TRI-CITY HEALTHCARE DISTRICT **REVISED**
AGENDA FOR A REGULAR MEETING
March 29, 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. Approval of prior Closed Session Minutes		
	d. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 1 Matters)		
7	Motion to go into Open Session		

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
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 Revenue Cycle – Ray Rivas, CFO	 15 min.	 CFO
13	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	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) LAFCO Update b) Consideration to approve a Memorandum of Understanding between Fallbrook Hospital and Tri-City Healthcare District related to Phasing of Tax increment	 10 min. 10 min.	 Board Counsel Board Counsel
	b) Consideration to amend TCHD Bylaws a) Article V, Committees	10 min.	Chair/Board Counsel
	c) Approval of Resolution No. 790, A Resolution of the Board of Directors of Tri-City Healthcare District Amending Conflict of Interest Code	10 min.	Board Counsel
	d) Consideration to amend Board Policy 18-042 related to section *"Promote quality medical care"*.	5 min.	CNE
17	Old Business - none		
18	Chief of Staff a. Consideration of March Credentialing Actions and Reappointments Involving the Medical Staff and as recommended by the Medical Executive Committee on March 26, 2018 b. Medical Staff Rules & Regulations: c) Medical Staff Rules & Regulations: 1) Division of Neurology	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	2) Division of Internal Medicine 3) Department of Radiology 4) Department of Pediatrics d) Recommendation from Medical Quality Peer Review & The Credentials Committee regarding Cardiothoracic Surgery		
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.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *(No meeting held in March, 2018)* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 1 *(No meeting held in March, 2018)* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **D. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Consideration to approve an agreement with Abbot/St. Jude Medical for a term of 48 months, beginning April 1,2018 through March 31, 2022 for an annual cost of $2,435,489 and a total cost for the term of $9,741,956. 2) Approval of an addition of Dr. Abigail Lawler to the current existing ED On-Call Coverage Panel for Neurology for a term of three months, beginning April 1, 2018 through June 30, 2018. 3) Approval of an agreement with Dr. Sharon Slowik, Coverage Physician for Inpatient Wound Care for a term of 12 months beginning May 1, 2018 through April 30, 2019, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200. 4) Approval of an agreement with Dr. Henry Showah, Coverage Physician for Inpatient Wound Care for a term of 12 months beginning May 1, 2018 through April 30, 2019, not to exceed an average of 20 hours a month at an hourly rate of $180 for a total	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	cost for the term of $43,200. 5) Approval of an agreement with Dr. Sharon Slowik, Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months, beginning May 1, 2018 through April 30, 2019, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200. 6) Approval of an agreement with Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months May 1, 2018 through April 30, 2019, not to exceed an average of 20 hours a month at an hourly rate of $180 for a total cost for the term of $43,200. 7) Approval of an agreement with Oxford for Coding Support for a term of 12 months, beginning May 1, 2017 through April 30, 2018 for an increased cost of $125,000 and a total cost for the term of $755,000.		
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) Release of Deceased to a Family Member Policy b) Safe Medical Device Act Tracking and Reporting Policy c) Safe Surrender d) Sponge, Sharps and Instrument Counts – Prevention of Retained Surgical Items 2) **Unit Specific** **A. Administrative** a) Success Service Recovery Program (SSRP) Formerly Star Service Plan **B. Behavioral Health Services** a) Approved Abbreviations b) Assisting MediCal Recipients with Grievances and Appeals c) Behavioral Health Unit Visiting Policy (DELETE) d) BHU Multidisciplinary Treatment Plan e) Clinical Assessment f) Community Meeting g) Conducting Searches Patient Rooms Patient Belongings h) Confidentiality i) Cleaning and Changing of BHU/CSU Bathroom Curtains j) Daily Environmental Safety Rounds k) Daily Schedule l) Direct Admissions to BHU m) Discharge Planning n) Dress Code for Patients o) Elopement Precautions p) Environmental Safety Standards in BHU		PAC

	Agenda Item	Time Allotted	Requestor
	q) Exclusionary Criteria (DELETE) r) Family Involvement in Treatment s) Food for the Unit t) Freedom of Movement u) General Supervision of Patients: Patient Rounds v) Hose Use During Garden Activity x) Inpatient Unit Admission Criteria y) Involuntary Hold Patients (DELETE) z) Management of Aggressive and Assaultive Behavior **C. Food & Nutrition** a) Clinical Nutrition Dietitian Staffing b) Nutrition Assessment and Care for Adult Geriatric Patients Protocol **D. NICU** a) Admission and Discharge Criteria for the NCU b) Ordering of Durable Medical Equipment (DELETE) c) Patient Assignment in NICU d) Patient Classification (Acuity) in the NICU **E. Outpatient Infusion Center** a) Infection Prevention and Control Activities (DELETE) **F. Pharmacy** a) Automated Dispensing Machine b) Licensure and Professional Standards c) Medication Preparation d) Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors **G. Progressive Care Unit** a) Custody Awareness Safety Guidelines b) Hunger Strike, CDCR c) Release of a Deceased – Justice Involved Patient		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 0 *(No meeting held in March, 2018)*		
	G. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in March, 2018)*		Audit, Comp. & Ethics Comm.
	(2) Minutes – Approval of: a) Regular Board of Directors Meeting – February 22, 2018 b) Special Board of Directors Meeting – February 20, 2018		Standard
	(3) Meetings and Conferences - None		
	(4) Dues and Memberships a) Modern Healthcare Subscription - $85.00/Board Member		
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
21	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (February, 2018) (d) Reimbursement Disclosure Report – (February, 2018) (e) Seminar/Conference Reports 1) CHA Legislative Days – Director Dagostino 2) ACHD Leadership Academy – Director Grass	0-5 min.	Standard
22	Legislative Update a) CSDA "Take Action" Form	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		

Procopio

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

AUSTIN
DEL MAR HEIGHTS
PHOENIX
SAN DIEGO
SILICON VALLEY

MEMORANDUM

ATTORNEY-CLIENT PRIVILEGED
ATTORNEY WORK PRODUCT

TO: Board of Directors
Tri-City Healthcare District

FILE NO: 116569/000004

FROM: Greg V. Moser
Adriana R. Ochoa

CC: Steve Dietlin, CEO

DATE: March 22, 2018

RE: Update regarding LAFCO Application, CVRA

LAFCO

As this Board of Directors is aware, Tri-City Healthcare District (TCHD) submitted an application to the Local Agency Formation Commission (LAFCO) on or about September 25, 2017, for the annexation and detachment of certain territories, and for an amendment to TCHD's sphere of influence. TCHD's LAFCO application proposes to change certain district boundaries to generally be more coterminous with the three cities' boundaries (Carlsbad, Oceanside, Vista).

BOS Approves Tax Exchange

The San Diego County Board of Supervisors approved a Property Tax Exchange Resolution relative to TCHD's LAFCO application at the February 14, 2018 BOS Board Meeting. Generally, this resolution proposed a renegotiated tax allocation by and between the "affected agencies" which are TCHD, the Fallbrook Regional Health District, the Palomar Healthcare District, and the County of San Diego. The impact of the renegotiated tax allocation for TCHD will be a net positive allocation of roughly an additional **$180,022.73** in property tax revenues beginning Fiscal year 19-20. This amount is approximate because the assessed valuation of land changes from year to year. Taxes are only being reallocated when a land is being transferred from a healthcare district to another agency (e.g., from Fallbrook Health District to TCHD, from TCHD to Palomar). No taxes are being reallocated for territory that was previously unserved by a district.

The largest transfer is happening via the Area D exchange (2,737 acres of land in Oceanside from Fallbrook Health District to TCHD), resulting in a property tax exchange of approximately $181,454.58 from Fallbrook to TCHD. The other two exchanges were very small - $1,224 from

TCHD to the County for the 25,541 acres in Camp Pendleton, and $207 from TCHD to Palomar Healthcare District for the 56 acres in San Marcos.

LAFCO Approves TCHD's Application

On March 5, 2018, the LAFCO Commission unanimously approved TCHD's application. A 30-day reconsideration period must run before LAFCO may record the new boundaries. Additionally, LAFCO imposed a condition on its approval requiring an agreement between TCHD and the Fallbrook Regional Health District to phase the implementation of the associated property tax exchange established for the reorganization by the County Board of Supervisors. The adopted condition's aim is to help lessen the near-term financial impact on FRHD (at the LAFCO hearing, FRHD's counsel represented that the $181,454 constitutes roughly 10% of FRHD's annual budget). As a result of LAFCO's imposed condition, TCHD is required to submit to LAFCO written notification confirming that TCHD and FRHD have executed an agreement regarding the phased implementation of FRHD's property tax revenue by no later than May 4, 2018, so that LAFCO may record the new boundaries in time for the Registrar of Voters to enact the jurisdictional changes ahead of the November 6, 2018 general election.

TCHD staff and counsel have conferred with FRHD staff and counsel, and have drafted a proposed Memorandum of Understanding Regarding the Phasing of Tax Increment Impact for LAFCO-Approved District Boundary Adjustment, which is listed in this month's agenda for consideration. The MOU proposes to phase the tax revenue into Tri-City over a three-year period:

FY 19-20: Fallbrook gets 60% of tax revenue, TCHD gets 40%. (TCHD to forward payment of the 60% to Fallbrook by no later than September 15, 2020, subject to TCHD's confirmation with the County of TCHD's receipt of the funds)

FY 20-21: Fallbrook gets 30% of tax revenue, TCHD gets 70%. (TCHD to forward payment of the 30% to Fallbrook by no later than September 15, 2020, subject to TCHD's confirmation with the County of TCHD's receipt of the funds)

FY 21-22 (and beyond): TCHD gets 100% of tax revenue.

We recommend the TCHD Board of Directors approve the MOU with Fallbrook. If TCHD declines to approve the MOU with Fallbrook, LAFCO cannot record the new jurisdictional boundaries proposed in TCHD's LAFCO application. Once TCDH submits proof of the executed agreement, LAFCO can record the new boundaries with the County.

CVRA

We anticipate bringing a draft Resolution that approves one of the draft maps previously reviewed by the Board and public for approval at the regular April board meeting. The Board should select one of the maps and set a sequence of elections for the new zones at that meeting. The Resolution, once approved, will incorporate the map that is selected, and the resolution and selected map will be sent to the County Registrar of Voters before May 4, so that the new zones and election sequence are in place for the November 2018 elections.

MEMORANDUM OF UNDERSTANDING
BETWEEN FALLBROOK REGIONAL HEALTH DISTRICT
AND TRI-CITY HEALTHCARE DISTRICT REGARDING PHASING OF TAX INCREMENT IMPACT FOR LAFCO-APPROVED DISTRICT BOUNDARY ADJUSTMENT

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is entered into and executed as of March __, 2018, by and between FALLBROOK REGIONAL HEALTH DISTRICT, a California local healthcare district organized and operating under Health and Safety Code section 32000 *et seq.* ("FRHD") and TRI-CITY HEALTHCARE DISTRICT, a California local healthcare district organized and operating under Health and Safety Code section 32000 *et seq.* ("TCMC").

RECITALS

A. In May, 2015, the San Diego County Local Agency Formation Commission ("LAFCO") released its Municipal Services Review ("MSR") of all four of the county's local health care districts. Included in the LAFCO MSR were a number of recommended boundary adjustments, including a recommendation that approximately 2,747 acres of real property comprising the Southwest portion of FRHD ("the Annexed Land") should be detached and added to TCHD, as the Annexed Land was located within the city limits and sphere of influence of the City of Oceanside;

B. The Annexed Land is described more specifically in **Exhibit A** hereto;

C. In accordance with the MSR recommendation, TCHD submitted an application for adjustment of Boundaries with LAFCO on or about September 25, 2017, which LAFCO named the "Proposed Tri-City Healthcare District Reorganization (SA17-09a&b; RO17-09)" (referred to herein as the "Proposal"). In its Proposal, TCHD requested, among other adjustments, that the boundary between FRHD and TCHD be adjusted to allow the Annexed Land to be detached from FRHD and annexed to TCHD;

D. On or about November 8, 2017, at TCHD's request and to help facilitate TCHD's plan to transition from at-large to zone-based elections for the November 2018 election, the FRHD Board of Directors formally voted to consent to the boundary adjustment sought by TCHD's application to LAFCO;

E. By letter dated January 11, 2018, the County of San Diego Auditor notified TCHD, with a copy to FRHD, of its findings relative to the property tax revenue generated within a jurisdictional change, including the revenue impact of the boundary adjustment for the Annexed Land ("auditor letter"). Per the information in the auditor letter, the detachment of the Annexed Land from FRHD and annexation to Tri-City would result in a loss (in current dollars) of $181,454.88 in property tax increment revenue to FRHD. This would represent just over 10% of FRHD's current share of the

property tax increment, though the proposed boundary adjustment affects only 3.8% of FRHD's total service area;

F. Between January 11, 2018, and February 14, 2018, FRHD and TCHD did not discuss or negotiate the revenue implications of the boundary adjustment as outlined in the auditor letter, as prescribed by Revenue & Tax Code Section 99. On or about February 14, 2018, the County Board of Supervisors considered and approved a Resolution Regarding Negotiated Property Tax Exchange Relative to Jurisdictional Changes ("BOS Resolution") as outlined in the auditor letter, as a prerequisite to LAFCO approval of TCHD's Proposal, which BOS Resolution is attached hereto as **Exhibit B**;

G. The BOS Resolution implements the property tax exchange identified in the County of San Diego Auditor letter of January 11, 2018 by, among other things, reallocating the Annual Tax Increment ("ATI") currently allocated to FRHD for the Annexed Land, which is identified as 0.02322049 (or roughly 2.34%), to TCHD;

H. The tax impacts of the property tax exchange as well as the boundary adjustment between FRHD and TCHD, if approved by LAFCO, will not take effect until July 1, 2019;

I. On or about March 5, 2018, the LAFCO Commission approved a Resolution of the San Diego Local Agency Formation Commission Approving the Proposed Tri-City Healthcare District Reorganization (RO17-19) and Associated Sphere of Influence Amendments for Tri-City Healthcare District and Palomar Healthcare District (SA17-09a and SA17-09b) and Establishing Special Sphere of Influence Study Area Designations for Tri-City Healthcare District and Palomar Health Heathcare [*sic*] District (the "LAFCO Resolution"), which LAFCO Resolution is attached hereto as **Exhibit C**;

J. The LAFCO Resolution approved the Proposal but conditioned the approval on, among other conditions, the receipt by the Executive Officer of a written agreement between TCHD and FRHD signed by their respective designees to phase the implementation of the corresponding property tax exchange before going into full effect no later than Fiscal Year 2022;

K. TCHD recognizes the potentially disruptive impact that a revenue loss of 10% could cause FRHD, and is willing to accept a phased in approach to the property tax increment adjustment which will follow the boundary adjustment effective on July 1, 2019, consistent with LAFCO's direction and condition of approval;

L. FRHD would prefer deferral of the full revenue impact of the boundary adjustment over a period of years, to allow FRHD the opportunity to adjust to the loss operationally, while still supporting needed health services to its community, including clinical programs in the community which provide care for patients who might have no

other recourse than to present in hospital emergency departments, as authorized under Health & Safety Code Section 32121(j) ; and,

M. TCHD recognizes that phasing in the tax exchange is a condition of LAFCO's approval of the Proposal and is also consistent with its powers and duties under Health & Safety Code Section 32121(j), which affords TCHD the right to provide assistance in the operation of one or more health facilities or health services "at any location within or without the district for the benefit of the district and the people served by the district."

THEREFORE, in consideration of their mutual promises and undertakings set forth herein, the parties agree as follows:

AGREEMENT

1. Purpose. In accordance with Revenue and Tax Code Section 99, TCHD and FRHD acknowledge and agree that the property tax exchange for the boundary adjustment contemplated by the Proposal, the BOS Resolution, and the LAFCO Resolution, shall be accomplished in three (3) phases, as follows:

a. For the Fiscal Year beginning July 1, 2019 and ending on June 30, 2020, TCHD shall retain forty percent (40%) of the ATI received from the County of San Diego for the Annexed Land for that fiscal year, and TCHD covenants and agrees that it will remit to FRHD an amount equal to 60% of the ATI received from the County of San Diego for the Annexed Land for that fiscal year, subject to TCHD's confirmation with the County of TCHD's receipt of the ATI for the Annexed Land, by no later than September 15, 2020. TCHD represents that it will diligently endeavor to obtain confirmation by the County of receipt of the ATI for the Annexed Land.

b. For the Fiscal Year beginning July 1, 2020, and ending on June 30, 2021, TCHD shall retain seventy percent (70%) of the ATI received from the County of San Diego for the Annexed Land for that fiscal year, and TCHD covenants and agrees that it will remit to FRHD an amount equal to thirty percent 30% of the ATI received from the County of San Diego for the Annexed Land for that fiscal year, subject to TCHD's confirmation with the County of TCHD's receipt of the ATI for the Annexed Land, by no later than September 15, 2021. TCHD represents that it will diligently endeavor to obtain confirmation by the County of receipt of the ATI for the Annexed Land.

c. For the Fiscal Year beginning July 1, 2021 and in all subsequent years thereafter, the entire ATI received from the County of San Diego for the Annexed Land will be implemented and allocated to TCHD in full, and TCHD shall keep one hundred percent (100%) of that ATI.

2. Further Assurances. The parties hereto agree to undertake all necessary and reasonable steps, including without limitation the filing of any additional applications or documents deemed required to implement the intent and purpose of this MOU, to allow for the tax exchange required by the LAFCO Resolution to be phased in over a three-year period beginning with the Fiscal year that begins on July 1, 2019.

3. Notices. Notices required by law or by this Agreement, shall be deemed sufficient if given, in writing and deposited in the United States Mail, postage prepaid, to the following:

To TCMC: Steve Dietlin, CEO
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

To FRHD: Bobbi Palmer, CEO
Fallbrook Regional Health District
138 S. Brandon Road
Fallbrook, California 92028

4. Severability. If anyone or more of the terms, provisions, promises, covenants or conditions of this Agreement shall be to the extent judged invalid, unenforceable, void or voidable for any reason whatsoever by a court of competent jurisdiction, each and all of the remaining terms, provisions, promises, or conditions of this Agreement shall not be affected thereby, and shall be valid and enforceable to the fullest extent allowed by law.

5. Agreement Not Partnership or Joint Venture; No Third Party Beneficiaries. Nothing in this Agreement shall be deemed to establish relationships between the parties other than those expressly described and set forth. The agreements contained herein are made solely for the benefit of the parties, and shall not be construed as benefiting any person who is not a party to this Agreement.

6. Authority to Enter into Agreement. Each party represents that it has the full power and authority to enter to this Agreement and to carry out the powers contemplated by it. Each party further represents that it has taken all action necessary to authorize the execution, delivery and performance of the Agreement. Each person signing below warrants that he/she has full power and authority to bind the party under which her/his signature appears.

7. Indemnification. FRHD shall indemnify, defend and hold harmless TCHD and its directors, officers, employees and agents, from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs arising out of this MOU. This Section 7 shall survive the expiration or termination of this Agreement.

a. FRHD agrees that it shall indemnify, defend and hold harmless LAFCO and its respective directors, officers, employees or agents, from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs arising out of this MOU

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and attested by their proper officers as of the date first above written.

FALLBROOK REGIONAL HEALTH DISTRICT

Signature: _____

Printed Name: _____

Title: _____

Date: _____

TRI-CITY HEALTHCARE DISTRICT

Signature: _____

Printed Name: _____

Title: _____

Date: _____

APPROVED AS TO FORM:

_____
Keene Simonds, Chief Executive Officer
San Diego LAFCO

EXHIBIT A

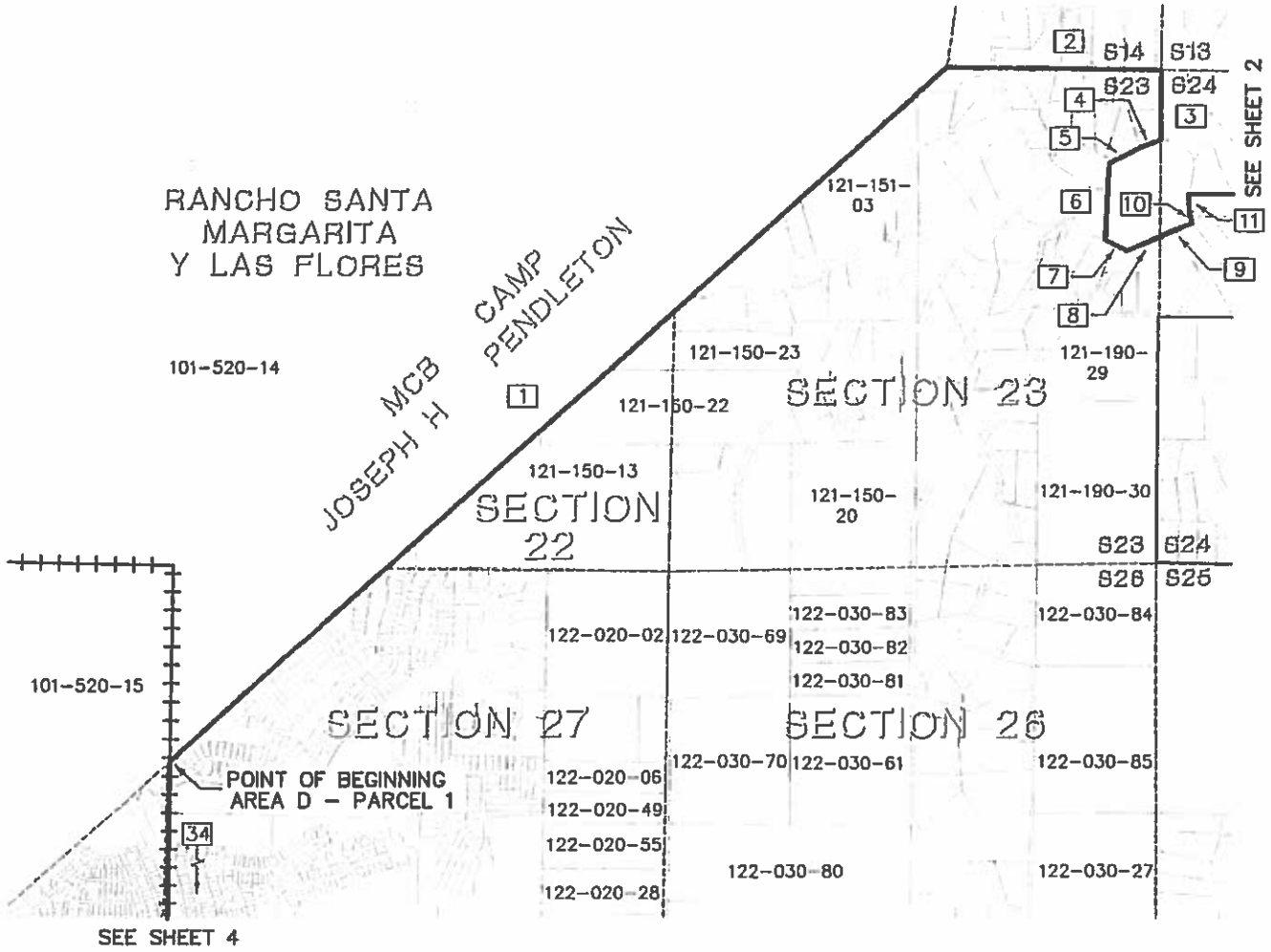


EXHIBIT AREA D

SHEET 1 OF 4

"BEING A PORTION OF SECTION 22, 23, 24, 25, 26, 27 & 34 IN TOWNSHIP 10 SOUTH, RANGE 4 WEST AND SECTION 31, TOWNSHIP 10 SOUTH, RANGE 3 WEST SAN BERNARDINO BASE AND MERIDIAN"

EXISTING BOUNDARY OF TRI CITY HD

PROPOSED BOUNDARY OF TRI CITY HD

COURSE TABLE

COURSE	BEARING/DELTA	RADIUS	LENGTH
1	N 48°03'38" E		11098.00
2	S 89°10'15" E		2291.34'
3	S 00°26'51" E		738.50'
4	S 68°51'12" W		250.00'
5	S 62°15'00" W		352.99'
6	S 02°23'10" W		812.00'
7	S 62°36'50" E		278.00'
8	N 67°03'10" E		370.00'
9	N 67°03'10" E		358.71'
10	N 10°06'50" W		132.50'
11	N 04°58'19" W		197.52'
34	N 00°49'40" E		3212.22'

0 1500' 3000'

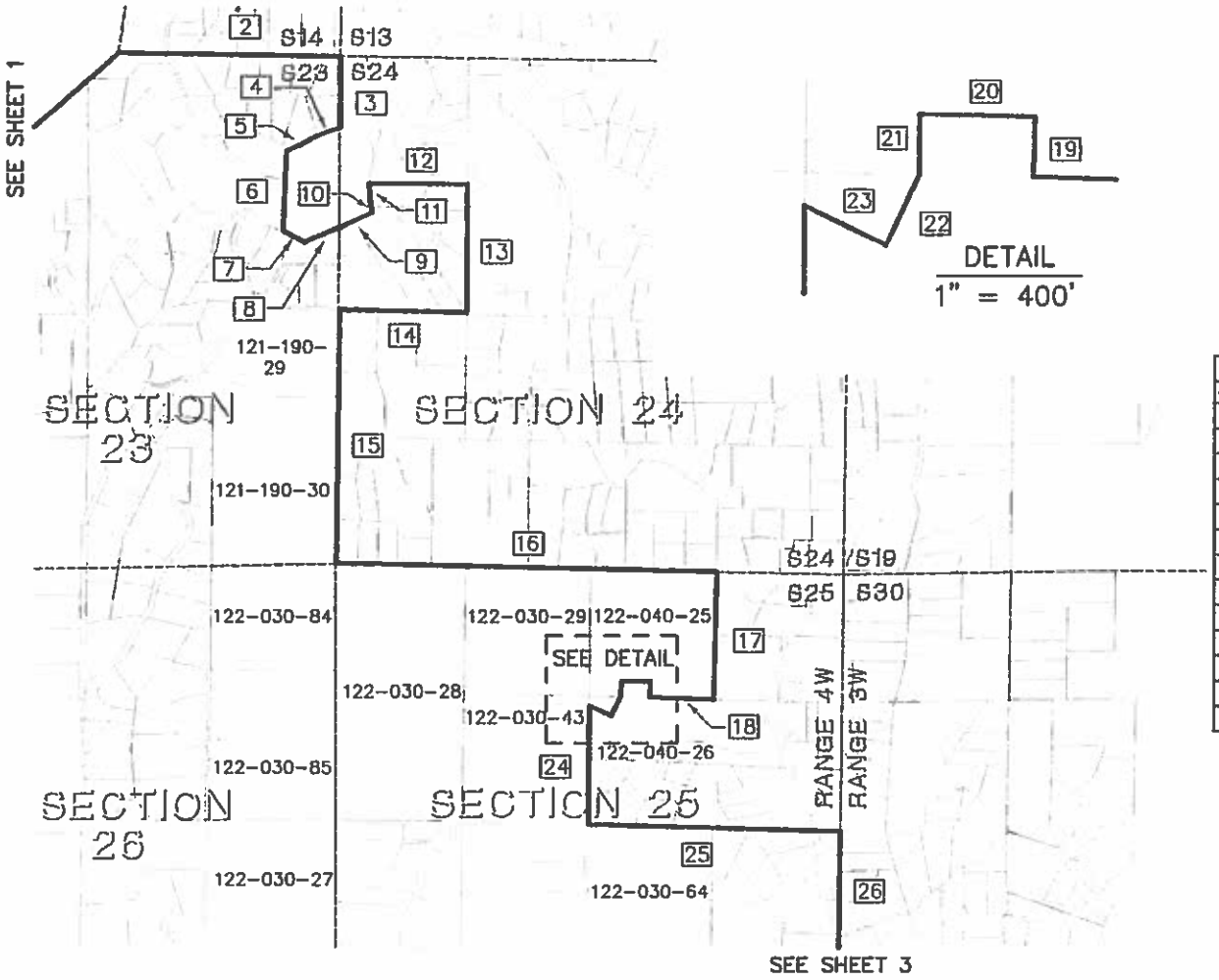
GRAPHIC SCALE

DISCLAIMER:
"FOR ASSESSEMENT PURPOSES ONLY. THIS DESCRIPTION OF LAND IS NOT A LEGAL PROPERTY DESCRIPTION AS DEFINED IN THE SUBDIVISION MAP ACT AND MAY NOT BE USED AS THE BASIS FOR SALE OF LAND DESCRIBED.

"TRI CITY HOSPITAL DISTRICT ANNEXATION" – AREA D DETACHMENT FROM FALLBROOK HOSPITAL DISTRICT	SAN DIEGO COUNTY ASSESSOR'S OFFICE MAPPING DIVISION	AREA: TOTAL 2747.37 +/–	DATE: 8/23/2017
		APN: VARIOUS	DRAWN BY: J. DELAROSA
LAFCO: XXXX–XX		SCALE: 1"=1500'	SHEET: 1 OF 4

EXHIBIT AREA D

SHEET 2 OF 4



"BEING A PORTION OF SECTION 22, 23, 24, 25, 26, 27 & 34 IN TOWNSHIP 10 SOUTH, RANGE 4 WEST AND SECTION 31, TOWNSHIP 10 SOUTH, RANGE 3 WEST, SAN BERNARDINO BASE AND MERIDIAN"

EXISTING BOUNDARY OF ALPINE FPD

PROPOSED BOUNDARY OF ALPINE FPD

COURSE TABLE		
COURSE	BEARING	LENGTH
2	S 89°10'15" E	2291.34'
3	S 00°26'51" E	738.50'
4	S 68°51'12" W	250.00'
5	S 62°15'00" W	352.99'
6	S 02°23'10" W	812.00'
7	S 62°36'50" E	278.00'
8	N 67°03'10" E	370.00'
9	N 67°03'10" E	358.71'
10	N 10°06'50" W	132.50'
11	N 04°58'19" W	197.52'
12	S 89°42'28" E	1017.54'
13	S 00°15'42" E	1315.76'
14	N 89°36'00" W	1340.52'

COURSE TABLE		
COURSE	BEARING	LENGTH
15	S 00°04'00" W	2622.81'
16	S 88°40'24" E	3958.81'
17	S 00°03'42" W	1306.70'
18	N 89°08'39" W	725.22'
19	N 00°06'14" E	145.20'
20	N 89°08'39" W	300.00'
21	S 00°05'14" W	145.20'
22	S 23°55'00" W	254.30'
23	N 62°50'20" W	215.83'
24	S 00°06'14" W	1204.74'
25	S 89°08'41" E	2597.36'
26	S 00°47'00" W	2661.57'

0 1500' 3000'

GRAPHIC SCALE

DISCLAIMER:
"FOR ASSESSEMENT PURPOSES ONLY. THIS DESCRIPTION OF LAND IS NOT A LEGAL PROPERTY DESCRIPTION AS DEFINED IN THE SUBDIVISION MAP ACT AND MAY NOT BE USED AS THE BASIS FOR SALE OF LAND DESCRIBED.

"TRI CITY HOSPITAL DISTRICT ANNEXATION" – AREA D DETACHMENT FROM FALLBROOK HOSPITAL DISTRICT	SAN DIEGO COUNTY ASSESSOR'S OFFICE MAPPING DIVISION	AREA: TOTAL 2747.37 +/–	DATE: 8/23/2017
		APN: VARIOUS	DRAWN BY: J. DELAROSA
LAFCO: XXXX–XX		SCALE: 1"=1500'	SHEET: 2 OF 4

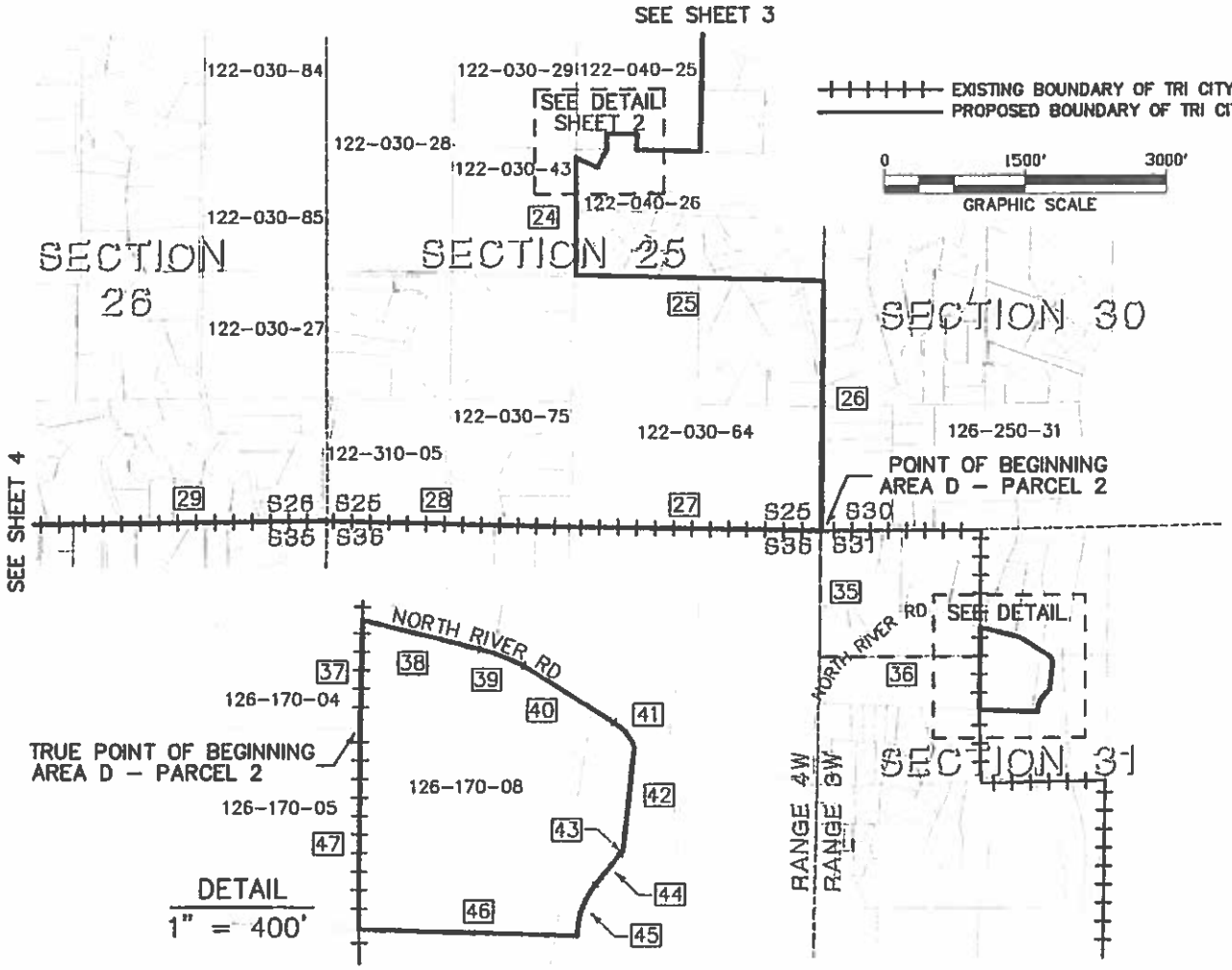


EXHIBIT AREA D

SHEET 3 OF 4

"BEING A PORTION OF SECTION 22, 23, 24, 25, 26, 27 & 34 IN TOWNSHIP 10 SOUTH, RANGE 4 WEST AND SECTION 31, TOWNSHIP 10 SOUTH, RANGE 3 WEST, SAN BERNARDINO BASE AND MERIDIAN"

COURSE TABLE

COURSE	BEARING/DELTA	RADIUS	LENGTH
24	S 00°06'14" W		1204.74'
25	S 89°08'41" E		2597.36'
26	S 00°47'00" W		2661.57'
27	N 89°06'00" W		2671.04'
28	N 88°27'06" W		2561.76'
29	S 89°09'19" W		2653.37'
35	S 00°00'47" E		1330.01'
36	N 89°51'48" E		1691.60'
37	N 00°06'04" E		294.38'
38	S 76°28'43" E		346.31'
39	19°01'01"	470.00'	156.00'
40	S 57°28'43" E		278.28'
41	32°50'02"	160.00'	91.69'
42	S 06°14'21" W		293.19'
43	03°26'53"	225.00'	13.54'
44	S 39°08'17" W		106.06'
45	40°04'36"	225.00'	157.38'
46	N 88°05'23" W		615.98'
47	N 00°06'04" E		576.42'

DISCLAIMER:
"FOR ASSESSEMENT PURPOSES ONLY. THIS DESCRIPTION OF LAND IS NOT A LEGAL PROPERTY DESCRIPTION AS DEFINED IN THE SUBDIVISION MAP ACT AND MAY NOT BE USED AS THE BASIS FOR SALE OF LAND DESCRIBED.

"TRI CITY HOSPITAL DISTRICT ANNEXATION" – AREA D DETACHMENT FROM FALLBROOK HOSPITAL DISTRICT	SAN DIEGO COUNTY ASSESSOR'S OFFICE MAPPING DIVISION	AREA: TOTAL 2747.37 +/-	DATE: 8/23/2017
		APN: VARIOUS	DRAWN BY: J. DELAROSA
LAFCO: XXXX-XX		SCALE: 1"=1500'	SHEET: 3 OF 4

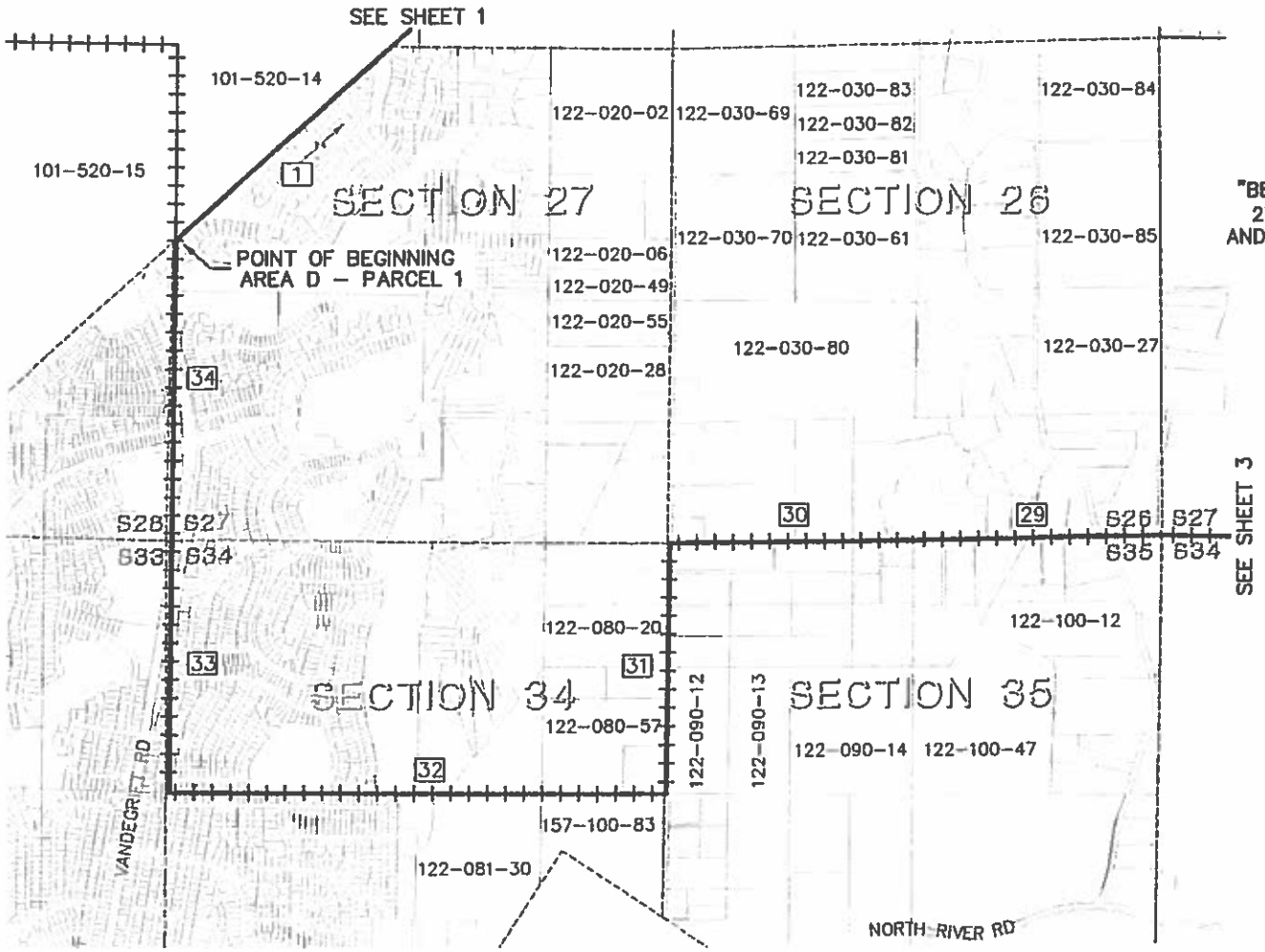


EXHIBIT AREA D

SHEET 4 OF 4

"BEING A PORTION OF SECTION 22, 23, 24, 25, 26, 27 & 34 IN TOWNSHIP 10 SOUTH, RANGE 4 WEST AND SECTION 31, TOWNSHIP 10 SOUTH, RANGE 3 WEST, SAN BERNARDINO BASE AND MERIDIAN"

EXISTING BOUNDARY OF ALPINE FPD
PROPOSED BOUNDARY OF ALPINE FPD

COURSE TABLE

COURSE	BEARING/DELTA	RADIUS	LENGTH
29	S 89°09'19" W		2653.37'
30	S 89°34'25" W		2608.90'
31	S 00°48'09" W		2661.26'
32	N 89°43'51" W		5262.04'
33	N 00°03'00" W		2661.85'
34	N 00°49'40" E		3212.22'
1	N 48°03'38" E		11098.00'

0 1500' 3000'
GRAPHIC SCALE

DISCLAIMER:
"FOR ASSESSEMENT PURPOSES ONLY. THIS DESCRIPTION OF LAND IS NOT A LEGAL PROPERTY DESCRIPTION AS DEFINED IN THE SUBDIVISION MAP ACT AND MAY NOT BE USED AS THE BASIS FOR SALE OF LAND DESCRIBED.

"TRI CITY HOSPITAL DISTRICT ANNEXATION" – AREA D DETACHMENT FROM FALLBROOK HOSPITAL DISTRICT	SAN DIEGO COUNTY ASSESSOR'S OFFICE MAPPING DIVISION	AREA: TOTAL 2747.37 +/-	DATE: 8/23/2017
		APN: VARIOUS	DRAWN BY: J. DELAROSA
LAFCO: XXXX-XX		SCALE: 1"=1500'	SHEET: 4 OF 4

GEOGRAPHIC DESCRIPTION – AREA "D"

"TRI CITY HOSPITAL DISTRICT ANNEXATION"
XXXX-XX

DETACHMENT FROM FALLBROOK HOSPITAL DISTRICT
(CITY OF OCEANSIDE)

PARCEL 1

ALL THAT PORTION OF SECTIONS 22, 23, 24, 25, 26, 27 & 34 IN TOWNSHIP 10 SOUTH, RANGE 4 WEST SAN BERNARDINO BASE AND MERIDIAN, IN THE COUNTY OF SAN DIEGO, STATE OF CALIFORNIA, ACCORDING TO UNITED STATES GOVERNMENT SURVEY, LYING WITHIN THE FOLLOWING DESCRIBED BOUNDARIES:

BEGINNING AT THE POINT OF INTERSECTION OF THE WESTERLY LINE OF SECTION 27, TOWNSHIP 10 SOUTH, RANGE 4 WEST WITH THE SOUTHEAST BOUNDARY OF RANCHO SANTA MARGARITA Y LAS FLORES, BEING ALSO THE EXISTING BOUNDARY OF THE CITY OF OCEANSIDE, AS ESTABLISHED BY THEIR ORDINANCE NO. 58-22, ADOPTED NOVEMBER 12, 1958;

1. THENCE ALONG BOUNDARY SAID CITY AND RANCHO SANTA MARGARITA, NORTH 48°03'38" EAST, 11098.00 FEET TO THE NORTH LINE OF SECTION 23 OF SAID TOWNSHIP;

2. THENCE ALONG THE NORTH LINE OF SAID SECTION 23, SOUTH 89°10'15" EAST, 2291.34 FEET TO THE NORTHEAST CORNER THEREOF;

3. THENCE ALONG THE EAST LINE OF SAID SECTION 23, SOUTH 00°26'51" EAST, 738.50 FEET;

4. THENCE SOUTH 68°51'12" WEST, 250.00 FEET;

5. THENCE SOUTH 62°15'00" WEST, 352.99 FEET;

6. THENCE SOUTH 02°23'10" WEST, 812.00 FEET;

7. THENCE SOUTH 62°36'50" EAST, 278.00 FEET;

8. THENCE NORTH 67°03'10" EAST, 370.00 FEET TO THE EAST LINE OF SAID SECTION 23;

9. THENCE CONTINUING NORTH 67°03'10" EAST, 358.71 FEET;

10. THENCE NORTH 10°06'50" WEST, 132.50 FEET;

11. THENCE NORTH 04°58'19" WEST, 197.52 FEET TO THE NORTH LINE OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER OF SECTION 24 OF SAID TOWNSHIP;

12. THENCE ALONG THE NORTH LINE OF SAID SOUTHWEST QUARTER OF THE NORTHWEST QUARTER, SOUTH 89°42'28" EAST, 1017.54 FEET TO THE NORTHEAST CORNER THEREOF;

13. THENCE ALONG THE EAST LINE OF SAID SOUTHWEST QUARTER OF THE NORTHWEST QUARTER, SOUTH 00°15'42" EAST, 1315.76 FEET TO THE SOUTHEAST CORNER THEREOF;

14. THENCE ALONG THE SOUTH LINE OF SAID SOUTHWEST QUARTER OF THE NORTHWEST QUARTER, NORTH 89°36'00" WEST, 1340.52 FEET TO THE SOUTHWEST CORNER THEREOF, BEING ALSO THE EAST QUARTER CORNER OF SECTION 23;

15. THENCE ALONG THE EAST LINE OF SAID SECTION 23, SOUTH 00°04'00" WEST, 2622.81 FEET TO THE SOUTHEAST CORNER THEREOF, BEING ALSO THE NORTHWEST CORNER OF SECTION 25 OF SAID TOWNSHIP;

16. THENCE ALONG THE NORTH LINE OF SAID SECTION 25, SOUTH 88°40'24" EAST, 3958.74 FEET TO THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF THE NORTHEAST QUARTER OF SAID SECTION 25;

17. THENCE ALONG THE EAST LINE OF SAID NORTHWEST QUARTER OF THE NORTHEAST QUARTER, SOUTH 00°03'42" WEST, 1306.70 FEET TO THE SOUTHEAST CORNER THEREOF;

18. THENCE ALONG THE SOUTH LINE OF SAID NORTHWEST QUARTER OF THE NORTHEAST QUARTER, NORTH 89°08'39" WEST, 725.22 FEET TO A POINT THAT IS DISTANT 594.78 FEET EASTERLY OF THE SOUTHWEST CORNER THEREOF;

19. THENCE NORTH 00°06'14" EAST, 145.20 FEET;

20. THENCE NORTH 89°08'39" WEST, 300.00 FEET;

21. THENCE SOUTH 00°05'14" WEST, 145.20 FEET;

22. THENCE SOUTH 23°55'00" WEST, 254.30 FEET;

23. THENCE NORTH 62°50'20" WEST, 215.83 FEET TO A POINT ON THE EAST LINE OF THE SOUTHEAST QUARTER OF THE NORTHWEST QUARTER OF SAID SECTION 25;

24. THENCE ALONG SAID EAST LINE, SOUTH 00°06'14" WEST, 1201.74 FEET TO THE SOUTHEAST CORNER OF SAID SOUTHEAST QUARTER OF THE NORTHWEST QUARTER OF SAID SECTION 25;

25. THENCE ALONG THE NORTH LINE OF THE SOUTHEAST QUARTER OF SAID SECTION 25, SOUTH 89°08'41" EAST, 2597.36 FEET TO THE NORTHEAST CORNER THEREOF;

26. THENCE ALONG THE EAST LINE OF SAID SOUTHEAST QUARTER OF SECTION 25, SOUTH 00°47'00" WEST, 2661.57 FEET TO THE SOUTHEAST CORNER OF SAID SECTION 25, BEING ALSO A POINT ON

THE EXISTING BOUNDARY OF THE FALLBROOK HOSPITAL DISTRICT, AS ESTABLISHED BY THEIR RESOLUTION NO. 154, ADOPTED JANUARY 21, 1975;

27. THENCE ALONG SAID DISTRICT BOUNDARY AND THE SOUTH LINE OF SAID SECTION 25, NORTH 89°06'00" WEST, 2671.04 FEET TO THE SOUTH QUARTER CORNER THEREOF;

28. THENCE CONTINUING ALONG THE SOUTH LINE OF SAID SECTION 25, NORTH 88°27'06" WEST, 2561.76 FEET TO THE SOUTHWEST CORNER OF SAID SECTION 25, BEING ALSO THE SOUTHEAST CORNER OF SECTION 26 OF SAID TOWNSHIP;

29. THENCE ALONG THE SOUTH LINE OF SAID SECTION 26, SOUTH 89°09'19" WEST, 2653.37 FEET TO THE SOUTH QUARTER CORNER THEREOF;

30. THENCE CONTINUING ALONG THE SOUTH LINE OF SAID SECTION 26, SOUTH 89°34'25" WEST, 2608.90 FEET TO THE CORNER COMMON TO SECTIONS 26, 27, 35 & 36 OF SAID TOWNSHIP;

31. THENCE ALONG THE EAST LINE OF SAID SECTION 34, SOUTH 00°48'09" WEST, 2661.26 FEET TO THE EAST QUARTER CORNER OF SAID SECTION 34;

32. THENCE ALONG THE EAST-WEST CENTER LINE OF SAID SECTION 34, NORTH 89°43'51" WEST, 5262.04 FEET TO THE WEST QUARTER CORNER THEREOF;

33. THENCE ALONG THE WEST LINE OF SAID SECTION 34, NORTH 00°03'00" WEST, 2661.85 FEET TO THE NORTHWEST CORNER THEREOF, BEING ALSO THE SOUTHWEST CORNER OF SAID SECTION 27;

34. THENCE ALONG THE WEST LINE OF SAID SECTION 27, NORTH 00°49'40" EAST, 3212.22 FEET TO THE INTERSECTION WITH THE SOUTHEASTERLY LINE OF SAID RANCH SANTA MARGARITA AND THE **POINT OF BEGINNING** OF PARCEL 1 OF THE HEREIN DESCRIBED RESOLUTION.

PARCEL 2

ALL THAT PORTION OF THE NORTHWEST QUARTER OF SECTION 31 IN TOWNSHIP 10 SOUTH, RANGE 3 WEST SAN BERNARDINO BASE AND MERIDIAN, IN THE COUNTY OF SAN DIEGO, STATE OF CALIFORNIA, ACCORDING TO UNITED STATES GOVERNMENT SURVEY, LYING WITHIN THE FOLLOWING DESCRIBED BOUNDARIES:

BEGINNING AT THE SOUTHEAST CORNER OF SECTION 25, TOWNSHIP 10 SOUTH, RANGE 4 WEST, SAID CORNER BEING A POINT ON THE EXISTING BOUNDARY OF THE CITY OF OCEANSIDE, AS ESTABLISHED BY THEIR RESOLUTION NO. 72-14, ADOPTED FEBRUARY 9, 1972;

THENCE ALONG THE BOUNDARY OF SAID CITY OF OCEANSIDE, THE FOLLOWING COURSES:

35. THENCE SOUTH ALONG THE WEST LINE OF SAID SECTION 31, SOUTH 00°00'47" EAST, 1330.01 FEET TO THE NORTH LINE OF LOT 2 OF SAID SECTION 31;

36. THENCE EASTERLY ALONG THE NORTH LINE OF SAID LOT 2 OF SECTION 31, NORTH 89°51'48" EAST, 1691.60 FEET TO THE SOUTHWEST CORNER OF THE NORTHEAST QUARTER OF THE NORTHWEST QUARTER OF SAID SECTION 31, BEING ALSO THE **TRUE POINT OF BEGINNING;**

37. THENCE ALONG THE WEST LINE OF SAID NORTHEAST QUARTER OF THE NORTHWEST QUARTER OF SECTION 31, NORTH 00°06'04" EAST, 294.38 FEET TO THE SOUTHERLY RIGHT OF WAY LINE OF ROAD SURVEY NO. 674 COMMONLY KNOWN AS NORTH RIVER ROAD;

THENCE CONTINUING ALONG SAID EXISTING BOUNDARY OF THE CITY OF OCEANSIDE AND ALONG SAID SOUTHERLY RIGHT OF WAY LINE OF NORTH RIVER ROAD, THE FOLLOWING COURSES:

38. SOUTH 76°29'43" EAST, 346.31 FEET TO THE BEGINNING OF A TANGENT 470.00 FOOT RADIUS CURVE, CONCAVE SOUTHWESTERLY;

39. THENCE SOUTHEASTERLY ALONG THE ARC OF SAID CURVE, THROUGH A CENTRAL ANGLE OF 19°01'01" A DISTANCE OF 156.00 FEET;

40. THENCE TANGENT TO SAID CURVE, SOUTH 57°28'43" EAST, 278.28 FEET TO THE BEGINNING OF A TANGENT 160.00 FOOT RADIUS CURVE, CONCAVE SOUTHWESTERLY;

41. THENCE SOUTHEASTERLY ALONG THE ARC OF SAID CURVE, THROUGH A CENTRAL ANGLE OF 32°50'02" A DISTANCE OF 91.69 FEET TO THE WESTERLY LINE OF CALIFORNIA STATE HIGHWAY XI-SD195F COMMONLY KNOWN AS MISSION ROAD;

THENCE CONTINUING ALONG SAID EXISTING BOUNDARY OF THE CITY OF OCEANSIDE AND ALONG SAID WESTERLY LINE OF MISSION ROAD, THE FOLLOWING COURSES:

42. SOUTH 06°14'21" WEST, 293.19 FEET TO THE BEGINNING OF A NON-TANGENT 225.00 FOOT RADIUS CURVE CONCAVE NORTHWESTERLY, A RADIAL LINE BEARING NORTH 54°18'36" WEST FROM SAID POINT;

43. THENCE SOUTHWESTERLY ALONG SAID CURVE, THROUGH A CENTRAL ANGLE OF 03°26'53" A DISTANCE OF 13.54 FEET;

44. THENCE TANGENT TO SAID CURVE, SOUTH 39°08'17" WEST, 106.06 FEET TO THE BEGINNING OF A TANGENT 225.00 FOOT RADIUS CURVE CONCAVE SOUTHEASTERLY;

45. THENCE SOUTHWESTERLY ALONG THE ARC OF SAID CURVE, THROUGH A CENTRAL ANGLE OF 40°04'36" A DISTANCE OF 157.38 FEET TO AN INTERSECTION WITH THE EASTERLY PROLONGATION OF THE NORTHERLY LINE OF THAT CERTAIN 11.67 ACRE PARCEL OF LAND AS SHOWN ON RECORD OF SURVEY NO. 1682 FILED IN THE OFFICE OF THE COUNTY RECORDER OF SAN DIEGO COUNTY;

46. THENCE LEAVING SAID WESTERLY LINE OF MISSION ROAD AND ALONG THE NORTHERLY LINE OF SAID 11.67 ACRE PARCEL AND ITS EASTERLY AND WESTERLY PROLONGATION NORTH 88°05'23"

WEST, 615.98 FEET TO THE WEST LINE OF SAID NORTHEAST QUARTER OF THE NORTHWEST QUARTER;

47. THENCE LEAVING SAID EXISTING BOUNDARY OF THE CITY OF OCEANSIDE AND ALONG THE WESTERLY LINE OF SAID NORTHEAST QUARTER OF THE NORTHWEST QUARTER, NORTH 00°06'04" EAST, 576.42 TO THE **TRUE POINT OF BEGINNING** OF PARCEL 2 OF THE HEREIN DESCRIBED RESOLUTION;

PARCEL 1 CONTAINING 2734.69 ACRES, **PARCEL 2** CONTAINING 12.68 ACRES: TOTAL COMPUTED ACREAGE CONTAINING 2747.37 ACRES MORE OR LESS.

FOR ASSESSMENT PURPOSES ONLY. THIS DESCRIPTION OF LAND IS NOT A LEGAL PROPERTY DESCRIPTION AS DEFINED IN THE SUBDIVISION MAP ACT AND MAY NOT BE USED AS THE BASIS FOR AN OFFER FOR SALE OF THE LAND DESCRIBED.

EXHIBIT B

Resolution No.: 18-025
Meeting Date: 02/14/18 (3)

RESOLUTION REGARDING NEGOTIATED PROPERTY TAX EXCHANGE
RELATIVE TO JURISDICTIONAL CHANGES

WHEREAS, Revenue and Taxation Code Section 99 requires the negotiation of any exchange of property tax revenues occasioned by jurisdictional changes between the areas affected; and

WHEREAS, under such circumstances the Board of Supervisors is authorized to negotiate such property tax revenue exchanges on behalf of service areas or special districts; and

WHEREAS, the jurisdictional changes shown on the attached maps between the County and Special Districts are proposed; and

WHEREAS, the Board of Supervisors has determined, that pursuant to Section 15378(b)(4) of the State CEQA Guidelines, this property tax exchange is not subject to the environmental impact evaluation process because the proposed action involves fiscal activities which do not involve any commitment to any specific project which may result in a potentially significant physical impact on the environment; and

WHEREAS, the Board of Supervisors has negotiated with the affected Cities and Special Districts to determine an equitable exchange of property tax revenues applicable to such jurisdictional exchange; NOW THEREFORE

IT IS RESOLVED AND ORDERED that the Clerk of the Board of Supervisors shall, on behalf of the adopting agencies, notify the County Auditor and the Local Agency Formation Commission of such negotiated exchange of property tax revenues by forwarding to them a copy of this Resolution.

CCSF, 30.01, 8/84

NEGOTIATION OF PROPERTY TAX EXCHANGE

ALLOCATION OF ANNUAL TAX INCREMENT (ATI)

Proposal

Property Tax Exchange Resolution: Tri-City Healthcare District Reorganization (Tri-City Healthcare District, Fallbrook Regional Healthcare District and Palomar Health Healthcare District, County General): RO17-09; SA17-09

Basis for Exchange:

A. If the proposal is approved as submitted by LAFCO, the following tables show the exchange of annual tax increment (ATI) being transferred. In addition to the ATI, base revenue shall also be transferred to the annexing agencies:

Local Agencies	Current ATI	Renegotiated ATI
Area A		
County General	0.16845674	0.19154775
Tri-City Healthcare District	0.02309101	0.00000000
All Other Taxing Jurisdictions	0.80845225	0.80845225
Total	1.00000000	1.00000000
Area B		
No Exchanges		
Area C		
No Exchanges		
Area D		
County General	0.18730220	0.18730220
Tri-City Healthcare District	0.00000000	0.02322049
Fallbrook Regional Healthcare District	0.02322049	0.00000000
All Other Taxing Jurisdictions	0.78947731	0.78947731
Total	1.00000000	1.00000000
Area E		
County General	0.14450745	0.14450745
Tri-City Healthcare District	0.01924398	0.00000000
Palomar Health Healthcare District	0.00000000	0.01924398
All Other Taxing Jurisdictions	0.83624857	0.83624857
Total	1.00000000	1.00000000
Area F		
No Exchanges		
Area G		
No Exchanges		

B. If the proposal is not processed as submitted by LAFCO, no property tax exchange shall occur

Approved as to form and legality
County Counsel

By: Randall Sjoblom, Senior Deputy

ON MOTION of Supervisor Roberts, seconded by Supervisor Horn, the above Resolution was passed and adopted by the Board of Supervisors, County of San Diego, State of California, on this 14th day of February, 2018, by the following vote:

AYES: Cox, Jacob, Gaspar, Roberts, Horn

- - -

STATE OF CALIFORNIA)
County of San Diego)SS

I hereby certify that the foregoing is a full, true and correct copy of the Original Resolution entered in the Minutes of the Board of Supervisors.

DAVID HALL
Clerk of the Board of Supervisors

By: _____
Elizabeth Miller, Deputy

Resolution No. 18-025
Meeting Date: 02/14/18 (3)

EXHIBIT C

Minute Item: 5
Ref. Nos.: SA17-09a; SA17-09b; RO17-09

RESOLUTION OF THE LOCAL AGENCY FORMATION COMMISSION OF THE COUNTY OF SAN DIEGO ADOPTING AMENDMENTS TO THE SPHERES OF INFLUENCE FOR THE TRI-CITY HEALTHCARE DISTRICT AND PALOMAR HEALTH HEALTHCARE DISTRICT AND ESTABLISHING SPECIAL SPHERE OF INFLUENCE STUDY AREA DESIGNATIONS FOR TRI-CITY HEALTHCARE DISTRICT AND PALOMAR HEALTH HEALTHCARE DISTRICT AND MAKING DETERMINATIONS, APPROVING, AND ORDERING THE "TRI-CITY HEALTHCARE DISTRICT REORGANIZATION" (TRI-CITY HEALTHCARE DISTRICT)

WHEREAS, Tri-City Healthcare District (HD) has filed a resolution of application with the Local Agency Formation Commission of the County of San Diego, hereinafter referred to as "Commission," pursuant to the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000; and

WHEREAS, the proposal seeks Commission approval to reorganize approximately 36,700 acres of lands located in northern San Diego County and involves the following jurisdictional changes affecting three subject agencies, Tri-City HD, Palomar Health HD, and Fallbrook Regional HD as shown in Exhibit "A" and involve: annexation of approximately 8,232-acres to the Tri-City Healthcare District; detachment of approximately 25,657-acres from the Tri-City Healthcare District; annexation of approximately 57-acres to the Palomar Health Healthcare District; and, detachment of approximately 2,747-acres from the Fallbrook Regional Healthcare District; and

WHEREAS, portions of the affected territory as proposed currently lies outside of the spheres of influence established for Tri-City HD and Palomar Health HD, and as a result requires conforming amendments to accommodate the requested reorganization under Government Code Section 56375.5; and

WHEREAS, the Commission's Executive Officer has reviewed the reorganization proposal and prepared a report with recommendations; and

WHEREAS, the Executive Officer's report and recommendations on the reorganization proposal and need for concurrent sphere of influence amendments involving Tri-City HD and Palomar Health HD have been presented to the Commission in the manner provided by law; and

WHEREAS, the Commission heard and fully considered all the evidence presented at a public hearing along with a necessary concurrent sphere of influence amendments for consistency under Government Code Section 56375.5 on March 5, 2018.

NOW, THEREFORE, BE IT RESOLVED, the Commission hereby finds, determines, and orders the following:

1. The hearing was held on the date set therefore, and due notice of said hearing was given in the manner required by law.

2. At the hearing, the Commission called for, heard, and considered all interested parties and read and considered the Executive Officer's report.

3. The Commission serves as lead agency under the California Environmental Quality Act (CEQA) in considering three distinct "projects" associated with the proposal and as detailed in the Executive Officer's report: (a) the proposed reorganization; (b) corresponding sphere of influence amendments for Tri-City Healthcare District and Palomar Health Healthcare District; and (c) establishment of special sphere of influence study area designations for Tri-City Healthcare District and Palomar Health Healthcare District. The Commission finds – and consistent with the Executive Officer's determination – all three projects are exempt from further environmental review because, pursuant to Section 15061(b)(3) of the State CEQA Guidelines, the sphere of influence amendments and the "Tri-City Healthcare District Reorganization" are not subject to the environmental impact evaluation process because it can be seen with certainty that there is no possibility for the proposed project to significantly impact the environment, and the activity is not subject to CEQA.

4. The Commission conditionally APPROVES amendments to the spheres of influence for Tri-City Healthcare District and Palomar Health Healthcare District as identified as SA17-09a and SA17-09b and shown in Exhibit "A". Approval conditions follow.

    a) Approval and completion of the associated proposed Tri-City Healthcare District Reorganization identified by the Commission as RO17-09.

5. The written statements of the Commission addressing the mandatory factors required for consideration any time spheres of influence are adopted, amended, or updated under Government Code Section 56425 are provided as Exhibit "B".

6. The Commission conditionally APPROVES the proposed Tri-City Healthcare District Reorganization identified as RO17-09 without modification or amendment and as shown in Exhibit "C". The following conditions must be satisfied within one calendar year – or March 5, 2019 – unless prior written request for an extension is received and approved by the Commission.

a) Completion of the 30-day reconsideration period provided under Government Code Section 56895.

b) Final confirmation by the County of San Diego Assessor's Office of the completeness of the map and geographic description of the affected territory for recording with the State Board of Equalization.

c) Payment of any outstanding fees and/or charges requested by the Executive Officer consistent with the Commission's adopted fee schedule.

d) Receipt by the Executive Officer of a written agreement between Tri-City Healthcare District and Palomar Health Healthcare District signed by their respective designees to phase the implementation of the corresponding property tax exchange separately established by Board of Supervisors.

7. The affected territory as designated by the Commission is inhabited as defined in Government Code Section 56046.

8. The Commission waives conducting authority proceedings under Government Code Section 56663 given that the proposed reorganization territory includes more than 1,000 property owners and registered voters and that a public hearing notice for the proposal was published on February 12, 2018 in the San Diego Union-Tribune. The public hearing notice for the proposal included the required language regarding the intent of the Commission to waive protest proceedings; the need for submittal of any written opposition prior to the conclusion of proceedings; and the potential for the extension or continuation of any previously authorized charge, fee, assessment, or tax by the local agency in the affected territory.

9. All three subject agencies subject to the reorganization – Tri-City Healthcare District, Palomar Health Healthcare District, and Fallbrook Regional Healthcare District – utilize the regular assessment roll of the County of San Diego.

10. Upon effective date of the reorganization proposal, any previously authorized charges, fees, special assessments, rules, regulations, and ordinances that were lawfully enacted by the three subject agencies – Tri-City Healthcare District, Palomar Health Healthcare District, and Fallbrook Regional Healthcare District – will be applied to the affected territory as reorganized.

12. The effective date of the reorganization proposal shall be the date of recordation of the Certificate of Completion.

13. The Commission conditionally APPROVES the establishment of special sphere of influence study area designations for Tri-City Healthcare District and Palomar Health Healthcare District as shown in Exhibit "D". Approval conditions follow.

a) Approval and completion of the associated proposed Tri-City Healthcare District Reorganization identified by the Commission as RO17-09.

14. As allowed under Government Code 56107, the Commission authorizes the Executive Officer to make non-substantive corrections to this resolution to address any technical defect, error, irregularity, or omission.

PASSED AND ADOPTED by the San Diego County Local Agency Formation Commission on March 5, 2018 by the following vote:

AYES:	Commissioner Blakespear, Jacob, MacKenzie, Sprague, Vanderlaan, Wells, and Zapf
NOES:	None
ABSENT:	Commissioner Horn Alternate Commissioners Cate, Cox, and Mathis
ABSTAINING:	None

Attested by:

Keene Simonds, Executive Officer
San Diego Local Agency Formation Commission

March 22, 2018

TRI-CITY HEALTHCARE DISTRICT

BYLAWS

Approved ~~December 14, 2017~~March 29, 2018

PREAMBLE

The name of this District shall be TRI-CITY HEALTHCARE DISTRICT, organized December 10, 1957, owning and operating TRI-CITY MEDICAL CENTER, under the terms of The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.)

The objectives of this District shall be to promote the public health and general welfare of the communities it serves.

This District shall be empowered to receive and administer funds for the attainment of these objectives, in accordance with the purposes and powers set forth in The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.) and other applicable law.

ARTICLE I

Purposes and Scope

Section 1. Scope of Bylaws.

These Bylaws shall be known as the "District Bylaws" and shall govern the TRI-CITY HEALTHCARE DISTRICT, its Board of Directors, and all of its affiliated and subordinate organizations and groups.

The Board of Directors may delegate certain powers to the Medical Staff and to other affiliated and subordinate organizations and groups, such powers to be exercised in accordance with the respective Bylaws of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups in the Bylaws of such other organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

The Bylaws of the Medical Staff and other affiliated and subordinate organizations and groups, and any amendments to such Bylaws, shall not be effective until they are approved by the Board of Directors of the TRI-CITY HEALTHCARE DISTRICT. In the event of any conflict between the Bylaws of the Medical Staff and any other affiliated or subordinate organization or group, and the provisions of these District Bylaws, these District Bylaws shall prevail. Purposes.

The purposes of the TRI-CITY HEALTHCARE DISTRICT shall include, but not necessarily be limited to, the following:

a. Within the limits of community resources, to provide the best facilities and services possible for the acute and continued care of the injured and all, regardless of disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code or set forth in Education Code section 220

b. To assure the highest level of patient care in the hospital of the District.

c. To coordinate the services of the District with community agencies and other hospitals providing health care services.

d. To conduct educational and research activities essential to the attainment of its purposes.

e. To do any and all other acts necessary to carry out the provisions of the Local Health Care District Law, accrediting agencies and other applicable law, and District Bylaws and policies.

Profit or Gain.

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits, to any individual, under any guise whatsoever, nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Disposition of Surplus.

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable hospital purposes. This may include the establishment of free or part-free hospital beds, or for improvements in the hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Law, other applicable law, and District Bylaws and policies.

ARTICLE II

OFFICES

Section 1. Offices.

The principal office for the transaction for the business of the TRI-CITY HEALTHCARE DISTRICT is hereby fixed at TRI-CITY MEDICAL CENTER, 4002 Vista Way, Oceanside, California. Branch offices may at any time be established by the Board of Directors at any place within or without the boundaries of TRI-CITY HEALTHCARE DISTRICT, for the benefit of TRI-CITY HEALTHCARE DISTRICT and the people served by TRI-CITY HEALTHCARE DISTRICT.

Section 2. Mailing Address.

The mailing address of TRI-CITY HEALTHCARE DISTRICT shall be as follows:

TRI-CITY HEALTHCARE DISTRICT
c/o Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

ARTICLE III

DIRECTORS

Section 1. Number, Qualifications, Election or Appointment.

The Board of Directors shall consist of seven (7) members, who are elected (or appointed) in accordance with the Local Health Care District Law of the State of California, and other applicable law, each of whom shall be a registered voter, residing in the District. The members of the Board of Directors shall be elective officers of the local health care district. (H&S Code §§ 32100 and 32100.5.)

Section 2. Term.

The term of each member of the Board of Directors elected shall be four (4) years, or until his or her successor is elected and has qualified. The person receiving the highest number of votes for each office to be filled at the health care district general election shall be elected thereto. A member of the Board of Directors elected (or appointed pursuant to the provisions of the Uniform District Election Law, Elections Code §§ 10500-10556) shall take office at noon on the first Friday in December next following the District general election. (H&S Code §§ 32002, 32100 and 32100.5; Elections Code § 10554.)

Section 3. Powers and Duties.

The Board of Directors shall have and exercise all the powers of a Health Care District set forth in the Local Health Care District Law (H&S Code § 32000 et seq.), other applicable law, and District Bylaws and policies, as well as the powers listed herein:

a. To control and be responsible for the management of all operations and affairs of the District.

b. To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction.

c. To appoint the President/Chief Executive Officer and to define the powers and duties of such appointee.

d. To delegate certain powers to the Medical Staff and other affiliated or subordinate organizations in accordance with their respective bylaws. The Medical Staff shall notify the Board of Directors upon election of the Chief of the Medical Staff and of all Chairpersons of the various medical departments and services, whose powers and duties shall be defined by the Medical Staff Bylaws as approved by the Board of Directors.

e. To approve or disapprove all constitutions, bylaws, rules and regulations, including amendments thereto; of all affiliated or subordinate organizations.

f. To appoint, approve and remove members of the Medical Staff. The Medical Staff shall make recommendations in this regard.

g. To establish policies for the operation of this District, its Board of Directors and its facilities.

h. To designate by resolution persons who shall have authority to sign checks drawn on the funds of the District.

i. To do any and all other acts necessary to carry out the provisions of these Bylaws or the provisions of the Local Health Care District Law and other applicable law.

j. To negotiate and enter into agreements with independent contractors, including physicians, paramedical personnel, other agencies and other facilities within the District's jurisdiction. (H&S Code §§ 32121 and 32128.)

Along with the powers of the Board of Directors, it shall be the duty of the Board of Directors to establish rules of the hospitals and other facilities within District jurisdiction, which shall include the following:

aa. Provision for the organization of physicians and surgeons, podiatrists, and dentists, licensed to practice in the State of California who are permitted to practice in the hospitals and other facilities within District jurisdiction into a formal Medical Staff, with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

bb. Provision for a procedure for appointment and reappointment of Medical Staff as provided by the standards of The Joint Commission.

cc. Provision that the Medical Staff shall be self governing with respect to the professional work performed in hospitals and other facilities within District jurisdiction; that the Medical Staff shall meet in accordance with the minimum requirements of The Joint Commission; and that the medical records of the patients shall be the basis for such review and analysis.

dd. Provision that accurate and complete medical records be prepared and maintained for all patients.

ee. Limitations with respect to the practice of medicine and surgery in the hospitals and other facilities within District jurisdiction as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership, as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California.

Members of the Board of Directors shall also have the following duties:

aaa. Duty of Care. Directors shall exercise proper diligence in their decision-making process by acting in good faith in a manner that they reasonably believe is in the best interest of the District, and with the level of care that an ordinarily prudent person would exercise in like circumstances.

bbb. Duty of Loyalty. Directors shall discharge their duties unselfishly, in a manner designed to benefit only the District and not the Directors personally or politically, and shall disclose to the full Board of Directors situations that they believe may present a potential for conflict with the purposes of the District.

ccc. Duty of Obedience. Directors shall be faithful to the underlying purposes of the District described in Article I, section 2, herein.

If it is found, by a majority vote of all of the Board of Directors in office at that time, that a Director has violated any of his or her duties to the detriment of the District, such Director is subject to removal from office according to the procedures set forth in section 9, subdivision a, of Article IV.

The rules of the hospitals and other facilities within District jurisdiction shall, insofar as is consistent with the Local Health Care District Law and other applicable law, be in accord with and contain minimum standards not less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board of Directors may adopt other rules which could be lawfully adopted by private or voluntary hospitals. (H&S Code §§ 32121 and 32128.)

Section 4. Compensation.

a. The Board of Directors shall serve without compensation, except that the Board of Directors, by a Resolution adopted by a majority vote of the members of the Board of Directors, may authorize the payment of not to exceed One Hundred and No/100 Dollars ($100.00) per meeting not to exceed five meetings a month as compensation to each member of the Board of Directors. (H&S Code § 32103.)

b. For purposes of this provision, "meeting" shall mean the following, to the extent permitted by applicable law: (1) any congregation of a majority of the members of the Board of Directors or of a committee or other body established by the Board of Directors, at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the Board of Directors or of the committee, if the congregation is subject to the open meeting requirements of Government Code Section 54953 and other applicable law; (2) and any other occurrences described in Government Code section 53232.1, if authorized pursuant to a written Board of Directors Policy; provided that payment of compensation shall be further subject to a member's compliance with such policies as the Board of Directors may establish. A Director is eligible for compensation under this provision for attendance at a regular or special meeting of a committee or subcommittee only if the Director is a duly-appointed member of that committee or subcommittee as of the date of attendance, or as may be authorized by Board of Directors Policy as an "occurrence" and permitted by law..

c. Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the District as approved by the Board of Directors in accordance with applicable law, including but not limited to the provisions set forth in AB 1234, as they may be revised from time to time. (H&S Code §32103.)

Section 5. Vacancies.

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code, State of California laws and other applicable law. (H&S Code §32100.)

Section 6. Resignations.

Any member of the Board of Directors may resign at any time by giving written notice to the Board of Directors, or to the Chairperson, or to the Secretary or to the Clerk of the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein and unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

Section 7. Absences From Meetings.

The term of any member of the Board of Directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive regular meetings of the Board of Directors, and the Board of Directors by resolution declares that a vacancy exists on the Board of Directors.

MEETINGS OF DIRECTORS

Section 8. Regular Meetings.

Regular meetings of the Board of Directors of the District shall be scheduled for the last Thursday of each calendar month at a time determined by the Board of Directors at least annually, in Assembly Room 3 of the Eugene L. Geil Pavilion, Tri-City Medical Center, 4002 Vista Way, Oceanside, California. The Board of Directors may, from time to time, change the time, the day of the month of such regular meetings and the location (provided the location is within the boundaries of the District) as dictated by holiday schedules or changing circumstances. (H&S Code § 32104; Gov. Code § 54954.)

Section 9. Special Meetings.

A special meeting of the Board of Directors may be called at any time by the presiding officer of the Board of Directors or by four (4) members of the Board of Directors, by providing written notice as specified herein to each member of the Board of Directors and to each local newspaper of general circulation, radio or television station requesting notice in writing.

The notice shall be delivered by any means to effectuate actual notice, including but not limited to, personally or by mail and shall be received at least twenty-four (24) hours before the time of the meeting as specified in the notice.

The call and notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Board of Directors.

The written notice may be dispensed with as to any Board of Directors member who at or prior to the time the meeting convenes files with the Clerk or Secretary of the Board of Directors a written waiver of notice. The waiver may be given by telegram. The written notice may also be dispensed with as to any Board of Directors member who is actually present at the meeting at the time it convenes.

The call and notice shall be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. (Gov. Code § 54956.)

Section 10. Quorum.

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business. (H&S Code §32106.) A quorum of the Board of Directors is the number of members that must be present in order to transact business. Members of the Board of Directors who are disqualified by law from participating in a given matter may not be counted toward a quorum for that matter. Members who are entitled to vote, but who voluntarily abstain from voting on a given matter, shall be counted toward a quorum for that matter.

Section 11. Number of Votes Required for Board of Directors Action.

In order for the Board of Directors to take action, a majority of the Directors entitled to vote on the matter and who have not abstained must vote in favor of the motion, proposal or resolution.

Section 12. Adjournment.

The Board of Directors may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular or adjourned regular meeting, the Secretary or Assistant Secretary of the Board of Directors may declare the meeting adjourned to a stated time and place and he or she shall cause a written notice of the adjournment to be given in the same manner as provided for special meetings, unless such notice is waived as provided for in special meetings.

A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within twenty-four (24) hours after the time of adjournment.

When a regular or adjourned regular meeting is adjourned as herein provided, the resulting adjourned regular meeting is a regular meeting for all purposes. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified for regular meetings by these Bylaws. (Gov. Code § 54955.)

Section 13. Public Meetings.

All meetings of the Board of Directors shall be open and public, and all persons shall be permitted to attend any meeting of the Board of Directors, except as otherwise provided in the Ralph M. Brown Act, the Local Health Care District Law and other applicable law. (Gov. Code §54953(a); H&S §§ 32106 and 32155.)

Section 14. Setting the Agenda.

At least seventy-two (72) hours before a regular meeting, the Board of Directors of Tri-City Healthcare District or its designee shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public. If requested, the agenda, shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132). In addition, the agenda shall include information regarding how, to whom, and when a request for disability related modification or accommodation, including auxiliary aids or services may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meetings. The agenda is developed by the Board of Directors' Chairperson, President/Chief Executive Officer and Board Counsel. Any other Board of Directors member has the right to place an item on the agenda through the Chairperson. In the absence of the Chairperson, the Vice Chairperson has the authority to place an item on the agenda, and in the absence of both the Chairperson and Vice Chairperson, the Secretary has the right to place an item on the agenda. In the absence of the Chairperson, Vice Chairperson, and Secretary, the President/Chief Executive Office or Board Counsel shall place an item on the agenda, as requested by any Board of Directors member. All requests by Board of Directors members regarding placement of an item on the agenda shall be in writing.

No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Board of Directors or its staff may briefly respond to statements made or questions posed by persons exercising their public testimony rights under Government Code Section 54954.3 of the Brown Act. In addition, on their own initiative or in response to questions posed by the public, a member of the Board of Directors or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of the Board of Directors or the Board of Directors itself, subject to rules or procedures of the Board of Directors, may provide a reference to staff or other resources for factual information, request staff to report back to the body at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

The Board of Directors may take action on items of business not appearing on the posted agenda under any of the conditions stated in subsection (b) of Government Code Section 54954.2 or other applicable law. Prior to discussing any item pursuant to subdivision (b) of Government Code Section 54954.2, the Board of Directors shall publicly identify the item.

There must be a determination by a majority vote of the members of the Board of Directors that an emergency situation exists, as defined in Government Code Section 54956.5, as it may be revised from time to time, or upon a determination by a two-thirds vote of the members of the Board of

Directors present at the Board of Directors meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that there is a need to take immediate action, and that the need for action came to the attention of the Board of Directors subsequent to the agenda being posted.

Section 15. Rules of Order.

The rules contained in Robert's Rules of Order on Parliamentary Procedure shall govern the meetings of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT in all cases to which they are applicable and in which they are not inconsistent with the law of the State of California, the United States, or these Bylaws and/or policies and procedures as adopted by this governing body.

Section 16. Conflicts of Interest.

The Board of Directors of TRI-CITY HEATHCARE DISTRICT shall comply with all applicable laws regarding conflicts of interest, including but not limited to the California Political Reform Act, the provisions of the California Government Code regarding Prohibited Interests in Contracts, the California Doctrine of Incompatible Offices, as these laws may be amended from time to time.

ARTICLE IV

OFFICERS

Section 1. Officers.

The officers of the Board of Directors shall be a Chairperson, a Vice Chairperson, a Secretary, a Treasurer, an Assistant Secretary, and an Assistant Treasurer. No person shall hold more than one office. Whenever a Board of Directors officer is authorized to execute a written instrument in his or her official capacity, other than for reimbursement of expenses, the Chairperson and Secretary shall do so.

The Board of Directors has the power to prescribe the duties and powers of the District President/Chief Executive Officer, the secretary, and other officers and employees of any health care facilities of the District, to establish offices as may be appropriate and to appoint Board of Directors members or employees to those offices, and to determine the number of and appoint all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the Board of Directors. (H&S Code §§32100.001 and 32121(h).)

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every calendar year by the Board of Directors at the regular December meeting. Board of Directors members who are unable to be present at the regular December meeting may attend via teleconference and vote on the election of officers provided their teleconference location meets the applicable legal requirements for participation. They shall assume office at the close of that meeting, and each officer shall hold office for one year, or until his or her successor shall be elected and qualified, or until he or she is otherwise disqualified to serve.

Section 3. Chairperson.

The Board of Directors shall elect one of their members to act as Chairperson. If at any time the Chairperson shall be unable to act, the Vice Chairperson shall take his or her place and perform his or her duties. If the Vice Chairperson shall also be unable to act, the Board of Directors may appoint some other member of the Board of Directors to do so and such person shall be vested temporarily with all the functions and duties of the office of the Chairperson.

The Chairperson, or member of the Board of Directors acting as such as above provided:

a. Shall preside over all the meetings of the Board of Directors.

b. Board of Directors Chairperson, or his or her designee, shall attend Medical Executive Committee, Joint Conference Committee meetings and other similar meetings of non-District organizations related to operations of the hospital (including those of Medical Staff committees and the hospital foundation) on behalf of the Board of Directors. Designees shall be Board of Directors members and shall at all times exclusively represent the interests of the Board of Directors. Designees may be removed at any time at the sole discretion of the Board of Directors Chairperson.

c. Shall sign as Chairperson, on behalf of the District, all instruments in writing which he or she has been specifically authorized by the Board of Directors to sign, provided that such instruments shall also be signed by the Secretary of the Board of Directors (other than for reimbursement requests).

d. Shall have, subject to the advice and control of the Board of Directors, general responsibility for management of the affairs of the District during his or her term in office. (H&S Code §32100.001.)

Section 4. Vice Chairperson.

The Board of Directors shall elect one of their members to act as Vice Chairperson. The Vice Chairperson shall, in the event of death, absence, or other inability of the Chairperson, exercise all the powers and perform all the duties herein given to the Chairperson.

Section 5. Secretary.

The Board of Directors shall elect one of their members to act as Secretary. The Secretary of the Board of Directors shall perform ministerial duties (i.e. sign legal documents on behalf of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. (H&S Code §32100.001.)

Section 6. Treasurer.

The Board of Directors shall elect one of their members to act as Treasurer. The Treasurer shall be required to fulfill the duties under Health and Safety Code Section 32127; provided, however, that these duties are hereby delegated to the District's Chief Financial Officer to the extent permitted by law. (H&S Code § 32127; Gov. Code § 53600 et seq.)

Section 7. Assistant Secretary.

The Board of Directors shall elect one of their members to act as Assistant Secretary. The Assistant Secretary shall in the event of death, absence or other inability of the Secretary, exercise all the powers and perform all the duties herein given to the Secretary.

Section 8. Assistant Treasurer.

The Board of Directors shall elect one of their members to act as Assistant Treasurer. The Assistant Treasurer shall in the event of death, absence or other inability of the Treasurer, exercise all the powers and perform all the duties herein given to the Treasurer.

Section 9. Removal, Resignation or Vacancy.

a. Any officer appointed or elected by the Board of Directors may be removed from that office for failure to discharge the duties of that office, for violation of any of the policies of the Board of Directors, or for any other good cause, as determined by a majority vote of all the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

b. Any officer may resign from said office at any time by giving written notice to the Chair of the Board of Directors, the Board of Directors Secretary or to the Clerk of

the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein, and, unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

c. In the event of a vacancy in the office of the Chairperson, the Vice-Chairperson shall succeed to that office for the balance of the unexpired term of the Chairperson. In the event of a vacancy in the office of the Secretary or Treasurer, the Assistant Secretary or Treasurer, as applicable, shall succeed to that office for the balance of the unexpired term of that officer. The Board of Directors may, but is not required to elect an officer to fill the vacancy in a subordinate office.

Section 10. Determination of and Sanctions for Willful or Corrupt Misconduct in Office

The following procedure may be used, in addition to any other procedures authorized by law or policy, to determine whether a Board of Directors member has engaged in willful or corrupt misconduct in office within the meaning of Government Code section 3060.

a. Any member of the Board of Directors may present an accusation in writing to the Board of Directors against another member of the Board of Directors alleging willful or corrupt misconduct in office, together with any written materials to support the accusation. "Misconduct in office" shall be broadly construed and include any willful malfeasance, misfeasance, and/or nonfeasance in office, and shall be interpreted in a manner consistent with Government Code section 3060.

b. After consideration of the accusation, the Board of Directors members present shall then vote on the question of authorizing a formal hearing on the accusation presented. A formal contempt hearing is authorized by the Board of Directors upon the concurrence of a majority of the members present, excluding the accused who shall not have a vote.

c. Within 7 days of the authorization for a formal contempt hearing, the Board of Directors shall serve upon the accused a copy of the accusation, a statement identifying the reasons for the hearing, and a notice of the date of the hearing. The date of the hearing shall not be less than 10 days from the service of the accusation. Service shall be in person, or if that fails, by leaving a copy of the accusation taped to the entry door of the accused's last known address in plain view.

d. The accused shall appear before the Board of Directors at the time and date stated in the accusation. However, if the date chosen by the Board of Directors is unacceptable to the accused for good cause as determined by the Board of Directors, another date shall be assigned, but shall not be more than 30 days beyond the original date set by the Board of Directors.

e. The accused may be represented by counsel in preparing for and/or to be present at the hearing. The cost of such counsel shall be borne by the accused. If the accused chooses to have an attorney represent him at the hearing, he must notify the Secretary of the Board of Directors in writing of that fact at least 5 days before the hearing. The Board of Directors may have a lawyer who is not the regular Board of

Directors lawyer, present at the hearing who will conduct the presentation of the Board of Directors' case and question witnesses. Formal rules of evidence shall not apply; however, witnesses and statements shall be made under oath and documentary evidence shall be authenticated. The Board of Directors may establish reasonable time limits on the duration of the hearing. Board of Directors counsel shall not participate in any way in the preparation of the accusation or presentation of evidence, but shall advise the Board of Directors on procedural matters.

f. Five days before the scheduled hearing, each party shall submit to the Secretary of the Board of Directors a witness list and outline of anticipated evidence, either oral or written, which they intend to introduce at the hearing. Upon demand by either party, this information shall be given to the opposing party by the Board of Directors Secretary on this date. A willful failure to supply this information on a timely basis may cause it to be excluded at the hearing.

g. At the hearing, the accused may introduce any oral testimony he or she feels will be helpful to the defense. The member of the Board of Directors who presented the accusation may introduce rebuttal evidence. The Board of Directors shall give weight to all evidence presented. The Board of Directors shall have the power to limit or exclude evidence which is repetitive, not relevant, or has little probative value. The proceeding shall be recorded.

h. The Board of Directors shall have the burden of establishing the willful or corrupt misconduct by the accused and the burden of proof shall be by a preponderance of the evidence. The Board of Directors may introduce any evidence, oral or written testimony, the Board of Directors feels will be helpful to its case.

i. If the accused fails to appear before the Board of Directors on the specified hearing date, the hearing may be held, based upon the evidence previously provided to the accused and other relevant evidence.

j. At the conclusion of presentation of evidence, the Board of Directors shall vote whether to hold the accused in contempt. The accused shall not be present during deliberation. A determination of misconduct shall be upon the concurrence of a majority of the Board of Directors members present, excluding the accused who shall not have a vote and cannot take part in deliberations.

k. Upon the determination by the Board of Directors of misconduct by the accused, the Board of Directors shall ask if the accused wishes to make a statement to the Board of Directors. Thereafter, the Board of Directors shall excuse the accused from the hearing and move to the determination of sanctions, which may include:

   1. A statement of censure, identifying the misconduct;

   2. Removal of the offending Board of Directors member from membership on one or more Board of Directors committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board of Directors officers;

3 Removal of the offending Board of Directors member from holding any Board of Directors office or other appointment currently held;

4. A determination that no compensation shall be earned by the offending Board of Directors member for attendance at the meeting at which the contempt occurred, or for a specified period;

5. A determination that the offending Board of Directors member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct;

6. Rendering the offending Board of Directors member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings (except those previously-approved for which expenses have been incurred prior to the time of the finding of misconduct, for a period of time or subject to conditions specified in the motion;

7. Referral of the matter to the County Grand Jury pursuant to Government Code section 3060, including the evidence adduced during the hearing.

ARTICLE V

ARTICLE V

COMMITTEES

Section 1. Committees

The Chairperson, with the concurrence of the Board of Directors, may, from time to time, appoint one or more members of the Board of Directors and other persons as necessary or appropriate, to constitute committees for the investigation, study or review of specific matters. At the time of appointing and establishing the committee(s), the Chairperson, with the concurrence of the Board of Directors, shall establish the responsibilities of the committee(s).

The Chairperson, with the approval of the majority of the Board of Directors, may, from time to time, with or without cause, remove one or more members of the Board of Directors and any other persons from membership in any standing or other committee, or may temporarily discontinue, change the functions of, or combine standing or other committees.

Notwithstanding the foregoing, to ensure adequate representation of the Board at committee meetings, the Chairperson may make a temporary appointment of one Director to serve on a standing committee without Board concurrence, whenever the Chairperson determines that a scheduled committee meeting would otherwise be attended by only a single Director, such appointment to be effective only for that meeting.

Form

Any committee(s) established to deliberate issues affecting the discharge of Medical Staff responsibilities shall include Medical Staff members.

No committee shall use written ballots, whether or not secret, for any purpose in its deliberations. No committee appointed shall have any power or authority to commit the Board of Directors or the District in any manner, unless the Board of Directors, by a motion duly adopted at a meeting of the Board of Directors, has specifically authorized the committee to act for and on behalf of the District.

Any advisory committee, whether permanent or temporary, which is a legislative body as defined in the Brown Act and other applicable law, shall post agendas and have meetings open to the public as provided by law.

Notices of meetings of committees which are legislative bodies shall be made in accordance with Article IV, Section 7 of these Bylaws.

Section 2. Standing Committees

Standing committees as defined by the Brown Act are open to the public and require posting of Notice of Meetings and Agendas. The following committees are the only current standing committees of the Board of Directors:

A. Finance, Operations & Planning Committee

B. Community Healthcare Alliance Committee

C. Governance & Legislative Committee

D. Human Resources Committee

E. Professional Affairs Committee

F. Audit, Compliance & Ethics Committee

The Board of Directors shall review annually the committees, their functions, and their membership.

ARTICLE VI

MANAGEMENT OFFICIALS

Section 1. President/Chief Executive Officer.

The Board of Directors shall select and employ a hospital administrator to be known as "President/Chief Executive Officer" who, subject to such policies as may be adopted and such orders as may be issued by the Board of Directors, or by any of its committees to which it has delegated power for such action, shall have the responsibility, as well as the authority, to function as the President/Chief Executive Officer of the institution, translating the Board of Directors' policies into actual operation. Additionally, the President/Chief Executive Officer has the authority to make recommendations to the Board of Directors on policies related to the effective ongoing operations of the District. The Chief Operating Officer/Chief Nurse Executive and/or the Chief Financial Officer are granted signing authority on behalf of the Chief Executive Officer, in order to maintain day-to-day operation of the District.

Section 2. Clerk of the Board of Directors.

The Clerk of the Board of Directors shall be the Executive Assistant under the immediate supervision of the President/Chief Executive Officer. The President/Chief Executive Officer may assign other staff members as may be necessary to complete the work of the Board of Directors. The Executive Assistant shall serve as Clerk of the Board of Directors for the purposes of Elections Code section 307.

Section 3. Chief Compliance Officer .

The Chief Compliance Officer shall advise the Board of Directors and Chief Executive Officer regarding the design and implementation of the organization's ethics and compliance programs. The Chief Compliance Officer shall report directly to the Chief Executive Officer and shall be responsible to the Board of Directors to timely and periodically report to it regarding the status of the compliance programs and material legal and compliance risks and mitigation efforts.

Section 4. President/Chief Executive Officer's Evaluation.

The Board of Directors shall evaluate the President/Chief Executive Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the President/Chief Executive Officer. The President/Chief Executive Officer shall have an opportunity to reply in writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors. (Gov. Code § 54957.)

ARTICLE VII

MEDICAL STAFF

Section 1. Medical Staff.

The physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in the State of California, who are permitted to practice in the hospitals and other facilities under the jurisdiction of TRI-CITY HEALTHCARE DISTRICT, shall be formed into a formal Medical Staff, in accordance with the Medical Staff Bylaws, Rules and Regulations, which have been approved by the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. The Medical Staff Bylaws shall include, but not be limited to, the following provisions:

a. Appropriate officers.

b. Staff appointments on an annual or biennial basis.

c. Procedure for appointment and reappointment of Medical Staff as provided by the Standards of The Joint Commission.

d. That the Medical Staff shall meet in accordance with the minimum requirements of The Joint Commission.

The Medical Staff shall be self-governing with respect to the professional work performed in the hospital and the medical records of the patients shall be the basis for such review and analysis of the professional work of the Medical Staff. The Medical Staff members shall be responsible for preparing and maintaining accurate and complete medical records for all patients (medical records to include, but not be limited to, identification data, personal and family history, history of present illness, physician examination, special examinations, professional or working diagnosis, treatment, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge and such other matters as the Medical Staff shall determine or as may be required by applicable law). The practice of medicine and surgery in the hospitals and other facilities under the jurisdiction of the District shall be within the limitations as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California. The Medical Staff shall be responsible for the development, adoption and annual review of the Medical Staff Bylaws and Rules and Regulations that are consistent with District policy and with any applicable law. The Medical Staff are subject to, and effective upon, appointment and reappointment by the Board of Directors in accordance with the standards of The Joint Commission (H&S Code § 32128.)

The Tri-City Healthcare District shall maintain a Quality Assurance/Performance Improvement ("QA/PI") Program developed by a committee composed of at least five (5) physicians who are members of the Medical Staff and one (1) clerical staff member. The QA/PI Program shall be implemented by the QA/PI Committee, and shall be a data-driven, quality assessment and performance improvement program, implemented and maintained on a hospital-wide basis, in compliance with the requirements of Section 482.21 of Title 42 of the Code of Federal Regulations, and other applicable law, as it may be amended from time to time.

Section 2. Medical Staff Membership.

Membership on the Medical Staff is a privilege, not a right, which shall be extended only to physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in this State whose education, training, experience, demonstrated competence, references and professional ethics, assures, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care. Each applicant and member shall agree to abide by the District Bylaws, Medical Staff Bylaws and Rules and Regulations of the District, and applicable law. The word "Physician" when used hereafter in this Article, shall be deemed to include physicians, surgeons, dentists, and podiatrists. (H&S Code § 32128.)

Section 3. Exclusion from the Medical Staff.

a. The Board of Directors shall have the power to exclude from Medical Staff membership, to deny reappointment to the Medical Staff, or to restrict the privileges of any physician, whether a general practitioner or specialist, in any hospital operated by the District, who has not exhibited that standard of education, training, experience, and demonstrated competence, references and professional ethics which will assure, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care.

b. In the case of both general practitioners and specialists, the medical resources available in the field of his or her practice shall be considered in determining the skill and care required. No physician shall be entitled to membership on the Medical Staff, or to the enjoyment or particular privileges, merely by virtue of the fact that he or she is duly licensed to practice medicine or surgery in this or any other state, or that he or she is a member of some professional organization, or that he or she, in the past or presently, has such privileges at another hospital. The burden shall be upon the physician making an initial application for membership to establish that he or she is professionally competent and ethical. (H&S Code §§32128 and 32150; B&P Code § 809.3.)

Section 4. Hospital Rules.

The Bylaws of the Medical Staff shall set forth the procedure by which eligibility for Medical Staff membership and establishment of professional privileges shall be determined. Such Bylaws shall provide that the Medical Staff or a committee or committees thereof, shall study the qualifications of all applicants in the establishment of professional privileges, and shall submit to the Board of Directors recommendations thereon. Such recommendations shall be considered by the Board of Directors, but shall not be binding upon the Board of Directors. The Medical Staff shall be responsible for a process or processes designed to assure that individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services and that the quality of patient care services provided by these individuals is reviewed as a part of the District's quality assurance programs. (H&S Code §32150.)

Section 5. Hearings and Appeals.

The Board of Directors hereby incorporates by reference the provisions of the Medical Staff Bylaws relating to hearing procedures and appeals regarding the professional privileges of any member of, or applicant for membership on, the Medical Staff, as those Bylaws may be amended from time to time, subject to applicable law. These provisions are presently outlined in the relevant sections of the Medical Staff Bylaws.

ARTICLE VIII

MISCELLANEOUS

Section 1. Title to Property.

The title to all property of the District shall be vested in the District, and the signature of any officers of the Board of Directors, authorized at any meeting of the Board of Directors, shall constitute the proper authority for the purchase or sale of property or for the investment or other disposal of funds which are subject to the control of the District. (H&S Code §§ 32121(c) and 32123.)

Section 2. Seal.

The Board of Directors shall have the power to adopt a form of Corporate Seal, and to alter it at its pleasure. (H&S Code § 2121(a).)

Section 3. Amendment.

These Bylaws may be altered, amended, repealed, added to or deleted, by a majority vote of all of the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

Section 4. Annual Review of Bylaws.

The Board of Directors shall review the Bylaws annually and make any necessary changes that are necessary to be consistent with District policy, any applicable laws or other rules and regulations connected with operation of a hospital or other facility within District jurisdiction.

Section 5. Board of Directors' Evaluation Policy.

The Board of Directors shall establish a written policy and procedure for evaluation and review of the Board of Directors' performance as a group. This written copy of the Board of Directors' policy and procedures shall be reviewed by the Board of Directors, the President/Chief Executive Officer and the Board Counsel for the Board of Directors.

Section 6. Affiliated Organizations.

a. Auxiliary Organizations. The Board of Directors may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

b. Foundations. The Board of Directors may authorize the formation of non-profit public benefit corporations, under applicable law, to assist in the fulfillment of the purposes of the District. Each such corporation shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

CODE FOR LEGISLATIVE AUTHORITY

H&S	-	The Local Health Care District Law, Health and Safety Code Section 32000 et seq., State of California
Elections Code	-	Uniform District Election Law, Elections Code, State of California
Government Code	-	Government Code, State of California
B&P	-	Business and Professions Code, State of California

This amendment to the TRI-CITY HEALTHCARE DISTRICT Bylaws is approved this_____ day of_____, ~~2017~~2018.

_____

James J. Dagostino Date
Chairperson

ATTEST:

_____

Leigh Anne Grass~~Laura E. Mitchell~~ Date
Secretary

RESOLUTION NO. 790

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT AMENDING CONFLICT OF INTEREST CODE

WHEREAS, the Tri-City Healthcare District ("District") is required to periodically review its Conflict of Interest Code pursuant to Government Code section 87306; and

WHEREAS, the Board of Directors has determined that changes in its Conflict of Interest Code should be adopted to specify that Statements of Economic Interest may be filed with the Executive Secretary of the Board per Government Code section 87500(p), and to update the designation of employees and consultants required to file Statements;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the District:

1. An amended Appendix to the Conflict of Interest Code, in the form attached hereto as Exhibit A, and incorporated herein by reference, is hereby tentatively adopted and promulgated.

2. The Chief Executive Officer is hereby directed to establish a forty-five (45) day public comment period to begin on March 30, 2018, by publishing a Notice of Intention to Amend the Conflict of Interest Code for Tri-City Healthcare District ("Notice") by posting the Notice on the District's employee bulletin boards and concurrently mailing the Notice to the Clerk of the San Diego County Board of Supervisors as the code-reviewing body for the District.

3. The amended Conflict of Interest Code shall become effective immediately upon:

   (a) Its final approval by the Board of Directors following the close of the public comment period and a public hearing, if requested, at its meeting on May 31, 2018; and

   (b) Its approval by the San Diego County Board of Supervisors as the code-reviewing body.

4. Upon the amended Conflict of Interest Code's final approval, the Chief Executive Officer of the District is hereby directed and authorized to submit a certified copy of

this resolution to the San Diego County Board of Supervisors for approval.

APPROVED AND ADOPTED this ___ day of March, 2018.

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
James J. Dagostino, DPT, PT
Chairperson, Board of Directors
Tri-City Healthcare District

ATTEST:

_____
Leigh Anne Grass, R.N., BSN
Secretary, Board of Directors
Tri-City Healthcare District

APPENDIX

CONFLICT OF INTEREST CODE
OF THE
TRI-CITY HEALTHCARE DISTRICT

(Proposed March 2018)

EXHIBIT "A"

OFFICIALS WHO MANAGE PUBLIC INVESTMENTS

District Officials who manage public investments, as defined by California Code of Regulations, title 2, section 18700.3, subdivision (b), are not subject to the District's Code, but are subject to the disclosure requirements of the Act. (Gov. Code § 87200 *et seq.)* These positions are listed here for informational purposes only, and are required to file a statement of economic interest with the Executive Secretary to the Board of the District. Upon receipt of Statements of Economic Interests from Members of the Board of Directors and the President/Chief Executive Officer, the Executive Secretary shall make and retain a copy and forward the original to the County of San Diego Clerk of the Board of Supervisors.

It has been determined that the positions listed below are officials who manage public investments[1]:

Members of the Board of Directors

President/Chief Executive Officer

Chief Financial Officer

DESIGNATED POSITIONS

GOVERNED BY THE CONFLICT OF INTEREST CODE

Designated employees listed below, and the Chief Financial Officer, shall file Statements of Economic Interests with the Executive Secretary who will retain the originals and make the statements available for public inspection and copying.

DESIGNATED EMPLOYEES' TITLE OR FUNCTION	DISCLOSURE CATEGORIES ASSIGNED
Chief Compliance Officer	All

[1] Individuals holding one of the above-listed positions may contact the FPPC for assistance or written advice regarding their filing obligations if they believe that their position has been categorized incorrectly. The FPPC makes the final determination whether a position is covered by Government Code section 87200.

~~Chief Marketing Officer/ Senior Vice President~~	~~All~~
~~Chief Strategy Officer~~	~~All~~
Chief Development Officer	All
Director of Facilities	5
Director of Finance	1,2
Senior Vice President of Information Technology	1,5
Director of Materials Management	5
Executive Vice President and Chief Operating Officer	All
Facilities Manager	6
General Legal Counsel	All
Board Legal Counsel	All
Purchasing Manager	5
Purchasing Clerk	5
~~Vice President of Hospital Transformation~~	~~1,5~~
Senior Director of Business Development	1,2,5
~~Chief Development Officer~~	~~All~~
Chief Human Resources Officer/ Senior Vice President	6
Vice President of Human Resources	6
Chief Nurse Executive/ Senior Vice President	5
Director of Total Rewards and HRIS	5
Senior Director of Nursing	5,6
Directors and Senior Directors (ALL others not specified)	6
Employee Fiduciary Retirement Plan Subcommittee Members	7

Consultant[2]

EXHIBIT "B"

DISCLOSURE CATEGORIES

The disclosure categories listed below identify the types of investments, business entities, sources of income, including gifts, loans and travel payments, or real property which the Designated Employee must disclose for each disclosure category to which he or she is assigned.

Category 1: All investments and business positions in business entities, and sources of income that are located in, do business in or own real property within the jurisdiction of the District.

Category 2: All interests in real property which is located in whole or in part within, or not more than two (2) miles outside, the jurisdiction of the District.

Category 3: All investments and business positions in, and sources of income from, business entities that are engaged in land development, construction or the acquisition or sale of real property within the jurisdiction of the District.

Category 4: All investments and business positions in, and sources of income from, business entities that are banking, savings and loan, or other financial institutions.

Category 5: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the District.

Category 6: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the Designated Employee's Department.

Category 7: All financial interests in investment advisors and managers; financial services providers, actuaries, and those providing fiduciary services (including record-keeping) to retirement plans.

---

[2] Consultants shall be included in the list of Designated Employees and shall disclose pursuant to the broadest disclosure category in this Code subject to the following limitation:
The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the disclosure requirements described in this Section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this Conflict of Interest Code.

TRICITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~17~~-18-042

POLICY TITLE: Duties of the Board of Directors

The purpose of this policy is to define the primary responsibilities of the Board of Directors as the governing body ultimately responsible for leadership of the organization.

Brief Job Description

The Board establishes the mission, vision, and goals for the organization. The Board is ultimately accountable for the quality of care rendered to its patients by both its medical and professional staffs, for its financial soundness and success, and for strategically planning its future. The Board hires the Chief Executive Officer, and approves the plans and budgets by which the CEO will accomplish the quality, financial and strategic goals of the Board. However, the Board has delegated to the CEO responsibility to run the day-to-day operations of all of the District's business enterprises; hence, the Board does not direct operations. Rather, the Board is responsible for ensuring that strategies developed by management will accomplish key goals, achieve the mission and fulfill the vision, and holding the CEO accountable for implementation of those strategies.

Primary Duties and Responsibilities

Financial.

1. Set objectives. It is the role of the Board of Directors, in cooperation with the Chief Executive Office, to specify key financial objectives which are aligned with Board-determined goals, mission and vision for the organization.

2. Oversee attainment of objectives. Through annual approval of the budget, and the ongoing activities of the Financial Operations and Planning Committee, the Board ensures that necessary financial planning activities are undertaken so that the organization's resources are effectively allocated across competing uses. The Board monitors and assesses the financial performance of the organization on an ongoing basis through review of periodic financial statements and other reports prepared and presented by the Chief Financial Officer.

3. Ensure transparency and accountability. Through the selection of independent auditors and acceptance of the annual financial audit report, together with targeted supplemental auditing activities of billing and collection activities for compliance with legal requirements, the Board ensures that appropriate accounting controls are in place and updated, as needed.

Community needs assessment and outreach.

The Board helps keep the organization informed about and sensitive to, community needs and perceptions. Conversely, the Board plays a key role in keeping the community informed regarding the services, activities, and plans of the organization.

Promote quality medical care.

1. Under its Bylaws and those of the Medical Staff, the Board appoints, reappoints and determine privileges of physicians who practice in the institution.

2. The Board hears periodic reports on indicators of quality, utilization and outcomes, as well as quality improvement implementation plans, for each area or department of the organization. The Board holds management accountable to ensure that effective risk management systems are in place and functioning effectively. In this manner, the Board takes responsibility for ensuring the quality of nursing and medical care rendered in the hospital.

3. The Board provides opportunities for members of the medical staff to participate in governance through membership on Board-appointed committees. The Board provides the Chief of the Medical Staff an opportunity to participate in Board meetings, including providing an agenda item at each regular meeting for reports from the Medical Staff.

4. The Board identifies the nurse executive function at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services.

Compliance oversight.

The Board ensures compliance with requirements of regulatory and accrediting bodies by: (a) promoting an ethical, self-governing culture throughout the organization through Board and employment policies; (b) overseeing the effectiveness of the compliance program; and (c) providing the resources required to implement effective system.

Responsibilities Defined Elsewhere:

Bylaws.

The Bylaws of the Tri-City Healthcare District Board of Directors set forth, in Article III, the legal powers and duties of the board of directors, as provided under the Healthcare District law. The Board's oversight of compliance activities is reflected in Article VI, §2 (establishing a Compliance and Audit Committee) and Article VII, §3, describing its reporting relationship with the Chief Compliance Officer. Article VIII describes the Board's relationship with the Medical Staff. Article IX, §5 requires the Board to maintain a policy regarding annual self-evaluations.

Board Policies.

Some of the responsibilities of the Board, including those specifically identified by the Joint Commission, are addressed by board policies. The Medical Staff provides input on equipment and services to be provided at the hospital under Policy 17-001. Minimum liability insurance requirements required for medical staff membership are described in a policy jointly-adopted by the Medical Staff. (Policy No. 15-038.) The Board oversees the prudent investment of excess funds under Policy No. 14-017, which is reviewed annually. Self-evaluations are conducted by the Board annually under Policy 14-012. Board member orientation and training are provided for in Policies 16-020 and 17-039. Board responsibilities for decision making on legal matters, including hiring Board Counsel. is described in Policy 17023. Other policies establish a Code of Conduct for the Board (Policy No. 17-039) and committee members (Policy No. 15-031), and conflict of interest rules (by resolution in accordance with the Political Reform Act). These are merely examples and are not intended to be a comprehensive list of policies describing Board responsibilities.

Reviewed by Gov/Leg Committee: 1/12/2011
Approved by the Board of Directors: 1/27/2011
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by Gov/Leg Committee: 10/6/2015
Approved by the Board of Directors: 10/30/15
Reviewed by the Gov/Leg Committee: 11/7/17
Approved by the Board of Directors: 12/14/17
Approved by the Board of Directors:

Tri-City Medical Center
MEDICAL STAFF

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

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 3/30/2018 – 2/29/2020)

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 3/30/2018 through 2/29/2020:

- **CAMPBELL, Leticia MD/OB/GYN (North County Health Services)**
- **IOSON, Peter MD/Ophthalmology (Tayani Eye Institute)**
- **KANE, Norman MD/Orthopedic Surgery (Orthopedic Specialists of North County)**
- **MOHAMEDALI, Burhan MD/Cardiology (Cardiovascular Institute of San Diego)**
- **POLLOCK, Max MD/Teleradiology (StatRad)**
- **TAYANI, Ramin MD/Ophthalmology (Tayani Eye Institute)**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 03/30/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **IAMSHIDI-NEZHAD, Mohammad DO** **General & Vascular Surgery**

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

- **MOUKARZEL, Elias M.D.** **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 4/01/2018 –3/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 04/01/2018 through 3/31/2020, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **GOLTS, Eugene MD/Cardiothoracic Surgery/Provisional**
- **GRAMINS, Daniel MD/Cardiothoracic Surgery/Provisional**
- **GUNTA, Sujana MD/Pediatrics/Active**
- **HOSSEINI, Puya MD/Anesthesiology/Active**
- **HOWE, Steven MD/Cardiothoracic Surgery/Provisional**
- **MUDD, Brian DDS/Oral & Maxillofacial Surgery/Active**
- **OLONAN, Christopher MD/Internal Medicine/Active**
- **POLLEMA, Travis DO/Cardiothoracic Surgery/Provisional**
- **PROCHERA, Ann Marie MD/Anesthesiology/Active**
- **SCHMITTER, Stephen MD/Radiology/Active**
- **TALLMAN, Garrett MD/Orthopedic Surgery/Active Affiliate**
- **WONG, Darryl MD/Dermatology/Refer and Follow**
- **YAMANAKA, Mark MD/Pulmonary Medicine/Active**
- **YOO, Frank MD/Neurosurgery/Active**

UPDATE TO PREVIOUS REAPPOINTMENT:

The following providers were given a term of 03/01/2018 through 2/28/2020; however, 2020 is a leap year so the correct time frame needs to be 03/01/2018 through 2/29/2020 to keep our records consistent with our process.

- **BOBZIEN, Bonnie MD/Pathology/Active**
- **BRUNO, Gillian MD/Internal Medicine/Active**

Attachment B

- IARAMILLO, Mary MD/Internal Medicine/Refer and Follow
- 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

RESIGNATIONS: (Effective date 3/30/2018 unless otherwise noted)

Voluntary:

- CHAPMAN, Todd MD/Teleradiology
- SORKHI, Ramin MD/General Surgery
- VICARIO, Daniel MD/Oncology
- ZUPANCIC, Michael MD/Neurology

Tri-City Medical Center
MEDICAL STAFF

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

Attachment C

PROCTORING RECOMMENDATIONS (Effective 3/30/18, unless otherwise specified)

- D'SOUZA, Gehaan MD — Plastic Surgery
- KLEIN, Martina MD — Psychiatry
- SCHILLINGER, Stephan PA-C — Allied Health Professional

I. **MEMBERSHIP**

A. The Division of Neurology consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and are actively pursuing certification by the American Board of Psychiatry and Neurology.

II. **FUNCTIONS**

The general functions of the Division of Neurology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluation of the quality, safety and appropriateness of care and treatment provided to patients within the division and develop indicators for use in the evaluation of patient care;

B. Recommend to the Department of Medicine and to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the division;

C. Conduct, participate in and make recommendation regarding continuing medical education programs pertinent to division clinical practice;

D. Review and evaluate division adherence to:

1. Medical Staff Policies and Procedures; and
2. Sound principles of clinical practice;

E. Submit written reports to the Department of Medicine, the ~~QA/PI/PS~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. The division's review and evaluation of activities, actions taken thereon, and the results of such action; and
2. Recommendations for maintaining and improving the safety and quality of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Recommend/request Focused Professional Practice Evaluation (FPPE) as indicated for Medical Staff members (pursuant Medical Staff Policy 509);

H. Approve On-Going Professional Practice Evaluation (OPPE) indicators;

I. Take appropriate action when important problems in patient care and clinical performance or opportunities to improve patient care are identified;

J. Formulate recommendations for Division Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Department of Medicine and the Medical Executive Committee.

III. **DIVISION MEETINGS**

A. The Division of Neurology shall meet ~~no less than annually, or a~~t the discretion of the division chief, or upon request of two or more division members. The division will consider the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the Department of Medicine, ~~QA/PI/PS~~Medical Quality Peer Review Committee and then to the Medical Executive Committee;

B. Twenty-five percent (25%) of the Active Division members, but not less than two members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

A. The Division of Neurology shall have a Chief who is a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in Neurology;

B. Division members shall elect the Division Chief every even numbered year by the Active Staff Members of the Division. If there are vacancies of any officer for any reason, the Department

Chairman shall designate a new officer(s), or call a special election. The chief shall be elected by a simple majority of members of the Division;

C. The Division Chief shall serve a ~~one~~ two year term which coincides with the medical staff year unless they resign, are removed from office, or lose their medical staff membership or clinical privileges in that division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEFS**

A. The Division Chief shall assume the following responsibilities of the Division:

1. Be accountable for all professional administrative activities of the Division; Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division; Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the division; Recommend clinical privileges for each member of the Division;
2. Assure that the quality, safety and appropriateness of patient care provided within the division are monitored and evaluated;
3. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
4. The Chief of the Division of Neurology shall attend the Department of Medicine Division Chiefs meeting; and
5. Other duties as assigned in accordance with the Medical Staff Bylaws.

VI. **PRIVILEGES**

A. Requests:

1. Request for general clinical privileges in the Division of Neurology shall be evaluated on the basis of the requesting physician's education, training, competence, judgment, character, experience (as demonstrated by treatment of at least **one-hundred (100) typical Neurology patients** within the past **six (6) months**) – excluding physicians just completing a ACGME American Board of Neurology Residency Program;
2. Recommendations for privileges are made to the Credentials Committee, Medical Executive Committee, and to the Board of Directors. Physicians shall practice only within the scope of the privileges as defined within the department's rules and regulations and stated on the privilege card;
3. All medical staff privileges are located on the Tri-City Medical Center's Intranet;

~~Privileges~~	~~Initial~~	~~Proctoring~~	~~Reappointment~~
~~Lumbar Puncture~~	~~Training~~	~~1~~	~~N/A~~
~~EEG Interpretation~~	~~Training~~	~~N/A~~	~~N/A~~
~~Nerve Conduction Velocities~~	~~Training~~	~~N/A~~	~~N/A~~
~~Electromyography~~	~~Training~~	~~N/A~~	~~N/A~~
~~Somatosensory Potentials~~	~~Training~~	~~N/A~~	~~N/A~~
~~Brain Stem Evoke Potential~~	~~Training~~	~~N/A~~	~~N/A~~
~~Visual Evoke Potential~~	~~Training~~	~~N/A~~	~~N/A~~
~~Intrathecal Medications~~	~~Training~~	~~1~~	~~1~~

~~NeuroThera Laser~~	~~Completion of an approved instruction course in the use of Neuro Thera Laser~~	~~N/A~~	~~N/A~~

B. Classifications:

~~1.~~ The Division of Neurology has established the following classifications of privileges:

i **Physicians – Neurology**

a. The Division of Neurology consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and are actively pursuing certification by the American Board of Psychiatry and Neurology and such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
2. Unexpected complications arise which are outside their level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar;

~~iii **Nurse Practitioner:**~~

~~a. Nurse practitioner means a registered nurse who posses' additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a neurologist will develop the standardized procedure or the protocols with the approval of the Division of Neurology;~~

~~iiii **Physician Assistant:**~~

~~a. A physician assistant may only provide those medical services which he/she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients care for by that physician assistant. The supervising physician must have approval from the Medical Board of California to act as a supervising physician. The supervising physician shall review, countersign, and date within seven (7) days the medical record of any patient for whom the physician assistant issues or carries out a drug order and shall also review, audit, and countersign every medical record written by the physician assistant within 30 days of the encounter.~~

VII. REQUIREMENTS FOR INITIAL

A. Members of the Division who are Board Eligible when initially granted privileges, and who were granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification within thirty-six (36) months of his/her appointment to the Medical Staff.

VIII. **REAPPOINTMENT**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

IX. **PROCTORING**

A. Each new medical staff member granted initial or additional privileges shall be evaluated by a proctor as delineated by the Division of Neurology. If enough cases have not been admitted, or evaluation of the new medical staff member's performance cannot be completed in the first year, then an additional year of provisional staff will be recommended;

B. Supervision of the new medical staff member by the proctor will emphasize concurrent or retrospective chart review and include direct observation of procedural techniques. The new medical staff member must notify his proctor at the time a procedure is scheduled or planned. If the proctor is not available, the new medical staff member must notify another physician in the appropriate subspecialty area. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

C. All active staff medical staff members of the Division of Neurology will act as proctors to monitor quality of performance of medical care with assigned privileges. An associate of the new medical staff member may monitor 50 % of the required proctoring. Additional cases may be proctored as recommended by the Division Chief:

D. A report shall be completed on which the proctor will address the patient's diagnosis, the overall impression and a recommendation (i.e. qualified, needs further observation, not qualified)

E. Forms will be made up by the new medical staff member admitting the patient and immediately forwarded to the proctor for completion. It is the responsibility of the new medical staff member to notify the proctor of each case;

F. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff ~~Office~~ Department for filing in the individual physician's confidential file within one week after the patient's discharge from the hospital;

G. Length of the Probationary Period:

1. Each new medical staff member(s) to the Division of Neurology granted initial membership status will have his or her initial six (6) in-hospital cases proctored by a member of the Division.

X. **EMERGENCY DEPARTMENT CALL**

A. Medical Staff Division Members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Please refer to Medical Staff Policy and Procedure #520;

B. Courtesy or provisional staff may participate in the Emergency Department Call Roster at the discretion of the division chief.

APPROVALS:

Division of Neurology:	07/01/2015
Department of Medicine:	07/02/2015
Medical Executive Committee	07/22/2015
Governance Committee	08/04/2015
Board of Directors Approval:	08/27/2015

I. **MEMBERSHIP**

The Division of Internal Medicine consists of physicians who practice within the specialties of:

- Allergy & Immunology
- Dermatology
- Internal Medicine
- Endocrinology
- Infectious Disease
- Nephrology
- Rheumatology
- Physiatry (Physical Medicine and Rehabilitation)

Division members practicing Internal Medicine shall be board certified in internal medicine by the American Board of Internal Medicine or American Osteopathic Board of Internal Medicine, or have successfully completed an ACGME or AOA-accredited residency in Internal Medicine and are able to demonstrate comparable ability, training and experience.

Division members practicing Endocrinology, Infectious Disease, Nephrology or Rheumatology shall be board certified in internal medicine and the applicable sub-specialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or successfully completed an ACGME or AOA-accredited residency in internal medicine and applicable sub-specialty residency/fellowship and are able to demonstrate comparable ability, training and experience.

Division members practicing Physical Medicine and Rehabilitation are board certified by the American Board of Physical Medicine and Rehabilitation, or have completed an ACGME/AOA-accredited physical medicine and rehabilitation residency training program and are able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Internal Medicine shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;
H. Recommend or Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of Internal Medicine shall meet at the discretion of the Chief, ~~but at least annually~~ or upon request of two or more division members. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every two years by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a ~~one~~ two year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:
A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department.

~~B.~~A. ~~By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~

~~C.~~B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

~~D.~~C. All members of the Division of Internal Medicine are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
2. Unexpected complications arise which are outside this level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~ ~~Consultation~~ ~~History and physical examination~~	~~1. Board certified in Internal Medicine or applicable sub-specialty by the American Board of Internal Medicine; or~~ ~~2.1. Successful completion of an ACGME or AOA accredited residency in internal medicine.~~	~~Six (6) in-hospital cases (At least three (3) must be telemetry or ICU admissions).~~	~~N/A~~
~~Surgical Assistant~~	~~See Policy 8710-536~~	~~See Policy 8710-536~~	~~See Policy 8710-536~~
~~Moderate sedation~~	~~See Policy 8710-517~~	~~See Policy 8710-517~~	~~See Policy 8710-517~~
~~INTERNAL MEDICINE PROCEDURES~~			
• ~~Arthrocentesis~~ • ~~Central venous catheter insertion*~~ • ~~Cyst Aspiration~~ • ~~Excision of subcutaneous lesions not requiring skin grafts~~ • ~~Flexible sigmoidoscopy~~ • ~~Incision and~~	~~1. Board certified in Internal Medicine by the American Board of Internal Medicine; or~~ ~~2. Successful completion of an ACGME or AOA accredited residency in internal medicine and documentation of ten (10) cases within 24 months prior to~~	~~Two (2) cases from this category~~	~~Ten (10) cases from this category. If a privilege is annotated with an asterie (*), one (1) case is required, which counts in the total category volume~~

~~Drainage~~ • ~~Lumbar puncture*~~ • ~~Paracentesis*~~ • ~~Percutaneous arterial catheter insertion*~~ • ~~Read EKGs/supervise treadmill EKGs~~ • ~~Removal of toenail~~ • ~~Skin biopsy~~ • ~~Suturing~~ • ~~Thoracentesis*~~ • ~~Treatment of patients in an intensive care environment~~ • ~~Venous cutdown~~	~~application~~		~~requirements.~~
~~**ENDOCRINOLOGY PROCEDURES**~~			
• ~~Admit, evaluate, diagnose, consult, perform history and physical examination, and provide treatment to patients presenting with illnesses, injuries, or disorders of the endocrine or metabolic systems, including diabetes.~~	~~1. Board certified in Endocrinology, Diabetes, and Metabolism by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine; or~~ ~~2.1. Successful completion of an ACGME or AOA accredited residency in internal medicine or applicable sub-specialty residency/ fellowship and documentation of the management of endocrinology, diabetes, and metabolism problems for at least twenty (20) patients with in the 24 months prior to application.~~	~~Six (6) cases~~	~~Twenty (20) cases~~

• ~~Fine-needle thyroid aspiration~~	~~Five (5) cases within 24 months prior to application~~	~~One (1) case~~	~~One (1) case~~
~~NEPHROLOGY PROCEDURES~~			
• ~~Continuous arteriovenous hemofiltration~~ • ~~Hemodialysis~~ • ~~Peritoneal dialysis~~ • ~~Plasmapheresis~~ • ~~Renal biopsy~~	~~1. Board certified in the subspecialty of Nephrology by the American Board of Internal Medicine; or~~ ~~2.1. Successful completion of an ACGME or AOA accredited internal medicine residency and either a residency or fellowship in nephrology, and documentation of ten (10) cases within 24 months prior to application.~~	~~Two (2) cases from this category~~	~~Ten (10) cases from this category~~
~~PAIN MANAGEMENT~~			
~~Pain management privileges~~	~~Per Medical Staff policy 8710-541~~	~~Per Medical Staff policy 8710-541~~	~~Per Medical Staff policy 8710-541~~

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued of deficiencies noted.

C. **THE MONITOR MUST BE PRESENT FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PHYSICIAN'S COMPETENCE.**

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
E. The member shall have free choice of suitable consultants and assistants.
F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
G. A form shall be completed by the proctor, and should include comments on pre-procedure workup, diagnosis, pre-procedure preparation, technique, judgment, post-procedure care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff ~~Office~~Department.
H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff ~~Office~~Department.

IX. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

A. The Department of Family Medicine (FM) Quality Review Committee and the Division of Internal Medicine (IM) Quality Review Committee shall be combined into the Internal Medicine/Family Medicine (IM/FM) Quality Review Committee (QRC). The combined IM/FM QRC shall be comprised of no less than two (2) Family Medicine Department members and two (2) Internal Medicine Division members. The Committee chairman may alternate between the Department of Family Medicine and the Division of Internal Medicine as determined by the QRC and each department/division shall have a representative on the Medical Quality Peer Review Committee The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members shall be eligible to succeed themselves. The QRC shall meet at least four (4) times per year.
B. **General Function**
   1. The IM/FM QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by department members to patients in the hospital.
C. **Specific Functions:**
   1. The QRC is established to:
      i Identify important elements of patient care;
      ii Establish performance monitoring indicators and standards related to these elements of care;
      iii Select and approve performance monitoring indicators;
      iv Integrate relevant information for these indicators and review quarterly as related to these performance monitoring indicators;
      v Review and evaluate physician practice when specific thresholds are triggered;
      vi Identify areas of concern and opportunities for improved care and safety, and educate Department members based on these reviews;
      vii Highlight significant clinical issues and present the specific information regarding qualify of care to the appropriate Department member, in accordance with Medical Staff Bylaws;
      viii Request, if needed, Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;
      ix Monitor and review the effectiveness of intervention and document change.
D. **Other Functions:**
   1. Assist in the reappointment process through retrospective review of charts;
   2. Review any Internal Medicine-related issues received from other departments;

3. Assist in the collection, organization, review, and presentation of data related to patient care, safety, and department clinical pathways;
4. Review cases involving death(s) in the hospital as applicable by approved departmental indicators.

E. **Reports**

1. Minutes shall be submitted to the Medical Quality Peer Review Committee and the Medical Executive Committee. The QRC shall provide minutes, and as needed, verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to Department members and to the Medical Quality Peer Review Committee.

X. EMERGENCY CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

While serving on the Emergency Department Call Roster, each member shall respond to requests from the Emergency Department by examining and treating patients in the Emergency Department, unless the member and the Emergency Department physician determines that such care may be provided in the member's office. Any member who elects to provide care in his/her office must do so without regard to the patient's ability to pay, and must provide a minimum level of care sufficient to respond to the patient's immediate needs.

When it is discovered that a staff member has previously treated a patient, that member will be given the opportunity to provide further care. The member will then determine whether to provide further care to an Emergency Department patient based upon the circumstances of the case. If a member declines, the on-call physician for unassigned patients will provide any necessary emergency special care.

Provisional and Courtesy staff members may be assigned to the Emergency Department Call Roster by the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Internal Medicine: 6/04/15
Department of Medicine: 6/12/15
Medical Executive Committee:6/22/15
Governance Committee: 7/07/15
Board of Directors: 7/30/15

I. MEMBERSHIP

A. The Department of Radiology consists of physicians who have a contractual relationship with the hospital to practice Radiology and are board certified or board eligible and actively progressing towards certification in Diagnostic Radiology and/or Nuclear Medicine by the American Board of Radiology.

~~B. The Department of Radiology, at its sole discretion, may also admit physician assistants (PAs) upon a majority vote of the physician members. These PAs must be certified by their certifying body (National Commission on Certification of Physician Assistants (NCCPA)) or be board eligible and achieve such status within two (2) years of appointment. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the Medical Board of California.~~

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Radiology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the ~~QA/PI/PS~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

K. Establish protocols for the supervision of Physician Assistants.

III. DEPARTMENT MEETINGS

The Department of Radiology shall meet at least quarterly or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Department members, exclusive of teleradiology providers, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

The Department shall have a Chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department.

The Department Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Department;
B. Continue surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
E. Recommend clinical privileges for each member of the Department;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
G. Assume other duties as recommended from the Medical Executive Committee.

VI. CLASSIFICATION: Privileges in the Department of Radiology are divided into the following categories:

A. Diagnostic Radiology - Diagnostic radiologists use x-rays, radionuclides, ultrasound, and electromagnetic radiation to diagnose and treat disease. Physicians are eligible for privileges in all routine radiographic and fluoroscopic procedures, and minor procedural components attendant to them as outlined in the Physician Privilege Table. All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.
B. Nuclear Medicine - Specialists in nuclear radiology use the administration of trace amounts of radioactive substances (radionuclides) to provide images and information for making a diagnosis. Members trained and certified only in Nuclear Medicine are eligible for only Nuclear Medicine privileges.
C. Interventional Radiology – Specialists in vascular and interventional radiology diagnoses who treat diseases with use of various radiologic imaging technologies, including fluoroscopy, digital radiography, computed tomography (CT), sonography, and magnetic resonance imaging (MRI). Physicians are eligible for interventional radiology procedures if they meet the credentialing criteria as outlined in the applicable Medical Staff policies/rules (see Interventional Privileges section of the Physician Privilege Table).
D. Teleradiology – Remote interpretation of diagnostic images for emergency, after hours and consultation purposes. Teleradiology only privileges are identified in the Physician Privilege Table.

~~E. Physician Assistants (PA) - A PA may provide medical services that are consistent with his/her education, training, and experience, and PA regulations as outlined in the PA's Delegation of Services Agreement. PAs are also subject to the Allied Health Professional Rules and Regulations. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols as designated in their Delegation of Service Agreement.~~

~~F. Nurse Practitioner (NP) - Nurse practitioners may provide medical services that are consistent with their education, training, and experience, and are outlined in the Standardized Procedures for a NP in the Radiology Department. Nurse practitioners are also subject to the Allied Health Professional Rules and Regulations.~~

VII. PRIVILEGES

A. Request for privileges in the Department of Radiology shall be evaluated on the bases of the member's education, training, experience, demonstrated professional competence and judgement, clinical performance and documented results of patient care and monitoring.

B. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the ~~Medical Staff Office~~Medical Staff Department.

~~C. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~

~~D.~~C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

~~E.~~D. Sites:

1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
2. Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside, CA 92056.

~~Physician Privilege Table~~			
~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~	~~Board certification or board eligible and actively progressing towards certification~~	~~Proctoring satisfied upon completion of proctoring for history and physical examination.~~	~~None~~
~~Consultation, including via telemedicine (F)~~			
~~History and physical examination, including via telemedicine (F)~~		~~Six (6) cases~~	
~~General Diagnostic Radiology and Fluoroscopy~~			
~~Arthrography/arthrocentesis/injection~~	~~Board certification or board eligible and actively progressing towards certification~~	~~Twenty-five (25) representative blend of cases~~	~~Fifty (50) representative blend of cases~~
~~Breast biopsy~~			
~~Computed tomography~~			
~~General diagnostic/fluoroscopy~~			
~~Hysterosalpingography~~			
~~Lumbar or C1-2 puncture/myelography~~			
~~Lymphocintigraphy~~			

Magnetic resonance imaging/spectroscopy			
Mammography			
Nuclear medicine (all routine)			
Positron emission tomography (PET)			
Radionuclide cysternography and shunt studies			
Sialography			
Ultrasonography/hysterosonography			
Vascular duplex ultrasound			
Venography			
Special Nuclear Medicine Procedures – Members of the Department trained and board certified only in Nuclear Medicine are eligible for Nuclear Medicine privileges only.			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
I-131 therapy for thyroid cancer or for hyperthyroidism	Board certification or board eligible and actively progressing towards certification	Three (3) cases representative blend	Five (5) representative blend of cases
Radionuclide therapy low dose < 33 mCi			
Radionuclide therapy high dose > 33 mCi			
P-32 intravenous or intracavitary			
Immune imaging (Zevalin, etc.)			
Teleradiology (for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges)			
Computed tomography	25 cases General Radiology and 10 Ultrasound, 10 Tomography, 10 MRI, and 10 Nuclear Medicine	Twenty-five (25) representative blend of cases	Fifty (50) representative blend of cases
General radiology			
General nuclear medicine			
Magnetic resonance imaging			
Ultrasonography			
Peripheral Vascular Interventional Procedures			
Peripheral angiography (extremity, visceral, thoracic, pulmonary, carotid, cerebral)	Refer to Policy 8710-504	Refer to Policy 8710-504	Refer to Policy 8710-504
Peripheral intervention (angioplasty, stent placement, thrombolysis, embolization, drug infusion, stent graft, chemoembolization, etc.)			
Venography and venous intervention (venous thrombolysis, tPA, stent, IVC filter, venous sampling, transjugular intrahepatic portosystemic shunt (TIPS), venous access procedures (Ports, Midline catheters, Tunneled lines))			
Interventional Procedures			
Endovascular AAA repair	Refer to Policy 8710-503	Refer to Policy 8710-503	Refer to Policy 8710-503
Vertebral Augmentation	Refer to Policy 8710-534	Refer to Policy 8710-534	Refer to Policy 8710-534

GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.	Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes	Two (2) cases	Twenty (20) representative blend of cases
Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.		Two (2) cases	
Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures		Two (2) cases	
Tumor Ablation Intervention (includes ablation by injection or Radiofrequency probe, Brachytherapy with implantable seeds			
Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas)	Refer to Policy 8710-530	Refer to Policy 8710-530	Refer to Policy 8710-530
Pain Management Privileges	Refer to Policy 8710-541		
Sedation Privileges			
Moderate sedation	Refer to Policy 8710-517		
Deep sedation			

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Perform history and physical examination	Per AHP Rules and Regulations	Ten (10) cases to include therapeutic procedures	Satisfactory evaluation by supervising physician
Furnish drugs consistent with the TCMC formulary and as outlined in the standardized procedures and protocols			
Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication			
General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)			
Recommend therapeutic diets and exercise			
Provide patient education and counseling			
Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation			

~~**Therapeutic Procedures**~~ ~~—A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.~~			
~~Bone Marrow Biopsy, image guided~~	~~Per AHP Rules and Regulations.~~ ~~Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.~~	~~Five (5) cases~~	~~Satisfactory evaluation by supervising physician~~
~~Central line insertion: femoral lines~~		~~Three (3) cases~~	
~~Central line insertion: PICC lines~~		~~Three (3) cases~~	
~~Lumbar Puncture, image-guided~~		~~Three (3) cases~~	
~~Paracentesis~~		~~Three (3) cases~~	
~~Abscess drainage tube manipulation/resuturing~~		~~Satisfied upon completion of General Patient Care Privileges proctoring~~	
~~Chest tube removal~~			
~~Keo feeding tube insertion/nasogastric tube insertion~~			
~~Liver biopsy, image guided~~			
~~Peripheral IV line insertion~~			
~~Removal of drains and/or tubes~~			
~~Removal of tunneled catheters~~			
~~Removal of venous port (Mediport)~~			
~~Subcutaneous local anesthesia~~			
~~Suturing and suture removal~~			
~~Moderate Sedation~~	~~Refer to Policy 8710-517~~	~~Refer to Policy 8710-517~~	~~Refer to Policy 8710-517~~

~~**Nurse Practitioner Privilege Table**~~			
~~**General Patient Care Privileges**~~	~~**Initial Appointment**~~	~~**Proctoring**~~	~~**Reappointment (every 2 years)**~~
~~Perform history and physical examination~~	~~Per AHP Rules and Regulations~~	~~Ten (10) cases to include therapeutic procedures~~	~~Satisfactory evaluation by supervising physician~~
~~Furnish drugs consistent with the TCMC formulary and as outlined in the standardized procedures and protocols~~			
~~Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication~~			
~~General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)~~			
~~Recommend therapeutic diets and exercise~~			
~~Provide patient education and counseling~~			

~~Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation~~			
~~**Therapeutic Procedures** – A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.~~			
~~Central IV access: femoral line insertion~~	~~Per AHP Rules and Regulations.~~ ~~Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.~~	~~Three (3) cases~~	~~Satisfactory evaluation by supervising physician~~
~~Central IV access: PICC line insertion~~		~~Three (3) cases~~	
~~Lumbar Puncture~~		~~Three (3) cases~~	
~~Paracentesis~~		~~Three (3) cases~~	
~~Abscess drainage tube manipulation/resuturing~~		~~Satisfied upon completion of General Patient Care Privileges proctoring~~	
~~Chest tube removal~~			
~~Keo feeding tube insertion/nasogastric tube insertion~~			
~~Peripheral IV line insertion~~			
~~Removal of drains and tubes~~			
~~Removal of tunneled catheters~~			
~~Removal of venous port (Mediport)~~			
~~Suturing and suture removal~~			
~~Subcutaneous local anesthesia~~			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors.

C. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the proctored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

D. ~~**THE PROCTOR MUST BE PRESENT IN THE PROCEDURE ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACITIONER'S COMPETENCE.**~~Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural

techniques. The monitor must be present in the Procedure Room for a sufficient period of time to assure himself/herself of the member's competence.

E. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
F. The member shall have free choice of suitable consultants and assistants. The proctor may assist the member.
G. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
H. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the ~~Medical Staff Office~~Medical Staff Department.
I. The proctor's report shall be confidential and shall be completed and returned to the ~~Medical Staff Office~~Medical Staff Department.

VIII. EMERGENCY DEPARTMENT CALL

Active department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. The Department Chair will be responsible for maintaining adequate coverage of the Emergency Department. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional or Courtesy staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Department.

APPROVALS:

Department of Radiology:	10/7/14
Interdisciplinary Practice Committee:	10/20/14
Medical Executive Committee:	10/27/14
Governance Committee:	11/4/14
Board of Directors:	11/6/14

I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee (MEC) guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions, and;
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/ or request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation (OPPE) indicators and formulate thresholds; and
   Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every two years by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a ~~one~~two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a ~~one~~two-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Other duties, as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

C. Requests for privileges in the Department of Pediatrics are evaluated based on the practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

1. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the

standardized procedure or the protocols with the approval of the Department of Pediatrics.

D. Classifications of Newborns:

1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. ~~An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair.~~ It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

C. For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

D. In elective cases, arrangements shall be made prior to scheduling i.e., the proctor shall be designated at the time the case is scheduled.
E. The member shall have free choice of suitable consultants and assistants.
F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
G. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.
H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.
I. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.
J. It is the responsibility of the member to notify a proctor when one is needed.

~~IX. EMERGENCY ROOM COVERAGE~~

~~A. Department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.~~

~~B. Any member who elects to provide follow-up care in his/her office must do so without regard to the patient's ability to pay and must provide a minimum level of care sufficient to respond to the patient's immediate needs.~~

~~C. Provisional or Courtesy Staff may participate on the unassigned call panel at the discretion of the Department chair.~~

~~X.~~IX. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

~~XI.~~X. **NICU M&M COMMITTEE**

The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.

APPROVALS:
Department of Pediatrics: 8/~~16~~17
Medical Executive Committee: ~~9/16~~

Medical Staff Pediatrics Rules & Regulations – Revised: 11/03, 05/04, 05/06, 02/07, 07/07, 06/08, 3/09, 5/09, 11/09; 01/10; 5/11; 9/12; 11/12; 5/13; 8/13; 2/14; 6/14; 6/15; 9/16; 8/17

Governance Committee: ~~8/16~~
Board of Directors: ~~9/16~~

Tri-City Medical Center
MEDICAL STAFF

TO: Medical Executive Committee/Board of Directors

FROM: Medical Quality Peer Review & Credentials Committee

SUBJECT: Cardiothoracic Surgery Activity & Proctoring

UCSD CT surgeons are required to meet the proctoring requirements and patient contact in place at TCMC. However, as there is (a) an existing Affiliation Agreement between UCSD & TCMC, (b) the volume of CT cases are not sufficient to support more than one primary CT Surgeon, (c) sufficient back up for Holidays / Emergency Situations is required, the Medical Quality Peer Review Committee recommends a special provision specific to the CT specialty be put in place to accept 100% of proctored cases & patient contacts from UCSD with the understanding that:

(1) Proctored CT cases are concurrent and performed within the past 90 days
(2) The Proctor is an Active TCMC Staff member who has satisfied the proctoring requirement for CT surgery
(3) UCSD physicians will advance Provisional Staff to Active-Affiliate Staff Status with clinical privileges

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

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

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

March 15, 2018

MEMBERS PRESENT: Chair Jim Dagostino, Director Laura Mitchell, Bret Schanzenbach, Carol Herrera, Danielle Pearson, Gigi Gleason, Guy Roney, Linda Ledesma, Mary Donovan, Mary Lou Clift, Marilou de la Rosa Hruby, Rick Robinson, Darrin Brant, Rosemary Eshelman, Sandy Tucker, Ted Owen

MEMBERS ABSENT: Barbara Perez, Dung Ngo, Jack Nelson, Jan O'Reilly, Mary Murphy, Roma Ferriter, Scott Ashton, Xiomara Arroyo

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; Susan Bond

NON-VOTING MEMBERS ABSENT: Scott Livingstone, COO; Audrey Lopez; Fernando Sanudo

OTHERS PRESENT: Brian Greenwald, Gwen Sanders

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	Due to Chair Julie Nygaard's absence (on vacation) the March 15, 2018 meeting was chaired by Board Chairman, Jim Dagostino. The March 15, 2018 Community Healthcare Alliance Committee meeting was called to order at 12:31pm by Jim Dagostino.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

March 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Introduction	Jim Dagostino introduced Darrin Brent with North County Health Services. Darrin will be representing NCHS while CHAC committee member Roma Ferriter is on maternity leave.		
Approval Of Meeting Agenda	Ted Owen motioned to approve the March 15, 2018 meeting agenda. The motion was seconded by Sandy Tucker and unanimously approved.		
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Bret Schanzenbach motioned to approve the February 18, 2018 CHAC meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved.		
Presentation: Dr. Cary Mells, MD, FACEP **Emergency Department Operations**	Dr. Mells presented information regarding Tri-City Medical Center's Emergency Department operations as follows: • On an annual basis, the TCMC ED sees apx. 65,000 patients. • Goals for 2017 include reducing LBMSE TO <3.5%, Door to MD time to <30 minutes, Discharge LOS to <275 minutes and to minimize paramedic wall time. • ED's are experiencing a great number of older, sicker and more complex patients in the future. • The US spends more on health per capita than 5 of the top spending 1st world countries.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Dr. Cary Mells, MD, FACEP **Emergency Department Operations**	• Bed space is often impacted by inpatient boarding, psychiatric boarding, and social issues. These are all national issues affecting ED's. TCMC generally maintains adequate personnel to match volume, but personnel can be impacted by nursing ratios, sickness, patient acuity and unexpected changes to the daily census. • Processes are continually reviewed and evaluated for effectiveness; however these changes are often affected negatively by staff resistance to change and unforeseen obstacles. • A new process recently implemented is "Keep Vertical Patients Vertical". This process has been successful with staff and patients as it eliminates time patients spend waiting for a bed. This process generally saves 60 minutes of wait time from beginning to end of stay. • Future plans include continued improvements to the flow between the ED and the Crisis Stabilization Unit reducing inpatient boarding, and expanding the vertical treatment area concept.		
CEO Update Steve Dietlin	CEO Steve Dietlin addressed the committee as follows: • Steve thanked Dr. Mells for his informative presentation, and urged committee members to take this positive information back into their communities.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (cont.)	• Steve noted that wait time is down and the patient's experience is better. Our great ER staff is helping patients have a better experience, and findings show it is providing more comfort in their distress and a greater sense of individual care. • TCMC continues to experience a percentage of repeat customers that require extra support. • Construction on the new parking lot has begun and it is anticipated that construction on the parking garage will begin this summer. • Steve noted that Dr. Victor Souza was a finalist in San Diego Business Journal's *Healthcare Heroes* awards ceremony. • Steve notified the committee of David Bennett's recent retirement.		
COO Update Scott Livingstone	Scott Livingstone, COO was not available to present.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

March 15, 2018

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Chief Of Staff Update Dr. Victor Souza MD	Dr. Victor Souza was not available to present.		
Committee Vacancies – Oceanside District Resident	A candidate for the Oceanside District Resident position is being considered. This candidate will be asked to attend the April meeting.		
Public Communications	No public communications.		
Committee Communications	• Sandy Tucker noted that the *Tails on the Trails Charity Dog Walk* is taking place Saturday, May 19th. Funds raised go to the Jr. Volunteer Scholarship Program and K9 units of Oceanside. The TCMC Auxiliary raises apx. $80,000.00 per year for TCMC. • Sandy also noted that the Jr. Volunteer Scholarship Program is a very popular program and was filled within 8 hours after opening for the 2018 year. • Mary Donovan noted that Operation Hope's *Enchanted Evening Gala* is taking place on April 24th. • Marilou de la Rosa Hruby thanked TCMC for supporting the recent *Soroptimist Salad Luncheon* at the O'side pier.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	Rosemary Eshelman noted that she recently wrote a grant to fund an on-campus BHU employee, stating that up to 150 kids per year would benefit from this program if the grant is approved. Jim Dagostino answered questions regarding the San Diego Food Bank's kids back pack food program. Jim will be updating the group on this program in the future.		
Next Meeting	The next CHAC meeting is scheduled for Thursday, April 19, 2018 at 12:30 pm.		
Adjournment	The March 15, 2018 CHAC meeting was adjourned at 2:05pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
March 20, 2018

Members Present	Director Julie Nygaard, Director Cyril Kellett, Dr. Marcus Contardo, Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber. Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingston, COO, Sharon Schultz, CNE, Carlos Cruz, CCO, Susan Bond, General Counsel
Others:	Director Laura Mitchell, Jeremy Raimo, Jane Dunmeyer, Colleen Thompson, Glen Newhart, Esther Beverly, Charlene Carty, Mark Albright, Cristina Barrera, Eva England, Sherry Miller, Tom Moore, Barbara Hainsworth
Members Absent:	Director Leigh Anne Grass

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:31 p.m.		
2. Approval of Agenda	Director Nygaard solicited approval from the members of the Committee regarding the addition of an item to the agenda, not included in the previously distributed packet: • 7.g. Coding Support Services – Contract Increase Proposal • Oxford Global Resources, LLC The write-up agreement was distributed to the committee members at this time.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved to accept the agenda of March 20, 2018.** **Members:** **AYES: Nygaard, Kellett, Contardo, Ma, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN: None** **ABSENT: Grass**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of February 13, 2018	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Contardo, Director Kellett seconded, that the minutes of February 13, 2018 are to be unanimously approved, with Director Nygaard and Dr. Ma abstaining from the vote.**	
5. Old Business			
6. New Business			
a. Community Member Recognition: • Mr. Steve Harrington	Director Nygaard conveyed gratitude on behalf of the committee members to Mr. Harrington for his valuable contribution to the Finance, Operations and Planning Committee, and presented him with a certificate of appreciation.		Chair
7. Consideration of Consent Calendar:	Mr. Harrington requested that the following item be pulled for discussion: 7.a. Abbott / St, Jude Medical – Product Purchase Commitment Proposal Mr. Lingenfelter requested that the following item be pulled for discussion: 7.g. Coding Support Services – Contract Increase - Oxford Global, LLC	**MOTION** **Director Kellett moved to approve the Consent Calendar minus the items pulled. Dr. Contardo seconded the motion.** **Members:** **AYES: Nygaard, Kellett, Contardo, Ma, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN: None** **ABSENT: Grass**	Chair
a. Abbott / St. Jude Medical – Product Purchase Commitment Proposal:	Mr. Harrington requested that this item be pulled for discussion. Eva England provided a brief PowerPoint presentation conveying the details of this proposal and emphasizing	**MOTION** **It was moved by Dr. Ma, seconded by Mr. Lingenfelter to authorize the agreement with Abbott / St. Jude Medical for a term of 48 months, beginning April 1, 2018 and ending March 31, 2022 for an annual cost of**	Eva England

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	both the 15% savings for Cardiac Rhythm Management (CRM), and that there is no expected capital outlay for this agreement. Brief discussion ensued.	**$2,435,489, and a total cost for the term of $9,741,956.** **Members:** **AYES: Nygaard, Kellett, Contardo, Ma, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN: None** **ABSENT: Grass**	
b. Physician Agreement for ED On-Call Coverage - Neurology • Abigail Lawler, M.D.		**Approved via Consent Calendar**	Sherry Miller
c. Physician Agreement for Covering Physician – Inpatient Wound Care • Sharon Slowik, M.D.		**Approved via Consent Calendar**	Sharon Schultz
d. Physician Agreement for Covering Physician – Inpatient Wound Care • Henry Showah, M.D.		**Approved via Consent Calendar**	Sharon Schultz
e. Physician Agreement for Covering Physician – Outpatient Wound Care / HBO • Sharon Slowik, M.D.		**Approved via Consent Calendar**	Sharon Schultz
f. Physician Agreement for Covering Physician – Outpatient Wound Care / HBO • Henry Showah, M.D.		**Approved via Consent Calendar**	Sharon Schultz
g. Coding Support Services – Contract Increase Proposal • Oxford Global Resources, LLC	Mr. Lingenfelter requested that this item be pulled for discussion. Ray Rivas detailed that this proposal is	**MOTION** **It was moved by Dr. Contardo, seconded by Dr. Yamanaka to authorize the agreement with Oxford**	Colleen Thompson

Topic	Discussions, Conclusion. Recommendations	Action Recommendations/ Conclusions	F ..son(s) Responsible
	necessary to satisfy outside coding expenses for the remaining term of the original agreement. He emphasized the importance of recruiting qualified coders to eliminate the need for outsourced coding services. Colleen Thompson noted that there have been challenges encountered in locating and hiring coding staff that are able to address the more complex accounts needed for timely billing of patient accounts. Discussion ensued.	**for Coding Support for a term of 12 months, beginning May 1, 2017 and ending April 30, 2018 for an increased cost of $125,000, for a total cost for the term of $755,000.** **Members:** **AYES: Nygaard, Kellett, Contardo, Ma, Yamanaka, Ferber, Harrington, Lingenfelter** **NOES: None** **ABSTAIN: None** **ABSENT: Grass**	
8. Financials:	Ray Rivas presented the financials ending February 28, 2018 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 239,606 Operating Expense $ 249,125 EBITDA $ 4,451 EROE $ (5,957) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 177 Adjusted Patient Days 75,881 Surgery Cases 4,289 Deliveries 1,560 ED Visits 41,279 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 29,214 Operating Expense $ 30,165 EBITDA $ 751 EROE $ (542) **TCMC – Key Indicators**		Ray Rivas

Topic	Discussions, Conclusion Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Current Month Avg. Daily Census 186 Adjusted Patient Days 9,201 Surgery Cases 528 Deliveries 169 ED Visits 4,619 **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. 48.9 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Wellness Center *(bi-monthly)*	Scott Livingstone provided a brief PowerPoint presentation detailing two key objectives that have been identified by district leadership: • Objective 1: Grow Membership • Objective 2: Decrease Financial Losses Scott detailed that there has been and 11% increase in membership from August 2017 to February 2018. If this growth potential continues, a record number of memberships could be anticipated by the close of March 2018. Significant discussion ensued regarding tax fee recovery, implementation of a productivity model, in-house marketing		Scott Livingstone

Topic	Discussions, Conclusions/ Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	strategies, GPO discounts and maximizing utilization of medical integrated programs.		
b. Meaningful Use *(semi-annual)*	Mark Albright offered a short PowerPoint presentation of the following items and their present status: • Meaningful Use Phases • MU Stage 3 Objective Roadmap • MU 3 Incentives = Penalty Avoidance Brief discussion ensued.		Mark Albright
c. Crisis Stabilization Unit (CSU) *(bi-monthly)*	Sharon Schultz furnished a PowerPoint presentation detailing the following: • CSU Payer Mix: 1/1/18-1/31/18 • CSU Overall Admission Volume & Average LOS: 1/1/18-1/31/18 • CSU Medi-Cal Admission Volumes & Average LOS: 1/1/18-1/31/18 • CSU Payer Mix: 2/1/18-2/28/18 • CSU Overall Admission Volume & Average LOS: 2/1/18-2/28/18 • CSU Medi-Cal Admission Volumes & Average LOS: 2/1/18-2/28/18 • Process Improvement-CSU Brief discussion ensued.		Sharon Schultz
d. Dashboard	No discussion		Ray Rivas
10. Comments by committee members			
11. Date of next meeting	Tuesday, April 17, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:25 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
Abbott / St. Jude Medical – Product Purchase Commitment Proposal

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

Vendor's Name: Abbott / St. Jude Medical

Area of Service: Cardiac Catheterization Lab

Term of Agreement: 48 months, Beginning, April 1, 2018 – Ending, March 31, 2022

Maximum Totals:

Committed Annual Cost	Committed Total Term Cost
$2,435,489	$9,741,956

Description of Services/Supplies:

- This proposal includes a 15% savings on all Cardiac Rhythm Management (CRM) implants
- 95% dual vendor commitment
- Current TCMC annual spend for all CRM $3,716,000
- Current TCMC annual spend for Abbott/St. Jude $2,075,000 (CRM & EP Equipment)
- 4 year Commitment includes "No Capital outlay EP equipment" (2 systems Cost @ $444,526)
- Shift from 4 CRM vendors to 2 CRM vendors
- Cost commitment includes all Abbott/St. Jude EP Equipment – Annual Spend $597,000

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

Person responsible for oversight of agreement: Eva England, Service Line Administrator, Cardiovascular Service Line / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Abbott/St. Jude Medical for a term of 48 months, beginning April 1, 2018 and ending March 31, 2022 for an annual cost of $2,435,489, and an total cost for the term of $9,741,956.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Neurology

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

Physician's Name: Abigail Lawler, M.D.

Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 3 months, Beginning, April 1, 2018 – Ending, June 30, 2018

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Neurology
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$740	365	$270,100
	Total:	**$270,100**

Position Responsibilities:

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

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Abigail Lawler M.D. to the currently existing ED On-Call Coverage Panel for Neurology for a term of 3 months, beginning April 1, 2018 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
PHYSICIAN AGREEMENT for Covering Physician - Inpatient Wound Care

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2018 - Ending, April 30, 2019

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2018, and ending April 30, 2019. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
PHYSICIAN AGREEMENT for Covering Physician - Inpatient Wound Care

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

Physician's Name: Henry Showah, M.D.
Area of Service: Inpatient Wound Care
Term of Agreement: 12 months, Beginning, May 1, 2018 - Ending, April 30, 2019
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2018, and ending April 30, 2019. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
PHYSICIAN AGREEMENT for Covering Physician - Outpatient Wound Care/HBO Center

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Outpatient Wound Care/HBO

Term of Agreement: 12 months, Beginning, May 1, 2018- Ending, April 30, 2019

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision of staff and patients undergoing HBO
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Design Quality Assurance and Performance Improvement program.
- Creates criteria for medical audits
- Timely communication with primary care physicians and/or other community health resources
- Audits patient care and records of care for opportunities in case delivery
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, and QAPI: Actively participate in Hospital's Medical Staff utilization review, quality, performance improvement and risk programs.
- Attends monthly QAPI meetings

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

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2018, and ending April 30, 2019. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
PHYSICIAN AGREEMENT for Covering Physician - Outpatient Wound Care/HBO Center

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

Physician's Name: Henry Showah, M.D.

Area of Service: Outpatient Wound Care/HBO

Term of Agreement: 12 months, Beginning, May 1, 2018 - Ending, April 30, 2019

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision of staff and patients undergoing HBO
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Design Quality Assurance and Performance Improvement program.
- Creates criteria for medical audits
- Timely communication with primary care physicians and/or other community health resources
- Audits patient care and records of care for opportunities in case delivery.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, and QAPI: Actively participate in Hospital's Medical Staff utilization review, quality, performance improvement and risk programs.
- Attends monthly QAPI meetings

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

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2018, and ending April 30, 2019. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 20, 2018
Coding Support Services – Contract Increase Proposal

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

Vendor's Name: Oxford Global Resources, LLC

Area of Service: Medical Records/Health Information

Term of Agreement: 12 months, Beginning, May 1, 2017– Ending, April 30, 2018

Maximum Totals:

Previously Approved Cost	Requested Cost Increase	Expected Total Term Cost
$630,000	$125,000	$755,000

Description of Services/Supplies:

- A request for increase in approved cost was originally brought to the Finance, Operations & Planning committee on January 16, 2018. This request includes a revised cost estimate.
- Exceeded original expenditure of $300K, approved in May 2017
- Continue to require outside service support for coding/billing in a timely manner while continuing to recruit qualified coder to address the more complex accounts for timely billing.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item: Original Cost, ($300,000)	X	Yes		No
Budgeted Item: Additional Cost, 1/16/18 ($330,000)		Yes	X	No

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Oxford for Coding Support for a term of 12 months, beginning May 1, 2017 and ending April 30, 2018 for an increased cost of $125,000, for a total cost for the term of $755,000.

DRAFT

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

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

Non-Voting Members Present: Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP , Carlos Cruz, Chief Compliance Officer and Marcia Cavanaugh, Sr. Director for Risk Management.

Others Present: Christine Carlton, Alisa Quirey, Lori Roach, Kim Posten, Courtnel Nelson, Debra Feller, Oska Lawrence, Candice Parras, Aimee Hardt, Joy Melhado, Patricia Guerra and Karren Hertz.

Members Absent: Steve Dietlin and Susan Bond.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:03 PM in Assembly Room 1.		Director Grass
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Schallock and seconded by Director Mitchell.	Director Grass
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Grass read the paragraph regarding comments from members of the public.		Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of February 2018.	Director Mitchell called for a motion to approve the minutes from February 8, 2018.	Director Schallock approved and Director Mitchell seconded the motion to approve the minutes from February 2018. Director Grass abstain from voting as she was not present in last month's meeting.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Release of Deceased to a Family Member Policy 2. Safe Medical Device Act Tracking and Reporting Policy 3. Safe Surrender 4. Sponge, Sharps and Instrument Counts- Prevention of Retained Surgical Items	It was clarified that the hospital rarely uses this procedure but we need to have this policy in place for compliance purposes. A question was raised on what category does the surgial mesh fall—Deb Feller stated that it is documented in the charts exactly the same way. There was no discussion on this policy. There was a minor grammatical error on Item 8 section a. This will be corrected and the policy will move forward for Board approval.	**ACTION:** The Patient Care policies and procedures were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific Administrative Policies 1. Success Service Recovery Program- SSRP (Formerly Star Service Plan)	Dr. Souza posed a question if we are tracking down which departments do this program and the amounts they used for this purpose. Marcia responded by saying that this program is being used frequently by the staff and had helped in numerous instances in making the situation better on incidents that patients/ family are upset due to a service delay or other unforeseen circumstances.	**ACTION:** The Administrative policy was approved. Director Mitchell moved and Dr. Souza seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Behavioral Health Services 1. Approved Abbreviations- Clean Copy Approved Abbreviations- Tracked Changes 2. Assisting MediCal Recipients with Grievances and Appeals 3. Behavioral Health Unit Visiting Policy 4. BHU Multidisciplinary Treatment Plan 5. Clinical Assessment 6. Community Meeting 7. C[illegible]ducting Searches	*Most of BHU policies contained in this list are self-explanatory with the exception of some as specified below.	**ACTION:** The Behavioral Health policies were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Patient Room Patient Belongings 8. Confidentiality			
9. Cleaning and Changing of BHU/ CSU Bathroom Curtains	The term PICU should be taken out (old term for CSU) and it was recommended that the BHU and CSU should be spelled out for better clarification in this policy. Also, this policy is not duplicated since from the last revision date, the doors from BHU were taken out as part of recommendation of the last JC survey.		
10. Daily Environmental Safety Rounds			
11. Daily Schedule			
12. Direct Admissions to BHU	There was a clarification made that the on-call physician can make a direct referral for a patient to be admitted to BHU.		
13. Discharge Planning			
14. Dress Code for Patients	Flip flops are discouraged in BHU since it is a tripping hazard in the units.		
15. Elopement Precautions	Joy fully explained the BHU staff rounding procedure. There is staff rounding in the unit every 15 minutes in BHU (60 minutes in CSU). In case there's an incident, a Mental Health Worker (MHW) designates another person to round on his/her behalf. This will ensure that one person is always rounding to check on the status of patients in this unit while the other one attends to [illegible] issue in		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	the unit.		
16. Environmental Safety Standards in BHU			
17. Exclusionary Criteria			
18. Family Involvement in Treatment			
19. Food for the Unit			
20. Freedom of Movement			
21. General Supervision of Patients: Patient Rounds			
22. Hose Use During Garden Activity			
23. Inpatient Unit Admission Criteria			
24. Involuntary Hold Patients			
25. Management of Aggressive and Assaultive Behavior			
Food and Nutrition			
1. Clinical Nutrition Dietitian Staffing	There was no discussion on this policy.	**ACTION:** The Food and Nutrition policies were approved. Director Mitchell moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Nutrition Assessment and Care for Adult Geriatric P[illegible]ients Protocol	There was minor typo on the criteria for nutritional assessment, the word greater than should say less than as i[illegible]orresponds		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	to the correct symbol (<).		
NICU 1. Admission and Discharge Criteria for the NICU- Clean Copy Admission and Discharge Criteria for the NICU- Tracked Changes 2. Ordering of Durable Medical Equipment 3. Patient Assignment in NICU 4. Patient Classification (Acuity) in the NICU	The spelling of inotropic was corrected and there was a clarification on the 44 weeks post conceptual which is essentially not one month gestation.	**ACTION:** The NICU policies were approved. Director Schallock moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Infusion Center 1. Infection Prevention and Control Activities	There was no discussion on this policy.	**ACTION:** The Outpatient Infusion Center policy was approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Pharmacy 1. Automated Dispensing Machine 2. Licensure and Professional Standards 3. Medication Preparation 4. Receiving and Tracking Narcotic Pump Refills P[illegible]pared by Outside	It was noted that the notification on ADMs (Automated Dispensing Machine) can be done remotely. It was clarified that if the pharmacy require assistance on overrides without orders, staff may contact the Pharmacy Director and/or Clinical Manager.	**ACTION:** The Pharmacy policies were approved. Director Schallock moved and Director Mitchell seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Vendors **Progressive Care Unit** 1. Custody Awareness Safety Guidelines 2. Hunger Strike, CDCR 3. Release of A Deceased-Justice Involved Patient	Lori Roach briefly stated that nursing students rotate in PCU. For visitors, TCMC still need to make sure visitors obtain a clearance before allowing anyone in the unit. Department of Corrections is in charge of of notifying the family in cases of death. The spelling of manager was corrected in this policy.	**ACTION:** The notice of privacy practice was approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Mitchell.	Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Schallock moved, Dr. Souza seconded and it was unanimously approved to go into closed session at 12:40 PM.	Director Grass
8. Return to Open Session	The Committee return to Open Session at 2:15 PM.		Director Grass
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Grass
10. Comments from Members of the Committee	No comments.		Director Grass
11. Adjournment	Meeting adjourned at 1:25PM.		Director Grass

PROFESSIONAL AFFAIRS COMMITTEE
March 8th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Release of Deceased to a Family Member policy	3 Year Review	Forward To BOD For Approval
2. Safe Medical Device Act Tracking and Reporting Policy	3 Year Review, Practice Change	Forward To BOD For Approval
3. Safe Surrender	3 Year Review, Practice Change	Forward To BOD For Approval
4. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects	Practice Change	Forward To BOD For Approval with Revisions
Administrative		
1. Success Service Recovery Program (SSRP) 272 (Formerly Star Service Plan)	3 Year Review	Forward To BOD For Approval with Revisions
Unit Specific		
Behavioral Health Services		
1. Approved Abbreviations – **tracked changes** Approved Abbreviations – **clean copy**	3 Year Review, Practice Change	Forward To BOD For Approval
2. Assisting Medi Cal Recipients with Grievances and Appeals	3 Year Review, Practice Change	Forward To BOD For Approval
3. Behavioral Health Unit Visiting Policy	DELETE	Forward To BOD For Approval
4. BHU Multidisciplinary Treatment Plan	3 Year Review	Forward To BOD For Approval
5. Clinical Assessment	3 Year Review	Forward To BOD For Approval
6. Community Meeting	3 Year Review	Forward To BOD For Approval
7. Conducting Searches Patient Room Patient Belongings	3 Year Review, Practice Change	Forward To BOD For Approval
8. Confidentiality	3 Year Review	Forward To BOD For Approval
9. Curtains, Cleaning and Changing of BHU Bathrooms	NEW	Forward To BOD For Approval with Revisions
10. Daily Environmental Safety Rounds	3 Year Review, Practice Change	Forward To BOD For Approval
11. Daily Schedule	3 Year Review, Practice Change	Forward To BOD For Approval
12. Direct Admissions to the BHU	3 Year Review, Practice Change	Forward To BOD For Approval
13. Discharge Planning	3 Year Review	Forward To BOD For Approval
14. Dress Code for Patients	3 Year Review	Forward To BOD For Approval
15. Elopement Precautions	3 Year Review, Practice Change	Forward To BOD For Approval
16. Environmental Safety Standards in BHU	3 Year Review, Practice Change	Forward To BOD For Approval
17. Exclusionary Criteria	DELETE	Forward To BOD For Approval
18. Family Involvement in Treatment	3 Year Review	Forward To BOD For Approval
19. Food on the Unit	3 Year Review, Practice Change	Forward To BOD For Approval
20. Freedom of Movement	3 Year Review	Forward To BOD For Approval

PROFESSIONAL AFFAIRS COMMITTEE
March 8th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
21. General Supervision of Patients Patient Rounds	3 Year Review, Practice Change	Forward To BOD For Approval
22. Hose Use During Garden Activity	NEW	Forward To BOD For Approval
23. Inpatient Unit Admission Criteria	3 Year Review, Practice Change	Forward To BOD For Approval
24. Involuntary Hold Patients	DELETE	Forward To BOD For Approval
25. Management of Aggressive and Assaultive Behavior	3 Year Review, Practice Change	Forward To BOD For Approval
Food & Nutrition		
1. Clinical Nutrition Dietitian Staffing	3 Year Review	Forward To BOD For Approval
2. Nutrition Assessment and Care Adult Geriatric Protocol	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
NICU		
1. Admission and Discharge Criteria for the NICU – **tracked changes** Admission and Discharge Criteria for the NICU – **clean copy**	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
2. Ordering of DME Equipment	DELETE	Forward To BOD For Approval
3. Patient Assignment NICU	3 Year Review, Practice Change	Forward To BOD For Approval
4. Patient Classification in the NICU	3 Year Review, Practice Change	Forward To BOD For Approval
Outpatient Infusion Center		
1. Infection Control and Prevention	DELETE	Forward To BOD For Approval
Pharmacy		
1. Automated Dispensing Machine	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
2. Licensure and Professional Standards	3 Year Review, Practice Change	Forward To BOD For Approval
3. Medication Preparation	3 Year Review, Practice Change	Forward To BOD For Approval
4. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors	3 Year Review	Forward To BOD For Approval
Progressive Care Unit		
1. Custody Awareness Safety Guidelines	3 Year Review, Practice Change	Forward To BOD For Approval
2. Hunger Strike, CDCR	NEW	Forward To BOD For Approval
3. Release of A Deceased Justice Involved Patient	NEW	Forward To BOD For Approval with Revisions

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/93	**SUBJECT:** RELEASE OF DECEASED TO A FAMILY MEMBER
REVISION DATE: 06/03, 08/07, ~~07~~08/13	**POLICY NUMBER:** IV.P.1

Department Review:	11/17
Clinical Policies & Procedures Committee Approval:	~~07/13~~11/17
~~**Patient Care Quality Committee Approval:**~~	~~07/13~~
Nurse Executive Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/18
Professional Affairs Committee Approval:	~~08/13~~03/18
Board of Directors Approval:	08/13

A. **POLICY:**

~~A.~~1. A decedent may be released for transportation by a family member only after the family has provided the following:

~~1.~~a. Death certificate

~~2.~~b. Burial permit

~~3.~~c. Valid transportation

~~B.~~2. Death Certificate: A death certificate must be obtained (blank form from a mortuary or other facility), properly completed by the attending physician, filed with Department of Health by the family member and presented to Tri-City ~~Medical Center~~**Healthcare District (TCHD)**.

~~C.~~3. Burial Permit: The family member must obtain and present to ~~Tri-City Medical Center~~**TCHD** a burial permit from the mortuary or cemetery at the point of destination, stating that said mortuary or cemetery will accept delivery of the decedent by the family member.

~~D.~~4. Valid Transportation: The family member must provide proof to the Department of Health that the decedent was properly embalmed and/or placed in a hermetically sealed coffin. The decedent cannot be transported in an airplane or across state lines without proof of a hermetically sealed coffin.

5. The family member shall sign the **Authority for** "Release of Deceased" Report in place of mortuary at time of pick-up.

~~1.~~6. **Exclusions: Justice Involved Patients.**

B. **FORM(S):**

~~2.~~1. **Authority for Release of Deceased Report – Sample**

Authority for Release of Deceased Report – Sample

Test, Fred MRN 00000547 FIN# 6002100724

2 SSN 487-66-5555 Room # 516

Oceanside CA 92056

Next of kin: Test, Fred Relation: Pt Phone Number: (111) 111-1111

Patient a donor: Yes

Attending Physician: Test, DME Physician

Pronounced Time: 04/04/2016 14:56 Medical Examiner Notified: Yes Waive No.: 55555

I acknowledge the receipt of personal effects (Acuso recibo de los efectos personales)

_____ _____ _____

Date (Fecha) Signature of next to kin (Firma del Paciente mas cercano) Relationship (Parentesco)

I hereby authorize Tri—City Medical Center to release the remains of (Por medio del presente documento, authorizo a Tri—City Medical Center liberar los restos de) Test, Fred

Patient (Paciente)

To (Al):

Mortuary/Procurement Agency funeral home _____ _____

(Nombre del Mortuario) (Codigo de Area o # de Telefono)

_____ _____ _____ _____

Date (Fecha) Signature of next to kin (Firma del Paciente mas cercano) Relationship (Parentesco con el Difunto) Phone Number (Codigo de Area o # de Telefono)

Physician to sign Death Certificate: Test, DME Physician Phone: ( ) –

Mortuary Notified Date & Time: _____ By _____

Received from Tri—City Medical Center the remains of patient listed above

_____ _____ _____

Date/Time Signature of Medical Examiner/Lifesharing Release by

Returned By: _____ _____ _____

Medical Examiner/Lifesharing Agent Accepted by Date/Time

Received from Tri—City Medical Center

_____ _____ _____

Date/Time Mortuary/Procurement Agency Release by

Public Administrator Notified _____ Date/Time _____

0

Tri-City Medical Center

Authority for Release of Deceased

00000547
Test, Fred
02/02/1954/62 Years/Male
TCMC/Inpatient/6002100724

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

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: ~~06~~08/12	**SUBJECT:** Safe Medical Device Act: Tracking ~~& Reporting~~
REVISION DATE:	~~POLICY NUMBER: XI.M~~
Department Review:	11/17
Clinical Policies & Procedures Committee Approval:	~~06/12~~12/17
Nurse Executive Council Approval:	~~06/12~~01/18
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~07/12~~02/18
Professional Affairs Committee Approval:	~~08/12~~03/18
Board of Directors Approval:	08/12

A. **POLICY:**

1. In compliance with the "Safe Medical Devices Act" of 1990 (effective 8/29/93), all implants and explants will be recorded into the patient's surgical record.

B. **DEFINITION(S):**

1. Permanently implantable device: A device that is intended to be placed into a surgically or naturally formed cavity for more than one (1) year to continuously assist, restore, or replace the function of an organ system or structure throughout the useful life of the device. (Does not include the devices intended and used for temporary purposes or that are intended for explanation within one [1] year or less).
2. Life-supporting or life-sustaining device used outside a device user facility: A device that is essential, or yields information that is essential, to the restoration or continuation of a bodily function important to the continuation of human life that is intended for use outside a hospital, nursing home, ambulatory surgical facility, or diagnostic or outpatient treatment facility.

C. **PROCEDURE:**

1. Examples of devices for tracking, including but not limited to:
   a. Permanently implantable devices:
      i. Abdominal Aortic Aneurysum (AAA) stent grafts
      ii. Automatic implantable cardioverter/defibrillator
      iii. Implantable pacemaker pulse generator
      iv. Cardiovascular permanent implantable pacemaker electrode
      v. Silicone gel-filled breast implants
      vi. Replacement heart valve (mechanical only)
      vii. Automatic implantable cardioverter/defibrillator
      viii. Cultured epidermal autographs
      ix. Implanted cerebellar stimulator
      x. Implanted diaphragmatic/phrenic nerve stimulator
      xi. Implantable infusion pumps
      xii. Temporomandibular Joint (TMJ) prosthesis
      xiii. Glenoid fossa prosthesis
      xiv. Mandibular condyle prosthesis
      xv. Throacic Aortic Aneurysm (TAA) stent graphs
      xvi. Transcatherter Pulmonary Valve (TPV) Prothesis
   b. Life-sustaining or life-supporting devices used outside device user facilities:

i. Breathing frequency monitors
ii. Continuous ventilator
iii. Ventricular bypass (assist) device
iv. **Direct current** (DC) defibrillator and paddles

2. Documentation of Implants (on Implant Record) must include:
   a. Name, address, telephone number and Social Security number of patient
   b. Name/type of implant, size if applicable
   c. Site of implantation
   d. Manufacturer of implant
   e. Catalog number of implant if available
   f. Serial, batch, model, lot number, or other identifier necessary to track device~~.~~
   g. Expiration date if noted on packaging
   h. Date of implantation
   i. Name, address and phone number of the surgeon implanting the device
3. If an implantable device has patient user information included in the packaging, this must be labeled with the patient's name and sent with the patient.
4. If the packaging includes a manufacturer tracking device form this must be completed and mailed back to the company for their records.
5. Documentation of explanted items must include:
   a. The date the device was explanted
   b. Name, mailing address, and telephone number of the explanting physician
   c. The date of the patient's death (if applicable)
   d. The date the device was returned to the manufacturer or distributor, permanently retired from use, or otherwise permanently disposed of.
6. Device Tracking Records:
   a. Device tracking records must be maintained for the useful life of the tracked device.
   b. Records required for the device **are documented in the patient's electronic ~~medical~~health record (EHR).** ~~tracking law must be kept in a centralized location.~~

D. REFERENCE(S):

1. **The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from:** https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf

Tri-City Health Care District
Oceanside, California

Patient Care Services

ISSUE DATE: 02/01 **SUBJECT:** Safe Surrender

REVISION DATE(S): 05/02, 05/03, 04/04, 12/05, 09/06, 11/09, 02/13 ~~**POLICY NUMBER: 380**~~

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

A. **PURPOSE:**

1. To provide guidance for Tri-City Healthcare District (TCHD) employees accepting custody of newborns up to 72 hours old who are voluntarily surrendered by a parent or other person with legal custody.
2. To implement the requirements of the **Safely Surrendered Baby Law**~~Newborn Abandonment Law. (Senate Bill 1368)~~

B. **POLICY:**

1. In compliance with Senate Bill 1368, TCHD has designated the Emergency Department (ED) as the safe surrender site within the facility and the employees on duty in the ~~Emergency Department (ED)~~ to receive abandoned newborns.
2. Any officer, employee or medical staff member on duty at the hospital must accept physical custody of an abandoned newborn up to 72 hours old~~ (H & S Code Section 1255.7)~~.
3. No person or entity that accepts a surrendered newborn will be subject to civil, criminal, or administrative liability for accepting and caring for the child in the good faith belief that action is required or authorized by this law. This includes situations where the child may actually be older than 72 hours, or where the surrendering person did not have lawful physical custody of the infant.
4. Notify ~~Emergency Department~~**ED** registration **to provide confidential ID number.**
   ~~5.~~**a.** The coded, confidential ID number should not be a Medical Record number.

~~6.~~**5.** The consent of the parent or other relative surrendering the newborn is not required for the Medical Screening Exam (MSE).

~~7.~~**6.** Newborns abandoned in accordance with law are eligible for MediCal coverage.

~~8.~~**7.** When a newborn is surrendered, the **registered nurse** (RN) ~~or LVN~~ will:

   a. Follow ED Standard for triage of patients. A MSE and any necessary medical care must be provided. (See **Administrative Policy:** EMTALA: Emergency Medical Screening~~, Administrative Policy #~~ 506)

   b. Access an abandoned newborn packet (Stored in the ED Triage**, Charge Desk, and Radio Room.**) ~~area).~~

      i. Contents of the packet must include a coded, confidential identification (ID) ankle bracelet; a matching coded arm ID bracelet; a coded, confidentially identified family medical history questionnaire (English and Spanish versions); ~~Letter to the Mother,~~**campaign brochure and law fast facts sheet** (English and Spanish) and a stamped envelope addressed to TCHD.

   ~~b.~~**c.** Place the coded ID bracelet on the newborn.

   ~~c.~~**d.** Make a good faith effort to give the matching coded ID arm bracelet to the person

surrendering the newborn. This will facilitate reclaiming the infant later.

~~d.~~e. Make a good faith effort to give the person surrendering the newborn a coded, confidential family medical history questionnaire, **campaign brochure, law fast facts sheet**~~Letter to the Mother~~, and a stamped addressed envelope.

~~e.~~f. Notify Child Protective Services (CPS) of the surrender as soon as possible and in no event later than 48 hours. CPS must assume temporary custody of the newborn immediately on receipt of notification, and must investigate.

~~f.~~g. Notify Social Services Department. Send appropriate paperwork for processing and keeping statistics.

~~9.~~8. If a person surrendering a newborn request that TCHD returns the newborn to her/him, the hospital must do so if it still has custody and if the dependency petition has not been filed. Contact Administration or Legal Services prior to returning newborn.

~~10.~~9. If a health practitioner at TCHD reasonably suspects that the child has been the victim of abuse or neglect, he/she must notify CPS rather than returning the child. Voluntary surrender of a newborn in accordance with law is not in and of itself a basis for reporting abuse or neglect. The statute does not provide immunity from personal injury or wrongful death, including malpractice claims. Legal counsel should be consulted immediately with questions.

~~11.~~10. If a dependency petition has already been filed through ~~Child Protective Services (~~CPS~~)~~, the person surrendering the newborn may reclaim the child within **fourteen** (14) days of the surrender. If TCHD still has physical custody of the newborn, a copy of the court order should be obtained, reviewed, and referred to legal counsel before releasing the child.

~~12.~~11. Any identifying information that pertains to a parent or individual who surrenders a newborn pursuant to the **Safely Surrendered Baby Law**~~Safe Surrender law,~~ that is obtained as a result of the questionnaire or in any other matter, must not be disclosed by any personnel of a Safe Surrender site that accepts custody of an infant.

~~C. LOCATED IN PATIENT CARE SERVICES FORMS/RELATED DOCUMENTS:~~

~~1. Newborn Family Medical History Questionnaire (English/Spanish)~~

~~2. Letter to the Mother from the Safe Arms Program (English/Spanish)~~

C. **EXTERNAL LINK(S):**

1. **Safely Surrendered Baby Medical Questionnaire – English: http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC861.pdf**
2. **Safely Surrendered Baby Medical Questionnaire – Spanish http://www.cdss.ca.gov/cdssweb/entres/forms/Spanish/SOC861SP.pdf**
3. **Safely Surrendered Baby Campaign Brochure http://www.cdss.ca.gov/Portals/9/FMUForms/M-P/PUB400.pdf?ver=2017-10-26-110106-193**
4. **Safely Surrendered Baby Law Fast Facts – English http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2_ENG_SSBFactSheet.pdf?ver=2017-09-05-161625-780**
5. **afely Surrendered Baby Law Fast Facts – Spanish http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/Fast%20Facts%20SP.pdf?ver=2017-09-05-161628-437**

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

~~3.~~1. **Administrative Policy: EMTALA: Emergency Medical Screening 506**

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

1. California ~~Healthcare~~ **Hospital** Association **(2017).** ***California Hospital,*** *Consent Manual.* **Sacramento, CA: California Hospital Association.** ~~2009~~
2. **Safely Surrendered Baby Law;** Senate Bill No. 1368, Chapter 824
3. ~~California~~ **Cal.** Health **&and** Safety Code **(HSC).** ~~§~~**Section** 1255.7 **(1973).**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SPONGE,SHARPS & INSTRUMENT COUNTS, PREVENTION OF RETAINED SURGICAL ITEMS**
Purpose:	To outline nursing responsibilities and accountability regarding sponges sharps, and instrument counts in the surgical/procedural areas.
Supportive Data:	Sponges, sharps, and instrument counts are performed during surgery/invasive procedures to provide for safe patient care and prevent retained surgical items. Counts for sponges/soft goods, sharps, and instruments are performed to account for all items used on the surgical field and to lessen the potential for injury to the patient as a result of a retained surgical item. All items are to be counted except those used for storage or disposal of items.
Equipment:	White Board, White Board Marker, Count Sheet(s), Sponge holders

A. **POLICY:**

1. Sponges, sharps, and miscellaneous item counts are required on all procedures except eyes and cystoscopies.
2. All counts shall be conducted both audibly and visually.
   a. Counted items shall be visualized by both the scrub person and circulator/designee~~, one of whom must be a Registered Nurse (RN)~~.
   b. At time of permanent relief of either the scrub or circulating **Registered Nurse** (RN), direct visualization may not be possible; the team shall account for all items.

~~b.~~**3. In surgery/obstetric operating room (OB-OR), one of the counting team members must be an RN.**

~~3.~~**4.** A count may be initiated by any member of the perioperative team.

~~4.~~**5.** Unnecessary activity and distractions should be omitted during the counting process.

~~5.~~**6.** To the extent possible, the initial count shall be completed before the patient is brought into the OR.

~~6.~~**7.** Counts may be omitted in an emergency.
   a. The emergent nature of a procedure or an unexpected change in the condition of the patient may necessitate omission of counts to preserve patient life or limb. In such cases, counts may be waived on order of the surgeon. The surgeon will document the omission of the count and rationale for the practice variation in the medical record.
   b. If counts were omitted due to an emergency, x-ray shall be performed and read prior to the completion of skin closure.
      i. Document events regarding the nature of the emergency.
      ii. Document the name of physician reading the x-ray and the x-ray results.
      iii. Complete an incident report.

~~7.~~**8.** If a patient is transferred to another department for completion of the procedure (i.e., transferred from OR to Interventional Radiology or transferred from Labor and Delivery to OR), an x-ray must be performed and read for retained surgical items prior to the completion of skin closure.

9. Sponge, sharps, and miscellaneous item counts shall be written on the white board. Instrument counts shall be recorded on the instrument count sheet(s).

B. **PROCEDURE:**

1. Surgical counts are classified as:
   a. ~~Baseline~~**Initial** count: count before the procedure begins to establish the baseline and identify manufacturer packaging errors.
   b. ~~New item~~ **Add** count: count new items added to the field after the baseline count is complete.
   c. Relief count: count at the time of permanent relief of the scrub or RN circulator.

Revision Dates	Operating Room Committee	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/03, 04/06, 08/09, 05/12, 01/13, 05/14, 04/15, 09/15, 10/17	06/14, 01/16, 12/17	06/12, 07/13: 05/14, 11/15, 02/16, 01/18	06/12, 02/13, 05/14, 02/16, 01/18	07/12, 07/14, 09/16, 02/18	08/12, 10/14, 10/16, 03/18	08/12, 11/14, 11/16

i. The relief count is performed by the incoming scrub and/or circulator who are assuming responsibility for the count as it stands at the time of relief.

d. Cavity count: count before closure of a cavity (e.g., uterus, bladder, stomach, peritoneum, placement of mesh to close a space).

e. Closing count: count before wound closure begins.

f. Final count: count after skin closure or end of procedure, when surgical items are no longer in use and all sponges (used and unused) are passed off the field, separated into sponge holders and confirmed by the surgical team.

2. Count in the following order:
   a. Sponges
   b. Needles
   c. Other sharps and miscellaneous items
   d. Instruments
3. Count items in the following sequence:
   a. Operative field
   b. Mayo stand
   c. Back table
   d. Items off field
4. Items passed off or dropped from the sterile field shall be retrieved by the circulating nurse, isolated from the field, and included in the final count. Countable items must never be subtracted from the count or removed from the operating room.
5. Members of the surgical team shall account for broken or separated instruments/items within the surgical field.
6. Multi-part items shall be counted as one unit (e.g., hypo and cap is counted as one unit), unless otherwise specified on the count sheet/whiteboard. Account for all individual pieces of multi-part items.
7. Items added to the field need to be recorded at the time they are added.
   a. Once the count has begun, recalled memory and/or counting packages cannot be used to reconcile a count.
   b. The number on the whiteboard/count sheets must match the number of items on the field at the time of the count, or the count is considered incorrect.
8. The count is to be recorded on the count board using a horizontal superscript running total format (~~i.e.~~**e.g.**, $10^{10}20^{10}30^{10}40$). No additional slashes, initials, equal signs, or extraneous marks are to be made.
9. The person adding countable items to the field is responsible for recording the items on the count board.
   a. If items are added by anyone other than the primary RN circulator, the person adding the items shall verbally report the additions to the primary RN circulator.
10. Inform primary surgeon of the count outcomes.
11. Incorrect Counts:
    a. Inform primary surgeon of count discrepancies.
    b. The surgeon should perform a methodical wound examination, and a thorough search of all areas should be completed by the surgical scrub and circulating nurse.
    c. Search the total room including floor, trash and linen:
       i. If item is not found, an X-ray of the patient must be taken prior to patient leaving the operating room.
          1) X-ray is not required if the missing item is not X-ray detectable.
       ii. If item missing is micro or CV needle (C-1 or smaller), X-ray is not needed.
       iii. Complete an incident report.
    d. Ensure sterile field remains sterile until item is found or x-ray is read
    e. Inform Assistant Nurse Manager (ANM)/charge nurse/designee of count discrepancies.
12. X-ray interpretation for incorrect counts, emergencies, and X-ray in lieu instrument counts:
    a. When possible, it is highly recommended that a radiologist read the X-ray before the skin is closed and the results of the reading, along with the name of the person who read the

X-ray, are documented.

b. At a minimum, the surgeon must interpret the film intraoperatively.

13. If an item is used to occlude the colpotomy during a da Vinci hysterectomy (i.e., asepto or glove), it becomes a countable item and must be accounted for at the end of the case.

C. **SPONGES/SOFT GOODS COUNT:**

1. Sponges (laps, baby laps, raytex) are issued in groups of ten.
2. The following counts are required for sponges/soft goods:
   a. ~~Baseline~~ **Initial** count
   b. ~~New item~~**Add** count
   c. Relief count
   d. Cavity count
   e. Closing count
   f. Final count
3. ~~Baseline~~**Initial** sponge counts shall be performed in the quantity as packaged by the manufacturer in order to identify manufacturer packaging errors (i.e., laps are counted in multiples of five and raytex are counted in multiples of ten), total count in multiples of ten.
4. If a package of sponges/soft goods is found to be defective when opened (e.g., wrong number, damaged, contaminated), the package and its contents will be removed immediately from the field, placed in a plastic bag, labeled, and removed from the operating room.
5. Sponges shall be counted in order from largest sponge to smallest sponge (e.g., laps then baby laps, then raytex).
6. All sponges shall be X-ray detectable.
   a. Never use X-ray detectable sponges for wound dressings.
7. Count each sponge and separate from other sponges during the count.
8. Remove all packing and wrapping materials and promptly discard in the trash.
9. All sponges must be opened and visualized during closing counts and separated into sponge holders.
   a. At the end of skin closure, ALL sponges are passed off the field, separated, opened to full length, and placed in sponge holders.
   b. Use a separate sponge holder for each sponge type (i.e., one for laps, one for raytex).
   c. Only one sponge should be placed in each pocket of the sponge holder.
   d. Load the sponge holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process will make visual determination of the filled holder easier to see from the OR table so empty pockets will be clearly visible to all in the room.
   e. Place the sponge inside the pocket with the blue tag or blue stripe visible.
   f. Place one sponge per pocket, two sponges per row, and 10 sponges per sponge holder.
   g. When a holder has 10 sponges, there will be no empty pockets.
   h. The final sponge count CANNOT be considered completed until ALL sponges opened during the case are bagged and visualized by the surgical team.
   i. The sponge holders are not disposed of until the patient leaves the OR.
10. Towels used in an open wound shall be x-ray detectable and shall be included in the count as miscellaneous items.
    a. Scrub person shall notify the circulating RN when a towel is placed in a wound/cavity and when it has been removed.

D. **SHARPS AND MISCELLANEOUS ITEMS COUNTS:**

1. The following counts are required for sharps and miscellaneous items:
   a. ~~Baseline~~**Initial** count
   b. ~~New item~~**Add** count
   c. Relief count
   d. Cavity count
   e. Closing count

f. Final count

2. Packaged needles containing an incorrect number shall be removed from the room.
3. All used needles are to be placed in a puncture-proof needle counter box.
   a. Place one needle in each numbered slot; do not double-up needles in a numbered slot.
   b. Obtain an additional needle counter box if the initial needle counter box is full.
4. Counting number of needle packages may not be used to reconcile an incorrect needle count.

E. **INSTRUMENT COUNTS:**

1. The following counts are required for instruments:
   a. ~~Baseline~~**Initial** count
   ~~a.~~b. Add count
   ~~b.~~c. Relief count
   ~~c.~~d. Closing count
2. The instrument count is driven by the instrument count sheet, used as a checklist. The circulating nurse/designee directs the instrument count by reading off the instrument count sheet and visualizing the counted instruments with the scrub.
   a. All instruments shall remain within the OR during the procedure until all counts are completed and resolved.
      i. Individual pieces of assembled instruments shall be accounted for within the instrument count (e.g., suction tips, wingnuts, blades, sheaths).
3. Instrument counts are required for cases entering the abdominal, thoracic, mediastinal, and retroperitoneal cavities.
   a. Instrument counts are required for any procedure where the incision is large enough for an instrument (including instrumentation, such as screws) to pass through.
   b. Instruments shall be counted at the start of all hernia repairs, laparoscopy, thoracoscopy, and robotic procedures since the possibility of converting to an open procedure or extending the incision exists.
      i. If the procedure does not convert to an open procedure or the incision is not extended to be larger than the smallest instrument used on the case, the closing instrument count may be waived.
   c. Closing instrument counts are required for vaginal hysterectomies and laparoscopic assisted vaginal hysterectomies. For all other vaginal procedures, the surgeon is to perform a methodical wound examination of the vaginal cavity at the conclusion of the procedure to ensure items are not retained in the vagina.
   d. Instrument counts may be omitted in certain cases with numerous and/or complex instruments or instrumentation. An X-ray is taken before the completion of skin closure to confirm instruments are not left in the wound. The following cases shall use an X-ray in lieu of instrument count:
      i. All anterior, posterior, and lateral spine cases.
      ii. Cervical spine cases.
      iii. Total joint replacements (hips, knees and shoulders).
      iv. Any orthopedic case using trays of screws, wires, or other complex instrumentation.
      v. Any case using loaner trays or large numbers of instruments which is prohibitive of completing an accurate instrument count.
      vi. If fluoroscopy is being used on the case, a fluoroscopic image may substitute for an X-ray if a permanent copy of the image can be recorded and retained.
      vii. When possible, it is highly recommended that a radiologist read the X-ray before the patient leaves the OR and the results of the reading, along with the name of the person who read the X-ray, are documented. At a minimum, the surgeon must interpret the film intraoperatively.
   e. Reverse total shoulder replacements: the surgeon shall announce when the humeral protector is placed into the wound and when it is removed and the RN circulator shall record it on the whiteboard.

F. **DOCUMENTATION:**

1. Document verification of all counts in the OR record.
   a. Types of counts (sponges, sharps, and instruments).
   ~~b. Cavity count must be written as a count.~~
   ~~c.~~**b. Initial count, relief count and** ~~T~~the number of ~~d~~**closing** counts.
   ~~d.~~**c.** Names and titles of persons performing counts.
   ~~e.~~**d.** Results of counts
      i. Actions taken if count discrepancies occur.
      ii. Rationale if counts are not performed or completed.
   ~~f.~~**e.** Complete an incident report for all incorrect counts or waiver of counts in the event of an emergency.

G. **REFERENCE(S):**

1. AORN Guidelines for Perioperative Practice, 201~~5~~7 Edition.
2. Verna Gibbs, MD. NoThing Left Behind®: Prevention of Retained Surgical Items Multi-Stakeholder Policy (2015).

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 07/02 **SUBJECT:** SUCCESS SERVICE RECOVERY PROGRAM (SSRP)

REVISION DATE: 12/02, 04/09, 09/10, 12/10 **POLICY NUMBER:** 8610-272

Department Approval:	**02/18**
Administrative Policies & Procedures Committee Approval:	**~~06/14~~02/18**
Professional Affairs Committee Approval:	**~~02/15~~03/18**
Board of Directors Approval:	**02/15**

A. **PURPOSE:**

1. The Purpose of the Success Service Recovery Program (SSRP)~~I~~ is:
   a. To promote guest satisfaction.
   b. To provide a mechanism that empowers staff to implement immediate Service Resolution or Recovery measures.
   c. To be used by employees to proactively intervene on behalf of guests to create a positive perception of Tri-City ~~Medical Center~~**Healthcare District** (TC~~MC~~**HD**).

B. **PHILOSOPHY:**

1. TC~~MC~~**HD** staff is encouraged to practice TC~~MC~~**HD**'s Service Standards.
2. Positive management of expectations should be the first response to each guest's concerns.
3. The SSRP may be utilized at any time if other interventions have been unsuccessful.

C. **DEFINITION(S):**

1. Guest: Inpatient, outpatient, or visitor.
2. Positive Intervention: Actions taken by an employee to promote guest satisfaction; not to be used for employee recognition.
3. Service Resolution: The process used to satisfy an unhappy guest in circumstances where other measures, e.g. initial service resolution steps, have been ineffective. Examples possibly requiring service resolution are: long wait times for procedures, cancelled procedure that inconvenienced the customer, inadequate explanations from staff, or dissatisfaction with TCMC's service from the guest's perspective.
4. LAST Approach: An initial process service for resolution steps. Initial Service Resolution steps include using the method of customer complaint resolution defined below:
   a. 'L' is for listening: Do not argue with a guest. Do not feel it is necessary to defend yourself. Use good eye contact. Consider summarizing to clarify what the customer is concerned about.
   b. 'A' is for apologizing: Remember, an apology does not mean an admission of guilt. It is an expression that you are personally sorry your guest is unhappy with his/her service.
   c. 'S' is for solving: Tell your customer you are going to take care of his/her problem. Ask them "What can I do to make it better for you?" If you are unable to change the outcome consider a gift from the SSRP ~~P~~ as an expression of an apology.
   d. 'T' is for thanking: Thank the guest for taking the time to tell you about his/her experience and giving you the opportunity to make a change.
5. SSRP Voucher: A voucher is a three-part form to be used in the Service Resolution process.
   a. Vouchers can be used at the following locations: Cafeteria, Gift Shop, and Coffee Cart.
   b. Vouchers can also be used by Administrative Supervisors, Managers, and Assistant Nurse Managers and above for purchased items in the form of flowers or plants.

c. Vouchers will be maintained in each department and restocked by unit secretaries, with oversight provided by the Quality Performance Improvement/Risk Management (QPI/RM) Department.

6. Petty Cash: Monies available to reimburse for personal expenses used in Service Resolution and not to exceed a maximum of $50 ~~(Administrative Policy # 208)~~.

D. **POLICY:**

1. TC~~MG~~**HD** encourages all of its employees to identify opportunities to demonstrate Service Excellence "above and beyond the call of duty."
2. Employees are empowered to proactively intervene and create positive perceptions of TC~~MG~~**HD**, its services, and its employees.
3. Resources such as vouchers and managerial support will always be available to respond to guest issues and concerns.
4. TC~~MG~~**HD** encourages guests to express issues/concerns so they may be addressed promptly to prevent future dissatisfaction.
5. Guest dissatisfaction issues are dealt with at the point of contact and are referred to management staff only when unresolved or when deemed necessary.
6. Any employee who encounters a guest complaint uses the LAST approach as the first line of intervention.
7. If this approach is unsuccessful, and the complaint is not resolved, an employee may resolve the complaint independently using vouchers from the SSRP Service.
8. All Employee interventions requiring use of a voucher are to be recorded on said voucher and brought to the attention of acting management at the time of service intervention/resolution. (This will be done to track trends and provide a means of resolving recurrent problems.)
9. Presentation of a complaint will not compromise a guest's access to care.
10. Each Unit/Department's "SSRP vouchers are to be kept in the ~~SSRP~~ **STAR Service Plan** Logbook. Vouchers are to be readily available to all employees. The QPI/RM department will maintain a backup supply of vouchers.
11. The employee selects the most appropriate intervention based on the nature of the circumstance.
12. To use the SSRP Service Plan:
    a. Employee provides selection from coffee cart, cafeteria, or gift shop.
        i. Voucher completed and White copy of voucher given to guest.
        ii. Guest or employee takes Voucher to provider of service.
        iii. Yellow copy placed in ~~SSRP~~ **STAR Service Plan** Logbook
        iv. Pink copy forwarded to SSRP Excellence Coordinator
    b. Employee purchases and presents gift less than $50 to guest.
        i. Voucher completed.
        ii. Employee submits White copy of voucher and petty cash form to Business Office ~~(Administrative Policy # 208)~~.
        iii. Yellow copy placed in ~~SSRP~~ **STAR Service Plan** Logbook
        iv. Pink copy forwarded to QPI/RM
    c. Employee purchases and presents $50 - $150 gift to guest.
        i. Voucher completed (Manager/Director approval required)
        ii. Employee submits White and Pink copy of voucher and receipt to OISE Department.
        iii. QPI/RM Department submits a Non-Stock Purchase Requisition Form, receipt and White copy of voucher to Materials ~~(~~**per** Administrative Policy: ~~#~~ 214 **Accounts Payable Check Processing**~~)~~.
13. Yellow Copy of Voucher placed in STAR Service Plan Logbook If a guest complaint is not resolved, the employee will forward the concern to the Department Director, Patient Representative, QPI/RM, and/or Administrative Supervisor ~~(refer to~~**per** ~~Administrative~~ **Patient Care Services** Policy: ~~#~~ ~~318~~**Patient Complaints and Grievances**~~)~~.

14. Administrative Supervisors, Managers, Assistant Nurse Managers, unit secretaries and the QPI/RM Department will maintain a supply of SSRP. White and yellow copies are to be collected and sent to the QPI/RM Department by the 5th of each month.

E. **FORM(S):**

1. Success Service Recovery Program Voucher

F. **RELATED DOCUMENT(S)**

1. **Administrative Policy: 214 Accounts Payable Check Processing**
~~1.~~2. **Patient Care Services Policy: Patient Complaints and Grievances**

Success Service Recovery Program Voucher

"SUCCESS is in our hands"
Service Recovery Program

A sincere Thank You for choosing Tri-City Medical Center!

Service Voucher

Date/Time_____

Name of Recipient (print)_____

Gift given_____

Amount of Gift _____

Name of employee giving gift (Print) _____

Department _____

_____

Reason for Intervention/Service Resolution_____

_____

_____

_____

_____

_____

_____

Follow-Up Requested: Yes____ No_____

Reason_____

_____

_____

Cost Center: 8742

[3 Copies: Original (white copy) to Guest/Provider of Service; Second copy (yellow copy) to "SUCCESS Service Recovery Program" Logbook; Third copy (pink copy) to Service Excellence Coordinator.]

6/9/14

Tri-City Medical Center
Oceanside, California

Clean Copy

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Approved Abbreviations, BHU and CSU Specific

ISSUE DATE: 03/08 **POLICY NUMBER:** 300
REVISION DATE(S): 08/09, 04/10, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	03/18
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the list abbreviations applicable to the Behavioral Health Unit (BHU) and Crises Stabilization Unit (CSU).

B. **POLICY:**
1. When documenting in the patient medical record clinical staff may use the following program and hospital approved abbreviations.
2. Other abbreviations are not acceptable and are not to be used in medical records.

C. **ABBREVIATIONS:**

BHOS	Behavioral Health Outpatient Services
CA	Cocaine Anonymous
O/H	Olfactory Hallucinations
PHP	Partial Hospitalization Program
PMR	Psychomotor Retardation
Q15	Every 15 minutes
Q30	Every 30 minutes
RI	Resulting In
RCF	Residential Care Facility
S/A	Suicide Attempt
S/I	Suicidal Ideation
S/R	Support and Reassurance
Th	Therapist
TPR	Treatment Plan Review

D. **EXTERNAL LINK(S):**
1. Neil-Davis Medical Abbreviation - MedAbbrev.com

E. **RELATED DOCUMENT(S):**
1. Patient Care Services: Abbreviations, Use of

Tri-City Medical Center
Oceanside, California

Tracked Change Copy

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Approved Abbreviations, BHU and CSU Specific**

ISSUE DATE: **03/08** **POLICY NUMBER:** **300**
REVISION DATE(S): **08/09, 04/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the list abbreviations applicable to **the Behavioral Health Unit** (BHU) **and Crises Stabilization Unit (CSU).**

B. **POLICY:**

1. When documenting in the patient medical record clinical staff may use the following program and hospital approved abbreviations.
2. Other abbreviations are not acceptable and are not to be used in medical records.

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

~~1:1~~	~~One-to-One Supervision of the patient or Individual encounter with the patient~~
~~ADR~~	~~Adverse Drug Reaction~~
~~A/H~~	~~Auditory Hallucinations~~
~~AA~~	~~Alcoholics Anonymous~~
~~ADD~~	~~Attention Deficit Disorder~~
~~ADL~~	~~Activities of Daily Living~~
~~AKA~~	~~Also Known As~~
~~AE~~	~~Adverse Effect~~
~~AEB~~	~~As Evidenced By~~
~~AMB~~	~~As Manifested By~~
~~B & C~~	~~Board and Care~~
~~BHU~~	~~Behavioral Health Unit~~
~~BIB~~	~~Brought In By~~
BHOS	Behavioral Health Outpatient Services
~~Bx~~	~~Behavior~~
~~C~~	~~With~~
~~CD~~	~~Chemical Dependence~~
~~C/O~~	~~Complaining Of~~
CA	Cocaine Anonymous
~~CC~~	~~Clinical Coordinator~~
~~CLC~~	~~Community Liaison Director~~
~~CMHC~~	~~Community Mental Health Center~~

~~CPS~~	~~Chronic Paranoid Schizophrenia~~
~~CQI~~	~~Clinical~~ **~~Continuous~~** ~~Quality Improvement~~
~~D/C~~	~~Discharge~~
~~DC~~	~~Discontinue~~
~~DD~~	~~Developmentally disabled~~
~~Dx~~	~~Diagnosis~~
~~G/H~~	~~Gustatory Hallucinations~~**~~Grooming and Hygiene~~**
~~H/I~~	~~Homicidal Ideation~~
~~IOP~~	~~Intensive Outpatient Program~~
~~IP~~	~~Inpatient~~
~~ITP~~**ITP**	**Interim Treatment Plan**~~Initial Treatment Plan~~
~~LOS~~	~~Length of Stay~~
~~LTG~~	~~Long Term Goal~~
~~MDD~~	~~Major Depressive Disorder~~
~~Med~~	~~Medication~~
~~MICA~~	~~Mentally Ill Chemical Abuser~~
~~MJ~~	~~Marijuana~~
~~MSE~~	~~Mental Status Exam~~
~~MTP~~	~~Master Treatment Plan~~
~~NA~~	~~Narcotics Anonymous~~
~~OA~~	~~Overeaters Anonymous~~
O/H	Olfactory Hallucinations
PHP	Partial Hospitalization Program
PMR	Psychomotor Retardation
~~PRN~~	~~As needed~~
Q15	Every 15 minutes
Q30	Every 30 minutes
RI	Resulting In
~~R/O~~	~~Rule Out or Reality Orientation~~
RCF	Residential Care Facility
~~Rx~~	~~Prescription~~
~~S~~	~~Without~~
~~SAD~~	~~Schizoaffective Disorder~~
S/A	Suicide Attempt
~~Sib~~	~~Siblings~~
S/I	Suicidal Ideation
~~SCUT~~	~~Schizophrenia, Chronic Undifferentiated Type~~
~~SNF~~	~~Skilled Nursing Facility~~
S/R	Support and Reassurance
~~Sx~~	~~Symptoms~~
Th	Therapist
TPR	Treatment Plan Review
~~Tx~~	~~Treatment~~
~~V/H~~	~~Visual Hallucinations~~

D. EXTERNAL LINK(S):

1. Neil-Davis Medical Abbreviation - MedAbbrev.com

E. RELATED DOCUMENT(S):

~~D.~~1. Patient Care Services: Use of Abbreviations

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Assisting Medi-Cal Recipients with Grievance and Appeals Processes**

ISSUE DATE: **03/08** **POLICY NUMBER:** **510**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	

A. **DEFINITION(S):**

~~A.~~1. ~~MHP:~~ **Mental Health Plan (MHP): Mental Health services are available to people on Medi-Cal in San Diego. Sometimes they are provided by a specialist and called "specialty" mental health services. These are provided through the San Diego ~~Mental Health Plan (MHP)~~, which is separate from the patient's attending psychiatrist on the Behavioral Health Unit (BHU). The San Diego County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP. Patients can use the San Diego MHP Access and Crisis Line (888)-724-7240 24 hours a day, seven days a week to obtain written and verbal interpretation of their rights, benefits, and treatments. The information will be made available in the patient's language of choice.**

B. **PURPOSE:**

1. To provide a mechanism by which Tri-City ~~Medical Center~~**Healthcare District (TCHD)** ~~Behavioral Health Unit~~**BHU** provides assistance to Medi-Cal recipients with grievances or appeals.

C. **POLICY:**

1. The ~~assigned Social Work~~ staff will be responsible to ensure that Medi-Cal recipients receive assistance in accordance with any grievances or appeals that they initiate while hospitalized on the inpatient ~~Behavioral Health Unit~~**BHU** at ~~Tri-City Medical Center~~**TCHD.**

D. **GUIDELINES:**

~~1. Definitions:~~

~~a. MHP: Mental Health Plan: Mental Health services are available to people on Medi-Cal in San Diego. Sometimes they are provided by a specialist and called "specialty" mental health services. These are provided through the San Diego Mental Health Plan (MHP), which is separate from the patient's attending psychiatrist on the Behavioral Health Unit.~~

~~b. The San Diego County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP.~~

~~c. Patients can use the San Diego MHP Access and Crisis Line (800) 479-3339 24 hours a day, seven days a week to obtain written and verbal interpretation of their rights, benefits, and treatments. The information will be made available in the patient's language of choice.~~

~~2.~~1. The ~~Behavioral Health Unit~~**BHU** will maintain Grievance and Appeals forms and self-addressed envelopes on both units where patients have reasonable access without having to request them.

~~3.~~2. ~~The Unit~~**BHU** will post notices explaining the Grievance and Appeals process in both units and will make language interpreting services available at no~~t~~ charge, along with toll-free numbers to help patients during normal business hours.

~~4.~~3. ~~The Social Work s~~**S**taff will provide information to patients, upon their request, related to an "expedited" grievance or appeal process, which means that the matter is reviewed more quickly because the patient's health or stability is at risk.

~~5.~~4. The patient has the right to authorize another person to act on his or her behalf during the grievance or appeal process, including the San Diego County MHP.

~~6.~~5. The patient will be assisted to contact the Mental Health Ombudsman Services Program if it appears that he or she needs additional information, direction or assistance getting services.

~~7.~~6. The patient will be permitted to request a review of a decision that was made about services that were provided through either the standard appeals process or the expedited appeals process.

a. The Standard Appeals process is a request for a review of a problem the patient has had with their MHP or their provider (TC~~MC~~**HD**) that involves denial or changes to services the patient believes he or she needs.
b. The Standard Appeals process may take up to 45 days for disposition.
c. The Standard Appeals process allows the patient to file in person, on the phone, or in writing.
d. The patient may authorize another person to act on his or her behalf in the appeal process, including the MHP. If the patient authorizes another person he/she will be asked to sign a form authorizing TC~~MC~~**HD** to release information to that person.
e. The patient or his or her representative will be allowed to examine his/her case file, including the medical record or other documents that will be considered during the Appeal process both before and during the appeal process.
f. The patient will be provided with opportunities to present evidence and allegations of fact or law either in person or in writing as part of the Appeals Process.

E. RELATED DOCUMENT(S):

1. **Patient Care Services Policy: Patient Complaints & Grievances**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health U
Crisis Stabilization Unit

DELETION: duplicate policy of Behavioral Health Services: Visiting in Behavioral Health Unit

ISSUE DATE: 04/84

SUBJECT: Behavioral Health Unit Visiting Policy

REVISION DATE(S): 07/85, 02/87, 09/91, 06/94, 05/97, 06/99, 05/03, 04/05, 03/13

POLICY NUMBER: 6340-014

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	03/18
Board of Directors Approval:	

~~A. Behavioral Health Unit Visiting Guides~~

~~1. The following criteria outline safety standards for visitors to the Behavioral Health Unit. The treatment team encourages family and friends to visit.~~

~~B. POLICY:~~

~~1. Hours:~~

~~a. Visiting hours have been established to limit interference with treatment activities/groups.~~

~~i. Weekdays 12:00PM to 1:00PM 5:00PM to 7:00~~

~~ii. Weekends/Holidays 12:00PM to 2:00PM 5:00PM to 7:00~~

~~b. Nursing staff may limit the number of visitors and/or length of visit based upon the patient's condition.~~

~~c. An overhead page shall remind visitors when visiting hours are concluded.~~

~~2. Visiting Locations and Exclusions:~~

~~a. Visiting may be conducted in the patio area, dayroom, and the dining room.~~

~~b. Visiting is discouraged in the patient's room as they are made for double occupancy, and~~

~~i. visitors for one person may be disruptive to the other occupant.~~

~~c. Children under 16 years of age may not visit.~~

~~3. Packages:~~

~~a. The nursing staff shall inspect all packages brought to patients as no sharp objects or other contraband is allowed on the unit.~~

~~4. Behavior Guidelines:~~

~~a. Visitors are expected to behave in a manner appropriate to the hospital environment. Visitors may be requested to leave by hospital or security personnel if their behavior is disturbing the unit.~~

~~5. Former Behavioral Health Unit Patients:~~

~~a. Former Behavioral Health Unit patients, 30 days post discharge, may visit by invitation of a current patient.~~

~~6. Denial of Rights:~~

~~a. If it necessary to deny a patient the rights to receive a visitor, an order and the reason shall be obtained from the physician. A denial shall then be completed.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **BHU Multidisciplinary Treatment Plan**

ISSUE DATE: **03/08** **POLICY NUMBER:** **726**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To have consistent guidelines for development of multidisciplinary plan of care for all patients admitted to the Behavioral Health Unit **(BHU)**.

B. **PROCEDURE:**
1. Every patient admitted to the BHU shall have a Multidisciplinary Plan of Care developed for every admission:
   a. Upon assessment the admitting **registered nurse** (RN) will begin to document identified problems in the patient treatment plan within 24 hour of admission.
   b. Each discipline will complete an admission evaluation and identify specify individualized treatment plan.
      i. Nursing
      ii. Psychiatrist
      iii. Social Work/Discharge Planner
      iv. Recreational Therapist
      v. Utilization Reviewer
   c. The Multidisciplinary Team will meet to discuss the treatment plan within 72 hours of the Patient's admission.
2. Nursing is responsible to meet with the patient to present the written treatment plan to dialogue about the goals and obtain the patients signature.
3. All treatment disciplines are responsible to review the patient's treatment plan and strive to assist the patient to meet their goals.
4. Every problem listed on the treatment plan will be addressed in the patient's chart at least once every 24 hours.
5. Every patients treatment plan will be reviewed weekly and as needed as the patient's condition warrants.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Clinical Assessment

ISSUE DATE: 03/08 **POLICY NUMBER:** 301
REVISION DATE(S): ~~08~~09/09, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

A. **PURPOSE:**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional assessments that are completed, as necessary or clinically indicated.

B. **POLICY:**

1. All patients who are admitted to the program will routinely have an Admission Psychiatric Assessment, Physical assessment, Nursing Assessment, Psychosocial Assessment, and Activity Therapy Assessment.
2. Patients are considered members of the treatment team and will be asked to provide information regarding their concerns, needs, limitations, physical health needs, pre-existing conditions and preferences as part of the assessment process.
3. Information from all assessments, including input from the patient, will be used in the formulation of the patient's individualized treatment plan that includes provision for ensuring the patient's safety when there are co-morbid medical conditions, physical limitations, or other safety issues.
4. Room placement in relation to the nurse's station, type of bed, and whether or not the patient will be placed with a roommate will be made based on the initial nursing assessment; these decisions may be modified as ongoing assessment continues throughout the hospital stay.

C. **PROCEDURE:**

1. All core assessments will be completed by appropriately licensed and qualified clinical personnel using Tri-City ~~Medical Center~~**Healthcare District (TCHD)** approved medical records forms.
2. Diagnostic formulation, problem identification, and treatment planning are dependent upon a thorough and on-going assessment of the patient.
3. The Interdisciplinary Treatment Plan is formulated and altered based on the assessment data collected by each member of the treatment team.
4. The clinician will use all available clinical resources to gather assessment data including but not limited to the patient's subjective report, objective observations, written information from laboratory and diagnostic testing, past medical record information, and information from family and significant others.
5. Types of core initial assessments and time frames for completion
   a. Psychiatric Assessment: The psychiatrist is consulted at the time the patient is evaluated by the Psychiatric Liaison and, in collaboration with the Psychiatric Liaison and other involved clinicians, performs an initial preliminary telephonic assessment to determine

that the patient meets criteria for inpatient hospitalization. The attending psychiatrist performs the initial face-to-face psychiatric examination of the patient, within 24 hours of the patient's admission to the unit. The assessment includes psychiatric history, presenting complaint (s) and a complete mental status examination. The psychiatrist formulates a DSM-V diagnostic statement and initial plan that will be brought forward to the Treatment Team meeting at the conclusion of the initial assessment.

b. Nursing Assessment: The Registered Nurse **(RN)** is responsible to begin an initial nursing assessment at the time of admission and by the end of the shift on which the patient was admitted. The assessment includes a system review, suicide risk, elopement risk, health history, co-morbid substance abuse history fall risk and psychiatric history. The ~~Registered Nurse~~**RN** identifies patient problems and establishes an initial treatment plan that will be brought forward to the Treatment Team meeting based on the Initial Nursing Assessment.

c. Psychosocial Assessment: The purpose of the Psychosocial assessment is to identify psychosocial and discharge planning needs of the patient and family in order to develop a plan to meet those needs. A psychosocial evaluation will be initiated within 24 hours of admission unless the patient is too medically or psychiatrically compromised for this evaluation to be initiated. The Initial Psychosocial Assessment will be completed within 72 hours of the patient's admission to the unit. The Social Worker or Marriage and Family Therapist formulates a preliminary discharge plan that will be brought forward to the Treatment Team meeting based on the Psychosocial Assessment.

d. Activity Therapy Assessment: The Activity Therapist (either Occupational Therapist or Recreational Therapist) initiates an evaluation of the patient within 24 hours of admission unless the patient is too medically or psychiatrically compromised for this evaluation to be done. The Initial Assessment will be completed within 72 hours of the patient's admission to the unit. The Activity Therapist formulates problems and goals that will be brought forward to the Treatment Team meeting based on the Activity Therapy Assessment.

e. History and Physical Examination: A physician/**Allied Health Professional (AHP)** will perform a history and physical examination on the patient within 24 hours of the patient's admission and will order additional evaluations as are clinically indicated.

6. Ongoing Assessment:

a. The Attending Psychiatrist will meet with and perform an assessment a minimal of five **(5)** days of every seven **(7)** days during which the patient is hospitalized and will document the results of that assessment and the plan for continued care in the medical record and will bring ongoing assessment information forward to the Treatment Team Review.

b. The ~~Registered Nurse~~**RN** will perform an assessment of the patient each shift. These assessments will be documented on hospital forms designed for this purpose in the patient's medical record and the RN will bring ongoing assessment information forward to the Treatment Team Review.

c. This assessment includes but is not limited to:
   i. System review
   ii. Update on co-morbid medical conditions
   iii. Suicide risk
   iv. Elopement risk
   v. Fall risk
   vi. Tobacco Use
   vii. Audit-C and CIWA assessment for Alcohol Use
   viii. Method of Communication
   ix. Response to interventions that have been provided for treatment of identified problems
   x. Nutrition
   xi. Mobility

xii. Vital signs

d. The Social Worker/Marriage and Family Therapist will meet with and perform ongoing assessment as is clinically indicated but at least three of every seven days during which the patient remains hospitalized. The Social Worker/Marriage and Family Therapist will document in a clinical note in the patient's medical record each contact with the patient or made on the patient's behalf with either family, significant others, referral resources, or community agencies and will bring ongoing assessment information forward to the Treatment Team Review.

e. The Activity Therapist will meet with and perform ongoing assessment as is clinically indicated and at least three of every seven days during which the patient remains hospitalized. The Activity therapist will document a clinical note in the patient's medical record at each individual or group contact with the patient and will bring ongoing assessment information forward to the Treatment Team Review.

7. Other assessments will be performed based upon the patient's clinical presentation. These may include but are not limited to, nutritional assessments, physical therapy, respiration therapy, medical specialists, obstetrical assessments and others.

8. Upon the patient's request, a chaplain or clergyman may visit the patient to assess and tend to the patient's spiritual needs.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Community Meeting**

ISSUE DATE: **03/08** **POLICY NUMBER:** **701**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**
1. To identify the forum for patients to discuss milieu issues, to identify daily goals, and to make announcements that affect the entire milieu.

B. **POLICY:**
1. Patients will be given the opportunity to increase their involvement in the therapeutic milieu and to discuss their issues and concerns in a daily meeting that includes other patients and members of the treatment team.

C. **PROCEDURE:**
1. A community meeting will be held in the patient day room every day at the beginning of both shifts. The evening meeting will be a wrap-up meeting to review patient daily goals and accomplishments.
2. Every patient on the unit will be invited and encouraged to attend.
3. The beginning of the meeting will be announced over the public address system.
4. All the common areas not being used for groups are closed during the Community Meeting.
5. All available staff will be encouraged to attend the daily Community Meeting.
6. The community meeting will follow a prescribed format
   a. The leader of the meeting is a patient who volunteers each day to conduct the meeting with the assistance of a designated staff member.
   b. Patients will be asked to volunteer for task related duties for the day; volunteers' names will be written on the chalk board in the day room.
   c. The president follows the meeting agenda and asks for patient and staff discussion on each agenda item.
   d. The daily schedule is discussed.
   e. Staff and patient announcements are made.
   f. New patients are introduced.
   g. Patients who will be discharged are introduced.
7. The role of the clinical staff who attends the Community Meeting is to help patients to establish communication within the group, maintain order, help patients identify daily goals, and assist the group in problem solving.
8. Emergency Community meetings may be called for specific reasons such as natural disasters, or unusual unit occurrences of an upsetting nature.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Conducting Searches: Patient Room/Patient Belongings**

ISSUE DATE: **03/08** **POLICY NUMBER:** **101**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for clinical staff who conduct searches of patients' rooms or personal belongings.

B. **POLICY:**

1. For the safety and protection of both patients and staff, a search of a patient's room and or his/her personal belongings may be conducted when there is reason to believe that the patient is in possession of illicit drugs, alcohol, and/or weapons, or when a theft has occurred on the unit.

C. **PROCEDURE:**

1. Patients will be informed at the time of their admission that drugs, alcohol, weapons, or other items that might inflict injury on the patient or others are not allowed on the **Inpatient Behavioral Health** Unit **(BHU)**. This statement will be presented to all patients, in writing, in the Unit Rules book at the time of their admission as well.
2. If it becomes necessary to conduct a search of a patient's room and/or his belongings, the patient will be provided with an explanation of the rationale for the search.
3. ~~2.~~ If the circumstances are such that a general search of all rooms is indicated the clinical staff, or a representative thereof, will meet with all patients in a special Community Meeting to provide an explanation of the rationale for the search.
4. ~~3.~~ When a patient's room or belongings are searched, the patient will always be afforded an opportunity to be present. All other patients will remain in the Community Meeting area until such time as their individual room is searched.
5. ~~4.~~ Two **(2)** members of the clinical staff will conduct the search. When it is advisable to do so a member of the Security Department will be asked to participate as well.
6. ~~5.~~ If a patient refuses to cooperate in the search a written physician order may be obtained~~,~~ (e.g. ~~"~~Have **two [2]** staff search patient's room for unsafe contraband)~~."~~
7. ~~6.~~ After a search is conducted there will be a patient debriefing meeting in which patient questions will be answered and concerns and comments will be addressed.
8. ~~7.~~ If contraband is found in a patient's room, a note describing the nature of the contraband will be entered into a clinical note in the patient's medical record.
9. ~~8.~~ If weapons are confiscated and the patient is on a 72-hour or 14 day hold, the weapons will not be returned to the patient at time of discharge. Security will be notified and will confiscate and store any/all weapons found during a patient search.

~~9.~~10. If illegal contraband is found during a search, i.e. crack pipes, drug paraphernalia, or illicit drugs, these will be given to Security for disposal and will not be returned to the patient at time of discharge.

~~10. Patients authorized to use medical marijuana will be asked to produce the appropriate documentation or have a medical order to return any marijuana or related equipment to have these items returned by Security at the time of patient discharge.~~

D. **REFERENCE(S):**

1. **~~In-Patient~~ Behavioral Health Unit Policy: ~~#6340-402-~~ Patient Belongings**
2. **Administrative Policy: ~~8610~~-217- Disposal of Drugs &and Drug Paraphernalia**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Confidentiality**

ISSUE DATE: **03/08** **POLICY NUMBER:** **505**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines to staff to ensure that they identify and respond appropriately to the importance of patient confidentiality.

B. **POLICY:**

1. The ~~Inpatient Behavioral Health~~**Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU)** staff will keep all patient information confidential and will engage in interactions with others in compliance with ~~all TCMC~~**Administrative** Policie~~s~~**y:** ~~related to~~ **455** Confidentiality.

C. **PROCEDURE:**

1. Both written and verbal information will remain confidential between the patient and the staff. It is the responsibility of the staff to emphasize the importance of patient confidentiality.
2. At admission all patients will be given a notice of Privacy Practices for Tri-City ~~Medical Center~~**Healthcare District (TCHD)** in accordance with HIPAA regulations.
3. Patients will be asked to sign a written Release of Information to allow staff to communicate with persons other than those who are currently providing mental health services to the patient. This includes but is not limited to family members.
4. Confidentiality also applies to telephone conversations and inquiries from the family and the public. Unless disclosure is authorized there will be no information given regarding patients' presence or treatment in the Inpatient ~~Behavioral Health Unit~~**BHU**.
5. Violation of patient confidentiality constitutes a breach of the patients' rights and will result in formal disciplinary action ranging from verbal warning up to and including possible termination. A privacy breach of Public Health Information (PHI) is reported to **California Department of Public Health** (CDPH) and the office of Civil Rights. The regulatory departments within these agencies request the name of the person at the facility that was responsible for the breach. The person responsible for the breach will be held liable for the fine.
6. Exceptions to this policy include incidents when the patient is threatening to harm an identified third party. In this case the staff must comply with the **Patient Care Services Policy:** ~~Tarasoff responsibility of~~ Duty to Warn **Potential Victims** ~~in compliance with the provisions of that policy~~. Other exceptions include reportable incidents such as child abuse, elder abuse, or domestic violence.

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

1. **Administrative Policy: 455 Confidentiality**

~~7.~~2. Patient Care Services Policy: Duty to Warn Potential Victims

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Cleaning and Changing ~~BHU/CSU~~Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU) Bathroom Curtains

ISSUE DATE: NEW **POLICY NUMBER:** 407
REVISION DATE(S):

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	03/18
Board of Directors Approval:	

A. **POLICY:**

1. ~~This Policy~~o provides ~~guidelines~~ for the cleaning and changing of curtains to prevent and control of infections.
2. Ensuring best practices to protect the patient, staff and visitors in the healthcare facility by minimizing the possible spread of infections in the facility.

B. **PROCEDURE:**

1. Replace a patient's bathroom curtain anytime it becomes soiled, or soiled after isolation to prevent cross contamination.
2. Wear gloves ~~&~~and Personal Protective Equipment (PPE) appropriate for a surface decontamination and cleaning task. Discard used PPE by using routine disposal procedures.
3. Soiled curtains should be handled with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen.
4. Bag or contain contaminated items in containers at the location where it last used and have them washed with detergent in hot water at a temperature of at least 160^0 F (71^oC) for a minimum of 25 minutes for an effective means of destroying microorganisms. If low temperature (<160^0F /[<71^0C]) laundry cycles are used, use the hospital provided soap only for each load. This detergent has activated oxygen enzyme bleach for wash/disinfection. This will help prevent accidental cross contamination and the spread of bacteria from one wash load to another.
5. Prior to laundering the curtains, run a full wash cycle using only bleach.
6. Machine dry curtains completely. Do not leave damp curtains in machines overnight.
7. Perform hand hygiene after removing gloves.
8. Wipe the track or ledges with the PDI Super Sani Cloth ("Purple Top") disinfectant prior to hanging the new curtain.
9. Night shift Assistant Nurse Managers (ANMs) to ensure quarterly cleaning, disinfection, and inspection for damage of curtains. If they are visibly soiled or soiled after isolation then they should be replaced before admitting a new patient into the room.
10. Curtains should be replaced when torn or damaged. Soiled curtains that need to be repaired should be cleaned first and tagged as "Clean".
11. Staff to perform Environmental Safety Audit twice per day on both ~~main~~ **BHU &and** ~~psychiatric intensive care unit (PICU)~~**CSU** areas to monitor environmental cleanliness and safety, and to ensure curtains are intact.

12. The Infection Prevention and Control Coordinator should be consulted if there is any question related to the disinfecting of the item.

C. **FORM(S):**

1. **BHU Environmental Safety Audit**
2. **Quarterly Cleaning of Bath Curtains Log**

D. **REFERENCE LIST:**

1. Guidelines for Environmental Infection Control in Health-Care Facilities (June 6, 2003). Retrieved from http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Daily Environmental Safety Rounds**

ISSUE DATE: **03/08** **POLICY NUMBER:** **400**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for staff who will be expected to conduct environmental safety rounds on each shift.

B. **POLICY:**

1. Safety rounds will be conducted on each shift to ensure that the milieu is free from hazards that could compromise patient or unit safety.

C. **PROCEDURE:**

1. A member of the outgoing shift and a member of the oncoming shift will conduct unit safety rounds every day.
2. During the rounds the staff will enter each patient's room to:
   - ~~2.~~**a.** **D**~~d~~etermine whether there are items present that have been determined to be contraband. Contraband includes but isn't limited to:
     - ~~a.~~**i.** Food (attracts insects and vermin)
     - ~~b.~~**ii.** Unopened beverages with the exception of water
     - ~~c.~~**iii.** Items that might be used to inflict injury as indicated in **Behavioral Health ~~U~~ Services** Policy:~~,~~ ~~"~~Personal ~~Property"~~**Belongings.**
     - ~~d.~~**iv.** Items that might have been brought in by visitors during the shift including plastic bags, plants, or sharp objects
     - **v.** Any other items of suspicion **(e.g. broken tooth brush or comb)**~~.~~
   - ~~e.~~**b.** **Inspect bathroom curtains to ensure they are not soiled and the Velcro stays in place. If they need to be replaced, follow the ~~procedure outlined in the~~ Behavioral Health Services Policy: "Cleaning and Changing BHU ~~and~~ /CSU Bathroom Curtains" ~~policy~~.**
3. Each patient will be afforded an opportunity to accompany the staff to their room during the safety rounds and will be given an explanation of the rationale for the removal of items from their room.
4. While in the room staff will check wastebaskets, under mattresses, desktops, and drawers for contraband items. They will also assess the room for environmental safety hazards such as burned out lights, sharp corners, broken equipment as well as for general care and appearance.
5. Patients will be reminded daily in Community Meeting about the purpose and procedure for daily safety rounds.

6. If~~/when~~ items are found in a patient's room that should not be kept there, the~~se~~ items will be removed from the room. If they are patient belongings, the items will be placed in the patient's personal property on the unit. If they are food or beverages they will be disposed of.
7. If items are found that appear to have been purposefully hidden for the purpose of inflicting self - injury, the items will be removed, the psychiatrist will be notified, and the patient will be thoroughly assessed for level of suicidal intent. Clinical interventions will occur as are deemed necessary to ensure patient safety and may include ~~transfer from the main unit to the PICU,~~ assignment to a higher level of supervision (~~e.g. Q 15 minute checks or~~**such as** one-to-one supervision).
8. The Registered Nurse **(RN)** will be responsible to document significant findings uncovered during safety rounds in the patient's medical record and will communicate these findings to the oncoming shift.

D. **RELATED DOCUMENT(S):**
1. **Behavioral Health Services Policy: Personal Belongings**
2. **Behavioral Health Services Policy: Cleaning and Changing BHU /CSU Bathroom Curtains**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Daily Schedule**

ISSUE DATE: **03/08** **POLICY NUMBER:** **702**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**

1. To organize and outline the various groups and activities offered in the Inpatient Behavioral Health Unit **(BHU)** and to assist patients in achieving their treatment goals.

B. **POLICY:**

1. A daily group schedule will be developed and arranged to address the treatment needs of the patient population served.

C. **PROCEDURE:**

1. A group schedule will be posted in the Dayroom ~~in both units (PICU and main unit).~~.
2. Group sessions will be offered ~~6 hours each day~~**throughout the day**, seven **(7)** days a week.
3. The schedule will be revised as is clinically indicated.
4. Each discipline~~,~~ (i.e. nursing, social work, activity therapy, and psychology)~~,~~ will provide group interventions. Individual groups will be led by clinical staff who are appropriately credentialed to lead that particular type of group.
5. To the extent that it is possible each therapy group will have a therapist and co-therapist.
6. Changes in daily group schedules will be discussed in the Community Meeting.
7. Patients will be told, upon admission, and throughout their hospitalization, that they are expected to attend and participate in group activities since these are considered to be a vital part of their treatment program.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Direct Admissions to the Behavioral Health Unit**

ISSUE DATE: **03/08** **POLICY NUMBER:** **201**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To reduce waiting times for patients meeting admission criteria who are known to the medical staff.
2. To help improve patient flow through the emergency department.

B. **POLICY:**
1. Patients known to the medical staff may be admitted directly to the Behavioral Health Unit **(BHU)** if they meet criteria for inpatient care.
2. The referring psychiatrist **or** ~~**physician's designee**~~**Allied Health Professional (AHP)** must be affiliated with Tri-City ~~Medical Center~~**Healthcare District (TCHD)** but is not required to be the attending psychiatrist.

C. **PROCEDURE:**
1. The referring physician/**AHP** ~~or the physician's designee~~ will notify the ~~Psychiatric Liaison Supervisor~~, Assistant Nurse Manager **(ANM)** or designee directly**, and the Medical Director BHU**.
2. The attending psychiatrist will be advised of the admission.
   - **a.** If the referring physician/**AHP** will be the attending physician, the on-call psychiatrist does not need notification**,** ~~**but**~~**and the referring physician/AHP will have to follow the patient throughout their duration of the hospital stay.**
   - ~~**2.b.**~~ If the referring physician/**AHP** will not be the attending physician, the on-call psychiatrist must accept the patient after consultation with the referring physician/**AHP**.
3. The physician/**AHP** who will be attending the patient on the unit must ~~call orders~~**enter admitting orders and notify** ~~to~~ the ~~Assistant Nurse Manager~~**ANM** or another registered nurse. In addition to orders, the referring physician/**AHP** ~~or his designee~~ should fax the following information to the inpatient unit:
   a. The patient's name and medical record number, if known.
   b. The patient's date of birth and social security number.
   c. The type of insurance and copies of any insurance cards.
   d. Current symptoms requiring hospitalization.
   e. Axis I through V diagnoses.
   f. ~~Whether the admission is for the PICU or the main locked unit, and~~ **The** legal status of **the** patient.
4. If pre-authorization is required by the patient's insurance, the referring physician/**AHP** ~~or his designee~~ is responsible for obtaining such authorization. In the event the referring

physician/**AHP** ~~or his designee~~ cannot obtain pre-authorization, the Psychiatric Liaison Supervisor, ~~Assistant Nurse Manager~~**ANM** or designee is responsible for obtaining such authorization.~~.~~

5. ~~An assessment will be performed by the on-duty behavioral health liaison as soon as possible after admission.~~The admitting **registered nurse** (RN), mental health worker, and security officer, if needed, will complete a safety assessment of patient and personal property. All contraband will be secured in the appropriate storage area ~~[Refer to~~**per Behavioral Health Services** Policy: ~~6340--502~~ **402** Patient Belongings~~]~~.

D. RELATED DOCUMENT(S):

~~6.~~**1. Behavioral Health Services Policy: 6340--502 402 Patient Belongings**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Discharge Planning

ISSUE DATE: 03/08 **POLICY NUMBER:** 703
REVISION DATE(S): 08/09, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

A. **~~DEFINITION(S)~~PURPOSE:**

1. To ensure that patient discharge occurs when treatment goals are met and the patient no longer meets criteria for inpatient hospitalization.
2. To provide assistance for each patient upon discharge in order to optimize the transition to the next level of care.

B. **POLICY:**

1. A social worker/discharge planner will be assigned to each patient for the purpose of assisting in discharge planning efforts.

C. **PROCEDURE:**

1. Each patient will be assigned to a social worker~~/discharge planner~~ upon admission based on past relationship, current caseload, and, in some instances, professional preference.
2. Discharge planning will begin on admission as a collaborative effort between the psychiatrist, ~~the~~ psychiatric liaison, ~~the~~ **nurse,** ~~the~~ social worker, ~~the~~ conservator, and the patient, all of whom provide information that will be utilized to plan a reasonable and optimal disposition.
3. The assigned **s**~~S~~ocial **w**~~W~~orker~~/Discharge Planner~~ will include the patient and support system (as consented to by the patient). The support system may include case managers, clinics, family, and/or significant others.
4. The **s**~~S~~ocial **w**~~W~~orker~~/discharge planner~~ will utilize objective and subjective data in developing a discharge plan.
   a. The initial discharge plan may change as additional assessment data becomes available.
   b. Patient preferences will be considered as is reasonable and clinically appropriate.
5. The discharge plan will be reviewed and discussed by the team daily in the interdisciplinary team meetings, and more formally, in treatment plan review sessions.
6. Upon discharge each patient will have an appointment that is documented in the discharge plan. The plan will be reviewed with the patient at the time of discharge and the patient will be educated about the importance of adherence with the plan.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Dress Code for Patients**

ISSUE DATE: **03/08** **POLICY NUMBER:** **705**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To define appropriate dress for patients hospitalized on the inpatient Behavioral Health Unit **(BHU)**.

B. **POLICY:**
1. To the extent that their clinical condition allows, patients will be expected to dress in a socially acceptable manner.
2. Staff members will assist patients to maintain appropriate dress as is clinically indicated.

C. **PROCEDURE:**
1. Patients will be given the following general guidelines at time of admission and during community meeting:
   a. All clothing should be age appropriate and clean.
   b. No tube tops, short shorts, bareback dresses or tank tops are to be worn.
   c. No bare torsos for either gender will be allowed.
   d. Clothing with profane or suggestive writing will not be allowed.
   e. Patients will be expected to bathe or shower regularly such that personal hygiene is maintained.
   f. Patients will be expected to wear footwear at all times on the unit when they are walking about. No bare feet or excessively high heels that could reduce mobility or increase fall risk will be permitted.
2. Problems with clothing that is assessed to be inappropriate will be addressed with the patient as a treatment issue.
3. For those situations in which a patient does not have clothing or if the patient has a medical condition that necessitates it, the patient will be provided with a hospital gown and slippers. If the patient is wearing hospital attire, the patient will be encouraged and or assisted to wear it such that modesty is preserved.
4. ~~An assigned s~~**Staff members** will assist patients with laundry and personal hygiene as is clinically indicated.
5. A patient will be asked to change clothing if/when it does not comply with minimum standards of modesty or good taste.
6. Family members will be asked to bring appropriate clothing from home as is indicated. In the absence of family involvement, patients will be given clean clothing from the clothing storage area of the unit.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Elopement Precautions**

ISSUE DATE: **03/08** **POLICY NUMBER:** **601**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for the management of a patient who is at risk for leaving the unit in an unauthorized manner.

B. **POLICY:**

1. Each patient who is admitted to the **Crisis Stabilization Unit (CSU) or** ~~inpatient psychiatric~~**Behavioral Health Uunit (BHU)** will be assessed for elopement potential upon admission and throughout his or her hospital stay.
2. The clinical staff will make every effort to prevent patients from leaving the unit without authorization and, if a patient does leave, will make reasonable efforts to return the patient to the unit safely.

C. **PROCEDURE:**

1. Common indicators of risk for elopement include, but are not limited to:
   a. History of elopement from previous treatment facilities
   b. Symptoms of restlessness, agitation, wandering
   c. Patient is frequently checking exits and doors; **patient** is testing door knobs and locked exits
   d. Verbalizations of intent to leave the unit
   e. Confusion
   f. Purposeful wandering
   g. Family or friends are not supportive of hospitalization and are encouraging patient to leave
2. Staff will engage in activities to discourage elopements from the unit including, but not limited to:
   a. Conducting patient rounds every **fifteen (15)** minutes in ~~the PICU and the main unit~~**BHU**~~,~~ at staggered times, to determine and accurately document the location of each patient.
   ~~a.~~**b. Conducting patient comfort rounds every 60 minutes in the CSU~~,~~ and monitoring patients in assigned chairs and unit surroundings~~,~~ (including patio)~~,~~ via ongoing camera monitor in nursing station.**
   ~~b.~~**c.** Conducting safety rounds on the unit at each change of shift to assure that all exits are secured.
   ~~c.~~**d.** Assessing each patient for elopement risk and documenting changes in risk in the medical record; sharing risk information during change of shift report.

~~d.~~**e.** Maintaining a clinical person in the ~~PICU dayroom and in the main~~**BHU** ~~unit~~ hallways **and CSU**.

f. **Staying in communication with the security officer** ~~who will be~~ **posted in the CSU and making rounds in both the CSU and BHU.**

~~e.~~**g.** Communicating clearly with each other when a need arises for any staff member to leave the unit; obtaining coverage for absences as clinically appropriate.

~~f.~~**h.** Discussing patients at risk for elopement at daily treatment plan review sessions.

~~f.~~**i.** Exercising care when leaving and entering the ~~PICU and main unit~~**BHU and CSU.**

~~i.~~**j.** ~~Avoiding the door that opens to the main hallway, from the PICU~~

~~ii.~~**k.** Observing the exit closely when visitors enter and exit ~~**(No visitors in CSU)**~~**.**

~~iii.~~**l.** Observing the exit closely when dietary or other departments enter and exit.

~~iv.~~**m.** Posting signs on the entry way doors when elopement risk is high.

~~h.~~**n.** Monitoring patients closely on the ~~PICU and main unit~~**BHU and CSU** patios during **fresh air**~~smoking~~ breaks.

i. One clinical staff member will be on the patio with patients during **fresh air**~~g smoking~~ breaks at all times **(-BHU only)**.

ii. Cameras in the nursing station will be used to visualize **the outside**~~smoking~~ patio.

iii. After ~~smoking~~ **fresh air** breaks a clinical staff will ensure that all patients have returned to the unit and that the patio door is locked **(BHU only)**.

~~i.~~**o.** Carefully assessing patients for psychiatric stability prior to allowing them to leave the unit for medical testing.

i. The **registered nurse** (RN) and physician**/Allied Health Professional (AHP)** will determine, collaboratively, when it is psychiatrically safe to allow a patient to leave the unit for diagnostic testing or treatment. Testing and treatment will be delayed, within safe limits, until the patient is determined to be stable enough to tolerate the procedure or test without risk of injury or elopement.

ii. When the patient is allowed to leave the unit, he ~~or~~ /she will be placed in a patient gown and **non-slip socks. In CSU the patient will be placed in scrub top, bottom, and non-slip socks.** ~~slippers.~~

iii. A staff member will accompany all patients who leave the BHU. In addition, Security will accompany all patients who are on involuntary legal status.

iv. The Assistant Nurse Manager **(ANM)** or charge nurse will be responsible for determining if voluntary patients will require staff or security accompaniment for diagnostic testing or procedures.

3. The ~~Registered Nurse~~**RN** may initiate elopement precautions if he ~~or~~ /she assesses the clinical necessity to do so based on the patient's history and current behavior. The RN will notify the physician**/AHP** as soon ~~i~~as practicable to obtain a written order that will be entered in the medical record. Only the physician**/AHP** may discontinue elopement precautions.

4. When it is discovered or reported that a patient has left the unit without authorization the ~~Assistant Nurse Manager~~**ANM** will:

a. Notify Security immediately, give a report to the Security Officer that indicates:
   i. Patient name
   ii. Gender
   iii. Age
   iv. Description, including clothing
   v. Time patient left (approximate)
   vi. Patient's last known whereabouts
   vii. Patient's home address
   viii. Reason for hospitalization and major concerns (i.e. danger to self, danger to a specific other, indication of weapons in the home, restraining orders, etc.)

b. Notify the treating physician**/AHP** of the event and surrounding circumstances.

c. Refrain from chasing the patient or engaging in physically restraining a patient who has left the unit.

d. Notify the Clinical Nurse Manager and Risk Management Department.
e. Notify the patient's family and/or friend (as indicated if the release of information consent is signed).
f. Ensure that the Oceanside Police Department has been notified (for LPS involuntary hold or conservatorship patients only). Involuntary patients only.
g. Ensure that an accurate QRR/RL Solutions is completed that provides a detailed time-line of the event.
h. Ensure that a clinical note is completed that provides a detailed time-line of the event.
   i. Time, and method of departure
   ii. Time and names of staff, family members, police officers who were notified
   iii. Time of patient return to the unit

5. If the patient returns to the unit the clinical staff will:
   a. Carefully check the patient's clothing and other belongings for contraband items.
   b. Observe patient for signs of illicit drug use and, as indicated, follow-up with attending physician/**AHP** for further assessment.
   c. Evaluate patient's current mental status, reason for leaving, and level of continued elopement risk.
   d. Document all assessments and follow-up in a clinical note
   e. Provide clinical care as indicated by patient's presenting symptoms and concerns
6. If the patient does not return to the **BHU**~~unit~~ the clinical staff will:
   a. Hold the bed open until at least midnight of the day of the event.
   b. Obtain a physician order to discharge the patient if the patient is absent beyond midnight of the day of the event.
7. **If the patient does not return to the CSU the staff will:**
   a. Notify NP or on-call physician/AHP.
   ~~c.~~**b. Consider patient left without treatment.**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Environmental Safety Standards in BHU**

ISSUE DATE: **03/08** **POLICY NUMBER:** **6340-401**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To provide guidelines for maintaining the safety of the unit, staff, and patients.

B. **POLICY:**
1. All clinical staff will be responsible for maintaining a therapeutic milieu that provides for the safety, health, and comfort of patients.

C. **PROCEDURE:**
1. Clothing and Personal Items:
   a. On admission each patient's belongings will be searched, in the presence of the patient or witnessed by another staff member if the patient is unable to be present.
   b. All patients will be transported from the Emergency Department **(ED)** to the **Behavioral Health Unit** (BHU) in a patient gown and will have their clothing searched in the ED for contraband items.
   c. All patients who are admitted directly to the unit and who arrive in street clothing will be asked to empty their pockets. A belonging search shall include a search of the patient's luggage, purse, or other items carried into the facility by the patient and/or family. This also includes checking electrical items/appliances for safety and contraband. Building Engineering staff shall inspect all electrical hygiene appliances for safety before they can be used. An inspection sticker shall be placed on the electrical appliance with date and initials of inspector if safe for use in the hospital.
   d. Staff will check patient billfolds and/or purses for contraband items.
   e. Ask the patient to remove his/her shoes and socks and all garments such as coats, sweaters, or jackets. All items shall be searched thoroughly including checking all pockets, rolled up cuffs or sleeves, hems and waistbands. Staff shall check the patient's pockets by asking the patient to empty pockets and turn the pockets inside out.
   f. Instruct the patient to put on a hospital gown, remove all clothing with the exception of undergarments. Once the hospital gown is on, the patient shall be requested to remove all undergarments (including bra for female patient). This shall be done under the supervision of the staff member in attendance.
   g. After all clothing is removed; carefully search the patient's personal clothing. Staff shall include pockets, hems, inside shoes and socks; and other places where items may be hidden. For new patients, the Skin Assessment is conducted at this time by the **Registered Nurse** (RN) and documented in Cerner.
   h. Invasive body searches are not conducted at Tri-City ~~Medical Center~~**Healthcare District (TCHD)**~~, Behavioral Health Unit~~**BHU**.

i. All items considered contraband such as glass, compacts, perfume bottles, sharp objects, hairspray, pen, pencil, etc. will be secured in a non-patient area.
j. Glass flower vases will not be permitted in patient care areas or patient rooms.
k. Clinical staff will monitor use of razors.
l. Cellular phones are not permitted on the unit.
m. Shoelaces are not permitted on the unit.

2. Food:
   a. Food items will not be allowed in patient rooms due to the possibility of insect infestation.
   b. Dietary trays will be permitted in the dining room and patio. Dietary trays are to contain plastic-ware only. Plastic knifes are not permitted.
   c. ~~No~~ **Food** ~~allowed~~ **from outside hospital is not allowed~~,~~ unless physician/Allied Health Professional (AHP)** ~~doctor has ordered.~~ ~~Visitors will be asked to check with staff before bringing in food and beverages to the patient.~~
   d. No beverages with caffeine will be permitted on the unit except with a written order by the physician/**AHP**.
   e. The kitchen will be kept locked when not in use.
   f. Snacks will be available between meals and in the evening at scheduled times
   g. No cans will be permitted on the unit.

3. Environment:
   a. A staff member will be in patient care areas at all times to observe the milieu and to monitor patients' whereabouts. An assignment sheet will be kept to indicate which staff member is assigned to unit observation and in what time periods.
   b. Staff will closely monitor the use of supportive aids such as walkers, canes, and crutches.
   c. The patient admission process will take place in a patient care area that affords privacy but that can be observed by other staff members.
   d. When a patient is placed on one-to-one supervision and the patient is in his or her room, the door to the room will remain open at all times.
   e. The medication room will be kept closed at all times when not in use.
   f. Doors to the nurse's station will be closed and locked when not occupied.
   g. Any craft items brought in by or for the patient will be first approved by the nursing staff and will be maintained for the patient in the belongings area.
   h. Patients may work on approved craft items only in patient care areas and not in patient rooms. Patients must be supervised with craft items.
   i. Patients will not be permitted to enter other patient's rooms under any circumstances.
   j. Environmental safety checks will be conducted twice daily at change of shift by nursing staff.
   k. Regularly scheduled environmental safety rounds will be conducted by hospital safety department personnel in the company of a clinical staff member from the BHU staff.
   l. Staff will regularly report environmental safety concerns to the Assistant Nurse Manager **(ANM)** who will be responsible for initiating work orders for needed repairs and following up to ensure that needed work is completed.
   m. The patio door ~~on the PICU~~ will be kept locked except when a clinical staff is present for direct and continuous observation.
   n. The patio door~~ on the main locked unit~~ has a delayed egress door that will activate alarm after **fifteen** (15) seconds. Clinical staff must be present for direct and continuous observation when patients are on the patio.
   o. During fire alarm, or testing of hospital generator (done monthly), the ANM/Charge RN will assign a staff member to monitor the main unit delayed egress door and the double door adjacent to the RT room, near back hallway of main unit.
   p. At least one staff member will be present on the patio during ~~smoking breaks~~ **fresh air breaks** ~~on the PICU and the main unit~~.

4. Patient Rules Related to Environmental Safety:

a. Patients will be instructed not to borrow from each other or to give their personal possessions to other patients.
b. Patients will be required to wear footwear at all times.
c. Patients will be reminded in daily Community Meeting to wash their hands frequently throughout the day and in particular before all meals. Alcohol based gel will be made available for this purpose by nursing staff.
d. Physical and sexual contact between patients will not be permitted.
e. Visitors will not be permitted to visit in patient rooms.
f. Patients will be expected to maintain at least minimum standards of hygiene. Nursing staff will assist patients who are unable to maintain these standards independently.

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

1. **Behavioral Health Services: Dress Code for Patients**
~~5.~~2. **Behavioral Health Services: Patient Belongings**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

DELETE: Information incorporated into BHS Policy Inpatient Admission Criteria 202.

SUBJECT: Exclusionary Criteria

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 3/10, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

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

~~To provide guidelines for admission to the inpatient psychiatric unit by defining those conditions which preclude acceptance into either the locked or main unit.~~

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

~~1. Adults who are referred for admission to the Inpatient Behavioral Health unit must meet DSM-IV-R Severity of Illness criteria, have a primary psychiatric diagnosis, and be able to derive benefit from the therapeutic milieu. Patients will be considered inappropriate for admission if they meet *any* of the following exclusionary criteria:~~

~~a. Under age 18.~~
~~b. Primary Substance abuse diagnosis~~
~~c. Primary dementia diagnoses~~
~~d. Co-existing medical condition(s) requiring care by nursing staff with specific medical-surgical nursing competencies including but not limited to:~~
~~i. Intravenous medication~~
~~ii. Indwelling catheter~~
~~iii. Tracheostomy~~
~~e. Individuals with developmental disabilities of such a degree that they are unable to participate in daily unit activities~~
~~f. Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.~~

~~2. **PROCEDURE:**~~

~~a. The Assistant Nurse Manager will collaborate with the Psychiatric Liaison and Attending Psychiatrist regarding patients who may or may not be deemed appropriate for BHU admission.~~
~~b. When a patient cannot be admitted to the BHU because of a coexisting medical condition, that patient may be admitted to another unit in the hospital for treatment.~~
~~1. The nursing staff of the medical unit will initiate a request for a psychiatrist consult when the patient's medical condition has been stabilized.~~
~~2. The Psychiatric Liaison will collaborate with the staff of the medical unit to facilitate interim psychiatric treatment and admission to the BHU as is clinically appropriate.~~
~~3. The Psychiatric Liaison is responsible to notify the nurse practitioner or on-call Psychiatrist to consult with patient on the medical floor.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Family Involvement in Treatment**

ISSUE DATE: **03/08** **POLICY NUMBER:** **707**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. To identify the role of the family in the patient's treatment.

B. **POLICY:**
1. When appropriate and with the patient's consent, the family or significant others will be involved in the patient's treatment.

C. **PROCEDURE:**
1. At the time of admission to the **B**~~b~~ehavioral **H**~~h~~ealth **U**~~u~~nit **(BHU) or Crisis Stabilization Unit (CSU)** the clinical staff will assess the opportunities for family participation in the patient's treatment.
2. With the patient's written consent, family members will be encouraged to participate in treatment planning, discharge planning and family therapy sessions as are clinically indicated.
3. The patient must sign a **Patient Consent Visitation and/or Telephone Calls** ~~Release of Information~~ Form before any interaction is initiated with the family or significant other and before any information can be provided to them.

D. **FORM(S):**
~~4.~~**1. Patient Consent Visitation and/or Telephone Calls 6340-1009**

Patient Consent Visitation and/or Telephone Calls 6340-1009

Your presence here is confidential and cannot be disclosed by staff without your permission. Please list the people you do not want to hear from or see while on the unit.

Do you wish to receive phone calls and/or have visitors? ☐ Yes ☐ No

Do we have permission to talk to your family, friends or significant other? ☐ Yes ☐ No

Please indicate whom we have permission to talk to regarding your care.

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

I DO NOT wish to have my presence here known or receive telephone calls and/or visitation from the following people:

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

Name: Patient/Representative _____ Signature: Patient/Representative _____ Date ___/___/___ Time ___:___ AM/PM

If signed by a person other than the patient, indicate relationship to patient. _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

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

INTERPRETATION / INTERPRETER'S STATEMENT

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI
☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

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

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

Note: Changes can be made to the above list adding or crossing out names. Please sign and date each change.

Affix Patient Label

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

6340-1009
(Rev 3/17)

PATIENT CONSENT VISITATION AND/OR TELEPHONE CALLS

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Food on the Unit**

ISSUE DATE: **03/08** **POLICY NUMBER:** **403**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To reduce occupational exposure and transmission of pathogens and discourage insects and vermin on the Behavioral Health Unit **(BHU) and Crisis Stabilization Unit (CSU)**.
2. To ensure compliance with the Occupational Safety and Health Administration (OSHA) and Joint Commission regulations.

B. **POLICY:**

1. Food and beverages will be managed in such a manner as to minimize health risk and to maintain the unit in accordance with regulatory guidelines.

C. **PROCEDURE:**

1. Food and beverages will not be kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
2. Staff food and beverages will not be intermingled with food and beverages for the use of patients. A separate staff refrigerator will be maintained in the staff lounge for employee use.
3. Beverages will be permitted in nurse's station in a sealed container in designated area. Food is not permitted in nurse's station.
4. **In the Inpatient ~~Behavioral Health Unit~~BHU, patients are encouraged to consume food and beverages in the dining room~~,~~ but they may eat in other designated areas, such as the patio, if staff(s) are present.**
5. **In the ~~Crisis Stabilization Unit (~~CSU~~)~~, food and beverages will be permitted in the patient care areas, as defined by CSU staff.**

~~4. Food and beverages will not be kept on patient bedside table, or places where specimens, or dirty instruments/devices might have been previously placed.~~

~~5. Patient food and beverages other than water are permitted in the patient dining area and on the patio. Patients may have food in the patient lounge only for movie night and other special occasions as determined by Recreational Therapy.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Freedom of Movement**

ISSUE DATE: **03/08** **POLICY NUMBER:** **508**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **DEFINITION(S):**
1. **Limitation: The constraint of a right for an individual recipient of services.**
~~A.~~2. **Restriction: General constraint of a right for all or a group of recipients.**

B. **PURPOSE:**
1. To einsure that each patient's freedom of movement is not restricted more than is clinically necessary.

C. **POLICY:**
1. Patients who receive behavioral health services in the Behavioral Health Units **(BHU)** are entitled to freedom of movement. Limitations and/or restrictions will be imposed only to achieve a therapeutic milieu and to safeguard the safety of the patient, other individuals in the environment, or property.

D. **PROCEDURE:**
~~1. Definitions~~
~~a. Limitation: The constraint of a right for an individual recipient of services~~
~~b. Restriction: General constraint of a right for all or a group of recipients~~
~~2.~~1. At the time of admission the patient will be informed of his/her right to freedom of movement, of those areas where patients may gather, and of those areas from which patient movement is restricted.
   a. The patient will be informed of areas that have been designated as off-limits for reasons of safety or that might impair the effectiveness of program operations with patients present.
   b. They will be informed of areas of usual access and the program schedule that describes the activities occurring in treatment areas throughout the day.
~~3.~~2. Every patient will be permitted access to areas designated for treatment, recreation, or vocational activities, eating, and social interaction activities in accordance with program scheduling unless a limitation is clinically indicated.
~~4.~~3. The rationale for implementing a restriction or a limitation will be limited to the following:
   a. The achievement of a treatment goal.
   b. The maintenance of a therapeutic milieu and to facilitate effective program operations.
   c. The protection of the patient or others from harm.
   d. The prevention of property damage.

~~5.4.~~ In the event a limitation is imposed on a patient's right to freedom of movement, a staff member will explain the rationale, the time frame for the limitation, and the right of the patient to appeal the decision including discussion of the proposed action and consensus of the treatment team and the initiation of a Rights Advocate complaint.

a. All limitations will be documented in the clinical record and will include the rationale for imposing the limitation.

b. The limitation or restriction will be removed when the circumstances that justified its adoption cease to exist.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: General Supervision of Patients: Patient Rounds

ISSUE DATE: 03/08 **POLICY NUMBER:** 708
REVISION DATE(S): 08/09, 06/10, 03/11, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

A. **PURPOSE:**

1. To provide guidelines for maintaining a system of observing patient behavior and location.

B. **POLICY:**

1. Each unit and each shift will maintain a rounds board that will be used to document rounds on all patients. Documentation will include the unit name ~~(PICU/Main Unit)~~, date, patient name, room number, and activity and any precautions. Each shift will document patient behavior and location every **fifteen** (15) minutes ~~on the PICU and every 15 minutes on the Main Unit~~, although individual patients on each unit may be monitored more frequently if clinically indicated and written as a physician order.

C. **PROCEDURE:**

1. The Assistant Nurse Manager (ANM) or Charge Nurse will assign rounds every shift. The person who is assigned to initial rounds on each shift will prepare the rounds sheet for that shift. The outgoing and incoming staff personnel will conduct a unit environmental safety check and will document its completion on the rounds sheet including his or her signature.
2. All staff assigned to rounds during a shift will update the rounds sheets to reflect changes in individual patient precaution level, room or bed changes, new admissions and/or discharges as they occur.
    a. The rounds sheet for each unit will include space for the staff member to document the patient's legal status. The staff will indicate changes in the status as they occur during the shift.
    b. The rounds sheet for each unit will include provision for documenting a patient's time in the quiet room either for time-out, seclusion, or restraint.
3. A staff initial at the bottom of each time block will indicate the completion of all rounds for that time increment. Staff initials must be legible. Staff initialing the round sheet will include their name and title in the appropriate section on each form.
4. The purpose of rounds is to check all aspects of security and safety while monitoring patient behavior and location.
    a. All patient accessible areas will be checked to see that patients are safe and behavior is appropriate. All patient accessible areas are also visually checked for contraband items or for damages. Contraband, damage or unsafe situations will be reported to the shift supervisor at once.
    b. Rounds will not be done in such a predictable manner that patients will have an opportunity to plan acting out in between checks. Staff will, at all times, conduct rounds

so that safety and supervision are maximized. Although all patients must be checked at least every **fifteen (15)** minutes (as ordered) the rounds will be performed at staggered intervals and in a varying pattern or sequence throughout the unit to minimize planned acting-out opportunities.

c. All doors that are to be locked will be checked to see that they are locked.

d. All areas will be checked visually for fire hazards, contraband and all other safety hazards.

5. Rounds will be made at the ordered frequency on both shifts. Any concerns regarding safety, security, whereabouts or behavior of a patient will be reported immediately to the shift supervisor or charge nurse.

6. Staff will be assigned to monitoring patient areas and being available on the floor at all times.
   a. It is critical having staff purposefully out in the milieu, posting at different areas on the floor, creating a caring and more secure environment.
   b. Ensuring that patients are not entering into rooms not assigned to them.
   c. Particular attention must be paid to supervising showers and bathrooms for patients who are on fall precautions.
   ~~d. Staff must be present in tub room with patient at all times. No supplies, food, or drinks are to be stored in the tub room. The tub room is to be cleaned between patient use with hospital approved disinfectant by Environmental Services.~~
   d. High risk times for patient acting out generally include changes of shifts, crisis de-escalation, meal times, visiting hours and during staff meetings. Staff will be vigilant and maintain a constant awareness of unit diversions and provide constant supervision during these high-risk times.

7. During the night or whenever patients are in bed, rounds will be made at the ordered intervals to be sure that the patient is in bed and safe. Staff is required to ensure that patients are breathing.

8. Every effort will be made to respect the patients' right to privacy during rounds. However, safety for the patient and staff is always the prevailing priority. Bedroom doors may be left open except while a patient is dressing or undressing if the patients' behavior or precaution level warrants.

9. Supervision and rounds extends to the patio areas.
   a. Staff will accompany patients to the ~~smoking area on both the PICU and the Main Unit~~**patio**.
   b. Patients will not be left unattended on the ~~smoking~~ patio ~~on both units~~ at any time.

10. Staff conducting rounds must verify ~~that~~ they are checking the correct patient~~. This can be done~~ by:
    a. Checking ID bands
    b. Asking the patient to state their first and last names
    c. Asking another staff member to verify the patient's identity.

11. When staff assigned to patient rounds must leave the unit for any reason that prevents them from doing rounds as ordered, it will be their responsibility to inform the shift supervisor or charge nurse so that another staff member can perform the rounds for that period.

12. Any errors in location or behavior should be circled. On the back of the rounds sheet the staff will write the correct patient, behavior, and location and will sign the correction with name, title, date and time.

13. When a patient is on 1:1 observation an additional observation record will be maintained.

14. All rounds sheets will be maintained as a permanent record but will not be a part of the patient's medical record. The original copy of each rounds sheet may be kept on the rounds board for up to one week after which the sheets will be filed in a binder that is kept expressly for this purpose.

15. The Night shift ANM will review the rounds sheets for the previous 24 hours for any missing entries. Missing entries will be noted on the chart deficiency list and reported to the oncoming ~~shift supervisor~~**ANM/Charge Nurse**.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Hose Use During Garden Activity**

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. The opportunity will be provided for patients to use a hose to water the garden during Recreation Therapy activity on the patio.

B. **POLICY:**

1. Patients on the Behavioral Health Unit **(BHU)** are eligible to participate in Recreation Therapy activities, specifically gardening. This includes using a hose to adequately water the plants, flowers, vegetables in the gardening boxes and planters on the patio.

C. **PROCEDURE:**

1. During Recreation Therapy held on the patio, patients under supervision of staff will have access to a garden hose to water the plants in the garden boxes and planters. Staff will use the water key to turn on the faucet while the assigned patient uses the hose to water the plants.
2. The hose will kept locked in the Recreation Therapy closet when not in use. The hose may only be used under staff supervision.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Inpatient Unit Admission Criteria

ISSUE DATE: 03/08 **POLICY NUMBER:** 202
REVISION DATE(S): 08/09, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

A. **DEFINITION(S):**

1. **Functional Impairment: This refers to the degree to which an individual is unable or has difficulty attending to one or more self-care needs, basic physical needs (nutrition, shelter, etc) to familial or social role expectations and/or to vocational or educational responsibilities due to impaired judgment, cognition, affective regulation, or impulse control related to a mental disorder.**
2. **Intensity of Service: The setting of care that usually corresponds to the types and frequency of needed services and supports to the degree of restrictiveness necessary to safely and effectively treat the individual.**
3. **Least Restrictive Environment: The least intensive/restrictive setting of care that is sufficient to effectively, safely, and appropriately treat the individual's condition and to achieve the purposes of treatment and/or rehabilitation.**
4. **Risk Estimation/Clinical Stability: The degree to which an individual is at risk of injury due to self/other harm inclinations, reckless activities (not arising from antisocial behavior or related traits) loss of ability to perform activities for daily living due to severely impaired judgment, impulse control, cognition or affective regulation, or due to lack of necessary skills or environmental supports.**
5. **Severity of Illness: Refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the individual's disorder. It is assumed that as the severity of illness increases, the level of care needed to treat the individual will increase in restrictiveness**

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

1. To provide guidelines for determining the appropriateness of admission for inpatient psychiatric treatment. To ensure that care is delivered in the least restrictive environment and that it is based on established severity of illness criteria.

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

1. Individuals who are admitted to Inpatient ~~psychiatric services~~**Behavioral Health Unit (BHU)** will be screened to ensure that they meet predetermined criteria. The severity of illness and intensity of service criteria for admission are based on the assumption that the patient is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairment, and manifesting a level of clinical risk that either individually or collectively are of such severity that treatment in a less restrictive environment would be unsafe and/or ineffective and that the patient has the psychological and cognitive capacity or potential capacity to

respond to the inpatient program. It is expected that active treatment provided at the medically necessary level of care will reasonably result in improvement in the patient's condition.

~~1.Definitions:~~

~~a.Functional Impairment: This refers to the degree to which an individual is unable or has difficulty attending to one or more self-care needs, basic physical needs (nutrition, shelter, etc) to familial or social role expectations and/or to vocational or educational responsibilities due to impaired judgment, cognition, affective regulation, or impulse control related to a mental disorder.~~

~~b.Intensity of Service: The setting of care that usually corresponds to the types and frequency of needed services and supports to the degree of restrictiveness necessary to safely and effectively treat the individual.~~

~~c.Least Restrictive Environment: The least intensive/restrictive setting of care that is sufficient to effectively, safely, and appropriately treat the individual's condition and to achieve the purposes of treatment and/or rehabilitation.~~

~~d.Risk Estimation/Clinical Stability: The degree to which an individual is at risk of injury due to self/other harm inclinations, reckless activities (not arising from antisocial behavior or related traits) loss of ability to perform activities for daily living due to severely impaired judgment, impulse control, cognition or affective regulation, or due to lack of necessary skills or environmental supports.~~

~~e.Severity of Illness: Refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the individual's disorder. It is assumed that as the severity of illness increases, the level of care needed to treat the individual will increase in restrictiveness~~

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

~~2.~~**1.** All candidates for admission will be screened by an appropriately credentialed clinician to determine suitability for admission using the following criteria:

a. Availability of a suitable bed.

b. The patient's assessed potential for response to the treatment services offered on ~~the unit~~**BHU**. Physical illness, developmental disability or organic impairment should not be of such severity that it precludes meaningful participation in the program.

i. It is expected that the patient will possess the potential to participate in and derive benefit from at least 50% of the program's scheduled activities.

ii. The patient's ability to adapt to the current milieu on ~~the unit~~**BHU** will be determined by the psychiatric liaison and/or the medical service director. In making this decision consideration will be given to the number and acuity of the patients already on ~~the unit~~**BHU**, the existing nurse to patient ratio, and the assessed needs of the patient being considered for admission.

iii. In all cases the safety of the patient and the milieu will be the determining factors in making a decision to deny an admission if the patient is clinically suitable for admission.

c. The patient must be medically stable as defined below:

i. The patient will have no condition that would prevent him/her from being able to be out of bed, with or without assistance, and have the capacity or potential capacity to participate in at least 50% of the unit scheduled activities.

ii. If the patient has a positive medical history for any major illnesses such as stroke, diabetes, hypertension, significant weight loss, etc. the patient will be medically cleared prior to inpatient admission.

d. Clinical presentation:

i. An individual will be considered for admission when it is determined that he/she is mentally ill and requires supervised care in a 24 hour protective setting.

ii. The severity of illness and intensity of service criteria will be based upon the judgment of the qualified screening clinician that the patient is displaying signs and symptoms of a serious psychiatric disorder.

iii. The decision to admit an individual under voluntary or involuntary status will be determined by the clinical presentation, i.e. whether the patient meets 5150

criteria regarding danger to self, danger to others, grave disability and if the patient is willing to consent to treatment. In those instances that the legal status is in question, the psychiatric liaison will collaborate with the attending psychiatrist in making the decision.

iv. Inpatient psychiatric hospitalization is indicated if it is determined that the patient is exhibiting functional impairments and demonstrating a level of clinical risk that are severe and it is determined that alternative treatment in a less structured and supervised setting would be unsafe and ineffective.

e. Diagnosis: The patient must be suffering from a major mental illness reflected in a primary validated DSM-~~5IV~~ Axis 1 diagnosis.

f. Severity of illness: The patient must exhibit at least one of the following manifestations with reasonable hope that inpatient therapy will relieve, retard, or reverse the active symptoms of the mental disorder:

i. Severe psychiatric signs and symptoms:

1) Thought disturbances including hallucinations, delusions and impaired perceptions.
2) Situational stress reactions that result in extensive interference with the individual's ability to perform activities of daily living and to function in daily routines in the community.
3) Demonstrations of disordered bizarre behavior or psychomotor retardation that prevent successful treatment at a lower level of care and interfere with the individual's ability to perform activities of daily living and to function in daily routines in the community.
4) Disorientation: A demonstration of memory impairment with impaired reality testing, poor judgment or impulse control problems that interfere with the individuals ability to perform activities of daily living and to function in daily routines in the community that are considered severe enough to endanger the welfare of the patient and/or others.
5) Mental disorders refractory to outpatient therapy such as a recurrent psychosis that is not response or a severe depression failing to respond to outpatient drug therapy.

ii. Clinical findings: Disruptions of self care and interpersonal functioning

1) The diagnosed mental illness is disabling the individual from independently attending to their basic self care needs such as food, clothing, shelter, transportation, and health care independently to the extent that it is severe enough to threaten life or vital bodily function (gravely disabled).
2) Severe impairments in interpersonal functioning such as severe social withdrawal are preventing the patient form meeting educational, occupational, legal, and recreational goals or expectations.
3) The individual is experiencing a recurrence of symptoms that are not responding to outpatient interventions and that are severely interfering with self care and/or interpersonal functioning.

iii. Clinical findings: Self harm

1) An attempt, plan, or ideation (such as depression with feelings of suicidal hopelessness) exists to engage in destructive behavior with the intent to inflict death upon him or herself. The severity of suicidality is collectively based on an assessment that includes:
   a) Seriousness of intent
   b) Degree of lethality
   c) Family history
   d) History of prior attempts
   e) Existence of a workable plan
   f) Level of impairment (intoxication or impaired rational thinking)

g) Current social support

iv. Self mutilation or reckless endangerment: The current behavior or a recent history provides evidence that there is a verbalized threat of a need/willingness to self-mutilate or become involved in other harmful high risk behaviors. The severity of self harm is determined by the following that together reveal an inability to maintain behavioral control:
1) Intent
2) Impulsivity
3) Judgment
4) Plan

v. Other self-injurious behavior: A suspicion of overdose is considered when the individual has a recent history of drug ingestion. Regardless of the need for detoxification, the individual could also require treatment of a substance induced psychiatric disorder.

vi. Clinical findings: harm to others
1) An attempt, plan, or ideation exists to engage in assaultive and destructive behavior with the intent to inflict harm upon another or others.
2) Serious assaultive behavior has occurred and there is a risk of escalation or repetition of this behavior in the immediate near future.
3) The intent to harm others is expressed and a plan is available to carry it out. The individual demonstrates an impaired level of impulse control such as might occur in response to command hallucinations, intoxication, impaired judgment, persecutory delusions, or paranoid ideation.
4) Significant destructive behavior toward property occurred in the recent past that endangered others.

vii. Clinical findings: drug/medication complications or co-existing general medical condition that requires care
1) The patient is experiencing significant side effects from prescribed psychotropic medication.
2) The patient is experiencing toxic effects from a prescribed psychotropic medication (e.g. Lithium level > 2.0 mEq/L).
3) The patient requires significant increases, decreases, or changes of psychotropic medication for stabilization and the adjustment or reinitiation of the medication requires close and continuous medical and nursing observation, supervision, or monitoring that cannot be accomplished at a less intense level of service based on the patient's condition.
4) There are concurrent physical symptoms or medical disorders that necessitate evaluation, intensive monitoring, and/or treatment, and inpatient hospitalization is recommended because the co-existing medical condition would hamper or complicate psychiatric treatment at a lower level of care.

~~3.~~**2.** Exclusion Criteria: An individual will not be considered appropriate for admission to the inpatient ~~psychiatric unit~~**BHU** if ~~one of the following is evident~~**they meet any of the following exclusionary criteria**:

a. Under age 18.

~~a.~~**b.** There is a primary substance abuse diagnosis or a dual diagnosis in which substance abuse is the primary problem at this presentation.

~~b.~~**c.** There is a primary dementia diagnosis.

~~c.~~**d.** There is a developmental disability of such an extent that the patient cannot actively participate in the therapeutic milieu.

~~d.~~**e.** The patient is not medically cleared.

f. Co-existing medical condition(s) requiring care by nursing staff with specific medical-surgical nursing competencies including but not limited to:

i. Intravenous medication

ii. **Indwelling catheter**
iii. **Tracheostomy**

g. **Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.**

h. **Unable to independently transfer from wheelchair or patient requiring electric wheelchair.**

~~a.~~**i.** There is lack of clinical evidence that would ordinarily indicate that the patient meets the severity of illness criteria.

Tri-City Medical Center
Oceanside, California

BEHAVIORAL HEALTH SERVICE

DELETE- Redundant policy, follow Patient Care Services: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy

SUBJECT: Involuntary Hold Patients
POLICY NUMBER: 6340-004

ISSUE DATE: 6/97
REVISION DATE(S): 6/97, 7/00, 4/02, 8/03, 12/04, 1/05, 03/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/13~~03/18
Board of Directors Approval:	03/13

~~A. Patients may be detained involuntarily for the purpose of evaluation and treatment when any person, as a result of a mental disorder, is a danger to others, to himself or herself, or gravely disabled, in accordance with the Welfare and Institutions Code, Division 5, the Lantenman-Petris-Short Act (LPS), section 5150. Only those individuals privileged to do so at Tri-City Medical Center and law enforcement official may put patients on involuntary holds. All patients being held involuntarily are afforded the same patient's rights as all other patients. According to the LPS Act, only the following functions related to the involuntary detainment of individuals are performed at Tri-City Medical Center:~~

~~1. 72-HOUR HOLD (5150)~~
~~a. Mental health professionals may detain patients on a 72 hour hold for the purpose of evaluation and treatment.~~

~~2. 14-DAY HOLD (5250)~~
~~a. After receiving an evaluation while on a 72 hour hold, individuals may be certified for not more than 14 days of intensive treatment. Individuals placed on a 14 day hold must have a second psychiatric consultation.~~

~~3. REISE HEARINGS~~
~~a. Reise hearings may be held for any involuntary patient (either 72 hour or 14 day holds or temporary conservatorship) who may be incapable of, or resistant to giving informed consent for psychotropic medications. The hearings insure that the patient's rights are protected before receiving such medications.~~

~~4. WRITS OF HABEUS CORPUS~~
~~a. All patients who are on legal holds (72 hour, 14 day or conservatorships) may request to leave the hospital. Upon such request, a Writ is filed on behalf of the patient and the Public Defender's office is notified. A hearing will be scheduled. At any time, the patient may withdraw their request to leave, and the Writ and hearing will be cancelled by notification to the Public Defender's office.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Management of Aggressive and Assaultive Behaviors**

ISSUE DATE: **03/08** **POLICY NUMBER:** **724**
REVISION DATE(S): **08/09, 06/10, 03/13**

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~03/13~~03/18**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To provide guidelines for the management of aggressive and assaultive behavior in a careful and reflective manner that utilizes the least restrictive interventions possible in any given clinical situation.

B. **POLICY:**

1. On the occasions when a patient displays aggressive or assaultive behaviors that places him or herself, or other patients or staff in danger, the patient may require a physical intervention by the clinical staff to prevent such injury.

C. **PROCEDURE:**

1. All employees on the **I**inpatient **B**~~b~~ehavioral **H**~~h~~ealth **U**~~u~~nit **(BHU)** will be required to successfully complete Non-~~-~~Violent Crisis Intervention (NVCI) training at the time of hire and annually thereafter as scheduled.
2. The program will also provide specific training which takes into consideration such factors as the program location, availability of staff, and proximity of assistance from outside sources.
3. An instructor who has completed a certification program in physical management or an instructor who has been trained by that individual will provide training.
4. The overall goal of physical management is to maintain the care, welfare, and safety of patients and staff as well as the integrity of the therapeutic milieu.
5. Techniques of non-violent crisis management will be employed in managing aggressive behaviors. Whenever possible, verbal interventions will occur first and these interventions will then follow the prescribed sequence form least to most restrictive.
6. When a staff member identifies a problematic circumstance, e.g. a situation that is escalating and could potentially result in injury or risk, he/she will communicate this immediately to other staff to obtain assistance and will implement the intervention most appropriate to the presenting situation.
7. All available staff, including Security Department personnel, will respond to a call for assistance by reporting to the location of the incident where they will await further instruction/assignment from the designated team leader.
8. A team leader will be identified and assignments will be made as soon as it is determined that the situation may result in a physical intervention.
   a. The team leader will be responsible to verbally direct the intervention and indicate the number of staff needed to safely manage the occurrence.

b. The team leader will communicate with other staff directly and will specifically indicate what he/she expects from each member present.
c. Staff who are not needed to safely control the patient will involve themselves, as assigned by the team leader, with removing and relocating other patients to a neutral location away from risk of injury.

9. Security officers will ~~be summoned to the program and~~ be available as a resource. Staff members will, however, make every reasonable effort to resolve the occurrence without the intervention of Security officers.
   a. When it is determined that Security may be needed, a designated staff member will ~~call and~~ provide the following information **to security**:
      i. A brief description of the patient (gender, age, height, weight), mental status as well as any other pertinent information such as pregnancy or physical infirmity.
      ii. The status of the present situation including its specific location, number of available staff and level of acuity.
      iii. The number of Security Officers it is estimated that will be needed to safely manage the situation.
      iv. The name of the team leader or an initial contact person.
   b. Officers will remove any articles that might inflict injury to self, other staff, or the patient, before responding.
   c. Officers will be given a brief update on the status of the situation upon arrival including the identified plan for intervention.
   d. The team leader will maintain responsibility for directing Security personnel and other staff members throughout the intervention and for requesting that specific interventions be utilized.
   e. If at any time during the intervention the team leader determines that the psychiatric staff cannot safely contain the situation he/she will specifically request that Security take control over the situation. At this point one Security Officer will assume the role of team leader and will direct the remainder of the intervention.
   ~~f. Chemical aerosol spray may not be used to subdue a patient.~~
10. Assigned staff will document an account of the physical management occurrence including the signs and symptoms of any significant clinical changes that may have occurred as a result of the physical management and follow up intervention to reduce or treat injury.
11. Staff will participate in a debriefing to discuss precipitants and to evaluate interventions as soon as possible after the occurrence.
12. **BHU** staff will also hold a patient debriefing session in a community meeting to allow patients who witnessed the occurrence to discuss it, ventilate their feelings and to restore an atmosphere of safety and security.
~~13. All episodes of physical intervention will be reported in accordance with the TCMC QRR process.~~
~~14.~~**13.** Any episodes that result in either patient or staff injury or a significant disruption in the milieu and those in which interventions that were used were in violation of this policy will be reported **in accordance with the Tri-City Healthcare District (TCM~~C~~HD) QRR process and** to the appropriate administrative personnel.
14. All episodes of physical intervention will require an entry in the patient's medical record. Seclusion/Restraint documentation will be completed in accordance with ~~policy as indicated~~**Patient Care Services Policy: Restraint-Seclusion for Violent-Self-Destructive Behavior**.

D. **RELATED DOCUMENT(S):**
~~15.~~**1. Patient Care Services Policy: Restraint-Seclusion for Violent-Self-Destructive Behavior**

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

SUBJECT: Clinical Nutrition Dietitian Staffing

ISSUE DATE: 4/3/06
REVISION DATE(S): 10/11

Department Approval Date(s):	**02/17**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s): -	**n/a**
Professional Affairs Committee Approval Date(s)	**03/18**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. Clinical dietitians are scheduled to assure continuity and consistency of nutrition care provided to patients.
2. Clinical dietitians are scheduled daily to assure consistency of care to patients.
3. A dietitian is scheduled for coverage for every weekend.
4. A dietitian is scheduled for coverage for each holiday.
5. Clinical dietitians complete a nutrition assessment within 48 hours for patients identified at nutrition risk by nursing upon completion of initial admission assessment. Consults are completed by clinical dietitians within 48 hours of receipt of consult.
6. Staffing of clinical dietitians is adjusted to patient census and workload; i.e. staffing is increased on Mondays/Fridays and as needed with increase/decrease in patient census.

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

SUBJECT: **Nutrition Assessment ~~&~~and Care for Adult ~~&~~Geriatric Patients**

ISSUE DATE: **03/88**
REVISION DATE(S): 06/08, 10/10, 11/11

Department Approval:	**11/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**01/18**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	**02/12**

A. **POLICY:**

1. ~~Function:~~ A systematic method for the Registered Dietitian **(RD)** to collaborate with the physician/**Allied Health Professional (AHP)** in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements **for patient age fourteen (14) years of age and older admitted to Tri-City ~~Medical Center~~Healthcare District**.
2. ~~Circumstances:~~
3. ~~Setting:All adult patients (age 14 years and older) admitted to or being treated at Tri City Medical Center~~
4. ~~Supervision:None required~~
5. **2.** Referrals for a nutrition assessment are generated if certain criteria are met via the adult admission assessment in Compass Power Chart.
6. **3.** ~~Registered dietitians (~~RD~~)~~ will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, nutrition history, medical history, medical therapies/treatments and laboratory values.
7. **4.** ~~Registered dietitians (~~RD~~)~~ may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, modification of food texture, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.

B. **PROCEDURE:**

1. Referrals for nutrition assessment are generated if any of the following criteria are met upon completion of the admission data base by nursing:
   a. **Greater than (>)** 75 years of age with abdominal or thoracic surgery
   b. Currently receiving **total parenteral nutrition** (TPN) or enteral feedings
   c. Unplanned weight loss of **greater than (>)** 10 **pounds#** in last month
   d. Hyperemesis with **greater than (>)** 10 **pounds#** weight loss
   e. Presence of pressure ulcer or skin breakdown
   f. Braden score of ~~**greater**~~**less than (<)** 15
   g. Eating disorder
   h. Impaired nutrient intake
   i. Nausea/vomiting/diarrhea
   j. Intake ~~**greater**~~**less than (<)** 50% of normal in the last **three** (3) days
   k. Aspiration risk
   l. **Gastrointestinal** (GI) problem other than constipation

2. ~~Registered Dietitian~~**RD** assesses all medical/surgical patients for nutrition risk upon referral. Upon completion of assessment, appropriate nutrition care plans are implemented.
3. ~~Registered Dietitian~~**RD** will review patient's medical history and current medical status.
4. ~~Registered Dietitian~~**RD** will assess patient's nutrition history, indicating patient's ability to tolerate various modes of feeding, recent intake, previous diet modification, food allergies or aversions, and appropriateness/adequacy of patient's current diet order.
5. ~~Registered Dietitian~~**RD** will document height/weight, **ideal body weight** (IBW), usual body weight and any other appropriate anthropometric measurements. Usual body weight is more useful than IBW in ill population.

Calculation of IBW	
1)	Males: 106# ~~-~~ **pounds** for first 5'; 6# ~~-~~ **pounds** for each inch over 5'
2)	Females: 100# ~~-~~ **pounds** for first 5'; 6# ~~-~~ **pounds** for each inch over 5"

a. Body Mass Index (weight [~~kg~~]/height [~~m2~~]) is determined to assess health and body fat).

Body Mass Index Body Size Classification Table	
Underweight	**less than (<)** 18.5
Normal Weight	18.5 -24.9
Overweight	25 - 29.9
Obesity	**greater than (>)** 30
Extreme Obesity	**greater than (>)** 40

6. **Patient will be assessed for malnutrition based on current American Society of Parenteral and Enteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines after assessment of weight history, appetite change, and nutrition focused physical assessment is completed.**
7. Dietitian will evaluate pertinent laboratory data to include: serum albumin, transferrin, **total iron-binding capacity** (TIBC), total lymphocyte count, hematocrit, hemoglobin, electrolytes, etc. Other pertinent laboratory data (i.e. BUN/CR, liver function tests, serum glucose levels, lipid levels) will be evaluated as necessary. ~~Causes of hypoalbuminemia include liver disease, infection, nephrotic syndrome, postoperative states, metabolic stress, inadequate protein intake, protein malnutrition, fluid imbalances, malabsorptive states, etc.~~

~~Albumin~~	
~~2.8-3.5g/dL~~	~~mild depletion~~
~~2.1-2.7g/dL~~	~~moderate depletion~~
~~<2.1g/dL~~	~~severe depletion~~

8. ~~Registered Dietitian~~**RD** will evaluate factors, which may affect nutrition intake, digestion, and absorption, including: medications, previous GI surgeries, on-going treatments, and chronic disease states, i.e. cancer or alcoholism.
9. ~~Registered Dietitian~~**RD** will confer with nursing, pharmacist, and physician/**AHP** regarding pertinent factors affecting nutrition status (medication, **intake and output** (I&O) intake, Braden Score, presence of decubitus ulcers, presence of diarrhea, vomiting, reduced oral intake, etc.).
10. ~~Registered dietitian~~**RD** will determine patients at nutrition risk based upon above assessment and to include, but not limited to, patients with actual or potential malnutrition, patients on altered diets or diet schedule, patients with inadequate nutrition intake, lactating and pregnant women, and geriatric surgical patients.
11. ~~Registered Dietitian~~**RD** will document protein/calorie and fluid requirements for patients as indicated. (See tables 1, 2, & 3).

Table 1 - Assessment of Energy Requirements	
(a)	Harris Benedict
	Men: 66.5 + 13.75 (w) = 5.0 (h) - 6.76 (a)
	Women: 655 + 9.56 (w) = 1.85 (a) - 4.68 (a)

	Apply appropriate activity & stress factors
(b)	20 Kcal/Kg to 25-30 Kcal/kg/d (disease specific guidelines follow)
(c)	Ireton-Jones Energy Equations: EEE(V) = 1784- 11 (A) + 5 (W) + 244 (S) + 239 (T) EEE(S) = 629 – 11 (A) + 25 (W) – 609 (O) EEE = kcal/day S = spontaneously breathing V = ventilator dependent A = age (years) W = body weight (kg) S = sex (male = 1, female = 0) T = trauma B = burn O = obesity (if present = 1, absent = 0)

Table 2 - Assessment of Protein Requirements

RDA = 0.8gm/kg IBW or actual weight

*modified to reflect requirements for specific diseases and/or metabolic stress (refer to disease specific guidelines to follow and various references available in department)

Table 3 - Assessment of Fluid Requirements

30-35ml/kg (18 to 64 yrs. of age) or 1ml/Kcal

12. ~~Registered Dietitian~~**RD** will develop a nutrition care plan indicating type of nutritional support (i.e. oral, oral with supplements, appropriate enteral feeding, or suggestion of parenteral feeding) to be given and its implementation. Determination of care plan will be based on assessment. Care plan will be individualized to meet specific needs of each patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. ~~Dietitian~~ **RD** will confer with ~~MD~~ **physician** for appropriate ordering and intervention, with **register nurse** (RN) for delivery of nourishment, with pharmacy and nursing for TPN and Drug Nutrient Interaction.
13. ~~Registered Dietitian~~**RD** will monitor intake, input and output, weight, changes in medical condition and/or treatment and laboratory data and make recommendations as necessary. Intake may be monitored via calorie count. (Refer to Policy and Procedure for Calorie Count.)
14. ~~Registered Dietitian~~**RD** will document patient's reaction and tolerance to dietary regimen.
15. ~~Registered Dietitian~~**RD** will assess adequacy of enteral and parenteral feedings in relation to patient's nutritional requirements (see ~~Policy and Procedures for~~**Food & Nutrition Policies:** Enteral Feedings and **Nutrition Assessment of** TPN Patient~~s~~).
16. ~~Registered Dietitian~~**RD** may offer appropriate nutritional supplements to patients at any time when a patient is consuming less than 75% of assessed calories/protein requirements~~.~~ (see Table 1 and Table 2). Selection of appropriate supplement will be based upon assessment of patient's diagnosis, laboratory values, tolerance, and personal preference.
17. ~~Registered Dietitian~~**RD** may implement texture changes in foods when indicated based upon patient tolerance and or personal preference (i.e. regular to mechanical soft or pureed).
18. ~~Registered Dietitian~~**RD** will periodically reassess patient's nutritional status throughout hospital stay and document on Nutrition Reassessment form in Compass Power Chart every **one (1)- to seven (7)** days depending upon patient's status and individualized needs.
19. Obstetric patients will not be assessed unless ~~Registered Dietitian~~**RD** is requested to do so by Physician/**AHP**/Nurse or if patient has nutritional risk factors, i.e. "lying in" or gestational diabetes. (See **Food & Nutrition** Policy: **Nutrition Assessment of** ~~for~~ High Risk OB Patient~~s~~.)

20. Behavioral Health patients will not be routinely assessed by the ~~Registered Dietitian~~**RD** unless requested to do so by Physician/**AHP**/Nurse or if patient has nutrition risk factors (see **Food & Nutrition** Policy: ~~for~~ Nutrition Assessment ~~of BHU patients~~).
21. Any significant change in the patient's condition, i.e. surgery, intubation, warrants a reassessment.
22. A significant change in diagnosis, i.e. cancer, warrants a reassessment.
23. Upon completion of the assessment, the dietitian will complete the initial nutrition assessment form. Additional documentation may be noted in the progress notes of the paper medical record

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

1. **Food & Nutrition Policies: Enteral Feedings and Nutrition Assessment of TPN Patient**
~~24.~~2. **Food & Nutrition Policy: Nutrition Assessment BHU**
~~25.~~3. **Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient**
4. **Nutrient Requirements for Specific Disease States**

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

1. **Gottlischlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum.* Kendall/Hunt Publishing Company, Dubuque, IA, 2001.**
~~26.~~2. ***Manual of Clinical Dietetics*, online edition. Academy of Nutrition and Dietetics, Chicago, IL, 2017.**
3. ***Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, 2000**
4. **Mueller, Charles, ed in chief: *The A.S.P.E.N Adult Nutrition Support Core Curriculum.* American Society for Parenteral Enteral Nutrition; 2nd ed. edition (2012)**
5. **Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice.* Kendall/Hunt Publ Co, Dubuque, IA, 2002.**

Nutrient Requirements for Specific Disease States

Disease State	Calories	Protein	Other considerations
Obesity **Critically Ill Obesity**	~~18~~-22-**25** kcal/kg ~~actual wt~~ **IBW** **BMI≥30-50:11-14kcals/kg actual wt** **BMI>50: 22-25 kcals/kg IBW**	1.2 to ~~1.5~~**2.0** gm/kg ideal wt **BMI 30-40: 2.0g/kg IBW** **BMI ≥40: up to 2.5g/kg IBW**	Consider lower protein requirements in presence of hepatic disease or renal insufficiency
Pulmonary/Respiratory	25 to 30 kcal/kg ARDS: 20 – 30 kcal/kg	1.0 to 1.5 gm/kg	Do not overfeed. If mechanically ventilated, limit CHO to 4-5 mg/kg/min. Consider small frequent feedings.
Renal	ARF: 30-45 kcal/kg CRF: 35-38 kcal/kg *may reduce requirements if wt loss desired or to avoid over-feeding in ventilated pts	Prerenal:0.6 – 0.8 gm/kg ARF: 1.0 – 1.5 gm/kg CRF: 1.0 – 1.2 gm/kg (with hemodialysis) 1.0 – 1.5 gm/kg (with peritoneal dialysis) Nephrotic syndrome: 0.8 – 1.0 gm/kg	Fluid & electrolytes as tolerated
Hepatic	Cirrhosis: 25-35 kcal/kg Hepatitis: 35 kcal/kg	Cirrhosis/hepatitis without encephalopathy: 1.0-1.2 gm/kg Cirrhosis/hepatitis with acute encephalopathy: 0.6 – 0.8 gm/kg; resume 1.0 – 1.2 gm/kg asap Cirrhosis with chronic encephalopathy: 0.6 – 0.8 gm/kg	If-persistent encephalopathy, consider BCAA (hepatic formula; i.e. Nutra Hep for enteral, Hepatamine for parenteral.)
Diabetes	Needs as per normal assessment	10-20% total calories	
Cancer	25 – 35 kcal/kg, dependent upon individual patient	~~1.0 –~~ 1.5 gm/kg **Cancer cachexia: 1.5-2.5**	Consider consequences of surgery, chemo, ~~rx~~**or**, radiation therapy.
Cardiac	25 – 30 kcal/kg	1.0 – 1.5 gm/kg	
Sepsis/critical care	25 – 30 kcal/kg Use obesity factors as applicable	1.2 – 1.5 gm/kg	Monitor glu levels; lipid levels if ventilated on propofol
Wound care	25 – 30 kcal/kg (adjusted levels as appropriate for obesity)	1.2 – 1.5 gm/kg	30 – 35 ml/kg Consider supplement with Vitamin C, zinc, Vitamin A if clinically deficient in these nutrients; evidence of clinical deficiency may be difficult to assess; thus,consider supplemental MVI with minerals.

27. Gottlischlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum.* Kendall/Hunt Publishing Company, Dubuque, IA, 2001.
28. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice.* Kendall/Hunt Publ Co, Dubuque, IA, 2002.
Manual of Clinical Dietetics, online edition. American Dietetic Association, Chicago, IL, 2000.

Tri-City Medical Center
Oceanside, California

Clean Copy

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **ADMISSION AND DISCHARGE CRITERIA FOR THE NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): **04/09, 06/11, 8/14, 12/15**

Department Approval:	**01/18**
Perinatal Collaborative Practice Approval:	**02/18**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**
1. To define the criteria for admission to and discharge from the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**
1. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.
   a. Consult and approval from on-duty Neonatologist is required prior to admission to NICU.
   b. Patients may be admitted as a direct admission from the community, after outside provider (Pediatrician) has consulted Neonatologist and received approval.
   c. Patients presenting to the Emergency Department (ED) without Pediatrician/Neonatologist consult must be triaged and Neonatologist consulted regarding admission.
2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge Registered Nurse (RN).
3. The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.
4. The attending physician shall be notified of patient arrival in the unit.
5. All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment by a Physician or Allied Health Professional (AHP) shall be completed within 30 minutes of admission and documented in the Electronic Medical Record (EMR) within 24 hours of admission.
   a. This admission assessment is done and documented on all NICU admissions.
6. Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. **ADMISSION CRITERIA:**
1. Inpatient admission criteria may include, but is not limited to the following:
   a. General:
      i. Patients with gestational age less than 36 weeks.
      ii. Patients with suspected or confirmed sepsis.
      iii. Patients less than 2000 grams.
      iv. Any patient requested by a referring physician.
      v. Patients with suspected seizure-like activity.
      vi. Patients requiring a medical subspecialist.

vii. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.
viii. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.
ix. Patients with suspected or confirmed necrotizing enterocolitis.

b. Respiratory system:
   i. Apnea requiring monitoring and observation
   ii. Respiratory instability (persistent tachypnea, grunting, cyanosis, etc.)

c. Cardiac system:
   i. Newly diagnosed or suspected arrhythmias.
   ii. Hemodynamic instability.
   iii. Suspected complex congenital heart defects.

d. Endocrine/Metabolic:
   i. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or inotropic support.
   ii. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.
   iii. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.
   iv. Acute Intraventricular Hemorrhage (IVH).
   v. Post-hemorrhahagic hydrocephalus
   vi. Twin-to-twin transfusion
   vii. Anemia of the newborn
   viii. Hyperbilirubinemia
   ix. Thrombocytopenia

2. Outpatient Admission Criteria: Neonates may be admitted from the community as either a direct admit, or via the Emergency Department (ED).
   a. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.
   b. The patient being admitted from the community must be screened for clinical symptoms and test negative for Respiratory Syncytial Virus (RSV) and influenza.
3. Procedure for Admission via ED:
   a. ED physician consults Neonatologist.
4. Procedure for direct admits from community/home:
   a. Pediatrician or AHP consults to Neonatologist.
   b. During admission consult, give Pediatrician/AHP the NICU fax number: 760-966-2240, and request appropriate documentation as available (prenatal, birth, postnatal, outpatient information, labs)
   c. Neonatologist assesses for infectious/contagious risk factors.
   d. If no risk factors, then to admit directly to NICU.
   e. Neonatologist/Secretary to obtain best parental contact number from Pediatrician/AHP.
   f. Either Secretary or Charge Nurse is to call parent to give instructions:
      i. Emphasize the importance of getting safely to TCMC as soon as possible for infant's admission.
      ii. Come straight to NICU for admission, do not stop in ED. Do not check into ED.
      iii. Obtain Translator services, if needed, to provide accurate instruction.
   g. It is preferred for the baby to come to the NICU first, and then a parent be sent down immediately to Registration.
   h. Unit Secretary or Charge RN to call registration to alert them that a parent is coming downstairs to register an infant who needs treatment ASAP.
   i. If 2 parents are present, one parent should go down to registration and one stay with the infant.

j. If baby was delivered at another hospital, have parent complete Medical Release Form and submit to the delivery facility's Medical Records Department.

D. **DISCHARGE CRITERIA:**

1. Transfer to other in-patient facility:
   a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
   b. The infant shall be referred to an attending Neonatologist.
   c. These babies may include, but are not limited to the following:
      i. Cardiac disease requiring surgical intervention and subspecialist follow up.
      ii. Patients requiring surgical intervention.
      iii. Neurologic disease needing subspecialist intervention and follow up.
2. To Home:
   a. Completion of discharge teaching.
   b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge, or per physician discretion.
   c. Ability to maintain temperature without artificial heat source.
   d. Stable nutritional status and weight ≥ 1800 grams.
   e. Stable medication regimen.
   f. Completed assessment of outpatient neurodevelopmental needs.
   g. Completed Car Seat Challenge as appropriate to policy and or Physician order.
   h. Completed Hearing screening and referrals as appropriate.
   i. Completed Newborn Metabolic Screening test.
   j. Confirmed outpatient physician follow-up.

E. **REFERENCE(S):**

1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.
2. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2017). Guidelines for Perinatal Care (8th ed.), 347-408.

Tri-City Medical Center
Oceanside, California

Tracked Change Copy

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **ADMISSION AND DISCHARGE CRITERIA FOR THE NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): **04/09, 06/11, 8/14, 12/15, 01/18**

Department Approval:	~~06/14~~**01/18**
Perinatal Collaborative Practice Approval:	~~08/15~~**02/18**
~~**Division of Neonatology Approval:**~~	~~**08/15**~~
Medical Executive Committee Approval:	~~10/15~~**02/18**
Professional Affairs Committee Approval:	~~11/15~~**03/18**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**

1. To define the criteria for admission **to** and discharge **from** ~~to~~ the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**

1. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.
   - **a. Consult and approval from on-duty Neonatologist is required prior to admission to NICU.**
   - **b. Patients may be admitted as a direct admission from the community, after outside provider (Pediatrician) has consulted Neonatologist and received approval.**
   - ~~1.~~**c. Patients presenting to the Emergency Department (ED) without Pediatrician/Neonatologist consult must be triaged and Neonatologist consulted regarding admission.**

2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge Registered Nurse (RN).

~~3. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.~~

~~4. The patient being admitted from the community must be screened for clinical symptoms of Respiratory Syncytial Virus (RSV) and influenza.~~

~~5.~~**3.** The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.

~~6.~~**4.** The attending physician shall be notified of patient **arrivale** in the unit.

~~7.~~**5.** All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment by a Physician or **Allied Health Professional (** ~~Nurse Practitioner~~**AHP)** shall be completed within 30 minutes of admission and documented **in the Electronic Medical Record (EMR)** within 24 hours of admission.
   - a. This admission assessment is done and documented on **all NICU** ~~patients admitted~~ **admissions.** ~~from any area of the hospital as well as transfers from other facilities.~~

~~8.~~**6.** Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. **ADMISSION CRITERIA:**

1. **Inpatient admission criteria may include, but is not limited to the following:**
   a. **General:**
      i. **Patients with gestational age less than 36 weeks.**
      ii. **Patients with suspected or confirmed sepsis.**
      iii. **Patients less than 2000 grams.**
      iv. **Any patient requested by a referring physician.**
      v. **Patients with suspected seizure-like activity.**
      vi. **Patients requiring a medical subspecialist.**
      vii. **Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.**
      ~~a.~~viii. **Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.**
      ix. **Patients with suspected or confirmed necrotizing enterocolitis.**
   b. Respiratory system:
      ~~9. Admission criteria may include but not limited to the following:~~
      i. Apnea requiring monitoring and observation
      ii. Respiratory instability (**persistent** tachypnea, grunting, cyanosis, etc.)
   ~~10.~~c. Cardiac system: ~~Patients with severe, life threatening or unstable cardiovascular disease. Conditions include but are not limited to:~~
      ~~a.~~i. Newly diagnosed or suspected arrhythmias.
      ~~b.~~ii. Hemodynamic instability.
      ~~c.~~iii. Suspected complex congenital heart defects.
   ~~11.~~d. Endocrine/Metabolic: ~~Patients with life threatening or unstable endocrine or metabolic disease or active life threatening bleeding. Conditions include but are not limited to:~~
      ~~a.~~i. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or ~~ionotropic~~ **inotropic** support.
      ~~b.~~ii. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.
      ~~c.~~iii. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.
      ~~d.~~iv. Acute Intraventricular Hemorrhage (IVH).
      ~~e.~~v. Post-hemorrhahagic hydrocephalus
      ~~f.~~vi. Twin-to-twin transfusion
      ~~g.~~vii. Anemia of the newborn
      ~~h.~~viii. Hyperbilirubinemia
      ix. Thrombocytopenia
2. **Outpatient Admission Criteria: Neonates may be admitted from the community as either a direct admit, or via the Emergency Department (ED).**
   a. **Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.**
   b. **The patient being admitted from the community must be screened for clinical symptoms and test negative for Respiratory Syncytial Virus (RSV) and influenza.**
3. **Procedure for Admission via ED:**
   a. **ED physician consults Neonatologist.**
4. **Procedure for direct admits from community/home:**
   a. **Pediatrician or AHP consults to Neonatologist.**
   b. **During admission consult, give Pediatrician/AHP the NICU fax number: 760-966-2240, and request appropriate documentation as available (prenatal, birth, postnatal, outpatient information, labs)**
   c. **Neonatologist assesses for infectious/contagious risk factors.**
   d. **If no risk factors, then to admit directly to NICU.**

e. **Neonatologist/Secretary to obtain best parental contact number from Pediatrician/AHP.**
f. **Either Secretary or Charge Nurse is to call parent to give instructions:**
   i. **Emphasize the importance of getting safely to TCMC as soon as possible for infant's admission.**
   ii. **Come straight to NICU for admission, do not stop in ED. Do not check into ED.**
   iii. **Obtain Translator services, if needed, to provide accurate instruction.**
g. **It is preferred for the baby to come to the NICU first, and then a parent be sent down immediately to Registration.**
h. **Unit Secretary or Charge RN to call registration to alert them that a parent is coming downstairs to register an infant who needs treatment ASAP.**
i. **If 2 parents are present, one parent should go down to registration and one stay with the infant.**
j. **If baby was delivered at another hospital, have parent complete Medical Release Form and submit to the delivery facility's Medical Records Department.**

~~12. Other:~~
~~a. Patients requiring a medical subspecialist.~~
~~b. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.~~
~~c. Patients less than 2000 grams.~~
~~d. Patients with gestational age less than 35 completed weeks (35 6/7).~~
~~e. Patients with suspected or confirmed sepsis.~~
~~f. Any patient requested by a referring physician.~~
~~g. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.~~
~~h. Patients with suspected or confirmed necrotizing enterocolitis.~~

~~C.~~D. DISCHARGE CRITERIA:

1. Transfer to other in-patient facility:
   a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
   b. The infant shall be referred to an attending Neonatologist.
   c. These babies may include, but are not limited to the following:
      i. Cardiac disease requiring surgical intervention and subspecialist follow up.
      ii. Patients requiring surgical intervention.
      iii. Neurologic disease needing subspecialist intervention and follow up.
2. To Home:
   a. Completion of discharge teaching.
   b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge, **or per physician discretion.** ~~:~~
      ~~The following infants will require home cardio respiratory monitoring:~~
      ~~i. SIDS sibling history.~~
   c. Ability to maintain temperature without artificial heat source.
   ~~c.~~**d.** Stable nutritional status **and weight ≥ 1800 grams.**
   ~~d. Ability to maintain temperature without artificial heart source~~
   e. Stable medication regimen.
   f. Completed assessment of outpatient neurodevelopmental needs.
   ~~f.~~**g. Completed Car Seat Challenge as appropriate to policy and or Physician order.**
   h. Completed Hearing screening **and referrals as appropriate.**
   ~~g.~~**i. Completed Newborn Metabolic Screening test.**
   ~~h.~~**j.** Confirmed outpatient physician follow-up.

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

1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.
2. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2017~~2~~). Guidelines for Perinatal Care (**8~~7~~th** ed.), ~~321-382~~**347-408**.

Tri-City Medical Center
Oceanside, California

WOMEN'S AND CHILDREN'S SERVICES MAN

DELETE – incorporated into Patient Care Services Policy: Special Order Durable Medical Equipment and Specialty Beds

SUBJECT: ORDERING OF DURABLE MEDICAL EQUIPMENT (DME)

ISSUE DATE: 09/06
REVISION DATE: 05/08, 04/09, 06/11, 08/12

Department Approval:	12/17
Perinatal Collaborative Practice Approval:	~~03/15~~02/18
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~04/15~~02/18
Professional Affairs Committee Approval:	03/18
Board of Directors Approval:	

~~A. **PURPOSE:**~~
~~1. To provide guidelines for case management in ordering durable medical equipment (DME).~~

~~B. **POLICY:**~~
~~1. It is the policy of Tri-City Medical Center to have a procedure in place for ordering DME for infants discharged from the NICU requiring additional home support for care.~~

~~C. **PROCEDURE:**~~
~~1. Requirements needed for the case manager to order equipment:~~
~~a. An order must be received from the NICU **physician**MD/DO, pediatrician or **Allied Health Professional (AHP)licensed independent practitioner (LIP).**~~
~~b. A documented reason for prescribing the equipment shall be included in the order.~~
~~c. Medical needs will be documented.~~
~~d. Oxycardiogram (OCG) test results (if performed) will be documented and infant's medical record signed. **The Certificate of Medical Necessity for Apnea Monitors form is completed for Medi-Cal patients.**~~
~~e. Facility where test was administered (if done) will be documented.~~
~~2. The case manager will arrange for the equipment to be delivered to the hospital unit prior to the infant's discharge.~~
~~3. A respiratory therapist from the DME agency will provide education on use of the monitor to the caregivers of the infant.~~
~~4. The pediatrician will follow the infant's progress.~~

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

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

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

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PATIENT ASSIGNMENT NICU**
Purpose:	To provide safe nursing care for all NICU patients based on patient needs and staff competency. To communicate and document patient assignments using consistent guidelines.
~~Supportive Data:~~	~~California Code of Regulations TITLE XXII, §70217. Joint Commission Comprehensive Accreditation Manual for Hospitals, Leadership Standards; LD.04.01.07, LD04.01.11,LD04.03.01,LD.01.03.07~~

A. **POLICY**

1. The Assistant Nurse Manager (ANM) or designee, who is a professional registered nurse, is responsible for patient care assignments at the beginning of each shift. A patient classification system is utilized. Nurse/patient ratios will be maintained to meet patient needs and Title XXII Regulations. ~~Staff floating from another unit or agency will have a TCMC NICU staff member assigned as a resource person for support.~~ The NICU Manager, ANMs or designee are responsible for monitoring appropriate patient assignments.
2. The NICU Nurse Manager has accountability for staffing and work schedules.

B. **PROCEDURE:**

1. The ANM or designee ~~utilizes~~ **determines** ~~the Cerner powerform for acuity tool to determine the number of nurses needed based on patient acuity as described in the Policy Patient classification in the NICU.~~ **the number of registered nurses for the NICU** ~~B~~based upon the information obtained **utilizing the Cerner acuity tool. This includes appropriate personnel to staff for the patient population. Reference Policy: Patient Classification in the NICU.** ~~the number of professional registered nurses are determined for the NICU including personnel with the necessary competencies for the patient population.~~
2. The ANM or designee develops the patient assignment utilizing the following criteria:
   a. The complexity of the patient's condition and the required nursing care.
   ~~b. The dynamics of the patient's status.~~
   ~~c.~~**b.** The knowledge and the skill of the nursing staff member to effectively assess and care for the patient.
   ~~d.~~**c.** The type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology.
   ~~e.~~**d.** The degree of supervision required by each nursing staff member based on his/her previous assessed level and current level of competence in relation to the nursing care needs of the patient.
   ~~f.~~**e.** Relevant infection control and safety issues.
   ~~g.~~**f.** The patient's geographical location within the NICU.
   ~~h.~~**g.** Continuity of care by reassigning staff to patients for whom they previously provided care**, including designated primary and associate nurses.**
   ~~i. Assigning patients to designated primary and associate nurses.~~
3. The assignment sheets include:
   a. Date and shift
   b. Location
   c. Manager
   d. ANM, or Designee
   e. Licensed personnel
   f. Unlicensed personnel used as support staff
   g. Preceptees/Oerientees
   h. Agency/Float personnel

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/14	06/14, 02/18	n/a	n/a	10/14, 03/18	09/10, 08/12, 11/14

4. Document the Following on the assignment sheet:
   a. Each patient assigned to an RN. The following positions may be utilized to assist the RN assigned to the patient and should be indicated on the assignment sheet:
      i. An RN with a partial assignment
      ii. Assignment/Break Nurse
      iii. Charge Nurse
      iv. ANM
      ~~v. NICU Manager~~
      ~~vi. Clinical Educator~~
      ~~vii. Clinical Nurse Specialist~~
   b. Indicate the name of the TCMC NICU nurse assigned as a resource nurse/**preceptor** ~~for float or agency nurses assigned to the unit for that shift.~~**as appropriate.**
   c. Document break/~~ and~~ meal times ~~and coverage,~~ and when necessary, in-service/meeting times on the break/meal log form **per current labor laws and TCMC policy. All employees working a shift of six hours or more will receive an unpaid meal period of 30 minutes.** ~~-~~Meal ~~breaks~~ **period breaks** are extended over enough hours to minimize the number of nurses out of the unit requiring coverage.
   d. Document the name of the RN providing relief.
   ~~d.~~**e.** Orientees are not utilized as direct care providers without supervision by ~~competent licensed~~ TCMC NICU **RN** staff.
   ~~e.~~**f.** Update the assignment sheet as patients are admitted or discharged, when a patient's acuity changes, and as personnel and/or assignments change.
   ~~f.~~**g.** The assignment sheets are archived by the TCMC NICU Nurse manager or designee. The archived sheets will be retained for the period of time as prescribed by the regulatory agencies.
5. Staffing for Periods of High Census
   a. The NICU will maintain a staffing strategy in order to accommodate staffing needs when census is high.
   b. The manager and designee (e.g. assistant nurse manager (ANM)/relief charge nurse) will make all attempts to use NICU core staff in an effort to provide consistency of care. Only nurses who are NRP certified can float to NICU. RNs that are floated to the NICU will only take care of CCS defined continuing care patients that do not require higher levels of care or competencies, (i.e., ventilator support, NCPAP, central lines or impending invasive procedures). Competencies of care will be documented for patient assignment.
   c. An RN who floats to NICU shall be assigned a resource nurse who may or may not be the ANM/relief charge nurse. On occasions when treatment modalities that the float RN does not feel competent performing arise unexpectedly, the resource nurse will perform the tasks for the float RN or the ANM/relief charge nurse will reassign the patient to ensure safe care.
   d. NICU will typically only take floats when there are appropriate acuity patients that can be assigned to them. Pre-booking through registry can be done during times that normally require a higher number of staff.
   e. Travelers are required to have the same competencies as the core staff in NICU. Attending high-risk deliveries is optional, especially for those who are only committed for a short time. Travelers may be given the opportunity to orient to high-risk deliveries, if requested.

C. **REFERENCE(S):**
1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
2. California Children's Service Manual of Procedures, Section 3.25.2.A2C

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PATIENT CLASSIFICATION (ACUITY) IN THE NICU**
Purpose:	The purpose of the Patient Classification System and tools is to determine the nursing care needs of the individual NICU patients that reflect the assessment by the professional registered nurse The framework for the Patient Classification system is the AACN Synergy Model for Patient Care that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies.
~~Supportive Data:~~	~~California Code of Regulations TITLE XXII, Section 70053.2~~ ~~Joint Commission Comprehensive Accreditation Manual for Hospitals, Leadership Standards~~

A. **CARE PROVISION:**

1. Synergy Model for Patient Care: The **Tri-City Healthcare District** (TC~~MC~~HD) model for nursing care that links clinical practice with patient outcomes:
2. Levels of Care: Categories that define the intensity of care requirements for individual patients based on the profession registered nurse's assessment. The levels of care follow a decreasing level of intensity:
   - a. Level 10 -1 RN to 1 patient
     - i. Care Intensity 1:1 — High ADL Needs
     - ii. Care Intensity 1:1 — Moderate ADL Needs
     - iii. Care Intensity 1:1 — Minimum ADL Needs
   - b. Level 9 - 1 RN to 2 patients
     - i. Care Intensity :High Care Needs — High ADL Needs
   - c. Level 8 -1 RN to 2 patients
     - i. Care Intensity High Care Needs — Moderate ADL Needs
   - d. Level 7 -1 RN to 2 patients
     - i. Care Intensity High Care Needs — Minimum ADL needs
   - e. Level 6 – 1 RN to 3 patients
     - i. Care Intensity Moderate Care Needs — High ADL needs
   - f. Level 5-1 RN to 3 patients
     - i. Care Intensity Moderate Care Needs — Moderate ADL needs
   - g. Level 4– 1 RN to 3 patients
     - i. Care Intensity Moderate Care Needs — Minimum ADL needs
   - h. Level 3– 1 RN to 3 patients
     - i. Care Intensity Minimum Care Needs — High ADL needs
   - i. Level 2– 1 RN to 3 patients
     - i. Care Intensity Minimum Care Needs — Moderate ADL needs
   - j. Level 1– 1 RN to 3 patients
     - i. Care Intensity Minimum Care Needs — High ADL needs
   - k. Please see Appendix A and B for additional information concerning Levels of care

B. **RESPONSIBILITIES:**

1. The NICU Manager, Assistant nurse managers (ANMs) or designees are responsible to ensure that the professional registered nurse complete the Patient Classification for their patient(s) each shift.
2. The NICU Manager and/or the ANMs will ensure that the Patient Classification system for the NICU is utilized accurately.
3. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform.

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/14	03/14, 02/18	n/a	n/a	10/14, 03/18	11/14

C. **PROCEDURE:**

1. The professional registered nurse determines each patient's care intensity and activity of daily living (ADLs) indicators based on the RN knowledge of the patient status, the plan of care for the patient and the nursing assessment.
   a. The Care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels
   b. The ADL indicator is defined by minimal, moderate and high
   c. Each care intensity and ADL indicator is specific to the NICU and has a weight associated to it that assists in determining the acuity of the patient.
2. A task will be triggered each shift to the professional registered nurse for each patient assigned. It is the responsibility of the professional registered nurse to complete the acuity of their assigned patients.
3. The ANM or designee is responsible to verify that the Acuity Powerform is completed for each patient each shift.
4. The ANM or designee will complete the Staffing Calculator by 1500 and 0300 which reflects the acuity of the patient(s) as completed by the professional registered nurse(s) and the minimum number of staff required based on acuity and minimum staffing ratios
5. This information is submitted electronically to Staffing Resource Center if completed by the time previously specified.
   a. If the information is late in being completed the ANM or their designee is responsible for faxing a copy of their daily summary reports to the Staffing Resource Center as soon as possible.
6. The Manager, ANM or designee reviews the required staffing based on the Patient Classification tool and the actual staffing used.
7. Trends and patterns are analyzed by the NICU Manager. Problems related to balancing ratios will be brought to the Director and CNE attention. Information will be used to plan future staffing needs.

D. **INTER-RATER RELIABILITY PROCESS:**

1. Inter-rater reliability is defined as the degree to which two observers, operating separately and independently, assign the same care level rating to the patient
2. The purpose of this process is to ensure consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) powerform.
3. Each shift a task will be triggered by Cerner to the ANM or designee to complete an Acuity Validation on patients in the NICU.
   a. The task is set to randomly pick 2 NICU patients
4. The information is monitored on a monthly basis and reported as appropriate
5. The NICU manager is responsible for ensuring completion of the validation tasks.

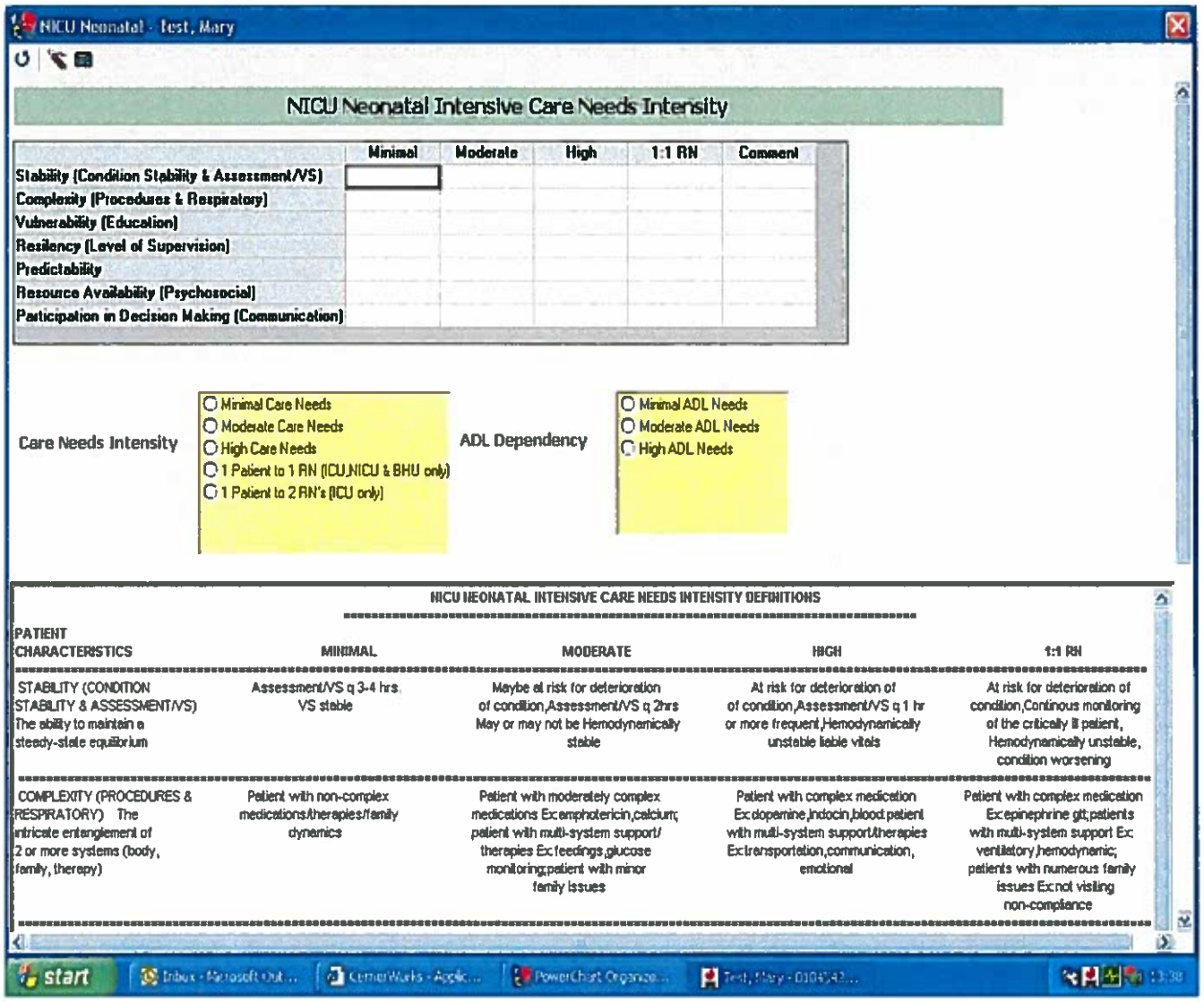
E. **ATTACHMENT(S):**

1. NICU Neonatal Intensive Care Needs Intensity
2. Care Needs

F. **REFERENCE(S):**

1. Hardin, S.R., & Kaplow, R., (2005). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Jones and Bartlett. Sudbury, Ma.

NICU Neonatal Intensive Care Needs Intensity



Care Needs

CARE NEEDS	ADL	ACUITY	CHARGE CODE
Minimum	Minimum	1	NICU 3 Level 1
Minimum	Moderate	2	NICU 3 Level 1
Minimum	High	3	NICU 3 Level 1
Moderate	Minimum	4	NICU 5 Level 1
Moderate	Moderate	5	NICU 5 Level 1
Moderate	High	6	NICU 7 Level 1
High	Minimum	7	NICU 7 Level 1
High	Moderate	8	NICU 9 Level 2
High	High	9	NICU 9 Level 2
1:1	Minimum	10	NICU 10 Level 3
1:1	Moderate	10	NICU 10 Level 3
1:1	High	10	NICU 10 Level 3

Tri-City Health Care District
Oceanside, California

DELETE: Follow Hospital Policies

OUTPATIENT INFUSION CENTER ~~– OCEANSIDE POLICY MANUAL~~

ISSUE DATE: 032/13

SUBJECT: INFECTION PREVENTION AND CONTROL ACTIVITES

REVISION DATE:

Department Approval:	06/16
~~MEDICAL/DEPARTMENT:~~	~~3/13~~
~~DIRECTOR APPROVAL:~~	~~3/13~~
Division of Oncology Approval:	03/17
Infection Control Committee Approval:	10/17
Pharmacy and Therapeutics Approval:	01/18
Medical Executive Committee Approval:	02/18
Professional Affairs Committee Approval:	03/18
Board of Directors Approval4:	03/13

~~A. PURPOSE:~~

~~1. A multidisciplinary team performs infusion related procedures. The department uses therapeutic medication and blood products. Percutaneous or vascular route of administration is the prior mode of therapy.~~

~~a. Aseptic Techniques~~

~~i. Wipe work surfaces with hospital approved disinfectant before setting up.~~

~~ii. If a sterile field needed, it is prepared as close to the time of use as possible.~~

~~b. Sharps~~

~~i. Sharps safety devices are used whenever possible.~~

~~ii. Contaminated sharps are disposed of in a puncture resistant container as soon as possible.~~

~~iii. If a puncture resistant container is not immediately accessible, there is a designated place on the field for temporary holding until the case has been completed.~~

~~c. Injection Safety~~

~~i. Are prepared for one patient only, any remaining contents are discarded. Vials of medication used are discarded immediately following the procedure.~~

~~ii. Use aseptic technique to avoid contamination of sterile injection equipment.~~

~~iii. Do not administer medications from a syringe to multiple patients even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.~~

~~iv. Use fluid infusion and administration sets, (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.~~

~~v. Use single dose vials for parenteral medications whenever possible.~~

~~vi. If multi dose vials must be used, both the needles or cannula and syringe used to access the multi dose vial must be sterile.~~

~~vii. Do not keep multi dose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.~~

~~viii. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.~~

ix. Infection control practices for special lumbar puncture procedures wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia.

x. Do not bend, recap, or break used syringe needles before discarding them into a sharps container

d. After the Procedure

i. Only items dripping with blood are discarded in red bio hazardous waste.

ii. Blood product containers should be disposed in red bio hazardous waste.

e. Cleaning

i. The procedure room is terminally cleaned between patients (see Environmental Services policy and procedure manual).

ii. Staff immediately cleans up spills of blood and/or body fluids with hospital-approved disinfectant.

f. Transmission Based Isolation Precautions

i. If a patient has a multi-drug resistant organism such as MRSA or VRE, any room surfaces they may have touched will be cleaned with a hospital approved disinfectant prior to the next patient.

ii. Patients on airborne or droplet isolation precautions will wear a surgical mask. In accordance with OSHA regulations, employees will use N95 respirators and a portable HEPA unit for patient with known or suspected aerosol transmissible diseases. These cases should be scheduled at the end of the day when possible.

g. Perform Hand Hygiene and Wear Clean Gloves Before Handling Tubing

i. Urinary catheters: do not elevate the urine bags above the bladder in order to reduce the incidence of reflux back into the bladder.

ii. Intravenous therapy: take care not to dislodge or contaminate IV sites and lines.

h. Linen Handling

i. Handle contaminated textiles and fabrics with minimum agitation to avoid contamination of air, surfaces, and persons.

ii. Bag or otherwise contain contaminated textiles and fabrics at the point of use.

iii. Use leak-resistance containment for textiles and fabrics contaminated with blood or body substances.

B. **REFERENCES:**

1. APIC Text of Infection Control and Epidemiology. Wash. DC, 2009.**Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection Control and Epidemiology, Inc.**

2. Sehulster LM, chin RYW, Arduino MJJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.

3.1. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf.

Tri-City Medical Center	~~Pharmacy Manual~~**Patient Care Services**
PROCEDURE:	**AUTOMATED DISPENSING MACHINE**
Purpose:	To define the operation of the Automated Dispensing Machine (ADM), roles of the personnel authorized to access the ADM, resolution of discrepancies and analysis of the medication usage through the ADM.
Issue Date:	06/00

A. **PROCEDURE:**

1. System Access:
   a. Nurse Directors or their designees, and Credentialing Staff from the Medical Staff Office are authorized to submit a Pyxis System Access Request form to request access to the **Automated Dispensing Machine** (ADM). The pharmacists, Medstation System Specialist, Pharmacy Technician Supervisor, and Controlled Substance Technician have the privileges to enter a permanent user into the ADM (See Pyxis System Access Request Form).
   b. The User **identification** (ID) will be the first three **(3)** letters of the last name followed by the first three **(3)** letters of the first name (e.g. Mary Smith SMIMAR). If that user name is taken, a single numeric digit will be added starting with one (1).
   c. First time users will be prompted to change their password the first time they sign onto the system. Passwords must be five **(5) to** ~~–~~eight **(8)** characters long (may be alpha or numeric or alpha-numeric). After selecting a permanent password, the user will register a fingerprint for the "Bio ID" Pyxis function. Thereafter, the user will log onto the Pyxis Medstation with the User ID and fingerprint. All users are set up for Bio ID which is the preference, but may be switched to password ID if problem arises with Bio ID.
   d. Users who forget their passwords will need to report to the pharmacy in person with their hospital ID badge.
   e. ADM privileges, areas of the hospital, security groups, override capabilities and console privileges are defined by the ~~users~~**user's** job title.
   f. Access to ADMs will be assigned by work areas. These will be:
      i. Nurses who float outside their normal areas shall have their permanent password activated at the new ADM by the **Assistant Nurse Manager** (AN~~U~~M) **or Relief Charge Nurse**, Administrative **Supervisor**~~Coordinator~~ **(AS)**~~, charge nurse~~ or pharmacist.
      ii. Traveler nurses will be granted a permanent password with locations and a **thirteen** (13) week expiration date, unless their term date is less than **thirteen** (13) weeks.
      iii. Registry nurses will be assigned a permanent password with no ADM locations. They will be activated at the station each time they work. The temporary activation remains in effect for **fourteen** (14) hours.
   g. Human Resources will notify the Pharmacy Manager, Medstation System Specialist, and Controlled Substance Technician via email when a nurse has separated from the hospital.
   h. Medical Staff Office will notify via email to the Pharmacy Manager when a physician is separating from the hospital.
   i. The Medstation System Specialist is the primary person responsible for deleting users from the system. The Pharmacy Manager and Controlled Substance Technician serve as an alternate in the event the Medstation System Specialist is not available.
   j. In addition to the Human Resources notifications, ADM users are routinely reviewed to ensure only current ~~TCMC~~**Tri-City Healthcare District (TCHD)** employees, Anesthesiologists, Nurse Travelers, Nurse Instructors, and Registry Staff have privileges to access to the system. This is done monthly by comparing the ADM user list against a

Department Review/~~Revisio~~ n	Clinical Policies & Procedure	Nurse Executive Committee	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Administration	Board of Directors
10/02, 11/03, 07/06, 05/15, 12/17	01/18	01/18	07/05, 07/06, 07/09, 01/12, 05/15, 01/18	07/05, 07/06, 07/09, 01/12, 07/15, 02/18	03/18	08/15	07/05, 07/06, 07/09, 01/12

current list of TC~~MC~~**HD** active employees, Traveler, Anesthesiologist, and nurse instructors.

k. Nursing personnel shall notify the Pharmacy Department when a unit which contains an ADM is closing. Once notification is received, the ADM shall be de-activated. De-activation of the ADM will prevent utilization of the system. When the unit is reopening, nursing personnel shall notify the Pharmacy and the ADM shall be reactivated.

2. Medication Access:
   a. Removal of medications from the ADM:
      i. Sign onto the ADM, go to the "Patient Care" section of the main menu.
      ii. Select "Remove" button.
      iii. Select a patient. Scroll using arrows on the side of the screen or type in the first three **(3)** letters of the patient's last name.
      iv. Using the patient's **medication administration record** (MAR) as the reference, search for the medication by type in the first three **(3)** letters of the drug name. If the medication is "gray", it means the pharmacist has reviewed the order but the medication is not loaded or is out of stock in the ADM.
      v. Select the quantity to be removed. This must be accurate for billing and inventory purposes.
      vi. If more than one **(1)** med is to be removed for this patient press 'Select Next Med' and repeat the process.
      vii. Press the 'Remove Now' button.
      viii. Verify beginning med count if prompted.
      ix. All ADM stored controlled substances have the 'Blind Count' option activated that required the user to enter the correct beginning count of a medication before removal. The system does not display the expected beginning count. The user is given two **(2)** attempts to enter the correct beginning count. If an incorrect quantity is entered on the first try, a second attempt is permitted and a warning banner is displayed that informs the user that a discrepancy is about to be created. If an incorrect quantity is entered on the second attempt, a discrepancy is created as the transaction is completed, and a discrepancy slip is printed for incorrect quantity as well as for the removal.
      x. For controlled substances, there is an option of wasting part of the dose upon removal (see waste section)
      xi. Remove the med from the correct pocket.
      xii. Conclude the removal process by verifying the patient name, medication and remove quantity on this final screen against the MAR, then shut the drawer.
      xiii. Press the 'Exit' button to log off the system.
   b. Clinical Data Screens:
      i. Clinical Data Screens appear between the select quantity screen and the opening of the drawer. These are intended to alert the practitioner about some aspect of the medication (e.g. Coumadin has significant drug-nutrient interactions which requires patient/family education). The practitioner **may be**~~is~~ required to select a response and press the 'Accept' button before the drawer will open.
   c. Patients:
      i. When the patient has not been officially admitted or transferred to the nursing unit by the hospital **admission, discharge, and transfer** (ADT) system, (s)he will not appear in the ADM. (e.g. when Affinity is down). Patients added at the ADM without the billing number will not have a Pyxis Profile available. To add a patient:
         1) From the list of patients press the 'Add Patient' button.
         2) Type in the patient's last name, first name and patient ID if known. If the patient's name is not known, type in 'Doe' for the last name and 'Jane or John' for the first name. If the patient ID is unknown, leave blank.

3) The patient added at the MedStation will show for 24 hours. Once the ADT information comes across to Pyxis, that patient will show up twice in the ADM. Only the patient entry from the ADT system (usually the one with the proper account number) will have the profile of medications. The patient manually entered at the ADM will not have a medication profile.
4) Billing for patients manually entered at the ADM will be done by the pharmacy.
5) Press the 'Exit' button to log off the system.
~~6) Menu timeout for ADMs on nursing stations are set at 60 seconds.~~

d. Wastage:
i. Wastage can be done at the time of removal or after the removal transaction. **If a witness is required, T**~~t~~he person witnessing the wastage shall confirm the correct medication and amount wasted in addition to documenting the transaction in the **ADM**~~Pyxis~~ system.
ii. **See Tri-City Medical Center (TCMC) Waste Disposal Guidelines for appropriate disposal of medication that is being wasted including controlled substances.**
iii. To waste at time of removal
1) After the quantity is selected, press the 'Remove Now' button.
2) The next screen that appears will ask if ~~you plan to administer~~ a full dose **will be administered.** If yes, the drawer opens and you proceed to remove the medication. If no, the system will identify the medications that require a witness for waste, press 'Accept'.
3) Another licensed person will be required to enter their user ID and password to document as a witness.
a) Approved licensed health care professional
i) Anesthesiologist
ii) Registered Nurse
iii) Licensed Vocational Nurse
iv) Respiratory Care Practitioner
v) Radiology Technician
vi) Pharmacist
~~3)~~**vii) Pharmacy Technician**
4) Enter the amount to be given and the amount wasted is automatically calculated.
5) Press the 'Accept' button.
6) Press the 'Exit' button to log off the system.
iv. To waste after removing:
1) From the main menu select 'Waste'.
2) Select the patient by typing in the first three **(3)** letters of the patient's last name. **A list of medications removed in the past 24 hours will appear.**
~~3)~~**a)** If the patient you want is not listed, select 'Add Patient' and manually enter the patient (see adding patients at the station).
3) Select the medi**cation** to be wasted from the list.
a) If the medication does not appear on the list, select 'All Meds'.
i) Use for wasting controlled substances that were not removed from same Pyxis
~~4)~~**b)** For multiple wastes, press 'Select Next Med', ~~You may~~ make multiple selections **if needed.**
~~5)~~**4)** Once all medications have been selected, press 'Waste Now'.
~~6)~~**5)** The system will identify the medications~~,~~ that require a witness for waste, press 'Accept'.

a) **When ~~T~~**the witness screen **appears~~comes next.~~ then ~~H~~have the** witness enter their User ID and Password.

~~7)~~**b)** **Upon completion of documentation, both staff signing for waste must properly dispose of excess medication based on the current TCMC Waste Disposal Guidelines.**

c) **When wasting PCAs, drips or epidurals the waste amount will be in milliliters**

d) **Narcotic PCA syringes will be wasted using the same procedure as above.**

e) **Morphine drips will be wasted using the Narcotic Drip entry.**

~~8)~~**f)** **To waste a fentanyl patch, estimate the amount used and document in Pyxis then fold the patch so that the adhesive side adheres to itself, then discard in the appropriate container per TCMC Waste Disposal Guidelines.**

~~9)~~**6)** Enter the amount given;~~,~~ the system will calculate the waste. If the entire dose is wasted and the patient needs to be credited, press the 'Credit Patient' button.

~~10)~~**7)** Press the 'Accept' button.

~~a) Special Note: Narcotic PCA syringes will be wasted using the same procedure as above. Morphine drips will be wasted using the Narcotic Drip entry. To waste a fentanyl patch, estimate the amount used and document in Pyxis then fold the patch so that the adhesive side adheres to itself, then discard in the appropriate container.~~

a) Press the 'Exit' button to log off the system.

e. Returns:
   i. From the Main Menu, select the 'Return' button.
   ii. Select the patient. Scroll using arrows on the side of the screen or type in the first three **(3)** letters of the patient's last name.
   iii. Select 'Remove Meds' to view previously removed meds or select 'All Meds' to view a complete list of meds.
   iv. Search for the medication using the first three **(3)** letters of the drug name and select.
   v. Verify or enter the number of meds returning.
   vi. Select 'Return Now' or for multiple returns select 'Select Next Med'.
   vii. Press the 'Exit' button to log off the system.
   viii. Medication removed from the ADM~~,~~ not administered~~,~~ and still intact, shall be returned to the ADM 'Return Bin' with the exception of refrigerated and some designated controlled substance medication. If the medication is a controlled substance and is too large to fit in the return bin slot, it must be wasted through Pyxis and the patient credited by touching the 'credit' button or **by** contacting the pharmacy for immediate pick up. For non-controlled medications that are too large, place into the 'Return to Pharmacy' bin.

f. Override Process:
   i. When overriding a medication which has not been reviewed by the pharmacist, the nurse is responsible for screening allergies, appropriate dose/route/frequency and all other relevant clinical criteria.
   ii. The ADM utilizes an override feature whereby a nurse may obtain a newly ordered medication not yet entered into the system by the Pharmacy.
   iii. The Pharmacy Department will manage the list of medications that may be overridden in the ADM based on their use in emergent/urgent situations. Not all medications are eligible for override.
   iv. Medications shall be removed through override access only if the indication is deemed by the healthcare provider to be urgent or emergent. All healthcare

providers that use the override function are expected to use professional judgment to determine appropriateness.

1) Urgent Indications: include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.
2) Emergent Indications: include situations in which life, limb or eyesight is threatened.
3) In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.

v. To access a medication through the override function:
   1) At the ADM Profile Screen, press the override button at the bottom of the screen.
   2) Type in the first three **(3)** letters of the medication.
   3) Select the medication.
   4) Proceed as instructed above to remove the medication.

vi. If the medication does not appear on the Pyxis override screens, the nurse does not have access to the medication and must call the pharmacist or Administrative Supervisor.

vii. An override report is generated on a daily basis and includes the patient name, drug, strength, amount taken, date/time and name of the nurse withdrawing the medication. A pharmacist reviews this report and reconciles override medications with physician orders. Any overrides without orders will be brought to the attention of ~~the Medication Safety Officer and~~a Nurse Manager for follow up. **Should the pharmacist require assistance in following up on any overrides without orders, they may contact the ~~Medication Safety Officer~~Pharmacy Director or Clinical Manager.**

viii. Critical Override gives the nurse the ability to override for any medication currently located in the ADM. This function will be turned on at each station during emergencies such as network failure.

g. Controlled Drug Discrepancy:

i. Nursing is responsible for reconciling all ADM discrepancies prior to the end of a shift per the Patient Care Services Policy: Controlled Substance Management. Pharmacy staff can be utilized to run reports and assist with resolution.

ii. If the discrepancy was caused my pharmacy personnel, then Pharmacy is responsible for resolving the discrepancy.

iii. The pharmacy monitors for open discrepancies that have been unresolved for greater than 24 hours. The Controlled Substance Technician will contact the Nurse Manager or Charge Nurse to make them aware of the need to resolve the discrepancy immediately. If no action is taken, the matter will be escalated to the Medication Safety Officer.

iv. Documented Discrepancies are reviewed daily to ensure all documented discrepancies have been resolved accurately and confirm no controlled substances are unaccounted for.

v. If during the course of a discrepancy investigation controlled substances are unaccounted for, further appropriate action shall be taken. This could include an audit of individuals and reporting to appropriate agencies.

vi. Nurses shall perform a physical inventory of all controlled substances as stated in Patient Care Services Policy: Controlled Substance Management.

3. ADM Inventory and Formulary:

a. The Pyxis Console automatically prints refill lists, stock outs and new loads for each MedStation.

b. Pharmacy technicians **will** refill and load the ADMs with stock from the main pharmacy inventory.

c. Medications that need to be refilled or have stocked out, shall be verified and initialed by two (2) technicians or technician and a pharmacist prior to leaving the pharmacy.

d. New loads will be verified and initialed by a technician and pharmacist prior to leaving the pharmacy.
e. Licensed pharmacy personnel will load or refill the medication(s) in the correct pocket(s) of the appropriate ADM.
f. The Medstation System Specialist in conjunction with a pharmacist will review the usage of medications for each ADM ~~twice a year~~**on an ongoing basis** and adjust minimum/maximum levels, establish new standard stock medications if indicated, ~~an~~**and** remove medications that have not been used recently and are not standard stock.
g. When medication stock outs occur, the pharmacy technician is encouraged to look at the present minimum and maximum levels and adjust if needed, using the following table as a guideline:
   i. Inventory Max and Min Levels (10 day usable inventory with a max/min ratio of 50%)

Max Level	**Min Level**
100	50
80	40
60	30
50	25
40	20
30	15
20	10
10	5
Patches	
6 (every day)	3
3 (every week)	1

h. Pharmacy personnel are responsible for utilizing the outdated med tracking function any time a medication is placed in the ADM.
i. An Outdated Inventory Report is run daily and pharmacy technicians shall utilize this report to remove all medications that are expiring in the near future.

4. Narcotic Vault (C-II Safe):
   a. All controlled substances (C-II through C-V) will be managed through the C-II Safe. Controlled substances which require refrigeration shall be placed in locked containers within a refrigerator. All other controlled substances shall be secured in the C-II Safe.
   b. Only Pharmacy personnel will have access to the C-II Safe.
   c. Controlled substances received from the drug wholesaler will be received into the C-II Safe by the Pharmacy Technician Supervisor or designee.
   d. All CII Safe receive reports are compared against the invoice by the Pharmacy Buyer.
   e. All controlled substances sent to a nursing floor will be placed in the ADM. Controlled substances removed from the Nursing Unit ADMs will be immediately returned into the C-II safe.
   f. All controlled substances used for compounding in the **intravenous** (IV) room will be managed through the C-II Safe.
   g. An inventory of the CII Safe shall be done monthly by the Controlled Substance Technician and a witness which may be any pharmacy personnel.
   h. Expired controlled substances that are awaiting pick up from a reverse distributor shall be placed in the expired/waste bin of the CII Safe and kept segregated from the rest of the inventory.

5. Downtime Procedures:
   a. All ADMs, the C-II Safe and the Pyxis Console will be plugged into red emergency plugs. Nursing shall contact the Pharmacy when an ADM is not functional.
   b. When facing the back of the MedStation:
      i. Key PL985 will unlock the left side and the refrigerator units.
      ii. Key PL981 will unlock the right side.

iii. ~~and~~ Key 6234 will unlock the computer lid.
iv. There is one set of back panel keys in the C-II Safe at all times which can be accessed by pharmacy personnel.
~~b.~~v. If the hospital emergency power is not functioning the pharmacy has enough back panel keys for every Pyxis MedStation. These extra keys along with the keys to unlock the doors to the C-II Safe will be kept in the Director of Pharmacy's office. The Director of Pharmacy or Pharmacy Technician Supervisor will need to be called to access these keys.

c. All medications removed from the ADM will be accounted for in the patient's chart as soon as chart is accessible.
d. Two **(2)** licensed personnel will perform controlled substance counts upon initiation of the ADM downtime procedure and at the end of each shift. The initial controlled substance count and all subsequent controlled substance activities will be recorded on a 'Daily Audit and Disposition for Controlled Drugs' Form ~~(see Attachment II)~~. Discrepancies will be resolved before any staff members are allowed to leave the unit.
e. Once the MedStation becomes functional, pharmacy personnel will update the inventory counts and capture charges. Two **(2)** nurses will inventory all controlled substances, reconcile against the 'Daily Audit and Disposition for Controlled Drugs' Form and resolve any discrepancies.
f. When interface communication is lost between the Pharmacy Computer System and ADM or the ADM console and the ADM, all new orders, changes in orders, admits, transfers and discharges will not be updated. If this condition lasts for more than **three (3)** hours, the ADM will be set to Critical Override so the licensed personnel can override any medication available in the ADM.

6. Reports:
   a. Override Reports are run daily.
   b. All C-II Safe Events - ~~Run~~**Ran** daily and kept on file for **three (3)** years. Fulfills Board of Pharmacy requirements.
   c. Charges and Credits- Run daily, billing is processed by the Medstation System Specialist for patients manually entered at the ADM. These billing adjustments are made directly into the hospital host computer system.
   d. Documented Discrepancy Report- Run daily
   e. C-II Safe vs. Pyxis MedStation Compare- Run throughout the day by staff accessing the CII Safe and reviewed by the Controlled Substance Technician.
   f. C-II Safe Activity Log- Run daily and reviewed by the Controlled Substance Technician for unusual occurrences. This report is kept on file for **three (3)** years.
   g. C-II Safe Open Discrepancy- Run daily (**Monday -through Friday**) and reconciled by the Controlled Substance Technician.
   h. Suggested Reorder Report- Run every Monday and Thursday by Pharmacy Buyer or designee.
7. Data Archival:
   a. A redundant copy of all information is automatically stored on a hard drive within the C-II Safe.

B. **FORM(S):**
1. Pyxis System Access Request Form
~~1.~~2. Daily Audit and Disposition for Controlled Drugs Form

C. **RELATED DOCUMENT(S):**
1. Patient Care Services (PCS) Policy Controlled Substance Management
~~1.~~2. Waste Disposal Guidelines

Pyxis System Access Request Form

PYXIS

PYXIS SYSTEM ACCESS REQUEST FORM
(To be completed by Unit Manager, Director, Administrative Coordinator)

USER IN FORMATION:

_____, _____ _____
Last Name First Name MI

Job Code: _____ (RN, LVN, Anesthesiologist, RT, Nurse Instructor, OR Tech, Radiology Tech, Psych Tech, Pharmacist, Pharmacy Tech)

Work Area(s): _____

SYSTEMS:

If only Supply Station send form to MDC, if Med and/or Supply send form to the Pharmacy Pyxis Specialist.

- ☐ Supply Station
- ☐ Med Station

PRIVILEGES: *Med and override privileges based on user category and work area.

- ☐ AUM, Shift Supervisor- Station login, witness ability, report access, activate/create temp users, credit patients, add temporary patients, independent refill.
- ☐ Staff RN, LVN- Station login, witness ability, report access, credit patients, add temporary patients.
- ☐ Temp/Traveler- RN privileges with 13-week expiration.
- ☐ Other- RT, Anesthesiologist, Radiology tech, Psych Tech, Pharmacist, Pharmacy Tech.
- ☐ Registry RN- Station Login, witness ability, report access, credit patients, add temporary patients.

_____ _____ _____
Approval: Signature Print Name Date

Pharmacy/Supply Use Only:

User ID: _____

Initial Password (Med Station only): _____

TCMC Waste Disposal Guidelines

						 
Regular Waste NO NEEDLES	**Biohazardous Waste** NO NEEDLES	**Sharps** NEEDLES OK	**Pharmaceuticals** NEEDLES OK	**Controlled Substances** NO NEEDLES	**RCRA Pharmaceuticals** NO NEEDLES	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM When in doubt, use red bag.	▫ **All sharps** ***Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples*** ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants ***Examples: Advair, Foradil*** **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** ***Examples:*** ▫ ***Insulin/Insulin Pen (needles removed)*** ▫ ***Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort*** ▫ ***Warfarin /Coumadin*** ▫ ***Used & Unused nicotine gum or patches, (include empty wrappers)*** ▫ ***Silver sulfadiazine cream*** ▫ ***Silver nitrate applicators (unused)*** ▫ ***Selenium sulfide shampoo*** ▫ ***Multiple trace elements*** ▫ ***Unused& residual alcohol/acetone/acetic acid*** **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication ***Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.*** **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p2s/documents/Q4%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf, County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/FAQs/12April24FAQ11_Art9.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 04/73 **SUBJECT:** Licensure and Professional Standards

REVISION DATE(S): 06/05, 07/06, 07/09, 01/12, 07/15

Department Approval:	~~05/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 05/15~~01/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 06/15~~02/18
Professional Affairs Committee Approval:	~~07/15~~03/18
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **POLICY**:

1. The Pharmacy Department will operate within all applicable state and federal laws, regulations and licensure requirements. In matters of professional judgment or practice standards, recommendations from the American Society of Health-System Pharmacists (ASHP) and The Joint Commission will be given first consideration and priority.
2. State of California: (Example)
   a. Pharmacy Department services will be provided according to the regulations of the Department of Health Services as stated in Title 22 for licensed acute care hospitals. These requirements will be integrated into policies and procedures where necessary.
      i. Pharmaceutical Services Definition (section 70261)
      ii. Pharmaceutical Services General Requirements (section 70263)
      iii. Pharmaceutical Services Staff (section 70265)
      iv. Pharmaceutical Services Equipment and Supplies (section 70267)
      v. Pharmaceutical Services Space (section 70269)
   b. All laws, regulations and licensure requirements of the California State Board of Pharmacy will be met and followed.
      i. The hospital's Pharmacy Department will have at all times a valid and current pharmacy permit issued by the board which will be posted in public view.
      ii. All Pharmacists, Pharmacist Interns and Pharmacy Technicians must maintain valid and current licensure with the board according to law and hospital policy. ~~A photocopy of license verification will be kept in the HR personnel file.~~
      iii. All Pharmacists, Intern Pharmacists, and Pharmacy Technicians shall renew licensure per Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430.
      iv. A current copy of State Pharmacy Law with Rules and Regulations is available on the California Board of Pharmacy website.
3. Federal:
   a. The hospital will comply with all laws, regulations and requirements of the Drug Enforcement Administration (DEA).
      i. The hospital will maintain current and valid registration with DEA. The registration certificate will be posted in public view in the Pharmacy.
      ii. All required records will be maintained by the Pharmacy Department, including order forms (DEA-222), disposal (DEA-41), loss (DEA-106) and the biannual inventory.
      iii. In accordance with DEA regulations, all schedules II, III, IV and V (CII, CIII, CIV & V) drugs will be stored separately in a locked cabinet in the main Pharmacy,

automated drug dispensing machines on the patient care units or double-lock storage cabinets in ancillary areas. Access is restricted to licensed personnel.~~.~~

b. The Pharmacy Department will comply with the Conditions of Participation for Medicare of the Centers of Medicare and Medicaid Services.

4. Practice Standards:
   a. Dispensing: A Pharmacist will review each medication prior to dispensing. Exceptions to this can be found in the Pharmacy **Policy:** Technician Checking Technician Program. ~~Policy~~
   b. Staffing Guidelines: The ratio of Pharmacy Technicians to Pharmacists will not exceed **two to one** (2:1), except that this ratio shall not apply to personnel performing clerical functions pursuant to California Code of Regulations and the ratio of Intern Pharmacists to Pharmacists will not exceed **two to one** (2:1) at any time.

B. **RELATED DOCUMENT(S):**
1. Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430
~~1.~~**2. Pharmacy Policy: Technician Checking Technician Program**

C. **EXTERNAL LINK(S):**
1. **California State Board of Pharmacy http://www.pharmacy.ca.gov/**
2. **Pharmacy Law Book with Rules and Regulations (2017). *California State Board of Pharmacy* http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf**

D. **REFERENCE(S):**
1. **Pharmaceutical Services Definition, Title 22 California Code of Regulations Division 5 § 70261.**
2. **Pharmaceutical Services Equipment and Supplies, Title 22 California Code of Regulations Division 5 § 70267.**
3. **Pharmaceutical Services General Requirements, Title 22 California Code of Regulations Division 5 § 70263.**
~~3.~~**4. Pharmaceutical Services Space, Title 22 California Code of Regulations Division 5 § 70269.**
~~4.~~**5. Pharmaceutical Services Staff, Title 22 California Code of Regulations Division 5 § 70265.**

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 06/80	**SUBJECT: Medication Preparation**
REVISION DATE: 06/05, 07/06, 07/09, 01/12, ~~5~~07/15	**POLICY NUMBER:** 8390-4102
Department Approval:	~~05/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 05/15~~01/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 06/15~~02/18
Professional Affairs Committee Approval:	~~07/15~~03/18
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **POLICY**:

1. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form will be used.
2. For medications not commercially available in unit dose form, medications will be repackaged from bulk containers into single unit packages so that they may be used in a unit dose system whenever possible.
3. All medications are prepared in a safe manner.

B. **PROCEDURE**:

1. To prevent contamination of medications prepared by the Pharmacy Department~~,~~ and ~~to prevent~~ medication errors, the following guidelines will be followed in the preparation of medications:
   - ~~1.~~**a.** The medication preparation and packaging operation will be isolated, to the extent possible, from other pharmacy activities.
   - ~~a.~~**b.** The preparation area will be maintained in a clean and uncluttered manner, functionally separate area for product preparation to minimize the possibility~~e~~ of contamination.
   - ~~b.~~**c.** Pharmacists and technicians will prepare only one (1) drug product at a time. No drug products other than the one being repackaged or prepared will be present in the immediate preparation area. No ~~other~~ labels other than for the product being repackaged should be present in the area.
   - ~~c.~~**d.** Pharmacists and technicians shall use clean or sterile techniques as appropriate to the medication being prepared. For injectable products, see Pharmacy Policy: Sterile Product Preparation.
   - ~~d.~~**e.** All unused labels (if separate labels are used) should be removed from the immediate preparation area.
   - ~~e.~~**f.** The integrity of the product being prepared and medications ready to dispense will be examined for evidence of damage, contamination, or other deleterious effects.
   - ~~f.~~**g.** The Pharmacist will be readily accessible to Pharmacy Technician staff during medication preparation.
   - ~~g.~~**h.** Unit dose packages and labels will comply with law and regulation standards. See Pharmacy Policy: Labeling Standards.
   - ~~h.~~**i.** Expiration dates will be checked and verified on all products prior to dispensing.
   - ~~i.~~**j.** High-risk medications will be stocked and stored in a way that minimizes the likelihood of an error occurring during preparation and distribution.
   - ~~j.~~**k.** All medications will be packaged and stored in a temperature-and humidity-controlled environment to minimize degradation caused by heat and moisture. ~~A relative humidity of 75% at 23 °C should not be exceeded.~~ Packaging materials should be stored in accordance with the manufacturer's instructions and any applicable regulations.

~~k.~~l. Applicable **Federal Drug Administration** (FDA) and **United State Pharmacopeia** (USP) requirements concerning the type of package required for specific drug products will be followed.

~~m. To optimize medication preparation and dispensing and to reduce the likelihood of medication preparation and dispensing errors, the Pharmacy Department utilizes a computerized order entry system and automated storage and distribution system.~~

~~n. The Pharmacy computer system includes special alerts/staff reminders identifying problematic drugs such as high-alert medications, look-alike and sound-alike drug names or medications with complicated/problematic packaging or labeling.~~

A. RELATED DOCUMENT(S):

1. **Pharmacy Policy: Sterile Product Preparation**
~~o.~~2. **Pharmacy Policy: Labeling Standards**

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 03/06

SUBJECT: Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors

REVISION DATE(S): 03/06, 07/09, 01/12, 09/15

Department Approval:	~~06/15~~12/17
Pharmacy & Therapeutics Committee Approval:	~~03/06, 07/09, 1/12, 07/15~~01/18
Medical Executive Committee Approval:	~~03/06, 07/09, 1/12, 08/15~~02/18
Professional Affairs Committee Approval:	~~09/15~~03/18
Board of Directors Approval:	~~03/06, 07/09, 1/12,~~ 09/15

A. **PROCEDURE**:

1. Narcotic pump refills for Tri-City Healthcare District **(TCHD)** patients will be processed in the following manner:
   a. The outside vendor will be instructed to always deliver the medication to TCHD inpatient pharmacy.
   b. All medications will be signed in on the sheet located on the C-II safe.
   c. All medication will then be ~~signed in~~**received into** the Pyxis C-II safe in the following manner:
      i. Go to 'increase meds'
      ii. Go to 'receive meds'
      iii. Type 'narcotic pump refill outside RX'
      iv. Type quantity under 'acq. qty' field
      v. Under 'Vendor' box, hit drop down arrow and select appropriate vendor
      vi. Enter the RX # in the invoice field
      vii. In the DEA-222 field, type patient's name
      viii. Hit the '+' (plus sign)
      ix. Select Save
      x. Place the vendor invoice (or the Pyxis load receipt if invoice not available) on the pharmacy buyer's desk
         1) Write patient's full name on C-II safe printout
         2) Write drug and dose on C-II safe printout
2. Medication sent to stations will be signed out in the following manner:
   a. Go to 'Decrease Meds'
   b. Go to 'Send Meds'
   c. Select location or floor med will be delivered to
   d. Select 'narcotic pump refill outside RX'
   e. Type the quantity of med being sent
   f. Select the '+' (plus) sign
   g. Check the 'print on save' box
   h. Hit the save key
      i. Write patient's full name on C-II safe printout
      ii. Write drug and dose on C-II safe printout
      iii. Return sheet to Pharmacy Buyer's desk

Tri-City Medical Center
Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE:	**NEW**	**SUBJECT:**	**~~Custody~~Safety Awareness for Justice Involved Patients**
REVISION DATE(S):			**POLICY NUMBER: 002**

Department Approval:	**12/17**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the state of California (CA) law enforcement agencies and Tri-City ~~Medical Center~~**Healthcare District**'s (TC~~M~~**HD**) rules for the well-being of hospital employees when providing care for outpatient and inpatient justice involved **(JI)** patients.

B. **DEFINITION(S):**

1. ~~Justice Involved (JI)~~ /Custody Patients – patients held involuntarily through operation of law enforcement authorities.
2. Correctional Officer (CO) – an employee of the **CA Department of Corrections and Rehabilitation** (CDCR).
3. Deputy- an employee of the San Diego **(SD)** County Sheriff Department Detention Facilities.
~~3.~~4. **Law Enforcement Personnel – any sworn Officer recognized by the County, State or Federal Government that authority to detain a citizen.**
~~4.~~5. Law Enforcement Restraint Devices – "restraint devices used by law enforcement officials for custody, detention, and public safety reasons" **(per the** Department of Health and Human Services).

C. **POLICY:**

1. ~~Justice involved~~**JI** patients have the same rights as all patients with certain safety considerations. These safety considerations are identified by **regulatory agencies, TCHD,** the CDCR, **the ~~and~~** SD Sheriff Department **and all Law Enforcement agencies.**
2. ~~Justice involved~~**JI** patients will be escorted throughout the hospital **with** two (2) ~~correctional~~ **Law Enforcement** officers ~~or Sheriffs~~ at all times.
~~3. Hospital staff must abide by the laws of the State of CA and the rules TCMC has devised for the well-being of the staff.~~
~~4.~~3. Hospital staff must:
   a. Display a professional attitude and demeanor at all times.
   b. Follow the instructions and advice of the ~~CO and Deputies~~ **Officers** related to safety issues at all times and ask if you are not sure of a circumstance.
      i. The ~~COs and Deputies~~ **Law Enforcement Officers** are responsible to ensure the safety of the public, and the JI~~/custody~~ patient.
   c. Avoid placing yourself~~, a CO, or Deputy~~ **or an Officer** in danger by not adhering to this policy.
   d. Follow the instructions and advice of the ~~CO/Deputy~~ **Officer** related to safety at all times. Ask questions if uncertain.
~~5.~~4. Safety Behaviors:
   a. Be aware of your surroundings at all times.
   b. Do not leave anything within hands/arms reach of a patients.

c. Be mindful of seemingly innocuous objects such as cardboard, paper, plastic, pens, **toothbrushes,** paperclips~~,~~ (these items may be used as weapons).
   i. Items such as tissue boxes (remove the tissue from the box); do not leave the box with the patient.

d. Do not walk too close or in between patient who is out of their room and ~~a CO or Deputy~~ **a Law Enforcement Officer.**

e. Cell phones and other personal electronic devices are not allowed **out** on the **Progressive Care Unit** (PCU). They are to be left at home or in a locker. Staff will be required to lock up any device that is found on their person while working on the PCU.

f. No one is allowed to photograph a JI~~/custody~~ patient or an officer at any time.

~~g. Do not engage of horseplay or similar behavior with custody patients or Law Enforcement Officer~~

~~h.~~**g.** Staff assigned or floating to the PCU will adhere to TC~~MC~~**HD**'s dress code and the following:
   i. No item shall be worn around the neck this includes a necklace**, ID tag holder or** ~~and~~ stethoscope**.**
   ii. Law Enforcement has asked that TC~~MC~~HD PCU staff do not wear solid orange or solid navy blue scrubs as these resemble clothing worn by JI individuals.
   ~~ii.~~**iii.** No provocative dress this includes but is not limited to:
      1) Low cut tops **and/**or cleavage revealing shirts, scrub tops, blouses**,** etc.
      2) Sheer, see through, revealing, tight, **and/**or short skirts, ~~/~~dresses~~/~~, pants **and/**or scrubs.
   ~~iii.~~**iv.** Long hair shall be tied or pulled back using ~~r~~-hair clips at all times ~~during~~ when assigned to patient care. Braids may not hang down and must be no longer than shoulder line.

D. **ENTERING AND LEAVING A PATIENT ROOMS:**

1. ~~Deputy~~ **Designated Officer** must enter occupied room ahead of staff. ~~Deputy/CO~~ **Officer** will remain in room at all times while staff is providing patient care.
   a. Address the ~~custody~~ **JI** patient by their last name.
   b. Never refer to a ~~custody~~ **JI** patient using endearing words such as honey, dear, or sweetie or by their first name.
2. Before entering patient room, consider the items you may have that may be considered potentially dangerous. ~~Do not take items in patient room that are not required to provide care. .~~
3. Do not take items into a JI~~/custody~~ patient's room that are not required to provide care of that particular patient.
   a. Items that you do not need immediately shall be placed outside of the patient's room on a table.
4. Never leave needles, syringes, scissors, thermometers, razors, pens, combs, wrappers from supplies, dressing supplies or paperclips in a patient's rooms. **Use caution when hanging glass intravenous (IV) vials. If accidentally dropped ensure that all pieces have been collected. Contact environmental services to clean and sweep floor.**
5. Remove and discard all items including ~~intravenous (~~IV~~)~~ tubing, IV bags, bandages, **oxygen (O_2) tubing,** etc. in a trash receptacle outside of patient's room.
6. Always scan the room, floor, bed, patient, and bedside table before leaving the room.
7. Do not place anything in the trash receptacle in the patient's room. Discard all trash outside of the patient's room.

E. **MEDICATION ADMINISTRATION:**

1. Medications may only be administered by licensed staff. See ~~TCMC~~**Patient Care Services:** Medication Administration ~~Policy~~. Approved nursing students:
   a. May administer oral medications only **under the direct supervision of a TC~~MC~~HD registered nurse (RN).**
   b. May not start ~~intravenous~~ **IV** lines~~.~~**.**

c. May not perform invasive procedures.

2. ~~COs or Deputies~~**Officers** may not administer or handle medications of any kind.
3. Do not leave medications unattended in patient's room.
4. Ensure you observe the patient swallowing the medications before leaving the room.
   a. You may ask the patient to open their mouths to ensure the medications are swallowed and not pocketed under their tongue or buccal.
   b. If medications are not properly swallowed (i.e.~~,~~ found in the buccal or under the tongue~~,~~ or you cannot validate the patient swallowed the medication)~~;~~, notify an **Officer** ~~CO or Deputy~~ immediately.
5. Intermittent IV medications; i.e.~~,~~ IV piggybacks (IVPB):
   a. When IVPBs are complete, remove the medication tubing from the room, and discard in the appropriate trash receptacle outside of the patient's room.

F. **MEAL TRAYS:**

1. Do not serve ~~custody~~ **JI** patients food items between regular scheduled meal times.
   a. Exceptions: crackers may be given if a medication is to be administered with food or if ordered by physician for obstetrics (OB) patients.
   ~~a.~~**b. Upon order by the physician, patients may receive snacks or other food item. Inform the ~~custodial~~ Officer that an order has been written.**
2. Breakfast, lunch, and dinner will be the only food served.
   a. Exceptions will be made with a physician's order.
3. Sodas, ice cream, milk, juices, or other snacks will not be served without a physician's order.
   a. Patients are not allowed to have snacks between meals or make request for meals.
      i. Exceptions: **OB patients,** vegetarian or vegan.
4. Meal trays may be distributed by staff to patients after they are inspected by an **Officer** ~~CO or Deputy.~~
   a. Eating utensils must be checked and approved by ~~Cos or Deputy~~ **an Officer.**
      i. Straws, metal silverware, and alcohol-based hand wipes are not allowed in patient rooms.
   b. Meal trays are left in patients' room per the ~~CO or a Deputy's~~ **Officers** instructions.
5. Meal trays may be removed from patient rooms after the tray is inspected. ~~by a CO or Deputy~~
   a. Patients are expected to eat their meals within 30 minutes.
6. **Nothing by mouth** (NPO) patient trays may be held in the kitchen. Trays may not be left in the medication room, nursing station, or in patient rooms.
7. Special Considerations:
   a. Patients admitted for swallowing foreign objects may not have small items such as juice boxes, straws, paper wrappers, or condiments left on their trays.
8. Hunger Strikes:
   a. Hunger Strike: California Department of Corrections and Rehabilitation Policy and the Division of Correctional Health Care Services, Chapter 22 or SD County Sheriff Department, depending on incarceration status**, have policies that address hunger strikes. The TC~~M~~CHD primary care RN will follow ~~TCMC~~ the Progressive Care Unit Policy: Hunger Strike: Justice Involved Patients~~-policy~~ regarding hunger strikes.**

G. **COMMUNICATION WITH ~~JUSTICE INVOLVED~~ YJI PATIENTS:**

1. All communication concerns shall be communicated to the PCU Manager or designee immediately.
2. Do not discuss personal affairs.
   a. **P**patients do not have a reason to know any of your personal information.
   b. Keep your relationship with patients professional.
3. Do not trade, sell, barter, lend or otherwise engage in any other personal transactions with custody patients.
4. Do not directly or indirectly give or receive from patients or member of the patient's family anything in the nature of a tip, gift, or promise of a gift **as this may be considered a violation of the law and you may be prosecuted.**~~.~~

5. Be mindful of the fact that they can hear your conversations with other staff in and outside of their room.
6. If touching a patient is not necessary, stay at arm's length when speaking to them.
7. Never argue with patient. Inform the ~~CO/Deputy~~ **Officer** of any conflict. It is the ~~CO/Deputy's~~ **Officers** responsibility to manage conflicts.
   a. If a patient becomes argumentative, leave the room.
   b. If a patient asks for extra pain medications educate patient they you can only give what is ordered by the physician.

H. **INAPP~~O~~ROPRIATE BEHAVIORS BY CUSTODY PATIEINTS:**

1. If a patient becomes uncooperative with medical treatment or exhibits inappropriate behavior, leave the room and ensure the appropriate ~~CO or Deputy~~ **Law Enforcement Officer** is informed.
2. Do not accept compliments or inappropriate gestures from patients.
3. Report incidents to the ~~COs or Deputies~~ **appropriate Law Enforcement Officer** immediately.

I. **RESTRAINT OR SECLUSION:**

1. Only TC~~M~~**CHD** employees may implement, apply, and monitor JI~~/custody~~ patients requiring restraint for non-violent~~-~~/-non self-destructive behavior.
2. Patients requiring Non-Violent Restraint:
   a. RNs providing care for patients requiring non-violent restraint shall follow ~~TCMC~~**Patient Care Services Policy:** Restraints, Used for Non-Violent~~/~~ Non-Self-Destructive Behavior ~~policy~~.
3. Patients requiring presenting with behaviors that are violent:
   a. RNs providing care for custody patients with violent behaviors shall inform the appropriate ~~CO or Deputy~~ **Officer** immediately.
   b. If restraint is required, implement the **Patient Care Services Policy:** Restraint~~/~~-Seclusion for Violent/Self-Destructive Behavior~~, Policy~~.
4. ~~COs and Deputies~~ **Law Enforcement Officers** may restrain custody patients using Law Enforcement Restraint Devices. TC~~M~~**CHD** employees may not assist ~~COs or Deputies~~ **Law Enforcement Officers** with the application **or removal** of the following law enforcement restraint devices:
   a. Handcuffs
   b. Manacles
   c. Shackles
   d. Chain-type restraint devices
   e. Restrictive devices used by law enforcement officials

J. **INCOMING CALLS:**

1. Calls received regarding a patients shall be directed to a ~~CO or Deputy~~ **Law Enforcement Officer.**
2. When asked questions by telephone regarding a patient, the standard answer is "I have no information on this patient".
3. Inform ~~CO/ Deputy~~ **a Law Enforcement Officer** and PCU Manager of any unusual telephone calls.

K. **VISITI~~O~~RS:**

1. JI~~/custody~~ patients will not generally have visitors unless prior arrangements and special circumstances dictate, TC~~M~~**CHD** must be notified of special circumstances.
2. Visitors must be approved through the institutional visitor's process and must comply with the PCU visitation practices which include removal of all personal items, this includes but is not limited to the following:
   a. Coats
   b. Jackets
   c. Purses

d. Backpacks

3. All staff and visitors must check in with an ~~C~~Officer.
4. Only visitors allowed per the ~~CO or Deputy~~ **appropriate Law Enforcement agency** are allowed on the unit.
5. Visitors allowed on the unit will be identified and escorted on the unit as appropriate.

L. **DIALYSIS PATIENTS:**

1. The primary RN assigned to the patient will inform the dialysis RN of the following:
   a. Do not enter the room without ~~a CO or Deputy~~ **an Officer.**
   b. Only items or equipment that will be used to provide dialysis may be brought in the patient's room.
   c. Every item brought in the patient's room must be removed immediately after use and at the completion of the dialysis treatment.
   d. Do not leave bleach or any solutions in the patient's room unless the dialysis machine is being cleaned.

M. **DISCHARGE:**

1. Patients are not to be informed of their discharge date, time or plans.

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

1. **Administrative Policy: 415** Dress and Appearance Philosophy
2. **Patient Care Services Policy:** ~~In-Custody~~**Justice Involved** Patients ~~Policy~~
3. **Patient Care Services Policy:** Medication Administration ~~Policy~~
4. **Patient Care Services Policy:** Plan for Nursing **Care**
5. **Patient Care Services Policy: Restraints, Used for Non-Violent/ Non-Self-Destructive Behavior** ~~Policy~~
6. **Patient Care Services Policy: Restraint-Seclusion for Violent/Self-Destructive Behavior**
~~5.~~**7. Progressive Care Unit Policy: Hunger Strike: Justice Involved Patient**

O. **REFERENCE(S):**

1. Department of Health and Human Services. *Federal registry part IV. Centers for Medicare and Medicaid Services (CMS) 42CFR part 482.*
2. Joint Commission (2015). *Hospital accreditation standards.* Retrieved from http://www.jointcommission.org

Tri-City Medical Center
Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE: **NEW** **SUBJECT:** **Hunger Strike: Justice Involved Patients**

REVISION DATE(S):

Department Approval:	**12/17**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/18**
Professional Affairs Committee Approval:	**03/18**
Board of Directors Approval:	

A. **PURPOSE:**
1. To delineate the roles of Tri-City ~~Medical Center~~**Healthcare District** (TC~~M~~**H**D) ~~and department of correction~~ when a justice involved (JI) patient participates in a hunger strike.
2. To ensure JI patients receive care to maintain their nutritional status as ordered by TC~~M~~**H**D physician.

B. **DEFINITION(S):**
1. JI Patient – patients held involuntarily through operation of law enforcement authorities.
2. Hunger Strike – refusal of necessary food and or fluids for political, mental health or other grievance-rated reasons.
3. Baseline – date and time that initial medical assessment and documentation occur for monitoring purposes.
4. Nutrition support – nutritional therapy such as food delivered by a tube to the stomach, central venous line, or by an intravenous line when usual diet is insufficient.
   a. Requires a physician order and must be administered in a licensed health facility.~~.~~
5. Forced treatment – forced treatment that shall occur only in an emergency or with a court order for a mentally incompetent JI patient as provided in California Penal Code Section 3200.
6. Medical Emergencies as defined in the California Code of Regulation (CCR), Title 15, § 3355 (A) and California Correctional Health Care Services (CCHCS):
   a. ~~"~~Any medical, mental health, or dental condition for which evaluation and treatment are necessary to prevent death, severe or permanent disability~~",~~.
   b. ~~"~~A medical emergency exists when there is a sudden marked change in a **JI** patient-~~inmate's [e.g. JI patient]~~ condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the **JI** patient-~~inmate [e.g. JI patient]~~ or others~~".~~

C. **POLICY:**
1. **California Department of Corrections and Rehabilitation** (CDCR) patients participating in a hunger strike shall be provided a medical and mental health assessment, monitoring, and necessary treatment, regardless of the reason for the hunger strike.
2. The identification of patient participating in a hunger strike will be performed by CDCR staff.
3. Registered ~~R~~**Nurses** (RN) assigned to a patient refusing to consume meals or stating they are participating in a hunger strike will notify the Progressive Care Unit (PCU), Clinical Manager (CM) or designee immediately and follow the CDCR Division of Correctional Health Care Services (DCHCS) guidelines outlined within this policy.
   a. The PCU, CM, or/designee will notify the CDCR Correctional Officer (CO) assigned to the patient.

4. Prior to administering a course of medical treatment, medical staff must first obtain the -patient's informed consent. To exercise this right, ~~a~~ must:
   a. Receive information about his/her medical condition
   b. The proposed course of treatment (including nutrition support)
   c. Prospect for recovery
5. Forced feeding (enteral or parenteral nutrition support) shall not take place except in a licensed health care facility by licensed clinical staff.
6. ~~Health care staff (~~TCM~~CHD~~ employees~~)~~ shall grant JI patients autonomy in health care decisions related to nutrition and shall not force feed the JI patient unless one of the following criteria are met:
   a. JI patient's condition meets the definition of emergency status.
   b. JI patient is deemed unable to give informed consent as defined as outlined in CCR Title 15, Article 8, § 3353.1 and the institution obtains an appropriate court order per CCR, Title 15, Article 8, § 3351(a) to treat a mentally incompetent inmate-patient.
7. ~~TCMC employees shall use the CCHCS Hunger Strike, Fasting, & Refeeding Care guide to assist with the care and assessments of patient.~~

D. **PROCEDURE:**

1. RN Responsibilities: Initial
   a. After a JI patient is identified as participating in a hunger strike ~~by a CO implement the following:~~.
      i. Complete all nursing interventions and assessments as outlined in the Standards of Care.
      ii. Review the patient's medical history for medical diagnosis, conditions, or diseases that are an immediate risk to the patient.
         1) Examples include but are not limited to the following; diabetes, end-stage renal disease, dialysis.
      iii. Notify the physician of the intended hunger strike and the following:
         1) immediate medical risk
         2) current nutritional intake
         3) output
         4) admission weight
         5) current weight
      iv. Notify the PCU Manager, Case Manager (CM) and on duty leadership (Assistant Nurse Manager ~~([~~ANM~~)~~] or Relief Charge RN).
         1) The CM~~/designee~~ or on duty leadership will notify the patient's facility Physician or RN on duty and provide the following information:
            ~~a) The patient's facility Phycian/RN will implement the CDCR's policies and procedures for a hunger strike~~
      ~~v. Document findings and interventions in the EHR~~
      ~~vi. Document the following on the CDCR Form 7230 Interdisciplinary Progress note and the patient's Electronic Health Record (EHR)~~
         ~~1)2) Stated reason and duration of hunger strike.~~
            ~~2)~~**a)** Most recent documented weight
            ~~3)~~**b)** Current measured weight
            ~~4)~~**c)** Physician condition and appearance
            ~~5)~~**d)** Emotion and /or psychological condition
            ~~6)~~**e)** Vital signs i.e., heart rate (HR), temperature, respirations, orthostatic blood pressure
            ~~7)~~**f)** Relevant medical history including allergies to food and medications
            ~~8)~~**g)** What the patient is refusing i.e., food or liquids
            ~~9)~~**h)** Current mental health status and history of mental disorders
            ~~10)~~**i)** Suicide risk assessment ~~and known suicide attempts~~

2. ~~RN Responsibilities: 48 Hours After Identifying a JI Patient's Participation in a Hunger Strike:~~
   ~~a. The RN will complete and document in the EHR the following:~~

~~i. Assess the patients per the Standards of Care~~
~~ii. Assess the following daily per the CDCR:~~
~~1) Weight~~
~~2) Physical condition~~
~~3) Emotional condition~~
~~4) Vital signs including orthostatic~~
~~5) Hydration status~~
~~iii. Notify the **CMO/Chief Physician and Surgeon (CP&S)** or designee of significant changes in the patient's health status~~
~~iv. Intake and output per the Standards of Care~~
~~b. Document the following in the EHR and on the CDCR's Form 7230~~
~~i. The CDCR daily assessment requirements identified in 2.b.~~
~~ii. Patient's refusal of any health care services using the patients' words (this is not an inclusive list)~~
~~1) Assessments~~
~~2) Medications~~
~~3) Treatments~~
~~4) Procedures and test~~
~~5) Nutrition~~
~~6) Nutrition supplement~~
~~c. Ensure the **HCM** of the health care services refused by the patient~~
~~3. CDCR Staff Responsibilities will follow the guidelines established by the CCHCS~~

E. **INFORMED CONSENT AND STAFF INTERVENTIONS:**

1. Prior to administering a course of medical treatment, medical staff must first obtain the ~~inmate~~ **JI** patient's informed consent. To exercise this right, a patient shall receive information about his/her medical conditions, the proposed course of treatment (including nutrition support and his/her prospects for recovery).
2. Patient has the right to refuse all medical treatment and care at TC~~M~~**HD** provided patient has the capacity and competency to do so. After discussion with the on duty Physician at the custodial institution, patient may be discharged **against medical advice** (AMA) back to the institution once accepted by the on duty Physician.

F. **REFERENCE(S):**

1. California Correctional Health Care Services (CCHCS). (2013, July). Cchcs hunger strike, fasting, & refeeding care guide. Retrieved from http://www.cphcs.ca.gov/careguides/MassHungerStrikeCareGuide.pdf
2. CCHCS. (2012, July). Emergency medical response system policy. 12*(4)*, Medical Services. Retrieved from http://www.cphcs.ca.gov/docs
3. San Diego County Sheriff's Department Medical Services Division (2015). Hunger Strikes, MSD.H.12, CCR Title 15, Section 1206

Division of Correctional Health Care Services: Hunger Strike Reference Tool

Day	Findings	Recommendations
0	• Carbohydrates provide for most of our energy requirements- we eat → blood sugar rises → insulin released → promotes glucose uptake and storage (glycogenesis), inhibits the breakdown of fats (lipolysis), and increases cellular uptake of potassium • When cant's store anymore glucose → turns into fat	
1-3 days	• Glucose levels begin to fall which results in the release of glucagon and a reduction in insulin secretion • Glucose levels are maintained by glycogenolysis but glycogen stores rarely last more than 72 hours	Initiate TCMC Hunger Strike Policy
4-7 days	• Brain and red blood cells (RBCs) and some other tissues require glucose so it starts being made by noncarbohydrate (most importantly muscle protein alanine) sources being metabolized to glucose (gluconeogenesis) • Fatty acids broken down to energy • Resultant loss of body fat and protein Accompanying depletion of potassium, phosphate, and magnesium – serum levels maintained at expense of intracellular stores – TOTAL body levels down Fasting generally well tolerated as long as fluid intake is sufficient "Hunger pangs" and stomach cramps disappear after 2nd or 3rd day Early fasting weight loss can be 1-2 kg/day	Follow TCMC Hunger Strike Policy Monitor patient weight o Stop nonessential medications o Stop antacids (interfere with phosphate absorption) o Stop diuretics if possible o Decrease dose of essential medications if appropriate
8-14 days 8-14 days continued	Risk of refeeding syndrome begins Day 10	Follow TCMC Hunger Strike Policy Monitor patient weight Offer patients: o Thiamine 100mg by mouth (po) daily o B complex 1 po dialy o Multi-vitamin (e.g. Tab-a-vite) one po daily o Encourage 1.5 liters or more/day fluid intake If patient has clinically significant dehydration: o Offer oral rehydration fluids: • Pedialyte: one liter of non-flavored contains: • Na: 25 mmole/liter • K: 20 mmole/liter • Glucose: 25 grams If patient refuses oral or is unable to tolerate offer: o D5NS IV (add Thiamine 100mg and MVI I amp if available)

		give one liter over 1-2 hours If patient has symptomatic hypoglycemia treat as clinically indicated using: (see Refeeding Reference) ○ Food if patient will accept ○ Carnation Instant Breakfast Lactose Free (if prolonged fast start with <500mL) ○ Glucose gel ○ D50 Before voluntary refeeding, assess risk per Refeeding Reference
After 15-18 days	Patient suffers from dizziness and "feeling faint" • Severe ataxia • Standing up may become difficult to impossible • Bradycardia • Orthostatic hypotension • Lightheadedness or inversely mental sluggishness • Sensation of cold • General sensation of weakness • Fits of hiccoughs • Loss of the sensation of thirst Hydration needs to be particularly monitored. Too much supplement sodium chloride (NaCl) may lead to hypokalemia By 3rd week average weight loss 0.3kg/day	As above Before voluntary refeeding assess risk per Refeeding Reference ○ Hydration needs to be particularly monitored ○ Thiamine deficiency occurs within 2-3 weeks ○ Because intravenous (IV) glucose can worsen thiamine deficiency, consider IV thiamine 100mg before receiving IV glucose for patients at high or extreme risk of refeeding.
Between 35-42 days At > or = 18% loss of initial body weight → Medical Complications	Problems with ocular mobility due to progressive paralysis of the oculo-motor muscles (thiamine deficiency) • Uncontrollable nystagmus • Diplopia • Extremely unpleasant sensations of vertigo • Vomiting • Extremely difficult to swallow water • Converging strabismus This has been described as the most unpleasant phase by those who have survived prolonged fasting One week after the "ocular phase" – once paralysis" once paralysis of the oculo-motor muscles is total nystagmus ceases and with it all associated problems such as vertigo, vomiting	As above Before voluntary refeeding assess risk per Refeeding Reference
From 42 days Onward	Progressive asthenia (lack or loss of strength) • Increasingly confused state • Concentration becomes difficult or impossible • Somnolent state • Indifference to surrounding • incoherence At this stage, it is impossible to evaluate intellectual	As above

30% loss of initial body weight → Life-Threating	functions and to determine what the hunger strikers state of mind is. Further even more serious complications follow: • loss of hearing/blindness • diverse forms of hemorrhage: gingival, gastro-intestinal, esophageal • body "shuts down" progressively: extreme bradycardia, Cheyne-Stokes respiration, all metabolic activity diminishes	Before voluntary refeeding assess risk per Refeeding Reference
Between 45-75 days	• Death occurs from cardio-vascular collapse and/or sever ventricular dysrhythmias (prolonged QT) • More rarely lactic acidosis from sepsis secondary to immune system dysfunction → and shortness of breath (SBO) and multiple organ failure	As above Before voluntary refeeding assess risk per Refeeding Reference

Evaluation and Management of Patients Voluntarily Requesting Refeeding After Hunger Strike

General

- Principles of management are to correct biochemical abnormalities and fluid imbalances
- The optimum timing for correction abnormalities in established Refeeding Syndrome (RFS) has been the source of controversy
  - The view that correction of electrolyte abnormalities must occur before commencement of feeding has been revised and recent National Institute of Health and Clinical Excellence (in the United Kingdom (UK)) guidelines indicate that feeding and correction of biochemical abnormalities can occur in tandem without deleterious effects to the patient- but no RCT data available to support either view.
- Prevention is key to management: 3 factors appear fundamental:
  - Early identification of at risk individuals
  - Monitoring during refeeding
  - Appropriate feeding regimen

- Clinical Evaluation:
  - Screening exam, review current medications
  - Risk assessment based on current BMI, weight loss and length of fasting
  - ECG if irregular pulse, abnormal HR, serum K or Phosphorus
- Labs:
  - Baseline Phosphorus, magnesium, calcium, potassium, urea, creatinine before refeeding (affects risk assessment)
  - Monitor electrolytes every day as indicated based upon refeeding risk (see below) or more frequently if clinically indicated
- Life-threatening changes usually in the first 3 days
- Monitoring:
  - Fluid intake/output and weight – fluid overload can develop- monitor lungs
  - If gain >1/2 lb per day or 3.3 lbs per week, likely fluid retention

Treatment: Determine based on risk assessment

Negligible Risk: Individuals who have fasted for less than 5 days, with BMI > 15.8 kg/m2 are at little or no risk of refeeding problems, Careful assessment of hydration status and possibly tests of renal function if they have refused fluid for several days	These individuals may be allowed to eat and drink freely and no monitoring is necessary

Refeeding Syndrome (RFS) after Hunger Strike

Definition:

- Refeeding syndrome describes the biochemical changes, clinical manifestations, and complications that can occur as a consequence of feeding a malnourished catabolic individual.
  - RFS is not defined by a clear set of signs and symptoms
- There are no internationally agreed definition of RFS, it is a term referring to a wide spectrum of biochemical abnormalities and clinical consequences
- Hypophosphatemia is the adopted surrogate marker for diagnosing RFS though low serum phosphate is not pathognomonic
  - There are limitations to relying on low serum phosphate as levels may be normal in patients with multiorgan failure or in the presence of impaired renal function

Physiology:

- Reintroduction of nutrition to a starved or fasted individual results in a rapid decline in both gluconeogenesis and anaerobic metabolisms mediated by the rapid increase in serum insulin
- Insulin stimulates the movement of extracellular potassium, phosphonate, and magnesium to the intracellular compartment → rapid fall in the extracellular concentration of these ions
  - Osmotic neutrality must be maintained resulting in the retention of sodium and water
- Reactivation of carbohydrate-dependent metabolic pathways increases demand for thiamine, a cofactor required for cellular enzymatic reactions
- The deficiencies of phosphate, magnesium, potassium, and thiamine occur to varying degrees and have different effects in different patients

Clinical Manifestations:

- Symptoms of RFS are variable, unpredictable, may occur without warning, and may occur late
  - Assessment of Risk
- Symptoms occur because changes in serum electrolytes affect the cell membrane impairing function in nerve, cardiac and skeletal muscle cells.
  - Variable clinical picture in RFS reflects the type and severity of biochemical abnormality
  - Mild derangements in theses electrolytes may cause no symptoms
- More often, the spectrum of presentation ranges from simple nausea, vomiting, and lethargy → respiratory insufficiency, cardiac failure, hypotension, arrhythmias, delirium, coma, and death
  - Clinical deterioration may occur rapidly
- Low serum albumin concentration may be an important predictor for hypophosphatemia, although albumin is not a nutritional marker

Risk	Interventions
Modest Risk: Individuals will be at some risk of refeeding problems if they fulfill any one of the following criteria: • BMI greater than 16 but less than 18.5 or • Loss of greater than 10% of their body weight during food refusal	• Advise to eat only limited amounts of varied foods (total of greater than 20 kcals/kg/day) for the first 2 days • May eat from CDCR Heart Healthy Diet tray ○ Example 170 lb man = 77 kg x 20 kcl/kg = 1540 kcal/day ○ Heart Healthy CDCR tray provides 2750 kcal/day ○ Patients to eat approximately ½ of each meal tray the first 2 days • If no problems arise over the first 48 hours of feeding, levels can be increased, building up to unrestricted ingestion by 5 days • Fluid provision should generally be limited to around 30mL/kg/day. This figure could be doubled if clear dehydration assessed either clinically or on

	urea/creatinine results • Labs should be done as outlined above before refeeding starts and repeated at approximately 24 and 48 hours of refeeding, with advice changing to that suggested for higher risk individuals as appropriate o Including sodium, potassium, phosphate, magnesium, calcium, and glucose • Daily multi-vitamin and trace element supplement o Thiamine 100mg po daily times 7 days o B complex 1 po daily times 7 days o Multi-vitamin (Vita-tab) one po daily times 60 days
High Refeeding Risk Individuals are at a high risk of refeeding problems if they fulfill either: • One of the following Major Risk Factors o BMI less than 16 kg/m2 o Unintentional weight loss greater than 15% of body weight since starting food refusal o Low potassium, magnesium or phosphate levels before the onset of feeding • Two or more of the following Lesser Risk Factors o BMI less than 18.5 kg/m2 o Weight loss greater than 10% o A history of alcohol or individuals on some drugs including insulin, chemotherapy, antacids, or diuretics Note: in all at risk cases, the blood tests suggest above should be taken before starting feeding and if abnormal reconsider risk category • The presence of any significant comorbidity or intercurrent infection also leads to greater risks and should also prompt re-categorization	• Refeeding should take place in a clinical setting with careful observation including 24 hour nurse cover and availability of daily laboratory, pharmacy, and dietary support (in most instances this will be a community hospital) o Patient must be monitored for any signs of fluid overload, infection or general deterioration and there should be a low threshold for moving to higher level or care should any clinical or biochemical abnormalities become concerning o Likely causes of such concern would include: • Potassium levels less than 3.0 mmol/l • Magnesium levels less than 0.5 mmol/l • Phosphate levels less than 0.5 mmol/l • Strongly consider providing prophylactic supplementation of phosphorus, potassium, and magnesium as outlined in table 1 even if baseline levels are within normal level • Intake 10 kcl/kg/day for the first 24 hours, taking either: o Small quantities of different food types (that are likely to provide a balance of protein, carbohydrate, and fat –CDCR Heart Healthy Diet provides 55% CHO, 30% Fat, 15% Protein) see starting day 2 o Carnation Instant Breakfast Lactose Free (CHO 51%m Fat 35%, Protein 14%) oral sips in small amounts spread throughout the 24 hours – see starting day 2 • If not problem occur, intake can be increased by increments of 5-10 kcl/kg/day • If patient at a community hospital and stable after 72 hours contact sending institution/UM to discuss discharge • All restrictions on food intake can be lifted after 5-7 days if no problems have arisen and patient is consuming a total of greater than 35-40 kcl/kg/day • Fluid provision should generally be limited to no more than 30mL:/kg/day. (may need to be increased if dehydration assessed either clinically or

	on urea/creatinine results ○ Example 170 lb man = 77kg x 30mL/kg = 2310 mL/day • Labs should be monitored ○ Daily during the first week, including sodium, potassium, phosphate, magnesium, calcium, and glucose ○ Liver function tests should be monitored at least twice weekly • Daily multi-vitamin and trace element supplement: ○ Thiamine 100mg po daily times 7 days ○ B complex 1po daily times 7 days ○ Multi-vitamin (Vita-tab) 1 po daily times 60 days
Supreme Risk Individuals at the highest risk of life threatening problems include those with more than one of the following risk factors: • BMI less than 16 kg/m2 • Unintentional weight loss greater than 15% of body weight since starting food refusal • Low potassium, magnesium, or phosphate levels before the onset of feeding • No food greater than 15 days • History of alcohol abuse or individuals on some drugs including insulin, chemotherapy, antacids or diuretics ○ Significant comorbidity or intercurrent infection either evident or clinical assessment or suggested by the development of either high or low white cell counts, rising CRP or falling albumin, or high or low blood glucose levels	• Individuals at the highest risk of life threatening refeeding problems should be admitted to hospital ○ Restoration and monitoring of circulatory volume, fluid balance and electrolytes • IV thiamine (start with 100mg) should be given prior to refeeding or using dextrose containing solutions including D5 solutions ○ Concurrent with refeeding provide prophylactic supplementation of phosphorus, potassium and magnesium (outline note) even if baseline levels are within normal limits ○ Feeding can begin with a goal of a total of 5 kcl/kg/day for day 1 and increasing as outline in tables 2 and 3 ○ Feeding may commence with constant levels of feeding via nasogastric tube or 2-4 hourly increments of complete liquid nutritional supplements if patient unable to drink or eat safely ○ If patient is able to tolerate drinking refeeding may begin with oral Carnation Instant Breakfast Lactose Fee or other LONS meeting the guidelines in table 1 ○ Refeeding can be done with food if the composition of the food provided is consistent with table 1 and the amount is limited in kcal/kg/day as outlined in table 3 ○ CDCR Heart Healthy diet meets composition requirements • Monitoring of the ECG for at least the first 48 hours of feeding – looking for evidence of electrolyte disturbance, potassium, calcium, magnesium especially QT prolongation • Labs should be monitored ○ Daily during the first week, including sodium, potassium, phosphate, magnesium, calcium, and glucose

Tri-City Medical Center	Progressive Care Unit
PROCEDURE:	**RELEASE OF A DECEASED ~~OF A~~ JUSTICE INVOLVED PATIENT**
Purpose:	To care for and release remains of deceased Justice Involved patients.
~~Supportive Data:~~	~~Patient Care Service (PCS) Policies: Organ Donation, Including Tissues and Eyes, and PCS Medical Examiner Notification, PCS Procedure Deceased Patient Care and Disposition, Security Department Policy # 224 and Authority for Release of Deceased Form and Consent of Anatomical Donation Form.~~

A. **PROCEDURE:**

1. The Registered Nurse (RN) will notify the Sergeant and Progressive Care Unit (PCU) Assistant Nurse Manager (ANM)/Designee to report the death.
2. All justice involved patient deaths are reportable to the **correctional facility~~'s~~ and County** Medical Examiner **(ME)**.
   a. The primary RN or designee RN will:
      i. Notify the **correctional facility and ME**~~Medical Examiners' Office (858-694-2895~~.
      ii. Provide the ME **or ME respresentative** ~~edical Examiner~~ with information as requested.
      iii. Document the ME ~~edical Examiner~~ or **ME** representative's name in the medical record.
      iv. Notify Lifesharing.
3. Nursing must adhere to the following procedure:
   a. ~~,~~The decedent's room is considered a crime scene.
   b. Patient is to remain attached (connected) to all equipment and devices such as the following~~:~~ (this is not an inclusive list). The equipment may be turned off.
      i. Ventilators
      ii. Infusion pumps
      iii. Cardiac monitor or Telemetry transmitter (tele box) – silence alarms~~—ask the MEedical Examiner if it is ok discharge the patient from the monitoring system~~
      iv. ~~Oxygen flow meter~~ **Sequential stocking pump**
      ~~iv.~~**v. Air mattresses should remain inflated to maintain decedents skin**
   c. Turn off the following and leave patient attached (connected)
      i. Oxygen flow meter
         1) Turn off the flowmeter and do not disconnect the patient from the oxygen tubing
      ii. Oxygen delivery devices e.g., nasal cannula, simple mask, non-rebreather etc.~~,~~
      iii. Turn off **intravenous (**IV**)** infusion(s) do not remove the IV catheter(s)
      iv. Urinary drains; e.g.~~,~~ Foley, PureWick, condom catheters or IV solutions
      v. Rectal tubes and rains
      vi. Chest drains
      vii. Dressings
      viii. Drains, etc., Jackson Pratt **(JP)**
      ix. Electrodes
      ~~ix.~~**x. Sequential stockings**
   d. Gather all nursing equipment such as stethoscopes before leaving room.
   e. Once you leave patients room it will be sealed and you will not be allowed to return until the ME~~edical Examiner~~ **or ME representative** arrives.
   f. Justice involved **(JI)** patients remain shackled until correctional officer **or ME**~~/Coroner~~ releases the **decedent** ~~body~~.
4. Correctional Officer/Sergeant/Deputy will provide the Death Record Packet that includes:
   a. Necessary paperwork

Department Review	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW 12/17	n/a	n/a	02/18	03/18	

b. Finger printing materials
c. Camera for pictures
d. "Initial Inmate Death Report":
   i. The "Initial Inmate Death Report" must be filled out by the attending physician (unless attending designates the specialist – this is not preferred) within 24 hours of death.
      1) Nursing **may not initiate or complete this form** ~~does not fill out this paperwork~~.
   ii. The PCU ~~ANM/~~Manager, **ANM/** designee **will** ~~must~~ fax the completed "Initial Inmate Death Report" to the **Chief Medical Officer** ~~(this acronym must be written out)~~ at the **justice involvedJI decedent's** ~~inmate's~~ institution within 24 hours of death.
   iii. This document is not part of the TC~~MC~~**HD** medical record. If the death occurs on a unit other than the PCU, nursing must bring the completed "Initial Inmate Death Report" to the PCU **MangerManager or** ANM/~~Manager~~/designee. The primary care nurse is responsible for completing all charting in Cerner.
   ~~iv. If the death occurs in an area such as Radiology/Surgery, the Rapid Response Nurse or the primary nurse will complete Cerner charting.~~

5. On arrival of the **ME or ME representative** ~~Coroner~~, the primary care **RN**~~Nurse~~ will:
   a. Enter patients room with ~~Coroner~~ **ME or ME representative** to ensure that all infusions and hospital equipment is in place.
   b. Ask permission from **ME or ME representative** ~~Coroner~~ to remove infusions such as narcotics in Patient Control Analgesia.
   c. Remove all narcotics and waste per Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine.
   ~~c.~~**d. Narcotics are not allowed to be kept with the patient or transported outside of TC~~MC~~HD.**
6. The **ME or ME representative** ~~Coroner~~ will complete the **ME**~~Coroners~~ portion of the "Initial Inmate Death Report" once his/her investigation has been completed. ~~The Coroner may~~
   a. The ME or ME representative may:
      i. Review the ~~look at the~~ medical record
      ~~a.~~**ii.** ~~and m~~**May** ~~Ask questions of the~~ staff **assigned to the decedent questions regarding care, diagnosis, excreta,** ~~(etc.,)that has had direct care of the patient.~~
      ~~b.~~**iii.** ~~c~~**C**lear the decedent's body for removal~~,~~.
   ~~c.~~**b. The primary** RN will ensure completion of the Authority for Release of Deceased Record.
   ~~d.~~**c.** The **ME or ME representative** ~~Coroners assistant~~ removing/transporting the **decedent's** body will fill out the bottom of the Authority for Release of Deceased Record.

~~B. FORMS:~~
~~1. "Initial Inmate Death Report"~~

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

1. **Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine**
2. Patient Care Services Policy: Medical Examiner Notification
3. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes
4. Patient Care Services Policy: Patient Valuables~~,~~ Liability and Control
5. Patient Care Services Policy: Release of Deceased
6. Patient Care Services Procedure: Deceased Patient Care and Disposition
7. **Security Department Policy: Morgue Release 224**

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

Audit, Compliance & Ethics Committee
(No meeting held in March, 2018)

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

February 22, 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 February 22, 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 RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Julie Nygaard

Also present were:

Adriana Ochoa, Board Counsel
Steven Dietlin, Chief Executive Officer
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 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Schallock to approve the agenda as presented. Director Kellett seconded the motion. The motion passed (6-0-0-1) with Director Nygaard absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the February 22, 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, Ms. Adriana Ochoa made an oral announcement of the items listed on the February 22, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; one Report Involving Trade Secrets, Approval of Closed Session minutes, Conference with Legal Counsel regarding two matters of Potential Litigation and Evaluation of Legal Counsel Services.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Schallock to go into Closed Session. The motion passed (6-0-0-1) with Director Nygaard absent.

6. The Board adjourned to Closed Session at 1:35 p.m.

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

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Nygaard

Also present were:

Adriana Ochoa, Board Counsel
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations 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 reported no action was taken in closed session.

10. Director Grass 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. Educational Session

Compliance Training 101

Mr. Carlos Cruz presented a presentation to the Board of Directors on Compliance Program Oversight. He reviewed the following:

- Corporate Governance Responsibilities of Board Members
- Responsibilities of Review and Oversight of the Compliance Program including the U.S. Sentencing Guidelines
- Overview of the TCHD Compliance Program
- Three Key Duties: Duty of Care, Duty of Inquiry and Duty of Loyalty

Mr. Cruz explained the Business Judgment Rule which provides that Directors may not be held liable for unfavorable outcomes or "bad decisions" when he/she acts in good faith and in the same manner as a reasonably prudent person.

Mr. Cruz reviewed the Seven Elements of an Effective Compliance Program:

- Policy
- Oversight
- Education/Training
- Monitoring
- Internal Review
- Investigational Remediation
- Discipline

Mr. Cruz summarized the Key Duties of Compliance Program Oversight which included:

- Assure Compliance Program is in place and:
  - Proactive
  - Adequately Funded
  - Effective
- Assure everyone is doing their job
- Assure process is being actively operated
- Be proactive and engaged.

Directors asked questions throughout Mr. Cruz's presentation. *(A copy of the presentation is attached to the file copy of the minutes.)*

No action taken.

13. Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg, Auxiliary President reported on past and future activities of the Auxiliary including the following:

- Currently there are 540 members serving in 27 Departments and three satellite areas in the Tri-City area. Volunteers range in age from 17 to 90. Ms. Gleisberg noted no other volunteer organization has such a wide range in age of their Volunteers. Ms. Gleisberg described the reasons why Tri-City is such a popular place to volunteer for our juniors.

- In 2017-18 a total of 67,000 hours were worked by our volunteers and $70,000 was donated to the hospital.

- On January 26th the Past Presidents of the Auxiliary were honored with a luncheon and tour of the hospital.

- Beginning Saturday, March 3rd the annual Auxiliary Refreshers will be conducted during the month. These are mandatory for all volunteers and provide important updates, along with reminders, for all volunteers on Auxiliary and hospital policies and regulations.

- April 23rd is the Volunteer Appreciation Luncheon.

- Scholarship Awards night is scheduled for May 3rd. Plans are underway and applications are now available online at Mira Costa, Palomar and Cal State San Marcos for students in the nursing program. Since the program began in 1973, $1,000,000 in scholarships has been awarded to worthy students at our local college.

- The *"Tails on the Trails"* annual Pet Walk is scheduled for Saturday, May 18th. Proceeds benefit the Tri-City Hospital Auxiliary Scholarships, Tri-City Medical Center's Pet Therapy Program, Oceanside and Carlsbad Police Department K-9 Unit, the Special Care Foundation for Companion Animals, Tender Loving Canines Assistant Dogs and Love on a Leash North County.

Director Grass requested additional leaflets on the dog walk for friends and neighbors.

No action taken.

14. Report from Chief Executive Officer CEO

Mr. Steve Dietlin expressed his appreciation to Mary Gleisberg and all the Auxilians for leading their organization of 540 volunteers. Mr. Dietlin commented on the recent Past President's Luncheon and how wonderful it is to see the Past Presidents from years gone by. He stated it is really is amazing that we have these past Presidents that are still involved and still volunteering. Mr. Dietlin stated the Tri-City Auxiliary really does make Tri-City a different hospital. Mr. Dietlin also commented on the upcoming Scholarship night. He stated it is one of his favorite nights and it is very exciting to see all of the students receive their scholarships.

Mr. Dietlin expressed his appreciation to Mr. Cruz for the compliance update and presentation. He noted it is important to be vigilant upfront to avoid costly issues down the road. Mr. Dietlin stated we have a robust program here and it's really about a culture of compliance. Mr. Dietlin stated it is important to set the tone of the organization where people are encouraged to bring issues forward that they have questions about. Mr. Dietlin also commented on the hotline (Values Line) where staff can voice their concerns anonymously. Mr. Dietlin stated the Compliance Program is a valuable program to have in place for the regulatory environment that we live in.

Mr. Dietlin commented on Ms. Schultz's update last month regarding the flu. Mr. Dietlin stated there is now over 16,000 confirmed cases and 269 deaths in San Diego County. Mr. Dietlin stated we saw the highest census in the January timeframe and

although we are not that high today there is still some flu around. He encouraged everyone to stay vigilant. Mr. Dietlin stated we had an Average Daily Census during the month of January of about 211 but we saw days at 240 and over and all hospitals in San Diego were at capacity. Mr. Dietlin expressed his appreciation to the Medical Staff and the Nursing staff for all their efforts during this flu season. He stated we have received some great feedback from patients who received care for the flu.

Mr. Dietlin stated from a financial standpoint one would assume it would be great to have so many patients in house. However reimbursement is based on a case rate or DRG and that reimbursement will be the same no matter how long the patient stays in the hospital. He explained in this this case there was no place to transfer the patients to which resulted in an extended length of stay for many patients and no additional reimbursement for the hospital. Mr. Dietlin stated as you will see when Mr. Rivas gives his financial report that even though we had a very high census, the reimbursement was not high and actually resulted in a loss. Mr. Dietlin stated we are here to serve the community however at times there are repercussions on the bottom line as we move forward with all of our initiatives. Mr. Dietlin stated it is becoming more difficult with healthcare reform. Reimbursement is a challenge and community hospitals and systems are closing facilities and cutting costs and that is something we will continue to see. Mr. Dietlin stated Tri-City has done a great job with quality clinical outcomes at a relatively low cost. Our safety rating remains at the top of North County and we remain committed to that mission -- to advance the health and wellness of this community. He stated we will continue to provide that excellent quality but we will also have to focus on reducing and being more efficient on operating expenditures to stay competitive.

With regard to Campus Development, Mr. Dietlin reported we placed financing about a year ago and have started our Phase One on the campus redevelopment with the surface parking lot. He stated it is important for people to know that there will not be an interruption to people coming in and out of the hospital. He explained that the surface lot behind the BAMS building will create an additional 290 spaces and the primary purpose of that is to alleviate parking issues now but also to create additional parking so that when the parking structure is built there will not be any loss of parking spaces. Mr. Dietlin stated the City of Oceanside has worked with us to get us all the clearances that we need and to approve a cut out off of Waring Road which is where the construction trucks will come in and out which means there should be minimal interruption for anyone visiting the hospital during the surface lot preparation.

Mr. Dietlin stated we are owned and governed by this community and it takes everybody in this community to participate to make it work here. He expressed his appreciation to the Auxilians, the Foundation, the Medical Staff, the Nursing staff, Administration, community leaders, the Board of Directors. He commented that we have a very different model that a lot of institutions do not have and it has been successful in serving this community with world class healthcare.

No action taken.

15. Report from Chief Financial Officer

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

- Net Operating Revenue – $210,391
- Operating Expense – $218,960

- EROE - ($5,415)
- EBITDA – $3,700

Mr. Rivas pointed out that the EBITDA profit of almost $4 million year to date indicates that we do have a positive cash flow.

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 176
- Adjusted Patient Days – 66,680
- Surgery Cases – 3,761
- Deliveries - 1,391 (Of those 1,391 deliveries 383 were C-sections which equates to approximately 28% YTD.)
- ED visits – 36,660

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

- Operating Revenue - $31,517
- Operating Expense - $33,369
- EBITDA - $81
- EROE – ($1,242)

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

- Average Daily Census – 211
- Adjusted Patient Days – 10,721
- Surgery Cases – 541
- Deliveries – 209 (Of those 209 deliveries, 53 were C-section)
- ED Visits – 5,201

Mr. Rivas noted that one indicator that is not on this report is admissions. He stated total admits were less than budget by 70 which contributed to our shortfall in income. He explained that reimbursement is based on the case rate or DRG not on patient days however expense is directly related to patient days. Patient days trended up significantly however our average length of stay shot up too. Thus, we continued incurring expense during the month even though we didn't have the revenue.

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

- Net Patient Accounts Receivable - $45.6
- Days in Net Accounts Receivable - 49.1

Chairman Dagostino commented on the state of the financials. Mr. Rivas stated we did and still do have promising strategies in place to grow our revenue however it is not growing as quickly as we anticipated. He stated Administration is taking a hard look at our expenses.

No action taken.

16. New Business

a. Consideration to approve a physician recruitment agreement with Dr. Anitha Rajamanickam, Interventional Cardiology Physician

Mr. Jeremy Raimo, Senior Director of Business Development provided a brief summary of Dr. Anita Rajamanickam's background and experience. He stated Dr. Rajamanickam brings the full scope of interventional cardiology to the table and she will be a wonderful resource for patients in this community. Mr. Raimo also reviewed the terms of the proposed two-year recruitment agreement and stated he is very excited to bring Dr. Rajamanickam to the Board for consideration.

Director Reno commented that Dr. Rajamanickam appears to be well educated in all aspects of Cardiology.

Chairman Dagostino questioned if Dr. Rajamanickam will be joining a group or if she will be independent. Mr. Raimo stated Dr. Rajamanickam is committed to coming to this community. He explained that we have been working on our strategy for cardiac care and she is a very prominent part of that. With the Board's support Dr. Rajamanickam will be able to care for high acuity patients right here in our Cath Lab and help grow our Cardiology program.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment Agreement with Dr. Anitha Rajamanickam, not to exceed $1,005,000 in order to facilitate this Interventional Cardiologist practicing medicine in the communities served by the District. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

17. Old Business –

a. LAFCO Update

Ms. Adriana Ochoa, Board Counsel reported the Board of Supervisors did approve the Property Tax Exchange Resolution at their February 14th Board of Supervisors meeting and our application for the boundary changes is on the agenda for LAFCO's March 5th Board hearing. Ms. Ochoa explained that once LAFCO approves our proposal there will be a 30 day reconsideration period and a protest hearing will likely be heard at their April 2nd Board meeting. She expects the new boundaries to record shortly thereafter. Ms. Ochoa recommended that the Board wait until the April meeting to adopt a map as the LAFCO hearing will have taken place and new boundaries will have been recorded. Ms. Ochoa stated she will provide an update at the March Board meeting with respect to how it went at the LAFCO Board meeting.

With respect to the maps, Ms. Ochoa stated we are just waiting for LAFCO to adopt the new boundaries.

With respect to the City of Poway litigation, Ms. Ochoa stated there is no update since the last Board meeting. She stated the preliminary injunction hearing was January 12th and there is still no decision.

Chairman Dagostino expressed his appreciation to Ms. Ochoa for her diligent work on this project.

18. Chief of Staff

a. Consideration of January Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 20, 2018.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the February Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 20, 2018. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

19. Consideration of Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Schallock seconded the motion.

Director Schallock stated he would be abstaining from the minutes of January 25, 2018. Director Reno stated she would be voting no on the minutes of January 25, 2018.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett and Mitchell**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**Schallock**
ABSENT:	**Directors:**	**Nygaard**

20. Discussion of items pulled from Consent Agenda

There were no items pulled from the Consent Calendar.

21. Director Mitchell commented on Chairman Dagostino's report from the CHA meeting he attended related to a bill about ambulances taking patients to non ER facilities. Chairman Dagostino stated there is talk in the legislature about allowing paramedic rigs to take patients to non-accredited emergency rooms. He stated there have been pilot projects regarding that, both in San Diego and Carlsbad. Chairman Dagostino

stated the association that represents Emergency physicians is not in favor of this. Community paramedicine has been very big in the rural communities and now it is extending to the cities to help decrease costs. He stated that most of the paramedics are on board. They want to treat patients in the field or transfer them to an urgent care center or hospital of their choosing. He noted trauma is not part of it. Directors expressed concern that the paramedics are making a judgment call beyond their scope of practice when they should be directed by a physician or nurse in the radio room. Dr. Souza stated that this issue was brought up at the MEC just last week and the consensus is that everyone is against it.

22. Legislative Update

Chairman Dagostino gave a brief Legislative update and discussed a proposed bill that would add a separate supplemental tax for CEO's whose salary exceeds $1 million.

Chairman Dagostino stated he will be representing the hospital at CHA Legislative Day on March 20-21 and will provide a report at next month's meeting.

23. Comments by Members of the Public

There were no comments by members of the public.

24. Additional Comments by Chief Executive Officer

There were no additional comments from the Chief Executive Officer.

25. Board Communications

Reports from Board Members

Director Schallock did not have any comments.

Director Kellett commented on a recent article in *Trustee Magazine* regarding the need for California hospitals to affiliate with other hospitals to help reduce costs. Director Kellett stated the article confirmed that Tri-City did the right thing by affiliating with UCSD and that the affiliation has benefited both institutions.

Director Reno commented that one of our first engineers here at Tri-City passed away recently, Mr. Pete Ritter.

Director Grass had no comments.

Director Mitchell had no comments.

26. Report from Chairperson

Chairman Dagostino reported we have finally moved on into the digital age and today is our first Board session using our new electronic devices.

Chairman Dagostino commented on the Auxiliary's scholarship program and suggested the Board consider making a donation on its behalf to the program.

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

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

February 20, 2017 – 3:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:12 p.m. on February 20, 2018.

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

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Larry W. Schallock

Absent were Director Julie Nygaard and Director RoseMarie V. Reno.

Also present were:

Steve Dietlin, Chief Executive Officer
Teri Donnellan, Executive Assistant
Brian Greenwald, Website Content Specialist
Chau Tran, Network Engineer
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 3:05 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Public Comments – Announcement

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

3. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (5-0-2) with Directors Nygaard and Reno absent.

4. Open Session

   a) Board of Directors Public Workshop for the purpose of review and discussion of:

   1) Board Portal Training

      Mr. Brian Greenwald, Website Content Specialist provided an interactive training session for Board members on the newly developed Board Portal. Board members received training on accessing the Portal via their IPADs which were also distributed

to those Board members in attendance. Board members will now be able to access Board meeting materials with the ultimate goal of eliminating the need for hard copy.

5. Comments from Members of the Public

There were no comments from members of the public.

6. There being no further business, Chairman Dagostino adjourned the meeting at 4:18 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Leigh Anne Grass
Secretary

Modern Healthcare

P.O. BOX 433290
Palm Coast, FL 32143-3290

GROUP SUBSCRIPTION RENEWAL INSTRUCTIONS

L00672

Customer Service: 800-669-6562
Fax Number: 386-447-6460

Remit By: 3/23/18

☐ I have enclosed $ _____ for ___ subscriptions.
PAYMENT IN U.S. FUNDS ONLY
☐ Check to renew/enter your own subscription.
☐ Check enclosed
☐ Charge to: [ ] VISA [ ] MASTERCARD [ ] AMEX

Acct No. _____
Expiration Date: _____
Signature: _____
Type of Business: _____
Email Address: _____

Federal Tax Payer I.D. #36-0708800

REF: 34508409 0601 R85209GG 26791328
A H00672 3/4/

TERI DONNELLAN
TCMC ADMINISTRATION
4002 VISTA WAY
OCEANSIDE, CA 92056-4506

5032700003450840 90 R85209GG4

PLEASE RENEW YOUR GROUP SUBSCRIBERS BELOW
Use reverse side to enter new group subscriptions

Renew (Circle One)	
YES	NO

503270000033896445 R85209GG4
JULIE NYGAARD
3405 SPANISH WAY, CARLSBAD, CA 92008
3389644 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

503270000074111940 R85209GG4
LARRY SCHALLOCK
PO BOX 428, SAN LUIS REY, CA 92068
7411194 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

503270000366527374 R85209GG4
CYRIL F KELLETT, TRICITY MEDICAL CENTER
2828 HIGHLAND DR, CARLSBAD, CA 92008
36652737 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

503270000386774335 R85209GG4
JAMES DAGOSTINO
3456 CAMDEN CIR, CARLSBAD, CA 92008
38677433 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

503270000394681567 R85209GG4
LAURA MITCHELL
161 POLK ST, OCEANSIDE, CA 92057
39468156 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

503270000403108336 R85209GG4
LEIGH ANNE GRASS
2882 WOODRIDGE CIR, CARLSBAD, CA 92008
40310833 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

YES NO

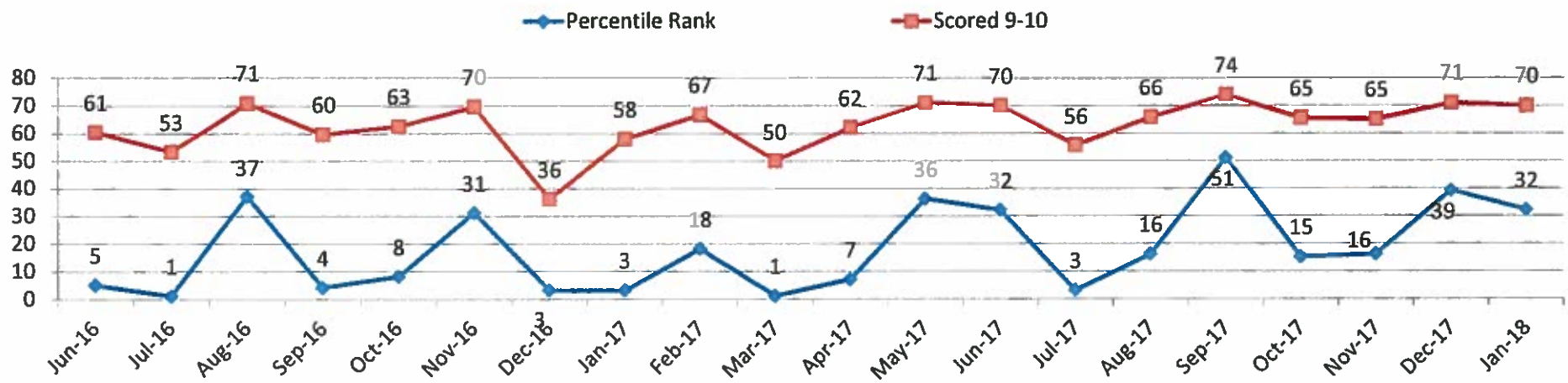
503270000901044116 R85209GG4
ROSEMARIE V RENO, TRICITY MEDICAL CENTER
4916 BELLA COLLINA ST, OCEANSIDE, CA 92056
90104411 EXPIRES MAY 2018 1 COPY 51 ISSUES $85.00

Return form in enclosed reply envelope/or mail to:

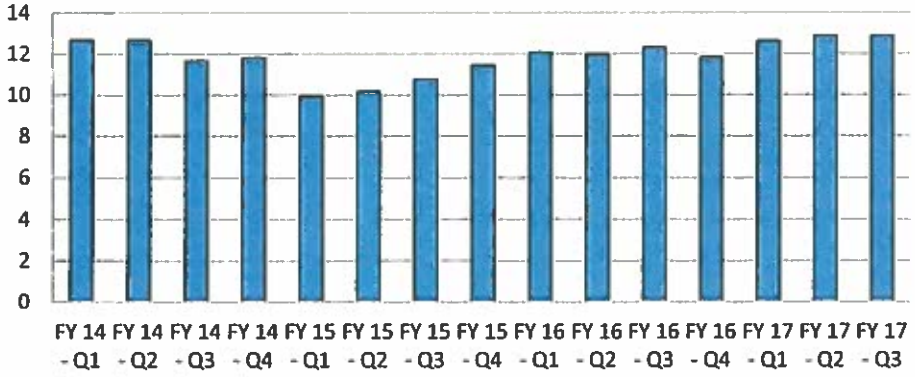
MODERN HEALTHCARE
SUBSCRIBER SERVICES
P.O. BOX 433290, Palm Coast, FL 32143-3290

Stakeholder Experiences

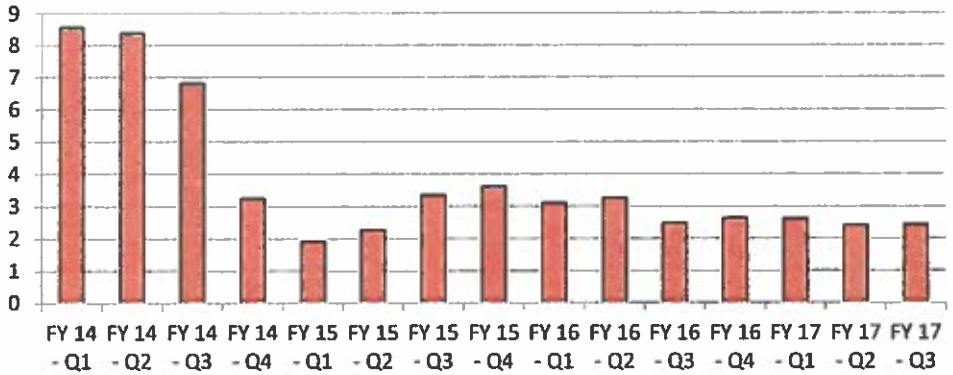
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

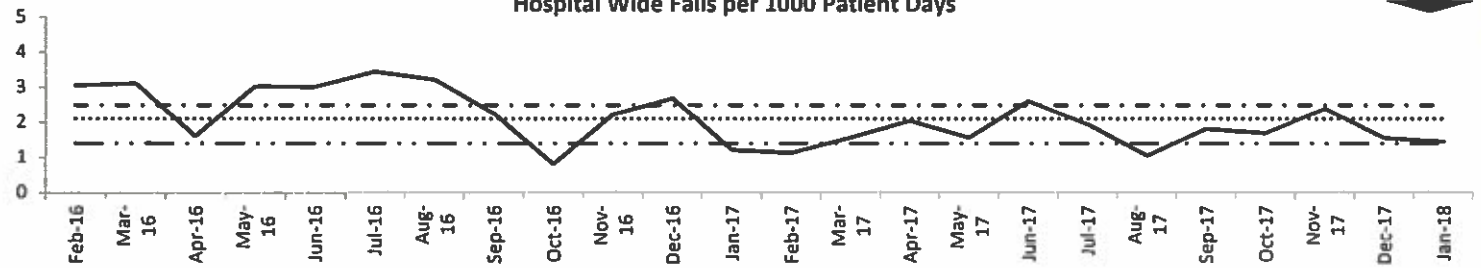


Current Trending Measures

TCMC Rate ····· Mean - · - · - CA Mean — · — · — TCMC Target

Better

Hospital Wide Falls per 1000 Patient Days

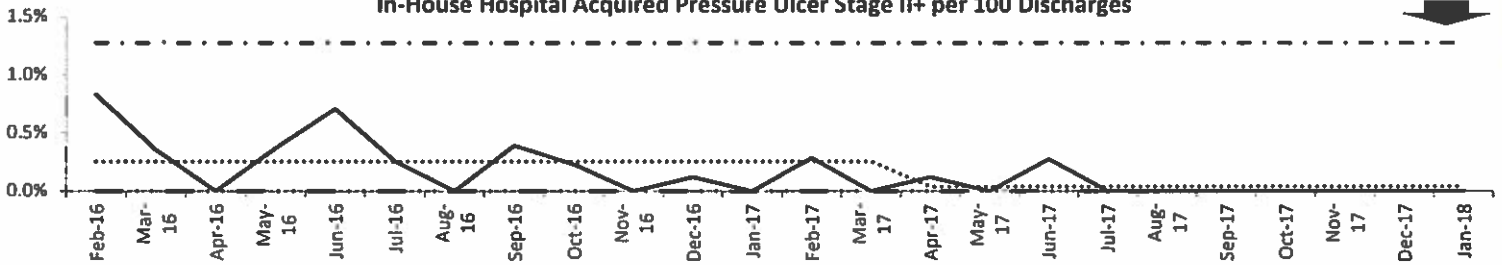


Action Plan

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. Continue to perform fall audit on Tuesdays and Thursdays. 5. Roll out the updated Falls Safety Plan for patient and family.

Better

In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges

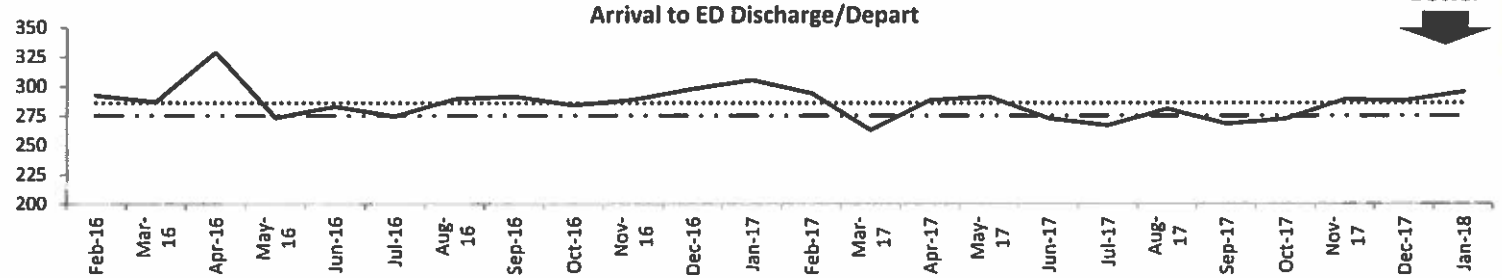


Action Plan

Request expansion of HAPI charter. 1. Perform regular assessments of high risk patients with Braden score of 18 or less. 2. Continue chart review for consistency of documentation of appropriate treatment/preventative measures. 4. Continue to enforce the implementation of the electronic report that identifies high risk patients.

Better

Arrival to ED Discharge/Depart



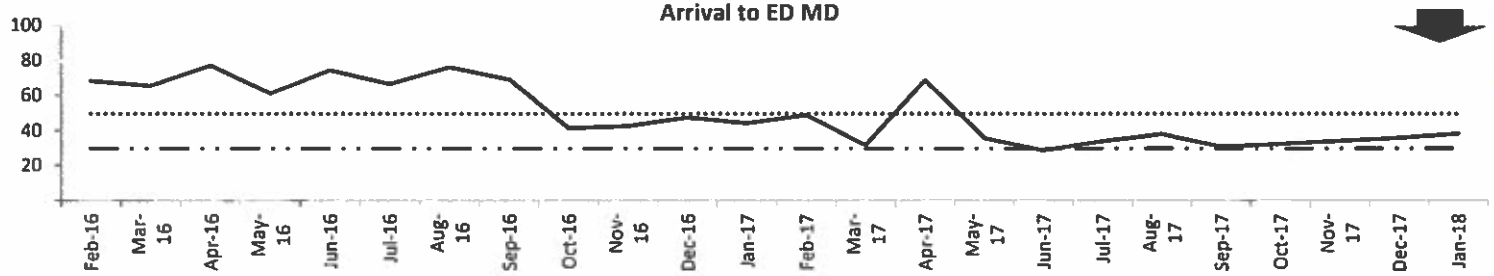
Action Plan

There as an influx of patients due to influenza and high acuity of illness. Continue to monitor

Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

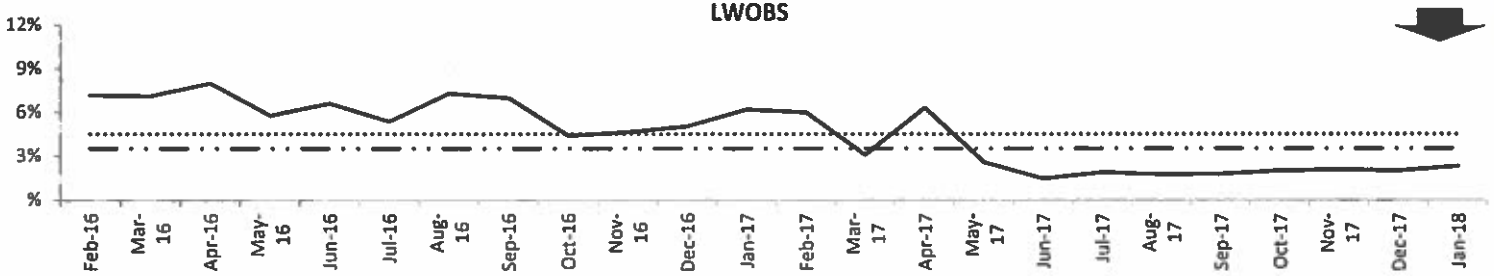
Arrival to ED MD



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

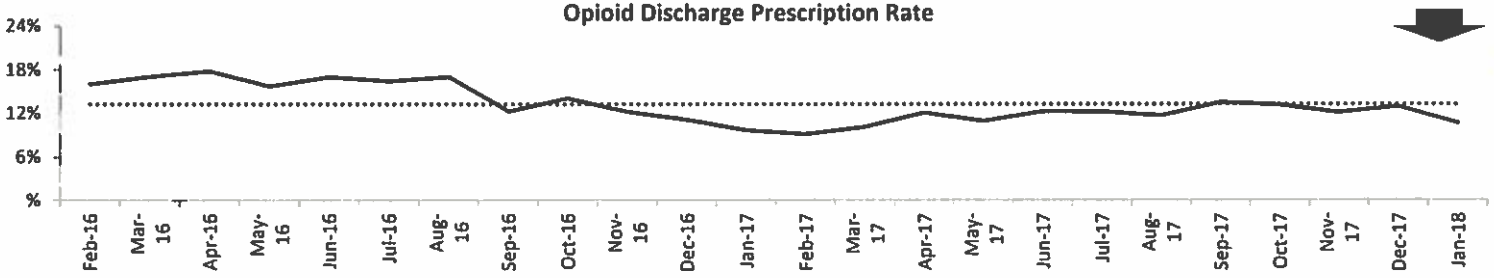
LWOBS



Action Plan

To-date TCMC is at 1.69%. 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 regristered at Triage. No wall time implemented with noted improvements

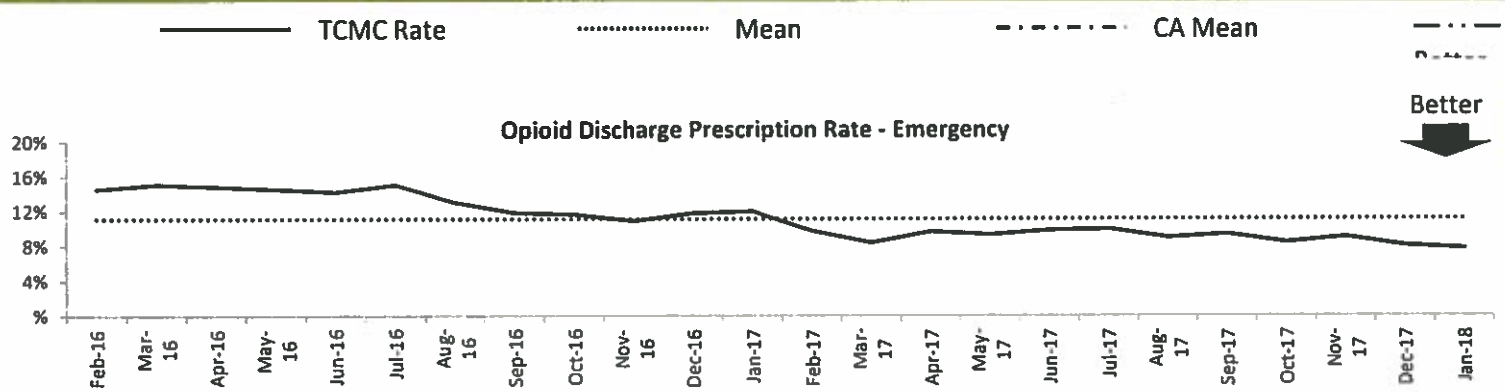
Opioid Discharge Prescription Rate



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 May with monitoring only. New safe disposal information has been added to patient discharge instructions

Current Trending Measures



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 May with monitoring only. New safe disposal information has been added to patient discharge instructions

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	23					191
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	8					84
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	12					118
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	19					143
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

Performance compared to prior year: Better | Same | Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	48	37	33	32	26	38	29	24					267
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5					14.5
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1	16.5	16.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7					7.9
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	12.7					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	185.8					177.3
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9	168.4	179.5

Performance compared to prior year:

Better	Same	Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194	206	184	166	209	169					1,560
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						34
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7	3	4	3	4						18
FY17	4	4	6	6	5	7	2	2	7	9	6	1	59

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	8	7	7	11	3	14	11	10					71
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	1.77					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	47.2					48.9	48-52
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1	46.5	50.0	

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	85.2					82.6	75-100
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6	79.9	81.5	81.9	82.3	

TCHD 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)	($542)					($5,957)	($1,187)
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$1,246	

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%	-1.86%					-2.49%	-1.33%
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%	5.04%	1.49%	

TCHD 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	$751					$4,451	$2,672
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)	$1,213	$1,558	$2,741	$5,094	

TCHD 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%	2.57%					1.86%	2.99%
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%	9.16%	6.09%	

TCMC 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	5.99					6.29	6.25
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18	6.56	5.88	

TCHD 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	$53.1					
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	

Education & Travel Expense
Month Ending February 2018

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	NURSE CALL SYSTEM SITE VISIT	20118	197.96	81883	MEREBETH RICHINS
6150	REVIEW NURSE CALL SYSTEM	20518	232.96	77850	PRISCILLA REYNOLDS
6185	ONS RECERTIFICATION	12418	103.00	82013	INJA KIM
6185	ONS RECERTIFICATION	12418	103.00	80217	CHANNGHIA LE
6185	CERTIFIED BREAST CANCER NURSE	12618	340.00	80217	CHANNGHIA LE
7010	PATIENT FLOW MANAGEMENT	13018	783.45	15694	CANDICE J PARRAS
7792	HAND THERAPY EDUCATION	21518	880.00	37799	PRIYA JOSHI
8381	IAHCSMM ANNUAL CONFERENCE	12918	500.00	78172	DEBRA MENDEZ
8710	2018 CME ESSENTIALS WORKSHOP	10218	603.82	81103	SHIRLENE TAYLOR
8720	NURSING EXECUTIVE CNTR NATIONAL MTG	10818	209.95	59683	SHARON SCHULTZ
8740	CA LAW & PROFESSIONAL ETHICS COURSE	22318	100.00	83202	BRENDA BALDERRAMA
8740	IAHCSMM CERTIFICATION	12918	125.00	18668	KIRK CONELEY
8740	NRP INSTRUCTOR CANIDATE COURSE	20818	130.00	83120	YAJAIRA PAREDES
8740	ACLS COURSE	20818	150.00	81810	MYRNA MARTIN REYES
8740	ACLS COURSE	20818	150.00	82463	ANNA MENDOZA
8740	ACLS COURSE	12918	150.00	83188	SUSAN AUSTIN
8740	PCCN CERTIFICATION	11818	199.00	69619	ROSEMARIE F MERCADO
8740	CERTIFIED HIPPA PROFESSIONAL EXAM	12918	200.00	82720	MARY G CANETE
8740	OCN CERTIFICATION	20818	200.00	83189	DINO REYES
8740	BASIC PATHOPHYSIOLOGY	20118	200.00	83190	IRMA YBARRA
8756	QUALITY HEALTH INSTITUTE CONFERENCE	111717	1,302.30	52610	JAMIE PIEARSON
8790	ENGLISH TO SPANISH TRANSLATION BOOKLETS	TJ458111	3,805.18	83196	STS TRANSLATIONS INC

**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.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending February 28, 2018

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term 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)	10,551.70	4/1/2016	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,540.00	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)	15,184.60	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Elfin 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	02/28/18	**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)	10,687.58	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	$2.50	(a)	27,970.32	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Total				**$ 188,340.50**			

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

March 23, 2018

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

California Hospital Association Health Policy Legislative Day March 21 &22 2018 Sacramento, CA

I attended the CHA Leg day in Sacramento. We were an integral part of the San Diego Team representing CHA on legislative issues important to us. We were joined by our colleagues from Palomar, Scripps, Sharp and UCSD and Kaiser. I had the opportunity to be tem leader for our Legislators in North County.

Seven bills were placed on the top priorities list and some time was devoted to the budget.

1 SB 2798(Support) This bill would create increased fees for the fourth consecutive time for CDPH Licensing and Certification. However it sets a time frame limit so if the application is not approved in a timely manner the project is considered approved.

2 SB 1795 – (Support) This bill co-sponsored by CH but has some issues enumerated by our Chief of ER Dr. Carey Mells. The bill allows EMS personnel transport behavioral health or intoxicated patients to alternative sites other than an emergency room. Pilot projects around the state have proven this to be valuable in decrease the clutter in emergency rooms. Many cities and counties have freestanding behavioral health treatment centers or sovereign centers. Dr. Mells pointed out in a presentation at CHAC North San Diego County does not have these type facilities. He was concerned that might place undue burden on our CSU. However more importantly he points out that EMS personnel would be placed in a position to diagnose at the scene of the accident and make a decision to transport without physician intervention. However our local EMS workers believed that they would continually be in radio contact with our emergency room might help them make that decision in the field. Dr. Mells was uncomfortable with this type of protocol. I got the opportunity to present his concerns to CHA in our closed session forum.

3 SB 1288(Oppose) this is a bill that would mandate maximum penalties for not being in compliance with the nurse patient ratio. As it is CPH has the ability to levy fines based on the severity of the violation is believed that that authority is working well and provides "fairness" in the system.

4 SB 152 (Oppose) This bill would prescribe a set of criteria in which homeless people would meet prior to discharge criteria is onerous and would require not discharging people in inclement weather, providing a hot meal two hours prior to discharge, mandated 30 day medical supply, and an excellent referral to a social services system prior to discharge. Many in the room felt that this would increase emergency room waits and is a burdensome law that may interfere with patient rights as well as placing a hospital in the position of having to solve the homeless crisis when all believe that this is a community problem.

1 AB 2759(Oppose) this is a bill that would mandate that hospitals not discriminate against two-year nursing programs take their students for training. This bill will be pulled and may reappear in another form.

2 Budget considerations- two item in the budget that are projected discontinuance of the 340 B drug discounts for hospitals are Medi-Cal patients. As we have discussed would be a major hit to Tri-City and it may interfere with our patient treatment especially in our infusion program. In our discussion with some of our legislators Assemblywoman Marie Waldron is willing to take a letter to her Republican caucus supporting to this program and given to the governor. Also included in the budget cuts would be to reduction of the tobacco tax monies that were to be given to the UC system for graduate medical education. We support restorations of those monies to increase the residency programs to help us make up for what is projected to be a 45,000 shortage of physicians in California.

In our downtime, I entered into discussions with her San Diego hospital colleagues about the budget cuts and staff reductions going on at each of our institutions. It was quite interesting to see that members of the Sharp Board of Directors along with Scripps follow Tri-City closely.

FROM THE DESK OF
LEIGH ANNE GRASS, RN, BSN, PHN

1565 Hotel Circle South
Suite 320
San Diego, CA 92108

Phone: (760) 458-2741 (C)
Phone: 619-450-4414 (W)
Fax: 619-450-4409 (F)

Leigh Anne Grass, RN, BSN, PHN
Tri-City Healthcare District
SEMINAR EVALUATION:

ASSOCIATION OF CALIFORNIA HOSPITAL DISTRICTS (ACHD)

09 February 2018

As the newest elected board member to Tri-City Healthcare District Board of Directors, I received the opportunity to attend the Association of Healthcare Districts 2018 Leadership Seminar for the second time. The intended purpose of attending this seminar was increase my knowledge base of public section resources and governance tools. As a successful leader in the community, attending seminars such as the Association of Healthcare Districts 2018 Leadership Seminar provides useful insight and opportunities for growth. Please let me extend my appreciation to the Tri-City Healthcare District for the opportunity.

During the seminar, a total of 9 speakers presented information, which was all relevant to district hospitals. Amber King, Vice President of Government Affairs for ACHD, and Sheila Johnston, Vice President of Member Relations for ACHD, jointly discussed how the ACHD Advocacy Team works with State Legislature to analyze and recommend action on bills impacting healthcare districts.

James A. Rice, PhD, Integrated Healthcare Strategies, discussed strategic governance structures for high performing boards. Much of what he discussed during his allotted time sounded much like information we received after our Self-Board Evaluation. His information would lead one to believe many boards have the same challenges, certainly from the audience questions, some have much larger problems than others.

Lou Anne Texeira, Executive Director of Contra Costa Local Agency Formation Commission (LAFCO), discussed key ways to understanding and work with local agencies. Ms. Texeira explained the roles and responsibilities of LAFCO within California and their relationships with special districts, especially hospital districts. Going through our current transitions certainly allowed for greater understanding of the subject matter.

Wes Alles, PhD., Director of Stanford's Health Improvement Program, was by far my favorite speaker. He discussed how career wellbeing was the number one driver of health. I learned about the Community Health Living Index funded by the CDC and the YMCA. It was most interesting to hear the national prevention strategies in place and those coming in the near future to promote community health. His subject matter was so interesting I took three pages of notes in one hour. Dr. Alles main focus for the past ten years has been to facilitate behavior modification programs for people with Type A behavior patterns. I'm fairly certain I would make an excellent candidate for his research.

Shayna Mittler Van Hoften, partner at Hanson Bridgett provided information on governance laws, public procurements, contracting, civil rights, grant programs, risk management, and constitutional matters. A portion of her time was dedicated to marketing do's and don'ts, which was vey interesting. Additionally, she discussed how healthcare districts should not contract with other healthcare partners if doing so limited the patients ability to choose which healthcare partner they preferred. She also discussed the backlash in store for hospitals that mainly refer to their own home health companies.

The Brown Act and Fair Political Practices Commission: AB 1234 Training, Sessions 1 on Thursday and Session 2 on Friday, ran a close second as my favorite. Gary Winuk, Counsel for Kaufman Legal Group, spoke on this subject matter over the two-day time span. His goal was to help participants of the conference better understand the Brown Act and know the purpose of the Fair Political Practice Commission. This was the second time to hear Mr. Winuk speak and each time he increases my foundation on the subject. His years of experience allowed him to easily explain how to identify methods of compliance and the implications of non- compliance. Of all the speakers, Mr. Winuk was the most informative for district matters. He was a 5-star speaker and resource. It was my pleasure to listen and learn from this gentleman. I had many "hypothetical" questions to ask after the conference, which he was most gracious to discuss and provide advice. Overall the conference was beneficial. If I had to rate it on a scale of 1 to 10, I would give it a solid 8. The venue was conducive to the purpose, the speakers were knowledgeable on their subject matter, and the messages were clear to understand. Audio and visual aids were useful and easy to navigate. Once again, thank you Tri-City Healthcare District for this opportunity.

Take Action: Return this form to CSDA

mail: CSDA, 1112 I Street, Suite 200, Sacramento, CA 95814
email: advocacy@csda.net
fax: 916.520.2466

Name: _____

District Name: _____

Email: _____

Grassroots Mobilization Survey

Do You Know Your Legislator?

Willingness to contact your personal legislative contacts regarding an issue of importance to special districts:

1 2 3 4 5

Names of state legislators with whom you are acquainted, and the strength of your relationship:

LEGISLATOR NAME	WEAK – STRONG
_____	1 2 3 4 5
_____	1 2 3 4 5
_____	1 2 3 4 5

Blog Sign-Up

Be the First to Hear the Latest

Receive email updates on the latest Capitol action, daily news clips, and breaking stories from CSDA's lobbyists.

Email frequency: ☐ Instant ☐ Daily ☐ Weekly

Outreach Champion

Help Get the Word Out

☐ I would be interested in signing my name to letters to the editor, speaking on the record to reporters, and participating in other opportunities to spread the word about special districts. I would have final sign-off on any communications attributed to me.

District NetWorks

Your Local CSDA Contact!

DANE WADLÉ
danew@csda.net
- Northern Network
- Sierra Network

COLLEEN HALEY
colleenh@csda.net
- Bay Area Network

CHRIS PALMER
chrisp@csda.net
- Coastal Network
- Southern Network

STEVEN NASCIMENTO
stevenn@csda.net
- Central Network

TAKE *ACTION*

Equipping special district leaders for grassroots advocacy and public outreach

CSDA

California Special Districts Association

Districts Stronger Together

Grassroots Advocacy

THE FOUR SEASONS OF ADVOCACY

Making every day Special Districts Legislative Day

Spring

- ☐ Attend Special Districts Legislative Days
- ☐ Update your CSDA Grassroots Mobilization Survey at www.csda.net.
- ☐ Respond to CSDA "Calls to Action" on priority legislation.

Summer

- ☐ Meet with each of your local legislators in their district offices.
- ☐ Respond to CSDA "Calls to Action" on priority legislation.

Fall

- ☐ Host your local legislators and their staff for tours of your district facilities
- ☐ Attend your local legislators' community events and invite them to yours

Winter

- ☐ Set up a "meet and greet" with each newly-elected local legislator
- ☐ Sign up for your local legislators' eNewsletters and social media and add them to yours.

271

Public Outreach

DISTRICTS MAKE THE DIFFERENCE

www.DistrictsMakeTheDifference.org

- Information and background about special districts
- Descriptions about how special districts serve communities
- News and compelling videos about special districts

Join the Campaign

- Like and Follow us on Facebook.com/CASpecialDistricts
- Follow and Retweet us on Twitter @CA_Districts
- Subscribe to our YouTube channel www.youtube.com/CASpecialDistrictsDMTD

Campaign Toolkit

In addition to engaging in our social media efforts, the campaign toolkit provides you with the tools to easily spread the word about special districts to the community through your website, newsletters, bill inserts or other media:

- Download a Districts Make the Difference logo for your use
- Link the logo on your homepage to www.DistrictsMaketheDifference.org
- Print out campaign tools for distribution to your community

California Special Districts Association
Attention: CSDA Legislative Assistant
1112 I Street, Suite 200
Sacramento, CA 95814

Place Stamp Here