TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 22, 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	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) RoseMarie Reno vs. Tri-City Healthcare District Superior Court Case No. 37-2017-00040507-CU-CR 2) Raymond Ball vs. Pengta A. Chiang, M.D., et al. San Diego Superior Court Case No: 37-2016-00007582-CU-MM-NC		
	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: August 31, 2018		
	d. Approval of prior Closed Session Minutes		

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

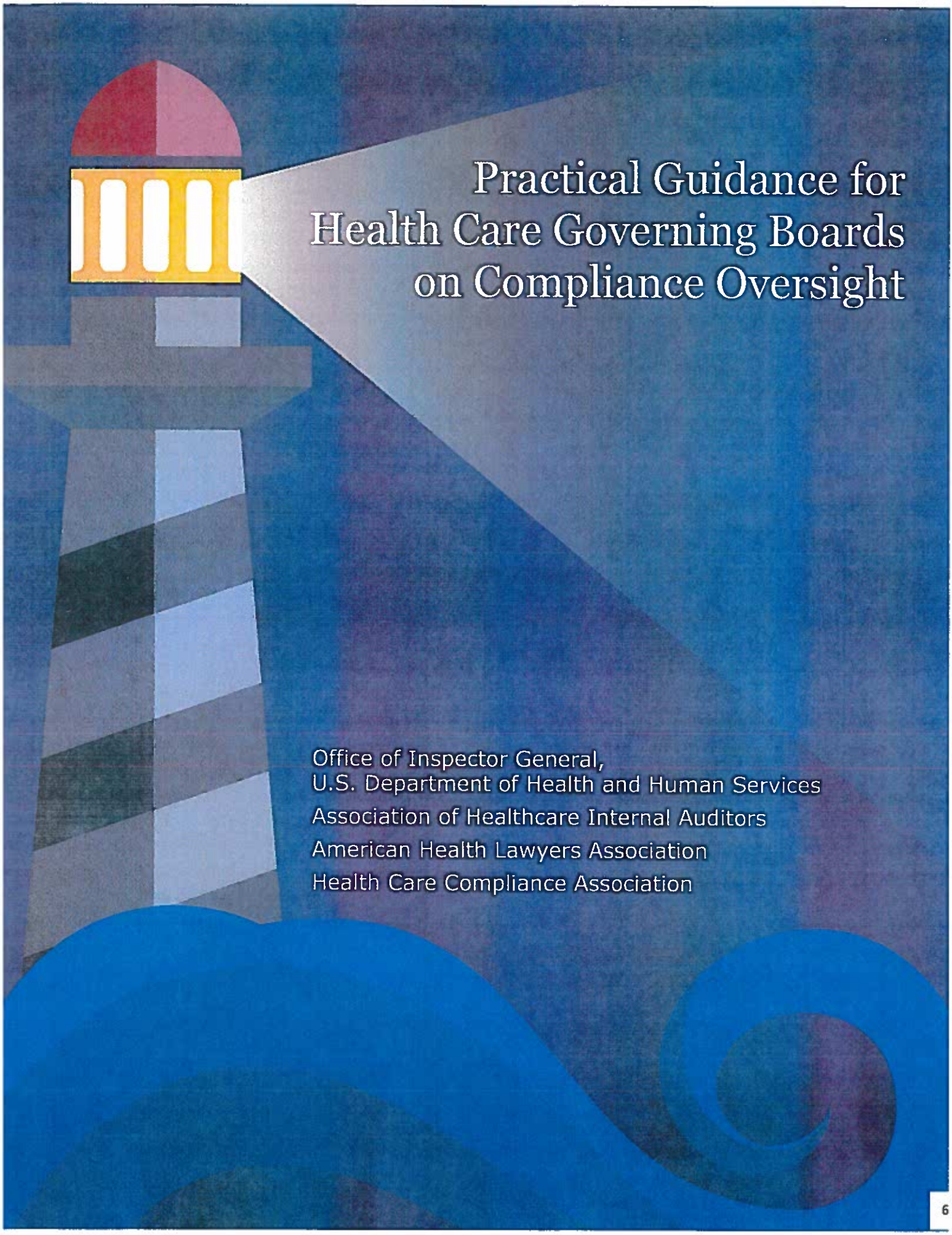
Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	e. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 Matters)		
	f. 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	Educational Session Compliance Training 101	30 min.	CCO
13	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	New Business a) Consideration to approve a physician recruitment agreement with Dr. Anitha Rajamanickam, Interventional Cardiology Physician	10 min.	Jeremy Raimo
17	Old Business a) LAFCO Update	10 min.	Board Counsel
18	Chief of Staff a. Consideration of February Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 20, 2018	5 min.	Standard
19	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

	Agenda Item	Time Allotted	Requestor
	A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0 *(No meeting held in February, 2018)*		HR Comm.
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 1 *(No meeting held in February, 2018)*		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)*		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)* 1) **Administrative Policies & Procedures** a) 8610-213 - Prior Authorizations for Non-Emergency Services for HMO/PPO Patients b) 8610-255 - Audits for Third Party Insurance c) 8610-268 - Medi-Cal Treatment Authorization Request (TAR) Requirements 2) Approval of an agreement with Managed Resources, Inc. for Clinical Appeals for a term of 24 months, beginning February 25, 2018 and ending February 20, 2020 for an annual expected cost of $154,824 and a total expected cost for the term of $309,648. 3) Approval of an agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staff of Allied Health Providers for a four-month term, beginning March 1, 2018 through June 30, 2018, for a total expected cost for the term of $660,000.		FO&P Comm.
	E. Professional Affairs Committee Director Grass, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **1) Patient Care Policies and Procedures** a) Code STEMI Policy b) Constavac, Reinfusion of Blood c) Duty to Warn Potential Victims Policy d) Minors Attempting to leave Without a Parent/ Legal Guardian e) Privacy Code Policy f) Special Order Durable Medical Equipment and Specialty Beds		PAC

	Agenda Item	Time Allotted	Requestor
	2) **Unit Specific** a) **Administrative** 1) Decision Making for Unrepresented Patients 2) Designation of Authority in Temporary and Voluntary Absences of Chief Executive Officer b) **Behavioral Health Services** 1) Duty to Warn Potential Victims Policy (DELETE) c) **Infection Control** 1) Aerosol Transmissible Diseases and Tuberculosis Control Plan 2) Required Reporting 3) Risk Assessment and Surveillance Plan d) **Medical Staff** 1) Adverse Incident Occurrence 1)Medical Record Documentation Requirements e) **Outpatient Behavioral Health** 1) Duty to Warn Potential Victims Policy (DELETE) f) **Pharmacy** 1) Pharmacy Patient Specific Information (DELETE) g) **Rehabilitation** 1) Job Site Assessment 2) Occupational Therapy Assistant Supervision 3) Therapy Pool Dress Code h) **Forms** 1) Notice of Privacy Practices i) **Pre-printed Orders** 1) Physician Orders 2) Remicade (Infliximab) Administration j) **Formulary Requests** Topical Epinephrine Monograph F. **Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 0 *(No meeting held in February, 2018)* G. **Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in February, 2018)*		Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	(2) Minutes – Approval of: a) Regular Board of Directors Meeting – January 25, 2018 (3) Meetings and Conferences (4) Dues and Memberships - None		Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (January, 2018) (d) Reimbursement Disclosure Report – (January, 2018) (e) Seminar/Conference Reports 1) CHA – Director Dagostino	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	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
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2.5 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		



Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services

Association of Healthcare Internal Auditors

American Health Lawyers Association

Health Care Compliance Association

About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

The following individuals, representing these organizations, served on the drafting task force for this document:

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

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Introduction

Previous guidance[1] has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.[2] The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),[3] OIG's voluntary compliance program guidance documents,[4] and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."[5] The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to "the size of the organization."[6] In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.[7] Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.[8] Smaller organizations may meet their compliance responsibility by "using available personnel, rather than employing separate staff, to carry out the compliance and ethics program." Board members of such organizations may wish to evaluate whether the organization is "modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations."[9] The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations' compliance and ethics efforts than their larger counterparts.[10]

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

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7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.[11] OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.[12] Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

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11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 *See* Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:

The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,[13] and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.[14] While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;[15]

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13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

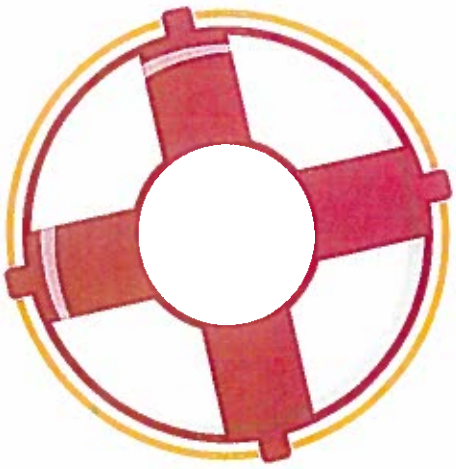
15 *See, generally, id.*

the same is true for internal audit.[16] To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

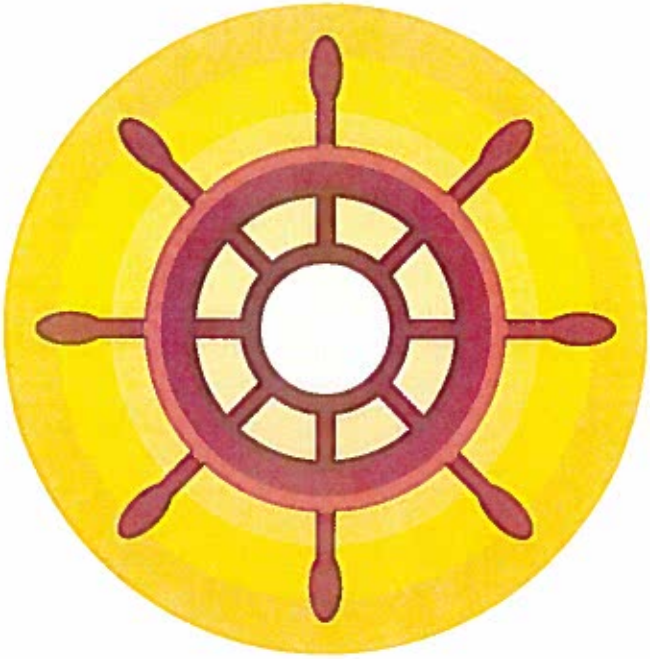
code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.



The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is "monitoring and auditing to detect criminal conduct."[17] Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.[18]

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[19] offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

Compliance is an enterprise-wide responsiblity.

In an effort to support the concept that compliance is "a way of life," a Board may assess employee performance in promoting and adhering to compliance.[20] An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html.

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.[21] The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is "identified" or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to "identify" an overpayment.[22] However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization's compliance program may be in correcting and remediating compliance issues.

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21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is "identified" when a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.") disregard or deliberate ignorance of the overpayment."); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

5

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG's Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management's responses to identified violations of the organization's policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization's compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

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23 *See* OIG, *Self-Disclosure Information*, http://oig.hhs.gov/compliance/self-disclosure-info.

24 *See id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).")

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

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FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 13, 2018
Physician Recruitment Proposal

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

Physician Name: Anitha Rajamanickam, M.D.
Areas of Service: Interventional Cardiology

Key Terms of Agreement:

Effective Date:	July 1, 2018 or the date Dr. Rajamanickam becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
Community Need:	TCHD Physician Needs Assessment shows significant community need for Interventional Cardiology
Service Area:	Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
Income Guarantee:	$495,000 annually ($990,000 for two-years with a three-year forgiveness period)
Sign-on Bonus:	$15,000
Relocation:	$5,000 (Not part of the Loan)
Total Not to Exceed:	$1,005,000 (Loan Amount)

Requirements:

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

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Steve Dietlin, Chief Executive Officer

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $1,005,000 in order to facilitate this Interventional Cardiology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period).

ANITHA RAJAMANICKAM MD – CURRICULUM VITAE

ADDRESS : 170 W. Dayton Street #3022, Pasadena CA 90115
E-MAIL: arajamanickam@gmail.com
CELL PHONE: [redacted]

BOARD CERTIFICATION

- *American Board (ABIM)of Interventional Cardiology:* Board Certified
- *American Board (ABIM)of Cardiovascular Medicine:* Board Certified
- *American Board (ABIM)of Internal Medicine:* Board Certified
- *American Board (ABVM)of Endovascular Medicine:* Board Certified
- *National Board of Echocardiography ASCeXAM® (NBE):* Board Certified
- *Certification Board of Cardiovascular Computed Tomography (CBCCT):* Board Certified
- *Certification Board Nuclear Cardiology (CBNC): :* Board Certified
- *National Lipid Association (NLA) Boards: :* Board Certified
- *American Society of Hypertension (ASH) Boards: :* Board Certified

LICENSURE

- *California Medical Board*– License Number : 137462 Issued: 07/03/2015
- *DEA Number*: BR9196204, Issue date: 04/30/2005 Exp. Date 04/30/2017
- *NPI Number* : 1225126600
- *Medicaid Number*: 2576814
- *Medicare Number:* RA4161391
- California Fluoroscopy License –: RHC00201748 Issued: 11/30/2015

CITIZENSHIP : American Citizen

POST-GRADUATE TRAINING

July 2013- June 2015
Interventional Cardiology Fellowship at Mount Sinai School of Medicine, New York Trained in complex coronary interventions, peripheral interventions and structural interventions and venous ablations

July 2010 –June 2013
Cardiology Fellowship at Jefferson University /Christiana Care Health System

June 2002 to June 2005
Internal Medicine Residency at University of Illinois, Chicago /St. Francis Hospital

MEDICAL EDUCATION

August 1994 – May 2000
Bachelor of Medicine, Bachelor of Surgery MBBS
Madras (Chennai) Medical College & General Hospital / Dr. MGR Medical University

WORK EXPERIENCE

June 2005 to June 2010
Assistant Professor/ Cleveland Clinic Learner College of Medicine and Case Western Reserve University
Associate Staff/ Department of Hospital Medicine, Cleveland Clinic
Cleveland, Ohio

Member and Director of multiple hospital Q and A committees, Hiring and defining roles of advanced nurse practitioners and academic hospitalists, research committee, scheduling committee, education committees, business intelligence and throughput committees.

September 2015 to June 2016
Interventional and Peripheral Cardiologist
High Desert Heart Institute/Desert Valley Hospital, Victorville ,California

September 2016 to Current
Comprehensive Cardiovascular Specialists, California

REFERNCES

- Roxanna Mehran MD
- George Dangas MD
- Jose Wiley MD
- Samin Sharma MD
- Annapoorna Kini MD
- Prakash Krishnan MD
- Willian Weintraub MD

BOOK PUBLICATIONS

BOOK PUBLICATIONS

- *Syncope. Anitha Rajamanickam, Saira Noor, Frank Michota*
Comprehensive Hospital Medicine: Expert Consult .Editors: Mark V. Williams et al. Publisher: Saunders;1072 pages

- *Mock Boards Simulation – Board Questions and Answers. Anitha Rajamanickam*
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- *History and Physical Examination in the diagnosis of peripheral artery disease.*
Anitha Rajamanickam,Prakash Krishnan Peripheral Vascular Disease, An Issue of Interventional Cardiology Clinics.Publisher: Elsevier Health Sciences

All the Chapters in the Textbook "Practical Manual of Interventional Cardiology" Publisher: Springer . ISBN-13: 978-1447165804 ISBN-10: 1447165802 Edition: 2014th

- *Basics of Radiation Safety*
Ravinder Singh Rao, Anitha Rajamanickam, and Joseph Sweeny

- *Achieving Perfect Vascular Access*
Anitha Rajamanickam and Robert Pyo

- *The Perfect Shot: Angiographic Views for the Interventionalist*
Anitha Rajamanickam and Annapoorna Kini

- *Physiological Assessment During Interventional Procedures*
Nagendra Boopathy Senguttuvan, Anitha Rajamanickam, and Annapoorna Kini

- *Antiplatelet and Antithrombotic Therapy in PCI*
Rikesh Patel, Anitha Rajamanickam, and Annapoorna Kini

- *Patient Selection and Appropriateness*
Anitha Rajamanickam and Samin K. Sharma

- *Guide Catheter Selection*
Anitha Rajamanickam and Samin K. Sharma

- *Guidewire Properties and Selection*
Christopher J. Varughese, Anitha Rajamanickam, and Samin K. Sharma

- *Assessment of Lesion Severity (Intravascular Ultrasound,Optical Coherence Tomography, NIRS, and Beyond)*

Sadik Panwar, Anitha Rajamanickam, and Annapoorna Kini

- *Basics of Intracoronary Devices*

Ravinder Singh Rao, Anitha Rajamanickam, and Annapoorna Kini

- *Hemodynamic Assessment: Right Heart Catheterization,Pulmonary Hypertension, Left to-Right Shunt, and Constriction*

Rikesh Patel, Anitha Rajamanickam, and Ajith Nair

- *Hemodynamic Assessment of Aortic/Mitral Stenosis and Regurgitation*

Rikesh Patel Anitha Rajamanickam, and Annapoorna Kini

- *Vascular Closure Devices and Complications*

Faramarz (Taj) Tehrani, Anitha Rajamanickam, and Robert Pyo

- *Basics of Intervention*

Anitha Rajamanickam and Annapoorna Kini

- *Difficult Stent Delivery*

Anitha Rajamanickam and Annapoorna Kini

- *Bifurcation Lesions*

Sadik Raja Panwar, Anitha Rajamanickam, and Annapoorna Kini

- *Ostial Lesion Interventions*

Mayur Lakhani, Anitha Rajamanickam, and Annapoorna Kini

- *Left Main Coronary Interventions*

Leslie Innasimuthu, Anitha Rajamanickam, and Samin K. Sharma

- *ACS: STEMI/Non-STEMI Intervention*

Rahul Sawant, Anitha Rajamanickam, and Joseph Sweeny

- *Coronary Artery Bypass Graft Interventions*

Anitha Rajamanickam and Samin Sharma

- *Calcific Lesion Interventions*

Anitha Rajamanickam and Samin K. Sharma

- *Coronary Complications of Percutaneous Coronary Interventions*

Mayur Lakhani, Anitha Rajamanickam, and Annapoorna Kini

- *Radial Coronary Interventions*

Christopher J. Varughese, Anitha Rajamanickam, and Robert Pyo

- *Advanced Hemodynamic Support*

Anitha Rajamanickam and Annapoorna Kini

- *Aortic Valve Interventions: Balloon Aortic Valvuloplasty/Transcatheter Aortic Valve Replacement*

Surabhi Madhwal, Anitha Rajamanickam, and Annapoorna Kini

- *Percutaneous Mitral Balloon Valvotomy*

Sadik Panwar, Anitha Rajamanickam, and Annapoorna Kini

- *Alcohol Septal Ablation*

Rikesh Patel, Anitha Rajamanickam, and Annapoorna Kini

- *Pericardiocentesis and Balloon Pericardiotomy*

Rahul Sawant, Anitha Rajamanickam, and Annapoorna S. Kini

- *Contrast-Induced Nephropathy Post Percutaneous Interventional Procedures*

Anitha Rajamanickam and Annapoorna S. Kini

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  Agarwal A*, Rajamanickam A*, Bajaj N, Griffin B , Catacutan T, Svensson L, G Anabtawi A, Tuzcu M , Kapadia S *-Both First Authors Cardiovasc Qual Outcomes 2013 Mar 1;6(2):193-200.doi:10.1161/ Circoutcomes.111.000091.Epub 2013 Mar 12.PMID: 23481524

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  Rajamanickam A, Butler S, Ellis S, Young JB, Kapadia S European Heart Journal. 2011 Aug; 32(S1): 752.

- *How accurate are stress tests in predicting specific areas of ischemia?*
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- *Risk of Permanent Hemodialysis after Cardiac Catheterization induced Contrast Nephropathy*
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  Rajamanickam A , Singh V, Aneja A Cleveland Clinic Journal of Medicine. 2006 Sep; 73(1): S7-9. Cited in PubMed; PMID: 17016938

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Patel P, Dhaliwal G, Rajamanickam A, Gebresalassie S, Harte B. J Hosp Med. 2010 Jul-Aug;5(6):366-70.(PMID: 20803678)

- *Development of an Electronic Medical Record Smart Set Form to Increase Standardization, Consistency, and Compliance with ACC/AHA Perioperative Guidelines*
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- *Queuing Theory for Designing Geographically Localized Hospitalist Units and Impact on Hospital Throughput.*
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ORAL PRESENTATIONS

- *Is CKMB Really Necessary In The Diagnosis Of Acute MI When Troponin Is Performed Simultaneously?*
  Oral presentation: European Society of Cardiology(ESC)Annual Congress 2012,Munich

- *Postoperative outcomes in Non Cardiac Surgeries (NCS) in patients with critical Aortic Stenosis (AS) prior to Aortic Valve Replacement surgery (AVR).*
  Oral presentation: European Society of Cardiology(ESC)Annual Congress 2011,Paris

- *A comprehensive and user-friendly online calculator for predicting the risk of Contrast Induced Nephropathy (CIN) and permanent HemoDialysis (HD) after Cardiac Catheterization (CC).*
  Oral presentation: European Society of Cardiology(ESC)Annual Congress 2011,Paris

- *Incidence and Predictors of Postoperative Atrial Fibrillation in Patients Undergoing Elective Noncardiac Surgery in a large cohort of patients.*

Oral Presentation: AHA Annual meeting 2010,Chicago

- *Post-discharge management programs for elderly heart failure patients: a systematic review and meta-analysis of randomized clinical trials.*
  Oral Presentation: ACC Annual meeting 2010,Dallas

- *Impact of Mitral Regurgitation on Post-Operative outcomes in Non Cardiac Surgeries.*
  Oral Presentation : AHA Scientific Sessions 2011; Orlando, FL.

RESEARCH --PROSPECTIVE STUDIES

- Co- Investigator: ATTRACT -Acute Venous Thrombosis: Thrombus Removal With Adjunctive Catheter-Directed Thrombolysis NIH-funded Investigator/Sponsor: Suresh Vedantham, M.D.
- Co- Investigator: Collaboration of Hospital Pharmacists and Hospitalists to Improve Glycemic Control of General Medicine Patients
- Use of Distal Embolization Protection Device to decrease the incidence of Periprocedural Myocardial Infarction in Patients demonstrating Increased Neoatheroma in Drug Eluting Stent-Restenosis
- DIAMOND- TRIAL - Differential Mechanism of Luminal Enlargement – A comparative study of the effect of Orbital Atherectomy and Rotational Atherectomy in severely calcified lesions
- SLYM STUDY [Structured Lifestyle modification and Yoga in Metabolic syndrome]- NIH study
- Use of Distal Embolization Protection Device to decrease the incidence of Periprocedural Myocardial Infarction in Patients demonstrating Increased Neoatheroma in Drug Eluting Stent-Restenosis

RESEARCH --RETROSPECTIVE STUDIES

- Primary investigator IRB 08-645. Hemodynamic findings of severe isolated tricuspid regurgitation and specifically to identify of incidence of equalization of diastolic pressures
- Primary investigator IRB 08-800. BMI/Cardiovascular System Database
- Primary investigator IRB 08-808. Preoperative Cardiac Risk Stratification, Noninvasive Cardiac stress testing and Cardiac outcomes in patients undergoing Bariatric surgery
- Primary Investigator IRB 08-093. Role of EKG in postoperative Cardiac Outcomes in Non-Cardiac Surgery
- Primary Investigator IRB 08-093.Valvular Heart Diseases and their Impact on Cardiac Outcomes in Non-Cardiac Surgery

- Primary Investigator IRB 8655.Improving Perioperative Cardiac Risk Assessment and Beta-Blocker Use for Non-Cardiac Surgery (INCREASE): The INCREASE Quality Improvement Project
- Primary Investigator IRB 06-163.The predictors of Renal Failure after Cardiac Catheterizations and Non-Cardiac surgery
- Co-investigaor IRB 08-093 with Dr.Mina Chung. The Role of Biomarkers and Other Risk Factors in Preoperative Risk Stratification.
- Co-Investigator IRB # 7731 with Dr.Irene Katzan. Risk of Hemorrhage in Patients on Combination Antithrombotic Therapy with Warfarin and Clopidogrel
- Co-Investigator IRB # 8557 with Dr.Tang. Admission Blood Sugar: Prognosis, Readmission Rate, Effect on Mortality and Hospital Stay in Acute Decompensated Heart Failure; The ASPIRE-ADHF Study
- Registry of Multimodality Intravascular Imaging of Drug Eluting StentRestenosis
- Comparisons Of Predictors Of Procedural Success And Outcomes In Severely Calcified Lesions Using OCT Vs Angiograms
- Guideliner Registry
- Ostial Flash Balloon-Registry

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
February 14, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/23/2018 – 1/31/2020)

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 2/23/2018 through 1/31/2020:

- BISHOP, Gregory MD/Psychiatry (UCSD)
- KIM, James T. MD/Cardiology (Cardiovascular Institute of San Diego, Inc.)
- LAWLER, Abigail MD/Neurology (North County Neurology Associates)
- MOREIRA, Lucila DO/Pediatrics (Children's Primary Care Medical Group)
- MOUSSAVIAN, Mehran DO/Cardiology (Cardiovascular Institute of San Diego, Inc.)
- MOUKARZEL, Elias MD/OB/GYN
- RAMOS, Gladys MD/Maternal & Fetal Medicine (UCSD)
- TARSA, Maryam MD/Maternal & Fetal Medicine (UCSD)
- WHITESIDES, Michael MD/Teleradiology (StatRad)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
February 14, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 3/01/2018 -2/28/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 03/01/2018 through 2/28/2020, 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:

- BOBZIEN, Bonnie MD/Pathology/Active
- BRUNO, Gillian MD/Internal Medicine/Active
- JARAMILLO, Mary MD/Internal Medicine/Active Affiliate
- LAFATA, John MD/Internal Medicine/Active
- LI, Yaohui MD/Anesthesiology/Active
- MARFORI, Beatriz MD/Psychiatry/Refer and Follow
- O'BRIEN, Mark DO/Internal Medicine/Active
- VERMA, Vishal MD/Teleradiology/Active Affiliate

UPDATE TO PREVIOUS REAPPOINTMENT:

- HAINIK, Christopher MD/Orthopedic Surgery/Active
- HOSALKAR, Harish MD/Orthopedic Surgery/Active
- ZIZZO, Paolo MD/Internal Medicine/Refer and Follow

RESIGNATIONS: (Effective date 2/28/2018 unless otherwise noted)

Automatic Resignation:

- SHERMAN, Christopher DO/Orthopedic Surgery

Voluntary:

- CARPENTER, Heather MD/Pediatrics
- DHESI, Shawnjit MD/Anesthesiology
- FENTON, Douglas MD/OB/GYN

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
February 14, 2018

Attachment B

- GUTHRIE, Carly MD/Anesthesiology
- LAU, Kenneth MD/Anesthesiology
- LEE, JEANETTE MD/Anesthesiology
- LI, Zhi MD/Anesthesiology
- MOHR, Andrew MD/Anesthesiology
- SCHOENFELD, William MD/Anesthesiology
- WATSON, Jeffrey MD/Otolaryngology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
February 14, 2018

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 02/23/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **KABRA, Ashish M.D.** — **Cardiology**

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 2/28/2018.

- **MOZAYANI-ISFAHANI, Arash MD** — **Ophthalmology**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 02/23/2018, unless otherwise specified)
The following practitioners have voluntarily relinquished the following privileges.

- **WAILES, Robert M.D.** — **Pain Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 14, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 2/23/18, unless otherwise specified)

- BOONJINDASUP, Aaron MD — Urology
- GENTILUOMO, Jesse MD — Emergency Medicine
- KABRA, Ashish MD — Cardiology
- MURPHY, Kayla CNM — Allied Health Professional
- QUAN, Maria MD — OB/GYN

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

Employee Fiduciary Subcommittee
(No meeting held in February, 2018)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
February 15, 2018

MEMBERS PRESENT: Chair Jim Dagostino, Director Laura Mitchell, Dr. Victor Souza, Audrey Lopez, Bret Schanzenbach, Gigi Gleason, Linda Ledesma, Jan O'Reilly, Mary Lou Clift, Sandy Tucker, Scott Ashton, Ted Owen

MEMBERS ABSENT: Barbara Perez, Carol Herrera, Danielle Pearson, Dung Ngo, Guy Roney, Jack Nelson, Marilou de la Rosa Hruby, Mary Donovan, Mary Murphy, Rick Robinson, Roma Ferriter, Rosemary Eshelman, Xiomara Arroyo

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; Scott Livingstone, COO

NON-VOTING MEMBERS ABSENT: Fernando Sanudo

OTHERS PRESENT: Brian Greenwald, Gwen Sanders, Darrin Brant

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	Due to Chair Julie Nygaard's absence (on vacation) the February 15, 2018 meeting was chaired by Board Chairman, Jim Dagostino. The February 15, 2018 Community Healthcare Alliance Committee meeting was called to order at 12:35pm by Jim Dagostino. In order to establish a quorum, Jim Dagostino moved to allow CEO Steve Dietlin voting status for the February 15, 2018 meeting. The motion was seconded by Ted Owen and approved.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Approval Of Meeting Agenda	Laura Mitchell motioned to approve the February 15, 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 motioned to approve the January 18, 2018 CHAC meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved.		
Presentation: Carlos Cruz, CCO **Tri-City Health Care Compliance Program**	Carlos Cruz presented information to the group regarding Tri-City's Health Care Compliance Program as follows: • Historically, compliance goals are established to reduce and prevent criminal conduct through a structural foundation of self-policing, via established programs that exercise due diligence and promote a culture that encourages ethical conduct and compliance. • The seven elements of an effective compliance program include: Policy Oversight, Education & Training, Monitoring, Internal Review, Investigation & Remediation, and Discipline.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Carlos Cruz, CCO **Tri-City Health Care Compliance Program (cont.)**	• Compliance program guidance was developed by the Office of Inspector General (OIG) of CMS, specifically for the health care industry. • Some benefits of an effective compliance program include allowing an organization to fulfill its mission of providing quality care, while identifying weaknesses in internal systems and demonstrating to the public the organization's commitment to responsible corporate conduct and improvement of services. • Several major threats face hospitals and it is imperative that measures be put in place to counter these threats as effectively as possible. Carlos thanked Steve Dietlin for promoting the ethical and compliant culture found at Tri-City Medical Center.		
CEO Update Steve Dietlin	CEO Steve Dietlin addressed the committee as follows: • Steve thanked Carlos Cruz for his presentation, noting that compliance must be an open, preventative process that is taken seriously. • The tone of management is very important for a healthy and compliance-focused workforce.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (cont.)	• Campus development is continuing with the surface lot kick-off this week. It is anticipated that the surface lot will take 2-3 months to complete, followed by ground-breaking for the parking structure. • TCMC continues its partnership with AHA with the recently developed on-campus walking trail, plus other events over the next months. Steve noted that the community engagement has been great, and will help in the advancement of pro-active health education. • The in-house retail pharmacy is expected to be ready by summer.		
COO Update Scott Livingstone	Scott Livingstone updated the committee as follows: • Scott noted that fencing is being installed today in anticipation of the surface lot prep this week. Construction machines will begin their work the following week. Surrounding areas should expect some dust during this time. • The campus is currently being studied to see what measures can be put into place to better secure vulnerable areas. Some ideas proposed include locked doors after 6pm, entry access through badges, locked entry areas, moving the location of the entry security officer.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CMO Update David Bennett	David Bennett was absent due to a scheduling conflict.		
Chief Of Staff Update Dr. Victor Souza MD	Dr. Victor Souza updated the committee as follows: • Dr. Souza also thanked Carlos Cruz for his compliance and ethics presentation and oversight. • The flu season seems to have reached its peak, and the hospital is edging its way back to a normal census count. There were many deaths throughout the county due to the flu. • There is a nationwide shortage in the production of opioids due to weather and recent catastrophic events. There is currently a need to prioritize the distribution of medications. • TCMC is continuing its work to improve quality for its patients through shorter stays, increased comfort, minimization of hunger for patients who require fasting prior to a procedure, and pain control. • Management would like to plan a Tea Party for the nurses near the end of May as a way to say thank-you.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Vacancies – Oceanside District Resident	Jim Dagostino noted that there is a possible candidate for the Oceanside District Resident position – future details will be forthcoming.		
Public Communications	No public communications.		
Committee Communications	Jan O'Reilly noted that a recent incident allowed her to better review TCMC's service first-hand. She complimented the hospital for its good service from start to finish. Linda Ledesma shared that the Carlsbad Boy & Girls Club is hosting the "Taste of Bressi" on March 10th. Gigi Gleason noted that the Oceanside Boy & Girls Club is hosting "Cuisine for Kids" on March 1st. Scott Ashton thanked TCMC for sponsoring the successful Meet the City event honoring Mayor Jim Woods. Lulu Clift stated that she is very happy about the appointment of Jan O'Reilly to the CHAC committee.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

February 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Next Meeting	The next CHAC meeting is scheduled for Thursday, March 15, 2018 at 12:30 pm.		
Adjournment	The February 15, 2018 CHAC meeting was adjourned at 1:46pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
February 13, 2018

lembers Present	Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Dr. Mark Yamanaka, Dr. Jeffrey Ferber. Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Sharon Schultz, CNE, Carlos Cruz, CCO, Susan Bond, General Counsel
Others:	Jane Dunmeyer, David Bennett, Thomas Moore, Jeremy Raimo, David Benitez, Eva England, Joni Penix, Charlene Carty, Barbara Hainsworth
Members Absent:	Director Julie Nygaard, Director Leigh Anne Grass, Dr. Gene Ma, Scott Livingstone

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Call to order	Director Kellett called the meeting to order at 12:31 p.m.	In Director Nygaard's absence, Director Kellett will chair this meeting.	
Approval of Agenda		**MOTION** **It was moved by Dr. Contardo, Dr. Yamanaka seconded, and it was unanimously approved to accept the agenda of February 13, 2018.**	
Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Kellett read the paragraph regarding comments from members of the public.		Director Nygaard
Ratification of minutes of January 16, 2018	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Contardo, Dr. Yamanaka seconded, that the minutes of January 16, 2018 are to be unanimously approved, with Director Mitchell and Drs. Yamanaka and Ferber abstaining from the vote.**	
Old Business			
New Business			

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
a. Introduction of New Committee Member: • Dr. Jeffrey Ferber	Director Kellett welcomed Dr. Ferber to the Finance, Operations and Planning Committee.		Chair
Consideration of Consent Calendar:	Mr. Lingenfelter requested that the following item be pulled for discussion: **7.c.** Locum Tenens Contracts for Crisis Stabilization Unit (CSU)	**MOTION** **Director Mitchell moved to approve the Consent Calendar minus the item pulled. Mr. Lingenfelter seconded the motion.** **Members:** **AYES: Kellett, Mitchell, Contardo, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN: None** **ABSENT: Nygaard, Grass, Ma**	
a. Policy Review: • Prior Authorization for Non-Emergency Services for HMO/PPO Patients, #8610-213 • Audits for Third Party Insurance, #8610-255 • Medi-Cal Treatment Authorization Request (TAR) Requirements, #8610-268		**Approved via Consent Calendar**	David Benitez Joni Penix David Benitez
b. Managed Resources, Inc. Proposal		**Approved via Consent Calendar**	Joni Penix
c. Locum Tenens Contracts for Crisis Stabilization Unit (CSU)	Mr. Lingenfelter requested that this item be pulled for discussion as the write-up reflects that this agreement has not been budgeted. Ray Rivas clarified that the funds for a portion of this agreement have been budgeted, but are actually	**MOTION** **It was moved by Director Mitchell, seconded by Mr. Lingenfelter to approve the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of**	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	designated in a different category. Sharon Schultz conveyed that the cost amounts are estimates based on the anticipated usage of locum tenens staffing. The rates range from $235-$315 per hour, dependent on the shift and overtime. She further explained that work is being undertaken with UCSD on a contract for Telemedicine, which will provide the coverage for nights and weekends. The intent is to keep the current TCMC per diem nurse practitioners on contract for emergencies.	**allied health providers for a 4 month term, beginning March 1, 2018 and ending June 30, 2018, for a total expected cost for the term of $660,000.** **Members:** **AYES: Kellett, Mitchell, Contardo, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN:** **ABSENT: Nygaard, Grass, Ma**	
d. Physician Recruitment Proposal • Anitha Rajamanickam, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
Financials:	Ray Rivas presented the financials ending January 31, 2018 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 210,391 Operating Expense $ 218,960 EBITDA $ 3,700 EROE $ (5,415) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 176 Adjusted Patient Days 66,680 Surgery Cases 3,761 Deliveries 1,391 ED Visits 36,660		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	TCHD – Financial Summary **Current Month** Operating Revenue $ 31,517 Operating Expense $ 33,369 EBITDA $ 81 EROE $ (1,242) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 211 Adjusted Patient Days 10,721 Surgery Cases 541 Deliveries 209 ED Visits 5,201 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 45.6 Days in Net A/R Avg. 49.1 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay		
Work Plan:			
a. Tri-City Real Estate Holding & Management, LLC *(annual)*	Ray Rivas conveyed that the properties within this LLC have either been sold or financing requirements satisfied. The LLC is to be dissolved, and therefore this will be the last report pertaining to this item.		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
b. Accountable Care Organization (ACO) *(annual)*	Steve Dietlin detailed that TCMC's ACO will to be dissolved, and the projected plan is to partner with UCSD in their ACO.		Scott Livingstone
c. Dashboard	No discussion		Ray Rivas
Comments by committee members			
Date of next meeting	Tuesday, March 20, 2018		Chair
Community Openings (0)			
Adjournment	Meeting adjourned 12:50 p.m.		

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 07/92

SUBJECT: PRIOR AUTHORIZATIONS FOR NON-EMERGENCY SERVICES FOR HMO/PPO PATIENTS

REVISION DATE(S): 07/94, 06/01, 10/05, 11/08, 09/10, 01/11

POLICY NUMBER: 8610-213

Department Review:	01/18
Administrative Policies & Procedures Committee Approval:	~~06/14~~01/18
Finance & Operations Committee Approval:	02/15
Board of Directors Approval:	02/15

A. **PURPOSE:**

1. To set forth guidelines to ensure Tri-City Healthcare District's (TCHD) control and compliance with the utilization policies of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) payeers and to reduce the number of denied services due to the lack of required authorization.
2. It is the intention of this policy to ensure prior-authorization is received from all payeers for all services performed at ~~Tri-City Medical Center~~TCHD.

B. **PROCEDURE:**

1. The Director or designee of each department that schedules non-emergency services which require prior authorization from either the HMO/PPO or physician groups will ensure that said services shall not be scheduled prior to receipt of an authorization number either by telephone, fax, or mail.
   a. In the event that a physician, physician's office, patient, patient's family, HMO/PPO staff or any other party or agent requests to be scheduled for a service that requires prior authorization but can-not provide the authorization number, he/she shall be referred to the referral specialist's office or to the patient's primary care physician.
      i. If a patient who presents for a scheduled service and ~~Tri-City Healthcare District~~TCHD does not have a record of the required authorization number, then the patient's service will be postponed until said authorization is obtained.
      ii. The Access Management Manager, Supervisor or designee will phone physician's office to inform them of the information.
      The Patient Access Director/Manager or designee can approve the scheduling of a procedure with a pending authorization based on patient's condition and service.

C. **CLARIFICATION:**

1. For clarification of this policy, contact the ~~Tri-City Healthcare District~~TCHD's Main Registration, extension 3151. ~~Department of Managed Care, ext. 3376.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 10/96 **SUBJECT:** AUDITS FOR THIRD PARTY INSURANCE

REVISION DATE: 10/99, 08/02, 12/02, 12/03, 11/08, 09/10 **POLICY NUMBER:** 8610-255

Department Review:	**01/18**
Administrative Policies & Procedures Committee Approval:	**~~02/15~~01/18**
Finance & Operations Committee Approval:	**~~03/15~~02/18**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. Cooperate with reasonable third-party payor audits performed in accordance with the provisions set forth herein.

B. **POLICY:**

1. To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges. ~~A comprehensive medical billing audit program will serve to:~~

C. **PROCEDURE:**

1. General Information:
   a. The scope of a medical billing audit is limited to verifying that charges on the detailed hospital bill are accurate, represent services rendered to the patient, and are ordered by a physician. However, services or items may be provided based upon standard hospital practices and/or Nursing protocols and procedures.
   b. The audit does not assess the "reasonableness" of the charges, or medical necessity related to patient bills. A review of medical necessity for the services provided may be performed, but the billing audit process does not encompass these tasks.
   c. Documentation: In concert with the position taken by the American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992), the hospital does not attempt to make the patient's Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that may be used to substantiate charges. In a business relationship, the hospital will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient.
2. Hospital Auditor Responsibilities:
   a. The hospital will designate an individual to be responsible for coordinating all medical billing audit activities (i.e., Patient Account Auditor; hereafter referred to as Chart Auditor). Medical billing audit activities are prompted via both internal and external processes, and include concurrent, focus, miscellaneous, patient request, and insurance defense audit types. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits), the Chart Auditor will serve as the primary liaison between the hospital and all outside parties requesting patient account audits. All medical billing audit activities are to be documented and logs maintained within the

hospital. All audit-related account adjustments are to be processed only after appropriate facility-level sign off approval has been obtained. All audit related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with applicable hospital record retention policies.

3. Third-Party Payeer (Insurance Defense) Audits:
   a. Tri-City ~~Medical Center~~**Healthcare District (TCHD)** will have a Chart Auditor on staff or a person assigned the responsibility to properly conduct third-party payeer (insurance defense) audits. This person will serve as the primary liaison between the hospital and any outside audit party. Direct contact by the payeer/outside audit parties with department heads is strictly prohibited. All questions regarding clarification of charging practices and protocols are to be directed to the Chart Auditor to prevent disruption of the normal flow of operation within the hospital.
   b. The hospital Chart Auditor must have a current Charge Description Master (CDM) in order to provide accurate billing to the Third-Party Auditor. He/she will submit all audit adjustments to the Chart Auditor at the conclusion of the audit.
   c. Third-party payeer (Insurance Defense) audits of patient accounts will be conducted in accordance with all policies and procedures set forth herein. The costs incurred, and utilization of resources imposed on the hospital in connection with such audits, must not be unduly borne by other patients. Therefore, these policies and procedures, along with associated fees and requirements, will be strictly enforced so that all reasonable audits can be performed efficiently. Involved parties must be aware that specific managed care contract language which references audit procedures is legally binding for the duration of the contract.
   d. Third-party payeer audits are not a forum for addressing questions concerning the level or scope of care, medical necessity, or the pricing structure of items or services delivered by the hospital. Qualified personnel and mechanisms exist to deal with these issues outside the scope of the medical billing audit process~~,~~ and, therefore, will not be considered during the course of the audit.
4. Written Notice of Intent To Audit:
   a. Any intent to audit an account requires written notice from the outside audit party to the hospital Chart Auditor within four months of patient discharge. Under no circumstances will telephone contact alone be sufficient means to initiate the audit process.
      i. The written notice must state the reason the claim was selected for audit and must contain the following information:
         1. Name of patient
         2. Patient account number
         3. Dates of service
         4. Name of insurance carrier requesting an audit
         5. Name of firm and name of person, if known, who will perform the audit
         6. Total charges to be audited
      ii. Written notice of intent to audit will not be considered if received more than four months after patient discharge. The onsite audit must be scheduled and completed within **sixty (60)** days of receipt of intent to audit. These guidelines are to be used for all external entities, unless there is a signed contract in place that has language specific to the audit process, and then the contract will supersede the audit policy.
      iii. Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide

written proof of their contractual relationship before an audit will be scheduled or conducted.

iv. All audits must be conducted on site. The hospital's Chart Auditor must ensure that only the portion of the Medical Record that applies to the account being audited is provided for onsite review. Under no circumstances is any portion of a patient's Medical Record to be provided to, reviewed, or considered by Third-Party Audit personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in **the previous** clauses (a) and (b) ~~of the previous sentence~~ apply to the account under audit, or such exceptions shall not apply to the audit. A complete Medical Record may not be copied for the purpose of offsite reviews.

v. A single account may not be audited by a third party more than once. Any additional third-party requests for an audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

vi. It is hospital policy to allow no offsite audits. All audits are conducted on site under the direction and coordination of the hospital Chart Auditor.

b. Account Status Requirements:
   i. Payment of 100% of policy benefits must be received prior to scheduling the audit.
   ii. The Medical Record must be complete prior to conducting the audit.
   iii. Audits will not be performed on interim bill claims.

c. Audit Fees:
   i. An auditing fee is required by the hospital if an internal audit of the account has previously been performed. The minimum audit fee of $1,000.00 must be received prior to, or upon commencement of the onsite audit, irrespective of any pre-audit payment of policy benefits.

d. Disclosure Authorization:
   i. Specific state regulations determine procedures for release of records containing sensitive information. Consult Medical Records' policy for handling of these records.

e. Pre-Audit Procedure:
   i. The hospital should respond to the written notice of intent to audit by supplying the Third-Party Auditor with a written copy of the ~~Tri-City Medical Center~~**TCHD** Third-Party Audit Policy Statement ~~(refer to Exhibit A)~~.
   ii. A log must be maintained by the hospital documenting dates and recipients of all audit policies sent to outside parties.
   iii. Onsite audits are not to be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the ~~Tri-City Medical Center~~**TCHD** Third-Party Audit Policy Statement.
   iv. All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within ten days of the originally scheduled audit date. An audit may be rescheduled only once.
   v. Should the auditor fail to appear as scheduled, the audit may not be re-scheduled.

f. Audit Process:
   i. All accounts, without exception, are to be pre-audited in their entirety by the hospital Chart Auditor prior to the date of the scheduled audit.

ii. To document the audit, an itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.

iii. An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final.

iv. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten **(10)** business days of the exit conference.

v. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report. These results must be detailed by description and price, and summarized by department.

vi. Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

vii. If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit.

viii. Charges submitted to the Chart Auditor are required to be itemized by line item. The Business Office is to be notified of the date the audit was completed and the total adjustment to the bill.

ix. If indicated, a net refund or adjustment of charges will be completed by the Business Office within the regular course of business.

g. Personal/Non-Covered/Unbillable Items:

i. Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

D. RELATED DOCUMENT(S):

~~ii.~~1. **Third-Party Audit Policy Statement**

E. REFERENCE(S):

~~iii.~~1. **American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992)**

Third-Party Audit Policy Statement~~Exhibit A:~~ - Sample

TRI-CITY MEDICAL CENTERTHIRD-PARTY AUDIT POLICY STATEMENT

The hospital wishes to cooperate with any commercial audits of patient accounts that are reasonable and that are performed in accordance with the provisions set forth herein. These policies and procedures, along with the associated fees and charges, are necessary so all audits can be performed efficiently, and the costs imposed on the hospital, in connection with such audits, will not be unduly borne by other patients.

In concert with the position taken by the AHA, the hospital does not attempt to make the patient's Medical Record a duplicate patient bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by Nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that can be used to substantiate charges. Moreover, questions regarding scope of care or medical necessity and/or issues relating to the cost of particular items or services are, as defined by the joint guidelines for billing audits, inappropriate in the forum of a charge audit.

POLICY DESCRIPTION

~~Policy 1~~

1. The hospital requires written notice of intent to audit be received within four months from the date of the discharge bill. Audit requests received after four months from the discharge bill will not be considered. Onsite audits are to be scheduled and completed within 60 days of receipt of intent to audit.

~~Policy 2~~

2. Written notice must state the reason for audit, and identify name of patient, account number, dates of service, carrier requesting audit, name of firm and name of person, if known, who will perform the audit, and total charges to be audited.

~~Policy 3~~

3. Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide written proof of their contractual relationship before an audit will be scheduled or conducted.

~~Policy 4~~

4. Upon receipt of written notice, the hospital will respond by sending the TRI-CITY MEDICAL CENTER Third-Party Audit Policy Statement. Audits will not be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the policy.

~~Policy 5~~

5. All audits will be conducted on site. Offsite reviews of photocopied records are unacceptable. Under no circumstances is any portion of a patient's Medical Record that does not pertain to the dates of service for the account being audited to be provided to, reviewed, or considered by the Third-Party Audit personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in clauses (a) and (b) of the previous sentence apply to the account under audit, or such exceptions shall not apply to the audit.

~~Policy 6~~

6. A single account may not be audited by a third party more than once. Any additional third-party requests for audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

~~Policy 7~~

7. Tri-City Medical Center personnel will provide copies of the discharge bill. All requests for itemized statements and UB-04's will be approved.

~~Policy 8~~

8. The Medical Record must be complete prior to conducting the audit. Payment of 100 % of policy benefits must be received prior to scheduling the audit. Audits will not be performed on interim bill claims.

~~Policy 9~~

9. Audit fees will be imposed in the absence of pre-audit payment of policy benefits. A minimum fee of $1,000.00 is required on any account previously audited internally. This fee is irrespective of any pre-audit payment of policy benefits.

~~Policy 10~~

10. All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within days of the originally scheduled audit date. An audit may be rescheduled only once. No-shows will not be rescheduled.

~~Policy 11~~

11. Third-Party Auditors will report to the hospital Chart Auditor upon arrival at the facility. To prevent disruption of hospital operations, Third-Party Auditors are prohibited from making direct contact with hospital department personnel. All questions regarding clarification of charging practices and/or protocols are to be directed exclusively to the hospital Chart Auditor.

~~Policy 12~~

12. An itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.

~~Policy 13~~

13. An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten business days of the exit conference. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report.

~~Policy 14~~

14. Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

~~Policy 15~~

15. If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit. If indicated, a net refund or adjustment of charges will be completed by the hospital Business Office within the regular course of business.

~~Policy 16~~

16. Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 04/99

SUBJECT: MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) REQUIREMENTS

REVISION DATE(S): 05/03, 01/06, 09/10, 01/11

POLICY NUMBER: 8610-268

Department Review:	**01/18**
Administrative Policies & Procedures Committee Approval:	**~~02/15~~01/18**
Finance & Operations Committee Approval:	**~~03/15~~02/18**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for all Medi-Cal admissions.

B. **DEFINITION(S):**

1. Medi-Cal Pending Patients: Patients who have applied to California Department of Public Health (CDPH) for assistance and have not been approved. These patients are considered cash paying and the hospital's deposit/payment policies apply.
2. Medi-Cal Eligible Patients: Patients who have provided valid proof of eligibility by way of a CDPH 1410 form and/or verification on the Medi-Cal Point of Service (POS) Online website (eTAR).
3. Approved TAR: A treatment authorization request, which has been submitted by the physician's office and has been approved by the field office. An approved TAR is required in advance of all elective and urgent procedures.

C. **POLICY:**

1. All Medi-Cal approved elective admissions or procedures requiring a TAR will have one obtained by the treating physician's office prior to the scheduled date of service.
2. Registration will follow the usual procedures for admission ensuring that the approved TAR has been received. Case Management and Registration will coordinate any questionable admissions to insure TARs are appropriate and timely.
3. It will be the responsibility of the Registration Department to notify Surgical Services of any change. Surgery Scheduling informs the physician's office a TAR is required prior to the services being rendered and if TAR is not received within 48 hours of the scheduled time the case will be rescheduled.
4. If Medi-Cal TAR is approved with a share of cost:
   a. Registration is responsible for verifying a patient's share of cost has been met. If the share of cost has not been met, Registration shall request payment in full or contact the in-house Preadmitter to make appropriate payment arrangements with the patient. In accordance with hospital policy, payment arrangements will not extend beyond a six month period.
   b. Medi-Cal pending admits will be handled as cash. The hospital policy regarding deposits and payment apply. Med Assist will, as needed, screen patients and continue to follow up to secure applications and/or ensure eligibility.

D. **PROCESS:**

1. Case Management will perform initial clinical review utilizing InterQual Criteria at Hospital points of entry (ED, Procedural Areas etc) and Case Management will contact the admitting / treating physician to discuss the case to determine appropriate level of care: Inpatient or Observation

level of care.

2. Case Management - performs concurrent daily clinical review for Managed Medi-Cal – (Molina, CHG for example and APRDRG clinical review for standard Medi-Cal beneficiaries)
   a. Case Manager's clinical reviews are documented in Allscripts under "TAR (Medi-Cal) REVIEW"
   b. Registration Staff presents the "TAR (Medi-Cal) REVIEW" Case Management with the E-TAR
3. Case Management will facilitate communication with treating physician to clarify any issues surrounding appropriate level of care (Inpatient versus Observation versus 10-Bed-Call) and obtain appropriate physician orders.
4. Case Management will facilitate communication with UM Medical Director for issues regarding medical necessity and to coordinate MD to MD communication
5. Registration is responsible for notifying Surgical Services of any changes.

E. REFERENCE(S):

~~5.~~1. **California Code of Regulations (CCR), Title 22, the Department of Health Care Services (DHCS), Medi-Cal Form 50-1 Treatment Authorization Request (TAR) http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx**

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 07/92

SUBJECT: PRIOR AUTHORIZATIONS FOR NON-EMERGENCY SERVICES FOR HMO/PPO PATIENTS

REVISION DATE(S): 07/94, 06/01, 10/05, 11/08, 09/10, 01/11

POLICY NUMBER: 8610-213

Department Review:	**01/18**
Administrative Policies & Procedures Committee Approval:	**~~06/14~~01/18**
Finance & Operations Committee Approval:	**~~02/15~~02/18**
Board of Directors Approval:	**02/15**

A. **PURPOSE:**

1. To set forth guidelines to ensure Tri-City Healthcare District's (TCHD) control and compliance with the utilization policies of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) payeers and to reduce the number of denied services due to the lack of required authorization.
2. It is the intention of this policy to ensure prior-authorization is received from all payeers for all services performed at ~~Tri-City Medical Center~~**TCHD**.

B. **PROCEDURE:**

1. The Director or designee of each department that schedules non-emergency services which require prior authorization from either the HMO/PPO or physician groups will ensure that said services shall not be scheduled prior to receipt of an authorization number either by telephone, fax, or mail.
   a. In the event that a physician, physician's office, patient, patient's family, HMO/PPO staff or any other party or agent requests to be scheduled for a service that requires prior authorization but can-not provide the authorization number, he/she shall be referred to the referral specialist's office or to the patient's primary care physician.
      i. If a patient who presents for a scheduled service and ~~Tri-City Healthcare District~~**TCHD** does not have a record of the required authorization number, then the patient's service will be postponed until said authorization is obtained.
      ii. The Access Management Manager, Supervisor or designee will phone physician's office to inform them of the information.
      ~~ii.~~**iii. The Patient Access Director/Manager or designee can approve the scheduling of a procedure with a pending authorization based on patient's condition and service.**

C. **CLARIFICATION:**

1. For clarification of this policy, contact the ~~Tri-City Healthcare District~~**TCHD's Main Registration, extension 3151.** ~~Department of Managed Care, ext. 3376.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 04/99

SUBJECT: MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) REQUIREMENTS

REVISION DATE(S): 05/03, 01/06, 09/10, 01/11

POLICY NUMBER: 8610-268

Department Review:	01/18
Administrative Policies & Procedures Committee Approval:	~~02/15~~01/18
Finance & Operations Committee Approval:	03/15
Board of Directors Approval:	03/15

A. **PURPOSE:**

1. To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for all Medi-Cal admissions.

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   a. Registration is responsible for verifying a patient's share of cost has been met. If the share of cost has not been met, Registration shall request payment in full or contact the in-house Preadmitter to make appropriate payment arrangements with the patient. In accordance with hospital policy, payment arrangements will not extend beyond a six month period.
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D. **PROCESS:**

1. Case Management will perform initial clinical review utilizing InterQual Criteria at Hospital points

of entry (ED, Procedural Areas etc) and Case Management will contact the admitting / treating physician to discuss the case to determine appropriate level of care: Inpatient or Observation level of care.

2. Case Management - performs concurrent daily clinical review for Managed Medi-Cal – (Molina, CHG for example and APRDRG clinical review for standard Medi-Cal beneficiaries)
   a. Case Manager's clinical reviews are documented in Allscripts under "TAR (Medi-Cal) REVIEW"
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4. Case Management will facilitate communication with UM Medical Director for issues regarding medical necessity and to coordinate MD to MD communication
5. Registration is responsible for notifying Surgical Services of any changes.

E. REFERENCE(S):

California Code of Regulations (CCR), Title 22, the Department of Health Care Services (DHCS), Medi-Cal Form 50-1 Treatment Authorization Request (TAR)
http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 13, 2018
Managed Resources, Inc. Proposal

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

Vendor's Name: Managed Resources Inc. (MRI)

Area of Service: Clinical and Coding Appeal Services for Revenue Cycle

Term of Agreement: 24 months, Beginning, February 25, 2018 – Ending, February 29, 2020

Maximum Totals:

Expected Monthly Cost	Expected Annual Cost	Expected Total Term Cost
$12,902	$154,824	$309,648

Description of Services/Supplies:

- MRI will review, at the direction of TCMC, encounters that have received a letter of denial from any carrier. Denials may be for any reason, including coding, admission or continued stay criteria.
- MRI will provide a team approach when reviewing combination denials. A Certified Coder will review and respond to coding denials. A Registered Nurse will review and respond to the clinical denials.
- MRI will send out an appeal letter on behalf of TCMC to address and appeal the denial.
- If additional levels of appeal are required, MRI will discuss available options with TCMC.
- MRI provides comprehensive reports to assist prospective prevention.
- MRI presents appeal results at a quarterly leadership meeting while also providing onsite education and recommendations to reduce denials.

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

Person responsible for oversight of agreement: Joni Penix, Director, Patient Financial Services / Ray Rivas, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Managed Resources, Inc. for Clinical Appeals for a term of 24 months, beginning February 25, 2018 and ending February 29, 2020 for an annual expected cost of $154,824, and a total expected cost for the term of $309,648.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 13, 2018
Locum Tenens Contracts for Crisis Stabilization Unit (CSU)

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

Vendor's Name: Locum Tenens Vendors (Nurse Practitioners/Physician Assistants)

Area of Service: Crisis Stabilization Unit (CSU)

Term of Agreement: 4 months, Beginning, March 1, 2018 – Ending, June 30, 2018

Maximum Totals:

Average Monthly Cost	Expected Term Cost
$165,000	$660,000

Description of Services/Supplies:

- Estimate is based on current and anticipated usage of locum tenens.
- Two per diem nurse practitioners have been hired but can only work weekends; difficult to retain as employees.
- Rates range from $235-315/hr., depending on the shift and any overtime.
- Working with UCSD on a contract they will have for Telemedicine to cover nights and weekends.
- Intent is to keep current TCMC per diem nurse practitioners on contract for emergencies.

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	N/A	Yes		No
Is Agreement a Regulatory Requirement: *(Per San Diego County Contract)*	X	Yes		No
Budgeted Item:		Yes	X	No

Person responsible for oversight of agreement: Candice Parras, Director, Crisis Stabilization Unit & Emergency Department / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of allied health providers for a 4 month term, beginning March 1, 2018 and ending June 30, 2018, for a total expected cost for the term of $660,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
February 8, 2018

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

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP , 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: Director Leigh Anne Grass (Chair), Dr. Johnson.

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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
the item.			
4. Ratification of minutes of January 2018.	Director Mitchell called for a motion to approve the minutes from January 11, 2018.	The minutes were ratified after making a couple of corrections from Director Schallock. Director Schallock and Dr. Souza seconded the motion to approve the minutes from January 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Code STEMI Policy	There was a recommendation to change the date on the graph describing the pre-hospital STEMI algorithm.	**ACTION:** The Patient Care policies and procedures were approved. Dr. Souza moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. CONSTAVAC, Reinfusion of Blood	There was no discussion on this policy.		
3. Duty to Warn Potential Victims Policy	This policy is now a hospital-wide policy so the unit specific ones are being deleted from the other departments.		
4. Minors Attempting to Leave Without a Parent / Legal Guardian	The minors that are being referred to in this policy are the unmarried minors.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
5. Privacy Code Policy	There is no discussion on this policy.		
6. Special Order Durable Medical Equipment and Specialty Beds	There is no discussion on this policy.		
Unit Specific Administrative Policies			
1. Decision Making for Unrepresented Patients	Decision making for unrepresented patients does not apply to urgent matters as the physician will make the decision in urgent cases.	**ACTION:** The Administrative policies were approved. Director Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Designation of Authority in Temporary and Voluntary Absence of Chief Executive officer	There is no discussion on this policy.		
Behavioral Health Services			
1. Duty to Warn Potential Victims Policy	This is a policy deletion.	**ACTION:** The Behavioral Health policy was approved. Dr. Souza moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
nfection Control			
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	Dr. Contardo mentioned that this policy has numerous pages of very long information. He inquired if there is a "Quick Reference" that the units can have as a summary so they don't have to go throught the whole policy all the time.	**ACTION:** Lisa Mattia mentioned that there is a Quick Reference Summary in the units for easy reference for the staff.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Required Reporting	It was clarified the State reports to the Feds but the hospital does not.	The Infection Control policies were approved. Dr. Souza moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	
3. Risk and Assessment and Surveillance Plan	There was no discussion on this policy.		
Medical Staff			
1. Medical Record Documentation Requirements	There was no discussion on this policy.	**ACTION:** The Medical Staff policy was approved. Dr. Souza moved and Dr. Contardo seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health			
1. Duty to Warn Potential Victims Policy	There was no discussion on this policy.	**ACTION:** The Outpatient Behavioral Health policy was approved. Directoir Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Pharmacy			
1. Patient Specific Information	There was no discussion on this policy.	**ACTION:** The Pharmacy policy was approved. Dr. Ma moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation			
1. Job Site Assessment	Priya made a clarification that the job site assessment is free for staff but there is a charge for community members.	**ACTION:** The Rehabilitation policies were approved. Dr. Contardo moved and Director	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Occupational Therpay Assistant Supervision	Priya stated the the Rehabilitation department tries to hire internal employees for this position.	Schallock seconded the motion to approve the policies moving forward for Board approval.	
3. Therapy Pool Dress Code	There was no discussion on this policy.		
Forms			
1. Notice of Privacy Practices	There was no discussion on this policy.	**ACTION:** The notice of privacy practice was approved to move forward to Board approval as moved by Dr. Contardo and seconded by Director Schallock.	Patricia Guerra
Pre-printed Orders			
1. Physician Orders 2. Remicade (Infliximab) Administration	There was no discussion on the pre-printed orders.	**ACTION:** The pre-printed orders were approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Schallock.	Patricia Guerra
Formulary Requests			
1. Topical Epinephrine Monograph	This topical is fairly new as it is only used for plastic surgery cases.	**ACTION:** The formulary request was approved to move forward to Board approval as moved by Director Schallock and seconded by Dr. Souza.	Patricia Guerra
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 Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
8. Return to Open Session	The Committee return to Open Session at 2:15 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 1:35PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
February 2, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Code STEMI Policy	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
2. Constavac, Reinfusion of Blood Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
3. Duty to Warn Potential Victims Policy	NEW	Forward To BOD For Approval with Revisions
4. Minors Attempting to Leave Without a Parent-Domestic Partner-Legal Guardian Policy	3 Year Review, Practice Change	Forward To BOD For Approval
5. Privacy Code Policy	Practice Change	Forward To BOD For Approval
6. Special Order Durable Medical Equipment (DME) and Specialty Beds Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Unit Specific		
Administrative		
1. Decision Making for Unrepresented Patients 397	NEW	Forward To BOD For Approval with Revisions
2. Designation of Authority in Absence of CEO 233	3 Year Review, Practice Change	Forward To BOD For Approval
Behavioral Health Services		
1. Duty to Warn Potential Victims	DELETE	Forward To BOD For Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11	Annual Review, Practice Change	Forward To BOD For Approval with Revisions
2. IC 12 Required Reporting	3 Year Review, Practice Change	Forward To BOD For Approval
3. Risk Assessment and Surveillance Plan	Annual Review, Practice Change	Forward To BOD For Approval with Revisions
Medical Staff		
1. Adverse Incident Occurrence 8710-512	3 Year Review	Approved by PAC on 01/11/2018. Forward to BOD for Approval with Revisions.
2. Medical Record Documentation Requirements 8710-518	3 Year Review, Practice Change	Forward To BOD For Approval
Outpatient Behavioral Health		
1. Duty to Warn Potential Victims	DELETE	Forward To BOD For Approval
Pharmacy		
1. Patient Specific Information	DELETE	Forward To BOD For Approval

PROFESSIONAL AFFAIRS COMMITTEE
February 2, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Rehabilitation		
1. Job Site Assessment 609	3 Year Review	Forward To BOD For Approval
2. Occupational Therapy Assistant Supervision 707	NEW	Forward To BOD For Approval
3. Therapy Pool Dress Code - 1710	3 Year Review, Practice Change	Forward To BOD For Approval
Forms		
1. Notice of Privacy Practices	Practice Change	Forward To BOD For Approval with Revisions
Pre-Printed Orders		
1. Physician Orders 8711-4010	3 Year Review, Practice Change	Forward To BOD For Approval
2. Remicade (Infliximab) Administration Guidelines 8711-2810	3 Year Review, Practice Change	Forward To BOD For Approval
Formulary Requests		
1. Topical Epinephrine Monograph	Addition	Forward To BOD For Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/09	**SUBJECT: Code STEMI**
REVISION DATE: 03/10, 08/11, 04/12, 09/13, 04/14	**POLICY NUMBER: IV.UU**

Department Approval:	03/17
Clinical Policies & Procedures Committee Approval:	~~11/13~~03/17~~09~~/17
Nursing Executive Council Approval:	~~11/13~~09/17
Division of Cardiology Approval:	12/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/14~~01/18
Professional Affairs Committee Approval:	~~04/14~~02/18
Board of Directors Approval:	04/14

A. **PURPOSE:**
1. To provide a systematic method for responding to ST Elevation Myocardial Infarction (STEMI) patients.
2. To assure compliance with Centers for Medicare and Medicaid (CMS) and San Diego STEMI Guidelines as outlined by the County of San Diego Emergency Medical Services (EMS) STEMI Receiving Centers (SRC) Standards.

B. **POLICY:**
1. The Emergency Department (ED) physician, cardiologist or Mobile Intensive Care Nurse (MICN) determines when a patient meets STEMI criteria by reviewing the 12 lead ECG obtained in the hospital or pre-hospital.
2. The Rapid Response Team (RRT) Registered Nurse (RN) determines when an inpatient meets STEMI criteria by reviewing the 12 lead ECG.
3. The decision for medical management by Coronary Angiography, Percutaneous Coronary Intervention (PCI) or the use of fibrinolytics will be in accordance with the decision of the treating physician.
4. The decision to transfer patient to a SRC, when a PCI cannot be initiated in a timely manner, will be in accordance with the decision of the treating physician.
5. Hospital EKG's should be completed within a goal of 10 minutes of being ordered and delivered directly to a RRT RN or physician for interpretation.

C. **PROCESS FOR EMERGENCY DEPARTMENT PATIENTS:**
1. STEMI Team activation:
   a. ED Secretary will activate the Code STEMI at the direction of the physician
      i. Contacts Private Branch Exchange (PBX) at 66 and requests Code STEMI activation to the ED.
      ii. Pages the on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
         1) If no response within 5 minutes, contact PBX and requests STAT page for on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
   b. MICN nurse will activate the pre-hospital STEMI based on ***Acute MI***/***ACUTE MI SUSPECTED*** on the field 12 lead ECG, or verbal report from the transporting agency of STEMI.
      i. Contacts PBX at 66 and requests Code STEMI activation to the ED.
2. STEMI Team Notification

a. PBX operator will notify STEMI team members by sending a bulk page indicating Code STEMI activation and indicate patient name and bed assignment in ED.
   i. Cardiac Cath Lab (CCL) team
   ii. EKG technician
   iii. Phlebotomist
   iv. Radiology technician

3. STEMI Team Response:
   a. Cardiologist will respond to page by calling ED and consulting with ED physician.
   b. Phlebotomist, EKG technician, and Radiology technician will report directly to patient bedside in ED within 10 minutes of receiving page.
   c. CCL team will respond to PBX confirming page was received and report to CCL and ED within 30 minutes of page.
4. STEMI Team Response Verification
   a. PBX will notify the Code STEMI originator of the STEMI team response.
   b. If no response from a CCL team member, PBX will notify the Cath Lab Supervisor on call.
5. STEMI Bypass Plan: MICN will maintain current status with the San Diego County MICN Data Entry Network as to the ability to receive STEMI patients.
   a. Cardiologist will be responsible for determining the need for STEMI Bypass.
   b. Criteria for Interfacility Transfer of patients, who are identified as STEMI patients, when PCI cannot be initiated, will be according to hospital policy.

~~6. STEMI Team Responsibilities:~~
~~a. STEMI Protocol Flowcharts see~~
~~i. Pre-Hospital STEMI Flowchart~~
~~ii. ED Walk-in Triage Process~~
~~iii. ED STEMI Pathway~~
~~iv. In-House Code STEMI Flowchart~~
~~b. STEMI Packet Instructions~~

~~7.~~**6.** Cancellation of Code STEMI:
   a. The ED physician or cardiologist evaluating the patient may, at his/her clinical discretion, cancel a STEMI activation.

D. **PROCESS FOR IN-PATIENTS:**
1. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS) on an Acute Care Unit, the primary Registered Nurse (RN) shall assess the patient and notify the Rapid Response Team (RRT) and the unit Assistant Nurse Manager (ANM) /Relief Charge RN.
2. Telemetry patients with new onset ST elevation, the primary RN shall:
   a. Initiate therapy as ordered and/or as outlined in the Patient Care Services (PCS) Standardized Procedure: Code Blue and Emergency Care (Cardiopulmonary Arrest): Chest Pain/(Related to Coronary Artery Occlusion or Spasm) AND
   b. Notify RRT and the unit ANM/Relief Charge RN
3. Rapid Response RN shall:
   a. Assess patient
   b. Order STAT ECG by dialing (760) 802-9484 or via PBX~~.~~
   c. Treat patient per PCS Standardized Procedure: Rapid Response
   d. ECG technician performs ECG and hand-delivers ECG to RRT RN
   ~~d.~~**e. The RRT RN will review the ECG:**
      i. If ECG is positive for ***Acute MI*** the RRT RN will:
         1) Dial 66 and request an IN-HOUSE CODE STEMI to room ___.
         2) Page attending physician to the patient's room to evaluate the patient.
         ~~2)~~**3) Call Pharmacy (x3012) to request delivery of STEMI Medication Kit**
      ii. If ECG is negative for Acute MI, RRT treats patient according to standardized procedure. RRT or primary RN pages attending/physician for orders.

~~e.~~**f.** PBX operator initiates IN-HOUSE CODE STEMI by announcing an overhead page "IN-HOUSE CODE STEMI room ___", and by sending a STEMI activation page to:
- i. Cardiac Cath lab (CCL) team
- ii. Phlebotomist
- iii. Radiology tech**nician**
- iv. Respiratory

~~f.~~**g.** The attending physician will respond to the patient's room when an overhead IN-HOUSE CODE STEMI is paged. If no response by the attending physician within 5 minutes the RRT RN will call the hospitalist/on-call hospitalist. If no response from the hospitalist/on-call hospitalist in 5 minutes, the RRT RN will call ED charge nurse at 760-940-3509 for stat ER physician assistance to evaluate patient:
- i. Physician will verify the ECG
- ii. If positive for Acute MI,~~.~~ RRT RN will call PBX to page on call cardiologist to 760 802-3727~~.~~
  - 1) If physician deems ECG to be negative for Acute MI, RRT will call PBX operator to cancel the IN-HOUSE CODE STEMI.
- iii. Attending physician, hospitalist/on-call hospitalist, ED physician communicates with the on-call Cardiologist.

h. A pharmacist or pharmacy technician will deliver a STEMI Medication Kit upon request from the RRT RN. If not delivered within 5 minutes, the RRT RN will place a second call to the Pharmacy and/or contact a pharmacy technician

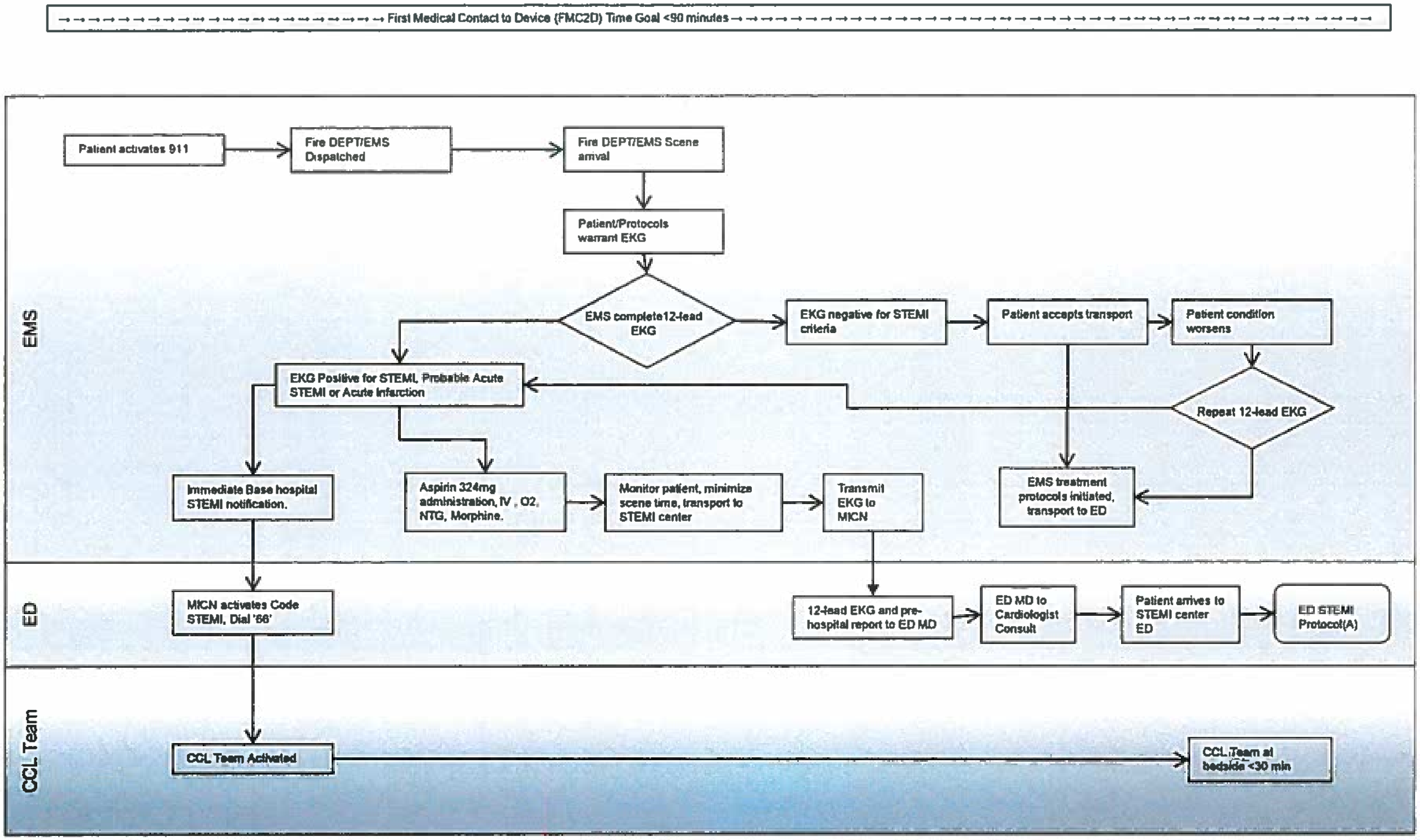
~~g.~~**i.** Cath lab team reports to patient room to obtain report and transport patient to the CCL

E. ~~**LOCATED IN PATIENT CARE SERVICES UNDER FORMS/RELATED DOCUMENT(S):**~~
1. Pre-hospital STEMI ~~Flowchart~~**Algorithm**
2. ED Walk-In Triage Process – Chest Discomfort & Equivalent
3. ED STEMI Pathway
4. In-House Code STEMI Flowchart
5. STEMI Packet Instructions

F. **REFERENCE(S):**
1. Cardiac Cath Lab Policies and Procedures
2. Medical Staff Policy 520 "Emergency Room Call: Duties of the On-Call Physician"
3. Patient Care Service Policy VI.D "Transfer of Patients"
4. Emergency Department Policies and Procedures

Pre-hospital STEMI Flowchart Algorithm

Pre-Hospital STEMI Algorithm



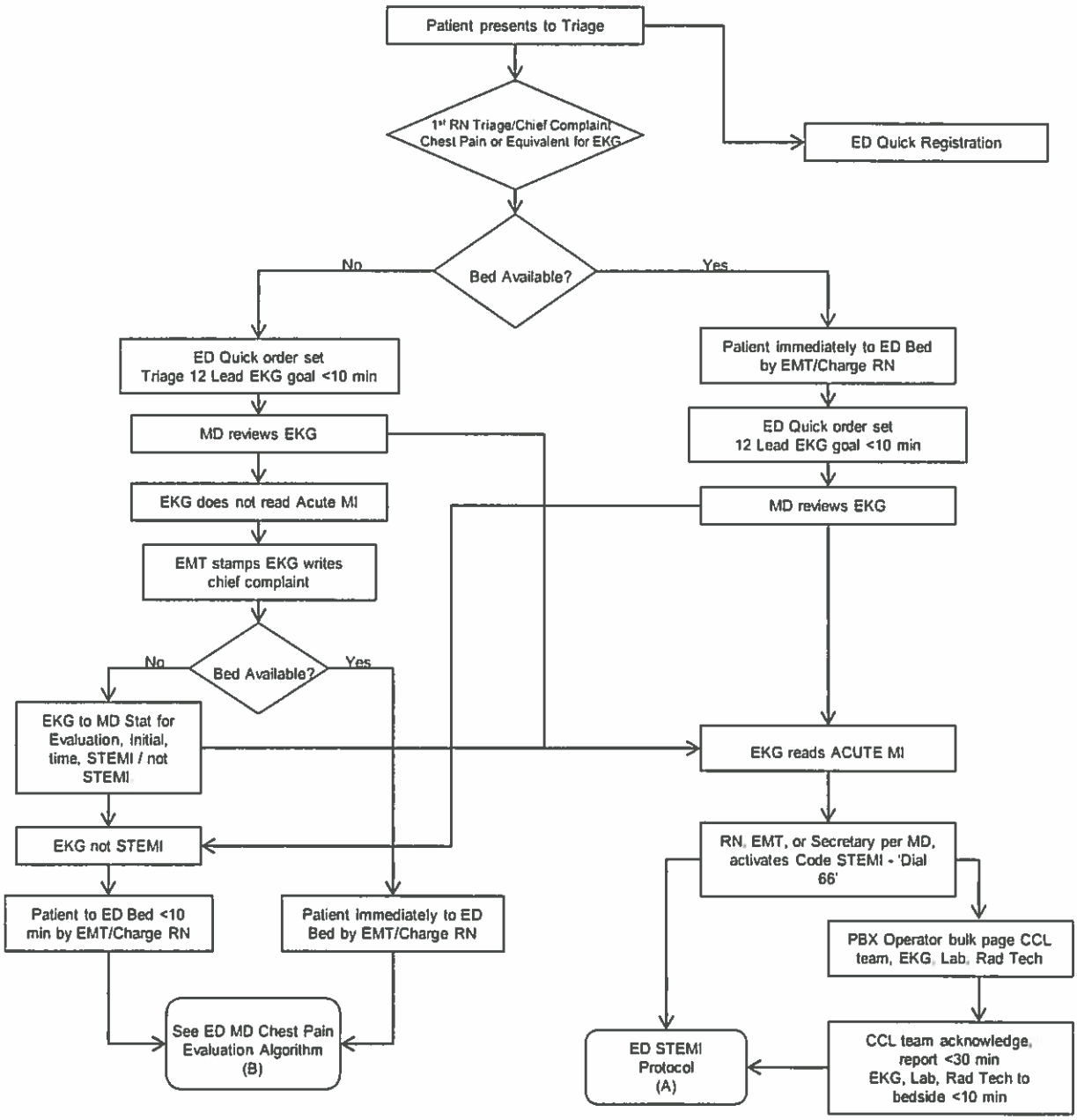
Cardiovascular HealthInstitute
Tri-City Medical Center

This Clinical Practice Guideline was developed to be of assistance to health care professionals by providing guidance and recommendations for particular areas of practice. The Guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The Guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The Guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgment of health care providers and each patient's individual circumstances.

Division of Cardiology
07/13, 10/14, 12/17

ED Walk-In Triage Process – Chest Discomfort & Equivalent

ED Walk-in Triage Process – Chest Discomfort & Equivalent



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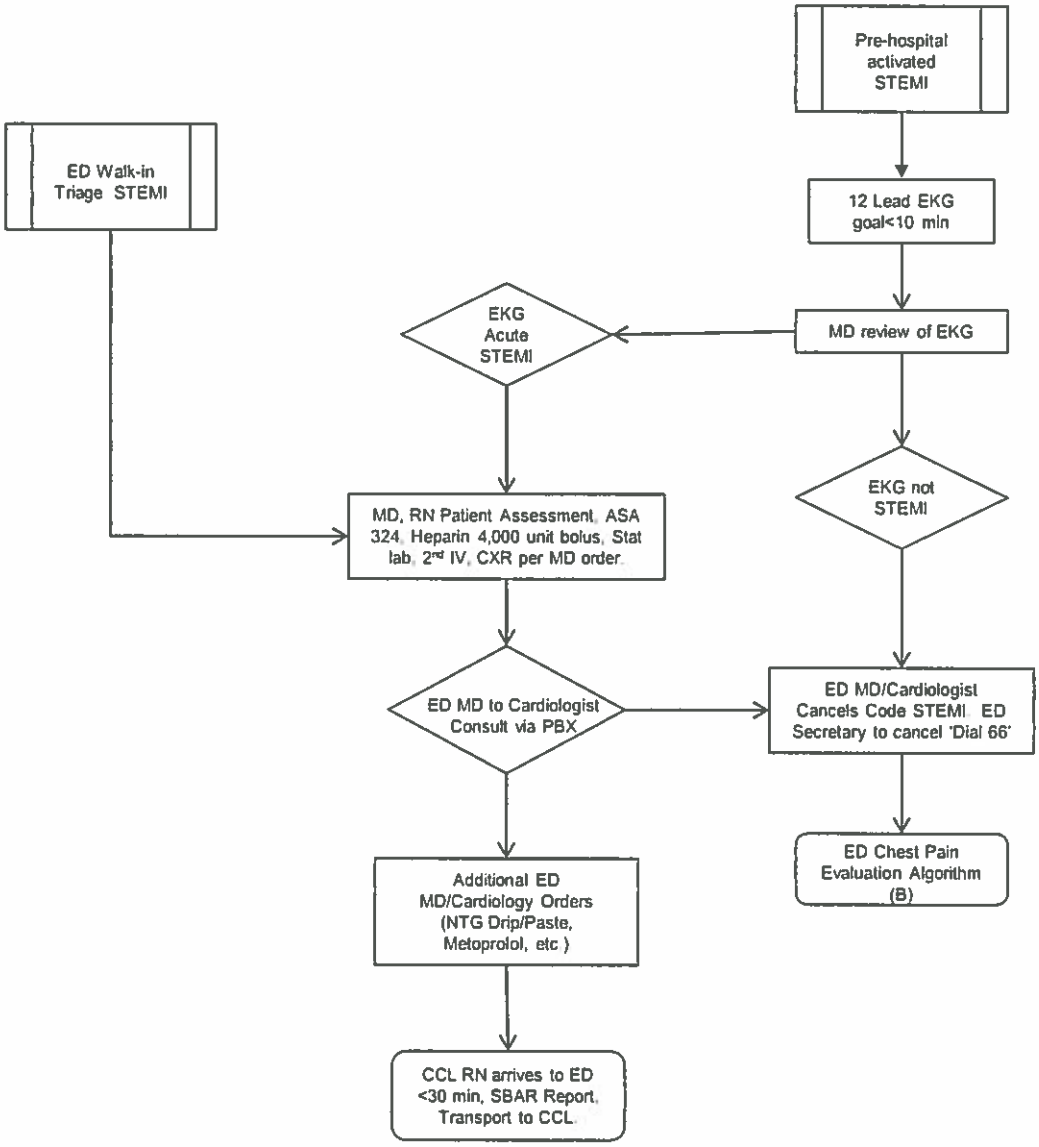
Division of Cardiology
09/12, 11/12, 12/17

ED STEMI Pathway

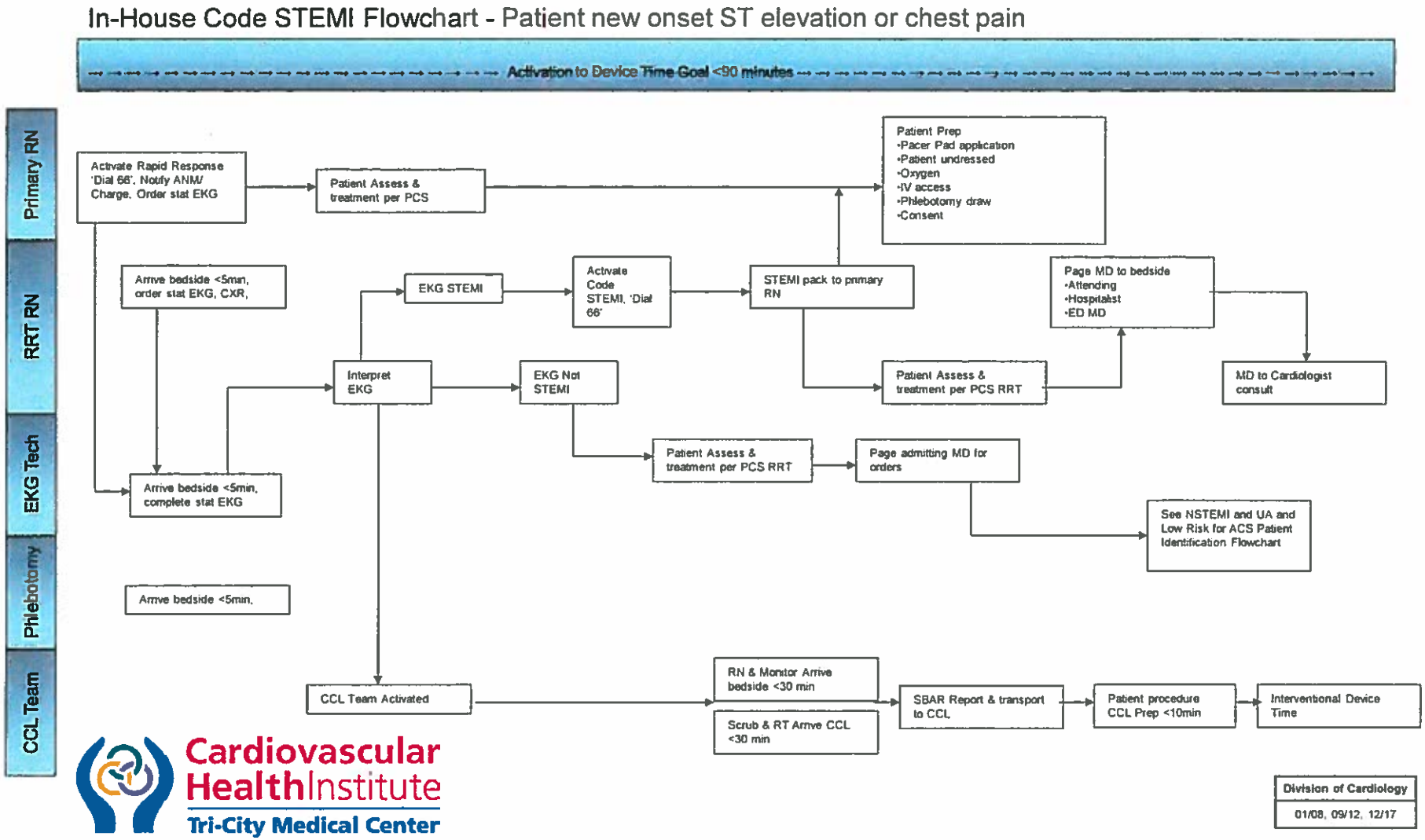
ED STEMI Pathway



Cardiovascular HealthInstitute
Tri-City Medical Center

Division of Cardiology
09/12, 11/12, 12/17

In-House Code STEMI Flowchart



STEMI PACKET INSTRUCTIONS

Goal – First Medical Contact to Intervention <90 minutes

Unit Departure to CCL <30 minutes

Code STEMI Activation

- ☐ Activate Red STEMI Packet, provide to the Unit Secretary or Primary RN.

Float RN / Tech

- ☐ Apply RADIOLUCENT pacer pads; anterior/posterior, cables pointing downward
- ☐ Undress patient completely, place clothing in belongings bag, encourage patient to void
- ☐ Obtain 1st vitals and bilateral BP's; BP q5 - 15 minutes thereafter
- ☐ Place patient on oxygen and insure oxygen tank on gurney is sufficiently full
- ☐ Make sure triple channel pump & portable defibrillator is available in room
- ☐ Complete patient belongings list and home medication list
- ☐ Shave patient's groin for procedure above knee to umbilicus both sides

Primary RN

- ☐ IV – 2 large bore (1 in left arm preferred), use extension tubing - Draw blood when starting IV (if possible)
  1) One red top, 2) One blue top, 3) One green top, 4) One small purple, 5) One large purple
- ☐ Medications: 1) Heparin bolus – NO drip (per physician order)
  2) Aspirin (ASA) (per physician order)
  3) Metoprolol (per physician order)
- ☐ Place preprinted consent on chart with patient sticker ready to be signed

If no pre-printed consent is available, prepare as follows: "Cardiac catheterization with contrast and possible percutaneous transluminal coronary angioplasty with stent and possible sedation"

- ☐ Provide Red STEMI Packet to Cath Lab RN

Cath Lab

- ☐ Provide Red STEMI Packet to Cath Lab Tech for completion

Packet includes:
- STEMI Checklist
- Preprinted Consent

NOT A PART OF THE MEDICAL RECORD

Division of Cardiology
07/12, 12/17

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CONSTAVAC®, REINFUSION OF BLOOD**
Purpose:	To provide guidelines for the RN regarding reinfusion of autologous blood via the constavac reinfusion system.
Supportive Data:	The reinfusion of collected autologous whole blood carries specific contraindications and requires specific practices
Equipment:	1. PPE 2. Constavac reinfusion system

A. **POLICY:**

1. The operating surgeon shall identify patients who are candidates for the Constavac reinfusion blood collection system in the operating room.
2. A physician's/**Allied Health Professional's (AHP)** order is required for blood reinfusion.
3. No reinfusion shall be initiated more than six (6) hours after the initiation of drainage.
4. The reinfusion shall be administered through blood tubing, using a **forty** (40) micro aggregate filter.
5. Blood tubing shall be flushed using only 0.9% NaCl solution. No other solution of medication shall be added to or administered concurrently through the same **intravenous** (IV) tubing.
6. Should the Constavac become contaminated or have a leak, reinfusion shall not be initiated.

B. **PACU AND INPATIENT UNITS:**

1. Upon arrival to the Post Anesthesia Care Unit (PACU) or the patient's room, the **registered nurse** (RN) shall assess the drain for suction and drainage.
2. The Constavac drain shall remain upright at all times.
3. The RN shall verify that the red vacuum indicator is inverted.
   a. If the red vacuum indicator is not inverted, initiate drainage by setting the vacuum dial at number II unless otherwise indicated by the physician/**AHP**.
4. The RN shall note the type and amount of drainage in Cerner with each vital sign.
5. When the drainage amount has reached 300 - 400 mL, the RN shall begin the first reinfusion of autologous blood.

C. **PROCEDURE:**

1. Initiating first reinfusion:
   a. Uncoil the blood bag and tubing. Hold the blood bag tubing so that it forms a half loop at the base of the reservoir while the bag is below the level of the reservoir.
   b. Fully depress and hold down the release lever on top of the Constavac unit to transfer blood into the blood bag.
      i. 75 - 100 mL of blood will automatically remain in the reservoir.
   c. When transfer is complete, release the lever and use slide clamp to clamp off the blood bag tubing as close to the blood bag as possible.
   d. Once the lever is released, the red vacuum indicator will become inverted and regain constant negative pressure.
   e. Reinfuse utilizing the standard blood administration tubing set and a **forty** (40) micro aggregate blood filter.
   f. Record the time and amount of blood reinfused in Cerner.
   g. Repeat the above process for further reinfusion when the drainage has reached 200 - 300 mL of blood within the six (6) hour time frame.
2. Wound Drainage:
   a. Six (6) hours after initiation of system discontinue blood tubing and reinfusion portion of the Constavac system.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/12, 08/17	12/12, 09/17	12/20, 09/17	12/17	n/a	01/18	02/13, 02/18	02/13

b. Cut the reinfusion tubing approximately **two (2)** inches from the reservoir, discard bag and blood tubing in a red bio hazardous waste bag and cap the end of the tubing using red cap.
c. Measure wound drainage output directly on the reservoir. Mark the time and amount of output on the canister and record in Cerner.

3. Change the reservoir when the air filter becomes saturated, as necessary to maintain system, or when canister is ¾ ~~s~~ full.
   a. Using aseptic technique, clamp evacuator tubing on each side of the quick connect.
   b. Twist quick connect to separate evacuator tubing from the canister.
   c. Discard Y-connector portion of evacuator tube from the new unit.
   d. Attach quick connect of the new unit to quick connect of evacuator tube attached to the patient.
   e. Set the vacuum level at prescribed setting, and unclamp tubing.
   f. Ensure that vacuum indicator is inverted.

D. **REFERENCE(S):**

1. CBC II Constavac Blood Conservation System Operating Instructions. (2011) Retrieved November 2012 from www.stryker.com/stellent/gourp/public/documents/web_content/141262.pdf.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT:** Duty to Warn Potential Victims

REVISION DATE(S):

Department Approval:	**10/17**
Clinical Policies and Procedures Approval:	**10/17**
Nurse Executive Committee Approval:	**10/17**
Division of Psychiatry:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**11/17**
Professional Affairs Committee Approval:	**02/18**
Board of Directors Approval:	

A. **PURPOSE:**
   1. To provide guidelines for the handling of threats of potential harm to an identified person.

B. **POLICY:**
   1. A therapist is responsible to warn, or take other appropriate action to protect, the foreseeable victim of a patient's violent tendencies, if a psychotherapist - patient relationship exists, the psychotherapist knows or should have known that the patient is dangerous, and there is a foreseeable victim of the patient's violent tendencies.
   2. In carrying out this duty, the therapist may need to release confidential patient information.
      a. The **California** Courts held that in such situations, the justification for protecting the confidentiality of the patient information (e.g. to encourage patients to seek treatment and fully disclose information to their psychotherapist) is outweighed by the need to warn potential victims so that they can protect themselves.
      b. In addition, legislation was enacted to provide for the release of confidential information when a therapist believes that a patient presents a serious danger of violence to a reasonably foreseeable victim or victims.
   3. The duty to warn arises not only when a patient expresses specific threats against an identifiable victim, but also when others report the threat to the treatment providers.
      a. If a family member or significant other reports such threats to the therapist, the therapist is obligated to follow reporting procedures.
   4. A therapist may be liable for injuries a third person suffers as a result of a patient's violent acts, if the therapist fails to carry out his duty to appropriately evaluate the patient and identify his or her dangerous propensities.
   5. In order to carry out the duty to warn, the therapist must strike a careful balance between protecting the confidentiality of the patient's disclosures and protecting the potential victim.
      a. Initially, the therapist should gather relevant information regarding the patient, including that pertaining to the patient's past treatment history.
      b. The therapist's decision regarding whether it is likely that the patient will carry out his or her threats, or that the patient presents a danger to another person, should be documented along with the information that led to the decision. This will provide important protection against claims that the therapist should not have released the information (if a warning is given) or that the therapist did not carry out his duty to warn the potential victim (if a warning was not given).
      c. If a warning is given, the therapist should disclose only that information which is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect him or herself. A general indication to a person that

perhaps the person should avoid the patient may not be sufficient warning.

d. Also, depending upon the patient's therapeutic condition and possible reaction, it is advisable to inform the patient that the warning will be given.

6. Situations in which a therapist may have a duty to warn a potential victim usually involve difficult decisions. The treatment team, including the physician/Allied Health Professional (AHP), needs to be informed regarding any such reports. An ethical or legal consultation may also be obtained to guide the team with their decision.

C. **PROCEDURE:**

1. When a threat is made, the therapist must notify the police department in the city in which the threat occurred. The following information is conveyed:
   a. Patient name
   b. Patient address
   c. Patient date of birth
   d. Patient gender and race
   e. Patient physical description
   f. Patient social security number and driver's license number (if available)
2. The police department in the city in which the intended victim resides must also be notified.
   a. Report must include information stated above, as well as, the name of the intended victim and address, if known.
3. The therapist must make all reasonable attempts to notify the intended victim of the patient's threats (i.e. contacts or registered mail).
4. The Manager and physician/AHP are notified of any such occurrence and a Quality Review Report is filed.
5. Documentation of the threat and action taken is written in the medical record.

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

1. Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396
2. Behavioral Health Services: Inpatient Unit Admission Criteria
3. Duty to Warn Letter – Sample

E. **REFERENCE(S):**

1. CA Civil Code, Section 43.92
2. CA Evidence Codes, 1010, 1024
3. CA Welfare & Institutions Code, Sections 5328, 8105 (c)
4. Ewing v Goldstein (2004) 120 Cal. App. 4th 807
5. Ewing v Northridge Hospital (2004) 120 Cal.App.4th 1289
6. HIPAA Privacy Regulations, 145 C.F.R. 164.512 (j)(l)(l)], Department Health & Human Services
7. Tarasoff v. Regents of the University of California (1976) 17 Cal. 3rd1425

Duty to Warn Letter – Sample

Tri-City Medical Center-Behavioral Health Unit
4002 Vista Way, Vista, CA 92056

To: Mr. Xxx
CC: Oceanside Police Dept.
3855 Mission Ave
Oceanside, CA 92054

CC: Oceanside Police Dept
3855 Mission Ave
Oceanside Ca 92054

April 13, 2010

Dear Mr. Xxx,

This letter is a written notice required by California law Civil Code 43.92 (commonly known as a "Tarasoff report") that mandates a psychotherapist has the "duty to protect" by making reasonable efforts to communicate with potential victims and to law enforcement, when in the course of performing work related functions a patient has communicated a "serious threat of physical violence against a reasonably identified victim or victims". This letter is to inform you that your student, (Princess) has made threats towards you (to harm you for giving her a failing grade in Biology) I recommend that you take the necessary precautions to protect yourself and anyone else that could be in possible danger due to this threat. In addition to notifying you, I have also notified Oceanside Police Department and spoke to Officer Chalayne, Badge #1268 and reported this incident and was given incident # 0900124874. I have also contacted (add same info as above if you contacted another law enforcement agency here) to report the incident as you live in their jurisdiction. Please contact the respective police department if you have any questions regarding the police reports.

Respectfully,

Xxx xxx , ~~RN~~**LCSW, LCMFT**

Tri-City Medical Center, BHU
760- 940-7396

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 08/05	**SUBJECT:** Minors Attempting to Leave Without a Parent/ ~~Registered Domestic Partner~~/Legal Guardian
REVISION DATE: 07/08, 05/11	**POLICY NUMBER:** VI.K

Department Approval:	10/17
Clinical Policies & Procedures Committee Approval:	~~03/11~~10/17
Nursing Executive Council Approval:	~~03/11~~10/17
Medical Executive Committee Approval:	~~04/11~~11/17
Professional Affairs Committee Approval:	~~05/11~~02/18
Board of Directors Approval:	05/11

A. **PURPOSE:**

1. ~~To provide a direction in cases where~~safety net for minors ~~are attempting to leave~~**Direction for healthcare providers at** Tri-City ~~Medical Center~~**Healthcare District (TCHD) when minors are leaving** without being accompanied by a ~~P~~parent~~/Registered Domestic Partner~~ or ~~L~~legal ~~G~~guardian.

B. **DEFINITION(S):**

1. Minor: a person younger than **eighteen** (18) years of age**, in the state of California.** ~~who may not consent to his or her medical treatment~~.
   ~~a. Refer to Administrative policy 360 *Consent for Minors.*~~
2. **Authorized individual: A parent, legal guardian or other person with the authority to consent to medical treatment for ~~the~~ a minor pursuant to ~~e~~r California Hospital Association (CHA) Consent Manual (2017), Chapter 4.**

C. **POLICY:**

1. **A minor shall be discharged to an authorized individual.**
2. ~~1.~~ If a minor is attempting to leave ~~Tri-City Medical Center~~**TCHD** without an **authorized ~~individual~~ adult**~~parent or legal guardian~~ present and the ~~P~~**p**hysician **or /Allied Health Professional (AHP)** deems it is not in the best interest of the minor to be discharged, the following actions ~~shall~~ **must** be taken:
   a. Verbal discussion of the risks of a premature discharge.
   b. Clear instructions to remain on the unit**/department.**
   c. Notification of hospital security and law enforcement. If the minor becomes combative, appropriate actions to detain the minor shall ensue, keeping patient and staff safety at the forefront.
   ~~c. Get signature for Release~~
3. If a minor is attempting to leave the facility without an **~~individual~~adult** ~~parent or legal guardian~~ present~~,~~ and the ~~P~~**p**hysician **or /AHP** releases the minor, the **authorized ~~individual~~adult** ~~parent/registered domestic partner/legal guardian~~ shall be contacted to pick up the minor.
4. **If the authorized ~~individual~~adult is not available to pick-up the minor in a reasonable period of time, consult with the Risk Manager to determine if the minor can be released to one that is authorized by the parent or legal guardian.**

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

~~2.~~1. **Patient Care Services: Consent for Minors Policy**

~~D.~~E. **REFERENCE(S):**

1. ~~2010~~-CHA Consent Manual **(2017), Chapter 4** ~~Title XXII~~
2. ~~Minors quick reference poster:~~ ~~http://www.calhealth.org/Download/2005minors.pdf~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/05	**SUBJECT:** Privacy Code
REVISION DATE: 08/07, 07/10, 11/10, 01/16	**POLICY NUMBER:** IV.CC

Department Approval:	09/17
Clinical Policies & Procedures Committee Approval:	~~11/15~~09/17~~11~~11/17
Nursing Executive Committee Approval:	~~12/15~~12/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~01/16~~02/18
Board of Directors Approval:	01/16

A. **DEFINITION(S):**

1. Privacy Code: a code or word selected by the patient~~/patient's representative~~ **or durable power of attorney** that contains a minimum of four (4) characters.

B. **PURPOSE:**

~~2.~~1. A privacy code is used by **staff**~~nursing~~ to identify patient **designee**~~representatives~~ who may receive healthcare information **when an individual is requesting protected health information (PHI) via the telephone or in person.**

- **a. Exclusions:**
  - i. Women's and Children's Services ~~are excluded from this policy~~ for infant security and privacy considerations. **For infant security and safety see department specific:**
    - 1) **Patient Care Services Procedure: Identification of Newborn**
    - 2) **Women and Newborn Services Policy: Infant Safety and Security**
    - ~~a.~~3) **Women and Newborn Services NICU Policy: Visitation in the NICU**
    - ~~3. A privacy code shall be established prior to mother's discharge for the newborn infant requiring continued care/observation in the Well Born Nursery (i.e., phototherapy).~~
  - ii. **Behavioral Health Services patients - for privacy information for behavioral health patients see:**
    - 1) **Administrative Policy Rights to Request Privacy Protection for Protected Health Information**
    - 2) **Behavioral Health Policy: Confidentiality**
    - 3) **Behavioral Health Policy: Release of Information**
  - iii. **Justice Involved Patients**

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

1. The patient~~/patient's representative~~ **or durable power of attorney** shall ~~be offered the option of~~ selecting a privacy code upon **each** admission to Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) as inpatient, ~~or~~ observation status patient **or surgical patient** ~~within 24 hours of admission~~. The patient shall be asked to **update their**~~select a~~ privacy **information**~~code~~ for each new admission; this can be ~~a~~ new **information**~~code~~ or remain the same from a previous admission.
   - **a. In the Emergency Department/Outpatient Areas:**

i. **When the patient or durable power of attorney presents to the department, staff will obtain verbal consent to discuss care/condition with person accompanying patient.**

ii. **When receiving telephone requests PHI, staff will obtain verbal consent from the patient to discuss care/condition with person requesting information via the telephone**

~~a.~~**1) Document name of person given PHI in electronic health record.**

2. If the patient is unable to select a privacy code **because of the patient's incapacity or emergency circumstance, disclosure may be made if the staff~~provider~~, in the exercise of professional judgement, determines the disclosure is in the best interest of the patient and discloses only the PHI directly relevant to the person's involvement with the patient's health care, or needed for notification purposes** ~~and the patient's representative (or closest available relative) is not available upon admission,~~

~~b.~~a. A~~a~~ reasonable effort shall be made to ~~obtain complete~~ **have the patient or durable power of attorney select** a privacy code ~~form~~ during the hospital stay **as soon as the patient is able to communicate.**

3. The Registered Nurse completing the admission process **for inpatient, observation status or surgery patients** shall ensure the privacy code **information has been addressed** ~~form is completedoption has been offered~~.

a. **Selection Process**

~~2.~~i. Once the privacy code has been selected, the code shall be entered into Cerner ~~under Nurse Orderable, "Privacy Code"~~.

~~a.~~ii. The patient~~/patient's representative~~ shall be instructed to provide the privacy code to **the designated** family members/caregivers involved in their care. The code authorizes those family members/caregivers to receive information **directly relevant to the person's involvement with the patient's health care or needed for notification purposes** ~~from TCMC regarding the patient's condition~~.

b. **Declination Process**

i. If the patient~~/patient's representative~~ **or durable power of attorney** declines **to select**~~the option of~~ a privacy code, document the declination in the medical record.

ii. **The patient or durable power of attorney will be educated:**

1) **No information related to their care will be given family or caregivers, either in person or via the telephone.**

~~3.~~2) **They will be responsible for updating family or caregivers regarding their care/condition.**

4. When the **staff**~~healthcare provider~~ receives a request for information on a patient, the staff shall ask who is calling, their relationship to the patient, and the privacy code.

a. Once the privacy code is verified, the staff may give the **designated** family member/caregiver the minimum information necessary regarding the plan of care for the patient.

5. ~~During urgent or emergency situations when there is not time to obtain the privacy code, the TCMC staff shall verify with patient, family member, and/or patient's representative who can receive information.~~

D. FORM(S):

~~6.~~1. **Privacy Code Form**

E. RELATED DOCUMENT(S):

1. **Administrative Policy: Rights to Request Privacy Protection for Protected Health Information**
2. **Behavioral Health Policy: Confidentiality**
3. **Behavioral Health Policy: Release of Information**
4. **Patient Care Services Procedure: Identification of Newborn**

5. **Women and Newborn Services NICU Policy: Visitation in the NICU**
~~7.~~6. **Women and Newborn Services Policy: Infant Safety and Security**

Privacy Code Form

Upon each admission to Tri-City Medical Center I, the patient, shall be asked to select a four (4)-digit Privacy Code or common word.

A Privacy Code is a 4-digit code or word to be utilized by the individuals I have designated below that authorizes Tri-City Medical Center to verbally provide information on my care/condition during this hospitalization. This protects my privacy but still gives my family members/caregivers access to information relevant to the person's involvement to my healthcare or needed for notification purposes.

I, the patient, will provide the code to the designated individuals listed below. It shall be required when they call the Medical Center requesting information regarding my care/condition.

☐ I select the following Privacy Code or word (minimum 4-characters)

CODE: _____

I designate the following individuals to receive information on my care/condition:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ I decline to select a privacy code. I do not authorize Tri-City Medical Center to share information regarding my care/condition with individuals requesting information about this hospitalization.

_____ _____ ___/___/___ ___:___AM/PM
Name: Patient/Durable Power of Attorney (DPOA) Signature: Patient/DPOA Date Time

Patient verbally provided the code but is unable to sign the form, state reason: _____

_____ _____ ___/___/___ ___:___AM/PM

_____ _____ ___/___/___ ___:___AM/PM
Witness – TCHD Representative (print name) Signature Date Time

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI

☐ Face-to-face. ☐ I have accurately and completely reviewed this document in patient preferred language with:

_____ ☐ Patient

_____ _____ ___/___/___ ___:___AM/PM
Interpreter ID number or Name Interpreter Signature (if present) Date Time

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

☐ Patient unable to provide privacy code. State reason: _____

_____ _____ ___/___/___ ___:___AM/PM
Witness – TCHD Representative (print name) Signature Date Time

Please place this completed form in the Inpatient chart (behind the Admission Tab) for all patients admitted to the nursing unit. This document is part of the patient's PERMANENT record.
Send to Medical Records with discharged record

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

Page 1 of 1

Privacy Code

Affix Patient Label

8700-1094
Revised (11/17)

Authorization
White – Chart Yellow – Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES~~POLICY MANUAL~~

ISSUE DATE: 03/02	**SUBJECT:** Special Order Durable Medical Equipment and Specialty Beds
REVISION DATE: 02/04, 11/06, 07/09, 11/12	**POLICY NUMBER:** IV.S

Department Approval:	11/17
Clinical Policies & Procedures Committee Approval:	~~12/12~~11/17
Nurse Executive Council Approval:	~~12/12~~12/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/13~~01/18
Professional Affairs Committee Approval:	~~02/13~~02/18
Board of Directors Approval:	02/13

A. **DEFINITION(S):**

1. Durable Medical Equipment includes all special order orthotic devices and specialty beds from outside vendors.

B. **POLICY FOR INPATIENTS:**

~~2.~~1. **Specialty Beds/Mattresses:**

a. **Do not require a**~~A~~ physician's**/Allied Health Professional's (AHP)** order ~~is required for special order durable medical equipment~~.

b. ~~The~~**A** order will be entered into Cerner for the specific item needed, i.e. **bed** **M**mattresses~~, brace, sling~~.

~~i. Physician ordering~~

~~ii.~~i. Order information – details

~~iii.~~ii. Special Instructions - Company preference if specified

~~c. All specialty beds and mattresses need an authorization number which is provided by the wound nurse during normal weekdays, or the Administrative Supervisor on off hours and weekends~~

~~d.~~**c.** Sterile Processing Department (SPD) will notify the ordering department of ~~supplying company and~~ delivery time**, including any anticipate delays**

~~e.~~**d.** SPD Manager will review and approve electronic invoice.

~~f.~~**e.** The Biomedical Department will perform a safety check and will retain the safety check paperwork.

f. SPD shall obtain the receipt.

g. **Notify SPD when bed/mattress is no longer required.**

~~3. Only pre-approved vendors for orthotic devices and specialty beds have standing purchase orders. If they are not on the pre-approved list, requests for other vendors will have to be sent to Materials Management and could result in a delay of the order.~~

C. **DURABLE MEDICAL EQUIPMENT UPON DISCHARGE:**

1. **Case Management to facilitate ordering of devices:**

a. **Neonatal patients:**

i. **An order must be received from the Neonatal Intensive Care Unit (NICU) physician, pediatrician or ~~Allied Health Professional (AHP)~~.**

ii. **A documented reason for prescribing the equipment shall be included in the order.**

iii. **Medical needs will be documented.**

iv. **The Certificate of Medical Necessity for Apnea Monitors form is completed for Medi-Cal patients.**
v. **The case manager/social worker will arrange for the equipment to be delivered to the hospital unit prior to the infant's discharge.**
vi. **A representative from the DME agency will provide education on use of the equipment to the caregivers of the infant.**
~~i.~~vii. **The pediatrician will follow the infant's progress.**

Tri-City Medical Center
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: NEW **SUBJECT:** Decision Making for Unrepresented Patients

REVISION DATE(S): NEW **POLICY NUMBER:** 8610-397

Department Approval: 07/17
Administrative Policies and Procedures Committee Approval: 07/17
Medical Executive Committee Approval: 08/17
Professional Affairs Committee Approval: 02/18
Board of Directors Approval:

A. **POLICY:**

1. Preamble:
   a. ~~This~~ Tri-City Medical Center policy provides a process for health care professionals to make medical treatment decisions on behalf of an incapacitated patient who lacks a surrogate decision maker and when there is no known family member who is **alive,** willing ~~and~~ **or** able to make medical treatment decisions on behalf of the patient. Despite their incapacity, such "unrepresented" patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency within the institutional setting of California's general acute care hospitals on the process to make medical treatment decisions for unrepresented patients.
   b. Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences, must be made in the patient's best interest and taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the institution~~s~~, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.
   c. This policy is procedural in nature and applies to most medical decisions for which informed consent **by the patient** is ~~usually~~ required. This policy is meant to support the institution's underlying consent policy.
   d. Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing the provision, withdrawing, or withholding of treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions **absent assignment of a conservator or public guardian.**
2. When Use of This Policy is Appropriate:
   a. This policy may be used when all of the following conditions are met:
      i. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) ~~to lack~~**lacking** capacity to make health care decisions. Capacity means a patient's ability to understand the nature

and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decisions. Conditions ~~for which~~ **with** psychiatric or psychological treatment ~~may be required~~ do not, in and of themselves, constitute a lack of capacity to make health care decisions.

ii. No agent, conservator, or guardian has been designated to act on behalf of the patient.

iii. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision maker.

iv. No surrogate decision maker or family member can be located who is reasonably available**, or does not exist,** and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

3. This policy does not address the criteria for determining and appointing an appropriate decision maker when one or more are available and willing to serve. ~~And finally~~**Additionally**, this policy is not meant to be applied in emergency medical situations.

B. **PROCEDURE:**

1. When use of this policy is appropriate, as outlined above, medical decisions will be made by a multi-disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient.
2. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, chair or vice-chair of the ethics committee, **legal counsel,** non-medical (community) member of the ethics committee or other appropriate committee and, if available and appropriate, consulting clinicians and pastoral care staff. It is very important to include on the multi-disciplinary team a person who will represent the patient's interests.
3. Some patients may have a family member or friend who is unable or unwilling to take full responsibility for making health care decisions on behalf of the patient, but who is willing to serve as part of this team. If no such person exists, the hospital may consider including an ombudsman, patient advocate, bioethicist, community member, **pastoral care,** or other person whose role is to protect the patients' interests. If it is not practicable to include such a person on the ~~IDT~~**multi-disciplinary team** in a particular case, document the reasons therefore.
4. In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:
   a. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.
   b. Determine appropriate goals of care by weighing the following considerations:
      i. Patient's previously-expressed wishes, if any and to the extent known
      ii. Relief of suffering and pain
      iii. Preservation or improvement of function
      iv. Recovery of cognitive functions
      v. Quality and extent of life sustained
      vi. Degree of intrusiveness, risk or discomfort of treatment
      vii. Cultural or religious beliefs, to the extent known
      ~~vii.~~**viii. Patient's current mental status**
   c. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.
   d. Notify the patient that, **once patient does not lack capacity**:
      i. He or she has been determined incapacitated;
      ii. It has been determined that he or she lacks a surrogate decision maker;

iii. Medical intervention has been prescribed; and
iv. He or she has the opportunity to seek judicial review of the above determinations.

~~e. A sample notification form is attached. Health care providers should modify it to fit their circumstances.~~

e. If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician.

f. **Periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.**

g. Limit end of life decisions (such as withholding or withdrawing life-sustaining treatment, ordering hospice care) to patients who are terminally ill, comatose, or in a persistent vegetative state.

5. Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.

6. Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.~~6,7~~ However, this policy shall not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts; specific laws apply to these procedures.

7. The multi-disciplinary team must assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

8. Agreement on Treatment:
   a. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.
   b. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.

9. Disagreement on Treatment:
   a. If the members of the multi-disciplinary team disagree about the care plan, the ethics committee, ethics resource expert(s) or other resource experts will meet with the team to explore their disagreement and facilitate resolution.
   b. If agreement is reached either to provide or to forgo treatment, the decision of the multi-disciplinary team then becomes final.
   c. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved. Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.
   d. In all cases, appropriate pain relief and other palliative care shall be continued.

~~10. Exceptional Circumstances:~~
   ~~a. Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:~~
      ~~i. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.~~
      ~~ii. The patient's condition was created or aggravated by a medical accident.~~

~~iii. The patient is pregnant.~~
~~iv. The patient is a parent with sole custody or responsibility for support of a minor child.~~

~~11.~~**10.** Documentation:

a. Signed, dated and timed medical record progress notes will be written **by the Social Work Case Manager** for the following:

i. The **due diligence** findings **from the multi-disciplinary team** used to conclude that the patient lacks medical decision-making capacity.

~~i.~~1) **If the multi-disciplinary team concludes the due diligence findings are not complete, documentation of the required items for the patient to be considered unrepresented.**

ii. The finding that there is no advance health care directive, no conservator, guardian or other available decision maker, and no health care instructions in the patient's medical record or other available sources.

iii. The attempts made to locate surrogate decision makers and/or family members and the results of those attempts.

iv. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment.

v. Any information from the ethics committee or other consult, should it be convened.

C. **REFERENCE(S):**

1. California Health and Safety Code Section 1418.8
2. California Probate Code Section 4735
3. California Probate Code Section 4650(c)
4. California Probate Code Section 4717
5. California Probate Code Section 4736
6. California Probate Code Section 4617
7. California Probate Code Section 4683
8. California Probate Code Section 4652
9. Health and Safety Code Sections 7100 (disposition of remains), 7113 (autopsy), and 7150 *et seq.* (anatomical gift).
10. California Probate Code Section 4734

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE:	**09/91**	**SUBJECT:**	**Designation of Authority In Temporary and Voluntary Absences of Chief Executive Officer**
REVISION DATE:	**09/91; 10/97; 5/02; 12/02; 01/09; 128/10**	**POLICY NUMBER:**	**8610-233**

Department Approval:	**~~04/17~~05/~~17~~11/17**
Administrative Policies and Procedures Committee Approval:	**~~09/10~~-05/~~17~~11/17**
~~**Finance, Operations and Planning Committee Approval:**~~	~~**10/10**~~
Professional Affairs Committee Approval:	**~~11/10~~02/18**
Board of Directors Approval:	**12/10**

A. **PURPOSE:**

1. To assure continuous, effective and efficient hospital operations.

B. **POLICY:**

1. Responsibility and Designation of Authority
   - a. During the **voluntary and/or temporary** absence **(e.g. vacation, temporary illness)** of the President/Chief Executive Officer (CEO), **a C-Suite Officer shall be designated by the CEO** ~~the Chief Operating Officer (COO) shall~~ **to** be in charge of the Medical Center.
   - ~~a. An immediate Vacancy, unanticipated short-term or long-term caused by the death or extended disability or incapacitation of the CEO is covered by Board Policy 167-037, Chief Executive Officer and Chief Compliance Officer Succession Planning Policy~~
   - ~~b. In the event that the CEO and COO are absent, the Chief Nurse Executive (CNE) shall be in charge of the Medical Center.~~
     ~~In the event that the CEO, COO and CNE are all absent, the Chief Financial Officer (CFO) shall be in charge of the Medical Center~~

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

1. **Board Policy 167-037: Chief Executive Officer ~~and Chief Compliance Officer~~ Succession Planning Policy**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

DELETE: Combining with Outpatient BHU Duty to Warn Potential Victims policy and changing it to the Patient Care Services manual.

SUBJECT: Duty to Warn Potential Victims
POLICY NUMBER: 521

ISSUE DATE: 3/08
REVISION DATE(S): 8/09, 3/13, 6/16

Department Approval:	10/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/18
Professional Affairs Committee Approval:	02/18
Board of Directors Approval:	

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

~~1. To provide guidelines for handling threats of potential harm to an identified person.~~

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

~~1. A therapist is responsible to warn or take other appropriate action to protect the foreseeable victim of a patient's violent tendencies IF, (a) a therapist-patient relationship exists, (b) the therapist knows or should have known that the patient is dangerous, and (c) there is a foreseeable victim of the patient's violent tendencies. In carrying out this duty the therapist may need to release confidential information about the patient. The Court holds that in such situations the justification for protecting the confidentiality of the patient information is outweighed by the need to warn potential victims so that they can protect themselves. In addition, legislation has been enacted to provide for the release of confidential information when a therapist believes that a patient presents a serious danger of violence to a reasonably foreseeable victim or victims.~~

~~The duty to warn arises not only when a patient expresses specific threats against an identifiable victim but also if a patient's previous history indicates that he or she would likely direct violence against a person who can be identified. In addition, if a family member or significant other reports such threats to the therapist, the therapist is obligated to follow reporting procedures. A therapist may be liable for injuries a third person suffers as a result of a patient's violent acts if the therapist fails to carry out his duty to appropriately evaluate the patient and identify his or her dangerous propensities.~~

~~In order to carry out the duty to warn the therapist must strike a careful balance between protecting the confidentiality of the patient disclosures and protecting the potential victim. Initially the therapist should gather relevant information regarding the patient including that pertaining to the patient's past treatment history. The therapist's decision regarding whether it is likely that the patient will carry out his or her threats, or that the patient presents a danger to another person should be documented along with the information that led to the decision.~~

~~This will provide important protection against claims that the therapist should not have released the information (if a warning is given) or that the therapist did not carry out his duty to warn the potential victim (if a warning is not given).~~

If a warning is given the therapist should disclose only that information that is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect him or herself. A general indication to a person that perhaps the person should avoid the patient may not be sufficient warning. Also, depending on the patient's condition and possible reaction, it is advisable to inform the patient that the warning will be given.

Situations in which a therapist may have a duty to warn a potential victim usually involve difficult decisions. The treatment team, including the physician, needs to be informed regarding any such reports.

C. PROCEDURE:

1. When a threat is made the therapist must notify the police department in the city in which the threat occurred. The following information is conveyed:
   a. Patient name
   b. Patient address
   c. Patient date of birth
   d. Patient gender and race
   e. Patient physical description, and
   f. Patient social security number and driver's license numbers

2. The police department in the city in which the intended victim resides must also be notified. The report must include information stated above as well as the name of the intended victim and address, if known.

3. The therapist must make all reasonable attempts to notify the intended victim of the patient's threats including telephone contact and registered mail.

4. Documentation of the threat and the action that was taken must be written in a clinical note in the patient's medical record.

5. Tarasoff Instructions:
   a. If you are the recipient of information from a patient (or a family member of the patient) that they want to kill or harm someone else, you have a duty to protect that person via telephone and in writing and to notify law enforcement.
   b. A tarasoff situation is defined as a "credible threat of serious violence towards an identifiable victim".
   c. Once you have determined that there is a credible threat, you should try to obtain the potential victim's name, address, and a contact number for them.
   d. Call Police Department to report the Tarasoff; they will usually take the information over the phone.
      i. Please obtain the officer's name, badge number and the incident number.
      ii. If the potential victim lives in another city, you need to call the law enforcement agency that serves that area and report the same information and obtain the same information from that officer as you did for the other law enforcement agency.
      iii. You should then contact the potential victims and relay the information that lead you to believe they are in danger and warn them to take appropriate measures to protect themselves.
      iv. Give them the names, phone numbers, and incident numbers from the law enforcement agencies at this time.
      v. Only reveal the information that they need in order to protect themselves; remember that you are breaking confidentiality and only that information needed by the potential victim (who made the threat, how, when, why, etc…, not

confidential information about the patient that is not relevant for these purposes) should be given.

vi. You then need to send a follow-up letter (See Tarasoff Letter Template Attachment), which is available on the (W) Drive in the "Tarasoff Folder" to all parties you have spoken to via registered mail.

vii. Include the incident numbers, phone numbers to the police stations, etc… in your letter to the potential victim.

e. You should keep a copy of the letter to the victim and the law enforcement agencies in the BHL Folder under the (W) Drive, in the Tarasoff Folder with the patient's last name and date.

f. Place a copy of the letters to the victim and law enforcement under the LPS section of the patient's chart. Indicate in your note that you informed the psychiatrist.

g. Make sure to use the "Tarasoff Template" when writing your letter.

h. Indicate on the BHL assessment that you performed a Tarasoff. It is very important to indicate this.

i. Place the letter in unsealed, addressed envelopes on the BHU administrative secretary's desk; and the administrative secretary will mail the letters through registered mail. Please remember to sign the letters as well.

D. ATTACHMENTS

1. Sample Letter Template

~~Tri-City Medical Center-Behavioral Health Unit~~
~~4002 Vista Way, Vista, CA 92056~~

~~To: Mr. Xxx~~
~~CC: Oceanside Police Dept.~~
~~3855 Mission Ave~~
~~Oceanside, CA 92054~~

~~CC: Oceanside Police Dept~~
~~3855 Mission Ave~~
~~Oceanside Ca 92054~~

~~April 13, 2010~~

~~Dear Mr. Xxx,~~

~~This letter is a written notice required by California law Civil Code 43.92 (commonly known as a "Tarasoff report") that mandates a psychotherapist has the "duty to protect" by making reasonable efforts to communicate with potential victims and to law enforcement, when in the course of performing work related functions a patient has communicated a "serious threat of physical violence against a reasonably identified victim or victims". This letter is to inform you that your student, (Princess) has made threats towards you (to harm you for giving her a failing grade in Biology) I recommend that you take the necessary precautions to protect yourself and anyone else that could be in possible danger due to this threat. In addition to notifying you, I have also notified Oceanside Police Department and spoke to Officer Chalayne,Badge #1268 and reported this incident and was given incident # 0900124874. I have also contacted (add same info as above if you contacted another law enforcement agency here) to report the incident as you live in their jurisdiction. Please contact the respective police department if you have any questions regarding the police reports.~~

~~Respectfully,~~

~~Xxx xxx-, RN~~

~~Tri-City Medical Center, BHU~~
~~760-940-7396~~

Tri-City Health Care District
Oceanside, California

Infection Control ~~Policy Manual~~

ISSUE DATE: 09/95

SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan

REVISION DATE: 09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16

Department Approval:	~~10/16~~09/17
Infection Control Committee Approval:	~~10/16~~10/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~10/16~~01/18
Professional Affairs Committee Approval:	~~01/17~~02/18
Board of Directors Approval:	01/17

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:**

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration **(OSHA)** and the Centers for Disease Control and Prevention **(CDC)** have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City ~~Medical Center~~**Healthcare District (TCHD)** to provide care to patients with ATD's with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Source Control Procedures including cough etiquette / respiratory hygiene.
   b. Implementation of an effective triage system and early identification of suspects and active cases
   c. Engineering control measures
   d. Respiratory protection programs
   e. Education and training of employees
   f. Evaluation and treatment of employees exposed to ATD's
   g. Protection of patients, employees and visitors from exposure to ATD's. These include:
      i. Pathogens requiring Airborne Precautions;
         1) Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
         2) Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
         3) Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
         4) Measles (rubeola)/Measles virus
         5) Monkeypox/Monkeypox virus
         6) Novel or unknown pathogens
         7) Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV)
         8) Smallpox (variola)/Varioloa virus (see vaccinia for management of vaccinated persons)

9) Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
    a) Any other disease for which the CDC or CDPH **(California Department of Public Health)**~~HS~~ recommends airborne infection isolation

ii. Diseases requiring Droplet Precautions;
1) Diphtheria/Corynebacterium diphtheriae – pharyngeal
2) Epiglottitis, due to Haemophilus influenzae type b
3) Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A streptococcus
4) Haemophilus influenzae Serotype b (Hib) disease/Haemophilus influenzae serotype b -- infants and children
5) Influenza, human (typical seasonal variations)/influenza viruses
6) Meningitis caused by the following organisms:
    a) Haemophilus influenzae, type b known or suspected
    b) Neisseria meningitidis (meningococcal) known or suspected
7) Meningococcal disease/Neisseria meningitidis: sepsis, pneumonia (see also meningitis)
8) Mumps (infectious parotitis)/Mumps virus
9) Mycoplasmal pneumonia/Mycoplasma pneumoniae
10) Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
11) Pertussis (whooping cough)/Bordetella pertussis
12) Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus~~,~~
13) Pneumonia caused by the following organisms:
    a) Adenovirus
    b) Chlamydia pneumoniae
    c) Mycoplasma pneumoniae
        i) Neisseria meningitidis
    d) Streptococcus pneumoniae (use droplet precautions if evidence of transmission within a patient care unit or facility)
14) Pneumonic plague/Yersinia pestis
15) Rubella virus infection (German measles) (-also see congenital rubella)/Rubella virus
16) Scarlet fever in infants and young children/Group A streptococcus~~,~~
17) Serious invasive disease
18) Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses

iii. Ebola disease: Special considerations: Please refer to Tri City Medical Center **Infection Control** Ebola Plan **Policy** for management of a patient with confirmed or suspected Ebola.
1) Patients are screened at Triage and/or admission to the facility
2) Place patient in negative pressure room C26
3) Patients without symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures must wear extended **personal protective equipment** (PPE) (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. Full face shield with ~~surgical~~ N95 respirator or higher.
4) Patients with symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures or

overall worsening of symptoms: must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. PAPR with full cowl or hood.

5) PAPR with extended PPE **must**~~should~~ be used prior to entering a patient's room with suspected or confirmed Ebola.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATD's and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.
   b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.
   c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATD's and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling ~~health care workers~~**staff** who have active ATD's. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.
   d. Department Directors are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; notification of the Infection Preventionist and Facilities Management when active TB patients or patients with other ATD's are admitted to their area.
   e. Administrative Supervisor is responsible for implementation of the TB control plan in the hospital during the hours of 1600-0800 and on weekends and holidays; and overseeing the reporting and discharge of suspected or confirmed cases of ATD or Tuberculosis on weekends and holidays.
   f. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATD's.
   g. The Director of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATD's.
   h. The Facilities Director is responsible for monitoring and verifying air pressures daily on Airborne Infection Isolation Rooms **(AIIR)**, when in use, and reporting of air changes and air pressures to the Infection control and Safety committees annually.
   i. The Director of Pulmonary Services is responsible for ~~developing,~~**training,** implementing and monitoring **respiratory staffs' adherence to the ATD and TB Control plan** ~~procedures~~ **including protection** for high-hazard procedures.
   j. The Facilities Director is responsible for maintaining and cleaning of portable HEPA

recirculators and providing portable HEPA recirculators to units as needed.

k. Microbiology Supervisor is responsible for the notification of the local health authority according to California and Federal regulations of ATD's and TB.

~~k.~~l. The Employees are responsible for early identification of suspects and active cases of ATD's and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; reporting of cases to the Infection Preventionist and/or the Public Health Nurse; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review report.

~~l.~~m. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.

iii. Treat all highly suspected tuberculosis cases with anti-tuberculosis medications pending sputum results.

iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.

v. Implement control measures when ATD is suspected.

E. AVAILABILITY OF THE PLAN:

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual in every department. OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
   a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
   b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
   c. The final and least effective control is the use of respiratory protection.

G. TUBERCULOSIS RISK ASSESSMENT:

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to

evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:

a. Community TB profile from public health department data
b. Number of infectious TB patients treated in outpatient and inpatient areas.
c. Drug susceptibility patterns of TB patients
d. Analysis of ~~healthcare workers~~**staff** PPD test results by area
e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
f. Observation of practice and review of engineering controls.

2. Considerations for determining the hospital's risk classification will be based on the following:

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

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved , alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, >10% below body **weight**, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases. ~~See Appendices A and B for a flow cart and sample questionnaire.~~
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until

an appropriate room is available.

6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the Engineering department to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
   a. ~~HCW~~ **Staff** wear N95 particulate respirators and visitors wear surgical masks when entering this area.
   b. If the patient is suspected or known to have infectious TB, the room must remain vacant for one hour after the patient leaves. The door is to remain closed and the filter running.
   c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a **surgical** mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection. ~~See Page 10 for algorithm.~~
   a. Emergency Department rooms should remain closed for 30 minutes after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

H. **MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:**

1. ~~Health Care Workers~~**Staff** who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission **Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.**~~Database screening questions.~~
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an Airborne **Infection**~~Illness~~ Isolation Room (AIIR) (i.e. negative pressure room: C-26, 143, 243, ~~443~~**287**, **387**~~287~~, **443**~~387~~, 487, **Maternal Child room** 200 and Progressive Care Unit (PCU) Rooms 301, 312 and 326~~)~~. The door must be closed and the HEPA filter running. Post the Airborne Precautions sign~~,~~ outside the room.
   a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call Engineering for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. ~~HCW~~ **Staff** wear N95 particulate respirators and visitors wear surgical masks when entering this room.
   b. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
3. Reporting:
   a. The Unit Secretary notifies Engineering (by placing a worker order) and the Infection Control office that an Airborne Precautions room is in use for tuberculosis.
   ~~b. The charge or patient's nurse must notify the Infection Preventionist of the patient's name, medical record and room numbePhone call is used.~~
   ~~c.~~**b.** On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
   ~~d.~~**c.** Laboratory Results: Hospitals and ~~health care providers~~**staff** are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
   ~~e.~~**d.** The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and

cultures is sent to the Public Health.

~~f.~~e. The Infection Preventionist **(xt 7410 or xt 5696)** or designee is responsible for reporting to public health. Tuberculosis (TB) Program Nurses are available 8:00-a.m. to 5:00-p.m., 7 days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 p.m. and 8:00 a.m. Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610 after 8:00-a.m. on the following day.

~~g.~~f. Person wanting to report a case of TB after 5:**00pm** ~~P.M.~~ should do one of the following:

i. Call pager (619) 540-0194 after 8:00 a.m. the following day to report directly to TB RN if they feel there is urgency about reporting; or

ii. Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

~~h.~~g. Persons requesting Discharge Approval should:

i. Contact TB RN between 8:00-a.m. and 5:00-p.m.

~~i.~~h. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5:**00pm** ~~P.M.~~, should do the following:

i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.

ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB RN on phone number (619) 692-8610 after 8:00-a.m. on the following day.

~~j.~~i. Persons calling about patients who are leaving against medical advice (AMA):

i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)

ii. Call intake RN between 8:**00**-am and 5:**00**-pm; after hours call 8:00-a.m. the next day

1) Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for the report form.

4. ~~Health care workers~~**Staff** (fit-tested and approved for use) will wear an N-95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health **& Wellness Policy Manual**~~section~~.

~~5. The nurse will initiate the Tuberculosis Management protocol and the Communicable Disease teaching protocol.~~

~~6.~~5. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as ~~are~~ adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.

~~7.~~6. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and **when** the areas are less crowded.

~~8.~~7. Limit the number of persons entering an isolation room to a minimum. All visitors (except ~~HCW~~ **staff** who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.

~~9.~~8. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.

~~10.~~9. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with

appropriate precautions.
a. The patient is in an Airborne Precautions room.
b. The portable air filtration system has been set-up in a regular room.

~~11.~~10. ~~Health care workers~~**Staff** must wear respiratory protection (Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who **are being ruled out for**~~may have infectious~~ Tuberculosis. See High Hazard Procedures.

~~12.~~11. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until **they are** outside **of** the hospital.

~~13.~~12. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. ~~Healthcare workers~~**Staff** entering the room before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.

~~14.~~13. Bronchoscopy considerations
a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever **performed on a suspect TB patient.**~~a suspect case is performed~~. Respiratory protection **must**~~will~~ be worn. **A Powered Air Purifying Respirator-PAPR must be worn by** ~~HCW~~**staff performing a Bronchoscopy on a suspect TB patient.** The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. **ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:**

1. ~~Operating Room~~**Surgery/Peri-Anesthesia Nursing Services**
a. **Postpone non-urgent or** ~~E~~**e**lective procedures on **suspected/confirmed TB** patients ~~with tuberculosis should be delayed~~ until the patient is no longer infectious.
b. If procedures must be performed, they should be done in OR rooms with door closed and traffic at a minimum.
c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.
~~c.~~**d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.**
~~d.~~**e. For patients with known or suspected Airborne Infectious diseases staff must wear a Positive Air Purifying Respirator (PAPR). Order PAPR's from SPD (xt 7728)**
i. Powered Air Purifying Respirator (PAPR) required to be worn by staff near the patient's head during intubation and extubation. Once the patient is intubated, all staff should wear N95 mask until the procedure is complete.
ii. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.
f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).
~~i.~~**g. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.**
~~e. Personnel present when operative procedures are performed on patients who have infectious tuberculosis should wear respiratory protection rather than standard surgical masks alone. Valved or positive pressure respirators are not appropriate for use during procedures requiring surgical masks.~~
~~f. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to~~

~~pulmonary and non-pulmonary sites.~~

~~g. A bacterial filter placed on the patient endotracheal tube or at the expiratory side of the breathing circuit of the anesthesia machine may be useful in reducing the risk of contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air when anesthesia is being administered to a patient with possible tuberculosis.~~

~~h. The suspected/confirmed~~pulmonary TB patient should be monitored during recovery in an individual room meeting Airborne Isolation room ventilation requirements.

~~i. Surgery Suites should be closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.~~

2. Autopsy Room
   a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total air changes per hour (ACH).
   b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection (see high hazard procedures)
   c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
   d. The autopsy room should remain closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
   e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the Medical Examiner.
3. Home Health Services
   a. ~~HCWs~~ **Staff** entering the home of a patient with confirmed or suspected TB or **aerosol transmissible disease** (ATD) should wear **appropriate** respiratory protection.
   b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
   c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
   d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
   e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). ~~HCWs~~ **Staff** will wear respiratory protection during the procedure
   f. Specific processes and procedures pertaining to ATD's in the home are found in the Home Health Care policy manual.

J. **DIAGNOSTIC EVALUATION:**

1. Diagnostic evaluation should include the following:
   a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.
   b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.
   c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.
   d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include

upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.

e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL). ~~(See Table 1). This will assist in determining if the patient is infectious.~~ Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.

f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.

g. Drug susceptibility should be performed on all initial isolates from patients with TB.

h. Contact Infection Control at Ext. 5696 or 7410 for the latest recommendations.

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL ~~OR~~ **or** when another diagnosis is confirmed
2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. **TB Control can be contacted at: 619-692-8610 or 619-540-0194.** ~~(This~~ **The Tuberculosis Discharge Care Plan** form can be accessed at: **http://www.sandiegocounty.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan2014.pdf**

~~1. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan.pdf)~~

   a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:
      i. The Department of Health TB Control to the specific county in which the justice involved patient is residing
      ii. The Public Health Department of the prison.

~~2.~~**b. For all other inpatient units:**

   i. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.

ii. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.
iii. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.
iv. Placement into case management (e.g. DOT) or outreach programs of the public health department.
v. The charge nurse,~~ shift supervisor,~~ patients nurse or Case Manager, will notify the Public Health Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.
vi. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194

2. Cleaning of the room after a known or suspected TB patient is moved or discharged:
   a. **If the suspected or confirmed TB patient** ~~The patient is infectious or might be infectious and~~ was ~~not~~ **NOT** in a negative pressure and HEPA filtered room:
      i. Post the Airborne Precautions sign and keep the door closed.
      ~~b.~~ii. Call Engineering for a HEPA filter. **To enter the room staff must wear an appropriate respirator (i.e. N95 or PAPR).** Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. ~~TCMC~~ Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

M. ROOM SHUT DOWN TIME:~~CHART:~~

Area	Length of Time Room is Closed
Orthopedics/Rehab (1N/S)	Two hours
Maternal/Child	Two Hours
South	Two hours
3 N/S	Two hours
Pavilion	One hour
E/W Tower	One hour
Surgery	One hour
Radiology	One hour
Emergency Department	30 minutes
Bronchoscopy area	30 minutes

   a. **If** the patient is still infectious and was in a negative pressure room:
      ~~3.~~i. **K**eep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. ~~TCMC~~ Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one-hour period has ended, discontinue Airborne Precautions.
   b. **If** the patient is no longer infectious or TB has been ruled out:
      ~~4.~~i. **N**o special precautions needed. The door may be immediately opened and the room cleaned as usual.

~~M.~~N. ANNUAL TUBERCULOSIS SCREENING:

1. Auxiliary and Employees: See the Employee Health **& Wellness Policy Manual:** ~~section 7.1,~~ TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners. **The following medical staff departments are required to be fit-tested upon hire and annually: Emergency Department, Operating Room, Interventional Radiology, Cath Lab,**

Pulmonary, and Infectious Disease.

~~N.~~O. **AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:**

1. A list of all job classifications in which employees have occupational exposure is available in the ~~Infection Control Manual~~ Employee Health **& Wellness Policy Manual:** Respiratory Protection Program **(see Appendix C).**

~~O.~~P. **ISOLATION PRECAUTIONS:**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant ~~Health Care workers~~**staff** (IC.5.2).

Q. **HIGH HAZARD PROCEDURES:**

1. **High hazard procedures include but not limited to**
   a. **Intubation and Extubation**
   b. **Sputum Induction**
   c. **Endotracheal & Tracheostomy Tube Care**
   d. **Bronchoscopy**
   e. **Pulmonary Function Tests**
   f. **Aerosolized administration of pentamidine or other medication**
   g. **Autopsy**
   ~~h.~~ ~~**Tracheotomy**~~
   ~~i.~~ ~~**Thoracotomoy**~~
   ~~j.~~ ~~**Lung Biopsy**~~
2. **For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator.**
3. **For patients with known or suspected Airborne Infectious diseases staff must wear a Positive Air Purifying Respirator (PAPR) except in an Operating Room or procedure room during an invasive procedure where there is a sterile field wear a N95 mask.**
   a. ~~**To o**~~**Order PAPR's from SPD (x7728)**

~~**List of HIGH HAZARD PROCEDURES requiring respirator protection:**~~

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

	~~Bronchoscopy~~ ~~Tracheotomy~~ ~~Thoracotomy~~ ~~Lung Biopsy~~ ~~Endotracheal & Tracheostomy Tube Care~~
~~Recovery~~	~~Endotracheal & Tracheostomy Tube Care~~ ~~Intubation or Extubation~~
~~Pathology~~	~~Autopsy~~

A. **SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS:**

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

in both Airborne and Droplet Precautions will be done in AIIR. See chart above ~~(section P)~~ for selection on type of respirator.

e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.

f. Airborne Infection Isolation rooms shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with Airborne transmissible disease has occupied the room. **(See Room Shut Down Time)**

4. Pulmonary Services
   a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
   b. N-95 respirators or PAPR's are used during Bronchoscopy.
   c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The ~~HCW~~ **staff** should wear an N-95 or PAPR during this treatment (see High Hazard Procedures).
   e. Bronchoscopy suite will remain closed for the designated time ~~(see L.2.a)~~ when procedure is performed on a patient with known or suspected ATD.
   f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.

~~5. Surgical Services~~
   ~~a. The Surgical Suite is a positive pressure environment.~~
   ~~b. Patients in Airborne and Droplet Precautions should have elective procedures delayed for the duration of illness. When this cannot be accomplished, surgery should be scheduled as the last case of the day.~~
   ~~c. Provide surgical mask for patients during transport.~~
   ~~d. Expiratory filters can be used for intubated patients during transport.~~
   ~~e. A portable HEPA unit should be utilized in the OR suite during intubation and extubation to supplement air cleaning but should not be used during surgery. HCW's shall wear N-95 respirator or PAPR See High Hazard Procedures.~~
   ~~f. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post operative patients are placed in a private recovery room with a portable HEPA unit.~~
   ~~g. Surgical suite shall remain empty for designated time (see L.2.a) with door closed when a procedure has been performed on a patient with known or suspected ATD. See Room Shut Down Time.~~

~~6.~~5. Maternal Child Health Services (MCH)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by Airborne Route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery and **Maternal Child Health** ~~Post Partum~~
      i. Labor rooms may have portable HEPA units installed for mothers who have suspected ATD.
      ii. ~~Healthcare workers~~**Staff** follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPR's for Airborne Precautions.
      iii. Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.

~~7.~~6. Behavioral Health
      i. Patients who develop symptoms of ATD will be assessed by the physician to

determine the need for medical intervention.

ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.

iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.

iv. If the patient is unable to wear a mask and non-compliant with containing respiratory secretions with tissues. ~~Healthcare workers (HCW)~~**Staff** will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).

v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.

vi. Airborne precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.

vii. Patients who are identified as needing and AIIR will be transferred within <u>five hours of identification</u>.

~~8.~~**7.** Laboratory Services

a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.

b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy

~~9.~~**8.** Facilities Management Staff

a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.

b. N-95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

~~10.~~**9.** Personal Protective Equipment

a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.

b. Respiratory Protection including N-95 respirators or PAPR's is required in any hospital location in the following circumstances:

i. Entering an Airborne Isolation Room occupied by a patient with an airborne transmitted ATD

ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.

iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any high-hazard medical procedure.

iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.

v. Attending high hazard procedures.

c. Respirator Shortages

i. In the event of reported shortages of N-95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):

1) ~~TCMC~~ **TCHD** will maintain a cache of N-95 respirators in accordance with the disaster plan.

2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.

3) According to available stock, N-95 respirators will be prioritized for distribution to Pulmonary Services, ICU, and Emergency Department for use in high hazard procedures.
4) Re-use of N-95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
5) Reuse of N-95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
   a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD .
   b) The respirator integrity remains intact
   c) During the care of intubated and ventilated patients (closed circuit suction systems).

ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N-95) the following steps may be considered:
1) Prioritize available N-95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N-95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPR's may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N-95 respirators, surgical masks will be provide to the employee.

iii. Positive Air Purifying Respirators (PAPR's)
1) PAPR's used for bronchoscopy are maintained in Respiratory Care Department.
2) SPD stores and maintains all other PAPR's.
3) Units are cleaned; disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used.

~~11.~~**10.** Admissions and transfers of patients with known or suspected Airborne transmissible ATD.
a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N-95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.

~~12.~~**11.** Influenza Season
a. From November 1 to March 31, all employees, volunteers, contract workers or others

covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.

b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.

c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

B. **MEDICAL SERVICES:**

1. Vaccinations are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATD's.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies.

C. **TRAINING:**

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
   a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

D. **REVIEW SCHEDULE:**

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected

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

1. **Active/Rule Out Tuberculosis (TB) Surgery Protocol**
2. **Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)**
~~1.~~3. Infection Control **Manual**~~Policy~~: Risk Assessment and Surveillance Plan
~~2.~~4. Infection Control Manual: Epidemiologic Investigation of a Suspected Outbreak
~~3.~~5. Infection Control Manual: Healthcare Associated Infections, Defined
~~2. Reducing Facility Acquired Infections~~
~~4.~~6. Employee Health and Wellness Manual: Immunization
~~5.~~7. Employee Health and Wellness Manual: Employee Health: Respiratory Protection

F. **REFERENCE(S):**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 **(last updated 02/15/2017)**~~.~~
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance www.cdc.gov
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. ~~Retrieved on September 28, 2015 from:~~ **https://archive.cdph.ca.gov/programs/ohb/Documents/HCResp-ATD-RespSelectGuide.pdf** ~~http://www.cdph.ca.gov/programs/ohb/Documents/HCResp-ATD-RespSelectGuide.pdf~~
5. California Department of Public Health: **January 20, 2015** ~~(2015, January 20).~~ Interim

Guidance on Personal Protective Equipment (PPE) to be used by Healthcare Workers in the Inpatient Hospital Setting during Management of Patients with Suspected or Confirmed Ebola Virus Disease in California. ~~Retrieved from: http://www.cdph.ca.gov/programs/ceder/Documents/CDPH%20-%20PPE%20Guidance%20for%20Management%20of%20Ebola%20Patients%20in%20an%20Inpatient%20Setting%20-FINAL%201-20-2015%20POSTED.pdf~~

6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
7. OSHA **Directive CPL 02-02-078 dated June 30, 2015: Enforcement Procedures & Scheduling for Occupational Exposure to Tuberculosis. https://www.osha.gov/SLTC/tuberculosis/** ~~Directives CPL 2.106 - Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis US Department of Health and Human Services. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=1586&p_text_version=FALSE~~
8. **CDPH:** Cal-OSHA Aerosol Transmissible Diseases Standard, August 5, 2009
9. **https://archive.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx**

~~9. New Guidelines for Purified Protein Derivative (PPD) Skin Test Interpretation and Treatment Modalities for Tuberculosis Infection. Pulmonary Perspectives, April 2001 Volume 18, Issue 1~~

10. **CDC: Tuberculin Skin Testing for TB dated May 11, 2016. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm**

~~10.~~**11.** Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.

12. **Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. Dated May 2015. https://www.osha.gov/Publications/OSHA3767.pdf** ~~TB Respiratory Protection Program In Health Care Facilities Administrator's Guide U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Centers for Disease Control and Prevention National Institute for Occupational Safety and Health September 1999~~

~~3.~~**13. CDPH/CTCA: California Tuberculosis Risk Assessment: Adults June 2017 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf**

ACTIVE/RULE OUT TUBERCULOSIS (TB)
Surgery Protocol

ADMINISTRATIVE CONTROLS	ENVIRONMENTAL CONTROLS	RESPIRATORY PROTECTION
• Postpone non-urgent procedures on suspected/confirmed TB patients until known to be non-infectious. • If necessary to proceed, schedule procedure as last case of the day, at low traffic times, whenever possible. **WHEN THE CASE IS SCHEDULED NOTIFY:** • Infection Control- (Lisa Mattia x5696) • POH (x5452) • PACU (x7264) • Engineering (x7148) of date/time of procedure to set up HEPA filters in OR and PACU • Anesthesia Charge to assure anesthesiologist has been fit tested and knows N95 size • Notify SPD to have five (5) PAPR units available • Notify pathology lab if TB specimens will be sent to lab. ***DAY BEFORE PROCEDURE, IF POSSIBLE:*** Assign staff and assure fit testing is completed and individuals know their N95 mask size. **DAY OF SURGERY:** • Obtain 3 Airborne Precaution Signs • Obtain five PAPR Units • Prior to transporting the patient to the OR, send OR RN to the patient's unit to pre-op patient and complete handoff report.	**PRE-OP:** • Admit patient directly to the OR from the floor/unit. Do not stop in POH. **OR:** • Notify Engineering (x7148) to place portable HEPA unit in OR, positioned near the patient's head. • Utilize the portable HEPA unit in the OR during intubation and extubation. Turn the unit OFF during the procedure. • Keep OR doors closed, minimize traffic in/out of room and in surrounding areas. • Display Airborne Precautions signs on all doors to OR. • Close all doors after leaving the OR and keep room vacant with HEPA filter running for **ONE (1) HOUR** after patient leaves room, then perform normal room turnover. • Notify Engineering (x7148) to remove HEPA unit. **POST-OP:** • Notify Engineering (x7148) to place portable HEPA unit in PACU cubicle. • Post Airborne Precautions signs on cubicle door. • Place patient in cubicle post-Op and keep cubicle door closed. • Close cubicle door after patient leaves and keep room vacant with HEPA filter running for **ONE (1) HOUR,** then perform normal room turnover. • Notify Engineering (x7148) to remove HEPA unit.	**PATIENT:** • Provide surgical mask for patient during transport. • Intubated patients: Anesthesiologist to place expiratory filter (from Anesthesia Workroom) on the ambu bag (at PEEP valve) during transport. **HEALTH CARE PROVIDERS:** • Powered Air Purifying Respirator (PAPR) required during intubation and extubation for the anesthesiologist and anyone assisting anesthesia at the head of the table. Order PAPR's from SPD (x7728). • *PAPR's are not to be used near the sterile field.* • Once the patient is intubated, all staff should wear N95 mask until the procedure is complete. • Fit testing for N95 mask must be completed each year. Healthcare providers who failed fit testing may not be scheduled in a sterile procedure with Airborne Precautions.

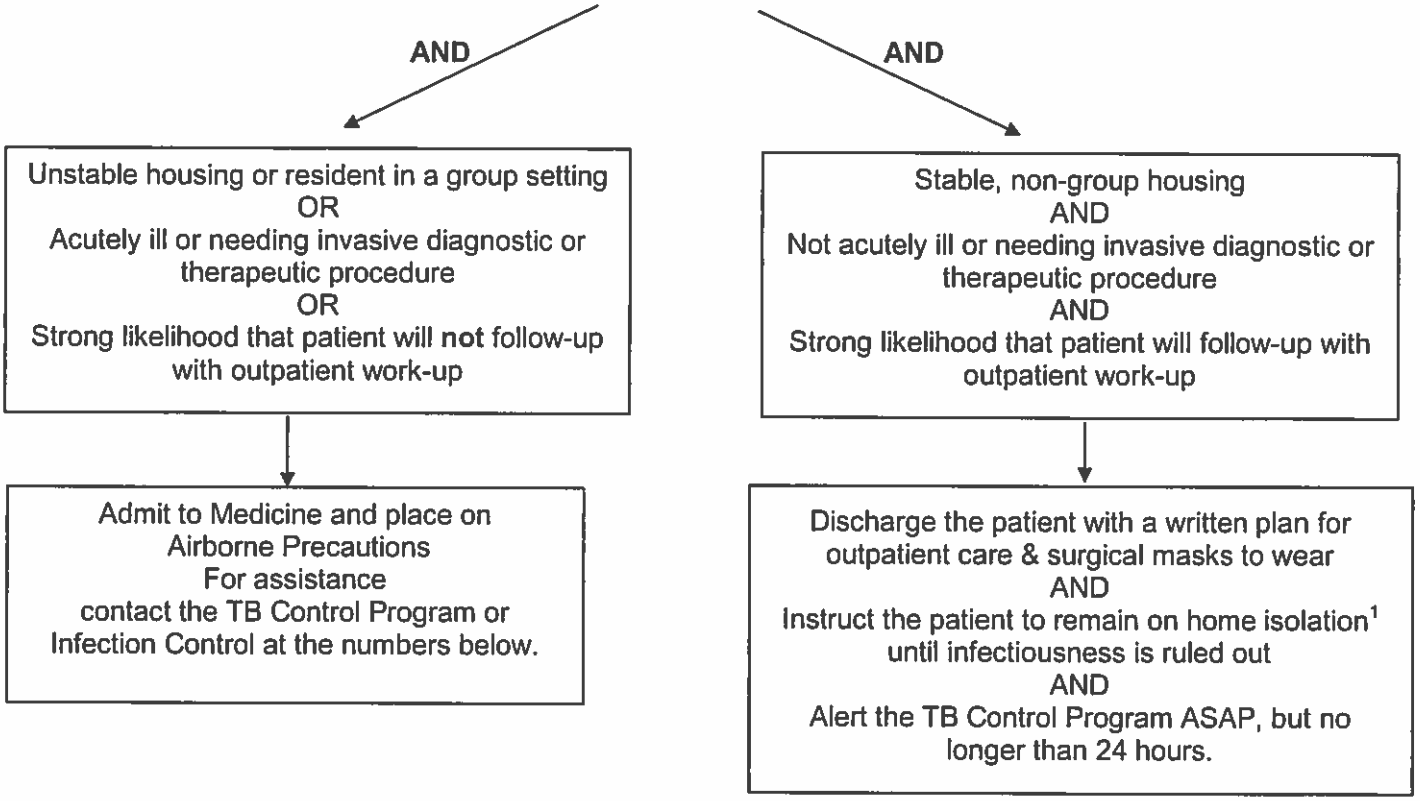
Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

~~TABLE 1~~
~~**Criteria for Infectiousness and placement in high-risk setting (PCU Unit only)**~~

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

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

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



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

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

Tri-City Health Care District
Oceanside, California

Infection Control ~~Policy Manual~~

ISSUE DATE: **09/01**	**SUBJECT: Required Reporting**
REVISION DATE: **~~0406/14~~**	**~~POLICY NUMBER: IC.12~~**
Department Approval:	**09/17**
Infection Control Committee Approval:	**10/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/14~~01/18**
Professional Affairs Committee Approval:	**02/18**
Board of Directors Approval:	**06/14**

A. **PURPOSE:**

1. To promote consistent reporting practices of Reportable diseases required by Title 17, California Code of Regulations for Reportable Diseases and to assist the hospital Infection Control Program to intervene rapidly when appropriate. State law mandates when and how to report (i.e. in writing, by phone, or fax transmission) depending on the disease or condition.

B. **PROCEDURE:**

1. Completing the required reporting to the local **public** health officer is the responsibility of every healthcare provider (physician, podiatrist, nurse practitioner, physician assistant, registered nurse, nurse midwife, or medical examiner) **whom** know**ings** of, or in attendance on a case or suspected case of any of the **required reportable** diseases or conditions.
   a. For inpatients, contact Infection Control (at 760-940-7410 or 760-940-5696) for reporting assistance.
2. A list of **required** reportable diseases **for healthcare providers** is listed on the Confidential Morbidity Report (CMR) available at:
   ~~http://www.sdcounty.ca.gov/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html~~
   a. http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html
3. The ~~Confidential Morbidity Report (~~CMR~~)~~ can be used for most reports (see TB and HIV/AIDS below). **Forms for reporting are available at the CMR website ~~mentioned above (in 2a)~~.**
   a. Urgent information should be reported via telephone:
      i. Epidemiology: 619-692-8499
      ii. STD: 619- 692- 8501
      iii. Tuberculosis: 619- 692- 8610
      iv. For diseases that require "immediate" reporting on weekend/holidays contact 858-565-5255.
   b. Most diseases are required to be reported within one working day and can be mailed, faxed or telephoned, refer to the CMR for disease specific reporting time frames.
   c. Mail information to the County of San Diego, Health and Human Services Agency, Public Health Services, 3851 Rosecrans St. ~~Suite Y15,~~ San Diego, California 92110. **Please note the department (i.e. Epidemiology, STD, TB Control, or Immunizations branch).**
   d. "Fax" information to:
      i. Epidemiology: 858-715-6458
      ii. STD: 619- 692- 8541
      iii. Tuberculosis: 619- 692- 5516

4. HIV infection and AIDS are reportable in California using the required form (not ~~a~~ CMR). The clinical laboratory or physician can notify Infection Control to report.
~~http://www.sdcounty.ca.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html~~
~~e.~~**a. http://www.sandiegocounty.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html**
5. Tuberculosis **(TB)** reporting is mandated by the Gotch Bill (AB 804) and requires a special form ~~(can be accessed at: http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf).~~
a. http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport2014.pdf
~~4.~~**b.** See the **Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan** ~~in the Infection Control policy manual IC.11 The TB Exposure Control Plan~~ for further TB reporting requirements. Notify Infection Control during regular work hours **Monday through Friday,** or the Administrative Supervisor during holidays and weekends for reporting assistance. ~~See http://www.sdcounty.ca.gov/hhsa/programs/phs/tuberculosis_control_program/reporting.html~~

~~5.~~**6.** Clinical Laboratory
a. Microbiology will telephone the San Diego County Health and Human Services for communicable diseases listed under Report Immediately or Report Within One Working Day.
b. **Infection Control will be immediately notified of positive** ~~Positive~~ **Acid-Fast Bacilli** (AFB) smears or cultures and positive ~~tuberculosis~~ **TB** results **in order for timely reporting and follow up.** ~~will be immediately telephoned to Infection Control for reporting.~~
c. Suspected or known meningococcal infections will be immediately reported to Infection Control or the Administrative Supervisor on evening, night and weekends, and holiday shifts.

C. EXTERNAL LINK(S):

1. **Confidential Morbidity Report (CMR): http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html**
2. **HIV/Aids Reportable Form: http://www.sandiegocounty.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html**
~~c.~~**3. Tuberculosis Reporting Form: http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport2014.pdf**

D. RELATED DOCUMENT(S):

~~6.~~**1. Administrative Policy:** Mandatory Reporting Requirements, ~~**Administrative Policy Manual**~~ ~~AP&P~~ 236
~~C.~~**2. Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan**
3. Infection Control Policy: Bloodborne Pathogen Exposure Control Plan ~~IC. 10~~
~~1. Participation of Staff in the Infection Control Program IC. 7~~

~~D.~~E. REFERENCE(S):

1. Consent Manual (20174, 44th ed.), ~~California~~ **Hospital** ~~Healthcare~~ Association ~~and~~
~~1.~~**2.** County of San Diego, Public Health Services Reporting Instructions and Requirements (Program specific Information through Community Epidemiology, Tuberculosis Control and Refugee Health Program, and the HIV, STD and Hepatitis Branch).
3. **https://archive.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf**

~~2.~~4. **Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions***

~~3.~~5. ~~Title 17, Section 2500, Control of Communicable Disease,~~California State Department of Health: **Communicable Disease Control and Prevention: Title 17 California Code of Regulations Section 2500.**~~, 1996~~.

Tri-City Health Care District
Oceanside, California

Infection Control ~~Policy Manual~~

SUBJECT: **Risk Assessment and Surveillance Plan**

ISSUE DATE: **03/02**
REVISION DATE(S): **07/13, 08/14, 05/16**

Department Approval ~~Date(s)~~:	**~~01/17~~12/17**
Infection Control Committee Approval:	**~~01/17~~01/18**
Medical Executive Committee Approval:	**~~02/17~~01/18**
Professional Affairs Committee Approval:	**~~03/17~~02/18**
Board of Directors Approval:	**03/17**

A. **PURPOSE OF RISK ASSESSMENT:**

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

B. **PURPOSE OF SURVEILLANCE:**

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

C. **RESPONSIBILITY:**

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

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

D. **LINKS WITH INTERNAL SOURCES:**

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

E. **LINKS WITH EXTERNAL SOURCES:**

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

F. **PERTINENT RISK FACTORS:**

1. Each facility is unique and we considered the following factors in our planning.
   a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
   b. A review of hospital specific surveillance data from years past.
   c. Medically fragile and at-risk populations such as newborns and those with invasive devices.
   d. The increasing antibiotic resistance in our facility and across the United States (as reported by the CDC in by NHSN).

e. The vaccination/immunity rates of the community and employees.

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

1. ~~Tri-City Medical Center~~**TCHD** is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.1 million residents, and is anticipated to grow to four million by 2020.
3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).
4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. Of residents under 18, 37% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate. Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are growing disproportionately compared to the rest of the population.
5. Demographic information on the three cities most often served by ~~Tri-City Medical Center~~**TCHD** is listed below.

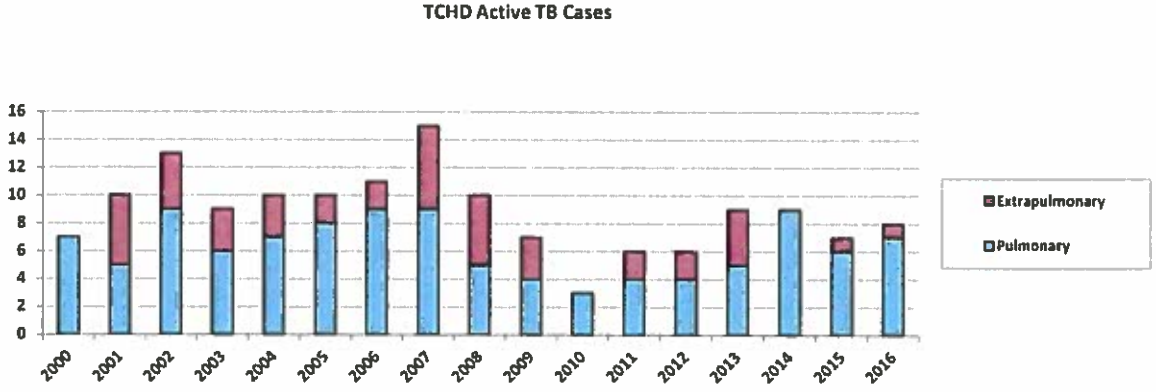
City	Median income	Total # residents	Percent increase since 2000	White	Hispanic	Asian & Pacific Islander
Oceanside	$ 6048,7203 ~~75~~	161,029 (2000) 174,558 (2014)	+8.4%	46.07 %	365.3%	8.26.3%
Vista	$ 67,42145,3 ~~22~~	89,857 (2000) 98,079 (2014)	+9.2%	40.86. ~~2~~%	48.444.5 %	4.17%
Carlsbad	$ 96,34682,6 ~~81~~	78,247 (2000) 112,299 (2014)	+43.5%	712.89 %	145.1.5%	7.749%

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

6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common mandated reported enteric illnesses in SD County are Campylobacter, Giardia, Hepatitis A, Salmonella and Shigella.
7. In San Diego, overall rates for the three major reportable sexually transmitted diseases (Chlamydia, Gonorrhea & Syphilis) have increased from 2015 to 2016. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California.
8. In 2015~~4~~, San Diego County reported **234~~220~~** cases of active tuberculosis while in 2016~~5~~, **258~~234~~** cases were reported. TB drug susceptibility information was available for **99~~100~~%** of the culture proven cases for 2016~~5~~ in San Diego. Multidrug-resistant (MDR-TB) strains were found in **3~~1~~** (**1.40.5%**) of the cases. In 2015, Tri City Medical Center reported 1 case of MDR-TB. **No**

cases were found in 2016. In SD County for **2016**, Hispanics had the highest rates of TB at **44~~53~~%**, Asian/Pacific Islanders at **41~~38~~%**, non-Hispanic Whites at 7% and non-Hispanic Blacks at **82**%.TB cases born outside of the US compromised 74% of San Diego County's cases.(Source: County of San Diego Tuberculosis Control Program 201~~6~~**5** Fact Sheet Date March **24~~18~~**, 201~~7~~**6**).

9. At TC~~MC~~**HD**, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 201~~6~~**5**, there were **7~~6~~** patients with pulmonary TB and 1 with extrapulmonary TB. An additional 21~~7~~ cases were reported as rule out TB in 201~~6~~**5**. The number of active TB patients seen annually at ~~Tri-City Medical Center~~**TCHD** varies from 5 –12.



10. Tri City Medical Center Financial Characteristics for Fiscal Year 201~~6~~
    a. The top six insurance coverage ~~seen the acute care setting~~ are as follows: ~~(Not including OB/Newborn, BHU and Rehab):~~

MEDICARE	**26.08~~33.64~~%**
MEDICARE SR HMO	**~~15.69~~12.59%**
MEDI-CAL HMO	**16.17~~12.33~~%**
HMO	**4.83~~6.91~~%**
Other Governmental	7.29~~00~~%
Medi-Cal	**17.52~~8.16~~%**

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

    b. Patient census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	~~137.4~~**128.3~~29~~**	3.78~~89~~	**46,828~~50,160~~**
ICU*	**14.6~~16.3~~**	3.03~~38~~	5,31~~8~~**945**
BHU	**16.0~~17.0~~**	**9.25~~6.76~~**	**5,854~~6,209~~**
NICU	**13.9~~15.5~~**	**9.35~~6.81~~**	5,08~~4~~**660**
Rehab Serv.	6.7~~2~~	**12.85~~13.70~~**	2,42~~9~~**275**

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

    c. In acute care FY 17~~6~~, the three largest age groups are 56-65 year olds (19.~~42~~%), 66-75 year olds (18.~~28~~%), and 76-85 year olds (18.~~77.8~~%).

    d. **Thirteen**~~Fourteen~~ percent (**8,290~~9,386~~/62,555~~5,828~~**) of Emergency Department patients are admitted to the hospital.

11. The total number of employees working at ~~Tri-City Medical Center~~**TCHD** FY 201~~7~~6 is approximately **2,627~~2,158~~** with about 1,61~~5~~**5~~403~~ (61.55%) staff providing direct patient care. **This number includes 579 employees which were terminated at some point during FY2017.**

12. ~~Tri-City Medical Center~~**TCHD**'s primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:
    a. Obstetrics
    b. Newborns & Neonates
    c. Musculoskeletal & Connective Tissue
    d. Circulatory System
    e. Infectious & Parasitic Diseases
    f. Digestive System
    g. Respiratory
    h. Nervous System
    i. Mental Diseases
    j. Kidney & Urinary Tract
13. Top five Inpatient Surgical Procedures (Fiscal Year 2017~~6~~): Cesarean section (CSEC), **spinal fusion (FUSN), laminectomy (LAM), cholecystectomy (CHOL) and knee prosthesis (KPRO).** ~~hip prosthesis (HPRO), knee prosthesis (KPRO), spinal fusion (FUSN), and open reduction of fracture (FX).~~
14. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2016 in Home Care:

Average LOS	Top Payers	Top 4 Primary DX Categories
38.63 days	Medicare- 523% HMO/PPO 2830%	-**Factors influencing Status/Sup Class**~~Other Health Services for Specific Procedures~~ -**Injury/Poisoning**~~Diseases of the Cardiovascular System~~ -**Circulator (not HTN, HF or CVD)**~~Diseases of the Respiratory System~~ -**Respiratory (not COPD)**~~Signs and Symptoms of Ill Defined Conditions~~

15. General Process
    a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:
        i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
        ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.
        iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.
    b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.
    c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services, Director of Regulatory Compliance, Medical Director of Infection Control and/or Chair of the Infection Control Committee.

H. **TARGETED AND FOCUSED SURVEILLANCE FOR FY 2017:**

1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract

infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include limiting unprotected exposure to pathogens throughout the organization, Enhancing hand hygiene and limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.

2. Surgical Site Infections:
   a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
   b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.
   c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (Centers for Disease Control and Prevention).
   d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs **and reports on** 25 of the procedures, they are listed below:

AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)
CARD	Cardiac surgery	Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting.
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery
CHOL	Gallbladder surgery	Cholecystectomy and cholecystectomy
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations
CSEC	Cesarean section	Obstetrical delivery by Cesarean section
FUSN	Spinal fusion	Immobilization of spinal column
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication
HPRO	Hip prosthesis	Arthroplasty of hip

HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision
KPRO	Knee prosthesis	Arthroplasty of knee
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures
OVRY	Ovarian surgery	Operations on ovary and related structures
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker
REC	Rectal surgery	Operations on rectum
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis
SPLE	Spleen surgery	Resection or manipulation of spleen
THOR	Thoracic surgery	Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.

~~d.~~**e.** GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

~~e.~~**f.** GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria
   a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant enterococci (VRE), Extended spectrum-beta-lactamase (ESBL), *and Carbapenem-resistant Enterobacteriaceae (CRE)*. MDRO and C.difficile infection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile infections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).
   b. GOAL#1: The number of healthcare associated MRSA infections will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 hospital acquired infections per 1000 patient days for the calendar year.

$$\frac{\text{\# Patients with + MRSA and/or VRE cultures}}{\text{\# Hospital Discharges}}$$

   c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).
4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism **&and** Clostridium difficile Infection Module (LabID Event Reporting).

a. All positive C. difficile results are entered into NHSN. Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.
b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.

5. Ventilator Associated Event – Adult Critical Care Unit
   a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed.. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator associated pneumonia (PVAP). All three tiers will be reported and each PVAP case will be reviewed.
      i. GOAL: There will be seven consecutive months without a possible ventilator associated pneumonia (PVAP- Tier 3).

$$\frac{\text{VAE cases in ICU} \times 1000}{\text{Total \# ventilator days for the month}}$$

6. Central Line Associated Bloodstream Infection (CLABSI) –
   a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. Current CDC/NHSN definitions are used to determine CLABSI events.
   b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
7. Catheter Associated Urinary Tract Infection (CAUTI)
   a. Symptomatic urinary tract infection – Patients with positive urine cultures and indwelling foley catheters are reviewed. Current CDC/NHSN definitions are used to determine CAUTI events.

$$\frac{\text{\# of CAUTI cases} \times 1000}{\text{Estimation of urinary catheter days}}$$

   b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).
   c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI rate for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).
8. Hand Hygiene
   a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the Managers, Directors, Regulatory Compliance Committee, and the Infection Control Committee. Tri City Medical Center follows the World Health Organization's 5 Moments model for hand hygiene.
   b. GOAL #1: Hand hygiene observations are performed in every patient care area at least once a month.
   c. GOAL #2: Overall hand hygiene compliance rate will be at least 90% per quarter.
9. Environmental and Patient Care Rounds
   a. Environment of Care rounds are performed monthly and overseen by the Environmental Health & Safety (EHSC) Committee. These rounds will identify risks associated with, but

not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.

b. GOAL #1: Infection Control assessments will be represented 90% of the time during scheduled environmental rounds.
c. GOAL #2 Infection Control assessments will be represented 90% of the time during scheduled tracers.
d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.

10. Reportable Diseases
    a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).
    b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.
11. Employee Health collects and reports the following:
    a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year
        i. Number of needle sticks injuries and details of department involved, device, and cause.
    b. GOAL#2: 100% of employees will complete the annual tuberculosis screen
        i. # Staff completing annual TB screening (PPD, blood test or survey)/ # Employees in whom compliance is required.
    c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.
        i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.
    d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient Acute Rehab unit and Behavioral Health Services staff (per NHSN definition) will receive influenza vaccine.
12. Home Care, collects and reports the following:
    a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
    b. GOAL #2: There will be less than two CAUTI infections in the calendar year.
        i. # Cases UTIs with foley catheter/Total # device days.
    c. GOAL #3: There will be no infections related to central lines in the calendar year.).
        i. # Cases BSI with Central Line/Total # device days.

I. REFERENCE(S):

1. County of San Diego Public Health & Human Services Agency, (June 2015) Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. (2017~~6~~) http://www.cdc.gov/nhsn/acute-care-hospital/index.html
3. County of San Diego Tuberculosis Control and Refugee Health Program. ~~(July 2015)~~ TB Statistics-**Fact Sheet 2016 (March 2017)**. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
4. Friedman, C. (2014). Infection Prevention and Control Programs in P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014
5. The City of San Diego (2015), Economic development: Population https://www.sandiego.gov/economic-development/sandiego/

J. RELATED DOCUMENT(S):

1. Infection Control Policy:~~-Manual,~~ Philosophy

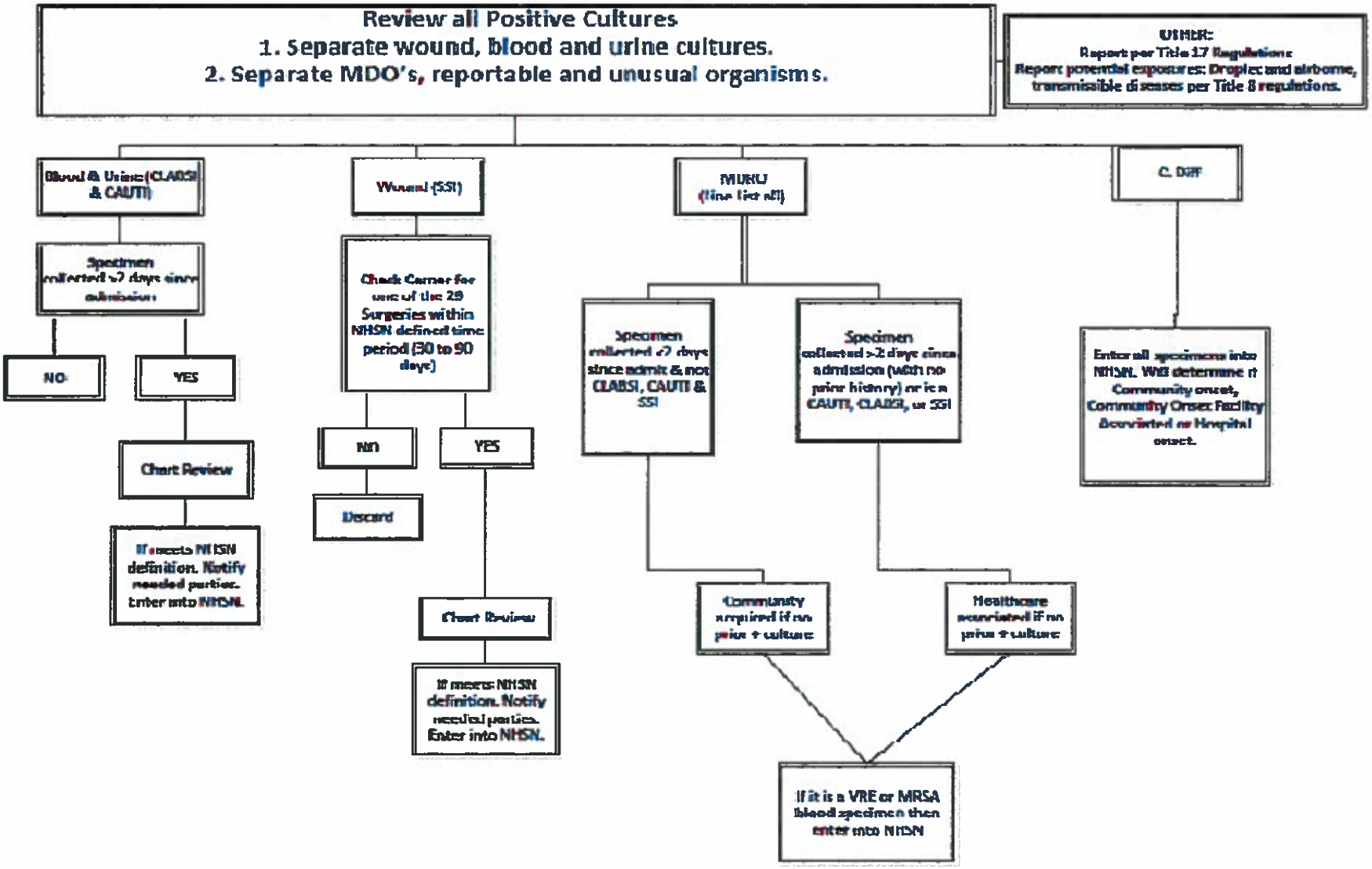
2. Infection Control Policy: ~~Manual,~~ Epidemiologic Investigation of a Suspected Outbreak

INFECTION CONTROL PROGRAM TIMELINE FY 20175

Infection Control Committee	Meet			Meet			Meet			Meet		
Targeted Surveillance	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
SSI	*			*			*			*		
Multi-antibiotic Resistant Organisms • VRE • MRSA • ESBL • CRE	*			*			*			*		
CLABSI	*			*			*			*		
CAUTI	*			*			*			*		
VAE in ICU	*			*			*			*		
Home Health report of CAUTI and CLABSI rates	*			*			*			*		
Outbreak Investigation and Disease Reporting	*	*	*	*	*	*	*	*	*	*	*	*
OSHA Compliance												
• Tuberculosis Exposure Control Plan Review				*						*		
• Bloodborne Pathogen Exposure Control Plan Review	*											
Employee Health												
• TB Screening (PPD or questions)	*											
• N95 Fit-testing	*											
• Sharps & BBP Exposures	*			*			*			*		
• Infectious Diseases Exposures	*			*			*			*		
• Influenza Campaign				Begin			*			*		
Environment of Care												
• Infection control staff review of current construction projects	*	*	*	*	*	*	*	*	*	*	*	*
• Sterile Processing Department Report	*			*			*			*		
• Pharmacy Report on Biologicals and findings	*						*					
• Environment of Care Officer, Patient Safety Officer and/or Engineering report	*			*			*			*		
Surveillance Plan												
• Managers or Directors Meetings (Education & Planning)	*	*	*	*	*	*	*	*	*	*	*	
• Input (Education & Planning)												

• Present Risk Assessment and Surveillance Plan to ICC	*						*			*		
• ICC Approval of Plan	*						*			*		
Performance Improvement Projects												
• Reducing Surgical Site Infections										*		
• Hand Hygiene Compliance	*	*	*	*	*	*	*	*	*	*	*	*
• Reducing CLABSIs												
• **Reducing CDiff**												
Education												
• New Employees	*	*	*	*	*	*	*	*	*	*	*	*
• Unit Based or Topic Specific (As requested)- Performed through Quest, during rounds, presentations, power minute.	*		Net Learning	*	*	*	*	*	*		*	*

*Presented to IC


Review all Positive Cultures
1. Separate wound, blood and urine cultures.
2. Separate MDO's, reportable and unusual organisms.
OTHER:
Report per Title 17 Regulations
Report potential exposures: Droplet and airborne, transmissible diseases per Title 8 regulations.
Blood & Urine (CLABSI & CAUTI)
Wound (SSI)
MDRO (Line list all)
C. DIFF
Specimen collected >7 days since admission
Check Cerner for one of the 29 Surgeries within NHSN defined time period (30 to 90 days)
Specimen collected <2 days since admit & not CLABSI, CAUTI & SSI
Specimen collected >2 days since admission (with no prior history) or is a CAUTI, CLABSI, or SSI
Enter all specimens into NHSN. Will determine if Community onset, Community Onset Facility Associated or Hospital onset.
NO
YES
NO
YES
Chart Review
Discard
Chart Review
If meets NHSN definition. Notify needed parties. Enter into NHSN.
If meets NHSN definition. Notify needed parties. Enter into NHSN.
Community acquired if no prior + culture
Healthcare associated if no prior + culture
If it is a VRE or MRSA blood specimen then enter into NHSN

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 03/03	**SUBJECT:** Adverse Incident/Occurrence for Post-Graduate Staff
REVISION DATE(S): 03/08, 08/12	**POLICY NUMBER:** 8710 – 512

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:	01/17
Board of Directors Approval:	

A. **PROCEDURE:**

1. The person(s) involved or witnessing an adverse incident or occurrence involving any of the interns, residents, or fellows shall immediately contact the supervising physician.
   a. If the supervising physician is not known or unavailable, then the program coordinator or program director shall be contacted. The program director or designee will investigate all issues and take appropriate measures, as necessary, to resolve and/or correct the behavior(s).
2. The outcome of the investigation will be reported to the Chief of Staff or his/her designee.
3. The outcome for any adverse event will be summarized on the annual Graduate Medical Education (GME) summary and presented to the Board of Directors.

~~**Approvals:**~~
~~**Graduate Medical Education Committee Approval: 07/12**~~
~~**Credentials Committee: 08/12**~~
~~**Medical Executive Committee Approval: 08/12**~~
~~**Board of Directors Approval: 03/08; 08/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**07/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE:	**07/07, 03/08, 09/08, 06/09, 09/09 11/09, 07/11, 05/12, 08/12, 02/15, 12/15, 11/17**	**POLICY NUMBER:**	**8710-518**

Department Review:	**11/17**
Medical Executive Committee Approval:	**~~10/15~~11/17**
~~Governance~~ Professional Affairs Committee Approval:	**~~12/15~~01/~~18~~02/18**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**
1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**
1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration, with medical staff approval, will determine the criteria for current, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor records to aid the physicians and other medical services in the Medical Center in trying to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**
1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports **for transcription** will be transcribed into the Medical Records Chartscript transcription system. Upon completion of transcription the report will be saved and sent electronically to the Cerner system (Clinical Notes folder).
   d. Paper-based documents will be scanned to the Clinical Notes section in Powerchart (Cerner) and will be signed electronically, if not already signed
   e. The Report Status in Cerner will be reflected as "Transcribed"
      i. Transcribed status reflects that the dictating physician has not yet authenticated the document.
   f. Physicians will utilize the Cerner Message Center function to authenticate transcribed documents in a timely manner.
   g. The Message Center feature supports the following actions to be taken by the physician:
      i. Sign/Review
         1) Physician reviews the transcribed/scanned document and selects the OK

button that updates the status of the report from "Transcribed" to "Auth (Verified)."

2) Only the responsible physician is eligible to sign a transcribed report.
   a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
   b) Resident reports will be signed by the supervising physician.
   c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician.

ii. Modify/Sign
   1) Physician may modify the transcribed document PRIOR to signature to correct/clarify any elements of the report.
   2) Modifications are to follow the structure of new information being **b~~B~~olded** and deleted information noted as a **s~~S~~**trike-through
   3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
   1) Physician identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician.
   2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.

2. Written Signatures
   a. It is expected that all members of the medical staff will utilize acceptable written signatures, including credentials (e.g., MD, PA, NP, CNM) for all paper documents being authenticated.
      i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, day surgery, and inpatient documentation.
   b. Acceptable written signatures are as follows:
      i. Legible full signature
      ii. Legible first initial and last name
      iii. Illegible signature over a typed or printed name
      iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
         1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
      v. Initials over a typed or printed name
      vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
   c. Unacceptable written signatures are as follows:
      i. Signature stamps alone
         1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
      ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
      iii. Unsigned typed note with provider's typed name
      iv. Unsigned typed note without provider's typed/printed name
      v. Unsigned handwritten note, the only entry on the page
3. The following criteria must be met before a chart is considered complete:

a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
   i. Identification data
   ii. Legal status if mental health patient;
   iii. Emergency care given prior to arrival if any;
   iv. Findings of assessment;
   v. Conclusions or impressions from history and physical;
   vi. Diagnosis or diagnostic impression;
   vii. Reasons for admission or treatment;
   viii. Goals of treatment and treatment plan;
   ix. Known advance directives;
   x. Informed consent for procedures and treatment;
   xi. Diagnostic and therapeutic procedures and tests and their results;
   xii. Operative and other invasive procedures performed;
   xiii. Progress notes;
   xiv. Reassessments if needed;
   xv. Clinical observations;
   xvi. Response to care;
   xvii. Consultation reports;
   xviii. Every medication ordered; every dose administered and any adverse reaction;
   xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
   xx. All relevant diagnoses established during care;
   xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
   a. All handwritten documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is available in multiple locations.
         1) Physician Order Forms
         2) Progress Notes
         3) TCMC Intranet – Administrative Policy 367

5. **History and Physical**
   ~~b.~~**a.** A complete history and physical examination shall be ~~recorded by the attending physician~~**present in the medical record no more than 30 days before or** within twenty-four (24) hours of admission.~~ and/or prior to any surgical or invasive procedure.~~
   ~~c. When the report is dictated it must be completed within twenty (20) hours of admission to allow for transcription and charting of the document.~~
      i. Legible, handwritten history and physicals are acceptable provided they meet the documentation requirements.
      ii. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
      iii. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
      ~~ii.~~**iv. For patients with H&P's not more than 30 days old (in lieu of ~~an~~a new H&P), an examination of the patient, including any changes in the patient's condition, must be present in the medical record within 24 hours of admission.**
      v. A history and physical completed more than 30 days prior to admission is not valid and must be completed.
      vi. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
   ~~d.~~**b.** The history and physical shall include the following elements:
      i. Chief complaint;

ii. Personal, past medical and surgical history;
iii. Allergy history;
iv. Current medications;
v. Family history;
vi. History of present illness;
vii. All important findings resulting from a review of systems;
viii. Physical examination;
ix. Diagnosis or diagnostic impression;
x. Plan of treatment.

c. ~~A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services~~**Surgeries or procedures requiring anesthesia services must have a history and physical present in the medical record, no older than 30 days.**

i. **Physician Pre-Procedure Documentation including an update to the H&P must be recorded on the patient's medical record on the same day, prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.**
ii. **If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:**
   1) **H&P was completed**
   2) **H&P was reviewed**
   3) **The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.**
iii. **When the required history and physical examination is not present before the time stated for the operation, the operation shall be postponed until the history and physical is present in the medical record or the physician has documented that such a delay would constitute a hazard to the patient.**

d. **History and physical for hospital outpatient procedures:**

i. **Ambulatory surgery patients undergoing invasive procedures with anesthesia, procedural sedation, patients with an American Society of Anesthesiologists (ASA) classification greater than 2, or procedures that could compromise the circulatory or respiratory status shall have a complete H&P as defined above prior to surgery.**
ii. **Hospital outpatients undergoing invasive procedures without a significant level of risk shall have at least a limited history and physical.**
iii. **A limited history and physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.**

~~The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.~~

~~e. An updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration. This is to occur prior to surgery or for a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.~~

~~The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.~~

~~If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:~~

~~H&P was completed~~
~~H&P was reviewed~~
~~The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.~~
~~The Physician Pre-Procedure Documentation form must be recorded on the patient's medical record prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.~~
~~A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.~~
~~Dictated documents are to reflect the date and time of both the dictation and transcription.~~
~~A history and physical dictated over 30 days prior to admission is not valid and must be re-dictated~~
~~When the required history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be canceled until the surgeon has documented a history and physical in writing or documented that such a delay would constitute a hazard to the patient.~~
~~i. History and Physical for Hospital Outpatient Procedures:~~
~~f. Ambulatory surgery patients undergoing anesthesia shall have a complete H&P as defined above prior to surgery.~~
~~g. Hospital outpatients undergoing invasive procedures with a significant level of risk shall have at least a limited History and Physical.~~
~~h. A limited History and Physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.~~

~~5.~~6. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
   a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
   b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
      i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

~~6.~~7. Medication reconciliation:
   a. Admission
      i. The admitting physician is required to review, complete and reconcile **a**~~A~~dmission **m**~~M~~edication **r**~~R~~econciliation information in Cerner collected upon admission of the patient within 24 hours.
      ii. If new information is later obtained, the physician or nurse may update the **m**~~M~~edication by **h**~~H~~istory I~~L~~ist in Cerner.
   b. Transfer
      i. All medications will be reviewed and revised as appropriate when patient is being transferred to ~~the next~~**another** level of care.
         1) Electronic Orders
            a) The physician will access the t~~T~~ransfer **m**~~M~~edication **r**~~R~~econciliation function and will reconcile each medication on the

active medication list to either be continued or not continued for the next level of care.

c. Discharge
   i. All medications will be reviewed against HOME medications in Cerner.
      1) Electronic Orders
         a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
         b) Prescriptions to be completed
            i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
            ii) Printed on the unit and handed to the patient
            iii) Handwritten on personal (physician's) prescription pad
      2) Written Orders
         a) Physician handwrites prescriptions on personal (physician's) prescription pad.
         b) Physician updates physician medication changes on the electronic **m~~M~~edication **l~~L~~ist through the **m~~M~~edication **r~~R~~econciliation tool.

~~7.~~**8.** Daily progress notes must be documented by the attending member on all acute patients in the hospital.
   a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.
   b. All members of the medical staff will document progress notes in any of the following methods:
      i. Written on the progress notes form placed in the patient's active record;
      ii. Electronic note may be a **p~~P~~rogress **n~~N~~ote typed by the physician or a **p~~P~~rogress **n~~N~~ote generated using a voice recognition software application (e.g. Dragon).
   c. All **p~~P~~rogress **n~~N~~ote entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.
      i. The electronic **p~~P~~rogress **n~~N~~ote shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).
   d. Progress **n~~N~~otes recorded by Residents and/or Physician Assistants are required to be co-signed by the attending physician member.
   e. Interdisciplinary **n~~N~~otes recorded by the other care providers are available in the Cerner system for review by the physician.
      i. These notes are recorded by non-physicians within the Power Note application in the Cerner system.
   f. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.
      i. Voice **r~~R~~ecognition~~/Dragon application~~ **software** may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.
      ii. These notes will be authenticated by the examining physician and will be displayed as part of **c~~C~~linical **n~~N~~otes.

~~8.~~**9.** Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

~~9.~~**10.** All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set

forth in Title XXII.

a. The informed consent documented will include the following:
   i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
   ii. The likelihood of the patient achieving his or her goals.
   iii. Any potential problems that might occur during recuperation.
   iv. **Reasonable alternatives including side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.**
   ~~iii.~~**v. Name of the person who will carry out the proposed care, treatment, and services.**

~~10.~~**11.** Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.

~~11.~~**12.** A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.

13. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient **and shall include:**

a. Respiratory function including rate, airway patency and oxygenation saturation;
b. Cardiovascular function, including pulse rate and blood pressure;
c. Mental status;
d. Temperature;
e. Pain;
f. Nausea and vomiting;
g. Anesthesia complications;
h. Post-operative hydration; and
~~a.~~**i. Additional types of monitoring and assessment as may be necessary.**~~.~~

~~12.~~**14.** Operative or other high risk procedure reports shall be **completed electronically or** dictated immediately after surgery and shall include:

a. Pre-operative diagnosis;
~~a.~~**b. Post-operative diagnosis;**
~~b.~~**c.** Date of procedure
   i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
   ~~i.~~**ii. Name of procedure;**
~~c.~~**d.** Anesthesia type;
~~d.~~**e.** A detailed account of the ~~findings~~**procedure including approach and technique used**;
~~e. Technical procedure performed~~
f. Estimated blood loss;
g. Specimen removed;
~~h. Post-operative diagnosis;~~
~~i.~~**h.** Name of the primary surgeon and any assistants;~~.~~
~~j.~~**i.** Complications;
~~k.~~**j.** Patient status;

~~13.~~**15.** A **post-~~no O~~operative/procedure** Note shall be ~~documented~~ **completed** immediately following surgery or other high-risk procedures **when the operative/procedure report is dictated pending transcription. An operative note is not required if the operative/procedure report is completed electronically and immediately available in the medical record.** Use of the ~~pre-printed~~**electronic post-o~~O~~perative procedure~~N~~ote** is necessary to document all required elements.

a. **Name of** Procedure ~~performed~~;
b. Pre-Operative diagnosis
c. Post-Operative diagnosis
d. Patient status
e. Estimated blood loss
f. Name of primary surgeon and any assistants
g. Anesthesia type
h. Specimen collected
i. Complications
j. Findings

16. **When the operative note is dictated, the electronic Post-Operative Note** ~~shall be completed and signed~~**must be completed by the surgeon prior to the patient being discharged or transferred from PACU.**

~~14.~~17. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
a. Name and hospital ID number of the patient
b. Name of anesthesiologist who administered the anesthesia
c. Vital signs reflecting patient status just prior to induction
d. Name, dosage, route, and time of administration of drugs and anesthesia agents
e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
f. Names and amounts of IV fluids, including blood or blood products
g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

~~15.~~18. The **electronic Post-**~~Operative Note shall be completed and signed~~**must be completed** ~~by the surgeon prior to the patient being discharged or transferred from PACU~~**, when the operative report is dictated.**

~~16.~~19. All orders, including verbal orders, must be dated, timed, and authenticated.
a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

~~17.~~20. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.

~~18.~~21. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders into Cerner or in writing.
b. All orders for treatment shall be entered **electronically to the medical record.** An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
ii. Vaccines
iii. Intravenous fluids
iv. Medication doses that if weight based would equal or exceed normal adult doses.

~~19.~~22. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
   a. Electronic Orders
      i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
      ii. Complete the Transfer Medication Reconciliation function
   b. Written Orders
      i. Rewrite all orders. ~~OR document the following, "I have reviewed all orders, and they are appropriate for this patient at this level of care."~~
      ii. The physician is not required to rewrite orders when a patient is undergoing one of the following minor procedures and returns to the same level of care:
         1) Heart Catheterization
         2) Interventional procedures including PICC line placement
         3) Endoscopy including bronchoscopies
         4) Inpatient dialysis
         5) Pain management

~~20.~~23. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.

~~21.~~24. Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

~~22.~~25. All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.
   a. Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.
   b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.

~~23.~~26. All clinical entries in the patient's medical record shall be accurately dated and authenticated.

~~24.~~27. Discharge/Depart Process
   a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
   b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
      i. Nursing will enter into the Depart Process application
      ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)

~~25.~~28. A Discharge Summary shall be dictated ~~at~~ for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
   a. Discharge Diagnosis
   b. Reason for hospitalization
   c. Significant findings
   d. Procedures performed and treatment given
   e. Condition on discharge
   f. Instructions given to the patient or patient representative
      i. Follow-up instructions
      ii. Diet instructions
      iii. **Discharge medications**

g. A written or dictated discharge note is acceptable for **all patients**~~patient~~ with a length-of-stay less than forty-eight (48) hours, **to include** normal obstetrical deliveries, and normal newborn infants.
   i. Requirements of the Note include:
      1) Discharge Diagnosis
      2) Instructions given to the patient or patient representative:
         ~~2)~~**i.** Follow-up instructions
         ~~3)~~**ii.** Diet Instructions
         ~~4)~~**iii.** Discharge Medications
      ~~h.~~**3)** Physicians having a Discharge Summary that requires dictation will be notified via the Message Center in Cerner. All physicians will be required to complete **all** pending dictations and/or signature within 14 days of **patient** discharge.

~~26.~~**29.** Physicians will be notified of outstanding charts requiring signature via their Message Center as well as via letter and call to their office.
   a. Physicians will be suspended per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).

~~27.~~**30.** Late Entry
   a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry will be made with the following required elements documented:
      i. The date and time of the observation
      ii. A note clearly identifying the documentation as "Late Entry"
   b. It is not permitted to have entries "backdated" or "predated".
   c. The chart shall be completed within fourteen (14) days of discharge; it is expected no **l**~~L~~**ate e**~~E~~**ntries will appear after this time period.

Tri-City Medical Cen
Oceanside, California

Outpatient Behavioral Health S

DELETE: Combined with Inpatient BHU Duty to Warn Potential Victims policy and changing to Patient Care Services manual.

SUBJECT: Duty to Warn Potential Victims

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

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	02/18
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To provide guidelines for the handling of threats of potential harm to an identified person.~~

~~B. **POLICY**~~

~~1. A therapist is responsible to warn, or take other appropriate action to protect, the foreseeable victim of a patient's violent tendencies, if (1) a psychotherapist - patient relationship exists, (2) the psychotherapist knows or should have known that the patient is dangerous and (3) there is a foreseeable victim of the patient's violent tendencies. In carrying out this duty, the therapist may need to release confidential patient information. The Court held that in such situations, the justification for protecting the confidentiality of the patient information (e.g. to encourage patients to seek treatment and fully disclose information to their psychotherapist) is outweighed by the need to warn potential victims so that they can protect themselves. In addition, legislation was enacted to provide for the release of confidential information when a therapist believes that a patient presents a serious danger of violence to a reasonably foreseeable victim or victims.~~

~~2. The duty to warn arises not only when a patient expresses specific threats against an identifiable victim, but also when others report the threat to the treatment providers. If a family member or significant other reports such threats to the therapist, the therapist is obligated to follow reporting procedures. A therapist may be liable for injuries a third person suffers as a result of a patient's violent acts, if the therapist fails to carry out his duty to appropriately evaluate the patient and identify his or her dangerous propensities.~~

~~3. In order to carry out the duty to warn, the therapist must strike a careful balance between protecting the confidentiality of the patient's disclosures and protecting the potential victim. Initially, the therapist should gather relevant information regarding the patient, including that pertaining to the patient's past treatment history. The therapist's decision regarding whether it is likely that the patient will carry out his or her threats, or that the patient presents a danger to another person, should be documented along with the information that led to the decision.~~

~~4. This will provide important protection against claims that the therapist should not have released the information (if a warning is given) or that the therapist did not carry out his duty to warn the potential victim (if a warning was not given). If a warning is given, the therapist should disclose only that information which is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect himself or herself. A general indication to a person that perhaps the person should avoid the patient may not be sufficient warning. Also, depending upon the patient's therapeutic condition and possible reaction, it is advisable to inform the patient that the warning will be given.~~

~~5. Situations in which a therapist may have a duty to warn a potential victim usually involve difficult decisions. The treatment team, including the physician, needs to be informed regarding any such reports. An ethical or legal consultation may also be obtained to guide the team with their~~

decision.

C. **PROCEDURE**

a. Who may perform/responsible: OPBHS clinical staff

2. When a threat is made, the therapist must notify the police department in the city in which the threat occurred. The following information is conveyed:
   a. patient name;
   b. patient address;
   c. patient date of birth;
   d. patient gender and race.
   e. patient physical description.
3. The police department in the city in which the intended victim resides must also be notified. Report must include information stated above (part A1), as well as, the name of the intended victim and address, if known.
4. The therapist must make all reasonable attempts to notify the intended victim of the patient's threats.
5. The Operations Manager and MD are notified of any such occurrence and a Quality Review report is filed.

6.1. Documentation of the threat and action taken is written in the medical record.

Tri-City Medical Center
Oceanside, California

PHARMACY POLICY MANUAL

DELETE – incorporate into Patient Care Services Policy Documentation in the Medical Record

ISSUE DATE: 2/06 **POLICY:** Patient Specific Information

REVISION DATE: 1/12, 05/15

Department Approval:	05/17
Pharmacy & Therapeutics Committee Approval:	~~3/06, 6/09, 1/12, 05/15~~07/17
Medical Executive Committee Approval:	~~3/06, 6/09, 1/12~~01/18
Professional Affairs Committee Approval:	02/18
Board of Directors Approval:	3/06, 6/09, 1/12

~~A. POLICY:~~

~~1. Patient information is accessible to licensed care practitioners and staff who participate in the management of the patient's medications.~~

~~a. Age~~
~~b. Sex~~
~~c. Diagnosis~~
~~d. Allergies~~
~~e. Sensitivities~~
~~f. Current medications~~
~~g. Height and weight (when necessary)~~
~~h. Pregnancy and lactation information (when necessary)~~
~~i. Lab results~~

~~B. PROCEDURE:~~

~~1. Access the patient's medical record through the hospital wide information system. Information available:~~

~~C.~~A. ~~Access patient's written chart if not electronic.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

SUBJECT: Job Site Assessment
POLICY NUMBER: 609

ISSUE DATE: 07/91
REVISION DATE(S): 11/94, 01/06, 01/09

Department Approval:	09/15
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	02/18
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To provide companies with data for specific workstation modifications using NIOSH standards to facilitate worker safety and injury prevention.~~

A. **POLICY:**

1. Provide **Tri-City employees and outside** companies with a Job Site Assessment upon request and written agreement with Tri-City Medical Center ~~Occupational Health Program MANUAL.~~

~~A.~~B. **PROCEDURE:**

1. Upon request, the Physical or Occupational Therapist will contact the company and schedule an evaluation of the specific workstation to be done during company working hours.
2. The onsite evaluation will include a thorough assessment of the workstation. The evaluation will focus on specified workstation setup relative to tasks, positions, repetitive motions, lifting, and proper body mechanics. A video camera may be used for assessment of findings and interpretation of data.
3. A written report of findings will be provided to the company upon conclusion of the analysis. Included in the report will be recommendations regarding workstation design, tools, equipment modification, and education programs to help increase worker safety and efficiency.
4. A copy of all reports, and videotapes if applicable, will be maintained in the Rehabilitation Services area. One copy of each final report will be forwarded to the Occupational Health Program Manager for placement in the company master file or saved on the network-shared drive.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

SUBJECT: OCCUPATIONAL THERAPY ASSISTANT SUPERVISION
POLICY NUMBER: 707

ISSUE DATE:
REVISION DATE(S):

Department Approval:	**10/15**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/18**
Professional Affairs Committee Approval:	**02/18**
Board of Directors Approval:	

~~A. PURPOSE :~~

1. ~~To comply with Title 16, Division 39 ~ 4181 of the California Code of Regulations for supervision parameters of Occupational Therapy Assistants.~~

~~B.~~A. POLICY:

1. The Occupational Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the occupational therapy assistant does not function autonomously.

~~C.~~B. PROCEDURE:

1. Appropriate supervision of an occupational therapy assistant includes, at a minimum:
   a. The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.
   b. Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.
   c. The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.
   d. The supervising occupational therapist shall provide periodic on-site supervision and observation of client care rendered by the occupational therapy assistant.
   e. The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.
   f. The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.

g. Occupational therapy assistants may supervise:
   ~~i.~~ **i.** Level I occupational therapy students;
   ii. Level I and Level II occupational therapy assistant students; and
   iii. Aides providing non-client related tasks.

h. The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.

~~D.~~B. REFERENCE(S):

~~1. CA OT Board's Code of Regulations for OT assistants~~
1. **California Board Of Occupational Therapy Regulations. (2015).** *Title 16, Division 39*
2. **California Code of Regulations**

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

SUBJECT: Rehabilitation Dress and Appearance Policy~~THERAPY POOL DRESS CODE~~
POLICY NUMBER: 1710

ISSUE DATE: 01/09
REVISION DATE(S): 05/12

Department Approval:	**07/15**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**02/18**
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To identify appropriate attire to be worn by therapy and fitness staff.~~

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

1. **Occupational therapy, Physical Therapy and Speech--Language Pathology is accountable through the Leadership Structure of** Rehabilitation **Services to demonstrate** professionalism, ~~competence~~**competency** and respect~~, yet allows for comfort and safety in~~ **by adhering to the** ~~hot, humid aquatic environment~~**mandated dress code as per Administrative Policy: Dress and Appearance Philosophy Policy 415.**

~~A. Aquatic staff will be appropriately attired in a manner that projects~~

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

1. **Employee Attire:**
   a. **The department manager and/or designee will review the dress code with new staff.**
2. **Employees are required to wear the designated department uniform.**
   a. **Black scrub top, preferably with Tri-City Medical Center Rehabilitation Services logo.**
   b. **Solid earth toned scrub bottoms, slacks, or dress pants only (i.e. khaki, grey, muted green, black).**

~~Clothing should be neat and clean.~~

~~No revealing, low cut, see through or tight clothing, including but not limited to any or all athletic wear.~~

~~Pants must be ankle length.~~

~~Centers for Disease Control (CDC) regulations and Tri-City Healthcare District (TCHD) policy that undergarments must be worn and must be chosen appropriately with regard to color and may not be visible through outer clothing.~~

~~Jewelry that could present as a potential hazard may not be worn.~~

~~Facial and tongue jewelry are not permitted, with earrings limited to three earrings of moderate size in each ear.~~

~~Safety requirements and TCHD policy indicates no open toed shoes may be worn.~~

~~Identification (ID) badge will be worn above the waist.~~

~~1.~~3. Staff providing treatment in pool will wear:
   a. ~~a.~~ Conservative **one (1)**- piece bathing suit with or without shorts/neat T-shirt~~.~~

~~a.~~**b.** When out of pool between treatments or when off duty, staff will wear cover-ups ~~or neat T-shirt, shorts, and tennis shoes/other shoes are acceptable~~ for brief trips out of pool area ~~(e.g. to copy machine, cafeteria),~~, but ~~dress for meetings or presentations should be same as~~ when not providing treatment in pool, ~~(see below)~~ **must adhere to** department dress code.

~~a. Same as above~~

~~2. On days when not getting in/out of pool, staff will wear:~~

~~a. Clothes and shoes that are neat and clean. Good quality T-shirts are acceptable if they do not have writing, pictures, or logos on them.~~

~~b. Socks or hose (hose not required).~~

~~c. Staff ID name tag.~~

~~3. Staff will not wear:~~

~~a. Cut off shorts~~

~~b. Boxers~~

~~c. Sweatpants~~

~~d. Jeans of any color~~

~~e. Revealing clothing or bathing suits.~~

~~6. The department manager will review the dress code with new staff.~~

C. EXTERNAL LINK(S):

1. **CAEHA Public Swimming Pools and Spas: http://www.sandiegocounty.gov/content/dam/sdc/deh/fhd/pool/poolcode.pdf**
2. **County of San Diego Swimming Pool Operator's Guide 1st Edition: http://www.sandiegocounty.gov/content/dam/sdc/deh/fhd/pool/poolop377_pp.pdf**
3. **Title 22 CCR Pool Chemistry Requirements: http://www.sjcehd.com/docs/pool%20info%20sheet.pdf**

D. RELATED DOCUMENT(S):

~~2.~~1. **Administrative Policy: Dress and Appearance Philosophy 415**

E. REFERENCE(S):

1. **California Association of Environmental Health Administrators (2015). *Public Swimming Pools and Spas.* Cameron Park, CA: CAEHA**
2. **County of San Diego Department of Environmental Health Food and Housing Division (2015). *Swimming Pool Operator's Guide 1st Edition.***
3. **Public Swimming Pools, CCR Title II Div. 4, Chapter 20.**

NOTICE OF PRIVACY PRACTICES

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

[Effective Date 01/05/2018]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CARFULLY.

If you have any questions about this notice, please contact our Privacy Officer at (760) 940-53813030

WHO WILL FOLLOW THIS NOTICE

This notice describes our hospital's practices and that of:

Any health care professional authorized to enter information into your hospital chart.
All departments and units of the hospital.
Any member of a volunteer group we allow to help you while you are in the hospital.
All employees, staff and other hospital personnel.
All affiliated entities, sites, and locations.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other hospital personnel who are involved in taking care of you at the hospital.

For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may tell the dietician if you have diabetes so that we can arrange for appropriate meals.

Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as skilled nursing facilities, home health agencies, and physicians or other practitioners.

For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give information about surgery you receive at the hospital to your health plan so it will pay us or reimburse you for the surgery.

We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you. However, we cannot disclose information to your health plan for payment purposes if you ask us not to, and you pay for the services yourself.

FOR HEALTHCARE OPERATIONS

We may use and disclose medical information about you for health care operations. These use and disclosures are necessary to run the hospital and make sure that all our patients receive quality care.

For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

FUNDRASING ACTIVITIES

We may use information about you or disclose such information to a foundation related to the hospital, to contact you in an effort to raise money for the hospital and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

HEALTH INFORMATION EXCHANGE

We participate in both the Commonwealth and San Diego Health Connect information exchanges with other healthcare providers. This Notice is to inform our patients that our clinical team exchanges information for patient care and you can OPT OUT of the sharing of your information by communicating your choice during the Registration process or by sending a message to our Privacy Officer via our website (tricitymed.org) or submitting a written request to our Privacy Officer (4002 Vista Way, Oceanside, CA 92056).

HOSPITAL DIRECTORY

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g. good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

MARKETING AND SALE

Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

TO INDIVIDUALS INVOLVED IN YOUR CASE OR PAYMENT FOR YOUR CASE

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make healthcare decisions for you (e.g. a family member or agent under a health care power of attorney).

FOR RESEARCH

Under certain circumstances, we may use and disclose medical information about you for research purposes.

For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information.

Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to

conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the hospital.

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

ORGAN AND TISSUE DONATION

We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

(A hospital that is component of the Department of Defense or Transportation should also include the following: "If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits.")

WORKERS' COMPENSATION

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES

We may use and disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

HEALTH OVERSIGHT ACTIVITIES

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil right laws.

LAWSUIT AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release medical information if asked to do so by law enforcement official:

- In response to court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

(A Hospital that is component to the U.S. Department of State should also include the following:

SECURITY CLEARANCES

"We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the U.S. Department of State who need access to that information for these purposes.")

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary

- for the institution to provide you with health care;
- to protect your health and safety or the health and safety of others; or
- for the safety and security of the correctional institution.

MULTIDISCIPLINARY PERSONNEL TEAMS

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some circumstances, your health information may be subject to restriction that may limit or preclude some uses or disclosures described in this notice.

For example, there are special restrictions on the use or disclosure of certain categories of information — e.g. tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

SITUATIONS THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

For uses and disclosure not described above, we must first obtain your authorization. For example, the following uses and disclosures will only be made with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of Protected Health Information;
- Most uses and disclosures of psychotherapy notes; and

Other uses and disclosures not described in this notice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include some mental health information.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us:

- What information you want to limit
- Whether you want to limit our use, disclosure or both; and

- To whom you want the limits to apply, for example, disclosures from your spouse

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website: tricitymed.org

To obtain a paper copy of this notice: contact our Registration department.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMMENTS OR COMPLAINTS

We welcome your comments about our Notice and our privacy practices. If you believe your privacy rights have been violated, you may file a complaint with:

TRI-CITY HEALTHCARE DISTRICT
CHIEF COMPLIANCE OFFICER
4002 VISTA WAY
OCEANSIDE, CA 92056

Or with the: Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Please be assured that no one will retaliate or take action against you for filing a complaint.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop by any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on our permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and update this Notice accordingly. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We post copies of the current Notice in the registration areas and on our internet sites. If the Notice is changed, we will post the new Notice in our registration areas and provide it to you upon request. The Notice contains the effective date on the first page, in the top right-hand corner.

Unapproved Abbreviation	*Preferred Term*	KNOWN ALLERGIES TO BE LISTED WITH EACH ADMISSION: **Admit status:** ☐ **Inpatient** ☐ **Observation** **(Check One)** Known or Suspected Communicable Diagnosis Requiring Added Precautions: ☐ Airborne ☐ Droplet ☐ Contact
c.c.	"mL"	☐ May interrupt Telemetry monitoring for transport to tests/procedures without nurse. ①
U	"Units"	
IU	"International Units"	
Q.D.	"Daily"	
Q.O.D.	"every other day"	☐ Read Back all T.O./V.O.orders Nurse's – Signature Date Time | Physician's – Signature Date Time
Trailing zero (X.0 mg)	Never write a zero by itself after a decimal point (X mg)	☐ May interrupt Telemetry monitoring for transport to tests/procedures without nurse. ②
Lack of leading zero (.X mg)	Always use a zero before a decimal point (0.X mg)	
MS MSO_4	"morphine sulfate"	
$MgSO_4$	"magnesium sulfate"	☐ Read Back all T.O./V.O.orders Nurse's – Signature Date 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	"mcg" or "micrograms"	
DO NOT use abbreviations for chemotherapeutic agents		☐ Read Back all T.O./V.O orders Nurse's – Signature Date Time | Physician's – Signature Date Time

Tri-City Medical Center
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8711-4010

PHYSICIAN'S ORDERS

Affix Patient Label

PROCEDURE: _____

DIAGNOSIS: _____

ALLERGIES: _____

STATUS: ☑ OUTPATIENT

ADMIT TO: ☑☐ ~~SPRA~~**Outpatient Infusion Center – Off-Site** ☐ **Outpatient Infusion Center – Main Campus**
☐ **Progressive Care Unit** ☐ **Other:** _____

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

CONSENT FOR: Infliximab (Remicade) infusion

Indications: All indications for GI, Crohn's Disease, and Ulcerative Colitis (with or without fistulas) require induction infusions ~~day 1, 2 weeks, and 6 weeks.~~at weeks 0, 2, and 6.

☐ Induction series of 3 infusions ~~day 1, 2 weeks, 6 weeks~~ **at weeks 0, 2, and 6**
☐ Maintenance – single infusion dose

~~Criteria~~ **Indication for use ~~and recommended dosing (must be completed)~~(Recommended dosing per indication)**

☐ Crohn's Disease moderate to severe **with or** without fistulas _____~~dose~~**(5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 8 weeks for maintenance therapy)**
☐ ~~Crohn's Disease with fistulas _____ dose(5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 8 weeks for maintenance therapy~~
☐ Rheumatoid Arthritis ~~– a series of 3 infusions (3 mg/kg each) day 1, 2 weeks, and 6 weeks and Q 8 weeks thereafter.~~**(3 mg/kg at weeks 0, 2, and 6 followed by 3 mg/kg every 8 weeks for maintenance therapy)**
☐ Ulcerative colitis — severe **(5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 8 weeks for maintenance therapy)**

☐ Other: _____

Pre-medicate 30 minutes before dose of Remicade.

☐ Acetaminophen 650 mg PO (and every 4 hours for aches or temperature greater than 38°C (101.5°F))
☐ Diphenhydramine (Benadryl) PO ☐ 25 mg or ☐ 50 mg

☐ **Start IV with Normal Saline @_____mL/hour when Infliximab (Remicade) not infusing:**
☐ **Infliximab (Remicade) dose = _____mg by IV infusion.** ☐ 5 mg/kg ☐ 3 mg/kg
☑ Dilute in 250 mL Normal Saline (0.9%) for final concentration between 0.4 mg/mL and 4 mg/mL
☑ Administer using tubing with a 1.2 micron (or less) non-protein binding filter
☑ Do not infuse other medications into the IV line with Remicade
☑ Flush with saline before and after medication administration
☐ **Start infusion rate @: 10 mL/hour for first 15 minutes, then increase as follows:**
20 mL/hour X 15 minutes
40 mL/hour X 15 minutes
80 mL/hour X 15 minutes
150 mL/hour X 30 minutes
250 mL/hour X 30 minutes

Monitoring:

☑ Assess patient's vitals and tolerance after each rate increase
☑ Observe patient for 30 minutes following infusion for 3 initial loading doses then 10 minutes each subsequent dose before discharge home
☑ Monitor and record presence/absence of infusion related reactions: fever, chills, hypotension, hypertension, or dyspnea.
☑ Patient to be monitored for hypersensitivity reaction.

If infusion related reaction occurs during Infliximab (Remicade) infusion:

☑ Stop Infliximab (Remicade) and restart 0.9% Saline IV solution
☑ Give Diphenhydramine (Benadryl) 25 mg IV X 1
☑ Give Methylprednisolone (Solu-Medrol) 125 mg IV X 1
☑ Call Physician prior to restarting Infliximab (Remicade)
☑ For anaphylaxis give:
☑ EPINEPHrine ~~1:1000~~**1 mg/mL** – give 0.5 mg ~~subcutaneous~~**IM**, repeat twice at 20 minute intervals and call Physician
☑ Oxygen by nasal cannula at 2 – 5 L/hour if needed for chest pain or dyspnea

For Nausea:

☐ Give Metoclopramide (Reglan) 10 mg IV **push** X 1

☐ Read Back all T.O./V.O.orders

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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8711-4010

REMICADE (INFLIXIMAB) ORDERS
~~ADMINISTRATION GUIDELINES~~
Page 1 of 2

- ☐ Give Prochlorperazine (Compazine) 5 – 10 mg IV push over 2 minutes X 1
- ☐ Give Promethazine (Phenergan) 12.5-25 mg IM or slow IV Ppush diluted in 9 mL Normal Saline X 1 dose
- ☐ Give Ondansetron (Zofran) 4 mg IV **push** X 1

☐ Read Back all T.O./V.O orders

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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REMICADE (INFLIXIMAB) ORDERS

~~ADMINISTRATION GUIDELINES~~

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Affix Patient Label

Epinephrine (Adrenalin), Topical1
Recommendation for Formulary Addition

Drug Class: Alpha/Beta Agonist

FDA Approval: N/A

FDA Labeled Indications[1]:
Decongestant

Manufacturer: PAR Pharmaceuticals

Available Dosage Forms: 1 mg/mL (30 mL vial)

Dosing Recommendations:
Decongestant: Intranasal: Apply 1mg/mL solution locally as drops or spray or with sterile swab

Administration/Preparation:
May be diluted with isotonic saline for a less concentrated solution. Apply locally as a drop or spray or with the use of a sterile swab as required.

Clinical Pharmacology/Pharmacokinetics:
Epinephrine stimulates alpha-1/beta-1/beta-2 adrenergic recpetors causing local vasoconstriction. Onset of local vasoconstriction when applied topically is about 5 minutes with an estimated duration of under 1 hour.

Breast Feeding/Pregnancy:
It is unknown if epinephrine crosses into the breast milk. It is known that when systemically administered, epinephrine does cross over to the placenta. Specific information concerning risks associated with topical administration are not available.
Epinephrine is a Pregnancy Risk Factor Category C drug.

Efficacy:

Capillary Bleeding[2]	Dose/concentration study performed assessing surgery duration and intra-operative bleeding for endoscopic sinus surgery using only topical epinephrine. Surgery time and bleeding was reduced in patients receiving the 1:2000 concentration of topical epinephrine

Contraindications:
Concurrent use with local anesthetics for injection of certain areas (fingers, toes, ears).

Boxed Warnings: None

Warnings and Precautions:
Use with caution in patients with cardiovascular diseases or cerebrovascular diseases.

Drug Interactions:
Alpha/beta blockers may diminish the vasoconstricting effects of epinephrine

Adverse Drug Reactions:
Headache, vasoconstriction, flushing, hypertension, palpitations.

Cost Impact (TCMC Acquisition Cost as of 11/15/17):

Epinephrine 1mg/mL (30 mL) vial (topical)	$91.51
Epinephrine 1 mg/mL (30 mL) vial (injectable)	$112.59
Cocaine 4% topical	$143.85

Data was not provided by the requestor on the estimated number of patients that would require treatment with this medication.

Conclusion:

Epinephrine has long been administered topically to mitigate capillary bleeding associated with minor procedures. While epinephrine in the 1 mg/mL (1:1000) strength is currently available on formulary in the 30 mL multi-dose vial, the ISMP strongly advises against the use of this formulation labeled for intravenous use, for topical administration. The ISMP cites a major medication error which occurred in Canada over a decade ago which resulted in the death of a patient that received the inadvertent injection of epinephrine when it was intended to be used topically. With regard to price, it is less costly than the injectable 30 mL vial of epinephrine which is formulary approved and also less costly than topical cocaine.

The P&T Committee has approved the addition of epinephrine topical solution (1 mg/mL, 30 mL vial) to the TCMC formulary with restriction to the Surgery Department. We believe that having a vial specifically labeled for topical application is an important first step in preventing medication errors. Additionally, restricting the availability of this product to the surgical areas will serve as an additional barrier to inappropriate use.

References:

1. Adrenaline (R) [package insert]. Chestnut Ridge, NY: Par Pharmaceutical; 2015.
2. Sarmento, KMA, Tomita, S, Octavio de Avila Kos, A. Topical use of adrenaline in different concentrations for endoscopic sinus surgery. Brazilian Journal of Otorhynolaryngology. 2009;75(2):280-289

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

Audit, Compliance & Ethics Committee (No meeting held in February, 2018)

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

January 25, 2018 – 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 January 25, 2018.

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

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno

Absent was Director Larry Schallock

Also present
Greg Moser, Board Counsel
Steven Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Susan Bond, General Counsel
Dr. Victor Souza, 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 1of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Nygaard to approve the agenda as amended. Director Mitchell seconded the motion. The motion passed (6-0-0-1) with Director Schallock absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the January 25, 2018 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Chairman Dagostino deferred this item to the Board's Counsel. Board Counsel, Mr. Greg Moser made an oral announcement of the items listed on the January 25, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included three matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; two Reports Involving Trade Secrets, Approval of Closed Session minutes, Conference with Legal Counsel regarding four matters of Potential Litigation, Public Employee Evaluation: CEO and Evaluation of Legal Counsel Services.

5. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Kellett to go into Closed Session. The motion passed (6-0-0-1) with Director Schallock absent.

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:40 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno

Absent was Director Schallock

Also present were:

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

9. Chairman Dagostino stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

10. Director 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 24.

12. Proclamation Recognizing Mayor Jim Wood

Chairman Dagostino read the Proclamation into the record recognizing Mayor Jim Wood for his 46 years of service to the City of Oceanside.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors present the aforementioned Proclamation to Mayor Jim Wood at this evening's reception. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

13. Educational Session

Mr. Brian Greenwald, Tri-City's Webmaster presented a high level demonstration of the Board Portal that Board members will see when they access the site via their IPAD. Mr. Greenwald explained that he created a Portal where Board members will be able to access their agenda materials as well as other important Board related documents via a password protected code. Mr. Greenwald provided an overview of today's agenda materials and explained how to navigate with the links to the corresponding agenda items. He also explained how Board members will be able to take notes and highlight using the Good Reader App. Mr. Greenwald stated once IT completes configuration of the IPADS a training session will be scheduled for all Board members.

Chairman Dagostino questioned how the training will be handled. Mr. Greenwald stated he recommended that training be held as a group so that Board members can benefit from each other's questions and comments. Ms. Donnellan suggested a Special Board Meeting be scheduled for training purposes and one to one training be provided thereafter as needed. Mr. Moser confirmed if the majority of Board members will be present the meeting must be noticed as a meeting under the Brown Act.

No action taken.

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

Mr. Glen Newhart, Chief Development Officer stated in a collaborative project with the Medical Center the Women's & Infant Services was renovated. Mr. Newhart presented a graph which reflected the percentile rank for HCAAPS for Patient Satisfaction increased by 60 points after the renovations were completed. Mr. Newhart commented that the care in Women's & Infants has always been great and now we finally have the facilities to match the level of care. Mr. Newhart stated this information was shared at the Donor Appreciation Dinner which was held earlier this week as it is important for donors to see the results of their donations.

Secondly, Mr. Newhart reported in 2015 we introduced Estate Planning/Gift Planning here at Tri-City. He stated that this is a free process which is available to everyone in the District. As a result of the program the Foundation has identified that individuals will be donating $8.5 million to the Tri-City Hospital Foundation in their estate plans

for the benefit of the District and those gifts will continue to increase as new people enter the program. At the same time they also identified other charities in the community with donations of nearly an equal amount. Mr. Newhart stated the Foundation believes this is an outstanding investment at a modest cost.

Mr. Newhart commented on the Marathon. He noted the Foundation had a group of 30 volunteers manning a water station. Mr. Newhart acknowledged the runners who participated in both the half Marathon and the full Marathon.

Mr. Newhart reported earlier this week the Foundation held their Annual Donor Appreciation Dinner in which 82 people attended. Mr. Newhart stated the donors appreciated hearing the updates on the hospital and many who attended will be key in our building process going forward.

Lastly, Mr. Newhart reported at our last Socks & Shoes drive we collected over 300 pairs of shoes and 400 pairs of socks. He anticipates an even larger amount of shoes and socks this year as people are asking for collection bins they can put at their businesses. In addition, a Foundation Board member will be reaching out to the shoe manufacturer Vans to see if they would get involved and support this cause. Mr. Newhart stated the need far exceeds socks and shoes and the Foundation's Executive Committee had an open grant for socks and shoes that exceeded the need and the committee voted to allow Social Services to take that additional money and use it to buy sweatshirts and sweatpants and other things these patients need during the cold weather. Mr. Newhart stated the Foundation will be expanding their efforts to include some additional items.

Director Mitchell questioned if we can still help the Foundation by making purchases through Amazon. Mr. Newhart responded that the Foundation will generate a new link where if you purchase on Amazon a percentage of your purchase is donated back to the Foundation. He explained that you simply follow the link and it is a way for Amazon to support non-profits without raising your costs.

No action taken.

15. Report from Chief Executive Officer CEO

Mr. Steve Dietlin stated Mayor Wood has been a huge advocate for the hospital for many and he is pleased to see that the Board has done a Proclamation to recognize him.

Mr. Dietlin stated Chief of Staff Dr. Victor Souza has designated 2018 as the year of gratitude and encouraged everyone to say thank you to others a little more. He expressed his appreciation to Dr. Souza and the entire Medical Staff for collaborating with the Board of Directors, Administration, the Foundation and Auxilians.

Mr. Dietlin stated that people do have a choice in healthcare and do choose Tri-City. He stated we have seen a lot of improvements in areas that people have asked for including reduced wait times in the Emergency Department. Mr. Dietlin stated that Tri-City has the lowest wall time in the county of San Diego.

Mr. Dietlin commented on our November census which was 160 and is about as low as we have seen. He stated in January the census has been well over 200 due

largely to the flu. Mr. Dietlin stated over 14,000 cases of the flu have been reported in San Diego County.

Mr. Dietlin stated February is heart month and encouraged everyone to take care of their heart. He stated we have developed a track around the hospital that is approximately a half a mile that we will be kicking off on the campus on February 2nd so staff can take advantage of health and wellness. Mr. Dietlin commented on our partnership with the American Heart Association and the importance of getting education out there. Mr. Dietlin stated we will be doing the second annual Heart Walk this year as well.

Mr. Dietlin commented on the Marathon and the many volunteers who manned the medical tents and water stations. He stated Board members were also in attendance holding the tape for runners and handing out medals to the runners. Mr. Dietlin stated the Marathon is a great community event that people can get involved in and really give back to the community. Mr. Dietlin commented on the Lucky 13 which is an amazing group of people who have overcome tremendous medical challenges and then participate in the half marathon or a marathon. Mr. Dietlin stated this year we added a 5K to get more people out there and plan to offer the 5K next year as well.

Mr. Dietlin stated in 2018 we will be moving forward with Strategic Planning, our budget and campus development. He stated next month we will be starting construction on the surface lot and that will be followed by a parking structure and a new entrance. Mr. Dietlin stated there will not be an interruption to the entrance of the hospital as there is a cut out that has been approved by the city. In addition, he does not anticipate an interruption in traffic in and out of the hospital. He stated the surface parking lot will provide much needed additional parking spaces which is another thing the community has really asked for.

Mr. Dietlin asked Chief Nurse Executive Sharon Schultz to provide an update on the flu season which has been quite severe this year.

Ms. Schultz stated there have been over 14,000 cases of the flu reported this year which is triple what we usually see and 74 deaths. She stated, here at Tri-City, since December 3rd we have seen 683 confirmed cases of the flu and 190 of the patients diagnosed with flu have been admitted. Of those admitted, 18% have been in the ICU. Ms. Schultz stated it has been a year of critical acuity for the patients and for our staff and physicians. She acknowledged our doctors, nurses and staff who have done an outstanding job of taking care of everyone. Ms. Schultz stated we also had our tent opened up at one point to get a lot of our flu cases processed.

Ms. Schultz acknowledged our Women's Center who was recently recognized in the newspaper as one of three hospitals in San Diego County that have lowered their C-Section rate for our moms. She stated we are leading the state in that area and are very proud of that.

Director Mitchell questioned what our current C-Section rate is. Ms. Shultz stated it is 23% and the benchmark is 25%.

Director Reno commented that since the CNA contract was finalized she has not received any telephone calls from nurses and she believes overall staff is happy.

No action taken.

16. Report from Chief Financial Officer

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

- Net Operating Revenue – $178,874
- Operating Expense – $185,591
- EROE - ($4,173)
- EBITDA – $3,619

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 170
- Adjusted Patient Days – 59,959
- Surgery Cases – 3,220
- Deliveries - 1,182
- ED visits – 31,459

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

- Operating Revenue - $30,355
- Operating Expense - $31.177
- EBITDA - $908
- EROE – ($383)

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

- Average Daily Census – 173
- Adjusted Patient Days – 9,205
- Surgery Cases – 512
- Deliveries – 166
- ED Visits – 5,345

Director Reno questioned if C-Sections are included in the Surgery or Delivery figures and asked that they be broken down separately in future reports.

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

- Net Patient Accounts Receivable - $45.7
- Days in Net Accounts Receivable - 49.0

Mr. Rivas reported in November we had the lowest census in years however it is trending upward. He stated the low census resulted in a "downspin" of our revenue and carried into December however we have rebounded. He noted in October we were "break even" year to date. Mr. Rivas stated we are looking at our expenses line by line and at anything we can do in the short term to compensate for this downspin in revenue.

17. New Business

a. LAFCO

Ms. Adriana Ochoa, Board Counsel stated with respect to LAFCO we are on track. She stated the Executive Director at LAFCO has indicated he believes the Property Tax Exchange will be on the Board of Supervisors agenda and that the LAFCO Commission can and likely will take action at their March 5th meeting. She stated we did receive a preliminary staff report and maps from LAFCO approving our Resolution. Ms. Ochoa stated that somewhat surprisingly LAFCO added on their own two special study areas which are two areas of land that they are proposing that we annex from Palomar. Ms. Ochoa stated these are two areas of land that we opted to keep out of our proposal because it would have required a lot of negotiation with Palomar and we did not want bad blood with our neighbor and it would have also required us taking some land that is in the City of Vista and in the City of Carlsbad from Palomar. We opted to keep those areas out and just focus on Shadowridge and east Carlsbad.

Director Reno questioned if those two areas are the ones we have had discussion on previously in our sphere of influence. Ms. Ochoa responded that those two areas are not currently in our sphere of influence but LAFCO is proposing we potentially include them in our sphere. Ms. Ochoa clarified that it doesn't require any changes to our maps at this point it is simply special study areas.

Ms. Ochoa stated per discussion at last month's meeting she did invite the LAFCO staff member in charge of our proposal to today's Board meeting however they had another engagement scheduled for today but they did send over the staff report which they felt should address all of our questions. She stated the LAFCO staff has always been very responsive to her e-mails and phone calls and if the Board has any additional questions for LAFCO they would be happy to answer them.

Ms. Ochoa stated if the LAFCO commission approves our application at their March 5th Board meeting then they are required to allow a 30 day consideration period and then hold a one day protest hearing and can record immediately afterwards. She anticipates LAFCO will be able to record the new boundaries in April. She noted the Board can decide whether it wants to adopt maps at the March Board meeting as we will have LAFCO approval by then or they can take action at the April meeting. Either way, once the boundaries are recorded we will make the Registrar of Voters May deadline. Ms. Ochoa stated it is looking more and more likely that we will have the new boundaries for the 2018 election.

b. Discussion Regarding Draft Maps for Change from At-Large to District Based Elections – Elections Code 10010(a) (2)

Chairman Dagostino recognized Mr. Victor Roy. Mr. Roy questioned what is the date of adoption of the maps and is the public input still being taken as far as adjusting some of the lines for these districts that are being proposed.

Ms. Ochoa reiterated the Board will adopt the maps at either the March or April Board meeting.

With respect to Mr. Roy's second question regarding whether members of the public are still allowed to comment, Mr. Ochoa stated members are able to

comment up until the time the Board adopts the new maps. She stated the deadline for anyone to submit a new map for consideration by this Board was January 8th at 5:00 p.m. and we did not receive draft maps from any members of the public so the time to submit a new map has passed.

Ms. Ochoa stated we did receive one request for a small revision to the Orange map. She explained that revisions are different than submitting a whole new map. The revision was published eight days ago as map Orange 2. Ms. Ochoa stated our demographer Doug Johnson incorporated a small move of a zone line between zones 1 and 4 and the new line does not disrupt any communities of interest and is a perfectly legal revision. She explained there will essentially be the seven maps available to the Board in March or April for consideration.

Ms. Ochoa read into the record comments from eight community members related to the maps.

Ms. Ochoa stated the City of Poway litigation involves a private citizen that has sued the city of Poway and the Attorney General alleging Poway's at large system is illegal and that generally the CVRA is illegal. She stated there has been a lot of activity on that case since our December meeting with approximately 18 new filings. Ms. Ochoa stated the most important thing that has occurred is that on January 12th the court heard the preliminary injunction motion. The court took the matter under submission and the court has still not issued a written order. She stated the Latino organization intervened and also on December 14th the City of Mission Viejo moved the court for leave to file an amicus brief and their request was granted. Mission Viejo is supporting the plaintiff's motion for a preliminary injunction. The City of Mission Viejo was also identified by Mr. Henchman and in an effort to avoid costly litigation agreed to change form at large to zone based elections however they feel this prejudices them and adopted a resolution that in essence states it is their intent to transition from at large to district based elections however they feel it is bad for their city and are supporting plaintiff's position. On December 18th the San Gabriel Valley Council of Governments, a JPA that represents dozens of small agencies, along with the City of Arcadia, the City of Fullerton, Glendora, West Covina, Barstow and Pasadena also moved the court for leave to file an amicus brief. They have also received letters from Mr. Shenkman and support the plaintiff's position at the preliminary injunction stage. On January 11th the City of Vista and the City of Mission Viejo filed joinder letters in support of the San Gabriel Council of Government's positon. Ms. Ochoa stated San Gabriel's brief was by far the most comprehensive. Ms. Ochoa stated the City of Poway continues to take no position. They just want the court to make a decision to act one way or another by May 1st so they know what is going on with their election in November. Ms. Ochoa stated if and when a written decision is published on the injunction she will let us know. Mr. Moser added that the basic argument by the dozen cities that filed the amicus brief is they are heavily minority based already and by having to go to district elections it will actually dilute the minority vote in those jurisdictions.

c. Consideration of nomination to serve as Special District Representative to the Redevelopment Oversight Board.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors nominate Director Nygaard to serve as Special District Representative to the Redevelopment Oversight Board. Director Reno seconded the motion.

Chairman Dagostino stated this nomination is about becoming more actively involved in groups and associations and governmental agencies that might help our community. He explained the Redevelopment Oversight Board is one that has oversight into how monies are spent around San Diego County.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

d. Consideration to approve UCSD Neurosurgical Services Agreement

Mr. Jeremy Raimo, Senior Director stated this agreement is a follow up to the decision the Board made a couple of months ago when they elected to have UCSD Neurosurgery take on the call panel for provision of Neurosurgical care at Tri-City Medical Center. He stated what this agreement forges is a very strong relationship for neurosurgical care not only for call coverage for the district residents but also the development of a neurosurgical program built around the infrastructure that the UCSD Neurosurgical Division has which is top tier in this community. Mr. Raimo stated UCSD has phenomenal providers that they are going to place here at Tri-City, specifically Drs. Jeswani, BenHaim and Tung and they are led by their chief Dr. Alex Khalssi. Mr. Raimo stated with these physicians providing the neurosurgical drive and oversight of this service line at the hospital we anticipate that the community is going to benefit from the high quality care that is provided by this continuous group of physicians. He stated the fact that we have one contingency taking care of those patients is really going to benefit the families and the community members. Mr. Raimo stated he is here today to request consideration of forging the relationship not only for call coverage but also the development of a robust neurosurgical program here at Tri-City.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the UCSD Neurosurgical Services Agreement. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

e. Consider granting temporary authority to the Board Chairperson to appoint a Director to committees, pending Bylaw changes.

Chairman Dagostino stated this agenda item provides the Board Chairperson with authority to appoint a Board member to a committee when necessary pending a bylaw change. Chairman Dagostino stated from time to time a Board committee member may be unable to make a meeting and this motion will allow the Board Chairperson to appoint a Board member to fill in on a temporary basis. He clarified that it is not a full time appointment but a mechanism to ensure the complement of the Board is present to do its business.

Mr. Moser explained this would be a temporary change over riding the District's Bylaws so the recommendation before the Board today is that you give the Chair the ability to appoint interim Board members to committees without the advice and consent of the rest of the Board which is what our Bylaws otherwise require however only until such time that the Governance Committee can take a look at amending the Bylaws.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors grant temporary authority to the Board Chairperson to appoint a Director to a Board committee, pending a Bylaw change. Director Reno seconded the motion.

Director Mitchell stated she would prefer to see the process in place before we vote on it. She questioned if this temporary appointment is allowed as far as the Brown Act and Health and Safety Code are concerned. Mr. Moser stated there is no legal violation however the District's Bylaws prescribe how committees are formed and the statute does not address committees at all. Currently the Bylaws provide that the Chair nominates and the Board consents to the nomination for committees. Mr. Moser further clarified that these are our own rules and it is not comprehensively covered in Roberts Rules. Director Reno cautioned regarding a Board member having a Conflict of Interest. Mr. Moser stated presumably that is something the Board Chair would take into account when making the appointment. Director Reno stated she supports the concept however commented on a policy that was pulled at a previous meeting because the Human Resources Committee hadn't approved it yet the Professional Affairs Committee did which is not allowed. It was clarified that the second reviewer was the Administrative Policy & Procedures Committee rather than the Board's Professional Affairs Committee which is standard procedure.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Mitchell**
ABSENT:	**Directors:**	**Schallock**

18. Old Business –

a. LAFCO Update (discussed previously in New Business)

19. Chief of Staff

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.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the January Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 22, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

b. Approval of NP Privilege Card – OB/GYN Revised

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the OBGYN Revised NP Privilege Card as recommended by the Medical Executive Committee at their meeting on January 22, 2018. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

c. Approval of Proposed X Robotic Privileges Criteria

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve the Proposed X Robotic Privileges Criteria as recommended by the Medical Executive Committee at their meeting on January 22, 2018. Director Kellett seconded the motion

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

20. Consideration of Consent Calendar

It was moved by Director Mitchell to approve the Consent Calendar. Director Kellett seconded the motion.

It was moved by Director Nygaard to pull item 20 (1) C) Community Healthcare & Alliance Committee minutes and item 20 (4) a) The

Governance Institute Limited Membership - $24,650.00. Director Mitchell seconded the motion.

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

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

21. Discussion of items pulled from Consent Agenda

Director Nygaard who pulled the Community Healthcare & Alliance Committee minutes stated that in the minutes Dr. Souza commented that the HCAHPS in the OB Department increased significantly and she concurs that it was due in part to the Foundation but also our nurses working extremely hard. She recommended that the Board send a letter to the Foundation and to our nurses congratulating them on raising their HCAHPS scores.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors send a letter to the Foundation and the OB nurses for their efforts in raising the HCAHPS scores. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

It was moved by Director Nygaard to approve the Community Healthcare & Alliance Committee minutes as presented. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

Director Nygaard who pulled the Governance Institute Dues and Membership questioned what benefits we are receiving from the Governance Institute's membership. Director Reno commented that a lot of good material comes out of the Governance Institute and they send a monthly journal. Director Mitchell questioned what other benefits we are receiving besides the monthly journal. Chairman Dagostino questioned if Board members have taken advantage of the Governance Institute's educational sessions. Ms. Donnellan responded that Board members have not attended many of the Governance Institute's conferences in the past few years. Director Reno clarified that at one time Board members did take advantage of the conferences offered by the Governance Institute. Director Reno suggested we ask the Governance Institute for a modification in price as they do provide a lot of good information. Director Reno stated in the past the Governance Institute would come and provide educational sessions for the Board. She referenced Roger Witalis who met with the Board related to their goals and objectives. Director Kellett clarified that service was not covered under the Governance Institute's membership but was billed separately. Director Kellett stated that he agrees that it is an expensive fee for the benefit derived. Ms. Donnellan referred the Board to page 202 of the Board packet which outlined the benefits of membership. Chairman Dagostino commented on the one time Board Self-Assessment. Ms. Donnellan stated the past two years the Board elected to go with ACHD for their Self-Assessment. Chairman Dagostino questioned if Director Nygaard is suggesting we eliminate this expense. Director Nygaard responded yes. Director Reno suggested that the Governance Committee evaluate this decision. Director Kellett recommended we cancel the subscription and reserve the right to reconsider should the Governance Institute come back with a modified proposal.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors cancel the Governance Institute subscription in the amount of $24,650.00 but reserve the right to reconsider a modified subscription if proposed. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Schallock**

22. Reports

There was no discussion on Reports.

23. Legislative Update

Chairman Dagostino stated proposals for laws are being created and we may have more to report on at the next meeting.

24. Comments by Members of the Public

Chairman Dagostino stated Mr. Victor Roy submitted a request to speak but has left the meeting.

Chairman Dagostino recognized Rosemary Smith, Oceanside resident.

Ms. Smith commented on an unfavorable patient experience.

25. Additional Comments by Chief Executive Officer

There were no additional comments from the Chief Executive Officer.

26. Board Communications

Reports from Board Members

Chairman Dagostino questioned if Board members had any time sensitive items to report. Hearing none, he suggested in the interest of time comments be omitted today to allow Board members to attend the reception honoring Mayor Woods.

27. Report from Chairperson

Chairman Dagostino did not have anything to report.

27. Oral Announcement of Items to be Discussion in Closed Session

Chairman Dagostino reported the Board would be returning to Closed Session to complete unfinished closed session business.

28. Motion to return to Closed Session.

Chairman Dagostino adjourned the meeting to closed session at 5:15 p.m.

29. Open Session

At 5:30 p.m. Chairman Dagostino reported the Board was back in open session. All Board members were present.

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

Chairperson Dagostino reported no action was taken in closed session.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:30 p.m.

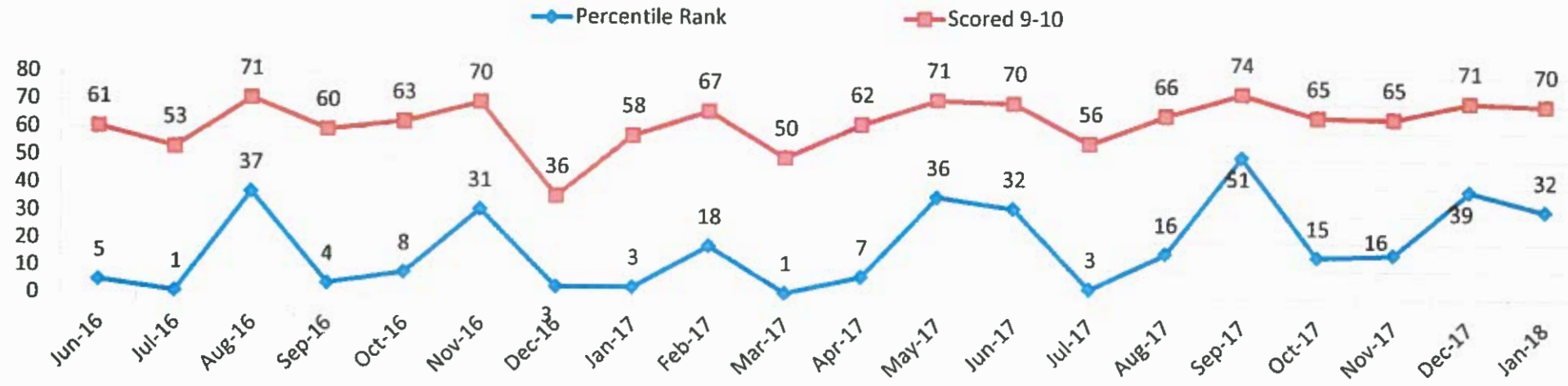
James J. Dagostino, DPT, PT
Chairman

ATTEST:

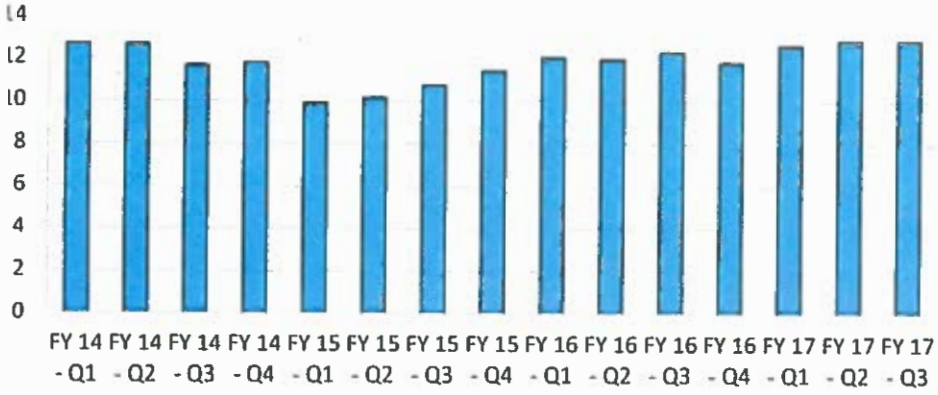
Leigh Anne Grass, Secretary

Stakeholder Experiences

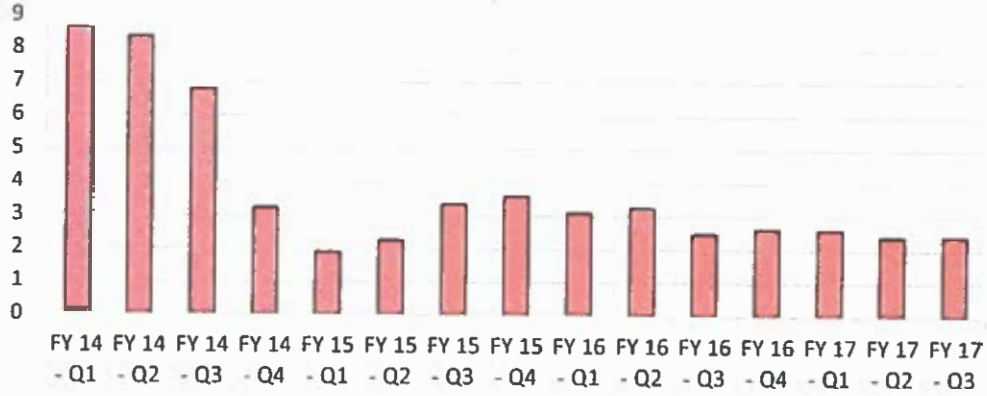
Overall Rating of Hospital (0-10)



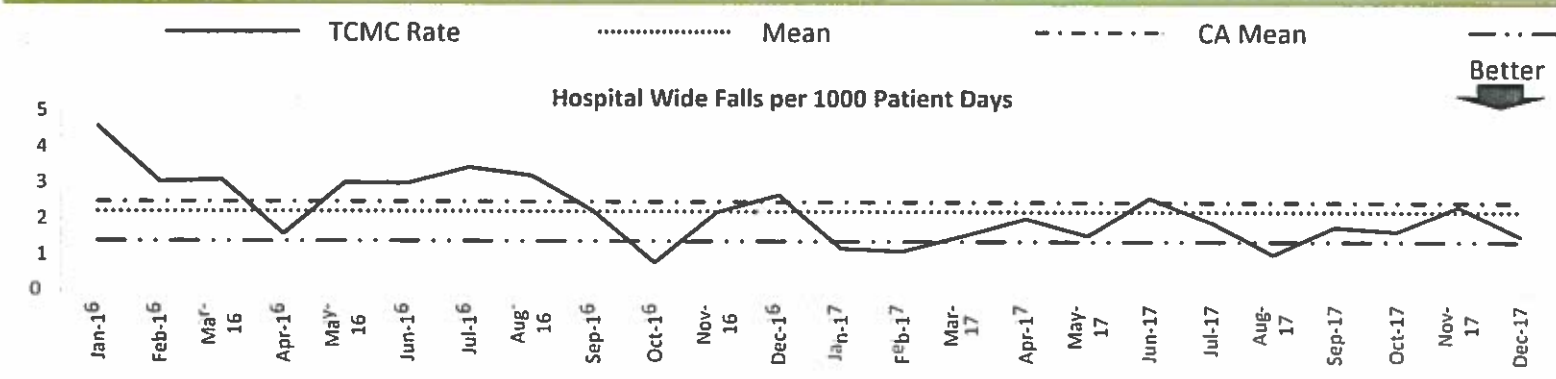
Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

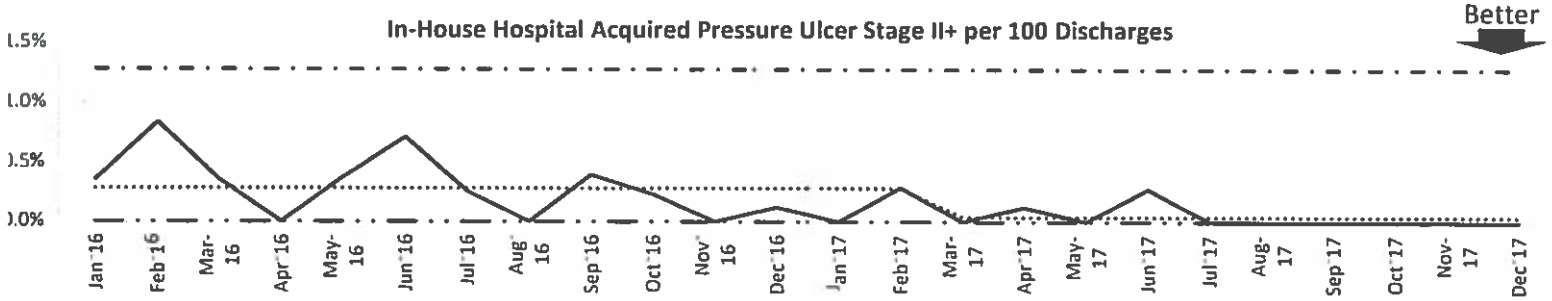


Current Trending Measures



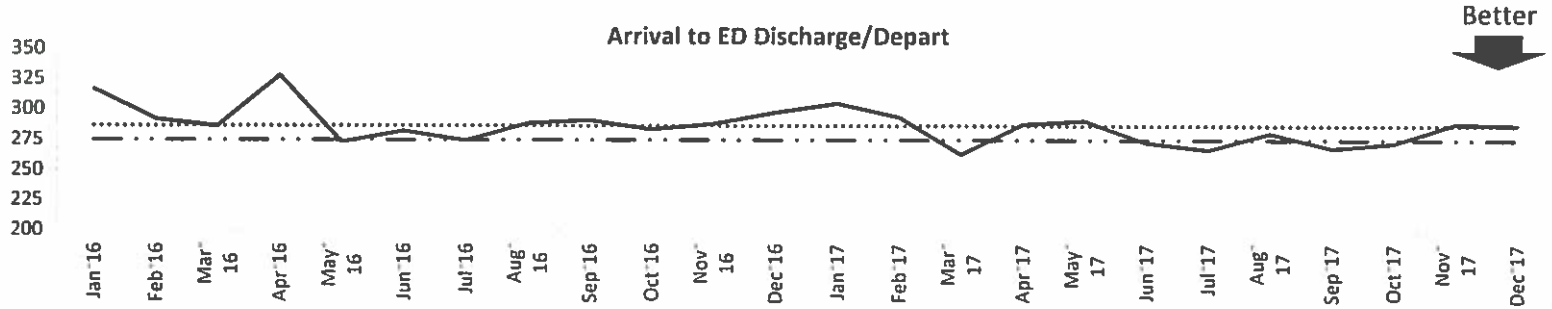
Action Plan

1.Majority falls are still related to BR2. Continue to hardwire hourly rounding3 train staff as needed on use of transfer equipment4.Audit all patients at a high fall risk4 Ongoing education to patients and family on "fall risk" for safety



Action Plan

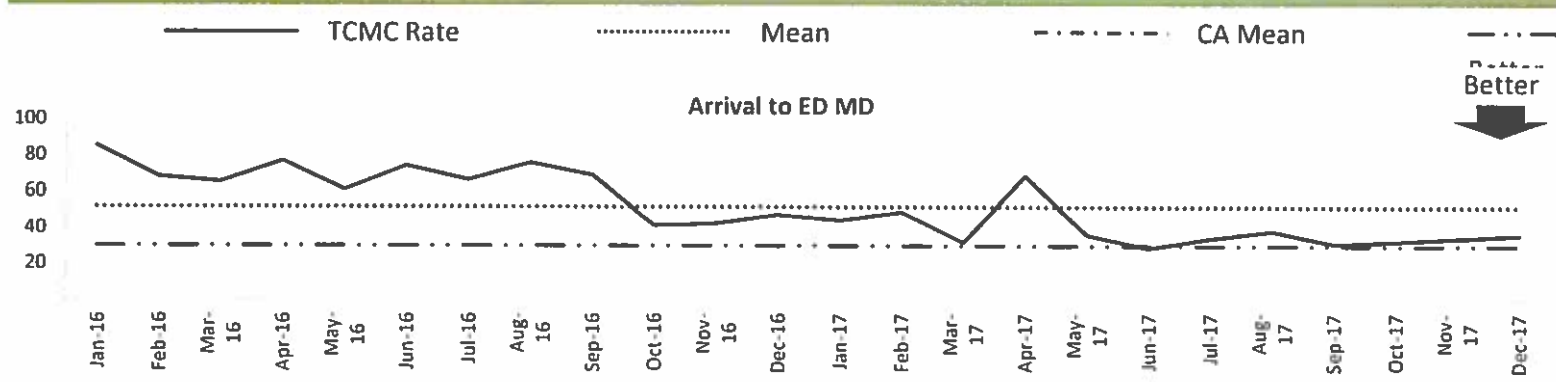
Request expansion of HAPI charter.1. conduct regular evaluation of high risk patients Braden score of 18 & less3. conduct IRR of EMR for consistency of documentation of appropriate treatments4 Hard wire current process to reduce any type of injury, i.e. vascular injury, pressure related injury, device injury5. Use of electronic tool that identifies "high"risk patients with a braden score of 18 or less



Action Plan

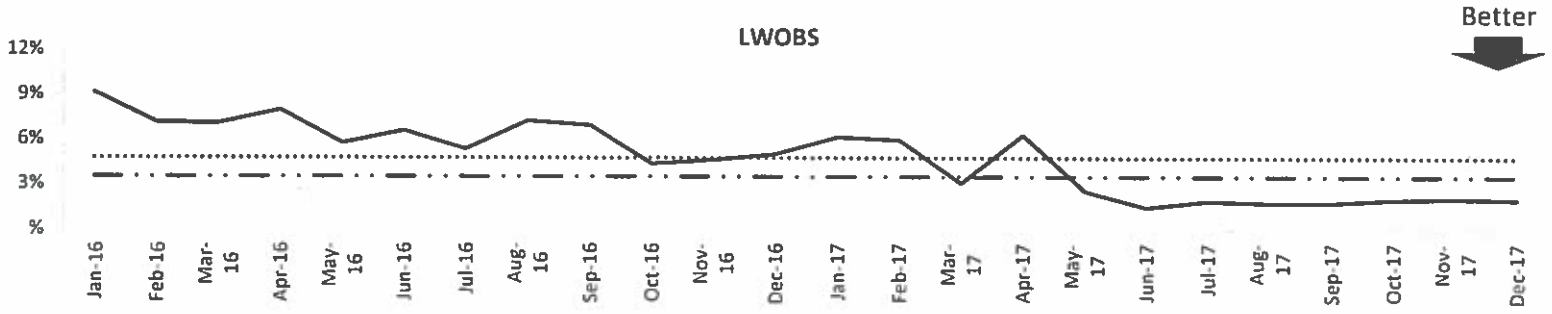
This process was at 5 points below TCMC & CA mean. Flu season has seen an increase in census, acuity, continue to monitor

Current Trending Measures



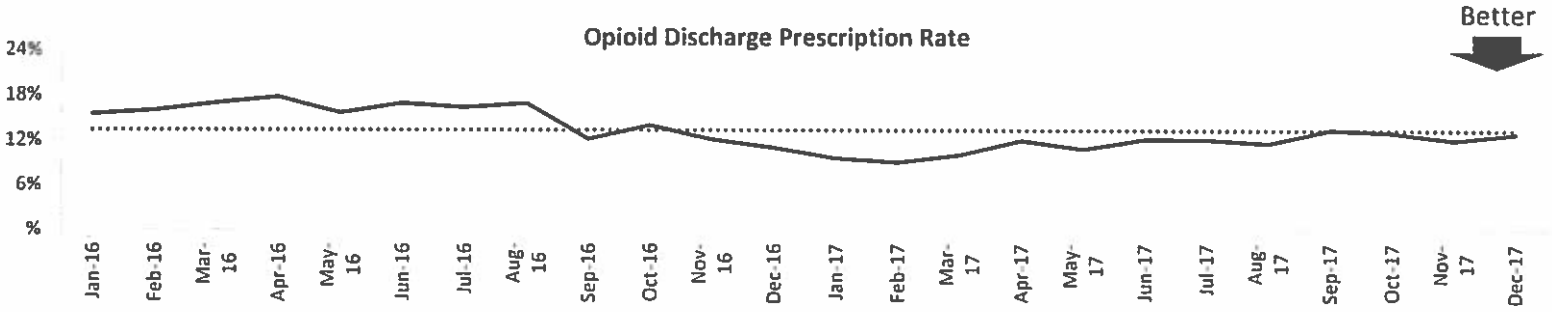
Action Plan

This process remains below CA Mean for a facility classified as a high volume facility/ED. Flu season has seen an increase in census, acuity, continue to monitor



Action Plan

To-date TCMC is at 1.61%. The Goal for 2016 was 6.9%, Goal for 2017 was 3.5%. Achieved 2017 goal. Continue to improve with extended hours for provider coverage in "team triage", improve patient communication regarding wait times and all patients are registered at Triage. No wall time implemented with noted improvements



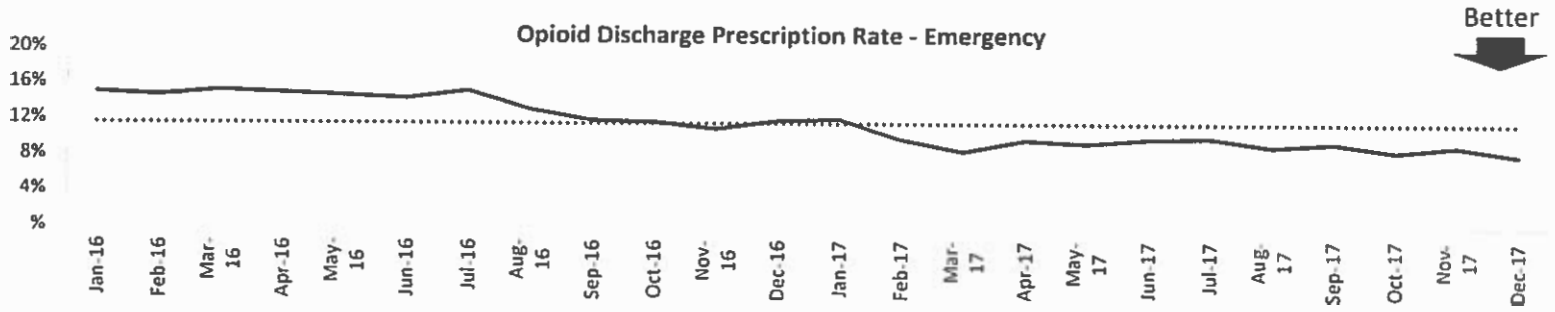
Action Plan

"CURES" program has been initiated at TCMC for RX usage for opioids. Process for education, tools, handbook completed. This process will be retired as a priority project in 4 months with monitoring only

Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

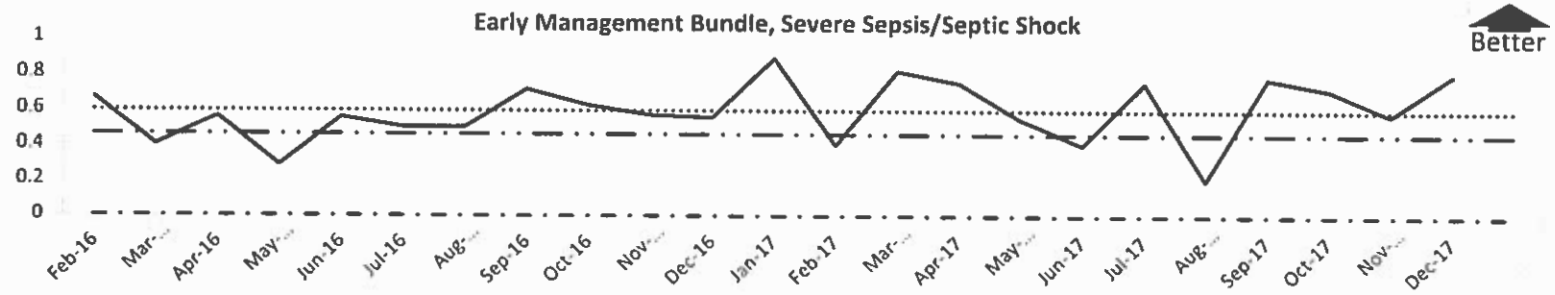
Opioid Discharge Prescription Rate - Emergency



Action Plan

"CURES" program has been initiated at TCMC for RX usage for opioids. Process for education, tools, handbook completed. This process will be retired as a priority project in 4 months with monitoring only

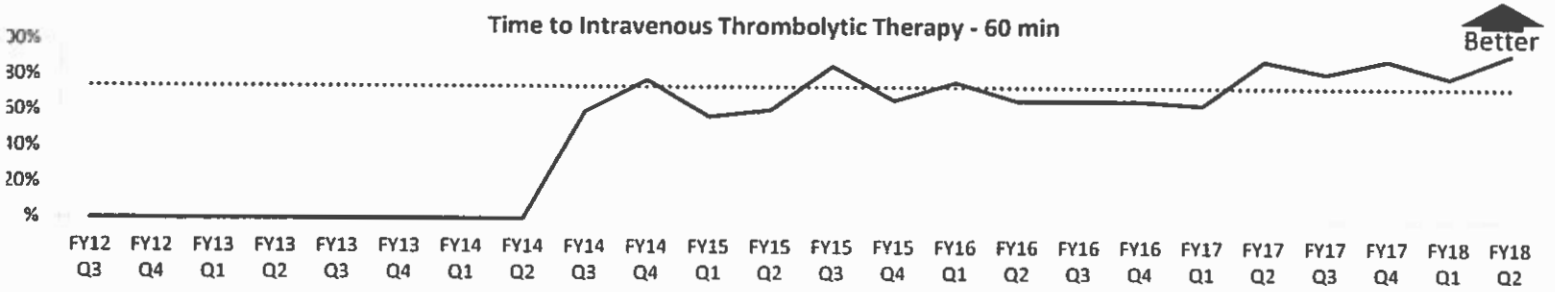
Early Management Bundle, Severe Sepsis/Septic Shock



Action Plan

The ED has the process defined and managed well. Next step is to work on early identification of in-house code sepsis. The fall-outs for not following sepsis criteria were in-house patients. The fall-outs were for initial lactate level drawn within time frame & blood cultures drawn within time frame. These cases will be sent for education to the MS Department

Time to Intravenous Thrombolytic Therapy - 60 min



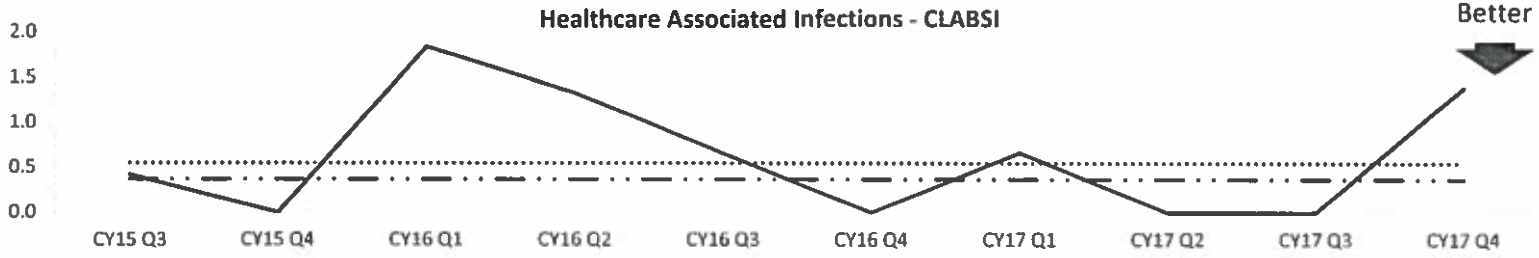
Action Plan

Implemented within CERNER "reason why" delay in tPN therapy. The CERNER fix has improved compliance with this required documentation

Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

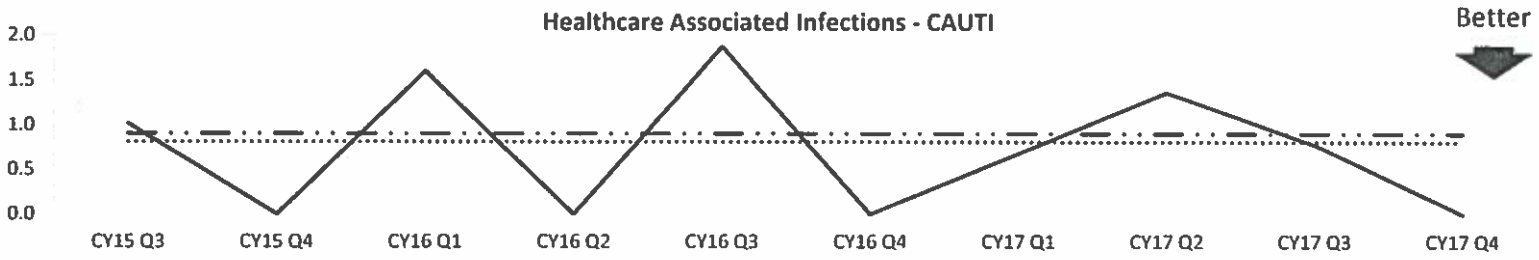
Healthcare Associated Infections - CLABSI



Action Plan

For QTR 1 & 3 a total of 3 CLABSI's. All records reviewed, infections noted outside the 24 hour window/insertion. Maintenance of line probable issue. All 3 patients high co-morbidities

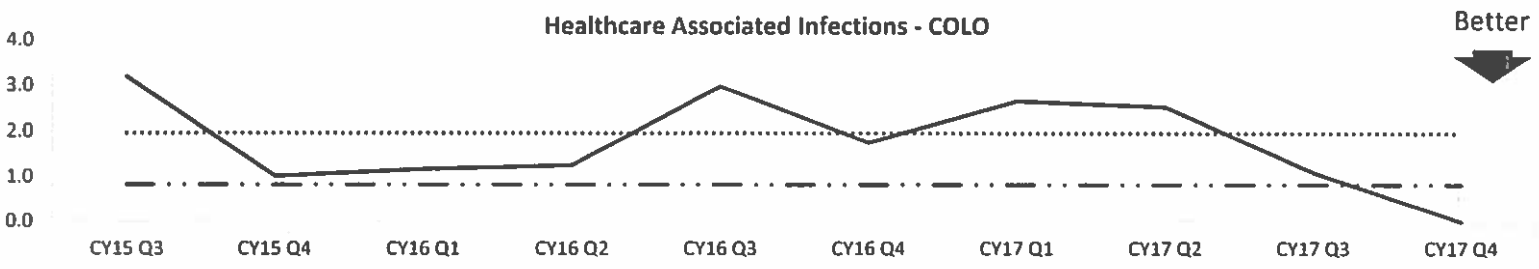
Healthcare Associated Infections - CAUTI



Action Plan

With purwick & male condom catherater rates reamin low. Did note that medical patients with HAC UTI / required reporting to Medical. Developing process. Total 5 for QTR 1-3. remains below predicted

Healthcare Associated Infections - COLO



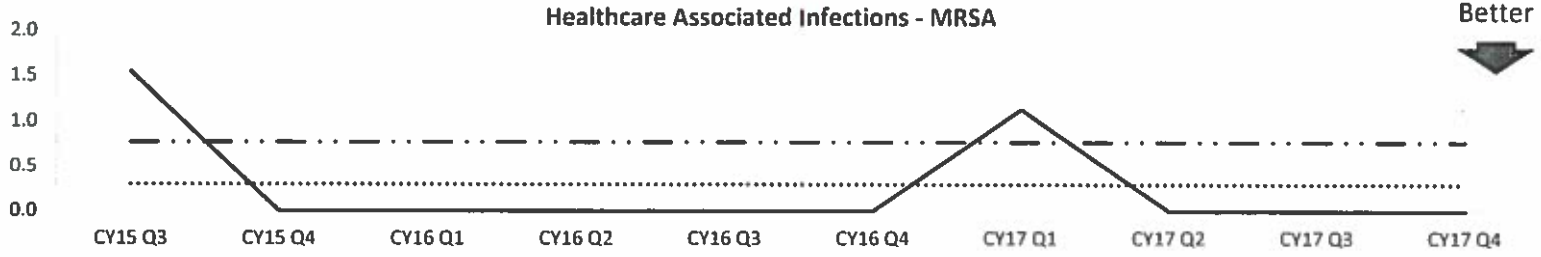
Action Plan

Colon-Rectal Bundle in OR developed/implemented, working with the MS to have a consistent dressing change process for nursing. Will be working with SNF's on tube and dressing change process

Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

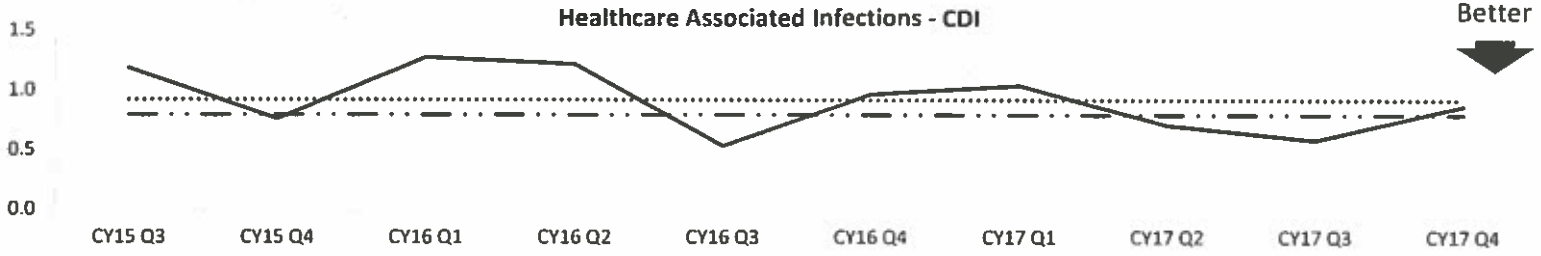
Healthcare Associated Infections - MRSA



Action Plan

Process remains in place. 1 reported hospital acquired MRSA QTR 1 17 none since. Process remains stable

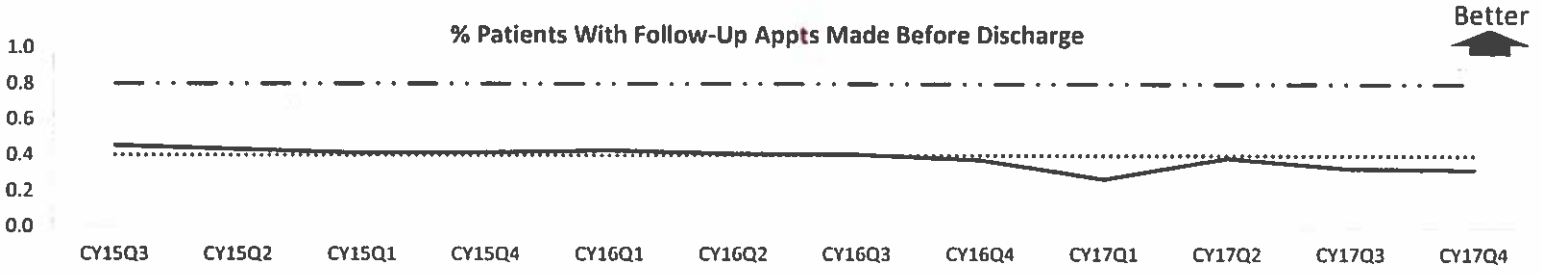
Healthcare Associated Infections - CDI



Action Plan

Diaherra tree, C-Dif descision matrix designed by pharmD & IC Doc for physicians to reference, HH still in place, high touch & bleach in place for room done

% Patients With Follow-Up Appts Made Before Discharge



Action Plan

Process remains problematic, patients do not want to select times before DC, staff forgetting to make follow-up appointments, ongoing education remains in-force

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	26	23	23	20	27	27	22						168
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	14						76
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	23						106
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	15						124
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

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	29						243
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Performance compared to prior year: Better | Same | Worse

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	16.7						14.8
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	7.2						7.8
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	12.5						12.9
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	210.7						176.2
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

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194	206	184	166	209						1,391
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	14						88
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Performance compared to prior year: Better | Same | Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7	3	4	3	4						32
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	11						61
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	1.64						1.76
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

Financial Strength

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8						49.1	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	49.9	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY18	82.1	79.1	78.8	83.4	87.7	81.3	82.9						82.2	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	85.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)						($5,415)	($1,246)
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$2,869	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%						-2.57%	-0.59%
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%	1.47%	

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81						$3,700	$8,039
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	$11,735	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%						1.76%	3.79%
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%	6.01%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95						6.33	6.28
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	6.04	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7					
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9	$64.0

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending January 31, 2018

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm 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)	10,636.29	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
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.56	(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	01/31/18	**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)	11,233.18	09/01/17	08/31/19	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste 100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.35	(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)	5,135.39	10/28/13	10/31/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri-City Orthopedic Bldg Partners 3905 Waring Road Oceanside, CA 92056 **V#83020**	10,218	$2.50	(a)	27,970.32	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Total				**$ 188,536.69**			

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending January 31, 2018

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	2018 LEAD ACADEMY	12418	310.00	83176	JONATHAN DEVERA
6185	ONS CERTIFICATE COURSE	11518	103.00	77582	ANNA CRUZADA
6185	MANAGING PATIENTS WITH BH NEEDS	1110173	345.00	14365	COURTNEY NELSON
6185	MANAGING PATIENTS WITH BH NEEDS	1110174	345.00	14365	DIANE SIKORA
7010	MANAGING PATIENTS WITH BH NEEDS	111017	345.00	14365	CANDICE PARRAS
7010	MANAGING PATIENTS WITH BH NEEDS	1110172	345.00	14365	HEIDI BENSON
7092	FIRST ASSIST COURSE	102017	6,070.78	83172	RUMIKO HARKNESS
7095	UCLA ULTRASOUND COURSE	80917	895.00	83173	RENEE TEBON
7290	NEW MEDICARE CONDITIONS WORKSHOP	11518	195.00	14369	MONICA TRUDEAU
7290	NEW MEDICARE CONDITIONS WORKSHOP	115182	195.00	14369	CYNTHIA BOATWRIGHT
7894	ONS CERTIFICATE COURSE	11918	103.00	80734	RENATA MACIK
8010	OHRP CONFERENCE	12218	300.00	80273	INGRID STUIVER
8650	HOTEL-RECRUITMENT CONFERENCE	113017	1,837.71	82746	A. MORRIS, M. RICHINS, C PARRAS
8710	2018 CME ESSENTIALS WORKSHOP	11718	300.00	82538	TERRY BOWEN
8740	IMAGING MALE BREAST CANCER	10418	125.00	29219	CONNIE J. GEORGE
8740	ACLS CERTIFICATION COURSE	10418	150.00	83174	MARK ANTHONY VITIN
8740	PCCN CERTIFICATE COURSE	121417	185.00	83154	LISA LEGANS
8740	ONCOLOGY PHARMACY SPECIALIST CERTIFICATION	1116172	200.00	18104	ANGELA ANSON
8740	CNA RECERTIFICATION COURSE	10418	200.00	82012	CHRISTINA HART
8740	CT BASICS COURSE	120717	200.00	83150	BRENNA CUNNINGHAM

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.

**Detailed backup is available from the Finance department upon request.

February 1, 2018

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

Governance Forum, California Hospital Association, January 31, 2018 Sacramento, California

I attended the Governance Forum of CHA. The Governance Forum is a subcommittee of the CHA board that allows trustees input into the legislative agenda. This forum represents both public and private hospitals along with CHA staff and board members.

Bill Emmerson Government Relations, discussed board's 2018 agenda for legislation CH will co-sponsor a Bill AB 1795 – Gibson to allow EMS rigs to take patients to facilities other than Hospital Emergency Departments. A companion bill has been introduced in the Senate SB 944- Hertzberg. Legislation re: homeless discharges from ED's may be introduced to tighten the criteria for a "safe discharge".

UHW has some proposed Propositions but the one gathering the most steam is a proposal to place staff limits on chronic dialysis units. Per Bill a law designed to bolster union membership at these facilities. A most notable Proposition that may appear is a proposal to raise taxes on the wealthy. The proposition promises some of that money will go to some Hospitals who are more rural or treat underserved. Tri City would not qualify but UHW is asking those hospitals to kick in a lot of money to support this effort.

Anne O'Rourke, Senior Vice President of Federal Relations presented the federal legislative report. As most probably already known, much of the funding for Medicare and Medicaid is still hotly debated. Alyssa Keefe, VP regulatory affairs, discussed many of the proposed CMS regulations. Less Quality measures are proposed for 2018 (5).The administration may be continuing to streamline regulations but Alyssa is not so sure about the CMS system.

We were introduced to the new CEO/President of CHA Carmella Coyle. She is a very sharp person and felt that was an important year for healthcare. We also heard a presentation form D. Grellman about possible Seismic legislation proposed for California. A "spot bill" has been introduced to increased non-structural regulations that are supposed to decrease costs for those of that have to meet 2030 deadlines. Structural proposals may have an impact on costs.

The Governor's budget was presented as it relates to healthcare. Nothing new but expect the Gov. to continue to dip his hands into promised healthcare pots to feed the California Legislative system.

I had an opportunity to talk with Angela Gilliard representative from the Office of The President UC system. She said she had spoken to Patty Maeisent from UC San Diego and knows how important it is from Tri City to have a healthy bottom line for 2019.