go to the AS.
- Once the body is released from the TCMCHD morgue it is no longer the responsibility of TCMCHD to accept the body back to our morgue. Fetal demises will be released from Pathology to the mortuary of choice.

C. THE SECURITY OFFICER WILL:

- Upon notice by PBX-AS of mortuary service or Medical Examiner's arrival, pick up Authority for Release of Deceased Report forms from the AS office. If no forms found, call the I-AS (760) 644-6968.
 - a. If the patient is to be picked up from their room, Security will follow the same process.
- Go to the morgue or patient's room with above paper work, identify Medical Examiner's agent, appropriate mortuary service/procurement agency, and verify the deceased with all identification as below:
 - Medical Examiner's agent: Request identification and verify the name of the decedent.
 - b. Mortuary: Request identification and verify the name of decedent.
 - c. Decedent: Check the Authority for Release of Deceased Report and Patient Identification Label/name against the hospital armband and bag/toe tags.
 - d. Verify that no personal belongings or valuables remain on the deceased. Return all valuables and/or belongings found to AS-or Security.
- Legibly sign the Authority for Release of Deceased Report along with driver.
- 4. Provide driver with unsigned copy of Authority for Release of Deceased Report
- 5. Complete Morgue Disposition Log, logging patient out of morgue (or back into morgue, if patient is returning from Medical Examiners/procurement agency).
- 6. Deliver signed copy of the Authority for Release of Deceased Report to the AS office and make a second copy of signed report.
 - a. Place original copy on clipboard labeled Medical Records and place in Returns box, this will be picked up daily by Medical Records.

- b. Update Deceased Tracking Report with morgue status daily.
- 7. Notify AS when a deceased is returned to the morgue from an outside agency.
- 8. Notify AS if any problems with morgue, or if any deceased is not in a morgue bay with their name.
- 9. Update morgue log with any deceased patient movement, either entering the Morgue or being removed from the morgue.
- 10. At no time will any Security Officer be required to: Adhere to all aspects of Security Department Policy and Procedure #224 regarding Morgue-Release.
 - a. At NO-TIME will any Security-Officer-Lift or attempt to lift any remains as assistance to the Mortuary Driver.
 - b. No Security Officer shall be required to transport a deceased patient's remains to or from the Morgue.
 - c. If it is necessary to escort the Mortuary Driver to the expired patient's room, the floor's Charge Nurse or ASANM/Relief Charge Nurse will be responsible for all paperwork.
 - d. No Security Officer shall be required to participate in any other functions of a Morgue Release than stated in this policy.
 - e. No Security Officer shall be required to prepare a deceased patient's body for viewing in the Morgue or any other location.
 - a. Security to get signatures with family.
- 10-11. Ensure that there is a family consent before allowing San Diego Eye Bank to take the body from the morgue and start the case. Security should first check with the AS to ensure that consent exists.

D. <u>SECURITY AFTER HOURS PROCESS:</u>

- When the AS is not available, Security will be the point of contact for Release of Deceased matters to include: family members signing the Authority of Release of Deceased Report, communication with mortuaries, donation services and release of remains from TCMCHD.
- 2. After Hours Procedure:
 - a. Lead-Security OfficerAS will be notified of request.
 - b. Security-AS shall contact/speak with family member and verify next of kin status or right to sign.
 - c. Security shall request that the family member come in to sign the Authority for Release of Deceased Report.
 - d. Upon family signing, Security Officer will release personal belongings.
 - e. Security AS will call the mortuary of choice for notification of release.
 - f. Security AS will document on the Authority for Release of Deceased Report time, date and signature.
 - g. Paperwork will remain with clip board in the PBX-AS office.

E. THE LIFT TEAM WILL:

- 1. Obtain a morgue key, retrieve the covered morgue transport gurney from the morgue, and transport it to the requesting unit of a deceased patient.
 - a. The patient should be in a body bag.
 - Lift Team will assist with placing patient in body bag if patient is large.
- 2. Transport patient to and from the morgue as requested by AS to accommodate family viewing or place patient on gurney in the morgue for viewing if needed a number 1 or number 2 will be written on the back side of the Authority for Release of Deceased Report.
- 3. Record requested information on Morgue Disposition Log, logging patient into or out of morgue.
- 4. Notify the AS if morgue bays are full, body is not in a morgue bay, or morgue equipment is not functioning properly.
 - a. AS to notify Engineering for temperature adjustment.
- 5. Rotate bodies as directed when there are more bodies than morgue bays available, under the direction of the AS.

Unclaimed bodies will be transferred to outside morque #2 as determined by the AS.

F. PROCESSING OF COMPLETED PAPERWORK BY ALL STAFF:

a. Original copies of all paperwork (All Consents, authorizations, and the electronic Authority for Release of Deceased Report) will be forwarded to the AS for processing.

G. MANAGEMENT OF CALLS RELATED TO RELEASE OF DECEASED ISSUES:

Addressed by the patient's nurse and AS.

H. DECEDENT'S PROPERTY:

- Except when there is reason to know of a dispute over a deceased patient's personal property, California law permits a decedent's personal property to be turned over to the decedent's residence, the patient's spouse or relative, or to the conservator of the decedent/guardian of the decedent's estate. If the estate is being administered, however, the property must be delivered to the personal representative (i.e., executor or administrator of the will/estate) upon request of the personal representative. If no member of the family or legal representative appears within a reasonable time, or fails to respond to hospital correspondence, the hospital can deliver the property to the public administrator and obtain a receipt to be kept in the decedent's medical record.
- The hospital may release the property promptly after the patient's death; however the recipient must provide reasonable proof of their status and identity. The hospital may rely on their driver's license, a passport, or photo identification card issued by the U.S. Government. The hospital must record the property released, and to whom the property was delivered, for a period of at least 3 years. The hospital must also obtain a signed receipt. Hospital will maintain a copy of the photo identification provided by the recipient, as well as the signed receipt, for the requisite time period.

!. RELATED DOCUMENT(S):

- 1. Emergency Procedure Department: Deaths of Pediatric Patients Procedure
- 2. Patient Care Services Policy: Medical Examiner Notification
- Patient Care Services Policy: Organ Donation, Including Tissue and Eyes Donation Option –
 Brain Death
- 4. Patient Care Services Policy: Patient Valuables, Liability and Control
- 5. Patient Care Services Procedure Deceased Patient Care and Disposition
- 6. Patient Care Services Procedure: Miscarriages and Stillbirth Identification and Disposition ProcedureDeceased Newborn/Stillborn, Care of
- 7. Patient Care Services Procedure: Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition) Differentiating Intrauterine Fetal Demises from Miscarriages
- 8. Patient Care Services Procedure: Wasting Narcotics, Documentation in the Pyxis Machine
- Progressive Care Unit Procedure: Release of a Deceased Justice Involved Patient
- 10. Security Policy: Morgue Release 224

J. FORM(S):

- 1. Authority for Release of Deceased Report Sample
- 2. Authorization for Autopsy Sample
- 2.3. Deceased Tracking Report Sample
- 4. Morgue Log Sample

Authority for Release of Deceased Form-Report – Sample

Test, Fred		DATEG	00000347	riv#	6002100724		
2		SSIN	487-66-5555	Room #	516		
Oceansida	CA 92056						
Next of kin: Test,	Fred Relati	n: Pt	F	hone Number:	(111) 111-1111		
Patient a donor:	Yes						
Attending Physici	an: Test, DME Physician						
Pronounced Time	: 04/04/201614:56 Medical	Examine	r Notified: Yes	Waive	No.: 55555		
I acknowledg	e the receipt of personal effects (Асизо, гас	ribo de loxefectos pe	ersonales)			
Date (Fecha)	Signature of next to kin		1 254	86	hip (Pacaotesco)		
	orize Tri—City Medical Center			madio del preser	ite documento.		
	ri—City Medical Center liberar	eofras Rol	de) Test, Fred Patient (Pacien	te)			
To (Al):	ocurement Agency funeral home						
(Nombre del 1					Area o # de Telefopol		
Date (Eecha)	Signature of next to kin (Firms del Paciente mas cerca	aa) (P.	Relationship trentesco con el Difi		Number Area o # de Telefono)		
Physician to sign !	Death Certificate: Test, DME P	h-minin n		Phones			
Macan to nen	Destil Cerubiale. Test Dail F	n) ncan			() –		
fortuary Notifie	i Date & Time:			By			
leceived from Tri	City Medical Center the rema	ns of pati	ent listed above				
Osta/Time Returned By:	Signature of Medical Exam	niner/Lifes	haring Re	lease by			
teturned by:	Medical Examiner Lifesharing A	gent	Accepted	by	Date/Time		
leceived from Tri	City Medical Center						
Date/Time	Mortuary/Procurement Ag	ency		Ralease by			
ublic Administrat	or Notified —		1	Date/Time			
				<u>_</u>			
TD 4 644			00000547 Test, ^{Feet}				
Tri-Cit	ty Medical Cente	ľ	02/02/1954/62 Yea	rs/Male			
Authority	for Release of Decease	,	TCMC/Inpatient/6002100724				

0

PLEASE MAKE COPY OF ORIGINAL WITH FAMILY SIGNATURES FOR MORTUARY PICK UP SERVICE

Authorization for Autopsy – Sample

AUTHORIZATION FOR AUTOPSY

Pa	tient's Name:				
Da	te:				
Tin	ne:				
1.	I am one of the following person named patient.	s authorized by law to c	firect disposition of the remains of the above-		
	Patient	☐ Parent			
	☐ Spouse	☐ Brother/Sister			
	Registered domestic partner				
Child (over the age of 18) Agent appointed in patient's Power of Attorney for health (copy of Power of Attorney must be attached.)					
	☐ Other:				
2.	I hereby authorize the performar	nce of a post-mortem ex	amination upon the above-named patient.		
3.	lives and well-being, the undersi	igned also authorizes the r organs, and to retain, p	benefit others by protecting or preserving their examining physician and surgeon to remove preserve, and/or contribute the same for such pe/she shall deem proper.		
4.	This authorization shall be subje	ect to the following restric	ctions:		
	· · · · · · · · · · · · · · · · · · ·				
5.	I understand that the examining hospital. They are independent	physician and other phy	sicians are not employees or agents of the		
Siç	gnature:				
Wi	tness;				
Wi	tness:				
(@	4002 Vista Way - Oceanside - CA - 92056	FIGN FOR AUTOROV	Affix Patient Label		

AUTHORIZATION FOR AUTOPSY



Deceased Tracking Report – Sample

Patien ts Name:	Medic al Recor d#	Roo m #	Expirati on Date	Expirati on Time	Corone rs Case (Y or N)	Organ Donati on (Y or N)	Autop sy (Y ar N)	Paperwo rk Location	Mortuar y: Physici an and Morticia n	Date Notifie d	Time Notifie d	Releas ed Date	Releas ed Time	Initial s
											ļ			
							4							
		- " - "												
					,,									<u> </u>
									-		-			

Morgue Log Sheet - Sample

PT LOCATION IN MORGUE	PATIENT NAME	ROOM # PICKED UP FROM	MR#	DATE/TIME IN	PRINT LIFT TEAM NAME & UNIT FROM	DATE/TIME OUT	PRINT NAME
	13.000						
			-				

LABORATORY (Neonates/fetus)

PT LOCATION	PATIENT NAME	ROOM # PICKED UP FROM	MR#	DATE/TIME IN	PRINT NAME & UNIT FROM	DATE/FIME OUT	PRINT NAME



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 08/01 SUBJECT: Substance Abuse, Patient

REVISION DATE: 06/03, 08/05, 04/09, 08/11 POLICY NUMBER: III.E

Department Approval: 03/1609/17

Clinical Policies & Procedures Committee Approval: 09/1104/1610/17

Nursing Executive Council Approval: 40/4110/17

Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval: 11/11/17
Professional Affairs Committee Approval: 01/12/01/18

Board of Directors Approval: 01/12

A. POLICY:

- B-1. Persons receiving medical treatment for problems related to the abuse of alcohol or drugs shall also be assessed for psychological/emotional needs.
- G.2. Appropriate consultations, referrals or plans for follow-up care related to substance abuse shall be a routine part of the treatment and discharge planning processes.
- D.3. Behavioral Health Unit/Social Services staff may be consulted for assistance with planning, evaluation, and referral.
- E.4. The attending physician/Allied Health Professional shall be informed of any suspected patient substance abuse during treatment to ensure appropriate follow-up and/or treatment options are considered.
- F-5. Psychiatric liaisons are appropriate persons to contact for a psychiatric/-chemical dependency (CD) consultation.

Administrative Policy **Patient Care**

ISSUE DATE:

09/05

SUBJECT: Assignment of Medical Record

Numbers and Standard Naming

Guidelines

REVISION DATE(S): 05/09, 08/12

POLICY NUMBER: 8610-390

Department Review:

12/17

Administrative Policies & Procedures Committee Approval:

08/12/12/17

Professional Affairs Committee Approval:

09/1201/18

Board of Directors Approval:

09/12

A. **PURPOSE:**

A unique medical record number specific to the patient will be assigned to each patient who is admitted or treated at Tri-City Medical CenterHealthcare District (TCMCHD) as an inpatient, outpatient, or Emergency Department patients. Each patient will be assigned a unique medical record number that will be utilized for every encounter or admission to any area throughout the medical center.

B. SCOPE:

The policy applies to all personnel who schedule or register patients for admission or treatment at TCMCHD as inpatients, Outpatients, or Emergency Department patients. The correction part of this policy also applies to Medical Records/Health Information Management (HIM) team members Department who are responsible for review/correction of duplicate numbers.

C. **POLICY:**

- Usage of this unique number will facilitate continuity of patient care through accurate medical record availability, and efficient processing of patients by the various registration locations throughout the hospital, as well as provide for accurate data quality for patient care and billing purposes.
- 2. Single number for each patient within the Master Patient Index (MPI).
- 3. Standardized search process to be used.
- 4. Standardized naming conventions to be utilized.
- 5. Correction and maintenance of the index is the responsibility of the Medical Records/Health InformationHIM Department.

D.

- Verification of Patient Identity:
 - Registration personnel will attempt to obtain the following data when performing the search for medical record number:
 - i. Patient's legal name including last, first and middle initial (when applicable)
 - ii. Correct spelling of the name by the patient
 - Patient's maiden name iii.
 - Patient's date of birth iv.
 - Patient's Gender
 - Patient's Social Security Number
 - All information will be double-checked including spelling of patient's name by reviewing b. photo-identification, insurance cards, and/or social security card.
 - Patient will be asked if previously treated at TCMCHD for inpatient or outpatient C.

services.

- d. The name(s) used during previous visit(s) will be verified.
- e. When a patient has been treated previously at TCMCHD and the alias screen displays, the Social Security Number should be used as a tiebreaker to correctly identify the patient.
- f. Duplicate Alias Warning Window:
 - i. States: "WARNING: This alias is assigned to another person or encounter".
 - ii. Appears in any conversation to indicate that the Social Security Number that has been entered is assigned to another individual in Cerner.
 - iii. When Alias warning appears: stop. Search for prior MRN by doing an SSN only search.
- g. The patient's address is to be included as a tiebreaker when identifying if the patient has been previously assigned a medical record number or treated at TCMCHD.
- 2. Patient Naming Conventions:
 - Order of the name:
 - i. Names will be entered in the order that the legal name is stated.
 - ii. Foreign names will be entered in the order that the legal name is stated.
 - b. Hyphenated Name:
 - Names containing a hyphen are entered with the hyphen, with no extra spaces before or after.
 - ii. The last name is entered in the order of legal name.
 - c. Mixed Case Name:
 - Names will be entered in using the "case" matching the legal name
 - 1) Example: McDonald, Ronald is entered with a capital "M" and a capital "D"
 - 2) Example: Smith, John is entered with a capital "S" and lowercase "mith"
 - d. Patient Legal Name vs. Nickname:
 - Patient's legal name including last, first and middle initial (when applicable) will be obtained.
 - e. Use of Punctuation:
 - i. Names will be entered without the use of punctuation
 - 1) Exception: Hyphens may be used.
 - 2) Periods, commas, apostrophes, etc. should not be included in patient's name.
 - a) Example: O'Brien, Patrick is entered as "O'Brien, Patrick"
 - f. Use of Spaces:
 - Include spaces in the last name if the legal spelling of the name includes a space.
 - g. Use of Title and Jr., Sr.:
 - i. Titles (e.g. Rev., Mr., Mrs., Jr., Sr., III, etc.) are not to be used for scheduling/registration.
 - h. Newborns:
 - i. The naming convention for newborns is the last name of the mother (as the baby's last name) and the gender of the baby (as the baby's first name).
 - ii. Pre-admitted baby will be entered as: Mother's Last Name, and Baby.
 - iii. Delivered baby's name will be edited to:
 - 1) Single Birth:
 - a) Last name = Mother's last name
 - b) First name = Boy or Girl
 - 2) Multiple Birth baby will be edited to:
 - a) Last name = Mother's last name
 - b) First name = Boy or Girl
 - c) Middle Initial
 - d) A (first born)

- e) B (second born)
- f) C (third born)
- iv. The Medical Record Birth Certificate Clerk updates the baby's name after the birth certificate information is completed and the newborn is discharged.
- 3. Search for Medical Record Number:
 - a. When a patient match has not occurred after a standard search is performed, a search by Social Security Number will be completed. A standard search includes entry of the following four data elements:
 - i. Date of Birth
 - i₊ii. Last name
 - ii.iii. First name
 - iii-iv. Gender
 - iv- Date-of-birth
 - b. Additional Search may be necessary to clarify correct patient.
 - i. Abbreviated Versions of Names:
 - 1) Jenny vs. Jennifer; Ben vs. Benjamin; Jeff vs. Jeffrey.
 - 2) Patient's legal name will be used for search.
 - ii. Maiden names:
 - If a female patient was at a TCMCHD facility previously but is not found during search, patient will be asked for her maiden name and search steps will proceed as above. When record is located, Compass is updated.
 - iii. Hyphenated married names:
 - 1) Both parts of a hyphenated name will be used during the patient search.
 - 2) Example: Susan Smith-Jones. Search by Smith-Jones (with first name, gender, and date of birth).
 - 3) If the hyphenated name is not found during the search and the patient states they have been here before, search again using the patient's stated Social Security Number only.
 - iv. Name Reversals:
 - 1) Reversed middle and first names
 - 2) Patient (e.g. William Paul Smith) likes to be referred to as another name (e.g. Paul Smith). Do not register as Paul Smith. Register patient under his/her legal name (e.g. William Smith, middle initial P).
 - v. Complex Name (e.g. Thomas Henry).
 - 1) Initial Search as Henry, Thomas. If search does not reveal a match complete a secondary search.
 - 2) Secondary Search (ase.g. Thomas, Henry). The first name will be reversed with the last name.
- 4. Medical Record Number Assignment During Times of System Unavailability:
 - Patients that are admitted and registered during downtime are assigned a downtime encounter number. No medical record number is assigned until the Cerner system is back up.
 - b. Downtime procedures direct Registration personnel to the Affinity system to identify a previous medical record number, when necessary.
- 5. If the patient's identification is unknown (e.g. John or Jane Doe):
 - a. Do a patient search for John or Jane Doe
 - b. If the search returns no patients enter the name as Doe, John (or Jane), leave a space, then use the letter A (as in Doe, John A)
 - c. Subsequent John or Jane Does will use letters B, C, D, etc. to differentiate between patients.
 - i. If the search returns other John or Jane Does, look to see the last letter used in the first name (e.g. Doe, Jane C)
 - ii. Register the next Jane Doe as: Doe, Jane D

- d. If the date of birth of John or Jane Doe is not known
 - Use the current day and month as the day and month of Jane/John Doe's birthday
 - ii. Example: Today is 2/24/04
 - John/Jane Doe's birthday to be entered as: 02/24
 - iii. The birth year is calculated as follows:
 - 1) If you think the patient's age is XX, use this birth year

a)	0-10	Year 2000
b)	11-20	Year 1990
c)	21-30	Year 1980
d)	31-40	Year 1970
e)	41-50	Year 1960
f)	51-60	Year 1950
g)	61-70	Year 1940
h)	71-80	Year 1930
i)	81-90	Year 1920
j)	91 and over	Year 1910

- e. A "John Doe" medical record will be generated through the Registration process.
- f. Continuous efforts will be made to establish correct identification throughout the patient's hospitalization.
- g. After the patient's identification has been determined and if the patient has no previous medical record number, the assigned temporary number will remain as the patient's permanent medical record number.
- h. After the patient's identification has been determined and if the patient has a previous medical record number, the individual in charge of the patient will notify the Medical Records or Registration Department.
- 6. Correction of Duplicate Medical Record Numbers:
 - a. The Medical Records/Health-InformationHIM Department is responsible for correcting any duplicate medical record number. This will be implemented in the following manner:
 - Request for correction of duplicate medical record number will be made in writing to the Medical Records/HIM Department. Submissions may be made by any staff member who identifies possible duplicate medical record numbers.
 - ii. The Data Correction sheet is faxed to the Medical Records Department (fax number 3414) or email MPI Specialist.
 - iii. The Medical Records/HIM Department follows a Prioritization Matrix to determine which duplicates are combined first.
 - iv. The Medical Records/HIM Department reports duplicate assignments by medical service for departmental follow-up.
- 7. Note: Patient information entered into the Cerner system is passed through to the Affinity Patient Accounting system. When documents are printed from Affinity (i.e. Facesheets, bills, reports) patient name information is displayed in all CAPS without hyphens or spaces.

Administrative Policy **District Operations**

ISSUE DATE:

02/97

SUBJECT: Coverage for Employee Vehicle

Insurance Deductible

REVISION DATE(S): 01/98, 04/06, 12/12

POLICY NUMBER: 8610-256

Department Review:

12/17

Administrative Policies & Procedures Committee Approval:

40/4212/17

Professional Affairs Committee Approval:

11/1201/18

Board of Directors Approval:

12/12

Α. **PURPOSE:**

To explain the Tri-City Healthcare District's (TCHD) coverage of insurance deductibles for employees who use their own vehicle for work-related business and are involved in an accident.

POLICY: B.

When an employee uses his/her vehicle for work-related business and is involved in an accident, the DistrictTCHD's administrative insurance policy is to will pay for the deductible that is not provided by the employee's insurance policy, if the employee is not at fault. If the police report or the claims adjuster determines the employee is at fault, the district will not pay the deductible. The District TCHD will cover the employee's out-of-pocket insurance deductible up to a \$1,000 maximum.

C. PROCEDURERELATED DOCUMENT(S):

Coverage for Employee Vehicle Insurance Deductible InstructionsProcess-instructions located on the intranet.

Coverage for Employee Vehicle Insurance Deductible Instructions

- 1. The employee must first report the accident to his/her insurance company and obtain a letter from the company providing proof of insurance coverage and deductible.
- 2. The employee must submit the following documentation to his/her Department Director and area Vice President or Chief for approval of payment:
 - a. A copy of the accident report.
 - b. A letter from the employee's insurance company as stated in number 1.
 - c. A copy of the vehicle repair estimate or invoice from repair shop showing cost of repair.
 - d. A completed check request made payable to the repair company on behalf of the employee for the amount of the employee's deductible not to exceed \$1,000.
- 3. After approval, the documentation will be forwarded to Accounts Payable for check processing.



Administrative Policy Compliance

ISSUE DATE:

03/03

SUBJECT:

FAXING OF PROTECTED HEALTH

INFORMATION (MEDICAL

RECORDS)

REVISION DATE:

05/09, 09/13

POLICY NUMBER: 8610-522

Department Review:

11/17

Administrative Policies & Procedures Committee Approval:

06/1412/17

Professional Affairs Committee Approval:

07/1401/18

Board of Directors Approval:

07/14

A.

To ensure confidentiality of patient protected health information transmitted via fax machine.

В.

- It is the policy of Tri-City Healthcare District (TCHD) to limit the faxing of patient information and outline standard procedures to ensure that patient confidentiality is maintained.
- 2. Faxing of patient information is to be limited to emergency situations (patients currently being seen in a physician's office or another health care facility) and those situations dealing with direct patient care (i.e. discharge planning, medical consultation, patient transfer, etc.)
- 3. The faxing of information for a patient who is not currently an inpatient is to be handled by the Medical Records/Health Information Department.
- 4. Care is to be taken to limit information being faxed is the minimum necessary to meet the needs of the recipient.
- 5. Departments which utilize the Cerner system to fax results/reports to physician offices are to ensure that test documents (non-patient related) have been transmitted and received without error prior to initiation of automated transmission of patient documents.
 - Annual review of the automated system fax number database is to be completed by the Information Technology (IT) Department with support by Health Information Management (HIM) as needed.and documented.
 - The IT Department to maintain signed agreement from MDthe physician's office b. reflecting steps to be taken when a fax number changes or is no longer valid.
- 6. Departments which have fax machines preprogrammed to transmit information to a designated office/unit are to ensure that test documents (non-patient related) have been transmitted and received without error prior to implementation of faxing documents without an accompanying transmittal sheet. (i.e. ABG results to staff MDphysician offices, Surgery Scheduling to Pre-Operative teaching, etc.)
 - Annual review of the automated system fax number database is to be documented. a.
 - Department to maintain signed agreement from MD's-the physician's office reflecting steps to be taken when a fax number changes or is no longer valid.
- 7. A transmittal form is to be completed on all manual fax transmittals. The transmittal form must include at minimum the following:
 - a. Patient Name
 - Medical Record number of the patient b.
 - Date of Service C.
 - Name of Person to whom information is being faxed d.
 - e. Date and time of fax transmission
 - Specification of record component being faxed f.

- g. Name of person faxing the information
- h. The protection clauses relating to further disclosure. Departments may create transmittal forms pertinent to their unit, which cover these required elements.
- 8. Patient information is not faxed directly to any patient. Departments/nursing units which do not have automated fax capabilities are to complete a fax transmittal sheet for each fax transmission.
 - a. The fax machine is to be set to generate a confirmation sheet that will be scanned to Cerner (Disclosure) upon completion of the transmission. This confirmation sheet is to be filed and maintained as part of the patient's permanent medical record under the face sheet. In cases where the confirmation sheet does not reflect the transmittal sheet information, confirmation of the transmission is to be recorded on the transmittal form.
 - b. If a confirmation sheet is not generated by the fax machine the person initiating the fax transmission is to contact the receiving party when possible to confirm receipt of the patient's information. Verbal confirmation of receipt of the information is to be recorded on the transmittal sheet, which is then to be filed on and maintained as part of the patient's permanent medical record.
 - c. If a transmittal and/or confirmation sheet is not utilized when faxing it is required that the following information be documented in the Progress Notes.
 - To whom the information was faxed.
 - ii. Identification of the specific information that was faxed.
 - iii. Written statement, which reflects receipt of the fax by the party to whom it was sent.
- 9. Every effort is to be taken to assure that information reaches its destination and is kept confidential in accordance with Administrative Policy: Confidentiality 455.
 - a. Should an employee/physician be informed that the intended party did not receive the faxed information, it is required that this be documented on the "transmittal" form and a Quality Review Report (QRR) is to be submitted to the Privacy Officer.
- C. REFERENCED-FORM(S)-WHICH-CAN-BE-LOCATED-ON-THE-INTRANET:
 - Medical Record/Health Information Department Fax Transmittal Sheet 8700-1027
- D. RELATED DOCUMENT(S):
 - 2.1. Administrative Policy: Confidentiality 455

Medical Record Department Fax Transmittal Sheet 8700-1027



FAX NUMBER: (760) 940-3414 PHONE NUMBER: (760) 940-3025

DATE: _____ NUMBER OF PAGES INCLUDING THIS SHEET: _____ TO: _____ ATTENTION: _____ FROM: PHONE: (760) 940-3051 THIS FAXED INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR, PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS: OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. **Patient Name** _____ MR # _____ Dis. Date ____ Information Sent Via Facsimile: Emergency Room Record Radiology Reports Discharge Summary Operative Reports ___ History & Physical Report _____Lab/Pathology Reports _____ Other Consultation Report (Please Specify) COMMENTS: Faxed By: This facsimile transmission is intended only for the use of the individual or entity to which it is addressed and may contain information which is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying of the transmitted material is strictly prohibited. If you have received this telecopy in error, please immediately notify me by telephone or arrange for return of the original transmission.

MEDICAL RECORD DEPARTMENT FAX TRANSMITTAL SHEET



Administrative Policy-Manual District Operations

ISSUE DATE:

02/07

SUBJECT: Space and Office Allocation

REVISION DATE: 08/09

POLICY NUMBER: 8610-289

Department Review:

11/17

Administrative Policies & Procedures Committee Approval:

02/1511/17

Professional Affairs Committee Approval:

03/1501/18

Board of Directors Approval:

03/15

A. PURPOSE:

1. Establish guidelines with regard to space allocation throughout the facility including off site locations. Office of Statewide Health Planning and Development (OSHPD) space shall be utilized for Patient Care revenue producing functions whenever possible.

B. **POLICY**:

- All requests for space shall be sent in writing via email using the Request-for-Space/Project Form-to the Facilities Management Department. Director of Facilities will review and approve any requests and depending on the scope will discuss with the C-Suite members as necessary.
- 2. Manager/Director levels and above should have private offices to facilitate staff confidentiality.
 - All other personnel requiring space shall share office space that meets Occupational Safety and Health Administration (OSHA) space guidelines.
 - b. No one shall have more than one office in any **Tri-City Healthcare District (TCMCHD)** building or buildings.
 - c. Temporary offices located in any converted patient rooms must have the ability to be reverted back to a patient room within 24 hours.
- 3. A request for office furniture, carpet, computers, etc. must be approved according to the Administrative Policy: #232 Signature Authority Policy and requests sent respectively to Facilities Management, or Purchasing or Information Technologies Departments.-and must be reflected on the Request for Space/Project form.
 - a. An inventory of potentially usable office furniture will be kept by Facilities staff and should be reviewed prior to ordering any furniture.
 - b. An ergonomic review prior to ordering office furniture is recommended.
- 4. Storage space shall be kept to a minimum to avoid clutter and possible fire code and/or safety violations.
 - a. Furniture or equipment that is no longer useful should be disposed of according to district guidelines per Administrative Policy: #200 Equipment Transfer, Storage, Trade-In, and Disposal and not kept in storage indefinitely. Once equipment or furniture is deemed unusable and needs to get disposed, the parent department will place the equipment or furniture in the dumpster located by the loading dock. If you need assistance, a work order needs to be submitted to the Environmental Services Department through the intranet.
- 5. There can be no storage in the corridors.

C. FORMS

Request for Space/Project

D.C. RELATED DOCUMENTS

- 1. Administrative Policy: 200 Equipment Transfer, Storage, Trade-In, and Disposal
- 2. Administrative Policy: 232 Signature Authority

Request for Space/Renovations

TRI-CITY MEDICAL CENTER

REQUEST FOR SPACE/RENOVATIONS



INSTRUCTIONS:

Complete a separate form for each project.

Forward original to the Engineering Department <u>WITH YOUR DIRECTOR'S SIGNATURE</u> for Space Planning Committee Review.

for Space Planning Committee Review.
Note: This request is for budgetary purpose only. This does not mean the project has been approved. A Capital Purchase Requisition must be filled out AND approved before the start of any project.
DATE SUBMITTED:
COST CENTER NUMBER
DEPARTMENT NAME
DEPARTMENT DIRECTOR:
ADMINISTRATOR'S APPROVAL:
CONTACT PERSON:
If this renovation is required for a budgeted equipment item, please list (from Equipment Budget form):
EQUIPMENT DESCRIPTION:
EQUIPMENT COST:
RENOVATION NEEDED IN FISCAL YEAR ENDING IN 2005, 2006, OR 2007:
PROJECT DESCRIPTION: (please provide as much information and detail as possible)
Based on the descriptions below, the priority level of this project is:
PRIORITY: A) Needed for JCAHO and/or Title 22 compliance and/or continuation of the service B) Needed to support growth or to upgrade services C) Desired to enhance departmental service
SPECIAL PROJECTS DEPT USE ONLY
DATE:
ESTIMATED COST:SIGNATURE:

Located on the Intranet under: TCMC Departments-Engineering-Electronic Forms-Request for Space/Renovations



Administrative Policy-Manual **District Operations**

ISSUE DATE:

08/93

SUBJECT: USE, SECURITY, AND ACCURACY

OF DATA

REVISION DATE: 04/94, 06/98, 08/99, 04/03, 12/05,

POLICY NUMBER: 8610-242

01/09, 02/11, 08/14

Department Review:

12/17

Administrative Policies & Procedures Committee Approval:

07/1412/17

Professional Affairs Committee Approval:

08/1401/18

Board of Directors Approval:

08/14

A.

To define the philosophy and policy of Tri-City Medical CenterHealthcare District (TCMCHD) related to the use, accuracy and protection of all data generated and maintained in the hospital information systems. Increased public and other third-party access to hospital and providerspecific data requires collaboration and a proactive approach to analyzing information.

B. **POLICY:**

- TCMCHD is committed to basing essential clinical and financial decisions on accurate and current information. All data used for these functions will be collected, interpreted, and utilized appropriately. Provider-specific data will not be released to outside entities except as mandated by state or federal statutes.
- 2. Physician specific data requests may initiate from the Department/Division chairperson, or from the Service-Line-team or institute.
 - All physician specific data will be coded to maintain confidentiality.
 - Studies initiated from a Department/Division must be in the Department/Division meeting b. minutes with approval documented.
 - Physicians not present at the meeting must be contacted in writing to inform them of C. study request.
 - Studies will not be initiated until authorized by the Quality Assurance/Performance d. Improvement/Patient Safety (QAPI) Committee.
 - The results may only be reported at a Medical Staff Department/Division meeting or a e. Medical Staff Committee meeting.
- 3. Clinical data will be used to:
 - Develop or refine systems to improve patient care and to use hospital resources costeffectively.
 - Illustrate patterns of care and variation in treatment through aggregate data by b. diagnosis, procedure, diagnosis-related groups (DRG), practitioner, or other defined
 - Support and facilitate coordination with other provider groups (i.e., PPOs, PHOs, HMOs)
- 4. Data Security:
 - Handling of and access to data will be directed by the Administrative Policy: fer Confidentiality (Policy # 455).
 - b. Employees and/or the Medical Staff are notified of data elements required by government and regulatory agencies. Specific internal data sources will be established by appropriate hospital or medical staff group.
 - Individuals assigned the task of collecting registration data from patients will be oriented C. to the hospital policies and procedures and to federal and state regulatory statutes to

- ensure accuracy, confidentiality, and compliance.
- d. Providers will have access to their own profile data through an established procedure designated by the Medical Executive Committee.
- e. Printed reports containing individual physician data will be protected by the use of a confidential numerical code system.
- f. Provider-specific data will not be released to outside entities except as mandated by state or federal statutes.
- g. All information protected under Evidence Code section 1157 will be protected to the fullest extent and will not be released without authorization from the Medical Staff and legal counsel.

Accuracy:

- a. Coding of clinical information for all inpatients, outpatient surgery, and emergency patients will be the responsibility of the Medical Records/Health Information Department.
- b. Routine validation of accuracy of data reports will be the responsibility of the individual department distributing or presenting the data.
- c. Identified inaccuracies will be referred to the appropriate department and Compliance Officer if applicable. Corrections will be completed.

C. RELATED DOCUMENT(S):

- 1. Administrative Policy: Confidentiality 455
- 2. Administrative Policy: Disclosure of Protected Health Information 513
- 3. Administrative Policy: Hospital Records Retention 237
- 4. Administrative Policy: Security Dept Incident Notification 234
- 5. Medical Records Procedure: Disaster Implantation Plan
- d.6. Medical Staff Bylaws Section 12.2
- 7. Patient Care Services Policy: HIV Testing: In an Occupational Exposure
- 8. Tri-City Medical Center Employee Handbook 2011/2012

C.D. REFERENCE(S):

- Administrative-Policy-and-Procedures:
 - a. Disclosure of Protected Health Information # 513
 - b. Hospital Records Retention #237
 - Security Department-Incident-Notification #234
 - d. Confidentiality #455
- 2. Patient Care Services Policies and Procedures:
 - a. HIV Testing Consent and Disclosure of HIV Test-Results #384
 - b. Confidentiality of Psychiatric, Alcohol or Drug Abuse Information #311
- 3. The Employee Handbook "General Rules of Conduct for Confidentiality"
- 4. Management-Information Systems "Disaster Recovery Plan"
- Medical Records "Disaster Recovery Plan"
- 6.1. Medical Record Availability. Title 22 CCR Section- 70751(b).
- 7.2. Medical Staff Bylaws Section 12.2 Evidence Code (1997) Cal. EVID § 1157.



Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

Report of Firearms Prohibition

POLICY NUMBER:

517

ISSUE DATE:

03/08

REVISION DATE(S): 08/09, 06/10, 03/13,

Department Approval:

Division of Psychiatry Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

01/18

Board of Directors Approval:

A. PURPOSE:

- 1. To define reporting requirements for persons admitted to the unit for whom a firearms prohibition report is indicated.
- 2. To identify procedures associated with such admissions.
- 3. To assure compliance with California statutes related to the prohibition of firearms.

B. POLICY:

- The hospital is required to submit a 'Mental Health Facilities Report of Firearms Prohibition' for each person who is taken into custody pursuant to a 5150-Cal. Welfare and Institute Code (WIC) §5150, assessed pursuant to a 5151-WIC §5150 and subsequently admitted on a 5152 (WIC) §5152 for 72 hours as a danger to self or others.
- 2. If a patient has been determined to be a danger to self or others, and is admitted as a voluntary patient, the form must also be submitted if not previously done.
- 3. The form is required for a patient certified for 14 days of involuntary treatment if the certification is upheld.
 - This includes persons held as gravely disabled.
 - b. This is a second report if the patient was originally on a 72-hour involuntary hold.
- 4. Prior to or concurrent with discharge, the patient must be informed that he or she is prohibited from owning, possessing, controlling, receiving, or purchasing any firearm for a period of five years. The patient must be informed at the same time that they may petition the superior court in their county of residence for an order permitting them to own, possess, control, receive, or purchase a firearm.
- 5. If requested, the patient must be supplied with a "Request for **Hearing for Relief from** Firearms Prohibition Hearing" BOF 400C Form.

C. PROCEDURE:

- 1. Firearms form will be completed electronically on the California Department of Justice secure website https://mhrs.doj.ca.gov
- 2. Print the mental health preview form then place in patient's medical record.
- Staff are to complete the Discharge Report Form (BOF 4009BD) upon discharge of patient from any involuntary status of more than 31 days from date of admission. Form must be faxed to: (916) 227- 1021
- A.4. Staff will place the Discharge Report Form hard copy in legal section of patient's medical record.

Inpatient Behavioral Health Unit Report of Firearms Prohibition Page 2 of 2

D. <u>EXTERNAL LINK(S):</u>

- B-1. California Department of Justice https://mhrs.doj.ca.gov/
 - a. Request for Hearing for Relief from Firearms Prohibition BOF 4009C Form
 - C.b. Discharge Report BOF 4009B Form

E. REFERENCE(S):

D.1. Detention of Mentally Disordered Persons for Evaluation and Treatment, Cal. WIC § 5150 et seq.



MEDICAL STAFF-POLICY-MANUAL

ISSUE DATE: 03/07 SUBJECT: Credentialing Requirements for

Fluoroscopy Supervisor and

Operator Permit

REVISION DATE(S): 03/08, 08/12 POLICY NUMBER: 8710-528

Department Approval: 07/17
Credentials Committee Approval: 11/17
Pharmacy and Therapeutics Approval: n/a

Medical Executive Committee Approval: 11/17

Professional Affairs Committee Approval:

Board of Directors Approval:

A. PURPOSE:

1. Physicians who utilize fluoroscopy in the medical center must obtain and maintain a valid California Fluoroscopy Supervisor and Operator Permit.

2. Privileges for fluoroscopy may be granted to qualified practitioners in order to demonstrate compliance with this standard.

B. **CREDENTIALING CRITERIA:**

 A valid Fluoroscopy Supervisor and Operator Permit issued by the California Radiologic Health Branch.

01/18

- 2. Proctoring criteria:
 - a. None
- 3. Reappointment requirements:
 - a. Continued valid Fluoroscopy Supervisor and Operator Permit.

C. <u>CROSS-REFERENCES:</u>

1. Radiology Unit Specific Fluoroscopy Procedures

Approvals:

Division of Imaging Approval:	08/12
	UO/ 12
Credentials Committee Approval:	08/12
Medical-Executive Committee Approval:	08/12
Board of Directors Approval:	03/00: 09/12



MEDICAL STAFF POLICY MANUAL

ISSUE DATE:

10/09

SUBJECT: Credentialing Standards for

Transoral Esophagogastric

Fundoplication (TIF)

REVISION DATE(S): 10/09

POLICY NUMBER: 8710-556

Department Approval:

Credentials Committee Approval: Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

07/17 11/17

n/a 11/17 01/18

Board of Directors Approval:

PURPOSE:

A.

The following criteria shall be used in credentialing physicians who request privileges for TIF.

B. **CREDENTIALING CRITERIA:**

Initial Application:

- The applicant must have completed an ACGME accredited residency program and a. possess board certification or board eligibility in Surgery.
- The applicant must also have completed a training course in EsophyX₂® TIF™2; or have performed at least five EsophyX₂[®] TIF™2 procedures in the past 12 months.

2. **Proctoring Criteria:**

- The proctoring will be waived if the applicant provides the certification that they attended EsophyX₂® TIF™2 training course. OR
- The first five (5) cases performed after granting of the privilege will be proctored by a b. practitioner who currently has the TIF privilege and has been released from proctoring.

3. Reappointment Criteria:

Three (3) cases performed annually during the reappointment cycle (6 cases total) with acceptable success and complication rates.

Approvals:

Medical Division Approval:	10/09
Credentials-Committee-Approval:	10/09
Medical-Executive Committee Approval:	10/09
Board of Directors-Approval:	10/00
Pour di bilottoro, ripprover.	10/08



MEDICAL STAFF POLICY MANUAL

ISSUE DATE:

9/03

SUBJECT: Quality Review Process for

Teleradiologists

REVISION DATE(S): 09/07, 08/12

POLICY NUMBER: 8710 - 525

Department Approval:

Credentials Committee Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval: Professional Affairs Committee Approval:

Board of Directors Approval:

07/17

11/17

n/a

11/17 01/18

A. **PURPOSE**

Ensure tracking and monitoring of the performance of teleradiologists.

В.

A system shall be in place for tracking and trending individual teleradiologists.

C. **PROCEDURE**

- Preliminary reports are received daily from StatRad via fax during the hours of 10:00 pm to 7:00 am. A member of North County Radiology Medical Group (NCRMG) administrative staff files the preliminary report with the patient's film jacket.
- 2. The on-site radiologist shall review the interpretation and record agreement or disagreement noting minor or major variance. The variances for all teleradiologists are tracked and given to the Medical Staff Office on a monthly basis for statistical analysis. Copies of the StatRad preliminary reports are kept on file.
 - If the on-site radiologist records minor or major variances, he/she shall record the results on the preliminary report form and note in the final report. Clinically significant variances are reported to the Emergency Department staff. All cases with major variances shall be forwarded to the Imaging Quality Assurance (QA) Officer for review and sent through the Imaging Division QA process.
- 3. The StatRad preliminary report with the noted discrepancy shall be faxed to StatRad QA department.
- 4. A spreadsheet is on file tracking the teleradiologists, volume of reports, turnaround time, average time, and variances on a daily basis.
- 5. The Chief of Imaging Division assures the quality and appropriateness of patient care provided by the teleradiologist.
- A deviation rate of ten percent (10%) or greater for any teleradiologists shall trigger a complete 6. quality review by the Imaging Division.

Approvals:

Division-of-Imaging-Approval:	04/12
	04) 1 <u>E</u>
Credentials Committee Approval:	08/12
• •	
Medical Executive Committee Approval:	08/12
Roard of Directors Approval:	00/07: 09/12
Roard of Ulrectors Approval:	



DELETE – now incorporated into Infection Prevention – NICU policy

WOMEN'S AND CHILDREN'S SERVICES MANUAL - NICU

SUBJECT:

HAND HYGIENE, NICU

ISSUE DATE:

11/08

REVISION DATE: 04/09, 06/11, 8/12

Department Approval:

Perinatal Collaborative Practice Approval:

Division of Neonatology Approval:

Pharmacy and Therapeutics Approval:

Infection Control Committee Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

01/18

Board of Directors Approval:

-PURPOSE:

1. The purpose of hand hygiene is to remove-microorganisms-and-reduce the risk of transmitting disease-and/or-significant pathogens to patients, healthcare workers, and visitors.

B. GENERAL INFORMATION:

- Hand hygiene-is-the-single-most important activity for preventing transmission of infectious microorganisms.
- b. Multiple studies have shown-that-the-hands of healthcare workers carry large numbers of germs. Transient flora-is-acquired-from patients or contaminated environmental surfaces and is more likely to cause facility-acquired-infections-than resident flora — bacteria always-found on the skin. Normal shedding of skin-cells spreads-germs-that-are carried on the skin.
- c. Artificial-fingernails and long natural nails carry twice the number-of-germs-compared to short (less than ¼ inch) natural fingernails. Freshly applied nail-polish-does not increase the number-of-bacteria but chipped nail-polish may support the growth of larger-numbers of organisms on fingernails.
- d. Wearing gleves does-not-provide complete protection against microorganisms. Up to 30% of healthcare workers who wear gleves during patient contact will be carrying germs from the patient they just touched after the gleves are removed. Bacteria and viruses gain access to their hands through-small heles in gleves and/or during gleve removal.
- e. Hand-jewelry, such as rings and watches should not be worn in the NICU.
- f.——For more information, refer to Human Resources policy 415, "Dress and Appearance Philosophy."

B. PROCEDURE:

- Healthcare workers and visitors that will have patient contact: upon initial entry into the NICU
 wash hands, wrists, forearms, and elbows with hospital approved soap and water for two
 minutes.
- Visitors to the NICU that will not have patient contact will-perform hand hygiene with hospitalapproved soap or the alcohol-based waterless product.
- Wash hands with hospital approved soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material (all body-fluids except sweat).
- 4. If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent.
- a. Perform hand hygione after contact with any patient even for simple activities, such as taking a pulse or blood pressure, or lifting a patient.

- Perform hand hygiene after contact with body fluids or excretions, mucous membranes, non intact skin, or wound drossings, as long as hands are not visibly soiled.
- Perform hand hygione if moving from a contaminated body site to a clean body site during patient care.
- d. Perform hand hygiene after initial contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
- Porform hand hygione before caring for patients.
- f. Decentaminate hands before denning gleves when performing invasive precedures such as inserting an intravascular catheter, indwelling urinary catheter or nasogastric tube.
- Decentaminate hands after removing gloves.

Hand hygiene techniques

- a. Waterless based products.
 - When decontaminating hands with a waterless alcohol-based hand rub, apply 1 pump of product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
 - If an adequate volume of an alcohol-based hand rub is used, it should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use.
- b. When washing hands with seap, wet hands first with warm water, apply 1 pump of detergent to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet.

Gloves

- Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin-will occur.
- Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients.
- Change gloves during patient care if moving from a contaminated body site to a clean body-site.
- Wear gloves when changing diapers.
- Glove use does not preclude the need for hand hygiene.

Long Sleeves

- For all staff, when in direct touch contact with patients, long sleeves must be pulled up to above the olbows during care.
- Sleeves may be pulled down when not providing direct care.
- Prior to, and after care when wearing long sleeves, a waterless alcohol based hand rub should be applied up to the elbows.

Parent/Visitor Teaching

- Caregivers will be instructed regarding a 2-minute hand scrub-upon entering the NICU.
- Caregivers will be instructed regarding hand hygiene practices, when to use seap and water, and when waterless based products may be used.

C. EXTERNAL LINKS:

D. REFERENCES:

- California Perinatal Quality Care Collaborative. (2007). Neonatal Hospital-Acquired Nosocomial Infection Prevention.
- Boyce, J. M., & Pittet, D. (2002) Center for Disease Control and Prevention. Guideline for hand hygiene in health care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC. MMWR, 51, 1-45.
- California OSHA. (1998). Title 8, Subchapter 7. General Industry Safety Orders, Group 16.
 Control of Hazardous Substances Article 109. Hazardous Substances and Processes, 5193.
 Blood Borne Pathogens, section L.
- US Department of Labor, OSHA Part 1910. (2001). Occupational Safety and Health-Standards, -29 CFR Toxic and Hazardous Substances 1910.1030 Blood Borne Pathogens.

Women's & Children's Services Manual - NICU Hand Hygiene in the NICU Page 3 of 3

E. APPROVAL-PROCESS

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

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WOMEN AND NEWBORN SERVICES NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT:

INFECTION PREVENTION - NICU

ISSUE DATE:

04/16

REVISION DATE(S):

Department Approval: 05/1602/17 **Perinatal Collaborative Practice Approval:** 08/1610/17 Infection Control Committee Approval: 10/17 Division of Neonatology Approval: 08/16 Pharmacy and Therapeutics Approval: n/a 11/17 **Medical Executive Committee Approval: Professional Affairs Committee Approval:** 01/18

Board of Directors Approval:

A. **DEFINITION**PURPOSE:

- To define infection prevention practices specific to newborns to prevent infection transmission and to comply with current health, infection prevention and control standards., nursery standards and aesthetics.
- 1.2. A CCS and Title 22 Policy Requirement.

| B. **POLICY:**

- The initial source of microbial colonization and infection of the newborn is the mother. In the nursery, the infants themselves are the major source of potential pathogens and strategies should be based on the principle that each infant is a potential source as well as recipient of microorganism. Immature host defenses and invasive procedures permit organisms that colonize the newborn to invade.
- 2. **General Statements:**
 - NICU Specific Hand Hygiene:
 - Emphasize good hand-washing technique.
 - In addition to Infection Control: Hand Hygiene IC 8 policy: The care of a.ii. neonates-necessitates frequent handling by personnel-and-microbes are transferred from one infant to another on the hands of personnel.
 - b.1) Healthcare workers and visitors that will have patient-contact: Upon initial entry into the NICU, healthcare workers and visitors who will have patient contact will wash hands, wrists, forearms, and elbows with hospital approved soap and water for two minutes.
 - c.2) Fingernails must be short, clean and in good condition. Artificial-nails of any kind are prohibited. Nail polish, if worn, must be free of chips or wear.
 - 3) Visitors to the NICU that will not have patient contact will perform hand hygiene with hospital-approved soap or the alcohol-based waterless product upon entering the unit.
 - d.4) Gloves will be worn when changing diapers.
 - Wash hands with hospital-approved soap and water when hands are visibly dirty or contaminated with blood-or-other-potentially infectious material (all body fluids except sweat).
 - If hands-are-not-visibly soiled, use an alcohol-based waterless antiseptic agent.

- Perform hand hygiene after contact with any patient-even for simple activities, such as taking a pulse or blood pressure, or lifting a patient. Perform hand hygiene after contact with body fluids or excretions. mucous membranes, non-intact skin, or wound dressings. Perform hand hygiene if moving from a contaminated body site to a-clean-body site during patient care. Perform hand-hygiene-after initial contact with inanimate objects (including-medical-equipment) in the immediate vicinity of the patient. Perform hand hygiene before caring for patients. Perform hand hygiene before donning gloves when performing invasive procedures such as inserting an-intravascular catheter, indwelling-urinary catheter or nasogastric tube. Perform hand-hygiene-after-removing gloves. Hand hygiene techniques Waterless based products. When decentaminating-hands with a waterless alcoholbased hand rub, apply 1 pump-of-product-to-palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. If an adequate volume of an alcohol-based hand rub is used, it-should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use. When washing hands with seap, wet-hands-first-with warm water, apply-1-pump of detergent to hands and rub hands-together vigorously for at least 15-20 seconds, covering all-surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly-with-a-disposable towel. Use the towel to turn off the faucet. **Gloves** Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious-materials, mucous membranes, and non-intact-skin-will-occur-Remove gloves after caring-for a patient. Do not wear the same pair-of gloves for the care of more than one patient, and do not wash gloves between patients. Change gloves during patient care if moving from a contaminated body-site to a clean body site. Wear-gloves when changing diapers. Glove use does not proclude the need for hand hygiene. Avoid sharing of equipment and supplies-between infants.
- b.
- i.c. Each infant should be supplied with its own dedicated stethoscope and thermometer.
- j₊d. Invasive procedures should be used cautiously and with appropriate aseptic or sterile technique.
- Infection risk-increases-with overcrowding and understaffing.
- 3. Personnel Health Standards- all personnel will comply with the following policies: All personnel will:
 - Administrative: Employee Health and Safety 477 a.
 - **Employee Health & Wellness: Immunization** b.
 - Submit to pre-employment and regular-screening, including immunizations, testing, treatment and monitoring.
 - Comply with Employee Health Immunization-policy

- iii. Promptly report blood-borne and communicable disease exposures.
- c. Receive post-exposure follow-up as outlined in the Employee Health & Wellness:
 Blood Borne Pathogens Occupational Exposure-Policy.
- d. Employee Health & Wellness: Guidelines for Reporting Exposures
- iv.e. Employee Health & Wellness: Work Restrictions for Personnel with Infectious Diseases
 - v. Comply-with off-work requirements for communicable-diseases.
 - vi. Receive PPD-skin-test-or-screening annually.
 - vii. Receive-influenza-vaccine or sign a declination statement during-the-annual influenza vaccination program.

2. Staff AttireDress Code:

- 4.a. In addition to the Administrative: Dress and Appearance Philosophy 415:
 - a.i. Scrub attire will be worn by personnel performing patient care.
 - b-ii. Long hair (below the shoulder) will be pulled back.
 - e-iii. Patient care providers may not wear clothing below the elbows. This includes jewelry such as watches, rings, and bracelets. Personnel should not wear large or dangly jewelry while on duty. Badges-should be displayed at chest level.
 - d.iv. Cover gowns will be worn while holding an infant by all personnel inclusive of volunteers. At the nurse's discretion, visitors may be asked to wear a gown while holding an infant.

5.3. Bedside Environment:

All bedside equipment and counter-space shall be disinfected at the beginning of each shift and when visibly soiled, using hospital approved anti-microbial wipes. and when visibly soiled.

4. Skin Care:

- 6.a. All skin care will be provided per the NICU: Standards of Care NICU or as directed by the physician/Allied Health Professional (AHP).
- a. Bathing: age-specific routine bathing should be performed-per-NICU-Standards of Care.
- b. Perineal Care: Cleanse-with a mild soap and water or a hospital provided disposable wipe with diaper changes as appropriate.
- Cord Care: as directed-by-the physician/allied health professional (AHP) or NICU Standards of Care.

5. Eye Care:

- 7.a. Reference Patient Care Services: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure.
- a. Newborns shall receive prophylaxis for ocular-genecoccal infection of erythromycin 5mg/gram-ophthalmic ointment.
- 8.6. Transmission Reduction Methods:
 - Reference Infection Control: Standard and Transmission- Based Precautions IC5
 i. All-personnel should implement Standard Precautions at all-times regardless of
 the patient's diagnosis, as outlined in the Standard & Transmission-Based
 Precautions policy.
 - b. Airborne, **Droplet, and Contact** Precautions:
 - i. Reference Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11
 - b-ii. Reference Infection Control: Type and Duration of Precautions for Selected Infections and Conditions IC 5-1r11
 - i. Diseases Requiring Airborne Precautions:
 - 1) Measles confirmed or suspected.
 - 2)----Chicken Pox (Varicella) confirmed or suspected.
 - i. Patient shall be placed in a negative air pressure room with the door closed at all times.
 - iii. Only-immune-personnel-should-enter and care for the patient. Personnel are not to enter the room unless they have had the illness or been vaccinated. All

personnel entering the room must wear-the N95 Particulate Filter Respirator (fit testing required). Post "Airborne Precautions" sign outside the patient's room. **Droplet-Precautions** Diseases requiring droplet-precautions: **Mumps** 2) Rubella Parvovirus Meningococcal disease Portussis | Pneumonic plague Diptheria Influenza, confirmed-or-suspected. **Adenovirus** Only-immune-personnel should enter and care for the patient. Personnel are not to-enter-the-room unless they have had the illness-or-been-vaccinated. Patient should be placed in a private room. The door may remain open. Personnel-must-wear-a-standard surgical mask when in the room. Post "Droplet Precautions" sign-outside the patient's room. NICU Methicillian Resistant Staphylococcus Aureus (MRSA) Contact Precautions: C. Infants with a positive MRSA screen will remain on contact precautions for the length of their stay. d.ii. Infants transferring to the NICU from another facility will be placed on Contact Precautions until an in-house MRSA screen done on admission is resulted. Diseases Requiring Resistant-Organism Contact Precautions: Methicillian Resistant Staphylococcus-aurous (MRSA). Vancomycin Intermediate-Staphylococcus aurous (VISA) Vancomycin Resistant Staphylococcus aureus (VRSA Vancomycin Resistant Enterococcus (VRE) Respiratory Syncytial Virus (RSV) Pseudomonas acruginosa, E coli, Enterobacter, Klebsiella, or Serratia, resistant-to-three (3) aminoglycosides* ESBL (Extended Spectrum Beta-Lactamase), as determined (See attachment-H) Infants in the NICU-or-Infant Observation Nursery born to a mother-who-is actively infected or historically-positive for MRSA or other resistant Other diseases of epidemiological-significance as determined by Infection Prevention Staff 101 Rotavirus Genececal conjunctivitis 111 Congenital-Rubella Parainfluenza-virus 13) 14) Horpes-simplex-virus 15) **Scabies** Clostridium Difficle Private room is suggested, door-may remain open. Cohorting of patients may be considered after consulting with Infection Prevention staff. Gown and gloves are to be worn during patient care or any contact with the patient's environment.

Post "Contact-Precautions" sign in the patient care area.

Women's and Newborn's Services - NICU Infection Prevention - NICU Page 5 of 5

- vi. All-patient-care equipment and supplies taken into the room or care area must be either discarded from supply carts, drawers and cabinets if disposable, or cleaned thoroughly with a hospital approved disinfectant upon removal from the room or care area.
- e.d. Infant Readmissions:
 - i. Infants readmitted to the NICU from home are to be isolated using Contact Precautions until a known infectious disease process can be ruled out.

B. RELATED DOCUMENT(\$):

- 1. Administrative: Dress and Appearance Philosophy 415
- 2. Administrative: Employee Health and Safety 477
- 3. Employee Health & Wellness: Blood Borne Pathogens Occupational Exposure
- 4. Employee Health & Wellness: Guidelines for Reporting Exposures
- 5. Employee Health & Wellness: Immunization
- 6. Employee Health & Wellness: Work Restrictions for Personnel with Infectious Diseases
- 7. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11
- 8. Infection Control: Hand Hygiene IC 8
- 9. Infection Control: Standard and Transmission- Based Precautions IC5
- 10. Infection Control: Type and Duration of Precautions for Selected Infections and Conditions IC 5-1r11
- 11. NiCU: Standards of Care NICU
- 12. Patient Care Services: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure

C. REFERENCE(S)-LIST:

- 1. APIC Text Online (2016) Chapter 41 Infection Among Neonates. Http://text.apic.org
- 2. Guidelines for perinatal care 7th edition (AAP/ACOG 2012) chapter 11.
- 3. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf



PHARMACY-MANUAL

ISSUE DATE:

08/12

SUBJECT:

Automatic Dose Rounding

REVISION DATE(S): 09/15

Department Approval:

Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval:

Board of Directors Approval:

07/12, 07/1510/17

07/12, 07/1511/17 08/12, 08/1511/17

09/1501/18

08/12, 09/15

A. PURPOSE:

1. To provide a procedure for rounding medication dosages to deliver high-quality, cost-effective pharmaceutical care while minimizing charge errors and medication waste.

B. **PROCEDURE**:

 It is preferred that the prescriber round the dose of a medication to the nearest available package size or closest measurable dose.

2. If the prescriber does not round to the nearest available package size or closest measurable dose, the pharmacist will round a dose to the nearest available package size or closest measurable dose providing the following criteria are met:

 Doses may be adjusted by the pharmacist for approved medications listed below or pursuant to an approved protocol (for example enoxaparin and heparin per the Pharmacy Procedure: Anticoagulation Dosing and Monitoring).

- i. Approved Medications:
 - 1) Chemotherapy
 - 2) Immune globulin
 - 3) G-CSF: granulocyte colony-stimulating factors (i.e., filgrastim)
 - 4) Erythropoetin stimulating factors (i.e. Epogen)
 - 5) Coagulation factors (VII, VIII, IX, Prothrombin Complex Concentrate)
 - 6) Alpha-proteinase inhibitors (i.e. Zemaira, Aralast)
 - 7) Antimicrobials, antifungals, and antivirals
 - 8) Tranexamic acid
 - 8)9) Monoclonal Antibodies
- b. Doses of non-chemotherapeutic agents will be adjusted within 10% (plus or minus) of the calculated prescribed dose.
- c. Chemotherapeutic agents may be adjusted pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.
- d. The dose for the ordered medication is within the normal dosing range based upon the indication, age, weight, and clinical status.
- 3. The pharmacist shall contact the prescriber prior to rounding the dose of an unapproved medication.
- 4. Dose-rounding for patients on an investigational protocol will occur based on protocol specifications only.
- 5. The prescriber shall be notified of potential rounding of doses greater than 10% for non-chemotherapeutic agents and shall approve the new dose prior to any changes made by the pharmacist. For Chemotherapeutic agents, the prescriber will be notified pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.
- 6. The pharmacist shall round the dose and complete the order "per protocol" in the patient

Pharmacy-Manual Automatic Dose Rounding Page 2 of 2

medical record.

| C. RELATED DOCUMENT(S):

- Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation Pharmacy Procedure: Anticoagulation Dosing and Monitoring 1.
- 2.



PHARMACY-MANUAL

ISSUE DATE:

05/92

SUBJECT: Clinical Intervention/Activity

Documentation Program

REVISION DATE: 05/97, 01/97, 08/00, 02/03, 07/06

01/12

Department Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

03/1510/17

06/05, 07/06, 07/09, 1/12, 05/1511/17 06/05, 07/06, 07/09, 1/12, 06/1511/17

07/1501/18

06/05, 07/06, 07/09, 1/12, 07/15

A. **PURPOSE:**

To provide a process for documentation of daily clinical pharmacy activities and programs, implemented for patient safety and cost-saving initiatives.

2. To provide a process for tracking and reporting of clinical intervention documentation activities for financial and quality improvement purposes and medication error reduction.

| B.

- During each pharmacy shift, the clinical pharmacist will document clinical pharmacy activities in Cerner or othera designated documentation-/tracking system to record all patient related clinical
- 2. The pharmacist will select the appropriate section and document the details of any cost savings interventions or therapeutic interventions that have a significant impact on patient care. Common interventions include but are not limited to:
 - Antibiotic Stewardship a.
 - b. Renal Dose Adjustment
 - Therapeutic Substitution C.
 - IV to PO Conversion d.
 - Therapeutic Duplication e.
 - **Drug-Disease Interaction** f.
 - **Drug-Drug Interaction** g.
 - Physician Near Miss h.
 - i. Dose, Duration, Frequency Optimization
 - Adverse Drug Event j.
 - k. Anticoagulation, Vancomycin, Aminoglycoside, TPN Consults
 - **Drug Information Question**
- Data will be collected and summarized monthly by the IT Pharmacy Analyst or Designee.
- 4.3. Pharmacy Clinical Interventions shall be reviewed monthly by the Clinical Manager and reported to the Pharmacy and Therapeutics Committee-meeting, as appropriate.



PHARMACY-MANUAL

ISSUE DATE: 01/85

SUBJECT: Drug Compounding for Medication

Not Commercially Available

REVISION DATE: 06/05, 03/06, 07/09, 01/12, 09/15

Department Approval:

Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

06/1510/17

06/05, 03/06, 07/09, 1/12, 07/1511/17 06/05, 03/06, 07/09, 1/12, 08/1511/17

09/1501/18

06/05, 03/06, 07/09, 1/12, 09/15

A. POLICY:

1. It is the policy of this institution to allow orders for compounded drugs or drug mixtures not commercially available as appropriate to meet the needs of the patient population, following applicable state and federal law, rules and regulations. Compounded drugs may be prescribed and when the licensed independent practitioner determines, in his/her professional judgment, that the compounded drug's benefits over any approved alternative, justify the risk for a particular patient. The goal is procurement or preparation of safe and effective products using the best available resources and techniques.

B. PROCEDURE:

- The Pharmacy Department may procure compounded drugs from a contracted Compounding Pharmacy in situations where drug products are not commercially available and/or a suitable alternative does not exist.
 - a. The following includes, but may not be limited to reasons for ordering and/or preparing compounded drugs:
 - i. The drug required is not manufactured in the needed strength.
 - ii. The prescriber requests a different form of the drug to improve patient compliance with prescribed drug therapy (for swallowing or taste purposes, etc.).
 - iii. The prescribed drug needs to be combined in forms not available from the manufacturer to improve patient response to prescribed drug therapy.
 - iv. The patient is allergic to inactive ingredients (dye, lactose, etc.) in the manufactured form of the drug.
 - v. The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).
 - vi. The prescribed therapy requires tailoring to the individual-patient (intravenous feeding solutions, chemotherapy, etc.).
- 2. The Pharmacy Department shall not prepare compounded drug products for administration into the eye or inhalation; or any drug product from non-sterile ingredientshigh-risk compounded sterile products which utilize non-sterile ingredients or devices. Refer to Pharmacy Policy Sterile Product Preparation section on High-Risk Level CSPs.
- 3. Extemporaneously prepared products by the Pharmacy Department must be supported by evidence-based literature and a recipe must exist for the preparation of the product.
- The drug to be compounded must be individually prescribed for an identified patient.
- 5. A bulk drug substance (the chemical that becomes the drug's active ingredient) qualifies for use in compounding when:
 - a. It is found in a FDA-approved drug.

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Drug Compounding for Medication Not Commercially Available
Page 2 of 2

b. It is listed in a book of widely used drug substances published by the United States Pharmacopeial Convention (authoritative body).

c. It is listed in a FDA rule as acceptable for pharmacy compounding.

- 6. Previously marketed drugs found to be unsafe or ineffective and removed from the market shall not be compounded.
- 7. If inclusion criteria are met and no exclusion criteria exist, prior to preparing the compounded drug, the Pharmacist will review the medical record of the patient. The risks of the patient receiving compounded drug, along with the benefits, will be weighed in the context of a specific patient's medical condition. If the Pharmacist, in his/her clinical expertise feels the risks outweigh the benefits, the prescriber will be contacted for revision of the order.
- 8. If the prescriber has ordered a compounded drug that is either found to be unsafe or ineffective and removed from the market, or is listed in the FDA's regulations as difficult to compound the prescriber will be contacted for discontinuation of the order.
 - a. If the prescriber refuses to discontinue the order and insists on preparation of the compounded drug, the Pharmacist will contact either the Pharmacy Clinical Manager or Pharmacy Director.
 - a-b. The Pharmacy Clinical Manager or Director will contact the Chairperson of the Pharmacy and Therapeutics Committee to resolve the situation with the prescriber.

C. RELATED DOCUMENT(S):

b.1. Pharmacy Policy: Sterile Product Preparation section on High-Risk Level CSPs

C.D. REFERENCE(S):

California Code of Regulations (CCR), Title 16, Division 17, Chapter 17, Article 4.5, Title 16, section 1735



PHARMACY

ISSUE DATE:

NEW

SUBJECT: DRUG SUPPLY CHAIN SECURITY

ACT

REVISION DATE(S):

POLICY NUMBER: 8610-NEW

Pharmacy Department Approval:

11/17

Pharmacy and Therapeutics Committee Approval:

11/17

Medical Executive Committee Approval:

-n/a11/17

Professional Affairs Committee Approval:

01/18

Board of Directors Approval:

A. BACKGROUND:

1. The Drug Quality and Security Act (DQSA) was signed into law in November 2013. Title II of the act, The Drug Supply Chain Security Act (DSCSA) established new definitions and requirements related to product tracing and outlines steps to building an electronic system that 10 years after enactment will identify and trace prescription drugs distribution in the United States. Many milestones will be implemented until DSCSA completion in 2023. Initial milestones are implemented for enforcement in 2015. This policy reflects the first phase.

2. The DSCSA replaces pedigree requirements of the Prescription Drug Marketing Act (PDMA)

and preempts state requirements unless state requirements are more stringent.

3. The DSCSA requirements apply to transactions or changes in ownership of finished dosage forms performed by authorized trading partners including dispensers (pharmacies).

B. PURPOSE:

1. To establish procedures in compliance with federal regulations defined in Title II of the Drug Quality and Security Act (DQSA), Drug Supply Chain Security that protect consumers by improving detection and removal of potentially dangerous, adulterated and/or counterfeit products from the pharmaceutical distribution supply chain.

C. **DEFINITIONS:**

- 1. **Trading partner** A manufacturer, repackager, wholesale distributor, dispenser or third-party logistics provider.
- 2. **Dispenser** A retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor.
- 3. Third-party logistics provider An entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product, nor have responsibility to direct the sale or disposition of the product.
- 4. Product A prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing (such as capsules, tablets, and lyophilized products before reconstitution); does not include blood or blood components intended for transfusion, radioactive drugs or radioactive biological products, imaging drugs, intravenous products, medical gas, homeopathic drugs, or a drugs compounded in compliance with section 503A or 503B.
- 5. **Transaction** The transfer of product between persons in which a change of ownership occurs. *Exemptions*: The term transaction does not include the distribution of; sample medications, blood and blood component products, IV fluids, dialysis solutions, medical gases, etc. See Attachment A: Exceptions to the DSCSA Tracing Requirements

- 6. **Transaction History (TH)** A statement in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.
- 7. Transaction Information (TI) TI includes:
 - a. Proprietary or established name or names of the product
 - b. Strength and dosage form
 - c. National Drug Code number
 - d. Container size and the number of containers
 - e. Lot number
 - f. Date of the transaction
 - g. Date of the shipment, if more than 24 hours after the date of the transaction
 - h. Business name and address of the person from whom ownership is being transferred
 - i. Business name and address of the person to whom ownership is being transferred
- 8. **Transaction Statement(TS)** A statement or attestation, in paper or electronic form, that the entity transferring ownership:
 - a. Is authorized as required under the Drug Supply Chain Security Act
 - b. Received the product from a person that is authorized
 - c. Received transaction information and a transaction statement from the prior owner of the product
 - d. Did not knowingly ship a suspect or illegitimate product
- 9. Suspect product A product for which there is reason to believe that such product is:
 - a. Potentially counterfeit, diverted, or stolen
 - b. Potentially intentionally adulterated
 - c. Potentially the subject of a fraudulent transaction; or
 - d. Appears otherwise unfit for distribution such that the product would result in serious
 i. adverse health consequences or death to humans

D. POLICY:

- It is the policy of Tri-City Hospital District (TCHD) to maintain awareness about suspicious
 activity or potential threats to the drug supply chain, and to devote attention and effort to detect
 suspect product.
- 2. Obtain pharmaceuticals only from authorized trading partners as defined by the Food Drug and Cosmetic Act
- 3. Trace, quarantine, investigate, retain samples, clear, notify others and dispose of suspect or illegitimate products
- 4. Accept ownership of product only if the prior owner provides the transaction history (TH), transaction information (TI), and transaction statement (TS)
- 5. Provide subsequent owners with the TH/TI/TS unless the transaction is exempt or the sale is from dispenser to dispenser to fill a specific patient need
- 6. Retain records of TH/TI/TS for no less than 6 years after the transaction
- 7. Respond to request for TH/TI/TS due to a recall or investigation of suspect or illegitimate product from the Secretary of Health and Human Services or other appropriate Federal or State official within 2 business days
- 8. Return a product to the trading partner where the product was obtained without providing tracing information
- 9. Have a written agreement with a third-party provider (i.e. authorized wholesaler, distributor or other third-party service provider) to maintain the required TH/TI/TS on behalf of the facility.

E. PROCEDURE:

- Confirm authorized trading partners
 - a. Pharmaceuticals are only obtained from authorized trading partners
 - Trading partners (manufacturers, repackagers, wholesale distributors, dispensers, and third-party logistics providers) are confirmed to be authorized as defined by the Food Drug and Cosmetic Act
 - c. Manufacturer's and repackagers are confirmed as authorized trading partners using

the FDA's drug establishment registration database

- d. Wholesale distributors, third-party logistic providers and dispensers, are validated with the state authority to confirm licensure
- Identification or suspect product
 - a. Characteristics that might increase the likelihood that a product is a suspect or illegitimate product are listed in <u>Attachment B:</u> Characteristics of Suspect or Illegitimate
 - b. Strategies employed to identify suspect product include, but are not limited to:
 - i. Avoid unsolicited offers and offers for product for sale at a very low price or one that is "too good to be true."
 - ii. Examine the package and the transport container (case or tote) for signs that it has been compromised (e.g., opened, broken seal, damaged, repaired, or altered).
 - 1) Identify any unexplained changes since it was last received
 - 2) Identify if product inserts are missing or do not correspond to the product
 - 3) Verify shipping addresses, postmarks, or other materials to validate that
 - the product did not come from an unexpected foreign entity or source
 - iii. Examine the label on the package, or the label on the individual retail unit, for;
 - Missing information, such as the lot number or other lot identification, NDC, or strength of the drug
 - 2) Altered product information, such as smudged print or print that is very difficult to read
 - 3) Misspelled words
 - 4) Bubbling in the surface of a label
 - 5) Lack of an Rx symbol
 - 6) Foreign language with little or no English provided
 - 7) Foreign language that is used to describe the lot number
 - 8) A product name that differs from the name of the FDA-approved drug
 - 9) A product name that is the product name for a foreign version of the drug
 - 10) Lot numbers and expiration dates on product that do not match the lot numbers and expiration dates of its outer container

3. Quarantine:

4.

- a. Identified suspect products are quarantined to prevent distribution or transfer until they are cleared for distribution or dispensing; or are determined to be illegitimate
- b. Suspect products are quarantined in a physically separate area that is clearly identified Notifications:
- a. Upon determination that a product is suspect or illegitimate, immediate trading partners and the FDA are notified within **24 hours** of the determination
- b. FDA notification:
 - i. FDA Form 3911 accessed at the FDA website http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm
- c. Termination of notification in consultation with the FDA:
 - To terminate notification in consultation with the FDA when the notification is believed to be no longer necessary access the FDA website http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm
- Investigation:
 - Upon identification of a suspect product, an investigation is promptly conducted in coordination with trading partners (wholesale distributor, manufacturer) to determine if the product is illegitimate.
 - b. Validate transaction history and transaction information and otherwise investigate to determine if the product is illegitimate
 - c. If investigation determines that the product is not illegitimate and the product is cleared, the FDA is notified and the product may be distributed or dispensed
 - d. If investigation determines that the product is an illegitimate product

Pharmacy Drug Supply Chain Security Act Page 4 of 6

- i. The product is removed from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal
- ii. A sample of the product is retained for further physical examination or laboratory analysis of the product by the manufacturer or other appropriate Federal or State official upon request
- e. Records of the investigation are retained for at least **6 years** after the conclusion of the investigation.
- 6. Obtaining, retaining and retrieving transaction records TH/TI/TS
 - Transaction records (TH/TI/TS) are obtained from authorized trading partners for all applicable products.
 - b. The records are maintained and retained in a readily retrievable manner for at least 6 years from date of the transaction
 - c. Wholesaler/ Distributor records are provided electronically and are retrievable at any time.
 - d. Direct Purchase from the Manufacturer all packing slips are verified to contain the required transaction records. Packing slips are scanned into electronic database and maintained bu buyer.
 - e. Borrow/Loan vs. Drug Transfer/Sale all non, patient-specific transactions will require documentation of T3.
- 7. Record retention requirements
 - Transaction records (TH/TI/TS), suspect product investigations and notifications must be retained for 6 years

F. REFERENCE LIST:

- Title II of the Drug Quality and Security Act-Drug Supply Chain Security
 (DSCSA) http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurityAct/ucm376829.htm Accessed April 2015
- 2. Draft Guidance: <u>Drug Supply Chain Security Act Implementation: Identification of Suspect Product and Notification</u> Accessed April 2015
- Draft Guidance: <u>DSCSA Standards for the Interoperable Exchange of Information for Tracing of</u> <u>Human, Finished Prescription Drugs: How to exchange product tracing information</u> Accessed April 2015
- 4. FDA Drug Supply Chain Security Act Implementation
 Plan: http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainS

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ATTACHMENT A: EXCEPTIONS TO THE DSCSA TRACING REQUIREMENTS

- Intracompany distribution of any product between members of an affiliate or within a manufacturer
- Distribution of product between hospitals or healthcare entities under common control
- Distribution of product for emergency medical reasons, which includes a public health emergency, and excludes a drug shortage unless caused by such a public health emergency
- Distribution of product samples by a manufacturer or a licensed wholesale distributor
- Distribution of blood or blood components intended for infusion
- Distribution of minimal quantities of product by a licensed retail pharmacy to a licensed practitioner for office use
- Products transferred to or from a facility that is licensed by the Nuclear Regulatory Commission or by a State pursuant to an agreement with the Commission
- Product comprised of a device and on or more other regulated components (such as a drug/device, biologic/device, or drug/device/biologic) that are physically, chemically, or otherwise combined or mixed and produced as a single entity
- Distribution of intravenous product intended for fluid and electrolyte replenishment (e.g., sodium, chloride, potassium) or calories (e.g., dextrose and amino acids)
- Distribution of intravenous product used to maintain equilibrium of water and minerals in body (e.g., dialysis solution)
- Product intended for irrigation or sterile water
- Distribution of medical gas
- Drugs compounded in compliance with section 503A or 503B.

Note: Additional exemptions and more detail can be found in Title II of the Drug Quality and Security Act-Drug Supply Chain Security (DSCSA)

(http://www.fda.gov/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/ucm 376829.htm Accessed April 2015

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ATTACHMENT B: CHARACTERISTICS OF SUSPECT PRODUCTS

Characteristics that might increase the likelihood that a product is a suspect or illegitimate product: Trading Partners and Product Sourcing

- Purchasing from a new source that is not confirmed as an authorized trading partner
- Receiving an unsolicited sales offer from an unknown source
- Purchasing on the Internet from an unknown source
- Purchasing from a source that a trading partner knows or has reason to believe has transacted business involving suspect products

Supply, Demand, History, and Value of the Product

- Product that is in high demand, volume or price
- Product that is in higher demand because of its potential or perceived relationship to a public health or other emergency (e.g., antiviral drugs)
- Product that has been previously or is currently being counterfeited or diverted (e.g., HIV, antipsychotic, or cancer drugs).
- Product that has been previously or is currently the subject of a drug shortage
 Appearance of the Product
- Appearance of a package or a container used for transport (e.g., case or tote) that seems suspicious (e.g., it has a label that contains misspellings or appears different from the standard label for that product in color, font, images, or otherwise)
- Package that uses foreign terms, such as a different drug identification number rather than the National Drug Code (NDC)
- Package that is missing information, such as the lot number or other lot identification, or the expiration date
- Package that is missing anti-counterfeiting technologies normally featured on the FDA-approved product that are easily visible to the eye, such as holograms, color shifting inks, or watermarks.
- Finished dosage form that seems suspicious (e.g., a different shape or color from the FDA-approved product, a different or unusual imprint, an unusual odor, or signs of poor quality like chips or cracks in tablet coatings or smeared or unclear ink imprints)

Draft Guidance: <u>Drug Supply Chain Security Act Implementation</u>: <u>Identification of Suspect Product and Notification Accessed April 2015</u>



PHARMACY PATIENT CARE SERVICES POLICY

ISSUE DATE:

07/11

SUBJECT: Risk Evaluation and Mitigation

Strategies (REMS)

REVISION DATE: 12/15

POLICY NUMBER: IV.H

Department Approval:

Clinical Policies & Procedures Committee Approval:

Nursing Executive Council Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

10/15

09/15

11/17

11/15

11/15

12/15

A. PURPOSE:

1. To define a process for managing medications with FDA Risk Evaluation and Mitigation Strategies (REMS).

- 1. Risk Evaluation and Mitigation Strategies (REMS) are strategies and recommendations put in place by the Food and Drug Administration (FDA) in conjunction with the pharmaceutical industry and healthcare providers to ensure that "Elements to Assure Safe Use" (ETASU) are in place for certain-drug and biological-products which the FDA has determined "pose a serious and significant public health concern". In most cases, those products require the distribution of FDA-approved patient medication information that is necessary to patients' safe and effective use of the drug products (a Medication Guide).
 - Section-208.1-(a) states, Medication-Guides apply primarily to human prescription drug products used on an outpatient basis without direct supervision by a health professional and are applicable to both new and refill prescriptions.
- 2. A Risk Evaluation and Mitigation Strategy (REMS) is a strategy to manage a known or potential serious risk associated with a drug or biological product. A REMS will be required if the Food and Drug Administration (FDA) determines that a REMS is necessary to ensure the benefits of the drug or biological product outweigh its risks. A REMS can include a Medication Guide, Patient Package Insert, a communication plan, elements to assure safe use, and an implementation system. The FDA can exercise "enforcement discretion" for individual drug and biological products when they are administered by a healthcare provider (i.e. inpatient hospital). If any patient requests a Medication Guide, it must be provided to the patient, regardless of inpatient or outpatient status

B. **DEFINITION(S)**:

- Medication Guide/Patient Package Insert (PPI) The FDA official Medication Guide is written information used to provide patient education. The guide is written using nontechnical language and a standardized format.
- 2. Communication Plan A communication plan is developed by the drug's sponsor to support implementation of an element of the REMS, and can inform key audiences (health care providers) about the risks of the drug. A communication plan educates, informs and raises awareness about the risks. Examples include letters to healthcare providers, communications to professional societies and/or professional education.
- 3. Elements to Assure Safe Use (ETASU) ETASU are required medical interventions or other actions healthcare professionals need to execute prior to prescribing or dispensing the drug to the patient. These special requirements or restrictions are to optimize safe

use of a drug. ETASU include a wide range of measures such as; special training for prescribers and/or dispensers, enrollment in a special registry, specialized distribution systems with select distributors or specialty pharmacies, patient monitoring requirements and more.

4. Implementation System – The drug's sponsor may be required to monitor, evaluate, and make efforts to improve the ETASU program.

2.5. Timetable for Assessment – Timetable for assessments must be at least by 18 months, 3 years, and in the 7th year after the REMS is approved. Assessment results may be used to modify the REMS, or even eliminate it after 3 years, if the assessment shows changes are needed or that the REMS has met its goal.

B.C. POLICY:

- Tri City Medical CenterHealthcare District (TCHD) will comply with all REMs required by the FDA as they pertain to the inpatient hospital setting.
 - a. Formulary medications with REMS are identified as part of the formulary review process. Drugs with active REMS are evaluated for applicable required elements to assure safe use
 - b. Non-formulary medications with REMS requirements are identified during order entry and/or review by the pharmacist prior to dispensing. A copy of the REMS communication plan and any other REMS requirements are communicated to other healthcare providers as applicable
 - 3.c. Patient own medications with REMS requirements brought into the facility and authorized for inpatient use are assessed and identified by the pharmacist during order review. Per the REMS, applicable requirements are verified and when necessary, communicated to other healthcare providers.
- 4.2. A list of drugs/biological products on the inpatient formulary that require REMs for inpatient use-will be maintained on the TCMC-Tri-City Intranet. in the "Clinical Reference" drop-down menu.
- 2.3. As other **formulary** drugs and/or biological products are identified by the FDA requiring REMS in the inpatient hospital setting, Tri City-Medical Center**TCHD** will update the **relevant** REMS references on the intranet.

C. FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER):

1. Risk Evaluation and Mitigation Strategies, Medications and Biological Substances.

D. REFERENCE(S):

- 1. The Food and Drug Administration Amendments Act of 2007 (FDAAA)
- 2. The Joint Commission Standard MM.01.01.03; MM.02.01.01; MM.05.01.01; MM.05.01.11; MM.06.01.01
- 3. Centers for Medicare and Medicaid Services (CMS) CoP §482.25 (a)
- 4. Healthcare Facilities Accreditation Program (HFAP) 25.01.20
- 5. DNV National Integrated Accreditation for Healthcare Organizations (NIAHO –DNV) MM.1, MM.2
- 6. ASHP REMS Database and Resources https://www.ashp.org/REMS (Accessed July 2017)
- 7. FDA Medication Guides http://www.fda.gov/Drugs/DrugSafety/UCM085729 (Accessed July 2017)
- 4.8. FDA REMS e-mail alerts (Accessed July 2017) https://public.govdelivery.com/accounts/USFDA/subscriber/new?topic_id=USFDA_340



PHARMACY

ISSUE DATE:

11/93

SUBJECT: Unlabeled Uses of FDA-Approved

Medications

REVISION DATE: 05/97, 08/00, 06/05, 07/06, 07/15

Department Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

03/1510/17

12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06,

07/09, 1/12, 03/1511/17

12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06,

07/09, 1/12, 06/1511/17

07/1501/18

12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06,

07/09, 1/12, 07/15

Α. **DEFINITION(S):**

For purposes of this policy "unlabeled use" includes the use of a drug product in (1) doses, (2) patient populations, (3) indications, (4) routes of administration that are not reflected in Federal Drug Admiration (FDA)- approved product labeling.

B. **POLICY:**

- Pharmacy shall consider the off-label use of FDA approved drugs as prescribed by a physician/Allied Health Professional (AHP) to treat chronic, disabling, or acute, lifethreatening illnesses medically necessary when:
 - The drug has been approved by the FDA for at least one (1) indication and a.
 - b. The drug is listed in a standard drug reference compendium for the off-label indication. such as:
 - i. The United States Pharmacopoeia Drug Information (USPDI)
 - ii. American Hospital Formulary Drug Information (AFHS-DI)
 - National Comprehensive Cancer Network (NCCN) iii.
 - iv. Thompson Micromedex DrugDex
 - Lexicomp ٧.
 - vi. Clinical Pharmacology

- The off-label use is supported substantially by accepted peer-reviewed medical literature
- 2. Off-label use of a drug shall not be considered if the FDA has determined said use to be absolutely contraindicated.
- 3. If the unlabeled use is not identified in the aforementioned compendia, the physician/AHP must present a proposal for said unlabeled use, along with documentation of safety and efficacy, to the Pharmacy and Therapeutics Committee at Tri-City Medical CenterHealthcare District (TCHD) for approval.
- 4. If the physician/AHP insists upon immediate use of a medication for unlabeled use not identified in the aforementioned compendia, the pharmacist will contact the physician/AHP for information regarding off label use and seek approval from the Clinical Manager. If information supporting off label use is verified by pharmacy, the electronic medication order will be verified by the pharmacist for immediate administration of the drug by nursing personnel.
- 5. If there is disagreement between the pharmacist and the prescribing physician/AHP, the Chairman of the Pharmacy and Therapeutics or his/her designee must be contacted for approval.

Pharmacy Unlabled Uses of FDA Approved Medications Page 2 of 2

- 6. If the Pharmacy and Therapeutics Chairman is unavailable, the chain of command is as follows:
 - a. Division Chief
 - b. Department Chairman or Vice-Chairman
 - c. Chief of Staff
- 7. Once a decision is made regarding the "unlabeled use" of a medication by the Chairman of the Pharmacy and Therapeutics Committee, or Division Chief, or Department Chairman, or Department Vice-Chairman, or Chief of Staff, the decision is final.
- 8. The decision will be communicated to the Pharmacy Department, and documentation in the chart will be noted by the pharmacist regarding the final decision.



REHABILITATION SERVICES POLICY MANUAL

SUBJECT:

Behavior Management/Supervision Technique

ISSUE DATE:

11/09

REVISION DATE(S): 03/10, 03/12, 05/12

Department Approval: 10/15
Department of Medicine Approval: 06/17
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 07/17
Professional Affairs Committee Approval: 01/18

Board of Directors Approval:

A. PURPOSE

1. To protect the safety of patients (adults and adolescents) and staff.

A. POLICY:

2.1. All potentially violent and/or suspicious behavior will be dealt with immediately to prevent any harm to patients and staff.

B. PROCEDURE:

- Responsibility/who may perform:
 - a. The individuals responsible for performing behavior management/supervision during transport to the Rehabilitation Gym are the following:
 - (1)i. Physical Therapists &and Physical Therapy Assistants who have active licenses to practice in the State of CA.
 - (2)ii. Occupational Therapists &and Occupational Therapist Assistants who have active licenses to practice in the State of CACalifornia.
 - (3)iii. Speech Language Pathologists who have active licenses to practice in the State of CACalifornia.
 - (4)iv. Assistants will be directly supervised by a therapist within the respective discipline.
 - b. To maintain safety during patient transport to/from Rehabilitation Services Gym area, move the patient to another area or remove the other patients from the area and call for staff assistance when violent or suspicious behavior is observed.
 - c. Should an event occur, the staff member will gather all information regarding behavior and assess the patient's mental status.
 - d. Implement the most appropriate response, which may be a time-out or verbal **de**-escalation techniques.
 - e. Physical restraint is not used as a clinical intervention. If a patient becomes violent, a "Dr. Strong" code must be called immediately by dialing 66 in the hospital. If the patient becomes violent at an offsite location, 911 should be called immediately.
 - f. The Director or designee will meet with all staff involved to process the incident. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.
 - g. Submit required documentation when necessary and forward to the Risk Management Department.
 - h. Document the incident and staff response in the patient's medical record.



REHABILITATION SERVICES

SUBJECT:

Computer Downtime/Printer Malfunction

ISSUE DATE:

11/88

REVISION DATE(S): 01/91, 01/94, 07/97, 10/99, 01/03.

12/03, 01/06, 09/08, 01/09, 03/12,

05/12

Department Approval:

12/15

Department of Medicine Approval:

n/a

Pharmacy and Therapeutics Approval: **Medical Executive Committee Approval:** n/a

Professional Affairs Committee Approval:

n/a 01/18

Board of Directors Approval:

ISSUE DATE: 11/88

SUBJECT: **COMPUTER DOWNTIME/ PRINTER**

MALFUNCTION

REVISION DATE: 1/91, 1/94, 7/97, 10/99,

1/03, 12/03, 1/06, 9/08, 1/09, 3/12, 5/12

REVIEW DATE:

STANDARD NUMBER: 500

CROSS-REFERENCE: APPROVAL:

PURPOSE

To identify a system to receive therapy orders in the event the Medical Center computer system is unavailablo.

POLICY

A. **POLICY: MANUAL**

Occupational therapy, Physical Therapy and Speech-Language Pathology is accountable through the Leadership Structure of Rehabilitation Services to follow TCMC Patient Care Services Policy: Compass (Cerner) Downtime. When the computer system is unavailable for use, therapy orders will be faxed or telephoned to the department by the Unit Secretary/appropriate hospital staff responsible for transcribing physician orders.

€.B. **PROCEDURE:**

- All therapy orders must be initiated via a physician's order. Orders are and be faxed (x4007) or telephoned (x7272) to the Rehabilitation Services Department by the Unit Secretary/appropriate hospital staff.
- 2. Department personnel will check the fax server or answer the phone calls and record the order. The and relay order is then relayed to the appropriate therapist.
- 3. When computer/printer is functioning properly, the ordering department personnel will input any received orders into Compass (Corner).the current computer system. The Rehabilitation Services receptionist/assigned staff will verify orders received with the orders already recorded.
- 4. In the event of downtime for Compass (Corner) the current computer billing system, Rehabilitation Services personnelstaff will bill when the system is operational to update billing for past services.

C. RELATED DOCUMENT(S):

Patient Care Services Policy: Cerner Downtime



Tri-City Medical Cente Oceanside, California

REHABILITATION SERVICES POLICY

DELETE: Contents covered in Rehabilitation Services: **Documentation of Progress Note** and Discharge Summary

SUBJECT:

Documentation Guidelines

POLICY NUMBER: 1000

ISSUE DATE:

12/87

REVISION DATE(S): 1/91, 2/94, 9/97, 10/99, 1/03, 12/03, 1/06, 10/06, 2/07

Department Approval: 10/15 **Department of Medicine Approval:** n/a Pharmacy and Therapeutics Approval: n/a **Medical Executive Committee Approval:** n/a **Professional Affairs Committee Approval:** 01/18

Board of Directors Approval:

ISSUE-DATE: 12/87

SUBJECT: **DOCUMENTATION**

GUIDELINES

REVISION DATE: 1/91, 2/94, 9/97, 10/99, 1/03.

STANDARD NUMBER: 1000

12/03, 1/06, 10/06, 2/07 **REVIEW DATE: 1/09, 4/12**

CROSS-REFERENCE:

APPROVAL:

Department Approval:

10/15

Department of Medicine Approval:

10/15

Board of Directors Approval:

PURPOSE

To-provide a consistent method of documenting Rehabilitation Services patient care and to maintain-interdisciplinary-communication.

Documentation of patient care and all related pertinent information, including the patient's participation/response to care, will be maintained in the patient's medical record in a clear. concise, complete, and timely manner. All patients referred receive an assessment, which may include physical, functional, and social status.

PROCEDURE

- -Decumentation-may-include, but is not limited to:
 - Reason for referral -- including physicians orders
 - Initial note and evaluation including goals and outlined treatment plan
 - Daily service notes
 - Progress summaries
 - Monthly progress summaries completed on patients receiving outpatient care. Pediatric progress summaries are submitted per authorization period.
 - Periodic goal reassessment and attainment including time frames, weekly or as appropriate.
 - Conference-reports, including updated discharge plan
 - Other decuments as required by specific services
 - Discharge Summaries including home programs or referrals for continued therapy as appropriate

Rehabilitation Services Policy Manual Documentation Guidelines Page 2 Of 2

- 2. In addition to the above, it is the responsibility-of-each therapy staff member to include the date, time the note is written, length of treatment and therapist's signature-in-each entry. Licensed personnel-will-co-sign-entries, as appropriate.
- 3. Copies of evaluations, progress summaries, and discharge summaries will be sent to the referring physician for all outpatients, as appropriate.
- 4. When errors of incorrect chart er-incorrect encounter are identified in the electronic chart, the providing therapist is notified to correct the documentation. If the provider who made the error is not available, the direct supervisor or manager (or their proxy) will-proceed. Documentation made in error is uncharted by identifying error document-in-Forms-section, right-clicking, and choosing "unchart." The reason for error is entered into the comment field. If a Clinical Note is documented-in-error, the providing therapist modifies the clinical note by adding an addendum stating the reason for error. Documentation is then completed in the correct chart utilizing the date and time of service. If the documentation is corrected by someone other than the providing therapist, the reason for correction and name of provider is documented by the supervisor or manager (or their proxy).
- 5.1. All-entries are to be written in black ink or documented electronically.



REHABILITATION SERVICES POLICY

DELETE- Items no longer stocked for dispensing.

SUBJECT:

EQUIPMENT EVALUATION.

DISPENSING & MONITORING

POLICY NUMBER: 1000

ISSUE DATE:

8/91

REVISION DATE(S): 1/94, 1/97, 10/00, 1/03, 1/06, 4/12

Department Approval:

08/15

Department of Medicine Approval:

08/15

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

01/18

Board of Directors Approval:

ISSUE DATE: 8/91

SUBJECT: **EQUIPMENT EVALUATION. DISPENSING-&-MONITORING**

REVISION-DATE: 1/94, 1/97, 10/00, 1/03, 1/06, 4/12

REVIEW DATE: 1/09

STANDARD-NUMBER:-502 **CROSS REFERENCE:**

APPROVAL:

Department Approval:

Department of Medicine Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

08/15 08/15 n/a n/a

PURPOSE

1. To ensure that all patients in need of assistive devices or equipment are provided for in a safe and cost-effective manner, regardless of age and size. Patient equipment is dispensed to assist in alleviating pain, restoring function to allow the patient to be as independent as possible, and to improve their quality of life.

POLICY

1. To provide patients (as appropriate) with assistive devices or equipment from items in stock or from-outside-vendors-

PROCEDURE

- 1. Upon physician's referral/prescription, the patient is evaluated for equipment needs.
- 2. If equipment is warranted, the patient is instructed (verbally and in written form, as appropriate) in the proper safe and effective use, care, and maintenance of the equipment. Proper use is determined by satisfactory return demonstration.
- In-stock assistive devices are utilized for evaluation and training purposes. All non-electrical equipment is maintained by the department and ordered as needed. Any equipment requiring a battery or electric current is checked for safety and effectiveness on an annual basis by biomedical engineering.
- 4. Non-stock equipment is ordered via a non-stock requisition form from a medical supply company or a mail order catalog. Upon receipt, the equipment is inspected to ensure safe operation for the patient. If any-piece of equipment is found to be defective or is recalled by the

Rehabilitation Service Equipment Evaluation, Dispensing & Mintoring Page 2 of 2

- manufacturer, Administrative Policy #229 is followed to ensure-immediate removal of the equipment. Patient-will-be referred to community resources for adaptive equipment, as appropriate.
- 5. Documentation of equipment-evaluation, patient satisfaction, suggestions, instructions, and satisfactory outcome related to usage and function are noted in the patient's medical record.



Tri-City Medical Center Oceanside, California

REHABILITATION SERVICES POLICY

DELETE: Exception reports are no longer utilized by patient accounting

SUBJECT:

EXCEPTION REPORTS

ISSUE DATE:

6/04

REVISION DATE(S): 1/06, 1/09

12/15 Department Approval: **Department of Medicine Approval:** n/a Pharmacy and Therapeutics Approval: n/a Medical Executive Committee Approval: n/a **Professional Affairs Committee Approval:** 01/18

Board of Directors Approval:

ISSUE DATE: 6/04

SUBJECT: EXCEPTION REPORTS

REVISION DATE: 1/06, 1/09

STANDARD NUMBER: 503

REVIEW DATE:

CROSS-REFERENCE:

A.—PURPOSE

To-define the process and responsibilities governing the management of the Billing-Department's Exception-Reports. This report itemizes (by cost center) those charges that were billed through Cerner-but-did not interface with Affinity and, therefore, did not get-posted to the patient's account-

-POLICY

- The Exception Report will automatically print-on-a-daily-basis-to-a printer in Inpatient Rehabilitation Services.
- The Office Coordinator, or designee, is responsible for reviewing the report each day (weekend reports will be reviewed on Monday) and ensuring the errors are corrected.

PROCEDURE:

- Review-of-the-report-consists of finding any items within rehabilitation services cost-centers. If there are none, the report-may-be-shredded.
- For each item listed within-rehabilitation-services cost centers:
 - Within Batch Charge Entry in the patient's account, establish which employee charged the account and determine the cause of the error.
 - (1) If the employee works at an outpatient facility (161 Thunder-or-Wellness Center), a copy of the pertinent page(s) is made and forwarded to the appropriate personnel of that facility, who will be responsible for follow-up, including #3 below-
 - -Inform-the-employee of the error and request that the charge-be-re-billed-appropriately-(if applicable). If a registration-error-was the cause of the exception, inform the manager of Admitting to correct the problem (if it cannot be resolved by one of our staff).

Every Monday-morning, a-report-of-the-previous week's exceptions is to be emailed to the Patient Accounting Revenue Cycle Manager, with a copy-to-the manager of the affected cost center(s).



REHABILITATION SERVICES

DELETE: Redundant information- does not need to be in policy.

SUBJECT:

RATIONALE FOR CLINICAL EDUCATION

POLICY NUMBER:

401

ISSUE DATE:

07/91

REVISION DATE(S): 1/94, 4/97, 3/00

Department Approval:

09/15

Department of Medicine Approval:

n/a

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval: **Professional Affairs Committee Approval:** n/a

Board of Directors Approval:

01/18

ISSUE-DATE: 7/91

SUBJECT: RATIONALE FOR CLINICAL

EDUCATION

REVISION DATE: 1/94, 4/97, 3/00

REVIEW DATE: 2/03, 1/06, 1/09, 5/12

STANDARD NUMBER: 401

CROSS REFERENCE:

APPROVAL:

ACADEMICALLY

1. Students benefit from the opportunity to practice skills and observe other therapists as role models. Schools receive feedback from clinics about their curriculum and its applicability to clinical practice.

CLINICALLY

Clinical education provides a means for staff to stay updated academically and onhance their teaching skills. Commitment to clinical education promotes public relations and facilitates recruitment of new staff.

PROFESSIONALLY

1. Clinical education ensures a standard-level of competency and provides a means of supporting the professions of physical, occupational, speech, and recreation-therapy.



TELEMETRY UNIT SPECIFIC POLICY

DELETE – incorporated into Patient Care Services Policy: Bed Utilization, Temporary Opening and Closing of Inpatient Beds/Units

SUBJECT: Opening/Closure of Telemetry Beds/Unit

POLICY NUMBER: 6150-109

ISSUE DATE: 7/96

REVISION DATE: 5/99; 12/02,1/03;05/05; 06/06; 03/10 8/10;12/10, 10/15

Department Approval: 03/1505/17

Division of Cardiology Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

02/11

N- PURPOSE:

To identify the process for opening-and/or closing Telemetry beds and opening or closing a
Telemetry unit.

B. POLICY:

- When the Telemetry census-does-not-require maintenance of 680 beds, the Clinical-Manager or Assistant Nurse Manager (ANM)/Relief Charge Registered Nurse (RN) may elect to:
 - a. Close-an-entire-unit-or-partial unit
 - b. Close beds on a unit
- Safe quality nursing care-is-of-prime consideration, when it is anticipated the census will fall below-48, the Telemetry ANM/Relief Charge Nurse shall-evaluate the possibility of closing beds on a specific unit or closing a unit.
- 3. The mechanism for closing beds is limited to the following:
 - a. Closure of room(s) due to non-operating-telemetry monitor; rooms may be used for everflow conventional care patient
 - b. Maintenance-of-room by Facilities Management; rooms-will-be-used-as-soon as repairs are-completed
- 4: The ANM/Relief Charge Nurse shall complete the following when opening or closing bods or a unit:
 - Use the Opening or Closure of Telemetry Bed Checklist
 - b. Notify the Telemetry Clinical Manager or the Administrative Supervisor (AS) of the possible opening or closure of bods or a unit.
 - c. Notify the staffing office for assistance with obtaining additional staff
 - d. Direct all admissions and transfers the open-units to minimize transfers should the closure of the unit occurs
- e. Evaluate the patient-population of the Intensive Care Unit (ICU) for potential transfers to

 Telemetry
 - f. Evaluate the current-Emergency Department (ED) status for possible-admissions-to-
 - g. Evaluate the availability of conventional care bods
 - h. Re-evaluate the closure of a unit, if there is a limited amount of ICU or conventional care beds available. Telemetry patients shall be evaluated according to priority.

C. <u>RELATED DOCUMENTS</u>

D. APPROVAL PROCESS

Closure of Telemetry Beds Checklist
☐—Confirm-the-appropriate-beds-are-available-six-beds-are-available-after all the transfers and/or
discharges are completed.
☐ Complete Narcotic Check-on-Pyxis (inventory)
□ Notify the following:
□ Administrative Supervisor (AS) and Staffing Office
☐—Pharmacy-to-turn-off-Pyxis-access, Ext. 3010.
□—Food-and-Nutrition-Services, Ext. 4890.
⊟—Environmental Services, Ext. 7294.
□-Facilities-Management, Ext. 7218.
□-Security-call-TCMC operator.
□PBX-Operator-
□ Plug in the non-invasive blood pressure machines and turn unit off.
□ Plug in and store infusion IV pumps in patient's room.
□ Store bedside commodes and visitor's chairs in patient's room.
☐ Store Life Scan, doppler and pulse eximeter in appropriate equipment in the appropriate storage
area
— □ On 3E place in Physician's dictation room.
☐ Count Telemetry boxes to confirm 12, place clean Telemetry boxes in storage baskets.
Leave Crash Cart with defibrillator and epicardial pacemaker-near-the-nurses' station; write on
Crash Cort Charlist "Charlist "Init Classed" On 25 place in Physician's distribution room
Cart Checklist "Checklist "Unit Closed". On 3E place in Physician's dictation room.
☐ Confirm all patient rooms are clean. ☐ Turn off the news to compute monitors (not CRII) the printer for machine
☐ Turn off the power to computer monitors (not CPU), the printer, fax-machine, ☐ Turn off lights on medication and supply Pyxis. Do NOT turn off Pyxis supply-stations.
☐ Turn off lights in kitchen, utility and supply rooms, nurses' lounge, all-patient-bathrooms and rooms
☐ Close doors to all patients' rooms and nurses' lounge.
☐ Turn off and unplug coffee makeroff, unplug-coffee maker, and ensure coffee decanter is emptied, if
——————————————————————————————————————
□ Lock the kitchen door from the inside.
Close fire doors to unit and ensure they are locked
□ Turn off light in Physician's dictation room, close and lock door, if applicable.
— Turn-off-lights-to-the-unit.
P—Close and lock-center-door.
☐ Confirm all doors leading to unit are locked
□ Place-unit-keys-in the ANM Office on 2 West.
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
RN Signature Date
Opening-Telemetry-Beds-Checklist
☐ Unit Clinical Manager, Assistant Nurse Manager (ANM) or Administrative-Supervisor (AS) has
confirmed the need to open overflow-unit
□ Notify the following:
AS of the time beds will be available for patient arrivals
☐ Pharmacy to restore Pyxis access, Ext. 3010
☐—Food-and-Nutrition-Services, Ext. 4890
☐—Facilities Management, Ext. 7218
□ Security - call operator
☐ Staffing has been confirmed for admissions
☐ Confirm telephones are working

□-Unlock-supplies and equipment. Return equipment to their-operating locations and plug them into a
power sources
□-Place-new batteries in Telemetry boxes for assigned beds
☐ Turn on monitors, printers, fax machinesmachines, and brightness on cardiac-monitoring-screen
☐ Turn on lights-on-medication and supply Pyxis
□ Check-crash cart. DocumentMark off the daysthe days-the-unit-was closed on the Crash Cart
Checklist as "Unit-Closed"
☐ Check Defibrillator and External Temporary epicardial pPacemaker
□-Open-the doors to the assigned patient rooms
☐ Unlock-the-kitchen door from the inside
☐ - Check-the-expiration date on food left in refrigerator per policy
□-Complete narcotic inventory per policy
☐ On 3E, remove equipment from Physician's dictation-room and
RN SignatureDate



ULTRASOUND AND VASCULAR IMAGING

ISSUE DATE:

05/11

SUBJECT: How to Report a Critical/Stat Read

REVISION DATE(S):

Department Approval: 08/17
Department of Radiology Approval: 10/17
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 11/17
Professional Affairs Committee Approval: 01/18
Board of Directors Approval: 05/11

A. **DEFINITION(S)**:

1. A critical result is identified as a result that changes the management of patient care. Some examples are deep vein thrombosis, ectopic, pseudoaneurysm

B. POLICY:

- After scanning a patient and speaking with a radiologist to confirm that it is a critical read the sonographer must contact the referring physician for further instruction.
- 2. A phone call will be placed to the referring physician office explaining the results and requesting further instructions for the patient.
- 3. The sonographer must document the phone call. Make sure the date, time and person the sonographer spoke to are documented on the requisition under the "critical results" area.
- 4. The sonographer will complete the exam in cerner and mckesson and scan in the documented critical results requisition.
- 5. The sonographer will speak with the patient regarding the instructions from the referring physician.
- 5.6. The Sonographer will scan the paperwork into Mckesson and then shred the paperwork
- 6. The sonographer-will-put a copy of the critical results documentation in the box-located-in the reading room.

A. APPROVAL PROCES

- 1. Ultrasound-Department-Director
- 2. Division of Imaging
- 3. Medical Executive Committee
- 4. Professional Affairs Committee
- 5. Board of Directors

Governance & Legislative Committee (No meeting held in January, 2018)

Tri-City Medical Center Audit, Compliance & Ethics Committee January 18, 2018 Assembly Room 1 8:30 a.m-10:30 a.m.

Members Present: Director Larry W. Schallock(Chair); Director James Dagostino; Director Jülie Nygaard; Faith Devine, Community

Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member

Non-Voting Members: Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO; Carlos Cruz, CCO, Susan Bond, General Counsel

Others Present:, Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Contract

Analyst - Paralegal

Absent: Cary Mells, M.D.; Physician Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8;30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. Chairman Schallock welcomed Board Member Julie Nygaard and introduced Scott Livingstone, newly appointed Chief Operations Officer.		
2. Approval of Agenda	It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam 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 = September 21, 2017	Chairman Schallock noted an additional page 8 was inadvertently included in the minutes which should be omitted. It was moved by Director Dagostino and seconded Mr. Leslie Schwartz to approve the minutes with the omitted page as described. The motion passed with Director	Minutes ratified.	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Nygaard abstaining from the vote.	STATE OF THE STATE	
5. Old Business a) Discussion regarding Fy2018 Financial Statement Audit	Mr. Ray Rivas, CFO stated at the direction of the committee he contacted Moss Adams to seek an audit proposal to conduct the FY2018 Financial Statement Audit with no increase in fees. Mr. Rivas stated Moss Adams has verbally stated the fees would not only remain the same but may actually come down slightly from last year. He explained there was a slight increase last year due to the single audit required in connection with the HUD loan. The committee directed Mr. Rivas to seek a letter of engagement with Moss Adams to perform the FY2018 Financial Statement Audit and bring forward at the April 19th meeting.	Mr. Rivas to seek letter of engagement with Moss Adams to perform the FY2018 Financial Statement Audit. Letter of Engagement to be presented to Committee at the April meeting.	Mr. Rivas
6. New Business	Tentamini Parametri Parame		
a) Administrative Policies & Procedures: 1. Medical Procedures & Interrogations Requested by Law Enforcement	Ms. Susan Bond requested that the Medical Procedures & Interrogations Requested by Law Enforcement Policy be pulled for further review. She noted this policy is based on implied consent laws stemming from an incident in Utah.	Medical Procedures & Interrogations Requested by Law Enforcement Policy to be presented at a future meeting.	Ms. Bond
b) FY2019-2019 Compliance Program Work)Plan	Mr. Carlos Gruz, CCO presented a comprehensive overview of the FY18-19 Work Plan. Key focus areas and goals were discussed including the following: 1) Compliance Office Structure Goal: To ensure that TCHD Compliance Office has the appropriate infrastructure and staffing in place to support an effective compliance program. Mr. Cruz introduced his staff Ms. Kristy Larkin, Director of Director of Compliance, Audit & Monitoring and Maria Carapia, Contract Analyst – Paralegal. Each staff member	Information Only.	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	gave a brief summary of their background and experience.		
	2) Compliance Program Marketing	MOTION CONTROL OF THE PARTY OF	
	Goal: To ensure that there is awareness of the Compliance Program by TCHD staff members	Very common of the common of t	
	3) Compliance Program Oversight	Valuation of the control of the cont	
	Goal: To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the	The state of the s	
	District and ongoing mitigation efforts.		
	Director Nygaard questioned the location of Mr. Cruz's office and staff accessibility. Mr. Cruz stated he is located in the		
	Administrative suite. He presented a flyer that will be distributed to staff regarding how to report a concern. Director Nygaard suggested the flyer also include a map		
	that reflects Mr. Cruz's office location. Mr. Cruz stated he will be creating a business type card that can be attached to		
	the employee badge with information on accessing Compliance staff and the Values Line. In addition a		
	Compliance Newsletter will be developed and distributed on a monthly basis. Chairman Schallock requested that the		
	Board also receive a copy of the Newsletter. Mr. Cruz reported that all staff will be receiving Fraud,		
	Waste and Abuse training as required by Medicare. He explained the training will be in the form of a Net Learning		
	module. Mr. Cruz stated he also intends to provide 30 minute Board of Directors training in February. He		
Vacamentalismonto Vacamentalis	explained the importance of highlighting the trends in regulatory and case law on a yearly basis.		
Televandering Control of Control	4) Compliance Policies & Procedure		
	Goal: To ensure that the appropriate compliance policies and procedures are implemented.		

Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
5) Compliance Training and Education Goal: To ensure compliance training and education is up to date and meets CMS requirements. 6) Auditing and Monitoring Goal: To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks:to:the District Mr. Cruz discussed the Meditract software that is utilized to upload contracts. He stated it has been very effective in making sure we have agreements in place and triggers to renew contracts prior to expiration. Ms. Fitzwilliam suggested Meditract be added to the Compliance Work Plan to ensure it meets controls. Mr. Cruz discussed the Compliance team is also looking at claims data and denials. He stated he may bring in external auditors from time to time to do auditing as well. Ms. Fitzwilliam Kathryn requested clarification on the monthly employee exclusions screening process. Mr. Cruz explained it is recommended that this screening be done on a monthly basis to determine if there is any staff on the exclusion list. He stated he is working with Human Resources to bring in a vendor to do conduct that screening. 7) Open Lines of Communication	Recommendations/	
Goal: To ensure that the TCHD Values Line is being utilized appropriately by staff members. At Chairman Schallock's request Mr. Cruz commented on the development of a "speak up culture" where staff will be educated on speaking up" and non-retaliation. 8) HIPAA Privacy & Security Goal: To ensure that TCHD has adequate controls in place		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	to protect patient's protected health information (PHI). Mr. Cruz stated in the past there has been a separate Privacy Officer however the Privacy component will be transitioned to Mr. Cruz where HIPAA, Privacy & Security will be centralized. Discussion was held regarding privacy related to physicians and texting of patient information. Mr. Livingstone stated in Cerner there is an application for secured texting however it is not up and running at this time. Discussion was held regarding a patient portal. Mr. Livingstone stated each facility makes the determination of data they wish to make available to the patient on their institution's portal. At Ms. Devine's request, Mr. Cruz reviewed the processes in place for investigation of Values line complaints. 9) Operational Support. Goal: To provide support to operational units and address critical risk areas as specified by leadership. Discussion was held regarding the Pension Plan and whether the Employee Fiduciary Subcommittee was the appropriate committee to provide oversight of the plan. Mr. Cruz stated compliance does not get involved in the day to day operations of the plan. Mr. Dietlin stated it is a highly regulated area. He explained the district has a fully funded plan that is managed by a third party. Mr. Livingstone commented that the third party that manages the plan is highly regulated as well and possibly even more so than us. Chairman Schallock expressed his appreciation to Mr. Cruz for presenting such a thorough Work Plan.	Conclusions The state of the s	
c) Approval of Committee Charter	Chairman Schallock reported the Committee Charter was	Recommendation to be	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	revised to reflect the changes made to the committee structure and meeting schedule. Ms. Fitzwilliam inquired as to whether the physician member has voting rights as the voting members should be an odd number. Chairman Schallock confirmed that the physician member has voting rights however Administrative members do not have voting rights. It was moved by Director Dagostino to approve the Charter as presented. Mr. Leslie Schwartz seconded the motion. The motion passed unanimously.	sent to the Board of Directors to approve the committee Charter as presented; item to be placed on Board agenda and included in packet.	
7. Motion to go into Closed Session	It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to go into closed session at 9:40 a.m.		
11. Open Session	The committee returned to open session at 9:56 a.m. with attendance as previously noted.		
12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
13. Comments from Committee Members	There were no comments from members of the committee.		
14. Committee Openings	There are no committee openings.	None	
15. Date of Next Meeting	Chairman Schallock stated the next meeting will be held on April 19, 2018.	The Committee's next meeting is scheduled for April 19, 2018.	
16. Adjournment	Chairman Schallock adjourned the meeting at 10:00 a.m.		

TRI-CITY HEALTHCARE DISTRICT

AUDIT, COMPLIANCE & ETHICS COMMITTEE CHARTER

Tri-City Healthcare District's (the "District") Audit, Compliance & Ethics Committee (the "Committee") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide assistance, and make recommendations, to the District's Board of Directors ("Board") by overseeing the Internal Audit Program, the external audit, the District's financial reporting obligations and the Ethics & Compliance Program. The Committee is responsible for making recommendations to the Board regarding the appointment, compensation, retention and oversight of the District's independent auditors; Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;

- Internal Audit Program and Ethics & Compliance Program Oversight. The Committee will oversee the District's Internal Audit Program and Ethics & Compliance Program, including the following:
 - a. Review and oversee the non-clinical contracts at least twice annually;
 - Review the District's compliance with applicable federal, state and local legal and regulatory requirements relating to providers and suppliers of healthcare services;
 - c. Monitor the development and implementation of the District's Internal Audit and Ethics & Compliance programs via periodic reports from the internal auditor, District's Chief Compliance Officer, the Internal Compliance Committee, and legal counsel;
 - d. Review risk assessments and work plans (including audit schedules) and the Ethics & Compliance Program, at least annually, as presented by the internal auditor, the Chief Compliance Officer, Internal Compliance Committee and/or legal counsel;
 - e. Review and oversee revision of the District's Administrative Code of Conduct;
 - Receive and revise draft policies from the Chief Compliance Officer and Internal Compliance Committee for presentation and recommendation to the Board;

- g. Review reports from the Internal Auditor, Chief Compliance Officer, and Internal Compliance Committee, and monitor implementation of corrective action as applicable;
- h. Make programmatic recommendations to the Chief Compliance Officer, senior management, and Board.

2. External Audit and Financial Reporting Oversight. The Committee shall:

- a. Review the accounting and financial reporting processes of the District and external audits of the District's annual financial statements;
- b. Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;
- c. Report to the Board regarding any issue involving the District's compliance with financial reporting and, if applicable, legal and regulatory requirements with respect to District financing, as well as any applicable federal and state regulatory requirements relating to Medicaid, Medicare, and state insurance and charity care requirements;
- d. Review the independence, qualifications and performance of the District's external auditors;
- e. Monitor and report to the Board regarding the adequacy, efficacy, and adherence to policies and procedures related to accounting, internal accounting controls, ethical concerns, or auditing matters;
- f. The Audit, Compliance & Ethics Committee Charter will be reviewed every three years.

II. Membership

The Committee shall consist of three (3) Directors of the District, one (1) physician on-staff at Tri-City Healthcare District, and a maximum of three (3) community members and an option for a subject matter expert who would not be a voting member and whose term would not expire. up to four (4) community members.

Each Committee member shall have at least a basic understanding of finance and accounting, the ability to read and understand financial statements, and experience and familiarity with the specialized issues relating to health care financial issues. At least one member of the Committee shall have accounting or related financial management expertise, as evidenced by the certified public accountant designation or other education and/or work-related credentials. Each Committee member shall have a basic understanding of the design and operation of the Internal Audit Program and an Ethics & Compliance Program, by: (i) review of Office of Inspector General/AHLA materials for Boards; (ii) review of OIG compliance program guidance; and (iii) attendance at relevant educational sessions presented by the Chief Compliance Officer.

Term of Membership: Per Board Policy 15-031 members shall serve terms of two years, with an option to renew the appointment for one additional two-year term and shall continue to serve until a successor is appointed by the Board.

III. Meetings

The Committee is anticipated to meet in January, April, July and October for the compliance component; May and September for the audit component.ne less than four times each year and as many times as may be needed.

IV. Minutes

The Committee will maintain written minutes of its meetings, which will be filed with the minutes of the meetings of the Board. Closed session minutes will be maintained consistent with Board procedures.

V. Reports

The Committee will report regularly to the Board regarding (i) all determinations made or actions taken per its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member shall comply with the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/.

Approved: Board of Directors: 9/29/11
Amended: Board of Directors: 4/26/12
Approved: Board of Directors: 3/28/13
Approved: Board of Directors: 5/30/13
Approved: Board of Directors: 5/29/14
Approved: Board of Directors: 8/25/16
Approved by Board of Directors:

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

December 7, 2017 – 3:00 o'clock p.m. Assembly Rooms 2&3 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way, Oceanside, CA at 3:12 p.m. on December 7, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT Director Leigh Anne Grass Director Cyril F. Kellett, M.D. Director Laura Mitchell Director Julie Nygaard Director RoseMarie V. Reno Director Larry W. Schallock

Also present were:

Steve Dietlin, CEO
Kapua Conley, COO
Susan Bond, General Counsel
Carlos Cruz, CCO
Dr. Victor Souza, Chief Of Staff
Doug Johnson, Demographer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

- 1. The Board Chairman, Director Dagostino, called the meeting to order at 3:00 p.m. at 4002 Vista Way, Oceanside, CA with attendance as listed above. Chairman Dagostino stated our Board Counsel is in transit due to traffic delays and the Board has agreed to start the meeting without him. Director Mitchell led the Pledge of Allegiance.
- 2. Public Comments Announcement

Chairman Dagostino read the Public Comments section listed on the Board Agenda.

3. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections – Elections Code 10010(a) (2).

On behalf of the Tri-City Healthcare District, Chairman Dagostino welcomed the public in attendance and gave a brief introduction to this California Voting Rights Act public hearing and announced some background and protocol. He explained this public hearing is being held in accordance with Elections Code section 10010(a)(2). Chairman Dagostino stated the change from the current at-large method of elections to zones will allow voters to now vote for the one Board member representing the zone where the voter lives once every four years.

Chairman Dagostino stated the District first published and made available four draft maps and corresponding sequences of elections on October 19, 2017. Two additional maps were published on November 28, 2017. Each of these six maps divides the

District into seven different voting zones. Three of these draft maps reflect the current boundaries of the District; three of these draft maps reflect the projected boundaries of the District after certain proposed LAFCO annexations are approved. All six maps are displayed on the poster boards and can also be found at www.tricitymed.org/zones. In addition, you can also access an interactive map viewer online which allows you to input addresses to see which district that addresses falls into in each version of the map. Chairman Dagostino stated we will be using the interactive map viewer today with the assistance of our Demographer, Doug Johnson.

Chairman Dagostino reported that today's public hearing is the fifth public hearing the District has held to discuss the maps published October 19th, and the fourth public hearing the District has held to discuss the maps published November 28.

Chairman Dagostino explained the process for any member of the public who wishes to address the Board of Directors regarding any or all of the six draft maps. He stated if members of the public do not wish to speak at today's hearing but would like to submit a comment or a question in writing, there is a line on the speaker slip where you can indicate that you do not wish to speak but that you'd like your question or comment read aloud.

Chairman Dagostino introduced Mr. Doug Johnson, California Voting Rights Act consultant.

Mr. Doug Johnson elaborated on why there are two sets of maps. He explained that we do not have any control over when LAFCO will approve the proposed changes and need to be ready for the 2018 elections with a set if LAFCO approves the changes and a set if LAFCO does not approve the changes in time. Mr. Johnson stated at decision time the Board is faced with choosing one map from each set as a preferred map and then as the election deadline gets closer see whether LAFCO has approved the changes and whichever set is appropriate will be formally adopted at that time.

Mr. Johnson stated the maps have a variety of different approaches and the intent is to show different options based on feedback by Board and the public. He stated equal population is an absolute requirement so it does not allow a lot of flexibility. Mr. Johnson noted some of the maps do follow the city lines very closely. He discussed the unincorporated territory mainly north of Vista and east of Vista that do not purely follow the cities borders. Mr. Johnson stated the Green map follows the cities borders most closely. He noted at the same time the cities have unique shapes and other maps don't follow the city lines as closely but try to stick to neighborhood by neighborhood groupings. Mr. Johnson stated that even when we do try to follow the cities borders there are seats because of the population requirement that blend differently.

Mr. Johnson stated he is here to answer questions both from the public and the Board and move the process along towards making a choice.

Director Mitchell questioned if the unincorporated areas in Vista get their get their city services from the City of Vista such as trash disposal and water. Mr. Clift, a community member indicated it is the city's responsibilities.

Director Reno questioned what powers the Registrar of Voters has in mapping information and information on the election of the Board Members. Mr. Johnson stated the Registrar's role is purely administrative and whichever map the Board adopts will be implemented. The Registrar of Voters will make the precincts match the lines. Mr. Johnson further explained that the Registrar of Voters does not have any discretion to

approve or disapprove a map. Director Reno questioned if the Secretary of State has any power to approve or disapprove the maps. Mr. Johnson stated "no" it is strictly a Board decision. Director Reno stated that concerns her and the only bodies that have governance over the Board is the Secretary of State and the FPPC. Mr. Johnson stated in this case an individual could sue and ask a judge to intervene but that is the only method of overriding Board approval. There is no governmental body approving the maps and this is by statute.

Chairman Dagostino recognized Mr. Victor Roy. Mr. Roy stated as was pointed out at one of the prior community meetings, it is important that communities of interest are not split. He stated each city has its own community of interest and he is against the concept of blended districts and zones should be divided to minimize any blending whatsoever.

Mr. Roy stated that Ms. Ochoa did mislead everyone at one of the previous hearings when a Board member questioned if there was any challenge to this districting process. He stated that Ms. Ochoa initially responded "no" however after Mr. Roy commented on the recently filed federal challenge from the ex-mayor of Poway Mr. Ochoa acknowledged that suit. Mr. Roy stated Ms. Ochoa should be dismissed as the legal counsel in this process and replaced with someone who will be honest and forth right with each point of the issue.

Lastly, Mr. Roy commented on the timeline for the Board of Supervisors to approve elimination of Camp Pendleton from the Healthcare District which will simplify the process and the two areas of annexation that are still possible that will complicate the matter considerably.

Chairman Dagostino recognized Mr. Lou Montulli. He stated the theme here remains that Vista has had no representation on this Board for 10 years and he believes in all fairness they deserve representation in the next election which means the Board should choose two Vista zones and allow Carlsbad to drop back to what they should lawfully have which is two Board members. He implored the map makers to have at least one such option so the Board has a choice whether to choose two Vista zones or not. Mr. Montulli stated it is the right season to be fair if not generous.

Chairman Dagostino stated Board Counsel is still in route and questioned if the Board felt counsel was needed to wind up the meeting. The Board indicated they wished to continue the meeting without Board counsel.

Mr. Johnson stated there are currently four maps that have two seats that are vacant and dominated by Vista.

Director Mitchell requested that Mr. Johnson display the street view of the maps. She commented that east Oceanside and West Vista are in different cities however each has similar communities of interest. In essence some of the communities of interest cross city boundaries and overlap. Therefore the maps being presented have taken all these factors into account when drawing the maps.

Director Reno challenged Director Mitchell's comments. She stated inasmuch as the communities of interest seem to overlap Mr. Johnson has indicated there will still be approximately 49,000 residents in each zone. Furthermore, she agreed with Mr. Roy's comments related to Ms. Ochoa. Director Reno stated district law does matter but apparently this new zoning supersedes district law to a point. Director Reno suggested the Board consider two members from each of the cities and one member at large based

on past experience. Mr. Johnson noted that would be illegal under the California Voting Rights Act.

Director Schallock commented in 1998 there were five Board members elected by zones and two elected at large which was considered unequal representation. In 2002 the Board chose to elect all seven Board members at large rather than create seven zones so that the public could choose their candidate of choice from any of the three cities.

Director Mitchell stated that the way the California Voting Rights Act is written, if there is one at large seat the system is considered at large. She further commented that the Poway case is different in that Poway's authority comes from a local form of authority such as the mayor or city council whereas the healthcare district's authority comes from the state. In other words, a healthcare district answers to state law versus a municipality that answers to local law.

Director Reno commented that the California Government Code was updated in 2011.

Mr. Johnson confirmed that anything in the form of an at large seat would be in violation of the California Voting Rights Act. He further explained even if the District had two Directors elected per city and one at large member it would be in violation of the Supreme Court's mandate of equal representation per Director.

Director Reno questioned what Mr. Johnson is proposing. Mr. Johnson stated the only way to conform to the California Voting Rights Act is seven equal population zones as reflected by the proposed maps.

Director Reno questioned why we need to wait until 2020 to have two representatives from Vista. Mr. Johnson stated when the Board votes on a map it will also choose which zones are up in the respective election years. He further explained the Board is free to choose two Vista zones in 2018 however that would mean that not all of the publicly elected Board members would be eligible to run for re-election in 2018.

Director Schallock commented on the importance of choosing a map that will meet the Registrar of Voters timeline and proposed the following motion.

It was moved by Director Schallock that the deadline to submit any additional maps is January 8, 2018 at 5:00 p.m. Director Nygaard seconded the motion.

Director Kellett questioned who has authority to submit a map. Mr. Johnson explained that a map submitted by a member of the public is essentially a public comment. He encouraged the public not to wait until the last minute to submit a map so that there is ample time to address any issues or questions before the deadline. Mr. Johnson clarified that any additional map that will be considered by the Board would need to be presented at two public hearings within a 45 day period.

Chairman Dagostino requested that Ms. Donnellan reiterate the motion. Ms. Donnellan read the motion as stated:

It was moved by Director Schallock that the deadline to submit any additional maps is January 8, 2018 at 5:00 p.m. Director Nygaard seconded the motion.

The vote on the motion is as follows:

AYES: Directors: Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

Chairman Dagostino commented that the Board is conducting these public hearings related to redistricting due to a lawsuit that was filed related to the California Voting Rights Act and to avoid litigation and not because the Board believes it is in their best interests. He stated in his opinion the Board is attempting to create the best scenario possible however it is clear that it is an imperfect system and will not solve everyone's problems however the Board will make the best of the situation to avoid causing the District any more legal fees.

Hearing no further questions or comments, the public hearing was closed.

4. Oral Announcement of Items to be discussed during Closed Session.

Chairman Dagostino reported the Board would be going into Closed Session to hear one report related to Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Nygaard to go into closed session at 3:45 p.m. The motion passed unanimously (7-0).

9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in closed session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 4:04 p.m.

ATTEST:	James J. Dagostino Chairman
Laura E. Mitchell Secretary	

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

December 14, 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 December 14, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
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 Susan Bond, General Counsel Greg Moser, Board Counsel Doug Strauss, Board Counsel Victor Souza, M.D., Chief of Staff Teri Donnellan, Executive Assistant Richard Crooks, Executive Protection Agent

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

Chairman Dagostino requested a Potential Litigation item be added to the closed session related to a claim update.

It was moved by Director Schallock to approve the modified agenda. Director Mitchell seconded the motion. The vote on the motion passed (6-1) with Director Reno voting no.

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the December 14, 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 Counsel. Board Counsel, Mr. Greg Moser made an oral announcement of the items listed on the December 14,

2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included three (3) matters of Existing Litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; one Report Involving Trade Secrets, Approval of Closed Session Minutes, Evaluation of Legal Counsel Services and Evaluation of CEO and two items of Potential Litigation which includes the item previously added.

5. Motion to go into Closed Session

it was moved by Director Kellett and seconded by Director Schallock to go into closed session. The motion passed unanimously.

- 6. The Board adjourned to Closed Session at 1:35 p.m.
- 8. The Board returned to open session at 2:00 p.m. with all Board members present.

Mr. Douglas Strauss, Legal Counsel requested a motion to exclude Director Reno from Closed Session on the matter of RoseMarie V. Reno vs. Tri-City Healthcare District.

It was moved by Director Nygaard to exclude Director Reno from the Closed Session on the matter of RoseMarie V. Reno vs. Tri-City Healthcare District. Director Schallock seconded the motion.

Mr. Strauss stated Director Reno has stated in closed session that she wishes to participate in this matter and counsel recommends that the Board exclude Director Reno from this matter for the following reasons: Director Reno is the named plaintiff with a direct interest in the outcome of the lawsuit. Director Reno has a financial interest in the lawsuit and thus a Political Reform Act conflict of interest. Director Reno has a conflict of interest under Government Code section 1090 and under common law, and Director Reno's presence would impair the attorney-client relationship and undermine the attorney-client privilege.

The vote on the motion was as follows:

YES: Directors: Dagostino, Kellett, Mitchell,

Nygaard and Schallock

NOES: Directors: Reno ABSTAIN: Directors: Grass

ABSENT: Directors: None

Mr. Strauss opined that Director Reno should not vote on the matter. Director Reno rescinded her vote.

- 2-

Chairman Dagostino adjourned the meeting back to closed session.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James J. Dagostino, PT, DPT 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:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Greg Moser, Board Counsel
Esther Beverly, VP/Human Resources
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

- 9. Chairman Dagostino reported no action was taken in open session however the Board will be returning to closed session to complete unfinished business.
- Director Reno 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 Presentation

AHA Association Banner - Jennifer Sobotka

Mr. David Bennett introduced Ms. Jennifer Sobotka, Executive Director of the American Heart Association.

Mr. Sobotka stated she is excited to be here today to share some of the successes of the Inaugural Heart Walk. The event which was held on September 30th had an amazing turnout with over 3,300 participants. Ms. Sobotka stated this could not have occurred without the partnership of Tri-City. Ms. Sobotka stated we raised over \$200,000 which is incredible for our first year event and had 18 different teams that were represented from the North County community.

Mr. Sobotka stated we already have a date set for in October for the 2018 walk and the American Heart Association is excited to be working with Tri-City again to grow this even further. She expressed her appreciation to CEO, Mr. Steve Dietlin for his leadership and support of this project and also the Board for their support in helping to launch this incredible event. Ms. Sobotka also expressed her appreciation to Mr. David Bennett, CMO and his team.

Ms. Sobotka presented an ROI report that was put together to reflect how Tri-City's investment helped to shape this incredible opportunity. She also shared some photos and a video of the event that showed how Tri-City's brand was showcased throughout North County and throughout all of San Diego leading up to the walk.

Ms. Sobotka introduced Mrs. Celine Showman, a special friend of the American Heart Association and of Tri-City. Ms. Sobotka stated Ms. Showman, an Oceanside resident suffered from a major cardiac arrest that sent her into an immediate coma. To save her life, doctors at Tri-City Medical Center placed her in the first ever therapeutic hypothermia treatment at Tri-City. Now 10 years later, Ms. Showman is preserving a healthy lifestyle and has become an advocate for heart health in the Oceanside community.

Ms. Showman stated she is proud to be working with the American Heart Association. She stated after her cardiac arrest she could barely walk a mile and now on Saturday will be one of the Lucky 13 participants in the half marathon. She expressed her appreciation to the American Heart Association for funding the research for the treatment she received. Ms. Showman stated she was delighted to hear that the American Heart Association and Tri-City are working together as she is very passionate about both organizations.

Ms. Sobotka stated Ms. Showman is a perfect example of why the American Heart Association and Tri-City are working together.

Lastly, Mr. Sobotka stated at the finish line of the event all participants signed banners. She presented Tri-City with the banners that displayed the names of the walkers.

On behalf of the Board of Directors, Chairman Dagostino expressed his appreciation to the AHA and Tri-City for their collaboration and stated he looks forward to next year's event.

13. Special Recognition -

Diane Sikora, RN CMSRN San Diego Business Journal's Women Who Mean Business Award

Ms. Sharon Schultz introduced Ms. Diane Sikora, RN, CMSRN who was a nominee from the hospital and won for one of the mega institutions for the San Diego Business Journal's *Women Who Mean Business Awards* this year. Ms. Schultz stated Ms. Sikora is responsible for five areas in the hospital which include the Infusion Center, various Inpatient areas and she also started up the Palliative Care Program. Ms. Schultz stated Ms. Sikora always says "yes", always gets the job done and is always volunteering to pilot different things in her areas. Ms. Schultz congratulated Ms. Sikora on a well-deserved award.

On behalf of the Board of Directors, Chairman Dagostino expressed his appreciation to Ms. Sikora for her efforts.

14. Educational Webinar – Presented by California Healthcare Association – Reimbursement 101 – How do California Hospitals get Reimbursed

Chairman Dagostino reported today our colleagues from CHA in Sacramento will be doing an educational presentation entitled *Reimbursement 101 – How do California Hospitals get Reimbursed.*

Chairman Dagostino introduced Ms. Peggy Wheeler, VP of Rural Healthcare Center and Governance Forum at CHA. Ms. Wheeler stated she has responsibility for the advocacy and representation of our small and rural hospitals and she and her colleague Mr. Ron Yow, VP of Finance & Economic Analysis will provide a one hour power point webinar. (A copy of the power point is attached to the file copy of these minutes for reference.)

Directors participated in an interactive discussion with the presenters asking questions throughout the presentation.

Director Schallock expressed his appreciation to Chairman Dagostino and Ms. Wheeler for setting this webinar up. He stated it is a good refresher course for all of us and also helpful for new members to have the opportunity to learn. He encouraged that the presentation be given to other California hospitals as it would be a good learning opportunity for them as well.

Chairman Dagostino commented that there were also public in the room that undoubtedly benefited from the presentation as well.

Chairman Dagostino noted going forward the Board has committed to do educational training in 15 minute segments or longer as necessary.

15. Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg, TCHD Auxiliary President reported the Auxiliary has had a very busy month and reported on the following activities:

- > Tree Trimming and Decorations for the Lobby
- Sunset Strummers on December 5th
- Workshop Volunteers presented 50 baby stockings and caps to Labor & Delivery Departments to give to babies born in December as well as one New Year's baby blanket, stocking and cap for the first baby born at Tri-City in the New Year.
- Annual Cookie Exchange was a huge success netting over \$2,000 with proceeds benefiting the Scholarship program. Leftover cookies were boxed up and taken to the Fire Stations in North County.
- 2018 Pet Therapy calendars are available in the Gift Shop and have been a big hit. Proceeds of the calendars will also benefit the Scholarship program.

Ms. Gleisberg invited Ms. Carol Saunders, Chair of Patient Advocates Department to the podium to talk about what the Patient Advocates do as well as provide information on a new project the Auxiliary has been working on with Ms. Sharon Schultz's guidance.

Ms. Saunders stated the Patient Advocates Program has been in place for almost five years. She explained the Advocates visit patients on the first and second day they are in the hospital and provide comfort, conversation and most importantly an ear to listen to their needs and comments. The Advocates also arrange Champlain visits

and dog visits. They also encourage patients to respond to surveys they may receive when they go home from the hospital.

Ms. Saunders commented on a new project that the Advocates have been working on with Sharon Schultz's guidance – Patient Activity Packets which include pens, pencils, crayons, coloring books and Sudoku puzzles and Word Finding puzzles. Ms. Saunders stated the Advocates see approximately 500 patients a month and give out these activity packets to 100 to 150 patients which the patients and family members have thoroughly enjoyed.

Ms. Saunders stated that Ms. Schultz was also interested in providing a library for patients. She stated the Advocates have been able to get books and the Medical Staff librarian has catalogued them and given the Auxiliary space to house the books.

Director Nygaard expressed her appreciation to the Auxiliary and the Patient Advocates. She stated the Auxilians are the face of Tri-City and they bring cheer and kindness to our patients.

Ms. Gleisberg commented that Tri-City is the only community hospital that has Patient Advocates. She stated that Ms. Saunders and her team do a phenomenal job and the feedback we get is so positive and that results in positive feedback to the hospital.

Director Grass stated the Auxiliary is the heart of the hospital.

16. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer reported 820 people attended the Diamond Ball. He stated the event was outstanding and everyone enjoyed special guest Dana Carvey. Mr. Newhart presented a brief video that encapsulated the experience.

Mr. Newhart recognized the six Co-Chairs of the event including Michelle Gonzales, MD, Kelly Ma, Jennifer Mayberry, MD, Jennifer Bean Paroly, Gabrielle Phillips, Himani Singh, MD who were a pleasure to work with.

Mr. Newhart invited Ms. Sharon Schultz to the podium to accept a recognition that should have occurred many years ago. He presented Ms. Schultz with the Diamond Society diamond which is a lifetime award for Ms. Schultz

Mr. Newhart invited Dr. David Tweedy, Foundation President to assist in the presentation of two checks:

1) \$82,054.00 for the SonoCine project.

Mr. Newhart stated this is the balance needed to complete the SonoCine project.

2) \$4,465.95 - NicView camera project.

Mr. Newhart stated the NicView camera project is something that is very important to the Foundation Board as well as the community as a whole. He stated there is a need for additional cameras and there was an opportunity to purchase those cameras at a substantial discount.

Lastly, Mr. Newhart reported the annual *New Socks and Shoes Drive* is coming up on March 15, 2018. He stated last year we collected 700 pairs of socks and over 300 pairs of shoes. Mr. Newhart also commented on the fact that our Social Services Department is also asking for sweatshirts and sweatpants and the Foundation is considering doing an online appeal to meet that need. Mr. Newhart stated there will be collection points throughout the community as well as a collection at the hospital drive.

Chairman Dagostino expressed his appreciation to the Foundation, our longest philanthropic partner.

No action was taken.

17. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO reported the Diamond Ball was a great event for a great cause and one of the many things that makes Tri-City different.

Mr. Dietlin congratulated Ms. Diane Sikora for her recognition in the *Women Who Mean Business* award. He stated Ms. Sikora does a great job and it was exciting to be able to see her receive that award.

Mr. Dietlin commented on the Inaugural American Heart Walk. He stated the AHA is a great organization to partner with and again with community purpose. He reported over 1,000 individuals participated in the walk from Tri-City from Board Members to Medical Staff and employees. It was a great event that gave us some great exposure and information about what Tri-City has to offer.

Mr. Dietlin also commented on the CHA webinar heard earlier today. He stated to summarize, "cost plus is long gone". He explained it is all about quality metrics and at the same time as being able to reduce your costs. Mr. Dietlin stated there will be continued pressure on reimbursement and he does not expect that to stop. He stated Tri-City provides extremely high quality clinical outcomes at a relatively low cost compared to our competitors and that will be an advantage going forward but we need to continue that drive.

With regard to the Auxilians, Mr. Dietlin stated it is always great to hear all the exciting things they are doing. He stated the Auxilians do make Tri-City different than any other hospital or healthcare institution that anyone would go to and are a pleasure to work with every single day.

As 2017 comes to a close, Mr. Dietlin stated he wanted to reach out and thank everyone who makes it possible every day to provide outstanding services to this community every day. Lives are saved and the needs of the patients come first. He stated this is a collaboration amongst the Medical Staff, nursing, clinical, non-clinical, volunteers, Foundation, Board of Director and even community leaders. It takes all these individuals to make it happen. Mr. Dietlin stated we continue to maintain the highest safety rating in North County. Our ED wait times are down and we have one of the lowest wall times in the entire San Diego County. In addition, we are moving forward with our UCSD affiliation, expansion of services available for this community, the Crisis Stabilization Unit for Mental Health, IORT for early stage breast cancers, state of the art CT equipment, Robotics and the OSNC partnership, to name a few.

These are all things we have been working on. Mr. Dietlin also discussed Tri-City's Prime programs which have been extremely successful. He stated we have been meeting those metrics and that is important for population health outcomes. He explained the program is about MediCal outcomes but it affects and improves the outcomes for the entire population.

Lastly, Mr. Dietlin wished everyone happy holidays and thanked everyone for participating and advancing the health and wellness of this community.

Chairman Dagostino stated there were no surprises in the CHA presentation as Mr. Dietlin and the Administrative Team have done an excellent job of keeping the Board updated on these issues.

No action was taken.

18. Reports from Chief Financial Officer

Mr. Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Operating Revenue \$121,365
- Operating Expense \$124,270
- ➤ EBITDA \$3,999
- > EROE (\$1,219)
- > Other Key Indicators for the YTD driving those results included the following:
- Average Daily Census 172
- ➤ Adjusted Patient Days 37,921
- Surgery Cases 2,208
- ➤ Deliveries 832
- ED Visits 21,167

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue \$31,312
- Operating Expense \$31,896
- EBITDA \$1,146
- ➤ EROE (\$171)

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census 173
- Adjusted Patient Days 9,689
- ➤ Surgery Cases 564
- Deliveries 206
- ➤ ED Visits 5.177

Mr. Rivas reported on the following indicators for FY18 Average:

- 8-

- Net Patient Accounts Receivable \$45.8
- > Days in Net Accounts Receivable 48.8

No action was taken.

19. New Business

a. Consideration and possible action to elect Board of Director Officers for calendar year 2018.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors nominate the following slate of Officers for 2018:

Chair - Director Dagostino
Vice Chair - Director Mitchell
Secretary - Director Grass
Treasurer - Director Nygaard
Assistant Secretary - Director Reno
Assistant Treasurer - Director Kellett
Board Member - Director Schallock

It was noted a second is not required for the motion.

It was moved by Director Reno that the Tri-City Healthcare Board of Directors nominate the following slate of Officers for 2018:

Chair – Director Grass
Vice Chair – Directors Kellett
Secretary – Director Mitchell
Treasurer – Director Nygaard
Assistant Secretary – Director Schallock
Assistant Treasurer – Director Reno
Board Member – Director Dagostino

Chairman Dagostino stated there are two slates on the floor.

Chairman Dagostino called for the vote on the first slate by Director Mitchell.

The vote on the motion was as follows:

YES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Nygaard and Schallock

NOES:

Directors:

Reno

ABSTAIN: ABSENT: Directors:

None None

The motion carried.

b. Consideration to award Surface parking lot contract to Sierra Pacific West

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors authorize an agreement with Sierra Pacific West for \$1,964,850.00 for the construction of the new Surface Parking Lot. Director Schallock seconded the motion.

Mr. Chris Miechowski, Director of Facilities reported we went through a public bid process and Sierra Pacific West was the lowest responsive bidder to construct the 290 stall parking lot.

Chairman Dagostino stated this is a temporary surface parking lot that will be utilized while we start construction on our permanent parking structure.

The vote on the motion was as follows:

YES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Nygaard, Reno and Schallock

NOES:

Directors:

None None

ABSTAIN:

Directors:

None

ABSENT: Directors:

c. Consideration of 2018 Board Committee Schedule

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the proposed 2018 Board Committee Schedules as recommended by the individual Board Committees. Director Nygaard seconded the motion.

The vote on motion was as follows:

YES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Nygaard, and Schallock

NOES:

Directors:

Reno

ABSTAIN:

Directors:

None

ABSENT: Directors: None

d. Consideration of CEO Contract

e. Consideration of amendments to Flexible Benefits Plan

Chairman Dagostino reported agenda items d. and e. will be heard following the conclusion of Closed Session.

20. Old Business

- a) LAFCO Update
- b) CVRA Community Meetings Recap

Ms. Adriana Ochoa stated she would be providing a brief update on our California Voting Rights Act issue, our LAFCO issue and the City of Poway litigation that was discussed at the October 26th meeting.

With regard to the California Voting Rights Act, Ms. Ochoa stated the District has held five meetings in total, — three community meetings and two public hearings to cover proposed maps. She stated the deadline set by the Board for anyone to submit a new map is January 8th at 5:00 p.m. She noted if no other maps are proposed by January 8th the Board can proceed on approving one of the six proposed maps.

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With regard to LAFCO, Ms. Ochoa stated there has been a slight shift in the timeline. She stated Fallbrook's counsel passed the motion in support of our LAFCO application at their November Board meeting. She stated she has also spoke with Palomar's counsel and they plan to put our item on their agenda for the December 19th meeting and will likely recommend supporting our motion as well.

Ms. Ochoa stated she spoke at length with the LAFCO Director regarding the status of our application. She explained two documents need to be approved by the Board of Supervisors before the new boundaries can be recorded. The first is the Property Tax Exchange Agreement or Resolution which must be approved by the Board of Supervisors before they can approve the LAFCO application. Ms. Ochoa explained the Property Tax Exchange has three stops before it passes including the Assessor's office, the Auditor's office and the Planning Department and right now we are at Stage 2 which is the Auditor's office. Ms. Ochoa stated she expects the auditors to hand it over to the Planning Department in the next week or two. At that point Planning will review it and have to place it on the Board of Supervisors agenda. Ms. Ochoa encouraged individuals who have contacts with the County Board of Supervisors to urge the Planning Department to find a placeholder on the Board of Supervisors agenda by no later than the February Board meeting. She explained that LAFCO anticipates approving the application at their March 5th Board meeting assuming the Property Tax Exchange is approved in February. Ms. Ochoa stated if the Board of Supervisors approves the application at that meeting there are still ad ministerial steps that need to be taken -- for example there is a 30-day reconsideration period that must be left open for people to protest. After that 30day reconsideration period, a protest hearing is held and if there is not a majority protest they can record the new boundaries immediately thereafter. Ms. Ochoa stated, with this timeline in mind, LAFCO expects to be able to record the new boundaries in the first half of April. She stated that she is aware that the Board had wanted to make the decision on the maps in March and there are different things that can be considered. She explained that the Board can vote on maps at the April Board meeting assuming LAFCO records in the first half and April or the Board can move forward as planned and adopt two maps in March, one with the current boundaries and one with annexed boundaries. If LAFCO approves by May 1st.

Director Schallock commented that a Special Board meeting could also be called in April as well. Ms. Ochoa stated that is indeed possible.

Director Mitchell questioned if there is likelihood that the Board of Supervisors could tweak those boundaries. Ms. Ochoa stated that any tweaking would have been done at the Assessor's Office and we have already passed that stage.

Director Reno suggested an educational session with LAFCO at our January or February meeting. She stated the Oceanside City Council is also interested in such a presentation and would join us. Ms. Ochoa stated she would reach out to LAFCO regarding their availability.

With regard to the City of Poway Litigation, Ms. Ochoa stated there has been a lot of activity on that case since then. She noted the case involves a private citizen who has sued the City of Poway and the Attorney General alleging that the California Voting Rights Act is illegal. Mr. Ochoa summarized some of the more important filings and stated they are asking the Court to make a Decision by May 1st one way

or another in order to give candidates sufficient time to file in advance of the July deadline when papers are due.

Director Nygaard questioned if the result of the Poway case has an impact on what happens with our redistricting issue. Ms. Ochoa stated it could potentially if Plaintiff wins as they are asking the court to declare that the CA Voting Rights Act is illegal. She stated it may not have an effect on us if we adopt maps and there is nothing preventing us from adopting district maps if we wanted to. There would also be no threat of a lawsuit if the Board chose to go back to at large elections. Ms. Ochoa stated there are potential effects across the state and she will update the Board in January on the status of the preliminary injunction. She noted if there is a preliminary injunction enforced against the Attorney General it might state that all California Voting Rights Act threats are on hold until the court decides the merits of the case and in that case the Board could choose to continue its path or choose to intervene or stop the process of changing to district elections because threats of litigation could be encompassed in the court order depending on how broad the court order is. Ms. Ochoa reiterated that it is a "wait and see" and she will update the Board in January.

On another note, Ms. Ochoa expressed her appreciation for funding the NicView cameras as she has had personal experience and the NicView cameras are a lifesaver to those families who have babies in the NICU.

c) Amended 2018 Board Meeting Schedule

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the amended Board Meeting Schedule for 2018. Director Schallock seconded the motion.

The vote on motion was as follows:

YES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Nygaard, Reno and Schallock

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT:

Directors:

None

c) Update on Board Portal

Director Mitchell reported Board member IPads are on order and we anticipate providing training in January. Director Mitchell stated paper is still an option however new Board Members will be encouraged to go digital.

d) Board Retreat Follow-up

- 1. Board Committee Recommendations regarding committee composition and meeting frequency.
 - a. Finance, Operations & Planning Committee
 - b. Professional Affairs Committee

Director Nygaard stated the Finance, Operations & Planning Committee has recommended that community members be reduced to two. In addition, the committee has recommended that the Medical Staff appoint a Primary Care Physician to the committee. Director Nygaard stated the committee plans to focus more on financial performance and look at critical areas. Lastly, the committee has recommended that a consent calendar be implemented for all items that are handled by write-ups.

Director Mitchell stated that the Professional Affairs Committee has recommended that they continue to meet on a monthly basis given the volume of policies that go through the committee.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the Board Committee Recommendations related to committee composition and meeting frequency as recommended by the committees. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Nygaard and Schallock

NOES:

Directors:

Reno

ABSTAIN: ABSENT:

Directors:

None None

21 Chief of Staff

a. Consideration of November 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 27, 2017.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors approve the November 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 27, 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:

Reno

22. Consent Calendar

It was moved by Director Schallock that the Tri-City Healthcare Board of Directors approve the Consent Calendar. Director Kellett seconded the motion.

It was moved by Director Reno to pull items 22 F. A) Board of Director Policy number 5) Approval Board Policy 17-021 – Use of Legal Counsel

- 13-

by Members of the Board of Directors and F. A) and Policy number 7) Approval of Board Policy 17-023 – Responsibility for Decision-making on Legal Matters. Director Kellett seconded the motion.

Director Nygaard stated she would be abstaining from the minutes. Director Reno stated she would be voting no on the minutes and would like the record to reflect that she was recused not absent.

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

AYES:

Directors:

Dagostino, Grass Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None None

ABSTAIN: ABSENT: Directors:

Nygaard

The vote on the main motion was as follows:

AYES:

Directors:

Dagostino, Grass Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None None

ABSTAIN: ABSENT: Directors:

Nygaard

23. Discussion of items pulled from Consent Agenda

Director Reno who pulled items 22 F. A) 5) Board of Director Policy number 5) Approval Board Policy 17-021 – Use of Legal Counsel by Members of the Board of Directors and F. A) 7) Board Policy 17-023 – Responsibility for Decision-making on Legal Matters stated she believes Board members have a fiduciary right to ask legal counsel questions and should not be required to go through the Chair to do so. Director Mitchell stated the only change made to the existing policies was to tighten up the language to reflect the terminology related to General Counsel versus Board Counsel. There were no other substantive changes.

It was moved by Director Schallock to approve Board Policy 17-021 – Use of Legal Counsel by Members of the Board of Directors and Board Policy 17-023 – Responsibility for Decision-making on Legal Matters as presented. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass Kellett, Mitchell,

Nygaard and Schallock

NOES:

Directors:

Reno None

ABSTAIN: ABSENT:

Directors:

None

- 24. Reports (Discussion by exception only)
- 25. Legislative Update -

Chairman Dagostino reported the American Hospital Association is planning to file lawsuit against CMS related to 340B cuts. He encouraged the Board to support that position and provide comments to the Board of Supervisors.

26. Comments by members of the Public

There were no comments from members of the public.

27. Additional Comments by Chief Executive Officer

There were no additional comments by the Chief Executive Officer.

28 Board Communications

Director Schallock commented on the outstanding turnout for the AHA Heart Walk as well as the Turkey Trot and Senior Turkey Trot. He stated the events were family fun events but also included top notch runners.

Director Schallock wished everyone happy holidays and stated he looks forward to a bright future.

Director Reno expressed her appreciation to the Foundation and Auxiliary for their support of this hospital. She also expressed appreciation for staff's diligence and hard work this past year. Lastly, Director Reno wished everyone a Merry Christmas and a Happy New Year!

Director Nygaard wished everyone a blessed and happy Christmas. She stated she is looking forward to working with everyone in 2018.

Director Grass wished everyone a Merry Christmas and a Happy New Year and stated she looks forward to 2018.

Director Mitchell wished everyone a safe and happy holiday season.

Director Kellett wished everyone a Merry Christmas and Happy New Year.

Dr. Souza expressed his appreciation to the Board and Administration for going above and beyond the call of duty. He stated he is excited and looking forward to 2018.

29. Report from Chairperson

Chairman Dagostino expressed his appreciation to his colleagues for allowing him to serve as Board Chair for another year.

Chairman Dagostino wished his colleagues a very happy holiday season and stated he believes the hospital is moving in the right direction.

- 30. Hearing no further business, Chairman Dagostino adjourned the meeting to continue closed session at 6:00 p.m.
- 31. The Board returned to Open Session at 7:15 p.m. with all Board members present.

Open Session (Continued)

- d. Consideration of CEO Contract
- e. Consideration of amendments to Flexible Benefits Plan

It was moved by Director Nygaard and seconded by Director Kellett that the Tri-City Healthcare District Board of Directors accept the recommendations from the CEO Evaluation Ad Hoc Committee as described in their report that includes the following:

- An amendment to the Chief Executive Officer's contract to extend the contract to a new four year term effective December 14, 2017 – December 14, 2021;
- ➤ An increase in base salary of \$25,000 and an increase of \$25,000 to base salary upon the second and third anniversary of the contract provided the CEO has achieved 75% of his goals as approved by the Board;
- An amendment to the Tri-City Healthcare District's Flexible Benefit Plan to increase the Chief Executive Officer's Benefit Percentage to 25% and reflect compensation changes during a Plan Year.

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

Mr. Dietlin expressed his appreciation to the Board and stated he very much enjoys living and working here. Chairman Dagostino stated we are very fortunate to have Mr. Dietlin as our CEO.

32. Adjournment

Hearing no further business, Chairman Dagostino adjourned the meeting at 7:20 p.m.

ATTEST:	James J Dagostino, DPT Chairman
Laura E. Mitchell, Secretary	



National Research Corporation is now doing business as NRC Health

INVOICE

Steve Dietlin Tri-City Medical Center 4002 Vista Way Oceanside, CA 92056-4506 NRC Health 1245 Q Street | Lincoln, NE 68508 o 800.388.4264 nrchealth.com



Invoice: 54685 Date: 12/5/2017

Client: HCA011

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Service/Product	Service Dates		Amount
The Governance Institute Limited Membe	ership		11
	Feb 2018 - Jan 2019		\$24,650.00
		Sub Total	\$24,650.00
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Thank you for your business.

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December 1, 2017

Steve Dietlin Chief Executive Officer Tri-City Medical Center 4002 Vista Way Oceanside, CA 92056

Dear Mr. Dietlin,

Thank you for being a part of The Governance Institute's member network. We are able to continually share leading practices because more than 1100 organizations have committed to belonging to the largest network focused on healthcare governance and strategy.

We strive to provide our members with the highest quality services, resources and support. In an effort to provide such, as well as clarity about the terms of your membership, we are asking all members to memorialize their membership with The Governance Institute by signing an updated Membership Services Agreement.

Enclosed is The Governance Institute's standard Membership Services Agreement for your review. It outlines Membership benefits, important terms and conditions for services, and the responsibilities of both The Governance Institute and Tri-City Medical Center. If this Agreement is acceptable to Tri-City Medical Center, please sign and return to our office.

Also enclosed, please find the invoice for your next membership year. If you have any questions about the agreement or the invoice, please contact me so we can address them promptly and ensure that you continue to receive the best possible service without interruption.

Again, thank you for your membership with The Governance Institute. We look forward to further collaboration with Tri-City Medical Center.

Best Regards,
Keirl Wygu T

Keith Wysocki

Director, Business Development

The Governance Institute

MEMBERSHIP SUBSCRIPTION AGREEMENT

This Membership Subscription Agreement ("Agreement") is entered into by and between National Research Corporation d/b/a NRC Health and Tri-City Medical Center ("Member"), effective as of the 1st day of February, 2018 (the "Effective Date"). This Agreement sets forth membership benefits, pricing, and Terms & Conditions (which are attached hereto and incorporated herein by this reference). Your signature below provides confirmation and acceptance of the Terms & Conditions, as well as the Summary of Benefits and pricing. Please return the executed Agreement to the attention of Justin Burns either via facsimile to (858) 646-3457 or via e-mail to: jburns@GovernanceInstitute.com.

The Governance Institute Membership

\$24,650.00

Notes: Payment will be due 30-days from the date of invoice. Upon receipt of the signed Agreement, membership benefits will begin as of the Membership Effective Date set forth above. The Governance Institute will continue to renew your membership annually each <u>February</u> unless otherwise terminated in accordance with the terms and conditions herein. A yearly fee increase of 5% may be applied. The pricing in this Agreement will expire in the event that the Agreement is not signed and returned within thirty (30) days of the date first stated above.

Summary of Benefits

The Governance Institute serves not-for-profit hospital and health system boards of directors, executives and physician leadership by leading informative research studies, tracking insightful healthcare industry trends and showcasing governance practices of leading healthcare boards across the country. Value-driven membership to The Governance Institute grants access to trusted, independent information and resources for hospitals and health system board members, healthcare executives, and physician leaders in support of efforts to lead and govern your organizations.

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One self-assessment of board performance (BoardCompass®)

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Seven tuition-free leadership conference passes for the year

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One tuition-free pass to our annual Governance Support Conference

 Online Governance Support Forum, which includes online resources, templates, a discussion board, and the Elements of Governance Support® series

We sincerely appreciate the opportunity to serve you, your organization and Board of Directors. If you have any questions, please do not hesitate to contact me at (877) 712-8778 or by e-mail at the address above.

Sincerely,

Justin Burns

Business Development Manager The Governance Institute

TERMS AND CONDITIONS

The following provisions are an integral part of the Agreement between National Research Corporation d/b/a NRC Health (hereinafter referred to as "NRC Health") and Member.

1. <u>CONFIDENTIAL INFORMATION.</u> Except as Member may authorize in writing, NRC Health and its employees shall: (a) treat and cause to be treated as confidential, all information furnished by Member to NRC Health which has been marked as proprietary or confidential information of Member, (b) limit access to such confidential information to NRC Health employees and NRC Health supervisory and support personnel; (c) neither use nor copy any confidential information except with the approval of Member or to the extent necessary for performance of the Services hereunder; and (d) not disclose to any third party the identity of any patient of Member. Confidential Information shall not include: information that (i) is in the lawful possession of NRC Health, without confidentiality restrictions prior to receipt under this Agreement; (ii) is or later becomes part of the public domain, except as the result of an unauthorized disclosure; (iii) is received from a third party having no obligations of confidentiality; (iv) is independently developed by NRC Health; or (v) is required by law or regulation to be disclosed.

2. <u>LIMITED WARRANTY; LIMITATION OF LIABILITY</u>.

- (a) NRC Health warrants that the Services will be performed in a good and workmanlike manner, and that the Services will conform substantially to the Agreement. NRC Health's sole obligation under this warranty is to correct and adjust the Services within a reasonable time from notification by Member that such Services do not substantially conform to this warranty.
- (b) NRC HEALTH'S LIABILITY AND MEMBER'S EXCLUSIVE REMEDY FOR DEFECTIVE PERFORMANCE OR NON-PERFORMANCE OF THIS AGREEMENT SHALL BE LIMITED TO CORRECTION AND ADJUSTMENT OF THE SERVICES WHICH DO NOT COMPLY WITH THIS WARRANTY, PROVIDED THAT MEMBER AFFORDS NRC HEALTH A REASONABLE OPPORTUNITY TO PROVIDE SUCH CORRECTIONS AND REASONABLY ASSISTS NRC HEALTH IN IDENTIFYING SUCH ERRORS OR OMISSIONS.
- (c) THE LIMITED WARRANTY PROVIDED IN SUB-PARAGRAPHS (a) AND (b) HEREOF IS IN LIEU OF ALL OTHER EXPRESS WARRANTIES AND ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR COURSE OF DEALING OR USAGE OF TRADE, ALL SUCH WARRANTIES BEING EXPRESSLY DISCLAIMED BY NRC.
- (d) IN NO EVENT SHALL NRC HEALTH BE OBLIGATED OR LIABLE TO MEMBER FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, SPECIAL OR PUNITIVE DAMAGES ARISING OUT OF OR IN CONNECTION WITH THE SERVICES PROVIDED BY NRC HEALTH TO MEMBER HEREUNDER, INCLUDING BUT NOT LIMITED TO LOSS OF REVENUE OR PROFIT, EVEN IF NRC HEALTH HAS BEEN ADVISED OR KNEW OR SHOULD HAVE KNOWN OF THE POSSIBILITY OF SUCH DAMAGES OR LOSS.

3. <u>OWNERSHIP OF MATERIALS; LICENSES</u>.

- (a) NRC Health owns all right, title and interest in and to the services ("Services") provided under this Agreement, all related software, technology, printed materials, associated media, documentation and systems, deliverables and all NRC Health content provided in connection with the Services, including all intellectual property rights relating to or embodied in the Services (collectively, "NRC Health Property"). NRC Health reserves all rights not expressly granted to Member in this Agreement. Member agrees not to reverse engineer, decompile, translate, or attempt to learn the source code of any software related to NRC Health Property. Member acknowledges NRC Health's right to injunctive relief in case of breach of this Agreement, in addition to any remedy for damages. The failure of NRC Health to enforce this provision shall not be a waiver of the rights of NRC Health to thereafter enforce such provision. NRC Health Property shall not include data provided by Member to NRC Health which shall remain the sole property of Member.
- (b) Subject to Member's compliance with the terms and conditions of this Agreement, NRC Health hereby grants Member a non-exclusive license during the term of this Agreement to use NRC Health Property for Member's own business purposes. This license is granted conditional upon the payment to NRC Health of the applicable Membership Fee in accordance with the terms and conditions of invoices provided by NRC Health to Member. In the event of delinquency in payment of any Membership Fee, any rights granted to Member to use NRC Health Property shall be revoked. Only Member and its authorized employees, agents or representatives shall be entitled to inspect, use or examine NRC Health Property. Unauthorized reproduction shall be cause for immediate termination of the License and this Agreement Member shall not sell, transfer, exchange, sub-license or disclose NRC Health Property to any third party whatsoever without the prior written consent of NRC Health, and shall establish and follow appropriate security measures to safeguard and prevent any unauthorized disclosure which shall be at least equal to the security measures taken by Member to safeguard its own confidential and proprietary information.
- (c) Subject to Member's compliance with the terms and conditions of this Agreement, NRC Health's board portal Licensor ("Licensor") hereby grants to Member a limited, non-exclusive, non-transferable right to access and use a board portal product ("Portal") during the term of this Agreement solely for Member's internal use, and solely for the period for which Member has paid the applicable Membership Fees under this Agreement. Member agrees that it will not (1) make the Portal available to, or use the Portal for the benefit of, any third party, (2) modify, sell, resell, license,

sublicense, distribute, rent or lease the Portal, or include the Portal in a service bureau or outsourcing offering, (3) use the Portal to store or transmit infringing, libelous, or otherwise unlawful or tortious material, or to store or transmit material in violation of third-party privacy rights, (4) use the Portal to store or transmit malicious code, (5) interfere with or disrupt the integrity or performance of the Portal or any third-party data contained therein, (6) attempt to gain unauthorized access to the Portal or its related systems or networks, (7) permit direct or indirect access to or use of the Portal in a way that circumvents a contractual usage limit, (8) copy or reproduce the Portal or any part, feature, function or user interface thereof, (9) frame or mirror any part of the Portal, or (10) access the Portal in order to build a competitive product or service, or (11) reverse engineer, decompile or otherwise attempt to determine the source code or algorithms of the Portal (to the extent such restriction is permitted by law), (12) delete or alter the proprietary rights notice appearing on the Portal. Member agrees to hold the Portal in confidence and will protect the same with at least the same degree of care with which the Member protects its own similar confidential information. Member acknowledges that both NRC Health and Licensors disclaim any warranty of any kind directly to Member, including any warranty of title, merchantability, fitness for a particular purpose or non-infringement. In no event will the Licensors be liable for any damages directly to the Member, whether direct or indirect, incidental or consequential, arising in connection with this Agreement and/or the Member's use of the Portal.

4. <u>TERMINATION</u>. Upon either party's failure to cure a material breach of this Agreement within thirty (30) days following written notice thereof from the other party, the non-breaching party may terminate this Agreement effective at the end of such thirty (30) day period. Either party may, at its option by written notice, terminate this Agreement immediately upon the other party's insolvency, inability to pay its debts when due, assignment for the benefit of creditors, ceasing to do business as a going concern, filing for protection of the bankruptcy laws, becoming the subject of any involuntary proceeding under federal bankruptcy laws, or upon the appointment of a receiver or trustee.

Member may terminate this Agreement at the date of renewal ("Renewal Date") by providing NRC Health with ninety (90) days written notice prior to the Renewal Date. In such event, Member shall pay all fees due and owing to NRC Health under the Agreement through the Renewal Date. In the event of termination, NRC Health will cease all Services and work in progress as of the Renewal Date. Member may opt to have NRC Health continue work in progress and associated Services until completed, so long as Member has paid all fees due and owing to NRC Health at that time. In such event, the Member agrees to pay a fee for activities completed by NRC Health beyond the Renewal Date that shall not be greater than the prorated Membership Fee currently in effect. Services to be completed and associated fees will be agreed upon in writing no later than thirty (30) days prior to Renewal Date. Any prepaid fees in excess of the work performed or to be performed will be refunded to the Member after work has ceased. Without prejudice to any other rights, NRC Health may immediately terminate this Agreement in the event that Member does not cure a failure to timely pay any invoice, and in such event, Member agrees to immediately cease any use of the Services and to immediately return NRC Health Property and all copies thereof to NRC Health. Failure to exercise, or any delay in exercising, this right to terminate for failure to pay shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy.

- 5. <u>COUNTERPARTS AND ELECTRONIC SIGNATURES</u>. This Agreement may be executed in several counterparts, each of which shall constitute one and the same instrument, and shall become effective when counterparts have been signed by each of the parties; it being understood that all parties need not sign the same counterparts. The signatures of the authorized representatives of the parties to this agreement which are scanned and sent by electronic mail or sent by facsimile transmission to the other party shall have the same force and effect as original signatures. Electronic signatures of the parties transmitted by electronic mail shall be deemed to be their original signatures for all purposes.
- 6. <u>ASSIGNMENT</u>. Member shall not assign its rights and obligations hereunder, in whole or in part, without the prior written consent of NRC Health. Any attempt to assign this Agreement without the appropriate written consent shall be immediately void and have no effect. Notwithstanding the above, this Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective legal representatives, successors, and permitted assigns.

MISCELLANEOUS.

- (a) This Agreement constitutes the entire agreement between the parties pertaining to the subject matter hereof and supersedes all prior agreements, representations and understandings of the parties with respect to the subject matter hereof. The Agreement may be supplemented, modified or amended only by a written instrument duly executed by authorized representatives of each of the parties.
- (b) NRC Health shall maintain and provide evidence of general liability, property, automobile, and workers' compensation insurance coverages. Upon request, a current certificate of insurance shall be provided and as policies are renewed or changed.
- (c) This Agreement is not intended to create a joint venture, partnership, or association of any kind between the parties and the relationship of the parties under this Agreement is that of independent contractors. NRC Health agrees that the persons retained by it to provide Services hereunder are NRC Health employees and are not employees of Member for any purpose, and therefore, such persons are not entitled to any rights or benefits, whether present or future, under any retirement plan of Member; or the payment by Member of social security taxes, workers' compensation premiums, unemployment insurance premiums, overtime or other compensation, and any other employee benefits, including withholding of federal or state income taxes, and that NRC Health shall be solely responsible for these obligations.

- (d) The waiver by one party of the performance of a covenant, condition or promise, or a failure to enforce a breach of any provision hereof under the Agreement shall not invalidate the Agreement nor shall it be considered a waiver by such party of any other covenant, condition or promise, nor shall any such waiver be construed as future waiver of the performance of any other like act, covenant, condition or promise. No waiver shall be binding unless executed in writing by the party making the waiver.
- (e) In the event that any provision of the Agreement shall be invalid or prohibited under applicable law, such provision(s) shall be ineffective only to the extent of such prohibition and the remaining provisions of the Agreement shall continue in effect.
- (f) This Agreement shall be governed by and construed in accordance with the laws of the state in which Member's principal place of business is located, without giving effect to the principles of choice of law of such state; provided, however, that in the event that Member initiates litigation against NRC Health relating to the subject matter of this Agreement, the laws of the state of Nebraska shall govern, without giving effect to the principles of choice of law of such state.
- (g) All notices of any kind required or permitted under this Agreement shall be in writing and shall be delivered by mailing a copy thereof by certified or registered United States mail, postage prepaid, with return receipt requested, or by overnight express delivery.
- (h) If either party is prevented from performed any portion of this Agreement (except obligations for the payment of money) by causes beyond its control, such party shall be excused for a period of time equal to the duration of the conditions causing such delay.
- (i) Unless otherwise objected to by Member, NRC Health shall be allowed to use Member's name and logo on NRC Health's website, social media sites, and in other marketing and promotional materials for the sole purpose of identifying Member as a member of NRC Health. NRC Health will not use Member's name or logo in any manner not provided for under this Agreement without Member's prior consent.

Tri-City Medical Center

Dated: ____

National Research Corporation d/b/a NRC Health

Dated: _____





(http://www.csda.net)

Core Benefits

Home (http://www.csda.net/) » Membership (http://www.csda.net/csda-membership/) » Core Benefits

CSDA's Core Benefits are designed to meet the specific needs of special districts in California.



Your Voice in the Capitol

CSDA is the one association that provides a strong voice for all independent special districts in California.

- Legislative Advocacy— CSDA is the only voice in the Capitol that represents and fights for all California special districts, regardless of services provided or affiliation with other organizations. CSDA's legislative advocate and in-house legislative staff review and monitor every bill introduced into legislation for its potential impact on California's special districts.
- Influence CSDA participates in a number of coalitions and working groups to ensure that special districts have a strong voice in state and local government decision making.
- · Revenue Protection CSDA works hard each year to defeat attempts to raid special district revenues.
- Weekly Legislative Updates CSDA keeps you informed by sending out crucial legislative updates on a weekly basis via the CSDA e-News.
- Legislative Committee CSDA's Legislative Committee members represent a wide variety of district types and sizes
- Special Districts Legislative Days CSDA's annual Special Districts Legislative Days provides updated information on legislation and public policy as well as coordinates legislative visits for your board and staff.

Cost Saving Programs

- CSDA Finance Corporation Tax-Exempt Municipal Financing
- Special District Risk Management Authority Workers' Compensation, Property & Liability and Health Coverages

Stay Connected & Informed

CSDA provides a myriad of benefits to help your special district stay apprised of the issues and changes affecting your district.

- California Special District magazine CSDA's bi-monthly magazine, California Special District, helps keep your
 district informed with the most current news from across the state. Feature articles in the magazine offer critical
 information regarding and affecting special districts.
- CSDA e-News CSDA's weekly email publication keeps your special district up-to-date with weekly legislative updates, current CSDA educational offerings, and other time sensitive material important to your district's operations.
- CSDA Website and Members Section CSDA's Members Section website houses tools and information useful to any and every special district. Features include:
 - Daily updates of special district news from across the state, tailored to your district
 - Direct contact information for YOUR legislators
 - Comprehensive legislative information that affects your district
 - A customized system that allows Calls to Action on legislation to appear only if they apply to your district
 - Pending bills, legislation and CSDA's current bill positions
 - Local contact information for media representatives in your region
 - Membership tools allowing you to register for events, order publications and update your district information
 - And much, much more!
 - Listserv CSDA's email Listserv provides a convenient, fast and easy way for CSDA members to discuss issues of importance to special districts, share relevant information, and get answers to questions from those most qualified to answer: people who have been through the same experiences.

Educate your Board and Staff

CSDA is the only association that offers educational opportunities designed specifically for independent districts of all sizes and types.

- Special District Leadership Academy (SDLA) CSDA's Leadership Academy is the recognized leader in governance training for district directors and trustees, endorsed by eight other special district associations. Special District Leadership Academy Courses are available as standalone modules or over the course of one two and a half day conference.
- Special District Board Secretary/Clerk Conference Offers premiere training for board secretaries and clerks. First time attendees can earn their Special District Board Secretary/Clerk Certificate and attendees are encouraged to come back year after year for exciting new breakout sessions tailored to the board secretary/clerk position.
- General Manager Leadership Summit a leadership conference for general managers and other management staff in special districts that occurs each summer. Attendees are able to access sessions that offer specific information & content to your position and network with others that hold your same position and take home ideas that you can immediately apply to your district.
- Annual Conference & Exhibitor Showcase Each fall CSDA brings together leading subject and policy experts,
 business partners and vendors for three days of educational and networking opportunities for board members and staff.
- Board Member Training CSDA offers this unique workshop designed by special districts for special districts to
 provide both the new and seasoned board member a solid understanding of the role of a board member and the laws by
 which a board member must abide.
- Webinars CSDA offers over 30 webinars each year, some at no charge, that provide you and your district easy
 access to the best in special districts education right at your desk.
- Workshops CSDA offers training throughout California designed to enhance the knowledge-base of your district's directors and staff.

Enhanced Benefits & Services

- Bookstore discounts CSDA members receive significant savings on various publications offered through CSDA's Bookstore. Some of these publications include:
 - CSDA Sample Policy Handbook
 - Open & Public IV A User's Guide to the Ralph M. Brown Act
 - Special District Administrative Salary & Benefits Survey
 - A Local Officials Reference on Ethics Laws
 - Everyday Ethics for Local Officials
 - Special District Reserve Guidelines
- Free Legal Advice CSDA offers each member one hour of free legal advice each year to help in resolving any legal issue or question. CSDA's legal counsel has been representing special districts for many years and is well versed in helping special districts in a variety of areas.

Hardworking & Dedicated Staff – CSDA's staff are fully motivated and working hard every day of the week to
represent you and ensure your success as a special district. CSDA's staff is focused on member services; we're here for
you!

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(http://www.districtsmakethedifference.org/)

CHOOSE WITH CONFIDENCE

Workers' Compensation Property/Liability Health Benefits



(http://www.sdrma.org/)

Membership

- Advertise With Us (http://www.csda.net/csda-membership/advertise-with-us/)
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- RFP Clearinghouse (http://www.csda.net/csda-membership/rfp-clearinghouse/)
- Buyers Guide (http://www.csda.net/csda-membership/buyers-guide/)
 - Buyers Guide Search (http://www.csda.net/csda.membership/buyers-guide/buyers-guide-search/)
- Value Added Benefits (http://www.csda.net/csda-membership/value-added/)
- Member News (http://www.csda.net/csda-membership/member-news/)
- Listserv (http://www.csda.net/csda-membership/listserv/)
- Sample Magazine (http://www.csda.net/csda-membership/sample-magazine/)

California Special Districts Alliance





Value Added Benefits

Home (http://www.csda.net/) » Membership (http://www.csda.net/csda-membership/) » Value Added Benefits

Value Added Benefits are special programs or discounts offered by our Business Affiliates - tailored just for CSDA members.



Consultant Connection

Digital Mapping Solutions

Discounted Purchasing

District Purchasing Card

Discounted Travel

Financing

First Aid & Safety Products

GASB45 Compliance

Human Resources

Investing

Job Search

Risk Management

Utility Cost Control

Website Design

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(http://www.districtsmakethedifference.org/)





(http://www.csda.net)

Legal Services

Home (http://www.csda.net/) » Login (http://www.csda.net/login/) » Legal Services

We provide the most relevant government information crucial to all California districts. We strive to make districts stronger together.



Free Legal Service Benefit

CSDA offers each member (district) one hour of free legal advice each year to help in resolving any legal issue or question. CSDA's legal counsel has been representing special districts for many years and is well versed in helping special districts in a variety of areas.

To use this benefit, please read the below information and contact our office with any questions, at 877-924-2732.

PLEASE NOTE THE FOLLOWING:

- · Legal Benefit does not include representation or litigation in a court of law.
- Members submitting questions should be in agreement/cooperation with the district's Board of Directors or General Manager and not working alone.
- Legal benefit is for district use only. This is not intended for personal use of any kind.
- Usage of this benefit will be tracked by CSDA staff. The request form will be sent to staff and forwarded directly to the attorney(s). Attorney(s) will contact the requestor directly to provide answers or seek additional information.
- · General response time for this benefit is approximately 2 weeks.
- Benefit hour will be tracked in units of 10 minutes. Any time over the alloted hour will be billed by the attorney directly to the district.
- Requests are sent to CSDA's contracted attorney. Requests to use outside attorneys for this benefit will not be permitted.
- You may choose to post your question to the CSDA listserv before using the legal benefit as other districts may be able to help. Listserv access can be found here. (http://www.csda.net/login/listserv/)

To continue your legal request, please submit the form below or contact our office at 916.442.7887.

Legal Benefit Form

Name *

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District (please no acronyms))				9	
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Email *						
Subject Matter						
Questions/Issues for the atto	ornev(s) to review. F	Please be as detail	ed as neces	arv		
				,		
Will you be emailing any sup mailto cassandras@csda.net		tion? If yes, please	email docur	nents to cassar	dras@csda.n	et
		Submit				

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(http://www.districtsmakethedifference.org/)

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Workers' Compensation Property/Liability Health Benefits



(http://www.sdrma.org/)

Login

- Magazine (http://www.csda.net/login/magazine/)
- Resource Center (http://www.csda.net/login/resource-center/)
- Legal Services (http://www.csda.net/login/freelance-advice/)
- Membership Directory (http://www.csda.net/login/membership-directory/)
 - Membership Directory Search (http://www.csda.net/login/membership-directory/membership-directory-search/)
- Sample Document Library (http://www.csda.net/login/sample-document-library/)
- Free Resources/Publications (http://www.csda.net/login/free-publications/)

California Special Districts Alliance



(http://www.csda.net)

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(http://www.csda.net)

Join CSDA

Home (http://www.csda.net/) » Membership (http://www.csda.net/csda-membership/) » Join CSDA

Join CSDA today and get access to all of our member services. By joining CSDA, you help make Districts Stronger Together.



Regular Member

(Voting) Includes independent special districts as defined by Government Code Section 56044 and/or public agencies whose governing body is composed of representatives of two or more public agencies (excludes JPAs, dependent districts, county and city agencies).

Join Now (http://www.csda.net/wp-content/uploads/2017/11/2018_RM_Application.pdf)

Here are a few reasons to become a Regular or Associate member of CSDA:

- Highlights of 2016 (http://www.csda.net/wp-content/uploads/2017/01/2016-CSDA-Highlights.pdf)
- Core Benefits (http://www.csda.net/csda-membership/core-benefits)
- Value Added Benefits (http://www.csda.net/csda-membership/value-added/)

Associate Member

(Non-Voting) Includes dependent special districts, JPAs, county and city agencies, and other public agencies not eligible for Regular membership.

Dues: \$1,299

Join Now (http://www.csda.net/wp-content/uploads/2017/11/2018_AM_Application.pdf)

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- Highlights of 2016 (http://www.csda.net/wp-content/uploads/2017/01/2016-CSDA-Highlights.pdf)
- Value Added Benefits (http://www.csda.net/csda-membership/value-added/)
- Core Benefits (http://www.csda.net/csda-membership/core-benefits)

Business Affiliates

Business Affiliates are private sector companies that offer professional services and products to the special district community.

Dues: \$750 - \$7,500 based on the level of benefits desired

Join Now (http://www.csda.net/wp-content/uploads/2017/12/2018_BA_Application.pdf)

For other opportunities to connect with special district leaders.

 Business Affiliate Brochure (http://www.csda.net/wp-content/uploads/2017/12/original-2018_opportunities_to_connect.pdf)

OPPORTUNITIES TO CONNECT

We provide the opportunity to connect with special district leaders! Make valuable contacts, develop new relationships and reconnect with existing clients.

Specialized Conferences

Take advantage of these targeted opportunities to network with special district leaders. Specialized training enables you to tailor your message and product to the most appropriate audience. Small conference sizes encourage one-on-one networking in unique settings.

All specialized conference sponsorships include: your logo on event website, pre-event publicity in the weekly CSDA e-News, ability to donate a prize to the raffle, tabletop display area for your promotional items, one conference registration including meals, your logo on event signage, special thank you from the stage, networking at two breakfast events, networking at evening reception(s) and post conference attendee list (electronic copy).

Annual Conference Sponsor/Exhibitor

Gain valuable name recognition and exposure by becoming a sponsor and/or exhibitor of CSDA's Annual Conference & Exhibitor Showcase. This opportunity will allow you to develop new relationships, reconnect with existing clients and make valuable contacts. If you only pick one tradeshow to exhibit at this year, this should be it!

CSDA Magazine

California Special District magazine, CSDA's bi-monthly, full-color publication, reaches a readership of over 20,000 special district decision-makers. It is the only magazine written specifically for an audience of special districts and is recognized as the leading publications for districts of all types.

Advertising in *California Special District* is one of the best ways to influence the users and buyers of your products and services. For inquiries on advertising in California Special District magazine, contact Diana Granger, Granger Marketing Works, at 530.642.0111. You may also download the media kit. (http://www.csda.net/wp-

content/uploads/2017/11/2018-Special-District-Media-kit-with-form.pdf)

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(http://www.sdrma.org/)

Membership

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 - Buyers Guide Search (http://www.csda.net/csda-membership/buyers-guide/buyers-guide-search/)
- Value Added Benefits (http://www.csda.net/csda-membership/value-added/)
- Member News (http://www.csda.net/csda-membership/member-news/)
- Listserv (http://www.csda.net/csda-membership/listserv/)
- Sample Magazine (http://www.csda.net/csda-membership/sample-magazine/)

California Special Districts Alliance



(http://www.csda.net)



California Special **Districts Association**

Districts Stronger Together

REGULAR MEMBER APPLICATION

VOTING MEMBERSHIP — Independent Special Districts (as defined by Government Code section 56044) and/or public agencies whose legislative body is composed of representatives from two or more public agencies. Excludes dependent districts, JPAs, and county and city agencies (may apply as Associate members).

Main Contact Name	#0.00 m				
Title:			× = -		
Email:			Phone:		
District Name	=				
Mailing Address:					
City:			State		Zip.
Physical Address:	0.000				
City:	5070-70	3	State		Zip
Referred By:					
2018 CSDA ANNUAL MEMBERSHIP DUES		- Wall Co.			
Dues are based on the district's annual opera agency operations such as payroll and other ac CSDA Board of Directors.	dministrative expenses should be included. R				
DUES TABLE (please theck operating revenue	SE TAME CHIEF	New Age			
OPERATING REVENUE	REGULAR DUES	OPERATING	REVENUE		REGULAR DUES
\$50k or lower	\$167	\$500 - \$62	5k		\$1,712
□ \$50 - \$75k	\$254	S625 - \$75	0k		\$1,836
S75k - \$100k	\$420	S750 - \$1N	1M		\$2,633
S100 - \$150k	\$587	□ \$1MM - \$1	.25MM		\$3,384
□ \$150 - \$200k	\$920	□ \$1.25MM	- \$1.5MM		\$4,102
S200 - \$250k	\$999	□ \$1.5MM -	\$1.75MM	GOT SLANK	\$4,802
\$250 - \$300k	\$1,078	□ \$1.75MM	- \$2.0MM		\$5,562
\$300 - \$350k	\$1,277	\$2.0MM -	The second secon		\$6,358
□ \$350 - \$425k	\$1,390	> \$5Million	1		\$6,842
□ \$425 - \$500k	\$1,558				
PAYMENT (Credit card Payments - may be su	conitted by mail or fax to 916-520 2470)		AV DOLLAR	113	State wood ver
☐ CHECK ☐ VISA ☐ MAS	STERCARD DISCOVER	AMERICAN EXPR	ESS		
Account Name:		Account Numb	er:		
Expiration Date.		Authorized Sign	nature:		
القائم الأخوموني ال			AMOU	NT S	E
Please return this form with dues investment new member file, QUESTIONS? Contact CS	nt to CSDA Member Services, 1112 Stree DA Member Services at 877,924,2732 or c	t#200, Sacramento CA athrinel@csda.net.	95814. Additional inform	ation will be	requested to complete your agency's

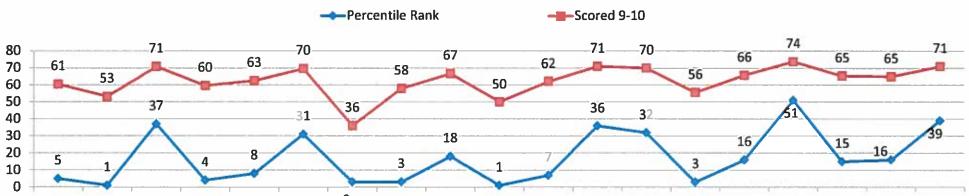
OBRA 1993 prohibits taxpayers from deducting, for federal income tax purposes, the portion of membership dues that are allocable to the lobbying activities of trade organizations. The nondeductible portion of your dues is estimated to be 8%.





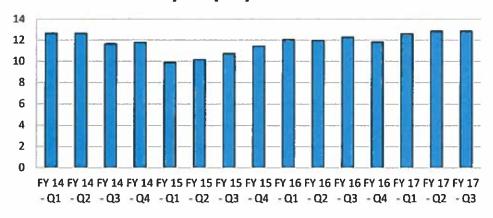
Stakeholder Experiences

Overall Rating of Hospital (0-10)

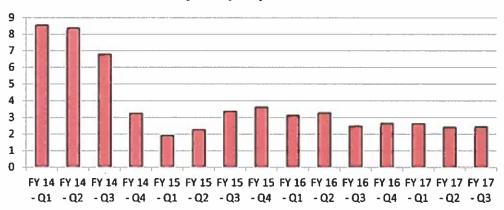


Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17

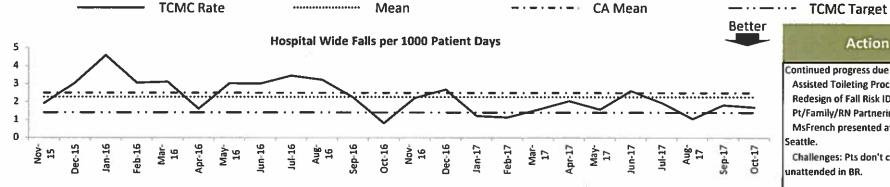
Voluntary Employee Turnover Rate

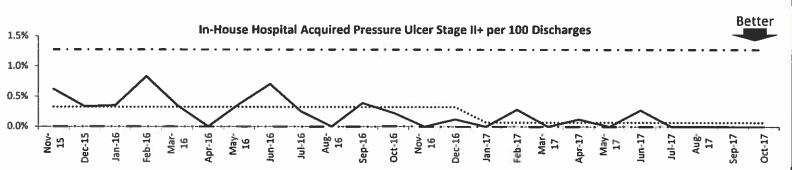


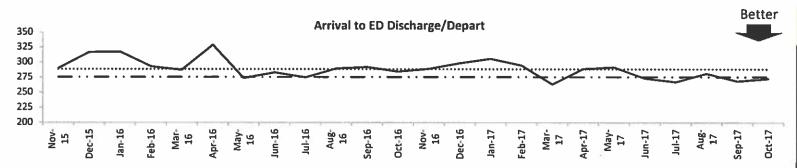
Involuntary Employee Turnover Rate



Current Trending Measures







Action Plan

Continued progress due to: **Assisted Toileting Process** Redesign of Fall Risk ID Pt/Family/RN Partnering Safety Plan MsFrench presented at CALNOC conf in

Challenges: Pts don't call: Pts occ left unattended in BR.

Action Plan

Continue meeting target. Implement wound redesign in EMR to improve documentation started 10/17. Vascular Injuries differentitated from pressure related injuries

Action Plan

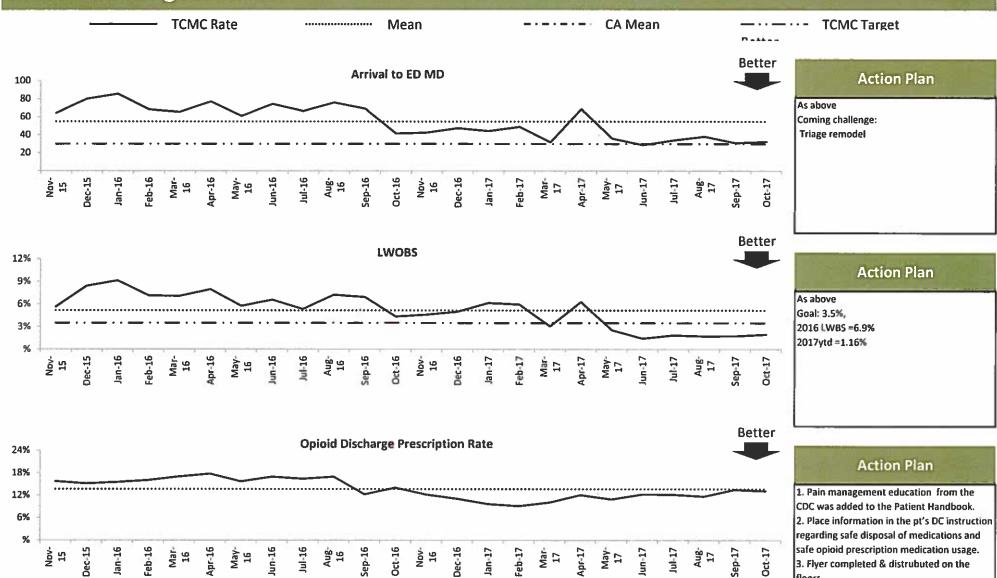
Changes Implemented:

These changes resulted in:

PA's providing MSE in triage 8a to 2a 3/17 Started MD's in triage 10a to MN.

Decreased LWBS Improved patient satisfaction HealthStream award for improved Patient Satisfaction score.

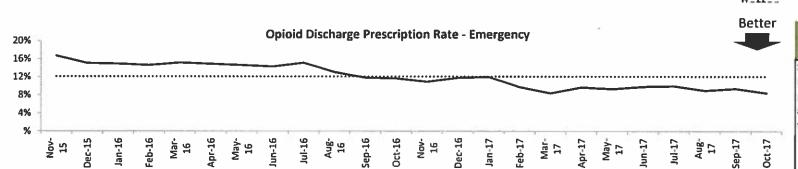
Current Trending Measures



4. Will provide data to MS QA Committee/departments quarterly

Current Trending Measures

TCMC Rate



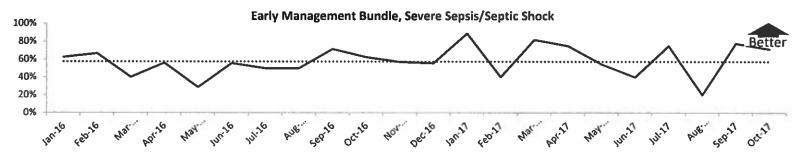
Mean

TCMC Target

CA Mean



Same as above. Standard will be compliant by 1/18. 2. Still pending implementation of power plans/MD/new pain management medications.4. Auxiliary has carts for patients that are offered daily as alternatives



Action Plan

Q3 pass rate 58% is above national avg. Successes:

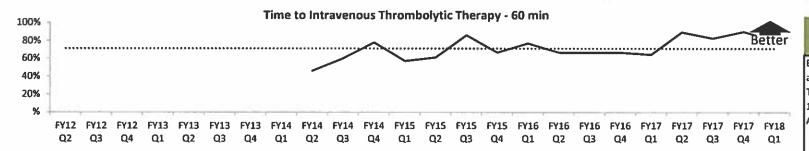
Improved automated proesses for Fluid challenges and lab redraw.

ED Code Sepsis initiation.

Challenges:

Septic Shock documentation.

Post admission onset of Severe Sepsis.



Action Plan

Built drop dow in Cerner for MD's to provide a valid medical reason for a delay. This removes case from denominator. 100% pass rate for Q3.

Again certified as Gold Plus status with AHA.

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	26	23	23	18	27	27			,				72
FY17	28	22	13	25	27	23	19	24	25	25	30	20	281

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	14	6	7	13	7	15							27
FY17	9	9	5	13	12	11	10	8	15	8	12	10	122

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11	12	12	14	16	18							35
FY17	8	11	8	13	12	8	12	10	12	11	17	21	143

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15	20	20	16	23	15							55
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

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
FY18	48	37	33	32	26	38			=				118
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15.7	14.5	16.2	16.3	9.9	14.2							15.5
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1	16.5	16.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	9.0	6.7	6.2	9.5	8.3	7.3		ici meth					7.3
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0	9.4	6.7

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11.3	16.4	12.4	13.9	13.5	10.5			- 3 at				13.4
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0	11.8	13.9

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	169.7	181.9	163.4	173.4	160.9	172.5	- 2,754	_		-1-985			171.8
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9	168.4	179.5

Performance compared to prior year:

Better	Same	Worse
E 100 100 100 100 100 100 100 100 100 10		

Deliveries

ME SE	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194	206	184	166							626
FY17	223	239	274	230	197	200	217	197	202	172	188	175	2,514

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	12	11	11	11	11	18		=		555 T SA			34
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7	3	4	3							18
FY17	4	4	6	6	5	7	2	2	7	9	6	1	59

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	8	7	7	11	3	14		. 1916.	W A HARDWA	0.75			22
FY17	10	9	8	7	6	9	8	6	16	9	6	6	100

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	1.75	1.80	1.81	1.80	1.83	1.72							1.79
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71	1.76	1.70

Performance compared to prior year:

Better	Same	Worse
		A STATE OF THE PARTY OF THE PAR

						Fin	ancial S	trength	ALC: U	III TO U				7 1
TCMC D	avs in Accou	nts Receivab	ole (A/R)										C/M	Goal
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY18	47.7	47.8	48.9	50.8	49.6	49.5							48.1	48-52
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1	46.5	50.0	101
TCMC D	ays in Accou	nts Payable	(A/P)										C/M	Goal
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY18	82.1	79.1	78.8	83.4	87.7	81.3							80.0	75-100
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6	79.9	81.5	81.9	82.3	
TCHD E	ROE \$ in Tho	usands (Exce	ss Revenue o	ver Expenses)								C/M	C/M
-	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
FY18	(\$394)	(\$429)	(\$224)	(\$171)	(\$2,571)	(\$383)							(\$1,048)	(\$1,187)
FY17	\$288	\$211	\$746	\$1,118	\$414	\$317	(\$226)	\$181	(\$2,912)	(\$63)	\$296	\$1,510	\$1,246	
TCHD EI	ROE % of Tot	al Operating	Revenue					59%				13 (2	C/M	C/M
1000	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	1.26%	7-10	- GELOW					-1.16%	-1.33%
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%	5.04%	1.49%	
TCHD EI	BITDA \$ in Th	ousands (Ea	rnings before	Interest, Tax	es, Depreciati	on and Amo	rtization)						C/M	C/M
- The same	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
FY18	\$898	\$864	\$1,091	\$1,146	(\$1,288)	\$908		5.72.	-		-	W ()	\$2,853	\$2,672
FY17	\$1,583	\$1,496	\$2,015	\$2,365	\$1,711	\$1,556	\$1,010	\$1,428	(\$1,630)	\$1,213	\$1,558	\$2,741	\$5,094	
TCHD EI	BITDA % of To	otal Operatio	ng Revenue							-1000			C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%		AMA	- Mariana			7	3.17%	2.99%
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%	9.16%	6.09%	
TCMC P	aid FTE (Full-	Time Equiva	lent) per Adi	usted Occupie	ed Bed								C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Арг	May	Jun	YTD	YTD Budge
FY18	6.51	5.92	6.90	6.26	6.50	6.43							6.42	6.25
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18	6.56	5.88	
TCHD Li	quidity \$ in N	Aillions (Casl	n + Available	Revolving Lin	e of Credit)			- Francisco	176-9162 84					20 (20 (10)
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	7-2-3	
FY18	\$58.5	\$49.8	\$42.3	\$48.2									18-40	

\$35.7

\$73.6

\$34.6

\$74.3

\$77.9

\$64.0

FY17

\$29.1

\$29.4

\$26.8

\$18.9

\$23.0

\$25.9

Tri-City Medical Center

ADVANCED HEALTH CARE

Building Operating Leases

Month Ending December 31, 2017	RUBSI	Base		Total Rent			
		Rate per		per current	Lease		
Lessor	Sq. Ft.	Sq. Ft.	900	month	Beginning	Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	\$3.48	(a)	44,164.55	07/01/17	06/30/27	OSNC - Carlsbad 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	1,558	\$2.39	(a)	4,917.74	01/27/17	05/31/20	PCP Clinic - Venus 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	\$1.86	(a)	10,445.70	4/1/2016	01/31/20	PCP Clinic - Radiance 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	\$2.63	(a)	20,106.00	2/1/2015	01/31/20	PCP Clinic - Vista 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 V#83025	Approx 4,995	\$2.50	(a)	15,184.80	07/01/17	06/30/22	OSNC - Vista 1958 Via Centre Drive Vista, Ca 92081
Efiln Investments, LLC Clancy Medical Group 20136 Etfin Creek Trail Escondido, CA 92029 V#82575	3,140	\$2.49	(a)	9,642.26	12/01/15	12/31/20	PCP Clinic - Clancy 2375 Melrose Dr. Vista Vista, CA 92081
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	\$1.92	(a)	3,398.15	01/01/13	12/31/17	Performance Improvement 3927 Waring Road, Ste.D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	\$1.86	(a)	11,697.32	09/01/17	08/31/19	OP Physical Therapy OP OT & OP Speech Therapy 2124 E. El Camino Real, Ste. 100 Oceanside, Ca 92054
Meirose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	\$1.35	(a)	10,101.01	07/01/16	06/30/21	Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	\$4.12	(a)	26,047.00	10/01/12	10/01/22	Chemotherapy/Infusion Oncology Center 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	\$1.10	(a)	5,039.70	10/28/13	03/03/18	Vacant Building 510 Hacienda Drive Suite 108-A Vista, CA 92081
Trl-City Orthopedic Bldg Partners 3905 Waring Road Oceanside, CA 92056 V#83020	10,218	\$2.50		27,970.32	07/01/17		OSNC - Oceanside 3905 Waring Road Oceanside, CA 92056

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



ADVANCED HEALTH CARE

Education & Travel Expense
Month Ending December 31, 2017

Cost

Centers	Description	Invoice #	Amount	Vendor#	Attendees
6183 A	AMERICAN SOCIETY OF ANESTHESIOLOGY COURSE	110617	697.26	80084	COURTNEY NELSON
7095 S	SUMMIT EDUCATORS	47	300.00	83020	MARC GARBER-OSNC
7095 H	HIP JOINT-MANUAL PT APPROACH	41	350.00	83020	REID BOUCHARD-OSNC
70 9 5 la	ASTM COURSE	93	375.00	83020	BAVID BRICK-OSNC
7095 N	MEDICAL MINDS IN MOTION	45	500.00	83020	GRETCHEN NELSON-OSNC
8631 A	AHP CONFERENCE	113017	1,244.99	79486	GLEN NEWHART
8710 N	MAMSS CONFERENCE	110617	2,724.44	82538	SHERRY MILLER
8740 A	ANNUAL SCANN CONFERENCE	120717	145.00	78614	MARINNEE CHOMPA
8740 A	ACLS-BLS COURSE	113017	168.60	83142	PATRICIA THOMSON
8740 A	ACLS COURSE	113017	190.00	79466	LETICIA HALLAHAN
8740 A	ACLS COURSE	113017	200.00	78175	DEBRA ROUGH
8740 N	MENTAL HEALTH NURSES CERTIFICATION COURSE	120717	200.00	78630	SHELLY VINCENT-GUTIERREZ
8740 0	CPHIMS PROGRAM	121417	200.00	82547	EVELYN SHEN
8740 E	BSN DEGREE	113017	2,500.00	82111	JENNIFER YONKER

^{**}This report shows reimbursements to employees and Board members in the Education

[&]amp; Travel expense category in excess of \$100.00.

^{**}Detailed backup is available from the Finance department upon request.