TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
June 28, 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) Leonie K Hall v Tri-City Healthcare District Case No. 16-cv-01693-GPC-AGS		
	b. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (4 Matters)		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		

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
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 – a) Presentation of Cardiovascular Awards – Eva England, Cardiovascular Service Line Director and Jennifer Sabotka 1) AHA CHF Gold Plus Recognition 2) AHA Gold Plus Recognition Stroke 3) AHA Mission: Lifeline Gold STEMI Award 4) AHA Mission: Lifeline NSTEMI STEMI Silver Recognition Award 5) National Cardiovascular Data Registry– GWTG Gold	15 min.	Chair
13	Report from TCHD Auxiliary – Mary Gleisberg, Auxiliary President	10 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	Report from Chief Governmental & External Affairs Officer	10 min.	Standard
17	New Business a. Consideration to approve Resolution No. 793, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2018 and ending June 30, 2019, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California b. Consideration to approve amended Bylaws to reflect change in committee structure and reference to District Zones for election purposes	5 min. 5 min.	CFO Chair
18	Old Business – a) Update and action on Board Committee Structure Recommendations 1) Consideration to establish Special Quarterly Board Meetings	10 min. 5 min.	Ad Hoc Comm. Ad Hoc Comm.
19	Chief of Staff a. Consideration of June Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on June 25, 2018	5 min.	Standard
20	Consideration of Consent Calendar	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(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 <u>require a second</u>.*** **A. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair *(No meeting held in June, 2018)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of an agreement with Drs. Anish Kabra, Mohammad Pashmforoush, Pargol Samani and David Spiegel as the Cardiology-General ED Call coverage physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily rate of $300, for an annual and term cost of $109,500. 2) Approval of an agreement with The Neurology Center physicians Drs. Bilal Choudry, Laura Desadier, Benjamin Frishberg, Gary Gualberto, Amy Nielsen, Ireno Oh, Remina Paduga, Jay Rosenberg, Mark Sadoff, Gregory Sahagian, Jack Schim, Anchi Wang, Chunyang Tracy Wang and Abigail Lawler as the Neurology ED Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily rate of $740, for an annual term cost of $270,100. 3) Consideration of an agreement with Dr. John LaFata as the Medical Director for Utilization Review/DRG program for a term of 24 months, beginning July 1, 2018 through June 30, 2020, not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $170, for an annual cost not to exceed $61,200 and a total cost for the term not to exceed $122,400. 4) Approval of an agreement with Dr. Chris Guerin as the Medical Director for Diabetic Services/Program for a term of 24 months, beginning July 1, 2018 through June 30, 2020, not to exceed 16 hours per month or 192 hours annually, at an hourly rate of $150, for an annual cost not to exceed $28,800 and a total cost for the term not to exceed $57,600. 5) Approval of an agreement with Dr. Chad Bernhardt as the Disaster Management Physician Liaison for a term of 24 months, beginning July 1, 2018 through June 30, 2020, not to exceed 3 hours per month or 36 hours annually, at an hourly rate of $150 for an annual cost of $5,400 and a total cost for the term of $10,800.		CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	6) Approval of an agreement with Drs. Jamshidi-Nezhad, Kabra and Spiegel as the Cardiovascular Health Institute Specialty Medical Directors for a term not to exceed 12 months, beginning July 1, 2018 and ending June 30, 2019 for an average of 36 hours per month or 432 hours annually, at an hourly rate of $210 for an annual and term cost of $90,720. 7) Approval of an agreement with Dr. Ponec as the Cardiovascular Health Institute Medical Director for a term of 12 months, beginning July 1, 2018 through June 30, 2019, for an average of 8 hours per month, not to exceed 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160. 8) Approval of an agreement with Dr. Scott Worman as the Physician Patient Safety Officer for a term of 24 months from July 1, 2018 through June 30, 2020, not to exceed an average of 8 hours a month, at an hourly rate of $170 for a total annual cost of $16,320 and a total term cost of $32,640. 9) Approval of an agreement with Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months beginning July 1, 2018 through June 30, 2019, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $42,000. 10) Approval of an agreement with Marcus Contardo, M.D. as the Professional Behavior Committee Chair for a term of 24 months, beginning July 1, 2018 through June 30, 2020, at a rate of $180.56 for a minimum of 30 hours per month or 360 hours annually, for an annual cost of $65,000 and a total term cost of $130,000. 11) Approval of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 24 months, beginning July 1, 2018 through June 30, 2020 at $57,917 a month for an annual cost of $695,000 and a total cost for the term of $1,390,000. 12) Approval of an agreement with San Diego Diagnostic Radiology Medical Group, Inc. to provide radiological services supervision and medical directorship coverage for a term of 3 years beginning July 1, 2018 through June 30, 2021. 13) Approval of an agreement with ophthalmology physicians Drs. Robert Pendleton, Mark Smith, Maulik Zaveri, Henry Hudson, Peter Krall, Srinivas Iyengar, Logan Haak, James Davies, Bradley Greider, Atul Jain, Neeta Varshney as the Ophthalmology ED Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019 at a daily rate of $300, for an annual and term cot of $109,500. 14) Approval of an agreement with Dr. Jack Schim as the Medical Director for the Stroke Program for a term of 24 months, beginning July 1, 2018 through June 30, 2020, not to		

	Agenda Item	Time Allotted	Requestor
	exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $200 for an annual cost of $28,800 and a total cost for the term of $57,600.		
	15) Approval of an agreement with Direct Difference for necessary additional data chart abstraction to add to the existing term currently ending on March 18, 2020, for an additional expected cost of $65,524 and a new total expected cost for the term of $300,000.		
	C. Professional Affairs Committee Director Grass, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)*		PAC
	1) <u>Patient Care Policies and Procedures</u> a) Code Pink Resuscitation – Standardized Procedure b) Computerized Axial Tomography (CT) Downtime Response Procedure c) Controlled Substances Management Policy d Discharge of Patients and Discharge AMA Policy e) Identification, Patient Policy f) Interpretation and Translation Services g) Stroke Code, In House h) Wasting Narcotics, Documentation in the Pyxis Machine i) WOCN-ET Standardized Procedure		
	2) <u>Administrative Policies and procedure</u> a) Smoke-Free Environment		
	3) <u>Unit Specific – Behavioral Health Services</u> a) Behavioral Health Unit/ Crisis Stabilization Unit Departmental Disaster Implementation Plan b) Notification of MediCal Beneficiary of Denial of Benefits c) Patient Rights		
	4) <u>Unit Specific – Medical Staff</u> a) Appropriate Use of Commercial Support and Exhibits b) CME Speaker & Honoraria Reimbursement c) Conflict of Interest Resolution d) Criteria Pain Management Privileges e) Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity		
	5) <u>Unit Specific – Surgical Services</u> a) Aseptic Technique Policy (DELETE) b) Reusable Airway Equipment Cleaning Procedure (DELETE) c) Steris Set-up, Use and Monitoring Procedure (DELETE) d) Testing C02 Laser Procedure (DELETE) f) Universal precautions in Surgery Policy g) Wound Classification Policy (DELETE)		
	6) <u>Unit Specific - Women & Newborn Services</u> 1. Skin to Skin Contact After Birth		

	Agenda Item	Time Allotted	Requestor
	7) **Formulary Requests** 1. Nitrofurantoin Suspension **D. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in June, 2018)* (2) Minutes – Approval of: a) Regular Board of Directors Meeting – May 31, 2018 b) Special Board of Directors Meeting – May 24, 2018 c) Special Board of Directors Meeting – June 7, 2018 (3) Meetings and Conferences – None (4) Dues and Memberships - None		Audit, Comp. & Ethics Comm. Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (May, 2018) (d) Reimbursement Disclosure Report – (May, 2018) (e) Seminar/Conference Reports 1) CHA Governance Forum – Director Dagostino	0-5 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 hours/ 30 min.	
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		

RESOLUTION NO. 793

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2018 AND ENDING JUNE 30, 2019 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA

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

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

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

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

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

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2018 and ending June 30, 2019 is not to exceed $14,758,710.

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

ADOPTED, SIGNED AND APPROVED this 28th day of June, 2018.

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

ATTEST:

Leigh Anne Grass, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

TRI-CITY HEALTHCARE DISTRICT

BYLAWS

Approved ~~March 29, 2018~~June 28, 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~~ designated district zone 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.

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.~~C. Professional Affairs Committee

~~F.~~D. 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 ~~29~~29th ~~day of March~~ day of June, 2018.

James J. Dagostino Date
Chairperson

ATTEST:

Leigh Anne Grass Date
Secretary

BOARD AD HOC COMMITTEE RESTRUCTURE RECOMMENDATIONS RELATED TO PROFESSIONAL AFFAIRS COMMITTEE

The Ad Hoc Committee of the Board recommends the following changes to the Professional Affairs Committee:

The Board will have oversight on a **quarterly, biannual or monthly basis** as deemed appropriate on the following areas:

1. **Quality**

   a) Hospital operating unit and quality intervention programs.

2. **Patient Safety**

   a) Patient safety improvement programs

   b) Incident reports to the California Department of Public Health (CDPH) including any findings

   c) Surveys from the Joint Commission, Center for Medicare and Medicaid Services, and other regulatory agencies

3. **Performance Improvement**

   a) Operating unit performance improvements

4. **Risk Management**

   a) Summaries of incident reports and complaints;

   b) Surveys from Joint Commission, CMD and CDPH visits;

   c) Sentinel Events/Root Cause Analyses; and

   d) Professional liability claims and lawsuits.

5. **Oversight Duties and Responsibilities**

   a) Review significant reports prepared by an individual performing significant quality assurance functions together with management's response and follow-up to these reports.

All remaining duties will remain with the PAC committee as described on the attached Charter.

It is anticipated the PAC committee will meet less frequently, perhaps on a quarterly or as needed basis.

TRI-CITY HEALTHCARE DISTRICT

PROFESSIONAL AFFAIRS COMMITTEE CHARTER

The Professional Affairs Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to assist the Board in providing healthcare delivery oversight and make recommendations to the Tri-City Healthcare District Board of Directors ("Board") regarding ~~quality, patient safety, performance improvement, and risk management~~ policies when needed and provide oversight of processes relating to actions taken including the following; ~~oversee development and implementation of the Quality Assurance, Quality Improvement, and Patient Safety (QA/QI/PS) Programs; and provide oversight of processes relating to the reporting, monitoring, investigation, and appropriate responsive/corrective actions taken in connection with any issues identified at the meetings, including the following:~~

~~1.~~ Quality. The Committee will review reports regarding quality of patient care, including:

~~a. Hospital operating unit and quality intervention programs;~~

~~b. Core measures and performance measures;~~

ae. Review of Clinical Contract Performance;

~~d. While Risk Management will retain responsibility for risk related issues, PAC will provide support and guidance for such issues; and~~

~~e. While Patient Care related issues will remain the responsibility of the CNE, PAC will provide input and support regarding these matters.~~

~~2. Patient Safety. The Committee will review reports regarding patient safety, including:~~

~~a. Patient safety improvement programs;~~

~~b. Incidents reported to the California Department of Public Health (CDPH) including any findings;~~

~~c. Surveys from The Joint Commission, Center for Medicare and Medicaid Services, and other regulatory agencies.~~

~~3. Performance Improvement. The Committee will review the following reports:~~

~~a. Operating unit performance improvements;~~

~~4. Risk Management. The Committee will review the District's risk management program, including:~~

~~a. Summaries of incident reports;~~

~~b. Compliments and complaints;~~

~~c. Surveys from Joint Commission, CMS, and CDPH visits;~~

~~d. Sentinel Events/Root Cause Analyses;~~

~~e. Professional liability claims and lawsuits.~~

Oversight Duties and Responsibilities. In addition, the Committee will:

a. Recommend any proposed changes to the Board for approval, and review and publish this Charter every three years in accordance with applicable regulatory authorities;

~~b. Review significant reports prepared by any individual performing significant quality assurance functions together with management's response and follow-up to these reports;~~

Review the District's policies and procedures ~~as necessary~~when Administration deems PAC assistance is needed or required by regulatory guidelines.

~~Review the Medical Staff Office procedures~~.

Review of hospital's clinical contracts.

~~f. Consult with appropriate Consultants as necessary to inform the deliberations and committee decisions as necessary.~~

II. Membership

The Committee shall consist of three Directors and ~~four~~ physician(s) as deemed appropriate by Administration. The CEO, COO, Risk Manager, and CNE shall support the Committee without vote but be counted towards a quorum as alternates.

III. Meetings

The Committee may establish its own meeting schedule annually. The Committee will adjourn into closed session to meet with the legal counsel and to hear reports when needed. ~~of the Hospital and QA/PI Committee.~~

~~IV.~~ Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

~~V.~~ IV. Reports

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

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved by BOD: 9/29/11
Approved by BOD: 3/28/13
Approved by BOD: 5/29/14
Approved by BOD: 9/29/16
Approved by BOD:

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
June 13, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 6/29/2018 – 5/31/2020)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 6/29/2018 through 5/31/2020:

- **ABBOUD, Jean Paul MD/Ophthalmology (Pendleton Eye Center)**
- **BALL, Lindsay MD/Emergency Medicine (TeamHealth)**
- **BRADFIELD, Harold MD/Teleradiology (StatRad)**
- **CATTAFI, Paul DO/Anesthesiology (ASMG)**
- **DALLA BETTA, Michael DO/Emergency Medicine (TeamHealth)**
- **DOAN, Michael MD/Anesthesiology (ASMG)**
- **GASTELUM, Jennifer MD/Anesthesiology (ASMG)**
- **LI, Terry MD/Emergency Medicine (TeamHealth)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
June 13, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 7/01/2018 –6/30/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 7/01/2018 through 6/30/2020, 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:

- **AHMED, Mohammed, MD/Psychiatry/Provisional**
- **BEN-HAIM, Sharona, MD/Neurosurgery/Provisional**
- **CONTARDO Marcus, MD/Pathology Anatomic/Active**
- **EIKERMANN, Eric, MD/Anesthesiology/Provisional**
- **ELCHICO, Erick, MD/Anesthesiology/Provisional**
- **EL-SHERIEF, Karim, MD/Cardiology/Active**
- **FERNANDEZ, Janice, MD/Anesthesiology/Provisional**
- **FIERER, Adam, MD/General/Vascular Surgery/Active**
- **GOKALADAS, Reshma, MD/Neurology/Provisional**
- **GOLD, Evan, DMD/Oral & Maxillofacial Surgery/Active**
- **HURD, Melissa, MD/Family Medicine/Active Affiliate**
- **JAIN, Atul, MD/Ophthalmology/Active**
- **JESWANI, Sunil, MD/Neurological Surgery/Active**
- **KATZMAN, LEE, MD/Ophthalmology/Provisional**
- **KAYAL, Anas, MD/Internal Medicine/Active**
- **KELLY, Jon, MD/Orthopedic Surgery/Active Affiliate**
- **KIM, James, MD/Anesthesiology/Provisional**
- **LEBOVITS, Marc, MD/Otolaryngology/Active Affiliate**

Attachment B

- LEE, Anna, MD/Pediatrics/Active
- LEE, Robert, MD/Internal Medicine/Active
- LINSON, Patrick, MD/Radiation Oncology/Active
- MATTHEWS, Oscar, MD/Cardiology/Active
- MITCHELL, Charles, MD/Radiology/Provisional
- PAZ, Pedro, MD/Neonatology/Active
- PERRICONE, Anthony, MD/Cardiothoracic Surgery/Provisional
- PERTL, Ursula, MD /Pediatrics/Active
- PRETORIUS, Gert, MD/Cardiothoracic Surgery/Provisional
- REEN, Sandeep, MD/Family Medicine/Provisional
- SEIF, David, MD/Anesthesiology/Active
- SHABANIAN, Leila, MD/Internal Medicine/Provisional
- SPRINGER, Dewain, DPM/Podiatric Surgery/Active
- SUBRAMANIAN, Rupa, MD/Oncology/Active Affiliate
- TUNG, Howard, MD/Neurological Surgery/Active

RESIGNATIONS: (Effective date 6/30/2018 unless otherwise noted)

Automatic:

- CHARLTON, Kimberly MD/Psychiatry
- CHU, James, MD/Pediatrics
- VIETS, Ryan, MD/Radiology
- ZACHARY, Alison MD/Pediatrics

Voluntary:

- GUPTA, Abhay MD/Plastic Surgery

Attachment B

- **KHORASHADI, Farhad MD/Radiology**
- **WATERS, Michael, MD/Family Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
June 13, 2018

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
June 13, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 6/30/18, unless otherwise specified)

• BURKE, Michael MD	Radiology
• GUTIERREZ, Miguel MD	Emergency Medicine
• HUANG, Stephanie PA-C	Allied Health Professional
• INOCELDA, Andrew PA-C	Allied Health Professional
• MOREIRA, Lucila DO	Pediatrics
• PASHMFOROUSH, Mohammad MD	Cardiology
• PERLMAN, Tamara CNM	Allied Health Professional
• PONEC, Donald MD	Radiology
• SAXON, Richard MD	Radiology
• VAYSER, Dean DPM	Podiatry

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT
June 2018 – Electronic Approval

Attachment B

BIENNIAL REAPPRAISAL: (Effective Dates 7/1/2018 – 4/30/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 7/1/2018 through 4/30/2020, 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:

- **LEVIEL, Linda CNM/Allied Health Professional**

Community Healthcare & Alliance Committee (No meeting held in June, 2018)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
June 19, 2018

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Wayne Lingenfelter, Jack Cumming
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, Thomas Moore, Jane Dunmeyer, Georgia McCullough, Sherry Miller, Diane Sikora, Anna Aguilar, Aaron Byzak, Merebeth Richins, Charlene Carty, Lisa Stroud, Eva England, Jaclyn Hunter, Steve Young, Barbara Hainsworth
Members Absent:	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:31 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Dr. Contardo, Director Grass seconded, and it was unanimously approved to accept the agenda of June 19, 2018.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN:** **ABSENT:**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of May 22, 2018	Minutes were ratified.	Minutes were ratified. **MOTION**	

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
		It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of May 22, 2018 are to be unanimously approved, with Mr. Cumming abstaining from the vote.	
5. Old Business			
a. Physician Agreement for ED On-Call Coverage – Cardiology, General (AMENDED)	Sherry Miller conveyed that this agreement was being brought back to the Finance, Operations & Planning committee to approve an increase in the rate for ED On-Call services for the Cardiology-General physicians from $200 to $300 per hour.	**MOTION** **It was moved by Director Kellett, seconded by Dr. Contardo to authorize the agreement with Drs. Anish Kabra, Mohammad Pashmforoush, Pargol Samani, and David Spiegel as the Cardiology-General ED-Call coverage physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019, at a daily rate of $300, for an annual and term cost of $109,500.**	Sherry Miller
b. Physician Agreement for ED On-Call Coverage – Neurology (AMENDED)	Sherry Miller explained that this agreement is being brought back to the Finance, Operations & Planning committee to change the write-up agreement verbiage from the individual physicians to "The Neurology Center". This modification permits the credentialed neurology physicians listed to be added to the ED on-call roster, without returning to the FOP committee in order to add them to the panel.	**MOTION** **It was moved by Director Kellett, seconded by Director Grass to authorize the agreement with "The Neurology Center" physicians Drs. Bilal Choudry, Laura Desadier, Benjamin Frishberg, Gary Gualberto, Amy Nielsen, Irene Oh, Remia Paduga, Jay Rosenberg, Mark Sadoff, Gregory Sahagian, Jack Schim, Anchi Wang, Chunyang Tracy Wang and Abigail Lawler as the Neurology ED-Call coverage physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at daily rate of $740, for an annual and term cost of $270,100.**	Sherry Miller

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
6. New Business			
a. Introduction of New Community Member • Mr. Jack Cumming	Director Nygaard welcomed Mr. Jack Cumming as the new Community Member to the Finance, Operations and Planning Committee.		
7. Consideration of Consent Calendar:	Director Nygaard requested that the following items be pulled from the Consent Calendar for discussion: • 7.a. Medical Director Agreement for Utilization Review / DRG Program - Dr. John LaFata • 7.k. Physician Agreement for ED On-Call Coverage – Ophthalmology • 7.m. Addendum to Abstraction Agreement Proposal - Direct Difference	**MOTION** **It was moved by Director Grass to approve the Consent Calendar, Mr. Lingenfelter seconded.** **Members:** **AYES: Nygaard, Kellett,, Grass, Ma, Ferber Lingenfelter, Cumming** **NOES: None** **ABSTAIN: Drs. Contardo, Yamanaka** **ABSENT:**	Chair
a. Medical Director Agreement for Utilization Review / DRG Program • John LaFata, M.D.	Lisa Stroud conveyed that the write-up for Dr. LaFata, as the Medical Director Agreement for Utilization Review / DRG Program has been amended to reflect a change in the previous hourly rate and an increase in the hours per month.	**It was moved by Mr. Lingenfelter, seconded by Dr. Contardo to authorize the agreement with Dr. John LaFata as the Medical Director for Utilization Review/DRG program for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020. Not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $170, for an annual cost not to exceed $61,200, and a total cost for the term not to exceed $122,400.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN:** **ABSENT:**	Lisa Stroud

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
b. Medical Director Agreement for Diabetes Services / Program • Dr. Chris Guerin		**Approved via Consent Calendar**	Diane Sikora
c. Disaster Management Physician Liaison Agreement • Dr. Chad Bernhardt		**Approved via Consent Calendar**	Jeff Surowiec
d. Cardiovascular Health Institute – Specialty Medical Directorship Proposal • Drs. Mohammad Jamshidi-Nezhad, Ashish Kabra & David Spiegel		**Approved via Consent Calendar**	Eva England
e. Cardiovascular Health Institute – Medical Directorship Agreement • Dr. Donald Ponec		**Approved via Consent Calendar**	Eva England
f. Physician Agreement for Physician Patient Safety Officer • Scott Worman, M.D. (CIBBADELA)		**Approved via Consent Calendar**	Merebeth Richins
g. Physician Agreement for ICU Medical Director • Mark Yamanaka, M.D.		**Approved via Consent Calendar**	Merebeth Richins
h. Medical Staff Leadership Agreement – Professional Behavior Committee Chair • Marcus Contardo, M.D.		**Approved via Consent Calendar**	Scott Livingstone
i. Medical Staff Leadership Agreement – Clinical & Anatomic Pathology		**Approved via Consent Calendar**	Scott Livingstone

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
Services • Marcus Contardo, M.D. (North Coast Pathology Medical Group)			
j. Radiological Services & Medical Director Contract Proposal • San Diego Diagnostic Radiology Medical Group, Inc.		**Approved via Consent Calendar**	Steve Young
k. Physician Agreement for ED On-Call Coverage - Ophthalmology	Sherry Miller conveyed that this write-up is being amended to remove physician Sally Mellgren, M.D. from the agreement, as she is no longer a member of the medical staff at Tri-City Medical Center.	**MOTION** **It was moved by Dr. Contardo, seconded by Dr. Ferber to authorize the agreement with with ophthalmology physicians Robert Pendleton, M.D.; Mark Smith, M.D.; Maulik Zaveri, M.D.; Henry Hudson, M.D.; Peter Krall, M.D.; Srinivas Iyengar, M.D.; Logan Haak, M.D.; James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Neeta Varshney, M.D. as the Ophthalmology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at a daily rate of $300, for an annual and term cost of $109,500.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN:** **ABSENT:**	Sherry Miller
l. Physician Agreement for Medical Director – Stroke		**Approved via Consent Calendar**	Sharon Schultz

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
Program • Jack Schim, M.D.			
m. Addendum to Abstraction Agreement Proposal • Direct Difference		**MOTION** **It was moved by Dr. Kellett, seconded by Dr. Contardo to authorize the agreement with Direct Difference for necessary additional data chart abstraction to add to the existing term currently ending on March 18, 2020 for an additional expected cost of $65,524, and a new total expected cost for the term of $300,000.** **Members:** **AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN:** **ABSENT:**	Jaclyn Hunter
8. Financials:	Ray Rivas presented the financials ending May 31, 2018 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 330,775 Operating Expense $ 343,298 EBITDA $ 6,885 EROE $ (7,380) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 175 Adjusted Patient Days 104,535 Surgery Cases 5,936 Deliveries 2,065 ED Visits 56,130 **TCHD – Financial Summary**		Ray Rivas

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	Current Month Operating Revenue $ 31,014 Operating Expense $ 31,897 EBITDA $ 900 EROE $ (408) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 162 Adjusted Patient Days 9,330 Surgery Cases 571 Deliveries 163 ED Visits 4,845 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 45.4 Days in Net A/R Avg. 48.3 **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. Physician Recruitment Tracking *(annual)*	Jeremy Raimo gave a brief PowerPoint presentation detailing the physician recruitment status since the last update. He explained that the recent physician recruitments have been performing very well, with each physician establishing a vigorous patient base. He conveyed that future recruitment prospects for consideration would likely be in the areas of primary care/internal medicine,		Jeremy Raimo

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	pulmonary, orthopedics (joint/spine, foot/ankle), general surgery and advanced gastroenterology.		
b. Dashboard	No discussion		Ray Rivas
10. Comments by committee members			
11. Date of next meeting	Tuesday, July 17, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 12:59 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, General

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

Physician's Name: Anish Kabra, M.D.; Mohammad Pashmforoush, M.D.; Pargol Samani, M.D.; David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El-Sherief, M.D.

Area of Service: Emergency Department On-Call: Cardiology, General

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

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

Rate/Day	Panel Days per Year	Panel Annual Cost
$300	FY19: 365	$109,500

Position Responsibilities:

- Provide 24/7 patient coverage for all Cardiology-general 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:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	*Yes		No

**To be included in the proposed FY Budget*

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Anish Kabra, Mohammad Pashmforoush, Pargol Samani, and David Spiegel as the Cardiology-General ED-Call coverage physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019, at a daily rate of $300, for an annual and term cost of $109,500.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Medical Director Agreement for Utilization Review/DRG Program

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

Physician's Name: John LaFata, M.D.

Area of Service: Utilization Review/DRG program

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$170	30	360	$5,100	$61,200	$122,400

Position Responsibilities:

- CMS "Conditions of Participation" and California Title XXII requirement the Utilization Review (UR) committee ensures DRG program compliance
- Dr. LaFata is the Medical Director of the UR Committee and he provides physician input, committee direction and medical staff liaison
- Renewal includes a decrease in reimbursement, but an increase in hours to accommodate the program responsibilities

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Lisa Stroud, Director, Case Management / Sharon Schultz, Chief Nurse Executive

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. John LaFata as the Medical Director for Utilization Review/DRG program for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020. Not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $170, for an annual cost not to exceed $61,200, and a total cost for the term not to exceed $122,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Neurology

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

Physician's Name: The Neurology Center**
Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

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

Rate/Day	Panel Days per Year	Panel Annual Cost
$740	FY19: 365	$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:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	*Yes		No

**To be included in the proposed FY Budget*

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize "The Neurology Center" physicians Drs. Bilal Choudry, Laura Desadier, Benjamin Frishberg, Gary Gualberto, Amy Nielsen, Irene Oh, Remia Paduga, Jay Rosenberg, Mark Sadoff, Gregory Sahagian, Jack Schim, Anchi Wang, Chunyang Tracy Wang and Abigail Lawler as the Neurology ED-Call coverage physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at daily rate of $740, for an annual and term cost of $270,100.

***The physicians within "The Neurology Center" group allowed to take ED Call via this contract may include the following: Bilal Choudry, M.D.; Laura Desadier, M.D.; Benjamin Frishberg, M.D.; Gary Gualberto, M.D.; Amy Nielsen, D.O.; Irene Oh, M.D.; Remia Paduga, M.D.; Jay Rosenberg, M.D.; Mark Sadoff, M.D.; Gregory Sahagian, M.D.; Jack Schim, M.D.; Anchi Wang, M.D.; Chunyang Tracy Wang, M.D.; Abigail Lawler, M.D.*

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Medical Director Agreement for Diabetes Services / Program

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

Physician's Name: Chris Guerin, M.D.

Area of Service: Diabetic Services / Program

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$150	16	192	$2,400	$28,800	$57,600

Position Responsibilities:

- Functions as the Medical Director for TCMC's Diabetes Program. The Medical Director develops, implements, and monitors Diabetic planning to ensure patient care quality and regulatory compliance
- TCMC's Diabetic program has achieved certification from TJC. As a requirement to maintain accreditation the program must have physician oversight (i.e. Medical Directorship)

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Diane Sikora, Director Acute Care Services/Staffing Resource / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Chris Guerin as the Medical Director for Diabetic Services/Program for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020. Not to exceed 16 hours per month or 192 hours annually, at an hourly rate of $150, for an annual cost not to exceed $28,800, and a total cost for the term not to exceed $57,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Disaster Management Physician Liaison Agreement

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

Physician's Name: Chad Bernhardt, M.D.

Area of Service: Disaster Management Physician Liaison

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate / Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$150	3	36	$450	$5,400	$10,800

Position Responsibilities:

- Functions as the TCMC physician liaison for our disaster management program
- The program conducts no less than three disaster drills annual (two required by TJC)
- He actively assists in coordination and education of provider on disaster preparedness
- As an ER physician, he is able to leverage his working relationship with local "first responders" to ensure proper communication and coordination for multiagency drill and emergencies

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Jeff Surowiec, Manager, Security / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Chad Bernhardt as the Disaster Management Physician Liaison for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020. Not to exceed 3 hours per month or 36 hours annually, at an hourly rate of $150 for an annual cost of $5,400, and a total cost for the term of $10,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Cardiovascular Health Institute - Specialty Medical Directorship Proposal

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

Vendor's Name: Mohammad Jamshidi-Nezhad, M.D., Vascular Surgery Medical Director
Ashish Kabra, M.D., Non-Invasive Cardiology Medical Director
David Spiegel, M.D., Invasive Cardiology Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	36	432	$7,560	$90,720	$90,720

Description of Services/Supplies:

- Physicians shall serve as respective medical directors and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Drs. Jamshidi-Nezhad, Kabra and Spiegel as the Cardiovascular Health Institute Specialty Medical Directors for a term not to exceed 12 months, beginning July 1, 2018 and ending June 30, 2019 for an average of 36 hours per month or 432 hours annually, at an hourly rate of $210 for an annual and term cost of $90,720.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Cardiovascular Health Institute - Medical Directorship Agreement

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

Vendor's Name: Donald Ponec, M.D., Cardiovascular Health Institute Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

Maximum Totals:

Rate/Hour	Hours Per month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	8	96	$1,680	$20,160	$20,160

Description of Services/Supplies:

- Physicians shall service as the Institute's medical director and shall be responsible for the medical direction of the Institute and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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

**To be included in the proposed FY Budget*

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Ponec as the Cardiovascular Health Institute Medical Director for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 for an average of 8 hours per month, not to exceed 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for Physician Patient Safety Officer

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

Physician's Name: Scott Worman, M.D. (CIBBADELA)

Area of Service: Physician Patient Safety Officer

Term of Agreement: 24 months, Beginning, July 1, 2018- Ending, June 30, 2020

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	Annual Cost	Term Cost
$170	8	96	$1,360	$16,320	$32,640

Position Responsibilities:

- Attend 80 % of Patient Safety Committee Meetings and Co-Chair with Administrative Lead
- Provide oversight for medical patient safety interventions
- Ensure that services provided are in compliance with regulatory standards
- Recommend Quality Assurance and Performance Improvement initiatives
- Timely communication with primary care physicians regarding patient safety
- Actively participates in Hospital's Medical Staff quality, performance improvement and risk programs
- Attends monthly QAPI meetings

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Merebeth Richins, Director ICU, Tele & Respiratory Care and Patient Safety Committee Chair / Sharon Schultz, Chief Nurse Executive.

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Scott Worman as the Physician Patient Safety Officer for a term of 24 months from July 1, 2018, and ending June 30, 2020. Not to exceed an average of 8 hours a month, at an hourly rate of $170 for a total annual cost of $16,320 and a total term cost of $32,640.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for ICU Medical Director

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

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

Area of Service: ICU

Term of Agreement: 12 months, Beginning, July, 1, 2018 – Ending, June, 30, 2019

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

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

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Merebeth Richins, Director, ICU, Telemetry and Pulmonary Services / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months beginning July 1, 2018 and ending June 30, 2019. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $42,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Medical Staff Leadership Agreement – Professional Behavior Committee Chair

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

Physician's Name: Marcus Contardo, M.D.

Area of Service: Medical Staff: Professional Behavior Committee Chair

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current Medical Staff Area of Service Coverage: Professional Behavior

Rate / Hour	Minimum Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$180.56	30	360	$5,416.67	$65,000	$130,000

Position Responsibilities:

- Perform the duties of Chair of the Professional Behavior Committee, as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Implement the Medical Staff Professional Behavior Policy #8710-57 (previously numbered 8710-511.1)

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Marcus Contardo, M.D. for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020 at a rate of $180.56 for a minimum of 30 hours per month or 360 hours annually, for an annual cost of $65,000 and total term cost of $130,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Medical Staff Leadership Agreement – Clinical & Anatomic Pathology Services

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

Physician's Name: Marcus Contardo, M.D. (North Coast Pathology Medical Medical Group, NCPMG)

Area of Service: Clinical & Anatomic Pathology Services

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

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

Monthly Cost	Annual Cost	Total Term Cost
$57,917	$695,000	$1,390,000

Position Responsibilities:

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

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory services for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020 at $57,917 a month for an annual cost of $695,000, and a total cost for the term of $1,390,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
Radiological Services and Medical Director Contract Proposal

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

Vendor's Name: San Diego Diagnostic Radiology Medical Group, Inc.

Area of Service: Radiology Services

Term of Agreement: 3 years, beginning July 1, 2018 – Ending June 30, 2021

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$0.00	$0.00	$0.00

Description of Services/Supplies:

- Provide Medical Director Supervision and overall responsibility for radiological services
- Provide 24/7 physician coverage for diagnostic radiological supervision and radiology procedure coverage
- Provide 24/7 consultation services to assure high quality radiological services
- Provide written diagnostic results for all radiological performed per regulatory requirements
- Provide strategic planning and consultation to ensure the District is current with healthcare technological trends
- No fees are associated with the agreement other than facility space and business supply needs for the physician on-site operations.

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:		Yes	N/A	No

Person responsible for oversight of agreement: Steve Young, Director Ancillary Services / Scott Livingstone, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with San Diego Medical Group to provide radiological services supervision and medical directorship coverage for a term of 3 years beginning July 1, 2018 through June 30, 2021.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Robert Pendleton, M.D.; Mark Smith, M.D.; Maulik Zaveri, M.D.; Henry Hudson, M.D.; Peter Krall, M.D.; Srinivas Iyengar, M.D.; Logan Haak, M.D.; James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Neeta Varshney, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Ophthalmology
No increase in Expense

Rate / Day	Panel Days per Year	Panel Annual Cost
$300	FY19: 365	$109,500

osition Responsibilities:

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

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

**To be included in the proposed FY Budget*

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with ophthalmology physicians Robert Pendleton, M.D.; Mark Smith, M.D.; Maulik Zaveri, M.D.; Henry Hudson, M.D.; Peter Krall, M.D.; Srinivas Iyengar, M.D.; Logan Haak, M.D.; James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Neeta Varshney, M.D. as the Ophthalmology ED-Call Coverage hysicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at a daily rate of $300, for an annual and term cost of $109,500.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
PHYSICIAN AGREEMENT for MEDICAL DIRECTOR, STROKE PROGRAM

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

Physician's Name: Jack Schim, M.D.

Area of Service: Stroke Program

Term of Agreement: 24 months, Beginning, July 1, 2018 – Ending, June 30, 2020

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 Month (Term) Cost
$200	12	144	$2,400	$28,800	$57,600

Position Responsibilities:

- Co-lead Stroke meetings.
- Provide ongoing education for the medical, nursing and ancillary staff.
- Assist the Stroke Team in reviewing data to validate utilization of services.
- Review indicator compliance for Stroke patients at least monthly.
- Make recommendations to the Medical Staff to improve patient outcomes and compliance to criteria.
- Champion the Joint Commission Comprehensive Stroke Certification with the Medical Staff.
- Meet with surveyors and assist in regulatory and accreditation matters, as requested.

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

**To be included in the proposed FY Budget*

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. Jack Schim as the Medical Director for the Stroke Program for a term of 24 months beginning July 1, 2018 and ending June 30, 2020. Not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $200 for an annual cost of $28,800, and a total cost for the term of $57,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 19, 2018
ADDENDUM TO ABSTRACTION AGREEMENT PROPOSAL

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

Vendor's Name: Direct Difference

Area of Service: Quality / Performance Improvement

Term of Agreement: 24 months, Beginning, March 19, 2018 – Ending, March 18, 2020

Maximum Totals:

Total Term Cost Not to Exceed
$300,000

Description of Services/Supplies:

- Chart Abstraction for IQR / OQR / IPFQR / TJC / CPQCC / CMQCC / GWTG-Stroke Measures
- The above listed chart abstracted measures are required by CMS / TJC and or state regulatory agencies.
- Cost increase for the CPQCC Charts is necessary because at the time the contract was initially executed TCHD did not have access to CPQCC to determine the abstraction requirements.
- The Addendum with Direct Difference will give TCHD the abstraction needs for this population.
- The Contract was initially budgeted for $235,476. The additional funds requested will put this contract over $250,000, requiring Board approval.

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

**To be included in the proposed FY Budget*

Person responsible for oversight of agreement: Jaclyn Hunter, Clinical Quality Manager / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Direct Difference for necessary additional data chart abstraction to add to the existing term currently ending on March 18, 2020 for an additional expected cost of $65,524, and a new total expected cost for the term of $300,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
June 14, 2018

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

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP, Susan Bond, General Legal Counsel, Carlos Cruz, Chief Compliance Officer and Jaclyn Hunter, Clinical Quality Manager.

Others Present: Steve Young, Sherry Miller, Bernadette Rosete, Oska Lawrence, Carol Reeling, Heidi Benson, Debra Feller, Patricia Guerra and Karren Hertz.

Members Absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:06 PM in Assembly Room 1.		Director Grass
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Mitchell and seconded by Director Schallock.	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 from May 2018.	Director Grass called for a motion to approve the minutes from May 10, 2018.	Director Mitchell approved and Director Schallock seconded the motion to approve the minutes from May 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures			
Patient Care Services 1. Code Pink Resuscitation - Standardized Procedure	There was a brief and quick discussion on the dilution process for bradycardia. Oska clarified this further to the group.	**ACTION:** The Patient Care policies and procedures were approved. Dr. Souza moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Computerized Axial Tomography (CT) Downtime Response Procedure	There was no discussion on this policy.		
3. Controlled Substances Management Policy	There was no discussion on this policy.		
4. Discharge of Patients and Discharge AMA Policy	The term "justice involved" is pertaining to patients who are in custody.		
5. Identification, Patient Policy	There was no discussion on this policy.		
6. Interpretation and Translation Services	Director Dagostino made a clarification on the process needed for communicatively impaired patients. Communicatively		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	impaired patients are individuals that have language deficits after an illness or injury.		
7. Stroke Code, In House	There was no discussion on this policy.		
8. Wasting Narcotics, Documentation in the Pyxis Machine	There was no discussion on this policy.		
9. WOCN-ET Standardized Procedure	The term AHP should be applied to all of the health practitioners as stated in this policy.		
Administrative Policies and procedure			
1. Smoke-Free Environment	There was no discussion on this policy.	**ACTION:** The Administrative policy and procedure was approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Unit Specific Behavioral Health Services			
1. Behavioral Health Unit/ Crisis Stabilization Unit Departmental Disaster Implementation Plan	It was noted that there is a disaster plan specifically unique to BHU. Bernadette also stated that there is no oxygen pipe-in connections in the BHU rooms which serves as an additional safety measure for BHU population.	**ACTION:** The Behavioral Health policies and procedures was approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Notification of MediCal Beneficiary of Denial of Benefits	There was no discussion on this policy.		
3. Patient Rights	There was a recommendation to add the		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	clause that a patient can decline to participate in BHU therapy group if patient prefers not to do it. Also, the denial of rights should be altered as declination of service. An external link and a form will be added to this policy as an additional information.		
Medical Staff			
1. Appropriate Use of Commercial Support and Exhibits	Director Mitchell had a question on who is the governing body that initiated the standards for this policy. Dr. Ma stated that ACCME is responsible for the governance on appropriate use of commercial support and exhibits.	**ACTION:** The Medical Staff policies were approved. Director Schallock moved and Director Mitchell seconded the motion to approve the BHU policies moving forward for Board approval.	Patricia Guerra
2. CME Speaker & Honoraria Reimbursement	There was no discussion on this policy.		
3. Conflict of Interest Resolution	There was no discussion on this policy.		
4. Criteria Pain Management Privileges	There was no discussion on this policy.		
5. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity	There was no discussion on this policy.		
Surgical Services			
1. Aseptic Technique Policy	There was no discussion on this policy.	**ACTION:** The Surgical Services policies were approved except for policy addressing blood in ice	Patricia Guerra
2. Reusable Airway	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Equipment Cleaning Procedure		chests. Director Mitchell moved and Director Schallock seconded the motion to approve the remaining policies moving forward for Board approval.	
3. Steris Set-up, Use and Monitoring Procedure	There was no discussion on this policy.		
4. Surgery Blood in Ice Chest Procedure	There was a discussion regarding the fact that there is no more blood in the freezer in Surgery Department. Since there is still uncertainty in some facts relating to this issue, this policy is being pulled out for further clarification.		
5. Testing C02 Laser Procedure	There was no discussion on this policy.		
6. Universal Precautions in Surgery Policy	There was no discussion on this policy.		
7. Wound Classification Policy	There was no discussion on this policy.		
Women and Newborn Services			
1. Skin to Skin Contact After Birth	Director Schallock had a clarification if any other person aside from the mother can have a skin to skin contact with the newborn after birth. Any family member can do this bonding process especially when the mother is not available.	**ACTION:** The Women and Newborn Services policy was approved and is moving forward for Board approval as moved by Dr. Souza and seconded by Director Schallock.	Patricia Guerra
Formulary Requests			
1. Nitrofurantoin Suspension	There was no discussion in removing this suspension from the formulary.	**ACTION:** The removal of Nitrofurantpoin suspension was approved and is moving forward for Board approval as moved by	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		Director Mitchell and seconded by Director Schallock.	
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 12:57 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 1:00 PM.		Director Grass

PROFESSIONAL AFFAIRS COMMITTEE
June 14th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code Pink Resuscitation Standardized Procedure	3 Year Review, Practice Change	Approved
2. Computerized Axial Tomography (CT) Downtime Response Procedure	3 Year Review, Practice Change	Approved
3. Controlled Substances Management Policy	3 Year Review, Practice Change	Approved
4. Discharge of Patients-Discharge AMA Policy	3 Year Review, Practice Change	Approved
5. Identification, Patient Policy	3 Year Review, Practice Change	Approved
6. Interpretation and Translation Services	1 Year Review	Approved
7. Stroke Code, In-House	3 Year Review, Practice Change	Approved
8. Wasting Narcotics, Documentation in the Pyxis Machine	DELETE	Approved
9. WOCN-ET Standardized Procedure	2 Year Review, Practice Change	Approved
Administrative Policies & Procedures		
1. Smoke-Free Environment 205	3 Year Review, Practice Change	Approved
Unit Specific		
Behavioral Health Services		
1. Behavioral Health Unit / Crisis Stabilization Unit Departmental Disaster Implementation Plan	3 Year Review, Practice Change	Approved with Revisions
2. Notification of MediCal Beneficiary of Denial of Benefits	3 Year Review, Practice Change	Approved
3. Patient Rights	3 Year Review, Practice Change	Approved with Revisions
Medical Staff		
1. Appropriate Use of Commercial Support and Exhibits 8710 -603	3 Year Review, Practice Change	Approved
2. CME Speaker & Honoraria Reimbursement 8710 - 604	3 Year Review, Practice Change	Approved
3. Conflict of Interest Resolution 8710 - 605	3 Year Review, Practice Change	Approved
4. Criteria Pain Mgmt Privileges 8710-541	3 Year Review, Practice Change	Approved
5. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710 - 600	3 Year Review, Practice Change	Approved

PROFESSIONAL AFFAIRS COMMITTEE
June 14th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Surgical Services		Approved
1. Aseptic Technique Policy	DELETE	Approved
2. Reusable Airway Equipment Cleaning Procedure	DELETE	Approved
3. Steris Set-Up, Use and Monitoring Procedure	DELETE	Approved
4. Surgery Blood in Ice Chests Procedure	3 Year Review, Practice Change	Pulled
5. Testing CO2 Laser Procedure	DELETE	Approved
6. Universal Precautions in Surgery Policy	3 Year Review, Practice Change	Approved
7. Wound Classification Policy	DELETE	Approved
Women & Newborn Services		
1. Skin to Skin Contact after Birth	NEW	Approved
Formulary Requests		
1. Nitrofurantoin Suspension	Remove from Formulary	Approved

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CODE PINK RESUSCITATION

I. **POLICY:**

A. Function: Management of impending or actual cardiopulmonary arrest in the pediatric patient **greater than 30 days of age through 13 years.**

~~A.~~**1. A Code Caleb will be activated for the resuscitation and stabilization needs of the high-risk neonate/ infant up to 30 days old. Please see Patient Care Services: Code Caleb Team Mobilization Policy.**

B. Circumstances:

1. Setting: Tri-City **Healthcare District (TCHD)**~~Medical Center~~.
2. Supervision: None required. However, upon arrival of a physician the Code Pink team will follow physician orders instead of the Standardized Procedure.
3. Patient contraindications: Patients with a written "No Code Order."~~A Code Pink will be called on any apneic and/or pulseless children greater than 30 days of age through 13 years (in the main hospital building, the Cardiac Rehabilitation building, Business Administration Management (BAM) building, and the Magnetic Resonance Imaging (MRI) building.~~

II. **PROCEDURE (CHILDREN GREATER THAN 30 DAYS OLD THROUGH 13 YEARS)** ~~14~~**:**

A. Data Base:

1. Subjective: None
2. Objective: Significant acute change in neurologic status, status epilepticus unresponsive, absent respirations status asthmaticus and/or rhythm disturbances (monitored patient) absent pulse, acutely hypotensive or absent blood pressure.
3. Diagnosis: Impending/Actual Cardiopulmonary arrest
4. Plan:
   a. Initiate Standardized Procedure as appropriate and initiate Code Pink (dial 66 on the telephone).
   b. Assessment: Patient will be reassessed after each intervention.
   c. Record Keeping: Events are to be recorded on the Cardiopulmonary Arrest Record~~ and clinical notes~~.

B. Respiratory Distress/Arrest:

1. Establish patent airway.
2. Administer oxygen to maintain O_2 saturation greater than 95%.
3. Begin Positive Pressure Ventilation (PPV) with 100% oxygen as necessary, monitoring adequate rise and fall of chest, breath sounds, color, and work of breathing.
4. Assist with intubation as appropriate.
5. Have adequate suction readily available.
6. Obtain STAT Arterial Blood Gas (ABG) and chest X-ray as needed.

C. Heart Rate less than 60 bpm (Bradycardia):

1. Initiate chest compressions.
2. Begin PPV with 100% oxygen.
3. Obtain Intravenous (IV) access:
   a. Establish IV access with Normal Saline (NS) at to keep open (TKO) rate (may be used for resuscitation medications or fluid bolusing as needed).

Department Review	Clinical Policies & Procedures Committee	Pharmacy & Therapeutics Committee	Nursing Executive Council	Department of Pediatrics	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/00, 08/07, 02/10, 06/11, 09/14, 05/17	01/11, 09/13, 09/14, 06/17	06/11,09/13, 09/14, 07/17	03/11, 09/13, 10/14, 08/17	11/14, 02/18	06/11, 02/14, 03/15, 04/18	06/11,02/14, 03/15, 05/18	05/15, 06/18	06/11, 02/14, 05/15

b. Get Intraosseous (IO) device ready for placement by physician if IV access is unobtainable (~~M~~must be placed by a physician **or supervised by a physician**).
c. Give fluid bolus for hypotension Systolic blood pressure less than (70 + [age in years times 2]) NS 20 mL/kg, Can repeat times 2 if lungs remain clear.

4. Medications for Bradycardia:
   a. Epinephrine:
      i. Indicated when heart rate remains less than 60 and patient is hypotensive.
      ii. Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.
      ~~iii. ET DOSING: (0.5 mg/mL/kg of 1:10,000 concentration) Administer every 3–5 minutes during arrest until IV/IO access is achieved. (Oska to update dosing for epinephrine)~~
      iii. IV/IO DOSING: **0.01 mg/kg** (0.1 ~~mg/~~mL/kg **of 0.1 mg/mL solution**)~~/kg of 1: 10,000 concentration~~) ~~Give~~**Maximum single dose 1 mg. Administer** every 3-5 minutes ~~during arrest.~~ **as needed.** ~~Maximum dose is 1 mg.~~
      iv. **ET DOSING: 0.1 mg/kg (0.1 mL/kg of 1 mg/mL solution). Maximum single dose 2.5 mg. Administer every 3- 5 minutes as needed until IV/IO access is established.** ~~(Oska to update dosing for epinephrine)~~
      v. Rate of administration is rapid.

D. Symptomatic Hypoglycemia:
   1. Obtain **a capillary**~~bedside~~ blood glucose value. If glucose level is less than 60 mg/dL then treat with ~~D25W 2 mL/kg via slow intravenous push (IVP) OR~~ D10W 5 mL/kg **via** slow IVP ~~OR D50 W 1mL/kg via slow IVP~~

E. Hypotension:
   1. IV/IO bolus for hypotension (SBP less than 70 + [age in years times 2]). Administer NS 20 mL/kg. May repeat times 2 if lungs remain clear.

F. Cardiac Rhythm Disturbances/Shock:
   1. Follow American Heart Association (AHA) 2015~~0~~ Pediatric Advance Life Support (PALS) guidelines:
      a. BLS for healthcare providers
      b. Pediatric Bradycardia with a pulse Algorithm
      c. Pediatric Tachycardia with Pulses and Poor Perfusion Algorithm
      d. Pediatric Pulseless Arrest Algorithm
      e. Septic Shock Algorithm
      f. Treatment of Shock Algorithm

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. **Registered Nurse** (RN) with current California license and working in the Emergency Department.
B. Education: Pediatric Advanced Life Support (PALS), or Emergency Nurse Pediatric Course (ENPC).
C. Initial Evaluation: Before an RN may initiate the Code Pink Standardized Procedure, the RN must be observed in the management of a pediatric resuscitative effort and demonstrate successful skills in PALS or the ENPC course.
D. Ongoing Evaluation: Annually.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Emergency Department Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Code Pink Resuscitation Standardized Procedure.

VI. RELATED DOCUMENT(S):

A. **Patient Care Services: Code Caleb Team Mobilization Policy**

VII. REFERENCES:

~~B.~~A. **American Heart Association: 2015 Pediatric Advance Life Support**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**COMPUTERIZED AXIAL TOMOGRAPHY (CT) DOWNTIME RESPONSE**
Purpose:	To outline process during CT downtime.

A. **POLICY:**

1. **Tri-City Medical Center (TCMC) has two (2) operational CT scanners. In the event that one (1) scanner is down the patients will be prioritized for examination based on patient acuity.**
2. **Downtime response is not required for routine maintenance of one (1) scanner at a time.**
3. **For scheduled downtime of one (1) machine lasting 24 hours or greater, a mobile CT scanner will be secured prior to the downtime.**
4. **If both scanners are anticipated to be down greater than (>) two (2) hours, an attempt to locate a mobile CT scanner will be immediately initiated.**

~~A.~~B. **PROCEDURE IF BOTH CT SCANNERS DOWN:**

1. Unanticipated Downtime:
   - **a.** Radiology calls:
     - i. ~~t~~The Emergency Department (ED) Assistant Nurse Manager (ANM)/designee at extension 3509 to provide an estimate of the duration of CT Scanner downtime.
       - **1)** The ED ANM/designee notifies ED physicians of CT downtime as appropriate.
     - **ii. The Administrative Supervisor**
       - ~~b.~~**1) Notifies Hospitalists and Administration as appropriate.**
   - ~~c.~~**b.** The ED ANM/designee and ED physicians evaluate the need for diversion of head injuries, potential stroke patients, and traumas.
   - **c.** The Mobile Intensive Care Nurse (MICN) enters this information into the **Image Trend Resource Bridge**~~Quality Collector System (QCS)~~ to notify agencies of diversion status.
   - d. **Radiology leadership will notify the Radiology Medical Director or Radiologist On-Call.**
   - ~~e. The ED physician determines need for standby Balboa ambulance.~~
     - ~~i. Contact Balboa Ambulance president at 619-885-0803, if no answer, leave message and call 858-637-3548.~~
   - ~~f. The ED ANM/designee arranges for an ED Advanced Care Life Support (ACLS) Registered Nurse (RN) to accompany patient(s) needing CT scan to the Outpatient Imaging Center, Room 111 (760-940-7562).~~
   - ~~g. The Administrative Supervisor (AS) arranges accompaniment for in-house patients requiring CT scan by either an ED ACLS RN or an Intensive Care Unit (ICU) ACLS RN.~~
     - ~~i. If ED RN unavailable for ED CT transport, then ED ANM/designee notifies ED Director.~~
   - **e.** Radiology notifies:
     - ~~ii.~~**i.** ED ANM/designee when CT is functioning.
       - 1) ED ANM /designee notifies MICN **and appropriate agencies,** ~~Balboa, EMS,~~ and AS when the CT is available.
     - ~~iii.~~**ii.** Administrative Supervisor
       - 1) **Hospitalists and Administration as appropriate.**
   - ~~h. AS shall notify the Director of Patient Financial Services of all patients who have been transported to the Outpatient Imaging Center.~~
2. Scheduled Downtime:
   - a. The Medical Imaging Director shall notify the ED Manager not less than 10 days prior to scheduled Preventive Maintenance (PM) date.
   - ~~b. The ED Manager shall secure nursing support.~~

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Department of Emergency Medicine	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
9/05; 12/08, 03/18	08/11, 04/18	08/11, 04/18	05/18	n/a	10/11, 05/18	11/11, 06/18	11/11

~~c. The ED Manager shall notify Balboa and Director of Managed Care of scheduled downtime.~~

~~d.~~**b.** The ED Manager shall notify ED physicians, MICN nurse, and staff of scheduled downtime.

~~e. The ED ANM/designee and ED physicians evaluate the need for diversion of head injuries, potential stroke patients, and traumas.~~

~~i. Manager/designee shall ensure a stand-by RN is scheduled for patient transports during CT downtime.~~

~~ii. Request that Balboa provide a critical care transport nurse to accompany patient if possible.~~

~~f. Arrange for Balboa Ambulance services to be on site.~~

~~g.~~**c.** Radiology notifies ED ANM/designee when CT is functioning.

i. ED ANM/designee notifies MICN, **and appropriate agencies**~~Balboa, EMS,~~ and AS when the CT is available.

~~h.~~**d.** ~~AS shall notify the Director of Patient Financial Services of all patients who have been transported to the Outpatient Imaging Center.~~

~~3. Transport RN Responsibilities~~

~~a. The transporting RN shall continually monitor patient's condition and document on Physician's Progress Notes.~~

~~b. If condition deteriorates while patient is outside of TCMC:~~

~~i. Dial 9-1-1.~~

~~ii. Initiate basic cardiac life support.~~

~~iii. Transport patient to TCMC Emergency Department.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**08/01, 11/12**	**SUBJECT:**	**Controlled Substances Management**
REVISION DATE:	**01/03, 03/03, 07/05, 04/08, 09/09, 11/12, 03/17**	**~~POLICY NUMBER: IV.J~~**	

Department Approval:	**~~08/15~~02/17**
Clinical Policies & Procedures Committee Approval:	**~~05/13~~09/15~~03~~/17**
Nursing Executive Committee Approval:	**~~05/13~~9/15~~03~~/17**
Pharmacy & Therapeutic Committee Approval:	**~~09/13~~06/16~~05~~/17**
Department of Anesthesiology Committee Approval:	**~~01/16~~05/18**
Medical Executive Committee Approval:	**~~12/13~~01/16~~05~~/18**
Professional Affairs Committee Approval:	**~~03/14~~06/18**
Board of Directors Approval:	**03/14**

A. **DEFINITION(S):**
1. Controlled Substance: as defined by the state and federal law.

B. **POLICY:**
1. Healthcare providers shall administer controlled substances in compliance with their respective Practice Acts, Tri-City **Healthcare District (TCHD)** ~~Medical Center~~ Policies and Procedures, and state and federal law.
2. All controlled substances for administration shall be maintained in the Pyxis MedStation.
3. Sequential dosing of controlled substances is not permitted at **TCHD**~~TCMC~~ except by physicians.
4. Abuses and losses of controlled substances shall be reported to the Director of Pharmacy.

C. **PROCEDURE:**
1. Replenishment:
   a. Pyxis System Controlled Substances:
      i. Pharmacy personnel shall automatically replenish the controlled drugs in each Pyxis Medstation.
      ii. All controlled substances removed from Pyxis for administration shall be documented on the patient **electronic or paper** Medication Administration Record (MAR). **Whenever possible, it is ~~best practice~~recommended that the nurse removing the controlled substance from the Pyxis is to be the nurse who administers the medication, thus ensuring the chain of custody of the medication.**
      iii. PRN response shall be documented on all narcotics.
2. Nursing Units Controlled Substance Accountability:
   a. Pyxis Nursing Units:
      i. The Pyxis home screen must be reviewed before the end of each shift to determine if there is an open discrepancy.
      ii. Any controlled substance discrepancy must be resolved by the end of each shift and resolution noted in the Pyxis.
      iii. Unresolved discrepancies are not acceptable and shall be reported to the Assistant Nurse Manager (ANM) /designee immediately.
      iv. A manual weekly inventory of all controlled substances is required.
3. Security/Storage:

a. Pyxis Nursing Units:
   i. All controlled substances are kept in the Pyxis Medstation.

4. Wasting Of Controlled Drugs:
   a. Any opened controlled substance not given or any unused partial doses shall be wasted; wastage shall be witnessed, documented, and co-signed by two licensed personnel based upon their scope of practice.
      i. The following licensed personnel may witness and co-sign wasting of controlled substances:
         1) Anesthesiologist
         2) Registered Nurse
         3) Licensed Vocational Nurse
         4) Respiratory Care Practitioner
         5) Radiology Technologist
         6) Pharmacist
         7) Pharmacy Technician
   b. Witnessing of wastage, documentation of wastage, and cosigning shall occur:
      i. Within one (1) hour after administration or removal of the drug
      ii. For procedural areas: within one (1) hour after completion of procedure
      iii. If medication is removed and not administered.
         1) Returned to Pyxis if intact
         2) Wasted if no longer intact
   c. The licensed personnel administering the medication shall document the amount wasted.
   ~~d. After removal of a used controlled substance patch (e.g. Fentanyl) dispose of by folding the adhesive side onto itself and discard into the sharps container~~**toilet.**
   ~~e.~~**d.** ~~Liquid~~ **ALL** controlled substance waste **(solid, liquid and patches)** shall be disposed of ~~in sink drains.~~**in the designated RX Destroyer container.**
      i. **Discard empty syringe into the trash unless a needle attached, then discard in sharps container.**
      ~~ii. Empty solution in sink~~
      ~~iii.~~**ii.** ~~Flush drain with running tap water~~
      ~~iv. Table/capsule controlled substance waste shall be disposed of in sharps container~~**the toilet.**

5. Controlled substances auditing procedure:
   a. The Pharmacy Department will perform regular retrospective audits on all hospital personnel who have access to controlled substances via the automatic dispensing machines.
      i. For all nursing units,
         1) Pharmacy personnel shall generate a Proactive Diversion Report monthly to identify user activity that falls out of the normal range compared to their peers.
         2) For users with a standard deviation of +3 or greater, pharmacy personnel shall notify the nursing manager and send a Pyxis Medstation Report and documentation form for review and completion.
         3) Nursing management shall conduct an investigation of reported users to verify controlled substances activity as appropriate.
         4) Nursing management shall return completed documents to pharmacy personnel within 14 days.
      ii. For Anesthesiology Department~~-~~,
         1) Pharmacy personnel shall generate a detailed ~~monthly~~ report of all audit activity, **at least monthly** and submit it to the Anesthesia Department Chair ~~and the Medical Staff Office~~ in order that evaluation and remediation may be carried out.

2) In the event that any single day the retrospective audit reveals a concerning non-compliance event, the individual Provider will be notified so prompt evaluation and remediation can be carried out. If the individual provider can't be contacted directly, the Anesthesia Department Chair ~~and the Medical Staff Office~~ will be notified so they can assist in contacting the Provider so prompt evaluation and remediation can be carried out.

6. Reporting of abuses and losses of controlled drugs:
   a. Abuses and losses of controlled substances **involving a medical staff credentialed provider will be reported to the Medical Staff Manager and** must be reported, in accordance with applicable Federal and State laws, to the Director of Pharmacy, and to the **Chief Nurse Executive or** chief executive officer, as appropriate.
   b. An investigation by the management team of the area where loss occurred and the pharmacy will be conducted. Findings along with recommendations for action will be made to appropriate staff.

D. RELATED DOCUMENTS:

~~7.~~1. TCMC Waste Disposal Guidelines

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), loncets, 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/p3s/documents/DHS%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/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01

SUBJECT: Discharge of Patients and Discharge Against Medical Advice (AMA)

REVISION DATE: 06/03, 01/04, 06/07, 07/07, 09/09, 02/10, 06/10, 03/11

~~**POLICY NUMBER: VI.C**~~

Department Approval:	**10/17**
Clinical Policies & Procedures Committee Approval:	**~~12/14~~11/17~~04~~/18**
Nursing Executive Council Approval:	**~~12/14~~04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/15~~05/18**
Professional Affairs Committee Approval:	**~~02/15~~06/18**
Board of Directors Approval:	**02/15**

A. **POLICY:**

1. Patients are discharged by order of the appropriate physician~~/Allied Health Professional (AHP).~~
   a. In the event of an internal or external disaster, the established policies and procedures for patient discharge are followed as per the Emergency Preparedness Plan.
   b. Observation patients may be discharged after meeting predetermined discharge criteria on the order of a physician~~/AHP~~. (Refer to **Patient Care Services Standardized Procedure:** Discharge from Outpatient Post-Anesthesia Nursing Service~~-Standardized Procedure~~).
   c. **Justice Involved Patients**
      i. **Justice Involved Patients are to be discharged following the Progressive Care Departmental discharge process.**
      ~~b.~~ii. **Justice Involved Patients have the right to sign out AMA and leave the hospital in the care of their custodial agency.**
   d. **Behavioral Health Services**
      i. **A voluntary patient may leave the hospital at any time by giving notice to any member of the hospital staff on his/her desire to leave and by completing usual discharge processes.**
      ii. **A Conservatee may leave in a like manner if the patient's Conservator gives notice.**
      ~~c.~~iii. **If a voluntary patient cannot be persuaded to continue his or her hospitalization, cannot be safely discharged, and meets criteria for involuntary hospitalization, an appropriately credentialed clinician will initiate a 72 hour hold and the patient will not be permitted to leave the unit.**
2. The primary nurse is responsible for providing verbal and written discharge instructions to the patient, family, and/or caregiver.
3. All patients discharged will receive discharge education completed by nursing.
4. A Registered Nurse (RN) and/or Case Manager ~~is~~**are** responsible for explaining discharge plans to patients and their family members.
   a. Discharge instructions including medication list, signs/symptoms of potential complications, educational information, and instructions for follow-up appointment will be sent with patient and/or family upon discharge.

b. Patients will be evaluated within one **(1)** hour of discharge for any change in condition. This shall include documentation of vital signs. Any abnormality will be communicated to the primary care physician**/AHP** prior to discharge.
c. Patients and/or family members will be advised if it is necessary to stop at the business office before leaving the hospital.
d. All patients being transferred to a Skilled Nursing Facility **(SNF)** or another hospital/facility (~~including Forensic~~ **justice involved** patients) will receive a transition of care document prior to transfer.

5. All inpatients who are ambulatory are to be discharged from the front entrance via wheelchair or stretcher, if appropriate, by a hospital employee or volunteer.
a. In the event the patient has a car in the ~~TCMC~~ **Medical Center** parking lot, the patient may be escorted by an employee or volunteer.
b. If patient has no transportation to their residence after the discharge order is processed, contact Case Management/Social Services personnel or Administrative Supervisor for further assistance in obtaining transportation.
c. Staff members are not to transport patients to their place of residence.

~~d.~~**6.** If being discharged via ambulance, patient will be discharged from the Emergency Department **(ED)** entrance. Hand-off communication shall be provided to the ambulance personnel before the patient leaves the unit.

~~6.~~**7.** A discharge transaction shall be entered into Cerner within one **(1)** hour after the patient has left the unit.

~~7.~~**8.** When a patient is discharged to Acute Rehabilitation or the Inpatient Behavioral Health Unit, the acute care chart is closed and a new encounter is created.

~~8.~~**9.** Provision of Transfer Summary to Patient Upon Transfer (**Health and Safety Code** [HSC] **§Section** 1262.5)
a. HSC **§Section** 1262.5 (d) requires that a transfer summary be signed by the physician~~/AHP~~ and accompany the patient upon transfer to a ~~skilled nursing~~**SNF** or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital.
b. A copy of the transfer summary must also be given to the patient, patient's closest available relative or patient's legal representative, if any, prior to the transfer.
i. To ensure compliance with HIPAA and California Privacy Law, ensure "the patient's legal representative" is clearly identified by a document signed by the patient approving release of information to that person.
c. The transfer summary must include essential information relative to:
i. Patient's diagnosis
ii. Hospital course
iii. Pain treatment and management
iv. Medications
v. Treatments
vi. Dietary requirement
vii. Rehabilitation potential
viii. Known allergies
ix. Treatment plan

B. **DISCHARGE AGAINST MEDICAL ADVICE (AMA):**

1. When a patient demands to leave the hospital and the patient's physician~~/AHP~~ has not ordered his/her discharge and has specifically indicated that the discharge is against medical advice, the following steps shall be completed:
a. Verify the patient is an adult with the capacity to make healthcare decisions regarding medical treatment.
b. If the patient lacks the legal authority to make healthcare decisions (minor) or if the patient lacks the capacity to make healthcare decisions, the patient has the right to have

legal representative make the decision to stay or leave against medical advice for him/her.

c. The RN will notify attending physician~~/AHP~~ immediately.

d. The attending physician~~/AHP~~ will be asked to discuss the request with the patient, either by person or by telephone as appropriate.

e. If the patient attempts to leave the hospital before discussing the matter with his/her physician~~/AHP~~, the RN shall:
   i. Inform the patient his/her physician~~/AHP~~ has been contacted
   ii. Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
   iii. Notify the Assistant Nurse Manager (ANM)/**Relief Charge**
      1) The ANM shall notify the unit director/manager as soon as possible.

f. The patient or a patient's legal representative shall complete the ~~"~~Leaving Hospital Against Medical Advice (AMA)~~"~~ Form.
   i. **ED:**
      1) The RN shall request the patient to sign the AMA form.
      ~~f.~~**2) The RN shall remove the patient from the electronic medical record as AMA.**

g. The AMA form shall state the patient has been provided information regarding possible risks that may result from the decision to leave AMA, the benefits of continued hospitalization, and any alternatives, such as transfer to another hospital or outpatient treatment.
   i. The AMA form must be witnessed by a responsible hospital employee and signed by the attending physician~~/AHP~~ he/she has explained the risks and benefits of continued hospitalization, when possible.
      1) If the attending physician~~/AHP~~ is not present to sign, the primary nurse shall document he/she called the physician~~/AHP~~.

h. If the patient refuses to sign the AMA form, the responsible hospital employee and/or RN shall:
   i. Document ~~in the (keep)~~Physician Notified~~"~~
   ii. Document on the patient's signature line, "patient refuses to sign"
   iii. The hospital employee shall sign the form in the designated space, including the exact time and date.

i. The primary nurse shall document a brief note concerning the ~~circumstances of~~**interactions with** the ~~refusal to sign~~ **patient:**
   i. Risks/benefits were reviewed.
   ii. ~~and the~~ Actions taken to ensure the patient's safety.
   ~~iv.~~**iii. Refusal to sign the AMA form, if applicable.**

~~i.~~**j.** The AMA form shall be placed in the medical record.

~~j.~~**k.** An ~~RL~~**quality review report** shall be completed.

2. Transportation Arrangements

a. The following reasonable steps shall be documented in the medical record:
   i. Attending physician~~/AHP~~ was consulted regarding patient's intent to leave and any concerns regarding transportation
      1) -Inform the patient his/her physician~~/AHP~~ has been contacted
      2) Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
   ii. Document disposition of patient off unit, i.e. ambulatory, wheelchair, with family member.
   iii. Caution patient that driving is not advisable due to their medical condition and/or medications taken.
   iv. If the patient appears helpless or in a condition which indicates he/she should not be allowed to leave the hospital alone, every attempt shall be made to arrange transportation that is appropriate for the patient's condition.

v. If patient refuses the appropriate recommended transportation and is under the influence of any narcotic or medication that would impair their ability to operate a vehicle safely contact the hospital security and the local police.

vi. Hospital personnel shall not accompany the patient once he/she leaves the hospital premises.

3. If there are concerns regarding the patient's psychiatric stability, the physician~~/AHP~~ may consider a 72-hour hold.
   a. In the Inpatient Units:
      i. A psychiatric consult shall be requested by the admitting or attending physician~~/AHP~~ to determine if patient meets criteria for a 72-hour hold.
   b. In the Behavioral Health Unit:
      i. The Psychiatrist must be notified to determine if the patient meets the criteria for a 72-hour hold.
      ii. The RN is responsible for documenting the psychiatrist's final decision in the progress note or clinical note.
      iii. Any orders (i.e., to place the patient on an involuntary hold) shall be documented as a physician's~~/AHp's~~ order.
      iv. Explain to the patient the reason they will not be permitted to leave unit
      ~~iii.~~**v. Complete involuntary hold advisement as applicable per PCS Policy: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy and Behavioral Health Services Policy: Advisement of Legal Status 72-Hour Hold**

C. **PATIENTS NO LONGER NEEDING ACUTE CARE WHO REFUSE TRANSFER OR DISCHARGE:**

1. If the patient has been discharged from the facility and the patient and/or patient's family is refusing~~,~~ or even actively blocking~~,~~ the patient's transfer or discharge, a case by case approach must be initiated.
2. Consider all available options. Try to identify the concerns and issues raised by the patient and/or family to see if resolution is possible.
3. Notify your immediate manager. If unable to resolve, the immediate manager must notify Administration and Risk Management of the situation. Social Services and/or Security shall also be involved as appropriate.
4. Inform the patient's physician~~/AHP~~ of the refusal to leave.
5. Should all efforts fail, legal remedies may be available and legal counsel shall be consulted.
6. Some permissible actions may apply during this duration, such as:
   a. The television is considered a luxury, not a necessity, and may be turned off.
   b. Food is a necessity~~,~~ and food trays must be nutritionally balanced. Depending on the patient's physical/medical condition, the diet may exclude such items as sodas, coffee, desserts, candies, and snacks, etc.
   c. Clean linen changes are not required. If the patient needs extra linen, it may be delivered, but staff is not required to make the bed.
   d. The issue of continuing nursing care shall be determined on a case by case basis, in consultation with the treating physician~~/AHP~~.
7. Follow all requirements of the applicable payer with respect to the patient's right to challenge a determination that they no longer need inpatient care. Medicare patients, for example, have the right to receive notice of their rights, including the right to appeal denials of benefits for continued services, as well as notice of any determination that they no longer require hospitalization.

D. **DISCHARGE TO SKILLED NURSING FACILITY:**

1. To ensure all appropriate steps and actions are taken to promote ~~Skilled Nursing Facility (~~SNF~~)~~ placement expeditiously, case managers, in collaboration with the interdisciplinary team, will identify patients who are appropriate for SNF.

2. The Case Manager and RN may arrange for SNF placements. Refer to Patient Care Services ~~(PCS)~~**Policy:** Discharge Planning ~~Policy, VI.E~~.
3. Prior to discharge to a ~~Skilled Nursing Facility (~~SNF~~)~~ or an intermediate care facility, primary nurse shall provide a copy of the following to the patient, family, and/or caregiver:
   a. Physician Discharge/Transfer summary
   b. Discharge (Medication Home List)
   c. Discharge instructions
4. The primary nurse shall ensure the following information is copied by the unit secretary or designee and sent with the patient to the SNF:
   a. Facesheet
   b. **History and Physical** (H&P), Consultations
   c. Physician transfer summary
   d. Physician transfer orders
   e. Physician progress notes
   f. Printed MAR (14 days)
   g. Medication reconciliation form (refer to **Patient Care Services Policy:** Medication Reconciliation ~~Policy, IV.JJ~~)
   h. Nursing transfer summary
   i. Lab results
   j. X-ray reports
   k. Therapy notes
5. The transferring/discharging nurse shall provide a hand-off communication to the SNF prior to discharge of the patient.

E. **DISCHARGE TO ~~TCMC~~ TCHD ACUTE REHABILITATION UNIT:**

1. When the primary physician~~/AHP~~ requests a stroke/neuro rehab assessment and/or a rehab consultation.
   a. The Unit Secretary enters into the computer a request for an acute rehab evaluation through Cerner.
   b. The Rehab Admission Coordinator, in collaboration with the Acute Rehab Medical Director, will complete the pre-assessment form and document the outcome in the medical record.
   c. When a patient is not accepted into the program or the patient is a potential rehab candidate and a bed will not be available for several days:
      i. A request for an order for a case manager/discharge planner consult will be made by the rehab admission coordinator in Cerner.
      ii. If the case manager/discharge planner is already involved, the rehab admission coordinator will notify the unit case manager of bed availability on the acute rehab unit.
   d. When the patient is discharged the primary nurse shall send the patient's chart and Discharge (Medication Home List).
   e. The primary nurse shall provide hand-off communication to the receiving nurse.

F. **ARRANGING TRANSPORTATION FOR THOSE WITHOUT MEANS:**

1. All patients shall be encouraged to arrange their own means of transportation whenever possible.
2. Case managers and social workers shall assist with difficult transportation needs.
3. During off hours, bus passes/taxi vouchers may be obtained from either the Administrative Supervisors or designee.
4. Refer to **Patient Care Services Policy:** Ambulance Transport for Patients ~~policy~~ for patients requiring ambulance transport.
5. The ~~Tri-City Medical~~**TCHD** Patient Transport Express is a free service providing transportation between ~~Tri-City Medical Center~~**TCHD** facilities and the patient's home (within a **seven [7]** mile

radius). This free service operates Monday-Friday 0630 - 1400. To schedule a ride, call 940-RIDE (7433) at least 24 hours in advance.

G. **FORM(S):**

~~6.~~1. **Leaving Hospital Against Medical Advice (AMA) Form**

~~G.~~H. **RELATED DOCUMENT(S):**

1. **Patient Care Services Policy:** Ambulance Transport for Patients ~~Policy, IV.R~~
~~1.~~2. **Patient Care Services Policy:** Discharge Planning ~~Policy, VI.E~~
~~2.~~3. **Patient Care Services Policy:** Medication Reconciliation ~~Policy, IV.JJ~~
~~3.~~4. **Patient Care Services Standardized Procedure: Discharge from Outpatient Post-Anesthesia Nursing Service**

I. **REFERENCE(S):**

1. **Cal. HSC § 1262.5 (1973).**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 8/01	**SUBJECT: Identification, Patient**
REVISION DATE: 3/03, 2/05, 6/06, 6/09, 2/12	**~~POLICY NUMBER: IV.A~~**
Department Approval:	**02/18**
Clinical Policies & Procedures Committee Approval:	**~~09/14~~04/18**
Nursing Executive Council:	**~~10/14~~04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/14~~05/18**
Professional Affairs Committee Approval:	**~~11/14~~06/18**
Board of Directors Approval:	**12/14**

A. **POLICY**

1. It is the policy of Tri-City Medical Center to reliably identify the individual as the person for whom the service or treatment is intended and co-match the service or treatment to that individual. Exception: Patients unable to provide identifying information, who experience conditions requiring emergency care will receive treatment prior to identification if such care and treatment is necessary to stabilize the patient's condition (example: unidentified patient arriving comatose to the emergency department, i.e. John/Jane/Baby Doe).
2. All patients must wear a correct and legible patient identification (ID) band at all times.
3. The patient's primary nurse is responsible for the accuracy of the patient's ID band.
4. Two patient identifiers are used when administering medication, blood or blood components, when collecting blood samples and other specimens for clinical testing and when providing treatments or procedures and diagnostic testing (excluding consultation and teaching) to ensure the correct patient is involved.
   a. The first identifier is the patient name (If the name is too long an exact match up to 13 characters is required).
   b. The second identifier is:
      i. Patient date of birth - ~~(~~Outpatient Areas~~)~~
      ii. Patient Medical Record Number - ~~(~~Inpatients~~)~~
      iii. Patient Account**/~~-vs-~~Financial** Number **(FIN)** - ~~(~~Emergency Department~~)~~

~~c.~~**5.** All containers used for blood and other specimens will be labeled in the presence of the patient.

~~5.~~**6.** Additionally, staff shall verbally assess the patient to assure proper identification, asking the patient's name **if appropriate for**~~consistent with~~ age, condition and ability to understand and matching the verbal confirmation to the written information on the identification band.

7. If a patient is to have blood products administered, a Transfusion Service ID band must be applied by either laboratory staff or nursing personnel and can only be removed by laboratory staff.
   a. Contact Lab to remove and replace the armband
   ~~6.~~**b. Surgical Services RNs may remove the transfusion service ID band if necessary for site access. The band must be immediately reapplied to the available site.**

~~7.~~**8.** Any staff person removing an ID band for any reason is responsible for replacing the ID band and ensuring accuracy and legibility.

~~8.~~**9.** If the patient is not alert, a family member or representative may verify accuracy of the information.

~~9.~~**10.** Name alert signs for similar patient names shall be posted on the chart and at the nurse's station.

~~10.~~11. All newborns must be banded before being separated from their mother (see Patient Care Services **Procedure:** Identification of Newborns ~~Procedure~~).

12. No procedure shall be conducted when patient identification cannot be verified because the imprinted band is illegible or missing. Defective or missing ID bands shall be replaced immediately with new, accurate, legible ID bands.

B. RELATED DOCUMENTS:

~~11.~~1. **Patient Care Services Procedure: Identification of Newborns**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11	**SUBJECT: Interpretation and Translation Services**
REVISION DATE: 10/13; 01/14; 01/15, 03/16	~~**POLICY NUMBER: II.J**~~
Department Approval:	~~**09/16**~~**04/18**
Clinical Policies & Procedures Committee Approval:	~~**10/16**~~**04/18**
Nurse Executive Council Approval:	~~**10/16**~~**04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**11/16**~~**05/18**
Professional Affairs Committee Approval:	~~**01/17**~~**06/18**
Board of Directors Approval:	**01/17**

A. **PURPOSE:**

1. To outline the policy and procedure for provision of interpretation services within Tri-City Healthcare District (TCHD) for patients with limited English proficiency.

B. **DEFINITIONS:**

1. Communicatively Impaired: A communicatively impaired individual has expressive or receptive language deficits that may be present after an illness or injury. This may include individuals with: voice disorders, laryngectomy, glossectomy, cognitive disorder, or temporary disruption of the vocal cords due to intubation or medical treatment.
2. Limited English Proficiency (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.
3. Primary or Preferred Language: the language the patient wants to use to communicate with his/her provider(s).
4. Interpretation and Translation: Interpretation involves the immediate communication of meaning from one language (the source language) into another (the target language). An interpreter conveys meaning orally, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments. A translation conveys meaning from written text to written text. A sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Interpretation and translation require different skills.
5. Interpreters:
   a. Bilingual Employees: Personnel with validated competency that specifies the parameters within which the employee, in the course of providing services, may communicate directly with patients, family members, surrogate decision makers and visitors in a foreign language. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   b. Dual-Role Employees: Personnel with validated competency that specifies the parameters within which the employee may serve as interpreter in the course of providing services within their unit or in emergency situations. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   c. Medical/healthcare Information Interpreter: Personnel with validated competency to interpret critical medical communications including but not limited to medical care, treatment, medical decision making. May include in-house healthcare interpreters and assessed/qualified dual role.

d. Service Information Interpreters: Personnel with validated competency to interpret limited topics related to critical service information.
e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.
f. Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.
g. Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.

6. Critical Medical Communications: Generally includes but not limited to:
   a. Consent and/or acknowledgement of information discussion
   b. Advance directive discussion
   c. "Do Not Resuscitate" (DNR) and discussion
   d. Explaining any diagnosis and plan for medical treatment
   e. Explaining any medical procedures, tests or surgeries
   f. Initial medication education
   g. Patient complaints
   h. Final discharge instructions
7. Critical Service Information: Generally includes but not limited to:
   a. Agreement for Services
   b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
   c. Applications to participate in a program or activity or to receive hospital benefits or services.

C. **POLICY**

1. TCHD provides qualified interpreters at no cost to patients whenever a language or communication barrier exists. Interpretation services are available on the premises or accessible by telephone or video remote interpreting (VRI) 24 hours a day, seven (7) days a week.
2. TCHD qualified interpreters will be utilized for interpretation appropriate to their level of competency.
   a. The telephone interpretation service or VRI shall be used in the absence of a TCHD qualified interpreter whenever necessary for any language.
3. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs.
   a. Patient refusal of TCHD's interpretation service must be documented in the medical record in addition to the name of the individual that the patient has selected to perform interpretation.
   b. Staff members may access a TCHD medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the patient and may have a hospital-designated interpreter monitor the communication.
4. Documents and forms shall be either provided in the preferred language of patient/family when available or explained verbally.
5. Notices advising patients and families of availability of interpretation services, procedures for obtaining assistance and lodging complaints are displayed in public areas on the Patient Rights posters and patient handbooks.
6. Education on interpretation services shall be provided in New Employee Orientation and as needed in department/committee meetings.

D. **PROCEDURE**

1. Registration

a. Upon first encounter (registration, check-in), Access personnel shall identify the patients preferred language for discussing health care. The designation shall be documented in the electronic health record as appropriate.
   i. A service information interpreter shall be utilized as needed

2. Inpatient or Outpatient Areas
   a. Assess and document patient needs and preferred methods(s) for interpretation services in the medical record and incorporate into the plan of care.
   b. Contact TCHD qualified interpreter based on the level of interpretation services (general information or critical medical communication) needed (see definitions and reference Tri-City Healthcare District qualified interpreters information on the Intranet).
   c. If a TCHD qualified interpreter is not available, contact either the facility designated telephone interpreting service (see Language Services Associates instructions on the Intranet), or facility designated video remote interpreting services (see Language Services Associates , NexTalk and Status instructions on the intranet).

E. DOCUMENTATION

1. Document the use of all interpretation/translation services, including patient selected individual for medical interpretation in the patient's medical record and include: date, interpreter's name or ID number, language, and reason for interpretation / call (i.e., "John Smith, patient's wife or "Mary Jones, Official Interpreter, or "telephone Interpreter ID # 123, Language: Korean, Reason: to discuss surgical procedure).

F. FORM/RELATED DOCUMENTS:

1. Interpretation and Translation Resources – Quick Reference & User Guides

G. REFERENCES

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. 42 CRF 124.602(c)
3. 45 CFR 84.52 (c) and (d)
4. Section 504 of Rehabilitation Act of 1973
5. Title VI of Civil Rights Act of 1964
6. Section 1259, California Health & Safety Code
7. National Standards for Culturally and Linguistic Appropriate Services (CLAS)
8. National Association for the Deaf: www.nad.org
9. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
10. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
11. Limited English Proficiency (LEP) A Federal Interagency Website (www.lep.gov).

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**STROKE CODE, IN-HOUSE**
Purpose:	To outline the procedure for prompt recognition and interventions for a patient with signs and symptoms of stroke or worsening stroke
Supportive Data:	Rapid response is critical for a prompt diagnosis and appropriate intervention.
Equipment:	Stroke Admission Packet

A. **POLICY:**

1. The primary **Registered Nurse** (RN) shall call the Rapid Response Team (RRT) if a patient is experiencing new or worsening "stroke-like" symptoms and will obtain a blood glucose level via point of care blood glucose meter prior to RRT arrival.
   ~~a. The Telemetry RN will also perform National Institute of Health Stroke Scale (NIHSS) 1,5, and 6 prior to arrival of RRT.~~
2. The RRT will do a patient assessment with the National Institute of Health Stroke Scale (NIHSS) detailed stroke scale assessment on the patient when they arrive on the unit.
3. The RRT will initiate the in-house stroke code by dialing 66 from the patient's room and inform the Public Branch Exchange (PBX) operator that there is an in-house stroke code on the unit and will give the patient's room number.

~~3.~~**4. The RRT or designee will order the In House Stroke Code power plan**

~~4.~~**5.** PBX Operator:
   a. The operator shall call a stroke code overhead and will page the Stroke Team which consists of the following staff members:
      i. Computerized technologist
      ii. Lab phlebotomist
      iii. Stroke coordinator
      iv. Radiology technologist

~~5.~~**6.** The primary nurse or designee will contact the on call hospitalist at (760) 966-2499 and inform the hospitalist of the in-house stroke code.

7. The hospitalist will come assess the patient and if the hospitalist agrees with the stroke code, the ~~primary nurse or designee~~**hospitalist** will contact the neurologist on call at (760)940-~~3000~~ **3002** ~~and provide the RRT return phone # (760) 802-3727~~
   a. The Stroke Code will continue unless cancelled by the hospitalist on call.
   ~~6.~~**b. If the hospitalist does not ~~respond~~arrive to assess the patient in a timely manner, the RRT will page the neurologist ~~after the STAT CT Stroke Code without contrast.~~and continue on with the stroke code.**
   ~~a. If the hospitalist doesn't agree, the stroke code will be cancelled~~
      ~~7.~~**i.** RRT to give the on call Neurologist the patient's NIHSS score and patient assessment details so the neurologist can verify the stroke code is appropriate and any further orders.
8. The RRT and/or Stroke Coordinator serve as the team leader:
   a. Evaluates timeline (time from symptom onset to intravenous thrombolytic administration should be less than 4.5 hours). Determines eligibility for thrombolytics in collaboration with Neurologist
   b. Performs patient NIHSS and patient assessment
   c. Orders necessary tests/labs –
      i. In House stroke code order set which includes:
         1) STAT **Computerized Tomography** (CT) Stroke Code without Contrast, **CT Stroke Code Angio COW (Circle of WILLIS), and CT Angio Carotid**
         ~~1)~~**a) ~~(n~~No need to wait for creatinine level or GFR prior to scans~~)~~**

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Division of Neurology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
~~New, 8/15~~	05/14, 9/15, 05/17	05/14, 09/15, 05/17	11/14, 04/18	n/a	11/14, 05/18	01/15, 06/18	01/15

2) **Prothrombin Time** (PT), **Partial Thromboplastin Time** (PTT), **International Normalized Ratio** (INR), **Chemical Panel** (Chem 12) and **Complete Blood Count** (CBC)

d. Discusses possible treatment options that may be ordered by physician with patient/family
e. Accompanies monitored patient to CT scanner as indicated by acuity
f. Administers thrombolytic agent if ordered
g. Monitors for signs/symptoms of bleeding, neurologic deterioration, changes in vital signs

9. The Neurologist shall collaborate with RRT and the attending physician when available during the stroke code.
10. Primary nursing:
    a. Administers supplemental oxygen as ordered
    b. Assesses vital signs
    c. Monitors cardiac rhythm(in monitored areas) and pulse oximetry
    d. Ensures **intravenous** (IV) access (prefer 18-20 g in antecubital or forearm)
    e. Considers/secures second IV as indicated for thrombolytic administration
    ~~e.~~**f. Administer thrombolytics as ordered**
11. Lab Phlebotomist:
    a. Draws stat blood tests as ordered, draws PT/INR, PTT, Chem 12 and CBC
    b. Immediately delivers to lab and hands off to technologist
12. Laboratory technologist:
    a. Performs testing
        i. If specimen hemolyzes, immediately initiate redraw. Notify RRT 760-802-3727 or physician of delay.
    b. Call results directly to the RRT (760)802-3727, and document the communication in Cerner.
        i. Time from order to communication of results should be less than 45 minutes
13. Pharmacist:
    a. RRT or designee will notify pharmacy of possible tPA candidate
    b. Pharmacy will verify inclusion/exclusion criteria and weight while awaiting tPA orders from Neurologist
    c. When tPA ordered pharmacy will prepare and send tPA to RRT RN
14. Assigned radiology transporter:
    a. Transports patient to CT scanner
15. Radiology technologist:
    a. Verifies with RN that Stroke Code notification was received.
    b. Prepares the CT scanner for emergent head CT as per imaging protocol
    c. Performs the CT.
        i. Time from order to completion of test should be less than 25 minutes for patients eligible for thrombolysis.
    d. CT alerts Radiologist to stroke code
16. Radiologist:
    a. Reads CT immediately and contacts the on-call neurologist with results: (Time from completion of test to communication with Neurologist should be less than 20 minutes for patients eligible for thrombolysis.)
17. The (ANM) Assistant Nurse Manager/designee shall assist RRT to assure patient is placed on the appropriate nursing unit.
    a. Patients receiving tPA shall be assigned to a bed in the Intensive Care Unit (ICU)
    b. All other patients, are assigned based on acuity or physicians order, to 4P or Telemetry
    c. Whenever possible patients must be in the monitored/camera beds on 4P
18. Post-Stroke Code Care; per CPOE Stroke Care Set (unless superseded by physician orders):
    a. Continuous cardio respiratory monitoring
    b. Blood pressure recording

c. Monitor temperature
d. Monitor neurological status: NIH Stroke Scale and neuro checks
e. Monitor peripheral circulation and end-organ perfusion (skin temperature, capillary refill, peripheral pulses, and urinary output).
f. Monitor for signs of bleeding or other complications if tPA administered.
g. Maintain two (2) intravenous lines (if tPA administered).
h. Monitor blood studies.
i. Measure intake and output

19. Documentation:
a. RRT shall document events in the patient's medical record. (NOTE: Obtaining CT scan and labs have highest priority and should not be delayed unless absolutely necessary for patient safety.)

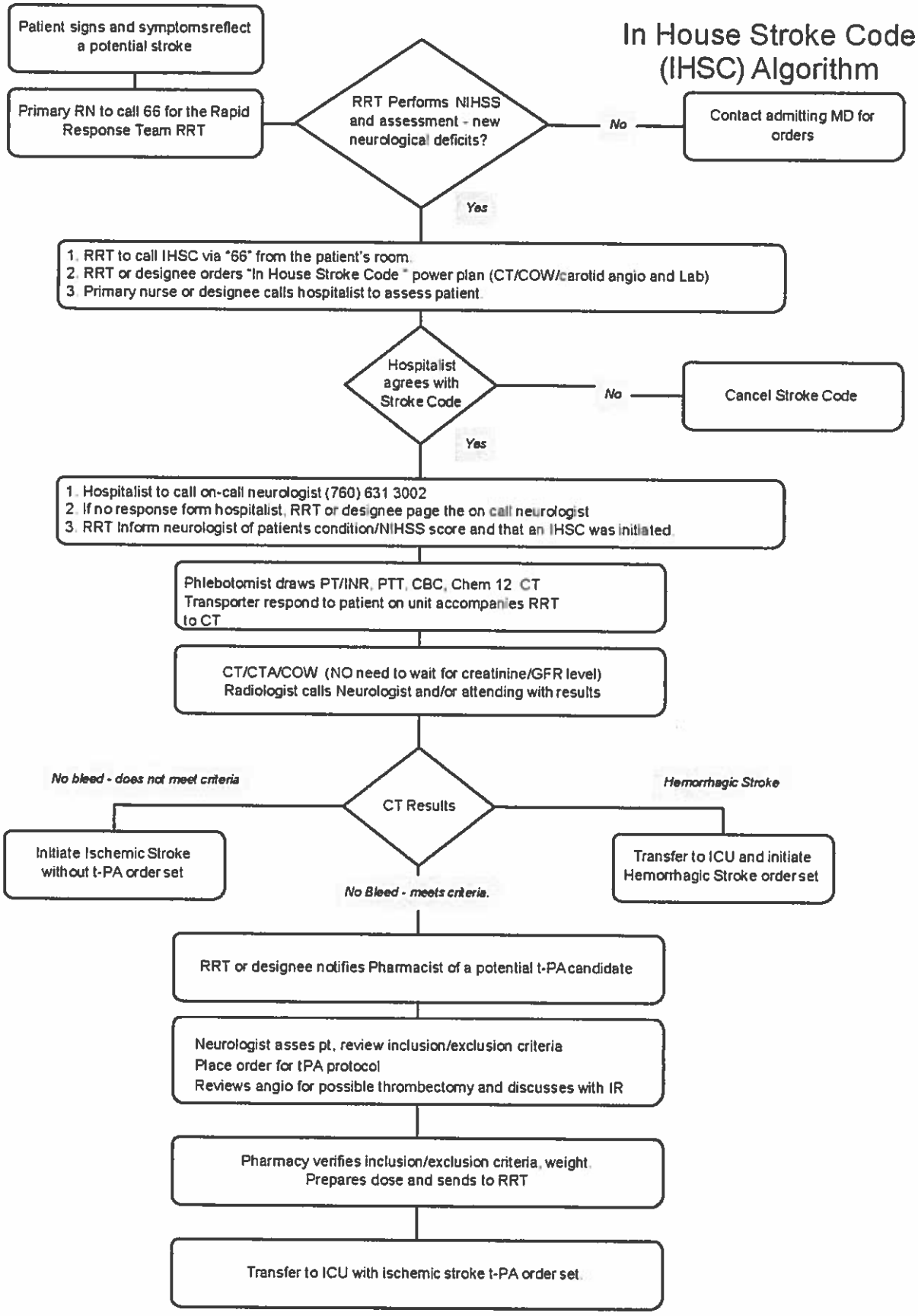
C. ~~FORMS (LOCATED IN PATIENT CARE SERVICES MANUAL; FORM/~~RELATED DOCUMENTS ~~FOLDER)~~:

1. Stroke Code; In-House Algorithm

D. REFERENCES:

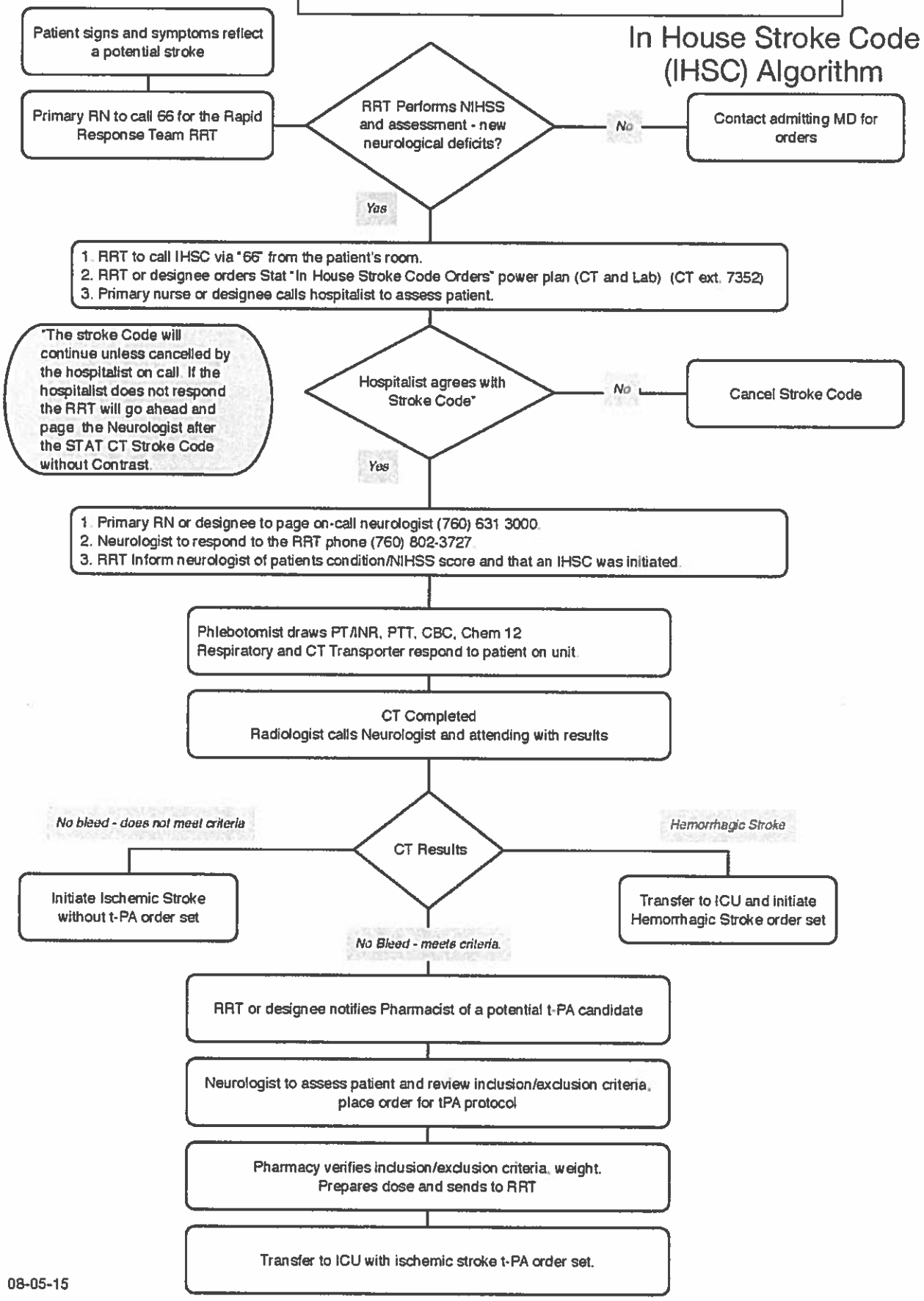
1. **Guidelines for Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association /American Stroke Association. ~~20132018:49e46-e99;44:870-947~~~~Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708~~**
~~1.~~**2. Scientific Rationale for the Inclusion and Exclusion Criteria for Intravenous Alteplase in Acute Ischemic Stroke. Stroke 2016;47:581-641**
~~2. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. N Engl J Med. 1995; 333:1581-7.~~

In House Stroke Code (IHSC) Algorithm



DELETE

In House Stroke Code (IHSC) Algorithm



08-05-15

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**WASTING NARCOTICS, DOCUMENTATION IN THE PYXIS MACHINE**
Purpose:	To outline the process and corresponding documentation for wasting controlled substances in the Pyxis.

DELETE – incorporated into Pharmacy/Patient Care Services Policy: Automated Dispensing Machine (Pyxis)

~~A. **DEFINITIONS:**~~

~~1. Pyxis: Automated Dispensing Machine used to dispense and~~

~~2. Approved licensed health care professional~~

~~a. Anesthesiologist~~

~~b. Registered Nurse~~

~~c. Licensed Vocational Nurse~~

~~d. Respiratory Care Practitioner~~

~~e. Radiology Technician~~

~~f. Pharmacist~~

~~g. Pharmacy Technician~~

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

~~1. Wasting Single Dose Narcotics and Patient Controlled Analgesia (PCAs):~~

~~a. Select "Waste" key~~

~~b. Select patient's name and a list of medications removed in the past 24 hours will appear.~~

~~c. Select medication to be wasted~~

~~d. Type in amount of medication given (amount to waste will be automatically filled in)~~

~~i. When wasting PCAs, drips or epidurals the waste amount will be in milliliters~~

~~e. Waste requires another nurse or other approved licensed health care professional to witness~~

~~f. Select "Accept" key~~

~~g. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the current waste disposal guidelines.~~

~~2. The above process can also be completed in Pyxis at time of medication removal. The Pyxis will prompt the nurse to enter information in steps d and e at time of removal. Steps a-c will not need to be completed.~~

~~3. Wasting controlled substances that were not removed from same Pyxis~~

~~a. Select "Waste" key~~

~~b. Select patient's name. Since the medication was not originally removed from this Pyxis, the medication will not be listed on the patient's profile.~~

~~c. Select "all meds" key and a list of all meds will appear on the screen~~

~~d. Select medication to be wasted~~

~~e. Type in amount of medication given (amount to waste will be automatically filled in)~~

~~f. Waste requires another nurse (or other approved licensed health care professional) to witness.~~

~~g. Select "Accept" key~~

~~h. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the current waste disposal guidelines.~~

~~4. See Waste Disposal Guidelines for wasting controlled substances.~~

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

~~1. Waste Disposal Guidelines~~

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/03, 06/09, 07/12, 09/15, 02/17, 12/17	07/12, 10/15, 03/17, 01/18	08/12, 10/15, 03/17, 01/18	12/15, 05/17, 01/18	08/12, 02/16, 06/17, 02/18	09/12, 07/17, 06/18	09/12, 07/17

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	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM	▫ All sharps *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples*	▫ 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*	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**
▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ 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.	▫ Trocars, introducers, guide wires, sharps from procedures etc.	**NO PHI**	**NO PHI**	**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/ais/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf, County of San Diego Department of Environmental Health Hazardous Materials Division: Sterilyte Healthcare Environmental Resource Center. Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/Publish/CH11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: WOUND, OSTOMY, CONTINENCE NURSE ~~/ ENTEROSTOMAL THERAPIST~~ (WOCN~~/ET~~) ~~STANDARDIZED PROCEDURE~~

I. **POLICY:**

A. Function: Wound, Ostomy, Continence Nurse~~/Enterostomal Therapist~~ (WOCN~~/ET~~) **consult or** referral for **wound team** evaluation and treatment of patients with **partial or full thickness** wounds, ostomies, **incontinence associate** impaired skin integrity**, fungal rashes,** ~~and~~ incontinence**, pressure injury prevention and treatment.**

B. Circumstances:

1. Setting: Tri-City Medical Center acute care setting
   a. Assessment management of **high risk patient for pressure injuries,** acute and chronic wounds, ostomy and peristomal problems, impaired skin integrity, and incontinence.
   b. Collaborating with physicians, and other health care disciplines including, but not limited to physical therapy, dietary consultation.
2. Supervision: None required
   a. The WOCN shall communicate with the physician for the following situations and any others deemed appropriate.
      i. Emergent conditions requiring prompt medical interventions.
      ii. Acute decompensation of patient situation
      iii. Problem that is not resolving as anticipated
      iv. Any adverse episode

II. **PROCEDURE:**

A. This Standardized procedure covers the assessment, management, and treatment of patients with acute and chronic wounds including, but not limited to pressure **injuries**~~ulcers~~, venous ulcers, arterial ulcers, diabetic foot ulcers, post-operative wounds, traumatic wounds, skin tears, superficial burns, ostomies, fistulas, and percutaneous tubes. Associated skin conditions may include, but are not limited to stasis dermatitis, **moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).**~~contact dermatitis, and cutaneous fungal infections.~~

B. Acute and Chronic Wounds:

1. Assessment data may include, but is not limited to:
   a. Historical information
   b. Review of previous treatment of current condition and response to treatment
   c. Review of current medications
   d. Review of associated risk factors
   e. Wound measurement: Length x width x depth
   f. Wound bed appearance: granulating, necrotic, presence of slough
   g. Wound drainage including amount, color, and consistency
   h. Periwound skin surface (intact, denuded, macerated)
   i. Presence of edema
   j. Circulatory status
   k. Wound type of stage / deep tissue exposed
2. Plan:
   a. Therapeutic regimen:

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/07, 06/11	03/11, **05/17**	03/11, **05/17**	06/11, **05/17**	06/11, **07/17**	06/11, **03/18**	**06/18**	06/11

i. Dependent upon the conclusion of the assessment process

b. Patient education regarding:
   - i. Disease process
   - ~~i.~~**ii. Prevention and treatment of pressure injuries**
   - ~~ii.~~**iii.** Risk factors / change in behavior and routine
   - ~~iii.~~**iv.** Procedures
   - ~~iv.~~**v.** Diagnostic testing
   - ~~v.~~**vi.** Medications

c. Treatment appropriate to the condition and status of wound, including but not limited to:
   - **i. Wound Culture as clinical indicated aerobic / anaerobic and gram stain**
   - **ii.** Application of dressings to maintain moist wound bed
   - ~~i.~~**iii. Negative pressure wound therapy**
   - ~~ii.~~**iv.** Conservative sharp debridement and autolytic debridement
   - ~~iii.~~**v.** Compression therapy
   - **vi.** Use of equipment
   - ~~iv.~~**vii. Specialty mattress and bed selection as clinical indicated**

3. Consultation:
   a. Consultation and referral to the appropriate specialist or health care professional is initiated when the condition necessitates.
4. Follow-up:
   a. Follow-up shall be initiated by the WOCN at his/her discretion as indicated to evaluate the patient's condition at appropriate time intervals.
   b. Evaluate for possible referral to the TCMC Center for Wound Healing and Hyperbaric Medicine.

C. Pressure **Injuries:** ~~Ulcers:~~
1. A pressure **injury** ~~ulcer~~ is any lesion caused by unrelieved pressure resulting in damage of underlying tissue.
2. Pressure **injury** ~~ulcers~~ are usually located over bony prominences **or under a medical device excluding mucosal membranes** and are graded or staged to classify the degree of tissue damage observed.
3. Treatment:
   - **a. Apply a prevention foam composite dressing to high risk areas or under a medical device to prevent injury. Assess under the dressing q shift and with a change in condition.**
   - ~~a.~~**b.** Turn and reposition patient at least every 2 hours **or more frequently as needed to prevent injury.**
   - ~~b.~~**c.** Assure the appropriate selection of support surface.
   - ~~c.~~**d.** Educate staff, **patient and or family** on pressure **injury** ~~ulcer~~ prevention and treatment per hospital policies.
   - ~~d.~~**e.** Dry Wounds:
     - i. **T**~~t~~opical wound care to include, but not limited to the use of hydrogels, ointments, creams, cover dressings.
   - ~~e.~~**f.** Wet Wounds:
     - **i. T**~~t~~opical wound care to include, but not limited to use of absorptive fillers, granules, paste, powder, alginates, **ointments** and absorptive cover dressings.
   - ~~a.~~**g. Prevention of Pressure Injuries is a comprehensive and collaboratiative approach involving the staff and the patient. This includes but is not limited to: product evaluation, patient recommendations for care, staff education and in-services, specialty bed selection, and as indicated Consultation with Wound Physician, Plastic Surgeon Service, Dietician, Physical Therapy.**
4. Adjunctive therapies:

a. Vacuum Assisted Closure (VAC) **or Veroflo**
b. Wound debridement:
   i. Autolytic
   ii. Enzymatic
c. Topical therapy for odor management and reduction of bacterial burden.

D. Ischemic (Arterial) Ulcers:
1. Arterial ulcers are caused by lack of blood flow and tissue perfusion. Pressure, trauma and other factors may precipitate their development.
2. Treatment:
   a. Circulatory status will determine treatment and management of arterial ulcers
   b. Assessment of circulatory status to include but not limited to:
      i. Palpation of pulses
      ii. Assessment of skin color, skin temperature, and capillary refill time
      ~~b.~~**1) Atrophy of the skin; skin cool to touch; absent hair**
      ~~ii.~~**iii.** Presence of hair and toenail changes
      ~~iii.~~**iv.** Dependent rubor
      ~~iv.~~**v.** Sensation, pain
      ~~v.~~**vi.** **Arterial duplex study to evaluate physiologic wave forms for wound healing** ~~ankle-Brachial Index~~
   c. Topical dressings may include hydrogels, absorptive wound fillers, **matrix dressing,** nonocclusive absorptive dressings, and hydrophilic dressings.
   d. Enzymatic debridement or conservative sharp tissue debridement after vascular status is established and as been ordered by the physician.
   e. Consultation with Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.
   ~~e.~~**f.** **Arterial wound should not be classified as pressure injury.**
3. Educate patient and staff on pressure reduction and trauma prevention to lower extremities.

E. Venous Ulcers:
1. Venous ulcers may be defined as ulceration secondary to chronic venous insufficiency. Veins can be normal, but patient may have poor venous return, due to calf muscle pump incompetence, i.e., paraplegics or rheumatoid arthritis.
2. Treatment:
   a. Assessment of circulatory status to include but not limited to:
      i. Presence of edema
      ii. Stasis dermatitis
      iii. Lipodermatosclerosis
      iv. Hyperpigmentation
   b. Topical wound care to absorb excess drainage and maintain moist wound bed.
   c. Compression therapy, if arterial circulation is satisfactory
      i. Stockings or tubular elastic bandage, compression socks, stockings or tubular elastic bandage
      ii. 2 or 4 layered wraps
      iii. Pneumatic compression device
      iv. Foot pumps

F. Alteration in Skin Integrity: **moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).**
1. Alteration in skin integrity may be the result of the following factors:
   a. Excessive exposure of the skin to moisture due to but not limited to:
      i. **P**~~p~~erspiration~~,~~
      ii. **W**~~w~~ound ~~——~~drainage~~,~~
      iii. **U**~~u~~rine and **F**~~f~~ecal **i**ncontinence~~.~~
   b. Mechanical trauma due to pressure, friction and shear

c. Adhesive tape removal
d. Fungal/yeast infections
e. Allergic
f. Ceontact dermatitis

2. Treatment of partial or full thickness skin loss:
   a. Partial or full thickness skin loss may present as maceration, redness, denudation, itching, dermal stripping, flaking, rash, macular or popular pustules, fluid-filled blisters, and skin tears due to trauma.
   b. Cleanse with normal saline or commercially prepared dermal cleanser.
   c. Treatment appropriate to the condition and status of the wound, such as application of wound gel, oil emulsion gauze, hydrocolloids, and/or transparent dressing.
3. Treatment of fungal/yeast infections:
   a. Fungal infections are classified as dermatophyte or yeast infections that grow in moist, warm, dark surfaces such as in skin folds or between toe webs.
   b. Cleanse with normal saline or use commercially prepared skin cleansers.
   c. Thoroughly dry skin and skin folds.
   d. Apply anti-fungal ointment, powder, or cream, per manufacturer's recommendations.
4. Treatment of hypergranulation:
   a. Hypergranulation is when granulation tissue exceeds the height of the epidermal layers.
   b. Cleanse wound with normal saline or commercially prepared dermal cleanser and pat dry.
   c. Moisten tip of silver nitrate stick with water.
   d. Apply to affected area. Neutralize with normal saline.
   e. Reassess treatment effectiveness with next dressing or ostomy pouch change.
5. **Treatment of Incontinence related Skin Damage:**
   a. Cleanse the perineal area with ph balanced peri wipes.
   b. apply protect ointment or paste to affected area as needed to repel urine and stool.
   c. consider implementation female urinary diversion device or male urinary diversion device.
   d. consider a fecal containment device for liquid stool incontinence.
   e. Reevaluate placement and patency to ensure a medical device does not cause injury.

G. Diabetic Foot Ulcers or Neuropathic Wounds:

1. **Diabetic Foot Ulcer (DFU) is a combination of local and systemic risk factors that result in ulceration in the foot. Wound healing and limb salvage outcomes are based on identifying the causative and contributing factors. Five key areas: patient, skin, circulation, limb, and wound. These factors influence wound treatment modality and limb salvage.**
   a. Peripheral Sensory Neuropathy:
      i. Semmes-Weinstein monofilament exam. This tests for neuropathy resulting in loss of protective sensation.
   b. Peripheral Arterial Disease:
      i. Evaluate vascular status by history of symptoms of intermittent claudication, ischemic rest pain, and peripheral vascular surgery; clinical signs of ischemia, such as skin temperature, dependant rubor, pallor, hair loss, and shiny skin and a clinical assessment of lower extremity pulses, ABI, or arterial duplex waveform study to determine perfusion status.
   c. Mechanical trauma due to pressure, friction and shear:,
      i. Evaluation of skin and nail changes

ii. **Musculoskeletal examination**

d. **Infection:**~~,~~

i. **Soft tissue and bone infection**

1) **X-ray or MRI**

e. **Prevention:**

i. **Evaluate risk factors and risk stratification to prioritize the patient's treatment according to the patient's needs. Preventive Education to reduce Diabetic Foot Ulcers.**

ii. **Protective Footwear and Pressure Redistribution**

1) **Primary role of therapeutic footwear is to protect the foot from repetitive injuries and eliminate the shoe as a source of pathology.**

2. **Treatment of Diabetic Foot Wound:**

a. **Antibiotic therapy and revascularization of ischemia will be initiated by Physician Team.**

b. **Sharp Debridement of the ulcer removes the devitalized tissue, reduces the bacterial load, eliminates proteases from the wound bed, and provides bleeding to the wound bed. Enzymatic debridement or autolytic debridement may be an option if sharp debridement is not possible or PAD.**

c. **Cleanse with normal saline or commercially prepared dermal cleanser, promote moist wound healing.**

d. **Treatment appropriate to the condition and status of the wound, such as application of wound vac or veroflo, ointments, enzymatic debridement ointments, composite dressings, silver dressings and/or foam dressing.**

e. **Off – Loading of wound to allow for wound healing.**

f. **Consultation with Wound Physician, Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.**

g. **Diabetic Foot Wounds should not be classified as pressure injury.**

~~e.~~**h. Educate patient and staff on pressure reduction and trauma prevention to Diabetic Foot Wounds.**

~~G.~~**H.** Ostomies, Fistulas, and Percutaneous Tubes

1. Treatment:

a. Assessment will include, but not limited to:

i. Description and evaluation of ostomy, fistula, peristomal skin, or percutaneous tube status

ii. Review of previous treatment of current condition and response to treatment

iii. Access stoma, fistula, or percutaneous tube drainage

iv. Presence of hernia or other stomal complications

b. Treatment appropriate to the condition:

i. Ostomy care and associated skin irritation

ii. Evaluation of stoma and peristomal skin condition to determine appliance choices

iii. Peristomal skin irritation, contact dermatitis interventions, such as:

1) Cleansing and application of protective skin barrier paste, powder, or barrier rings

2) Treatment of peristomal hypergranulation with silver nitrate cautery

iv. Management and removal of stents, drains, or stomal bridges as ordered by the physician

v. Evaluate fistula and perifistular skin condition to determine appropriate method to contain drainage

vi. Treatment of perifistular skin irritation, contact dermatitis, and skin erosion due to drainage

vii. Cleansing and application of wound containment device or topical wound product
viii. Barrier ointments or dressings to treat and protect the surrounding skin

c. Percutaneous tube skin treatment:
i. Cleansing, use of barrier powder, creams or ointments
ii. Dressing changes appropriate to drainage volume, or
iii. Use of containment devices.

III. **DOCUMENTATION:**

A. The WOCN shall document services provided and patient response to treatment in the medical record.

IV. **REQUIREMENTS FOR RNS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.
B. Education:
1. Be a graduate of an approved Wound, Ostomy, Continence Education Program ~~with current certification,~~ or
~~2. Be a graduate of a professionally recognized school of Enterostomal Therapy.~~
2. Participate in 30 hours of continuing education every 2 years.
~~2.~~**C. Annual Competency Assessment including Sharp Conservative Debridement Validation**

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Wound, Ostomy, and Continence Nurse Standardized Procedure.

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 11/08 | **SUBJECT: SMOKE-FREE ENVIRONMENT**

REVISION DATE: 5/12 | **POLICY NUMBER: 8610-205**

Department Approval:	**03/18**
Administrative Policies & Procedures Committee Approval:	**~~01/15~~04/18**
Medical Executive Committee	**~~02/15~~05/18**
Professional Affairs Committee Approval:	**~~03/15~~06/18**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

~~1. The purpose of this policy is to describe the Tri-City Healthcare District (TCHD) smoke-free environment.~~

~~2. Smoking of tobacco is a known danger to health and a cause of material discomfort and a health hazard to those who are present in areas where tobacco is being smoked. The United States Surgeon General has concluded that smoking tobacco can lead to numerous diseases for the smoker as well as others, as there is no risk free level of exposure to second hand smoke, the smoke created by another individual smoking tobacco.~~

~~3.~~ ~~The policy recognizes the health, safety and comfort benefits of smoke free air, and the District's responsibility to establish and maintain an optimally healthy, safe environment for its patients, employees and visitors. Effective November 20, 2008 TCHD will become a smoke free campus.~~

~~4.~~**1. To provide adequate guidelines regarding Tri-City Healthcare District's commitment to providing a safe and healthful work environment for all employees, contracted staff, medical staff, vendors, patients, visitors and other customers**

~~5.~~**2. Smoke inhaled from direct smoking, as well as, indirectly from other's who are smoking nearby is a major cause of preventable disease and death.The hospital serves as a model for our community in the area of promoting good health of our staff and influencing public attitudes about smoking. It is therefore, TCHD's policy to provide a smoke free environment.**

~~B. SCOPE:~~

~~1. This policy is in effect during and after work hours and applies to all individuals working, visiting, or receiving medical care within all of the District's inpatient and outpatient facilities. It includes all property and buildings owned or leased by TCHD including parking areas.~~

~~C.~~B. **DEFINITIONS:**

~~1. District premises: All property and buildings owned or leased by TCHD including parking lots.~~

~~2.~~1. Tobacco products: Any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes).

~~3.~~2. Electronic cigarette: Any electronic device designed or intended to produce smoke or vapors for inhalation.

C. **POLICY:**

1. **It is the policy of TCHD to provide a safe, healthful and comfortable work environment for all employees, contracted staff, vendors, patients visitors and physicians by prohibiting smoking or all tobacco based products at all facilities owned or operated by TCHD.**
2. **Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products on or in any TCHD facility, adjacent**

grounds, including parking lots and TCHD leased or owned vehicles. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products in their own or others vehicles when they are parked on TCHD property.

D. **PROCEDURES:**

~~Prohibition of Tobacco Use~~

~~a. Smoking of any kind is prohibited on all TCHD owned and/or leased locations/premises; entrances and exits and in all TCHD owned and/or leased vehicles. In addition, use of all tobacco products, which produce smoke or vapor, is prohibited.~~

~~2.~~**1.** Communication of Policy

a. Signs bearing the message "Smoke-Free Campus" are posted at strategic locations around the property (as applicable), and each building owned or leased in full will display a decal that states "Smoke Free Facility." No ashtrays or smoking shelters are provided on the campus property.

b. Patients and their families/friends will be informed of this policy upon arrival or as soon thereafter, as is medically appropriate.

c. ~~Patients will be informed of the smoking policy on admission.~~

d. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, medical staff, patients, and visitors.

~~3.~~**2.** Tobacco Cessation Programs

a. TCHD is committed to providing support to all TCHD employees who wish to stop using smoking products. TCHD is committed to ensuring that TCHD employees have access to smoking cessation assistance.

b. Supervisors are encouraged to refer employees and other personnel to Employee Health for information on available services.

~~4.~~**3.** Responsibilities

a. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving medical care within TCHD as cited above. Compliance with this policy is mandatory and will be strictly enforced. Policy violations by employees will be subjected to the standard TCHD disciplinary actions.

b. Employees who choose to use smoking products must do so on their own time

c. Respectful monitoring of this policy will be shared by all TCHD staff and Security.

~~5.~~**4.** Enforcement - Employees

a. This policy will be enforced through administrative action by supervisors and managers.

b. ~~Any person who observes violations of the policy is encouraged to report these violations to their supervisor and/or security.~~ Once the employee's supervisor has been notified of a violation by an employee under their direction, the supervisor is responsible for discussing the violation with the employee and taking appropriate disciplinary action. ~~The same disciplinary approach should be applied that is used in addressing violations of other TCHD policies.~~

c. Standard disciplinary procedures will be followed for compliance with staff. Violations of this policy will result in progressive disciplinary actions, up to and including termination.

~~b.~~**d. All personnel are responsible for adherence to and enforcement of the smoke free policy**

~~6.~~**5.** Enforcement – Patients and Visitors

a. Patients, visitors, and any other guests who fail to comply with this policy will be reminded that TCHD is a smoke-free facility and will be advised of resources available to assist with compliance while they are on TCHD property.

b. Patients will not be permitted to smoke during hospitalization. Refer to Patient Care Policy, *Patient Smoking* for management of patients refusing to comply with this policy.

E. **RELATED DOCUMENTS:**

1. Administrative Policy 424: Coaching and Counseling for Work Performance Improvement

2. Administrative Policy 234: Security Department Incident Notification
3. **Behavioral Health Services Policy: Smoke Free Environment**

F. **REFERENCES:**

1. Centers for Disease Control and Prevention. *Healthy Workforce Initiative:* Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.cdc.gov/nccdphp/dnpa/hwi/toolkits/tobacco/index.htm
2. The Joint Commission (2011). *Keeping your hospital Property Smoke-Free: Successful strategies for effective policy enforcement and maintenance.* Retrieved from: **http://www.jointcommission.org/assets/1/18/Smoke_Free_Brochure2.pdf**
3. The Joint Commission (2015). Caution: E-Cigarettes pose potential hazards: Follow standards and update smoking policies to maintain compliance. *The Joint Commission Perspectives*

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

ISSUE DATE: 11/88

SUBJECT: Behavioral Health Unit (BHU) / Crisis Stabilization Unit (CSU) Departmental Disaster Implementation Plan

REVISION DATE(S): 09/93, 03/97, 5/00

Department Approval:	**08/16**
Division of Psychiatry Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**05/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To assure proper management **and safety for staff, patients and visitors in the Behavioral Health Unit (BHU)/Crisis Stabilization Unit (CSU)** ~~of the department~~ during a disaster **or emergency situation**.

B. **SCOPE:**

~~B.~~**1. This document outlines the disaster emergency response actions to be taken in the event or series of events which is, or may become, detrimental to the well-being of the patients, staff, workers or visitors within the Inpatient** ~~**Behavioral Health Unit (**~~**BHU~~**)** **and Outpatient** ~~**Crisis Stabilization Unit (**~~**CSU~~**).**

C. **PERSONNEL:**

1. **Manager, Assistant Nurse Manager (ANM),** ~~**Director; Charge RN;**~~ **Registered Nurses (**R~~.~~N~~.~~'s~~)~~**;** ~~**,**~~ **Advanced Care Technicianss (ACTs)/**~~**L.V.N.'s; L.P.T.'s;**~~ **Nursing Assistants (**N~~.~~A~~.~~'s~~)~~; Unit Secretaries; Mental Health Workers (~~MHU~~**MHW); Psychiatric Liaisons; Marriage Family Therapist (MFT); Licensed Social Workers; Therapeutic Recreational Specialist (TR); Family Support, Peer Support, and Mental Health Interns.**

D. **EQUIPMENT:**

1. ~~Telephone call call back list~~ **Staff Disaster Call-Back Roster**
2. ~~Supplies list~~ **Supply Inventory**
3. Department Specific Information Lists **(patient census, medication lists, staff rosters)**

E. **PROCEDURE:**

1. Disaster Plan Implementation:
   a. The **Private Branch Exchange** (PBX) operator will announce "Code Orange" three times over the intercom.
   b. Communication Chain of Command:
      i. The ~~Director~~ **Manager or designee** will ~~contact~~ **instruct** the ~~Charge RN~~**ANM** ~~and~~ **to** initiate the ~~telephone~~ **Staff Disaster Call-Back Roster** ~~Call back tree~~**in an event where additional staff members may be needed.**
      ~~i.~~**ii.** The ~~acting charge nurse~~**ANM or nurse in charge** at the time of the disaster will continue to be in charge of the unit.
      ~~ii.~~**iii.** All personnel off the unit on duty will return immediately.
      ~~iii.~~**iv.** All personnel called into the hospital will be required to wear their I.D. badges in order to be admitted. **Arriving staff**~~They~~ will report directly to the **BHU** Unit~~.~~ **or**

Labor Pool location **as directed by Manager or designee.**~~:~~ **If their employee badge is not available the staff member will be directed to Employee Health** ~~for~~ **to obtain a temporary badge.**~~: French Room 3.~~

c. Child Care Provisions:
   i. ~~Employees~~ **Personnel** called back to the hospital **will be advised if the child care program has been activated for them to bring their children if necessary.**~~may bring their children to the child care center on site. (if itthe child care program is activated)~~
   ii. In the event of a major disaster, child care provisions ~~will~~**may** be made at **an alternative care site away from the facility**~~the First Baptist Church~~.

d. Department Disaster:
   i. If the disaster has occurred on the BHU, all **additional** personnel will report to the **Labor Pool location as designated by the Command Center**~~designated Labor Pool site~~.

e. Summary of Locations:
   i. Incident Command Center **(ICC)**: French Rooms 1 and 2 **(or alternative location).**
   ii. Labor Pool: French Room 3 **(or alternative location) as designated by Command Center.**

f. Duties of the ~~Charge Nurse~~**ANM**:
   i. Determine number of staff on the unit.
   ii. Determine patient census and number of empty beds on the unit.
   iii. Assess those patients who could be discharged and who could be moved to other areas of the unit if beds are needed.
   iv. **All** ~~This~~ information will be communicated to the ~~Command Center~~**ICC**.

g. Assessment:
   i. The ~~charge nurse~~**ANM** will determine the number of personnel who will remain on the unit and how many can be released to the Labor Pool.

h. Services to be Provided:
   i. Routine care may be discontinued at the discretion of the Incident Commander **(IC)**, ~~Director~~**Manager** or ~~charge nurse~~**ANM** until all disaster casualties have been admitted to the unit or the emergency no longer exists.
   ii. Patients will ~~be asked to meet in~~ **be directed to** the day room on the BHU and be reassured by the nursing staff.
   iii. The BHU can accept acute med**ical-surgical** patients if necessary.
   iv. The nursing staff will be available to provide support to all patients and family members affected.
   v. Status reports will be completed by either the ~~Director~~ **Manager** ~~or the~~ ~~charge nurse~~**ANM, or Designee** and communicated as directed to the Command Center in French Rooms 1 and 2.

2. Discharge Plan**:**
   a. The ~~Director/charge nurse~~**Manager /ANM or Designee** will determine which patients can be safely discharged in collaboration with the Medical Director of the Behavioral Health Unit.
   b. This information will be communicated to Patient Placement who will contact the Medical Staff Director. The Medical Staff ~~Director~~ retains the final responsibility in designating which patients can be discharged. ~~Patient Placement will be stationed in the Business Office.~~
   c. As requested by the Command Center, a bed availability status/report will be made by the ~~Director~~ **Manager** ~~or the~~ **/ANM**~~charge nurse~~ **or Designee.**
   d. The **Manager**~~Director/charge nurse~~**ANM** will communicate with the Discharge Unit Leader.
   e. When a patient is cleared for discharge, **an**~~the floor runner~~**RN/MHW** will escort the patient off the BHU through the ~~southwest~~ **front door** exit**, patio or recreational therapy room**. ~~The Business Office and Patient Placement will be notified by phone or by a designated runner as soon as the patient has been discharged.~~

F. **INFORMATION SPECIFIC TO THE ~~BEHAVIORAL~~ BHU/CSU~~HEALTH UNIT~~ IN THE EVENT OF A DISASTER:**

1. Personnel:
   - **a. Manager/ANMs**
   - **b.** R.N.'s
   - ~~a. (8)~~
   - **c. Psychiatric Liaisons (PLs), Marriage Family Therapists (MFTs), Liscensed Clinical Social Workers (LCSW)**
   - ~~b.~~**d. ACTs/N.A.s** ~~L.V.N.'s and L.P.T.'s (6)~~
   - ~~c.~~**e.** Unit Secretaries **(US)** ~~(1)~~
   - ~~d. Manager~~Director (1)
   - ~~e.~~**f.** Per diem personnel, **Therapeutic Recreational Specialist (TR), Family Support, Peer Support, Mental Health Interns** ~~(7)~~
2. Bed Capacity:
   - **a.** BHU has ~~20~~**18 general locked** ~~open unit~~ beds **and one observation**~~seclusion~~ **room.**
   - ~~a.~~**b.** ~~and~~**CSU has** ~~9 locked unit beds~~**12-16 crisis stabilization** ~~unit~~**stations/recliner chairs and 2 seclusion rooms**.
3. Oxygen/Suction: **(Contact Engineering if cover plates need to be removed for access)**
   - ~~a. Piped in O2~~ **Oxygen (02)** ~~is present in Rooms 171, 172, 173, and in the treatment room.~~
   - ~~b.~~**a.** Suction is present in Rooms 168, 169, 170, 171, 172, 173, and the treatment room.
   - ~~c.~~**b.** Portable oxygen and suction is also on crash cart.
   - ~~d.~~**c.** Staff ~~will~~ **shall** know the location of the O2 Shut ~~off~~ **Off** Valve for the unit **but shall not shut off without notification or approval from unit Manager, ANM, ~~or~~ Designee, or the Engineering department**.
4. Emergency Equipment:
   - a. Four fire extinguishers (3 on **general locked**~~open~~ unit; 1 in ~~O.T.~~**CSU**).
   - b. Crash cart with ~~defibrillator~~**AED** and emergency medications.
   - c. **Hard Rubber / Plastic** ~~Leather~~ restraints and postural supports.
5. Population:
   - a. Some of the patients which comprise the BHU are ambulatory and self-care.
   - b. Agitated or non-ambulatory patients may be transported via wheelchair **or gurney**.
6. Environment:
   - a. Staff lounge, ~~O.T~~**Recreation Therapy (RT) room**., the dining room, or the day room may be used for a conference or triage room.
   - ~~b. Treatment room with one exam table available on unit.~~
   - **b.** Washer/dryer present on unit.
7. **Shelter in Place (SIP):**
   - **a. During certain types of events (examples: active shooter/fire/hostage situation in another building or when evacuating may be more harmful to the patients, visitors or staff), it may be advisable to shelter-in-place (SIP). At the discretion of the CEO or IC, local law enforcement, or fire department, a decision may be made to keep the patients and staff members sheltered in place within the BHU/CSU.**
     - **i. If necessary, the Engineering department can be called to shut down the HVAC ventilation system.**
     - **ii. Access into and exiting the unit can be controlled with the badge readers and locking mechanisms on the doors. Staff should not allow individuals into the BHU/CSU unless they are able to clearly identify the person(s) attempting to enter.**
     - **iii. BHU/CSU staff members may move patients into areas deemed safe locations within the BHU/CSU units (examples: Away from windows, seclusion rooms, offices with locked doors).**
     - **iv. Transfers to alternative safe locations within the medical center may be utilized to provide patient care services. Examples of locations that may be used for temporary alternative care sites might include: The ED Fast Track due to the location's access controlled environment, the Special Procedures Recovery Area (SPRA) due to ability to house patients in a**

location with close observation abilities and limited entrance/exit routes).

8. Evacuation:
   a. Evacuation procedures shall be implemented in the event of a fire or other emergency within the BHU or nearby location that could threaten the well-being or safety of the staff, ~~and/or~~ patients or visitors.
   b. An evacuation of the BHU unit may be partial or full or it may be part of a full evacuation of the entire medical center.
   c. The authorization to evacuate depends on the situation. A voluntary evacuation is at the discretion of the Chief Executive Officer (CEO) or in the event the CEO is not available, then his/her designee(s) in the following order: Chief Operating Officer (COO), Chief Nurse Executive (CNE), or the Safety Officer. A mandatory evacuation is an evacuation that is ordered by an authorized governmental authority having jurisdiction. Government authorities with jurisdiction include, but are not limited to, fire, law enforcement, OSHPD and local emergency services.
   d. On-Site evacuation: If possible, all BHU/CSU patients, visitors and staff shall evacuate the building and exit into the large secured patio area located outside the general locked unit.
      i. Alternate option would be to evacuate the individuals located in the CSU ~~patients~~ out of the building and into the CSU secured patio area and the individuals in the general BHU ~~patients~~ into the large secured patio area outside of the general locked unit.
      ~~c.~~ii. In the event that the patio areas become unsafe/life threatening, the patio gate doors may be unlocked by the BHU staff. Every effort will be made to keep the patients safe and accounted for during the evacuation.
   ~~d.~~e. Off-Site evacuation: In the event that behavioral health patients require being transferred to alternative care site or facility, the Incident Command Center (ICC) would contact the San Diego County Emergency Medical Services for assistance and direction of where and when the evacuation transfers would occur. The Liaison Officer will be responsible for inter-facility communication between the medical center and the designated alternative care site.
      ~~e.~~i. Transportation would depend on the level of medical needs and may be provided by TCHD patient transport vans, BLS ambulance, or Specialty Care ambulances. The Manager/ANM and BHU/CSU Medical Director in conjunction with the ICC would determine the appropriate level of transportation needed to safely transfer the patients.

~~f.~~9. Recovery/Repopulation post evacuation:
   ~~g.~~a. Repopulation of the BHU or CSU areas post evacuation is at the discretion of the CEO or IC in conjunction with the BHU medical staff, department manager and may require the approval of the California Department of Public Health (CDPH), other public safety and utility agencies, as appropriate.
   ~~h.~~b. Prior to repopulation surveillance of temperatures, refrigeration, air/water quality, pharmaceuticals, facility security, and perishables need to be assessed and replaced/restocked or corrected as appropriate.

~~i.~~G. <u>RELATED DOCUMENT(S):</u>

~~j.~~1. ~~Tri-City Medical Center's~~ Emergency Operations Procedure Manual: Emergency Operations Plan ~~(EOP)~~

~~G.~~H. <u>REFERENCE(S):</u>

1. Hospital repopulation after evacuation guidelines and checklist (2011). *California Hospital Association*
~~a.~~2. Hospital Evacuation Plan (Checklist 2011). *California Hospital Association*
~~b.~~3. Hospital Shelter in Place (Checklist 2011). *California Hospital Association*
~~2.~~4. Planning for psychiatric patient movement during emergencies and disasters (2012). *U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response*

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

ISSUE DATE: 03/08

SUBJECT: Notification of Medi-Cal Beneficiary of Denial of Benefits

REVISION DATE(S): 08/09, 03/13, 06/16

POLICY NUMBER: 103

Department Approval:	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that all Medi-Cal beneficiaries are notified in a manner consistent with CCR, Title 9, Chapter 11, Section 1850.210 when the Point of Authorization ~~(United Behavioral Health: UBH)~~**Optum** denies continued inpatient hospitalization services to the beneficiary by the Mental Health Provider (MHP), i.e. Tri-City ~~Medical Center~~**Health Care District (TCHD)** Behavioral Health Services **(BHS)**.

B. **POLICY:**

1. When it becomes known, through the continued stay utilization review process, that payment for continued stay on the Inpatient Behavioral **Health** Unit **(BHU)**, known herein as the ~~Mental Health Provider (~~MHP~~)~~ has been denied, the Utilization Review Manager will notify the Medi-Cal beneficiary of the action and of his/her right to appeal the payment decision and will discuss the beneficiary's rights to appeal.

C. **PROCEDURE:**

1. A fax will be sent from ~~UBH~~**Optum** to the MHP indicating that further treatment days will be denied.
2. The Utilization Review Manager will discuss the faxed information with the patient. The Notice of Action includes:
   a. The reason the mental necessity criteria was not met.
   b. The beneficiary's options for obtaining care outside of the MHP, if applicable.
   c. The beneficiary's right to request a second opinion on the determination.
   d. The beneficiary's right to file a complaint or grievance with the MHP.
   e. The beneficiary's right to a fair hearing including the method by which a hearing may be obtained and information that describes that the beneficiary may be either ~~self represented~~**self-represented** or be represented by an authorized third party such as legal counsel, relative, friend or another person, as well as the time limits for requesting a fair hearing.

D. **REFERENCE(S):**

~~f.~~1. **CCR, Title 9, Chapter 11, Section 1850.210**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

ISSUE DATE: 3/08

SUBJECT: Patient Rights

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

POLICY NUMBER: 514

Department Approval:	**05/18**
Division of Psychiatry Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the rights of patients.
2. To identify justification to deny patient rights.
3. To define restoration of patient rights.

B. **POLICY:**
1. Behavioral health patients have the right to:
   a. To wear their own clothes, to keep and use personal possessions including toilet articles, and to keep and spend a reasonable sum of their own money for expenses and small purchases.
   b. To have access to individual storage space for private use.
   c. To see visitors each day.
   d. To have reasonable access to telephones, both to make and receive confidential calls or to have calls made for them.
   e. To have ready access to letter-writing materials, including stamps, and to mail and receive unopened correspondence.
   To refuse convulsive treatment, including, but not limited to, electroconvulsive treatment, any treatment for a mental condition that depends on the induction of a convulsion by any means, and insulin coma treatment.
   g. To refuse psychosurgery, defined as those operations referred to as lobotomy, psychiatric surgery, behavioral surgery, and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:
      i. Modification or control of thoughts, feelings, actions, or behavior.
      ii. Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.
      iii. Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behaviors.
      iv. Psychosurgery includes prefrontal sonic treatment if there is any possibility of destruction of brain tissue or brain cells.
   h. ~~D~~**To decline a specific service**
   i. To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the patient.
   j. Other rights, as specified by regulation.

~~i.~~**k. The rights specified in this section may not be waived by the person's parent, guardian, or conservator.**

2. Denial of Rights: Patients' rights may be denied only when there is good cause to do so. Good cause exists when:
   a. Exercise of the specific right would be injurious to the patient.
   b. There is evidence that the specific right, if exercised would seriously infringe upon the rights of others.
   c. The unit or hospital district would suffer serious damage if the specific right were not denied.
   d. There is no less restrictive way of protecting the interests specified above.
   e. The reason used to justify the denial of a right to a patient must be related to the specific right denied. A right must not be withheld or denied as a punitive measure nor shall a right be considered a privilege to be earned. When a right has been denied, staff must use the least restrictive means of managing the problem that led to the denial.

C. **PROCEDURE:**

1. Notification of rights:
   a. Each patient will be given a Patient Rights Handbook at the time of admission to the unit.
      i. The handbook will be in a language that is accessible to the patient
      ii. The patient will be asked to sign a statement indicating that he or she received the rights information; the signed statement will be kept in the patient's medical record.
      iii. Patients will be informed to the processes available to them if they believe a right has been compromised.
   b. Rights information posters will be displayed in a prominent place on the unit in the approved threshold languages.
   c. Additional copies of Patient Rights Handbooks will be made available to patients upon request.
   d. Patients will be informed of their rights related to the 14-day certification process in the event that such a certification occurs (See Policy: Notice of Certification and Advisement of Rights).
   e. Patients will also receive advisements related to their treatment when indicated by their legal status and changes therein.
   f. Patients will be given a Tri-City Medical Center Patient handbook at the time of their admission.

2. Declination of Service
   a. If the patient declines a service, the nurse will document the declination in the electronic health record.

~~2.~~**3.** Denial of Rights
   a. Each denial of a patient's rights must be noted in the medical record.
   b. Documentation must take place immediately whenever a right is denied, and each denial of a right must be documented regardless of the gravity of the reason for the denial or the frequency with which a specific right is denied either in the unit or to a particular individual.
   c. If a patient in seclusion or restraints is denied any right, the denial must also be documented.
   d. The documentation must include:
      i. The specific right denied.
      ii. The date and time the right was denied.
      iii. The reason (good cause) for denial of the right.
      iv. The date of review if the denial of the right extended beyond 30 days.
      v. The signature of the professional person in charge of the unit or a designee.
   e. The patient must be told the contents of the note.
   f. Quarterly reports of the number of persons whose rights were denied, and the specific right or rights denied, must be submitted to the local mental health director, who must report to the state Department of Mental Health.

~~3.~~**4.** Restoration of Rights

a. A right may not be denied a patient when good cause for its denial no longer exists. **The rights that is denied is evaluated on a daily basis by the physician or designee, and assigned nurse to ensure that good cause for its denial no longer exists.**

b. The date a specific right is restored must be documented in the patient's medical record.

D. EXTERNAL LINK(S):

1. **State of California – Department of Health and Human Services – Department of Health Care Services Patients' Rights Denial - Monthly Tally Form: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/Mental_Health/DHCS_1803.pdf**
2. **Mental Health Patients' Rights: http://www.jfssd.org/site/News2?page=NewsArticle&id=6363#certification**

Sample

State of California – Health and Human Services Agency — Department of Health Care Services

PATIENTS' RIGHTS DENIAL – MONTHLY TALLY

Patient I.D. Number	Month	Year
Admission Date	Discharge Date	State Hospital

Patient's Current Legal Status

☐ Legal Hold ☐ Voluntary ☐ Conservatee ☐ Other _____

General Instructions:

1. Individual Denials of Patients' Rights MUST be documented in the patient's record in accordance with Title 9. CAC, Sections 865.1, 865.2, and 865.4.
2. GOOD CAUSE for denial of rights shall be documented on the Doctor's Sheet or Nurses' Notes in the patient's treatment record in conformity with Title 9, Section 865.3.
3. RESTORATION OF RIGHTS shall be documented in the patient's treatment record in conformity with Title 9, Section 865.5.

SEE INSTRUCTIONS FOR USE OF THIS FORM ON REVERSE SIDE

DAY OF MONTH

RIGHT DENIED	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1																															
2																															
3																															
4																															
5																															
6																															
7																															
8																															
9																															
10																															

LEGEND

1. The right to wear one's own clothes.
2. The right to keep and use one's own personal possessions.
3. The right to keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases.
4. The right to have access to individual storage space for one's private use.
5. The right to see visitors each day.
6. The right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them.
7. The right to have ready access to letter writing materials, including stamps.
8. The right to receive and mail unopened correspondence.

RESTRICTIONS IMPOSED

9. Seclusion. (Isolation of a patient in a locked room.)
10. Restraint. (Any physical device used to immobilize patient because of behavioral problems.)

Sample

State of California – Health and Human Services Agency | Department of Health Care Services

PATIENTS' RIGHTS DENIAL – MONTHLY TALLY

INSTRUCTIONS
MH 306

1. This form is to be filed in the patient's treatment record as a daily record of rights denials.

2. After documenting denial as required by Title 9, place an "X" in the box under the date denial occurred on the line which corresponds to the specific right or rights denied. If denial continues beyond one day, a notation must be made for each day the right continues to be denied.

3. Recapitulate the monthly total of the days denied each right, and enter onto Form MH 307 (formerly MH 1070) next to the patient's I.D. number.

4. Submit with the completer Form MH307 to the local mental health director by the 10th day of the following month.

5. Insert a new tally sheet into the patient's treatment record.

NOTE:

Seclusions and restraints MUST be reported and documented because these actions imply the denial of other specific patient's rights, such as the right of access to the telephone.

These implied denials need not be documented in the patient's chart and should not be reported on this form.

If, however, the exercise of a particular right is specifically requested by the patient and denied by the staff while the patient is in restraint of seclusion, the denial of that right MUST be documented in the patient's record and reported on this form.

Sample

MENTAL HEALTH PATIENTS' RIGHTS

MOSAIC FOREST — Alice Washington, 2004

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.

YOU HAVE THE RIGHT:

- To dignity, privacy and humane care
- To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect
- To receive information about your treatment and to participate in planning your treatment
- To consent or refuse to consent to treatment, unless there is a legally- defined emergency or a legal determination of incapacity
- To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities
- To treatment services which increase your ability to be more independent
- To prompt medical care and treatment
- To services and information in a language you can understand and that is sensitive to cultural diversity and special needs
- To keep and use your own personal possessions including toilet articles
- To have access to individual storage space for your private use
- To keep and spend a reasonable sum of your own money for small purchases
- To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you
- To have access to letter-writing material and stamps —to mail and to receive unopened correspondence
- To social interaction, participation in community activities, physical exercise and recreational opportunities
- To see visitors every day
- To wear your own clothes
- To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services
- To religious freedom and practice
- To participate in appropriate programs of publicly supported education
- To be free from hazardous procedures
- And all other rights as provided by law or regulation

FOR MORE INFORMATION, CONTACT YOUR LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE.

Jewish Family Service
Patient Advocacy Program
8804 Balboa Avenue
San Diego, CA 92123
Tel (619) 282-1134
Toll-Free 1-800-479-2233

California Office of Patients' Rights
1831 K Street, Sacramento, CA
95811-4114
(916) 504-5810, http //
www.disabil-tyrghtsca org/
Department of Health Care Services
Mental Health Services Division
Ombudsman

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 3/06	**SUBJECT: Appropriate Use of Commercial Support and Exhibits**
REVISION DATE: 5/08; 10/12	**POLICY NUMBER: 8710-603**
Department Approval:	**03/17**
CME Committee Approval:	**04/08; 10/12; 10/15; 01/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/08; 11/12; 11/15; 05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	**05/08; 11/12; 12/15**

A. **PURPOSE:**
1. To describe appropriate behavior in planning, designing, implementing, and evaluating **continuing medical education** (CME) activities for which commercial support is received.

B. **DEFINITIONS:**
1. Commercial Support: Financial and other support provided by commercial organizations to enhance the quality of CME activities.

C. **POLICY:**
1. Tri-City ~~Medical Center~~**Healthcare District** adheres to the **Accreditation Council for Continuing Medical Education** (*ACCME) ~~2004~~ Standards for Commercial Support: Standards to Ensure the Independence of CME Activities*. In operational issues, the CME Program is guided by what is in the best interest of the public, and decisions are made with the principles of independence from commercial interests, transparency and keeping CME separate from product promotion.
2. **STANDARD 1: Independence**
   a. ~~Tri-City Medical Center~~ **TCHD** CME Committee ensures that CME activity content is free of control of a "commercial interest" including the identification of CME needs; determination of objectives; selection and presentation of content; selection of all persons and organizations that will be in the position to control the content of the CME; selection of educational methods; and evaluation of the activity.
   b. ~~Tri-City Medical Center~~**TCHD** does not jointly sponsor CME activities with a commercial interest.
3. **STANDARD 2: Resolution of Personal Conflicts of Interest**
   a. Relevant financial relationships with commercial interests of everyone who is in the position to control the activity content must be disclosed. Relationships in any amount and occurring within the past 12 months that create a conflict of interest are to be disclosed.
   b. Individuals who refuse to disclose relevant financial relationships will be disqualified from being a planning committee member and cannot have responsibility for the development, management, presentation or evaluation of the CME activity.
   c. ~~Tri-City Medical Center~~**TCHD** CME Committee will identify and resolve all conflicts of interest prior to the CME activity taking place, using the **Medical Staff** policy 8710-605, "*Conflict of Interest Resolution Policy.*"
4. **STANDARD 3: Appropriate Use of Commercial Support**
   a. All commercial support for ~~Tri-City Medical Center~~**TCHD** CME activities shall be obtained as unrestricted grants and dispensed by the CME Committee/designee in

accordance with the Accredited Council for Continuing Medical Education (ACCME) Commercial Support Standards.

b. ~~Tri-City Medical Center~~**TCHD** CME Committee makes all decisions regarding the disposition and disbursement of commercial support and all funding must be received by Tri-City Medical Center to support the expenses associated with Tri-City Medical Center sponsored activities.

c. ~~Tri-City Medical Center~~**TCHD** is not required to accept advice or services from the commercial interest regarding teachers or content as conditions of contributing funds or services. Content development must remain beyond the control of the commercial supporter. Content validation by the provider should be established.

d. ~~Tri-City Medical Center~~**TCHD** must be aware of all commercial support associated with the CME activity and must approve all such support. Tri-City Medical Center and its agents (joint sponsors) must decide what commercial support will be accepted and how it will be utilized, not the commercial interest.

i. **Written Agreement documenting terms of support**

1) ~~Tri-city Medical Center~~**TCHD** and the commercial supporter will have a written agreement indicating the terms, conditions, and purposes of the commercial support for all directly and jointly sponsored activities. ~~(See Appendix).~~

2) The Letter of Agreement specifies the commercial interest at the source of the commercial support.

3) The Letter of Agreement must be signed by ~~Tri-City Medical Center~~**TCHD** (accredited provider) and commercial supporter.

ii. **Expenditures for an individual providing CME**

1) ~~Tri-City Medical Center~~**TCHD** adheres to its policy 8710-604, "CME Speaker & Honoraria Reimbursement" which governs honoraria and reimbursement of out-of-pocket expenses for planners, teachers, and authors of CME activities. Honorarium amount is set by the CME Committee.

2) ~~Tri-City Medical Center~~**TCHD** CME Committee/designee is responsible for payment of honoraria and expense reimbursement in compliance with policy governing such.

3) No additional payment may be given to the planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.

4) When teachers or authors also participate as a learner, their expenses can be paid for their teacher or author role only.

iii. **Expenditures for learners**

1) Social events or meals at CME activities will not take precedence over the educational events and will be planned by the CME Coordinator or designee.

2) Commercial support funds are used to underwrite the expenses for developing and presenting the activity, including expenses of teachers and staff working on the activity.

iv. **Accountability**

1) Tri-City Medical Center maintains all income and expense documentation related to its directly and jointly sponsored activities. This will detail the receipt and expenditure of the commercial support.

5. **STANDARD 4: Appropriate Management of Associated Commercial Promotion**

a. Commercial exhibits or advertisements cannot interfere with the presentation nor be a condition of the provision of commercial support.

b. Product promotion material or product specific advertisement of any type is prohibited during CME activities. Staffed exhibits and/or presentations or enduring printed or electronic ads must be kept separate from CME. Adherence to the ~~2004~~ *Standards for Commercial Support Standard 4.2* is required.

c. Educational materials such as slides, abstracts and handouts cannot contain any advertising, trade name or product message.
d. The program book which contains non-CME elements that are not directly related to the transfer of education may include product promotion material or product specific advertisement.
e. Commercial interests cannot provide a CME activity to learners either by distribution of self-study activities or arranging for electronic access to CME activities. The commercial supporter may distribute promotional materials developed by the provider.
f. CME Exhibits are not considered "Commercial Support;" however, the ACCME Standards of Commercial Support apply with regard to the location of the exhibits.
   i. Exhibitors may not display exhibits in the same room as the CME activity or in the direct path of the activity.
   ii. Exhibitors may not promote products or services directly prior to, during, or immediately following the CME activity in the same lecture hall.
   iii. Exhibitors/vendors are required to complete a "CME Exhibit Request Form." Prior approval from the CME Committee/designee is required for vendors to exhibit during a ~~Tri-City Medical Center~~**TCHD** sponsored CME activity.
   iv. Reasonable exhibit fees shall be assessed to exhibitors in an amount to be determined by the CME Committee, but shall not be less than $500, and are due and payable to "~~TCMC~~ **TCHD** Medical Staff Treasury" prior to the activity.

6. **STANDARD 5: Content and Format Without Commercial Bias**
   a. ~~Tri-City Medical Center~~**TCHD** CME activities and related materials promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.
   b. Presentations must give a balanced view of therapeutic options and use generic names when possible; or use multiple trade names, not the trade name from a single company. CME must be free of commercial bias and not promote products or services, but promote improvements in healthcare.
7. **STANDARD 6: Disclosures Relevant to Potential Commercial Bias**
   a. Relevant financial relationships of those with control over CME content
      i. Individuals must disclose to the learners all relevant financial relationships, including the name of the individual, the name of the commercial interest, and the nature of the relationship. Disclosure is preferred to be written and available to all learners. Verbal disclosure may be used to supplement written disclosure when the event is televised.
      ii. Disclosure must also be made when the individual has indicated no relevant financial relationships.
   b. Commercial support for the CME activity
      i. The source of commercial support must be disclosed to learners, and the "in-kind" support must include specific information about the actual support, e.g. equipment loan.
      ii. Trade names or product group message must never be included in such disclosure.
   c. Timing of disclosure
      i. Disclosure of relationships and support by a commercial interest must be provided to the learners prior to the beginning of the educational activity.

D. ~~**REFERENCE**~~**RELATED DOCUMENTS:**
1. **Medical Staff** Policy 8710-604: CME Speaker & Honoraria Reimbursement
2. **Medical Staff** Policy 8710-605: Conflict of Interest Resolution
3. **Written Agreement for Commercial Support**
~~2.~~4. **CME Exhibit Request Form**

~~1.~~E. **REFERENCES:**

~~2.~~1. Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support

~~3.~~2. *Institute for Medical Quality (IMQ)/California Medical Association (CMA) ~~2011~~ **2017** CME Accreditation Standards Manual/ Essential areas and their Elements/ ~~2006~~ Accreditation Criteria*

a. Element 3.3: The provider must present CME activities in compliance with the ACCME's policies for disclosure and commercial support

~~**A. APPENDIX:**~~

~~1. Written Agreement for Commercial Support~~

~~2. CME Exhibit Request Form~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 10/05	**SUBJECT: CME Speaker & Honoraria Reimbursement**
REVISION DATE: 5/08, 4/09	**POLICY NUMBER: 8710-604**
Department Approval:	**03/17**
CME Committee Approval:	**4/09; 10/12; 10/15; 01/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**5/09; 11/12; 11/15; 05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	**5/09; 11/12; 12/15**

A. **PURPOSE:**

~~A.~~1. To outline the process utilized by the **Continuing Medical Education** CME Committee to determine honoraria and reimbursement expenses paid to individual faculty, authors, planners, and activity support staff and volunteers.

B. **POLICY:**

1. Tri-City ~~Medical Center's~~**Healthcare District's (TCHD)** ~~Continuing Medical Education~~**CME** Committee is responsible for approving funds for speaker honoraria.
2. The CME Committee Chairperson/designee is responsible for approving honoraria and reimbursement expenses greater than $500.
3. Honorarium shall not be paid to the director of the CME activity, CME Committee members, teachers, authors, joint sponsor, members of the medical staff involved with the supported activity, or others involved with the supported activity, unless funded by commercial support. No other payment as aforementioned shall be provided.
4. Members of the medical staff, who provide educational presentations, may request reimbursement for their expenses, i.e., development of PowerPoint/slide presentation as outlined in the following procedure.

C. **PROCEDURE:**

1. The CME Coordinator may contact commercial support in an effort to secure an unrestricted educational grant.
   a. All commercial support funds shall be made payable to "TCMC Medical Staff Treasury".
2. The CME Coordinator shall inform the speaker of the approved, offered honorarium.
   a. The CME Coordinator shall obtain a completed W-9 form from the speaker.
   b. Upon completion of the CME activity, the CME Coordinator shall mail the honorarium check, "Thank You Letter", and a copy of the activity "Evaluation Summary" to the speaker.

D. **REFERENCE:**

~~D.~~1. ACCME Standards of Commercial Support – Standard 3.7

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 5/08	**SUBJECT: Conflict of Interest Resolution**
REVISION/REVIEW DATE: 5/08; 10/12; 7/14	**POLICY NUMBER: 8710-605**
Department Approval:	**03/17**
CME Committee Approval:	**04/08; 10/12; 08/14; 01/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/08; 11/12; 08/14; 05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	**05/08; 11/12; 08/14**

A. **PURPOSE:**
~~A.~~1. To outline a process that will ensure all stated potential conflict of interest of anyone in control of content for *AMA PRA Category 1 Credit(s)™* is resolved.

B. **DEFINITIONS:**
1. Conflict of Interest: A relationship with a commercial interest that benefits the individual in any financial amount and that has occurred within the past twelve (12) months; and has the opportunity to affect **continuing medical education** (CME) activity content with respect to the commercial interest's products or services.
2. Resolution of Conflict of Interest: To alter the financial relationship with the commercial interest; and/or alter the individual's control over the CME activity content with respect to the commercial interest's products or services.

C. **POLICY:**
1. All conflict of interest for individuals who are in the position to control content for Category I CME activities shall be disclosed and resolved.
2. If conflict of interest status cannot be identified or resolved, the individual(s) shall not have any content control for Category I activities.

D. **PROCEDURE:**
1. Document all conflict of interest that is not resolved in CME Committee minutes.
   a. If a conflict of interest is identified for a CME activity-planning member (to include significant other), he/she shall recuse themselves from contributing to the discussion of content planning.
   b. If a conflict of interest is identified for a speaker/author with the ability to control content, the CME Committee or designee shall do one of the following:
      i. Replace the speaker/author.
      ii. Review the speaker/author's presentation materials prior to the CME activity to ensure they are free of commercial bias.
      iii. Notify the speaker/author that he/she is not to discuss any therapeutic options.
      iv. Choose the materials from which the therapeutic recommendations will be made.
   c. If it is determined that the chosen speaker/author with a conflict of interest is the best candidate to deliver the presentation, the speaker/author shall read, complete, and sign the following documents:
      i. Faculty Disclosure & Resolution Declaration Form ~~(Appendix)~~
      ii. Content Validation Form ~~(Appendix)~~
2. Ask participants if commercial bias was observed in the speaker/author's presentation.

3. If commercial bias is determined, appropriate action shall be taken by the CME Committee/designee to rectify future CME activities and reduce the potential for commercial bias in these activities.

E. **~~APPENDIX~~FORMS**:
1. Faculty Disclosure & Resolution Declaration Form; Content Validation Form

F. **REFERENCE**
1. ACCME Standards of Commercial Support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 02/03	**SUBJECT: Criteria for Pain Management Privileges**
REVISION DATE(S): 12/07	**POLICY NUMBER: 8710 – 541**
Department Approval:	**02/17**
Department of Anesthesiology Approval:	**05/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/07~~05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	**12/07**

A. **PAIN MANAGEMENT DEFINITION:**

1. Pain management is the medical specialty concerned with the evaluation and treatment of patients suffering from acute or chronic pain.

B. **REQUIRED QUALIFICATIONS FOR PAIN MANAGEMENT PRIVILEGES:**

1. Initial Applicant: (applicants must meet all of the following)
   a. **Medical Doctor** (M.D.) or D.O.
   b. Successful completion of an **Accreditation Council for Graduate Medical Education** (ACGME) (or equivalent) accredited training program in Anesthesiology, Diagnostic Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation.
   c. Successful completion of a minimum of **twelve** (12) months of formal training (or fellowship) that includes the diagnosis and management of patients with acute and chronic pain, interventional technology or completion of the equivalent of **twenty-four** (24) months of continuous, full time pain management practice.
   d. Certification in Anesthesiology, Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation or Pain Management by the American Board of Medical Specialties (ABMS), or actively involved in the examination process.
   e. Provide documentation of a minimum of **twenty** (20) pain management patients in the previous **two** (2) years.

C. **ELIGIBILITY:**

1. Eligibility for the granting of Pain Management Privileges shall be based on documented education, training and experience, demonstrated current professional competence and judgment, physical and mental health status and the ability to cooperate with others and to deliver care at a generally recognized level of professional quality.

D. **CONSULTATION:**

1. All practitioners are expected to exercise good judgment and request consultation when:
   ~~1.~~**a.** Diagnosis and/or management remain in doubt for an undue period of time, especially in the presence of a life threatening illness;
   ~~2.~~**b.** Complications or conditions arise which are outside their level of competence or scope of practice.
   ~~3.~~**c.** Specialized treatments or procedures are contemplated with which they are not familiar.

E. **PAIN MANAGEMENT CORE PROCEDURES:**

1. Epidural Procedures: Translaminar and transforaminal Epidural injections (cervical, thoracic, Lumbar); Epidural blood patch
2. Joint Injections: Facets, **Sacroiliac** (SI) joint
3. Sympathetic Blocks
4. Chemo Denervation: Stellate Ganglion Block, Peripheral Nerve Block, Botox Injections, Intramuscular Phenol Injections
~~4.~~5. **Discograms**
~~5.~~6. Initial Application: See required qualifications for Pain Management privileges. Current certification required for fluoroscopically-guided procedures.
~~6.~~7. Reappointment Criteria: Documentation of twenty (20) cases within the previous two (2) years and ongoing **continuing medical education** (CME) in pain management are required to maintain clinical competency.
~~7.~~8. Proctoring: Five **(5)** cases (of core pain management privileges) should be proctored, which should include at least three spinal (thoracic or lumbar) cases; with the exception of cervical cases, which would require an additional three cases be proctored.

F. **PAIN MANAGEMENT SPECIAL PROCEDURES:**

~~Discograms:~~

~~4. Initial Application: See required qualifications for Pain Management privileges. Must provide documentation of training in "Discograms" in Residency of fellowship, or provide documentation of a hands-on training course in discography. Must also provide documentation of the performance of a minimum of ten (10) Discograms during the previous twenty four (24) months.~~

~~5. Reappointment Criteria: Five (5) cases within the previous two (2) years with acceptable outcomes.~~

~~6. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at TCMC (Tri-City Healthcare DistrictMedical Center) (TCHD) with the same privileges being proctored.~~

1. Radiofrequency Thermocoagulation Lesion Ablation (RFTC):
   ~~1.~~a. Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in "RFTC" in Residency of fellowship, or provide documentation of a hands-on training course in RFTC.
   ~~2.~~b. Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
   ~~3.~~c. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD**~~(Tri-City Medical Center)~~ with the same privileges being proctored.
2. Intradiscal Electrothermal Annuloplasty:
   ~~1.~~a. Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intradiscal Electrothermal Annuloplasty in residency or fellowship, or provide documentation of a hands-on training course in Intradiscal Electrothermal Annuloplasty.
   ~~2.~~b. Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
   ~~3.~~c. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD**~~(Tri-City Medical Center)~~ with the same privileges being proctored.
3. Implantables (Intrathecal or Epidural Infusion Pumps with Tunneled Catheter, Spinal Cord Stimulator):

~~1.~~**a.** Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator in residency or fellowship, or provide documentation of a hands-on training course in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator.

~~2.~~**b.** Reappointment Criteria: Three (3) cases within the previous two (2) years with acceptable outcomes.

~~3.~~**c.** Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at ~~TCMC~~ **TCHD** ~~(Tri-City Medical Center)~~ with the same privileges being proctored.

4. Cranial Nerve Blocks – All Types

~~1.~~**a.** Initial Granting: Five **(5)** cases within two years of Residency

~~2.~~**b.** Reappointment: One **(1)** per year (two **(2)** per reappointment cycle)

~~3.~~**c.** Proctoring: Two **(2)** cranial nerve blocks – all types

~~**RELATED DOCUMENT(S):**~~

~~4. Peer Review Table~~

~~**Approvals:**~~

~~**Medical Division Approval:** _____~~

~~**Medical Executive Committee Approval:** _____ **11/07**~~

~~**Board of Directors Approval:** _____ **12/07**~~

~~Peer review TableAttachment A~~

~~Peer Review~~

~~INDICATOR~~	~~THRESHOLD~~	~~THRESHOLD~~
~~Infections~~	~~Any infection related to any pain management / or devise insertion for pain / procedure~~	~~# Infections related to pain management~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Bleeding~~	~~Any bleeding related to any pain management / or devise insertion for pain / procedure~~	~~# Bleeding related to pain management~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Unexpected Hospitalization~~	~~Any Hospitalization related to any pain / or devise insertion for pain / procedure~~	~~# Hospitalization related to pain management~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Sepsis~~	~~Any patient admitted with a diagnosis of sepsis related to any pain management / or devise insertion for pain~~	~~# Patient admitted with DX of Sepsis related to pain management~~ ~~# Pain management procedures / devices~~ ~~Review all occurrences~~
~~Any other related complications~~	~~Any complications associated with any pain management procedure~~	~~All occurrences~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION ~~POLICY MANUAL~~(CME)

ISSUE DATE: 10/05	**SUBJECT: Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity**
REVISION DATE: 5/08, 4/09; 7/12	**POLICY NUMBER: 8710-600**
Department Approval:	**03/17**
CME Committee Approval:	**4/09; 7/12; 10/15; 01/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**5/09; 8/12; 11/15; 05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	**5/09; 8/12; 12/15**

A. **PURPOSE:**
1. To outline criteria utilized for educational planning and evaluation of a **continuing medical education** (CME) activity.

B. **DEFINITIONS:**
1. Prioritization Grid – a tool utilized to organize the educational needs of the medical staff and assigning a CME scheduling priority according to the impact topics have on performance, HWOP, JCAHO functions, cultural/linguistic implications, and National Patient Safety Goals.
2. FOCUS-PDCA Tool – an organization-wide process used for performance improvement.
3. Professional Practice Gap – The difference between health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge.

C. **EDUCATIONAL PLANNING – NEEDS ASSESSMENT**
1. Annually our physician's learning needs are surveyed to: a) identify educational needs or professional practice gaps, and b) evaluate the performance of the continuing medical education component at Tri-City ~~Medical Center~~**Healthcare District**. This data is then summarized and provided to the CME Committee to use in planning educational activities and in determining the potential value of the activity.
2. Identified needs from multiple sources are used to initiate and support the planning process. Need documentation is the first step in planning a CME activity.
3. Each source of need requires a supporting document to use in setting methodology, design, objectives, and evaluation of the CME activity.

D. **EDUCATIONAL PLANNING - OBJECTIVES**
1. Based upon the identified needs, the objectives are developed for each CME activity.
2. The purpose or objectives of the activity describes learning outcomes in terms of physician performance or patient health and are consistently communicated to the learner.
3. The target audience is identified and stated in all learning materials.
4. Background requirements of the prospective participants are listed when indicated.
5. Learning outcomes in terms of knowledge, skills, and/or attitudes are indicated and communicated to the learner.

E. **EVALUATION & IMPROVEMENT**

1. All educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by satisfaction, knowledge, or skills.
2. When applicable, educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by practice application and/or health status improvement.
3. The overall CME program is evaluated regularly by the CME committee with review of its mission and activities of the previous year.
4. Improvements are made in the CME program by incorporating suggestions of the CME committee into the operating CME policies and procedures.
5. Outcomes in physician behavior which influence the health of the population are measured when applicable by repeated surveys or statistical review of morbidity data.

F. PROCEDURE

1. ACTIVITY REQUEST - Upon request, the CME Coordinator will provide the activity planner with an "Activity Request" form for *AMA PRA Category I Credit*™.
2. CME COMMITTEE REVIEW/APPROVAL PROCESS:
   a. The CME Coordinator will submit the completed Activity Request form to the CME Committee for review/approval.
   b. A quorum of the CME Committee members has the authority to approve a CME Activity Request outside of committee via electronic mail response. The CME Coordinator will make a copy of the electronic mail responses and file with the Activity Request form.
   c. *AMA PRA Category I Credit*™ requests shall be granted at the discretion of the CME Committee.
   d. The CME Committee may utilize prioritization grids and/or the FOCUS-PDCA tool in planning CME activities to organize and prioritize topics maximizing the impact CME activities have on physician performance and patient outcomes.
3. DOCUMENTS – The CME Coordinator ~~will~~ **may** utilize the CME checklist ~~(appendix)~~ for each activity, and will provide the following documents to the activity planner following approval by the CME Committee:
   a. Confirmation ~~letter~~ **notification** with A-V form;
   b. Faculty disclosure form for disclosure of financial relationships with resolution declaration should a conflict of interest exists;
   c. Cultural diversity form;
   d. Content validation form;
   e. Commercial guidelines (ACCME Commercial Support Standards);
   f. W-9 form (if applicable)
4. REQUIRED DOCUMENTS – The CME Coordinator shall ensure documentation is on file for each approved CME activity per the CME Checklist. The activity planner will provide the following completed and signed documents to the CME Coordinator. Note: *AMA PRA Category I Credit*™ will not be assigned to a course if the following are not provided in a timely manner before the course date.
   a. Faculty's curriculum vitae (mandatory);
   b. Faculty disclosure form (mandatory);
   c. Content validation form (mandatory);
   d. Original handout material, and/or electronic (PowerPoint) presentation (if applicable);
   e. W-9 (if applicable);
   f. Audio-visual (AV) requirements (if applicable);
5. PROCESSING TIME - Processing time for CME requests is typically 60-90 days.
6. ADVERTISEMENT - All *AMA PRA Category I Credit*™ approved activities shall be advertised to the Medical Staff. The CME Coordinator will assure that the advertisements include:
   a. Title of the activity and topics to be presented
   b. Statement of desired outcomes
   c. The CME accreditation and credit designation statement
   d. Acknowledgement of educational grants or other financial contributions (if known at the time of the publication)

7. RELEVANT FINANCIAL RELATIONSHIPS (Conflicts of Interest) – Disclosure of relevant financial relationships will be provided at every CME activity. *See Commercial Support and Disclosure of Interest policy.*
8. EVALUATIONS/SIGN-IN SHEETS – An activity evaluation form and a sign-in sheet shall be provided at every CME activity where *AMA PRA Category I Credit*™ is awarded.
9. FACULTY - The CME Coordinator shall summarize the evaluations and provide a copy of the evaluation summary, a letter of appreciation and honorarium (if applicable) to the speaker within ~~two~~ **four** weeks of activity closure.
10. LEARNERS – The CME Coordinator ~~shall~~ **may** send a follow-up e-mail to the learners six (6) weeks following the activity.
11. CME COMMITTEE – The CME Coordinator shall provide the CME Committee with a summary of evaluations.
12. CME CREDIT - The CME Coordinator shall provide ~~TCMC~~ **TCHD** Medical Staff members a copy of their CME records ~~on an annual basis, and within 72 hours of~~ **upon** request.
13. RECORD MAINTENANCE - CME records shall be maintained for a minimum of six (6) years.

G. REFERENCE:

1. *Institute for Medical Quality (IMQ)/California Medical Association ~~2011~~ **2017** CME Accreditation Standards Manual Essential areas and their Elements 2006 Accreditation Criteria*
2. Element 2.1: The provider must use a planning process that links identified educational needs with a desired result in its provision of all CME activities.
3. Element 2.2: The provider must use needs assessment data to plan CME activities.
4. Element 2.3: The provider must communicate the purpose or objectives of the activity so the learner is informed before participating in the activity.
5. Element 2.4: The provider must evaluate the effectiveness of its CME activities in meeting identified educational needs.
6. Element 2.5: The provider must evaluate the effectiveness of its overall CME program and make improvements to the program.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

DELETE
PCS Sterile Technique policy covers this content

SUBJECT: ASEPTIC TECHNIQUE

ISSUE DATE: 06/09
REVISION DATE(S): 11/12

Department Approval Date(s):	03/18
Department of Anesthesiology Approval Date(s):	n/a
Operating Room Committee Approval Date(s):	03/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	05/18
Professional Affairs Committee Approval Date(s):	06/18
Board of Directors Approval Date(s):	

A. PURPOSE:

To provide guidelines for establishing and maintaining a sterile field.

B. POLICY:

1. All members of the surgical team shall demonstrate competence in understanding the basic principles and practices of aseptic technique.
2. Scrubbed persons shall wear sterile gowns and gloves.
   a. Materials for gowns shall be selected according to recommended practices for protective barrier materials.
   b. Surgical hand scrubs/surgical hand asepsis shall be performed before donning sterile gown and gloves.
   c. The scrubbed person shall don sterile gown and sterile gloves from a sterile field away from the main instrument table.
   d. Sterile gowns shall be considered:
      i. Sterile from two inches above the elbow to the cuff
      ii. Unsterile at the neckline, shoulders, underarm, back and sleeve cuff
   e. The scrubbed person shall inspect gloves for integrity after donning them.
      i. The preferred method for changing contaminated gloves is for one member of the sterile team to glove the other.
      ii. The alternative method for changing contaminated gloves is by the open-glove method.
3. Sterile drapes shall be used to establish a sterile field.
   a. Surgical drapes shall be selected according to AORN recommended practices for protective barrier materials.
   b. Sterile drapes shall be placed on the patient and on all furniture and equipment to be included in the sterile field.
   c. Sterile drapes shall be handled as little as possible.
   d. During draping, the draping material shall be compact, held higher than the OR bed and draped from the operative site to the periphery.
   e. During draping, sterile gloves shall be protected by cuffing the draping material back over the hand.

f. Once the sterile drape is placed in position, it shall not be moved.

4. Items used within the sterile field shall be sterile.
   a. Packaging materials shall meet AORN recommended practices for selection and use of packaging systems.
   b. Methods of sterilization, storage and handling of sterile items shall meet AORN recommended practices for disinfection, storage and handling.
   c. All items presented to the sterile field shall be checked for proper packaging, processing, moisture, seal integrity, package integrity, and appearance of sterilization indicator.
5. All items introduced onto the sterile field shall be opened, dispensed and transferred by methods that maintain sterility and integrity.
   a. When opening wrapped supplies, unscrubbed persons shall open the wrapper flap farthest away from them first, then the side flaps, and the nearest flap last.
   b. Wrapper edges shall be secured when supplies are presented to the sterile field.
   c. Sterile items shall be presented to the scrubbed person or placed securely on the sterile field.
   d. Sharp or heavy objects shall be presented to the scrubbed person or opened on a separate surface, to avoid making a hole in the sterile barrier.
   e. When dispensing solutions to the sterile field, the entire bottle contents shall be poured into the receptacle and/or the remainder discarded.
      i. Solution receptacles shall be placed near the edge of the table, or held by the scrubbed person.
      ii. Solutions shall be poured slowly to avoid splashing.
6. A sterile field shall be constantly monitored and maintained.
   a. Sterile fields shall be prepared as close as possible to the time of use.
   b. Sterile fields shall not be covered.
   c. Unguarded sterile fields shall be considered contaminated.
   d. Every team member shall observe for events that may contaminate the sterile field and initiate corrective action.
   e. Conversation shall be minimal in the operating room.
   f. Non-perforating devices shall be used to secure equipment to the sterile field.
   g. Non-sterile equipment brought into or over the sterile field shall be draped with sterile material.
7. All persons moving within or around a sterile field shall do so in a manner to maintain the integrity of the sterile field.
   a. Scrubbed persons shall remain close to the sterile field and shall not leave the room.
   b. Scrubbed persons shall keep arms and hands at or above the level of the sterile field.
   c. Scrubbed persons shall avoid changing levels and shall be seated only when the entire surgical procedure will be performed at this level.
   d. Scrubbed persons shall change positions by moving face-to-face or back-to-back, maintaining a safe distance between each other.
   e. Scrubbed persons shall always face the sterile field.
   f. Unscrubbed persons shall face sterile areas, maintaining an awareness of distance so as to avoid contacts with sterile areas.

DELETE

Content covered in PCS Policies High Level Disinfection & Immediate Use Sterilization. Process has been moved to SPD.

Tri-City Medical Center	Distribution: Su
PROCEDURE:	**REUSABLE AIRWAY EQUIPMENT CLEANING**
Purpose:	To outline nursing and Anesthesia Tech respe airway equipment: • Laryngoscope handles • Magill forceps and reusable Laryngeal M • Fiberoptic scopes • Glidescopes & Glidescope stylet • Anesthesia machines
Supportive Data:	When anesthesia equipment is used it is necessary to have a standard procedure for decontamination and disinfection that is followed routinely by all personnel performing cleaning.
Equipment:	• Laryngoscope handles • Magill forceps • LMA's • Fiberoptic scopes • Glidescopes • Glidescope stylet • Anesthesia machines • Instrument cleaning solution (Enzymatic cleaner) • Soaking container/bucket • Sanicloth • Gloves • Eye protection

A. LARYNGOSCOPE HANDLES, MAGILL FORCEPS, LMA's

1. Don gloves.
2. Remove laryngoscope handles, Magill forceps, and LMA's from anesthesia cart after use.
3. Cover item(s) and transport to dirty utility room, following Body Substance Isolation Protocol.
4. Soak Magill forceps and LMA's in enzymatic cleaner solution in dirty utility sink.
5. Rinse item(s) and sterilize in autoclave (Immediate Use Sterilization) on 3-minute gravity cycle. Follow Patient Care Services Procedure "Immediate Use Sterilization, Intraoperative".
   a. Magill forceps may be processed in the Steris or autoclave.
6. Allow Laryngoscope handles and LMA's to cool completely, then place in a clean wrapper.
7. Return all equipment to the proper location.

B. FIBEROPTIC SCOPES

1. Transport used scope to the dirty utility room in a closed container.
2. Don gloves and eye protection.
3. Clean scope according to PCS Procedure "High Level Disinfection" and process the scope according to Steris manufacturer's directions.
4. Document, including patient ID sticker, in the Steris log book.
5. After successful completion of the Steris cycle, label the scope with date

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/18	n/a	03/18	n/a	05/18	06/18	

processed and staff initials.

6. Hang clean scope in scope box on difficult airway cart.

C. GLIDESCOPES & GLIDESCOPE STYLET

1. Place attached cap over electronic connection of used (dirty) Glidescope.
2. Transport used Glidescope and Glidescope stylet (if used) to the dirty utility room in a closed container.
3. Clean items according to PCS Procedure "High Level Disinfection" and process the items according to Steris manufacturer's directions.
4. Document, including patient ID sticker, in the Steris log book.
5. Allow items to dry and place individual item(s) in separate peel packs.
6. Return item(s) to drawer on difficult airway cart.

D. ANESTHESIA MACHINE EQUIPMENT

1. Don gloves.
2. Clean machine after each case with Sanicloth.
   a. Wipe down all horizontal surfaces and drawer handles.
3. Clean all cables; return to hanging position on IV pole, ready to use.
4. Change all one-time use items (i.e. breathing circuit, suction assembly)
5. Change sodasorb when color changes to lavender, or monthly (whichever is first).
   a. Sodasorb containers are labeled with date opened.
6. Check that machine is assembled correctly and completely prior to bringing next patient into the room. Anesthesia checks machine before use.

E. DOCUMENTATION

1. For all anesthesia items reprocessed via High Level Disinfection, document the following in the logbook:
   a. Patient name (in writing or place patient sticker in log book)
   b. Description of bronchoscope that was used (i.e. Large, Small, OB)
   c.a. Serial number of Glidescope

Tri-City Medical Center	Distr
PROCEDURE:	**STERIS SET-UP, USE AND MONITORING**
Purpose:	To ensure a standard and effective ste... through an automated, microcomput...
Supportive Data:	The Steris process will sterilize immersible medical instruments and rinse the instruments with sterile water. The effectiveness of the Steris process is dependent upon the proper cleaning and mechanical preparation of instruments prior to processing, and contact of all external and internal surfaces of the medical instruments with the liquid sterilant. The instruments are sterile rinsed and ready for immediate use upon successful completion of the processing cycle. The use of instruments sterilized should be in a manner consistent with "Immediate Use" processing and delivery.
Equipment:	• Steris System 1E Machine • Steris S40 sterilant concentrate • Appropriate Steris base tray with clean instruments to be sterilized • Chemical monitoring strip and orange holder • Appropriate Quick Connector for Endoscopes

DELETE

Info added to PCS Immediate Use Sterilization, Intraoperative and covered in Steris manufacturer's IFU's

A. **SET-UP, USE AND MONITORING**

1. Assemble clean instruments in Steris tray.
   a. Consult instrument manufacturer recommendations to determine if the instrument is compatible with the Steris process.
   b. Instruments must be clean to ensure proper sterilization.
   c. Failure to properly position instruments so that all surfaces will be exposed to the liquid sterilant and overloading the container may result in an ineffective sterilization process and/or damage the instruments.
2. Fasten chemical indicator in orange holder and place in tray with instrument(s).
   a. Chemical indicator will indicate, by turning to a pink color, that the instruments have been exposed to the sterilizing process.
3. Place lid on container.
4. Place container in Steris machine.
   a. Align fluid port located on bottom of tray over the fluid port in the bottom of the Steris machine. The container should be resting on the red fluid port gasket.
5. Remove Steris S40 container from box.
   a. Always open Steris S40 box using pull tab. Always inspect Steris S40 box and cup for leaking or damaged contents. Leaking of the internal cup is signaled by a strong pungent odor similar to that of vinegar and/or a yellowing of the inside box.
6. Place Steris S40 sterilant container in sterilant chamber.
   a. Sterilant chamber is located in the lower right hand corner of the Steris machine. DO NOT attempt to manually open the sealed container. Avoid contact with skin as the active ingredient is 35% peroxyacetic acid and is corrosive. DO NOT use Steris S40 after the expiration date indicated on the label. DO NOT use leaking or damaged containers.
7. Push down sterilant container in chamber until flush with tray.
   a. Pushing down the cup will open bottom of sterilant container.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/18	n/a	03/18	n/a	05/18	06/18	

8. Insert aspirating probe into top of sterilant container.
   a. Position tip of the probe over crisscross cuts located in the center of the lid. Flexible connecting tube should be in the 5 o'clock position. Ensure tubing is not kinked.
9. Close lid of Steris machine.
   a. If resistance is met, stop and inspect position of tray and/or aspirator assembly. Do not force lid close.
10. Interpret & document results on Steris Sterilization Log Sheet located next to Steris machine.
   a. Press start button on Steris control panel.
   b. Printer will start in approximately 30 seconds. The printout will advance to show Steris logo, date, time, load ID and remarks.
   c. Sterilization cycle is approximately 12.5-15 minutes. Cycle time is dependent on temperature and pressure of incoming water and filter cleanliness. As the cycle advances, the yellow stage lights will sequentially be turned on indicating the process of the cycle.
11. When sterilization cycle is complete:
   a. Press CANCEL only once; an audible tone of 6 one-second beeps will be heard.
   b. Pressing CANCEL more than once will cause the machine to move to another function and the lid will not open.
12. Wait for seal to deflate then lift handle and open lid.
   a. Printer will start and the printout will advance to show sterilization parameters.
13. Check printout for sterilization parameters.
   a. Check temperature between (46-54°C)
   b. Check exposure time (6 minutes)
   c. Check concentration (>175)
   d. Inlet temp (42-48°C)
   e. Fill time <5 min (change filter "A" if fill time is >5 minutes).
14. Check printout for "Warning: Sterilization not complete".
   a. Steris machine will cancel cycle if there is a problem with the sterilization cycles.
15. Remove aspirator probe from sterilant.
   a. Remove probe carefully as it is plastic and may break. If it breaks, call BioMed for replacement.
16. Remove empty sterilant container and discard.
   a. Always verify that sterilant cup is empty. If cup not empty refer to Steris manual for instructions on disposal of Steris S40. Call Customer Service. FLUSH with copious amounts of water.
17. Remove sterilized tray.
   a. Instruments in covered tray are sterile. If applicable, ensure connector is still connected to scope.
18. After being removed from Steris unit, sterilized items must be used immediately.
   a. Devices not used immediately must be reprocessed prior to patient use.
19. Document on tape: date, time, case number, name of item sterilized, and initials of operator.
20. Ensure the tray remains covered; it may be carried by the handles with unsterile gloves and transported through the hallway to the point of use.
   a. The covered tray houses a sterile interior and does not communicate with outside air.

21. Verify chemical monitor by the scrub nurse/tech.
    a. Scrubbed personnel verifies the instruments have been exposed to the sterilization process.
22. Remove sterile instruments from tray to sterile field.
    a. Scrubbed personnel using sterile technique removes the instruments to the field.
23. Run a diagnostic test every 24 hours without sterilant or instruments & document.
    a. Diagnostic test will ensure the machine filter is operating properly and ready for use.
24. Document patient name, cycle #, OR #, names of items run in Steris, code # and initials in Steris log. Tape the processed indicator to the log book in the designated space.

B. ENDOSCOPES

1. Clean and leak test the endoscope following instructions provided by the manufacturer of the endoscope and according to PCS Procedure "High Level Disinfection".
2. Following the instructions provided by Steris, attach the irrigating tubes to the scope.
    a. Refer to Steris Instruction Manual for each scope.
3. Perform Steps 1 through 22 of the above Steris procedure.
4. If processor is cancelled, document the reason it is cancelled.
5. Dispose of any remaining sterilant per Steris Instruction Manual.

Tri-City Medical Center	Distribution: Surgic

DELETE
We no longer have a CO_2 laser.

PROCEDURE:	**TESTING CO2 LASER**
Purpose:	To outline nursing responsibilities in setting up and before use in surgical procedures.
Supportive Data:	Ensuring safe, effective use of the CO2 laser used in surgical procedures to perform directed, precise cutting during a surgical procedure.
Equipment:	• Basin of tap water • "DANGER: Laser in Use" signs • Laser goggles • Wet tongue blade • Wet blue towel • Laser key (in OR Pyxis) • CO2 Laser • Microscope & micromanipulator (per case requirements)

A. **TESTING CO2 LASER**

1. Place "DANGER: Laser in Use" signs on each doorway to the room.
   a. Precautions must be taken to protect those entering the room while the laser is in operation.
2. Ensure that laser goggles are available for all persons in the laser room while it is operated. Have a pair of goggles outside of room for anyone entering.
   a. Eye protection must be worn when the CO2 laser is in operation.
3. Prepare a basin of tap water and bring to the room where the laser is tested.
   a. Water must be available in case of laser generated fire.
4. Place a wet tongue blade on a wet towel on the prep stand.
   a. Laser must be tested on **wet** materials ONLY, to prevent fire.
5. Attach the laser hand piece (with lens inside) onto laser arm. If laser is being used with the micromanipulator you must test with it in place.
   a. Test laser in mode in which it is being used. Exception- sterile laparoscope.
6. Insert key and turn on laser.
   a. Laser will perform a self check.
7. Enter the mode on which to test the laser. Laser is ready to be tested.
   a. Test the laser on continuous mode. Be sure the red laser beam is directly in the center of the tongue blade.
8. Enter the amount of wattage used for testing. The recommended power for testing is 10 watts on continuous power.
9. Place tip of laser hand piece directly on wet tongue blade.
10. Place laser in "ready mode".
11. Depress foot pedal of laser emission.
    a. Testing time should be approximately one second. You should see smoke rising from the tongue blade.
12. Check for accuracy.
    a. The laser burn mark should match where the red laser beam was directed.
13. If burn mark does not appear on tongue blade, place unit in stand by mode and repeat steps 6 through 12.
    a. If unable to test laser, Call BioMed at x7711 to request they test the laser.

B. **REFERENCE**

1. American National Standards Institute ANSI (2007).

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/18	n/a	03/18	n/a	05/18	06/18	

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

ISSUE DATE: 06/09	**SUBJECT: ~~UNIVERSAL~~ STANDARD PRECAUTIONS IN SURGERY**
REVISION DATE(S): 11/12; 07/15; ~~03/18~~	

Department Approval:	**03/18**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**03/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/18**
Professional Affairs Committee Approval:	**06/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify those practices used by surgical ~~care~~ personnel in addition to the hospital ~~Universal~~ **Standard** Precautions policy, to protect both patients and ~~themselves~~ **personnel** from exposure to bloodborne pathogens.

B. **POLICY:**

1. ~~Universal~~ **Standard** precautions shall be used for all invasive procedures.
2. Blood and body fluids from all patients shall be considered infectious.
3. Protective barriers shall be made available to all personnel to reduce the risk of exposure.
4. **Personal** ~~P~~protective equipment **(PPE)** shall depend upon the degree of exposure anticipated and may include:
   a. Goggles
   b. Glasses with side barriers
   c. Face shields
   d. Masks
   e. Gowns (including impervious)
   f. Shoe covers
   g. Gloves
5. Eye protection shall be worn by all scrubbed personnel.
6. Scrubbed personnel are strongly encouraged to double glove for added personal protection.
7. Perioperative personnel shall take precautions to prevent injuries caused by scalpels and other sharp instruments.
   a. The "hands-free, Neutral Zone" technique shall be used when possible, to transfer sharps between personnel.
   b. Used needles shall not be sheared, bent, broken, or recapped by hand. If recapping is necessary, an instrument, or the one~~-~~handed **scoop** technique shall be ~~employed~~**used**.
   c. Knife blades shall be loaded and removed using an instrument.
   d. Disposable sharps shall be placed in a puncture resistant, labeled, or color-coded leak proof container.
   e. Reusable sharps shall be placed in a puncture resistant container, isolated from other surgical instruments.
   f. Use gloves and an instrument to pick up sharp items that have fallen on the floor.
8. Perioperative personnel shall handle specimens as potentially infectious material.
   a. All specimens shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.

b. Specimen containers received directly from the operative field shall be placed in a leak-proof plastic bag.

9. Perioperative personnel shall control work practices to minimize the risk of exposure to bloodborne pathogens. This includes prohibition of eating, drinking, applying cosmetics, and handling of contact lenses in restricted and semi-restricted areas.
10. Perioperative personnel who have exudative lesions or weeping dermatitis shall refrain from providing direct patient care or handling of medical devices used in performing invasive procedures.
11. Perioperative personnel who participate in invasive procedures are encouraged to receive Hepatitis B immunization.
12. Perioperative personnel shall adhere to Employee and Occupational Health Service (EOHS) policies regarding work restrictions for personnel with infectious diseases.
13. Patients requiring Isolation Precautions shall be placed in a private cubicle in Pre-Op and Post-Op, **when possible.**~~and are not to be placed in general Pre-Op Hold or PACU area.~~
    a. Transport gurneys will be cleaned as soon as the patient is transferred to the operating table, prior to leaving the surgical suite.
    b. The post-operative receiving unit shall be notified of patient diagnosis as soon as possible.
    c. ~~A p~~**Patients on Airborne Precautions, including those** with suspected or active pulmonary tuberculosis ~~should~~**shall** be recovered in a private cubicle with a portable ~~Hepa~~ **high efficiency particulate air (HEPA)** filter.
14. Unopened supplies may be returned to stock after the surgical procedures if there has not been contamination or compromise in the packaging.

C. **REFERENCES:**

1. **Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**

~~TRI-CITY MEDICAL CENTER~~
~~Oceanside, California~~

~~SURGICAL SERVICES POLICY MANU~~

DELETE
PCS Wound Classification During Surgical Intervention covers this content

SUBJECT: WOUND CLASSIFICATION

ISSUE DATE: 04/94
REVISION DATE(S): 02/05; 08/11; 11/12

Department Approval Date(s):	03/18
Department of Anesthesiology Approval Date(s):	n/a
Operating Room Committee Approval Date(s):	03/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	05/18
Professional Affairs Committee Date(s):	06/18
Board of Directors Approval Date(s):	

~~A. PURPOSE:~~

~~To classify all wounds according to the likelihood and degree of wound contamination at the time of surgical intervention.~~

~~B. SUPPORTIVE DATA:~~

~~1. The American College of Surgeons' definitions of Surgical Wound Infections (SWI) should be used for routine surveillance because of their current widespread acceptance and reproducibility.~~
~~2. A wound can be considered infected if purulent material drains from it, even if a culture is negative or not taken.~~
~~3. A positive culture does not necessarily indicate infection since many wounds, infected or not, are colonized by bacteria.~~
~~4. Infected wounds may not yield pathogens by culture because the pathogens are fastidious, culture techniques are inadequate, or the patient has been treated.~~

~~C. CLASSIFICATIONS:~~

~~1. CLEAN WOUND, *Class I*~~
~~a. Uninfected operative wounds in which no inflammation is encountered, and neither respiratory, alimentary, genitourinary tracts, nor oropharyngeal cavity is entered.~~
~~b. Cases are elective, primarily closed, and if necessary, drained with closed drainage.~~
~~c. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.~~
~~2. CLEAN-CONTAMINATED WOUND, *Class II*~~
~~a. Operative wounds in which the respiratory, alimentary, or genitourinary tract is entered under controlled conditions and without unusual contamination.~~
~~b. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in sterile technique is encountered.~~
~~c. All clean returns to surgery.~~
~~d. Any tube that involves a skin incision.~~
~~3. CONTAMINATED WOUNDS, *Class III*~~

a. Include open, fresh, accidental wounds, a chest tube, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered.

4. DIRTY AND INFECTED WOUNDS, *Class IV*
   a. These include old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.
5. UNKNOWN
   a. This classification will be used when the status of a wound cannot be determined utilizing the above criteria.
6. NOT APPLICABLE
   a. When there is no wound, i.e. for such procedures as:
      i. Closed reductions (where there is no break in the skin)
      ii. Examination Under Anesthesia (EUA)
      iii. Esophageal Dilatation

D. DOCUMENTATION:

Wound classification of operations shall be recorded on the Intraoperative Record using Arabic numbers 1, 2, 3, 4, 5 and 6 only.

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**SKIN TO SKIN CONTACT AFTER BIRTH**
Purpose:	To define the provision of skin to skin contact between mother, father and/or identified individual by the family and infant following birth.
Supportive Data:	Early skin-to-skin contact (~~SSC~~**STS**) is a recommended best practice for healthy term newborns because ~~SSC~~ **STS** provides both newborns and mothers with numerous health benefits. Evidence shows that placing infants skin-to-skin with their mothers immediately after birth increases the success and lengthens the duration of breastfeeding, promotes bonding, and facilitates thermoregulation. ~~SSC~~ **STS** can also be accomplished with another individual identified by the family, if the mother is unable to experience this for whatever reason.

A. **CONTENT**:

1. Initiation of ~~SSC~~ **STS** as soon as possible after birth (vaginal or cesarean birth) shall be supported as a standard of practice if the infant is asymptomatic, no contraindications are present, and mother and infant are medically stable.
2. If the mother is Hepatitis B or Human Immunodeficiency Virus (HIV) positive, infant should be bathed as soon as possible and receive necessary medications per protocols prior to implementing ~~SSC~~**STS**.
3. Contraindications to immediate skin to skin include, but are not limited to:
   a. A mother who received general anesthesia
   b. A mother who has postpartum hemorrhage concerns
   c. An infant with a five minute APGAR score of 6 or less
   d. A premature infant less than 35 weeks gestation.

B. **PROCEDURE**:

1. Dry and stimulate infant following Neonatal Resuscitation Program (NRP) protocol and place infant prone on the mother's chest wearing only a hat and/or diaper.
2. The mother will have on no clothing/sheets/blankets between herself and the infant to disrupt the ~~SSC~~**STS**. The infant should be able to access the mother's breasts with no interference from any bras, gowns, etc.
3. A warm blanket will be laid over the infant and mother once the infant is placed skin to skin.
4. Continue uninterrupted ~~SSC~~**STS** until the first breastfeeding occurs. (First breastfeeding should occur within the first hour of life).
   a. After the first breastfeeding, ~~SSC~~**STS** will continue as long as mother desires and is feasible for the infant.
5. In the case where the mother chooses to formula feed, the initial period of ~~SSC~~**STS** will last at least one hour. (The infant should still feed within the first hour of life).
6. In the case of Cesarean **(C/S)** birth, the infant will be placed skin to skin with the mother in the Operating Room (OR) as soon as possible after birth and after the initial resuscitation and evaluation at the warmer by the resuscitation team. The infant will not go from C/S birth directly to ~~SSC~~**STS** without assessment from the resuscitation team.
   a. Mother's ~~left~~ arm will be unsecured from arm board at the initiation of ~~SSC~~**STS** and infant should be positioned in a way that does not interfere with her airway and the surgical site.
   b. ~~SSC~~**STS** will continue in the OR as long as mother is able to maintain contact and infant remains stable.
   c. The Transitional care nurse will remain with the infant during ~~SSC~~**STS** and is responsible for removing the infant if the mother or infant becomes unstable.
   d. Upon arrival to the recovery room, uninterrupted ~~SSC~~**STS** will continue until the first breastfeeding occurs.

epartment Review	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/16	06/17	07/17	08/17	03/18	n/a	05/18		

e. If mother is unable to provide ~~SSC~~**STS** in the OR, she may designate the father, a family member, or other support person to provide ~~SSC~~**STS**.
   i. If anyone other than the mother is to provide ~~SSC~~**STS**, it must be done in the recovery room on **Labor& and Delivery** in a stationary chair.
   ii. The individual identified, will be offered a hospital gown to wear with gown opening to the front and asked to remove shirt, bra, etc. to ensure infant is able to be positioned skin to skin.
   iii. Efforts should be made to ensure privacy with ~~either a~~ privacy curtain, portable screen, and/ or individual seated in a position facing away from traffic patterns.

7. Routine newborn procedures (measurements, initial assessment, medications, bathing) will be postponed until after the first feeding. Infant monitoring, vital signs (temperature, heart rate, respiratory rate), and assessment can continue while the infant is skin to skin with the mother/ identified support person.
8. If mother and infant require initial separation, staff shall ensure skin to skin and initiations of breastfeeding begin/resume as soon as medically possible.
9. If infant demonstrates any signs of distress, requires further assessment/interventions, or if mother is unable to provide ~~SSC~~**STS** and no one has been identified to provide ~~SSC~~**STS**, the infant shall be brought to the warmer by delivering provider or nurse and the "Care of the Newborn Standardized Procedure should be implemented.

C. **REFERENCE(S)**:

1. Beiranvand, S., Valizadeh, F., Hosseinabadi, R., & Poumina, Y. (2014). The effects of skin to skin contact on temperature and breastfeeding success in full term newborns after cesarean section delivery. International Journal of Pediatrics, Vol 2014-, p 1-7.
2. Carmichael, A., Matoulionis, B. (2014) Implementing the gentle c-section: A birth experience more like a vaginal delivery. *JOGNN (43)* S1, S13
3. Elliot-Cater, N., Harper, J. (2012) Keeping mothers and newborns together after cesarean. *Nursing for Women's Health (16)* 4, 290-295
4. Grassley, J. and Jones, J. (2014). Implementing skin to skin contact in the operating room following cesarean section birth. Worldview on Evidence Based Nursing, 11:6 414-416.
5. Haxton, D., Doering, J., Gingras, L., Kelly, L. (2012) Implementing skin-to-skin contact at birth using the Iowa model. *Nursing for Women's Health (16)* 3, 220-230.
6. Stevens, J., Schmid, V., Burns, E., & Cahlen, H. (2014) Immediate or early skin to skin contact after cesarean section: A review of the literature. Maternal and Child Nutrition, 10, pp 456-473.

Nitrofurantoin Suspension Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Nitrofurantoin suspension routinely expires on the shelf in the Pharmacy department.

Background: Nitrofurantoin is an antibiotic primarily used for the treatment of uncomplicated urinary tract infections.

Assessment:

- Nitrofurantoin suspension (230 mL) bottles cost $315 each
- Usage history revealed that there have been zero orders for this product in the last 3 years
- Sulfamethoxazole/Trimethoprim (Septra) is a first-line formulary alternative for uncomplicated cystitis and is available in suspension form

Recommendation(s):

- The Pharmacy Service recommended that nitrofurantoin suspension be removed from the formulary given lack of use in several years and the availability of formulary alternatives
- P&T approved the recommendation to remove this drug from the TCMC formulary at its May meeting

Audit, Compliance & Ethics Committee
(No meeting held in June, 2018)

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

May 31, 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 May 31, 2018.

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

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Colin Coffey, Board Counsel (via teleconference)
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

   Chairman Dagostino requested item 20 D. 7) Agreement for Neurology ED Call Coverage be pulled for further review; Dr. Souza requested the Medical Record Delinquency Report be pulled from the Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

   It was moved by Director Kellett to approve the agenda as amended. Director Grass seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the May 31, 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 made an oral announcement of the items listed on the May 31, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Approval of Closed Session minutes and Conference with Legal Counsel regarding five (5) matters of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Grass to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:30 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 Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Esther Beverly, VP, Human Resources
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. Special Recognitions:

Nurses, Support Staff and RN Educator of the Year for 2018

Director Mitchell stated the Board would like to recognize the nurses and support staff of the year in the various categories of Inpatient, Outpatient (two were awarded due to a tie), RN Educator and Support Staff. She invited the managers of the respective areas to the podium who recognized the following individuals:

- Inpatient Nurse of the Year (Susan Azarian, RN – NICU);
- Outpatient Nurses of the Year (Julie Derouin, RN - Interventional Radiology and (Leeann Vargas, RN - Home Health);
- RN Educator of the Year (Davina Lam, RN -IP Behavioral Health); and
- Patient Care Support Staff of the year (Ermalinda Solano) *who was not available to attend today's meeting.*

On behalf of the Board of Directors Chairman Dagostino expressed his appreciation to all of the recipients of the awards.

13. Educational Session

a) Perioperative Surgical Home – Dr. James Johnson

Dr. James Johnson, a full time practicing Anesthesiologist here at Tri-City provided an educational presentation to the Board on the Perioperative Surgical Home (PSH). He explained the PSH is a patient-centered physician-led interdisciplinary and team based system of coordinated patient care spanning from the entire experience from decision of the need for any invasive procedure whether surgical, diagnostic or therapeutic to discharge from the acute care facility and beyond. Dr. Johnson stated the goal of the PSH is to enhance value and help achieve a better patient experience, better health care and lower costs. Key components of the PSH include leadership of perioperative care team; assessment of patient's current condition; preparative management: "prehabilitation" to optimize patient health status; intraoperative and intraprocedure care; postoperative care in PACU, ward, ICU and coordinate transitions of care. Dr. Johnson stressed that collaboration is key and the PSH is not intended to replace the surgeon's patient care expertise and responsibilities but leverage abilities of the entire perioperative team. *(A copy of Perioperative Surgical Home presentation is attached to the file copy of these minutes for reference.)*

Chairman Dagostino expressed his appreciation to Dr. Johnson and his team. Dr. Souza also acknowledged the work that is being done. He stated it is a team effort and thanked Dr. Johnson for leading the way in making this happen.

No action taken.

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

Mr. Glen Newhart, Chief Development Officer provided an update on the activities of the Foundation. He shared photos from our physician and nurse celebrations and expressed appreciation to Dr. Souza for getting the Foundation involved in the celebrations. He stated 112 Tri-City affiliated physicians were individually recognized by community members as an outstanding physician for 2018.

Mr. Newhart stated the Foundation's Newsletter *"For Good:"* went out to homes recently. It shows a representation of some of the online imagery the Foundation is using for their "promo". Mr. Newhart stated each story in the magazine has been broken down with a self-contained piece that is being promoted across social media.

He stated this has been their best performing Newsletter to date and expressed his appreciation to the patients for allowing the Foundation to tell their story.

Mr. Newhart reported the *Health & Money Matters* which is held at the Oceana Community Center has proven successful on many fronts. 70-80 individuals are expected at the next meeting. For those that show an interest in estate planning appointments are scheduled with Kenneth Turpen. June appointments are completely full and there is just one opening in May.

Mr. Newhart reported on two big events coming up in the fall. The first is the Golf Event which is driven by our corporate counsel partners. Thus far 140 players have registered. The Diamond Ball is the second major event and is scheduled for October 27th with Grammy nominated and platinum recording artist Bill Engval.

Mr. Newhart reported over 80 people attended the Corporate Council mixer at Urge in San Marcos that generated new Corporate Council members and sponsorships.

Lastly, Mr. Newhart reported that we have been selected by Senator Pat Bates as one of the 2018 California Non-Profits of the Year for her Senate District and he will be traveling to Sacramento next week to accept the award on behalf of their Board members, donors and staff who make what the Foundation does possible.

Chairman Dagostino congratulated the Foundation on the award.

No action taken.

16. Report from Chief Executive Officer CEO

Mr. Steve Dietlin stated it is quite an honor for the Foundation to be recognized by State Senator Pat Bates as one of the 2018 California Non-Profits of the Year. He congratulated everyone involved including the Foundation Board members and their generous donors.

Mr. Dietlin also expressed his appreciation to the hundreds of Auxilians for everything they do every day for the community. He commented on the Scholarship Awards Night where thousands of dollars were given to hundreds of deserving scholarship recipients who demonstrated tremendous academic and community commitment and involvement. Mr. Dietlin stated the scholarship awards are a great vehicle for tomorrow's healthcare leaders and we hope to see many of those recipients working back here at Tri-City in the years to come. Since inception the Auxiliary produced over a million dollars in scholarships and it is a tremendous opportunity for a lot of committed students.

Mr. Dietlin extended his congratulations to the Nurses, Support Staff and RN Educator of the Year for 2018 who were recognized today for their outstanding service to Tri-City. In addition, Mr. Dietlin gave a special thank you to the hundreds of nurses here at Tri-City who are really the backbone of healthcare delivery. Mr. Dietlin commented on the Nurse's Tea led by Tri-City's Chief of Staff, Dr. Victor Souza which was a great event that was extremely well received and showed some collaboration among the clinical professionals.

Mr. Dietlin announced that Tri-City earned the 2018 *Get with the Guidelines* Heart Failure Gold Plus Quality Achievement Award/Heart Failure Honor Award. He

explained it is an award that recognizes the commitment to success in implementing the highest standard of heart failure care by ensuring that our heart failure patients receive treatment that is nationally accepted based on evidence based standards and recommendations. Tri-City is one of only 37 hospitals nationwide to receive this award.

Mr. Dietlin expressed his appreciation to Dr. Johnson for leading the educational session on the Perioperative Surgical Home. To summarize, the Perioperative Surgical Home Initiative is designed to improve clinical outcomes with reduced patient time in the hospital at a lower cost with non-opioid blocks. Mr. Dietlin stated Tri-City is at the forefront of where healthcare is going.

Mr. Dietlin introduced Mr. Aaron Byzak, Chief Governmental & External Affairs Officer. He stated Mr. Byzak will be providing a legislative update later on today. Mr. Dietlin explained that Mr. Byzak will be instrumental in getting information out to the community on all of the great clinical outcomes that we have here and all of the services that Tri-City has to offer for this community.

Mr. Dietlin reported over the past month Administration, the Board of Directors and the Chief of the Medical Staff have been working together collaboratively regarding our Strategic Plan for the upcoming fiscal year. Next month in open session we will present the FY19 budget for discussion and consideration and approval. Mr. Dietlin stated it is critical to maintain our commitment to quality and at the same time ensure financial viability while navigating all the challenges and changes and uncertainty in the current and future healthcare environment. Now more than ever we need to stay true to our mission but at the same time remain flexible and resilient in order to preserve a positive future for healthcare delivery in this community for a lot of years to come.

No action taken.

17. Report from Chief Financial Officer

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

- Net Operating Revenue – $299,760
- Operating Expense – $311,401
- EROE - ($6,972)
- EBITDA – $5,985

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 177
- Adjusted Patient Days – 95,142
- Surgery Cases – 5,365
- Deliveries – 1,902
- ED visits – 51,285

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

- Operating Revenue - $29,339
- Operating Expense - $30,432

- EBITDA - $571
- EROE – ($679)

Mr. Rivas stated we did show some improvement from last month.

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

- Average Daily Census – 163
- Adjusted Patient Days – 8,983
- Surgery Cases – 528
- Deliveries – 156
- ED Visits – 4,835

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

- Net Patient Accounts Receivable - $45.6
- Days in Net Accounts Receivable - 48.5

No action taken.

17. New Business

a) Settlement and Terms of Reno Lawsuit

Chairman Dagostino reported Director Reno filed a lawsuit against the District alleging her rights had been violated when she was excluded from certain closed sessions of the Board of Directors. That lawsuit was recently dismissed after a settlement was reached. The settlement was paid by the insurance carrier AIG and no monies were paid by the District. The Board approved the settlement with four Board members in favor (Kellett, Grass, Mitchell and Nygaard) and two opposed (Schallock and Dagostino). Chairman Dagostino stated this matter is now considered closed. Director Reno questioned if Chairman Dagostino's comments are considered a public apology as well. Chairman Dagostino stated Director Reno will receive a statement signed by Chairman Dagostino as outlined in the settlement agreement. Ms. Bond stated signed copies will be delivered to Director Reno's counsel. Director Reno requested that the Board provide a copy of the settlement to her today. Director Reno stated she has additional comments however she will reserve those comments until it is her turn to speak under Board communications.

Chairman Dagostino recognized Ms. Jessica Godfrey, TCMC employee. Ms. Godfrey stated she has questions for Director Reno and the Board of Directors regarding the Reno litigation matter. Board Counsel Colin Coffey suggested Director Reno consult with her own attorney before she pursues personal statements or dialogue involving the matter as it could impact the settlement in some way. Mr. Coffey further stated that Board meetings are considered business meetings and are traditionally not a forum for individual board members to engage his dialogue with members of the public however it is the Board's prerogative to determine whether business meetings are to evolve into Q&A sessions. Director Reno stated she was not advised that her attorney could attend the meeting. Director Reno stated she would like to take the liberty to answer some questions. She questioned if Ms. Godfrey was the individual who sent a letter to the California Nurses' Association regarding her suing the District. Ms. Godfrey responded that

she did not send any letter to the California Nurses' Association. Ms. Godfrey stated she will respectfully take into consideration the fact that this is a business meeting, however she wished to comment on the matter. Ms. Godfrey stated she has been an employee here for eight years and time and time again employees are educated on the hospital's mission statement to advance the health and wellness of those we serve and the values for our district including quality, caring safety, integrity, innovation and stewardship. Ms. Godfrey stated regardless of the situation, in her mind a Board member or elected official should be held to those standards. Ms. Godfrey questioned if Director Reno believes it shows integrity and stewardship by suing the district. Mr. Godfrey also commented that regardless if the settlement is paid by the insurance carrier there are still legal bills and likely an increase in our insurance premiums. In closing, Ms. Godfrey asked Director Reno is she has the satisfaction of receiving a settlement and was this in the best interest of her and the hospital.

Director Reno stated it is a personal issue and a legal issue between her and the hospital and it has been ongoing for more than five years. She stated she did not want to sue the hospital but was told she could not sue individuals. She commented that integrity runs both ways and her integrity has been imbued. Director Reno read into the record a letter from the FPPC dated October 9, 2015. Mr. Coffey interjected that the Board was veering from the topic and should not be discussing anything beyond the settlement. Director Reno stated she would reserve further comments to Board Communications.

b) Consideration to amend Board Committee structure

Chairman Dagostino stated there has been some discussion regarding streamlining the Board's business and Board members have expressed an interest in taking a serious look at the Board committee structure. As a result, an Ad Hoc Committee was appointed which consisted of Chairperson Grass, Director Nygaard and Director Dagostino.

Director Grass moved that the Tri-City Healthcare District approve the following recommendations for the Board Committee structure:

1) That the Community Healthcare & Alliance Committee (CHAC) be suspended for the months of June – August, 2018 and that the Grant process be folded into the Philanthropic Funding philosophy for sponsorships with justification for meeting the needs of the Tri-City Healthcare District and it remain with the Ad Hoc committee for now;

2) That the Professional Affairs Committee remain with the Ad Hoc Committee for additional evaluation and reconstruction that will continue on this next month;

3) That the Governance & Legislative Committee be dissolved and the duties reflected in the Charter be assigned to the most appropriate entity as follows:

a) Changes in best practices and legal requirements relating to healthcare district governance and healthcare reform initiatives be overseen by the Board as a whole;

b) The District's governing documents including Bylaws, Policies, Committee Charters and other governance or policy matters be overseen by the Board as a whole;

c) Proposed amendments to the Medical Staff Rules & Regulations, Amendments to Medical Staff Bylaws will be overseen by the Medical Executive Committee with ratification by the Board of Directors;

d) Significant changes to state and federal laws, rules and regulations and accreditation standards applicable to the District, with special attention to the legislative and policy agendas of associations of which the District is a member (e.g. Association of California Healthcare Districts and California Hospital Association) will be overseen by the Chief of Government & External Affairs Officer who will report governmental actions to the Board on a quarterly basis.

4) That the Employee Fiduciary Subcommittee be dissolved and direct administration to propose a venue such as a quarterly Special Board Meeting to hear reports and provide oversight of the Employee Pension Plan.

5) That the Human Resources Committee be dissolved and the duties reflected in the Charter be assigned to the most appropriate entity as follows:

a) Human Resources policies and procedures be referred to the Professional Affairs Committee for recommendation to the Board;

b) Programs to hire, train and retain employees who exhibit safe quality expert care will remain an administrative function;

c) Market-competitive compensation and benefits that reward employee performance for non-executive employees will remain an administrative function;

d) Changes to employment laws and regulations will be relayed to the Board by Administration on an as needed basis;

e) Collective Bargaining Agreements will continue to be negotiated by Administration and brought to the forward for consideration.

Director Mitchell seconded the motion.

With regard to the Community Healthcare & Alliance Committee, Director Nygaard stated she would like to give Mr. Byzak the opportunity to get up to speed since he will be working with the CHAC Committee and be involved in the grant process. Therefore she is recommending that the Board suspend the CHAC meetings for the summer. Director Grass commented that she wants to ensure the Board is giving funds to organizations that are benefiting the three cities in our district. Director Reno commented that it is extremely important to keep that committee as the community has a right to know what is going on. Director Grass clarified that the recommendation is only to suspend the meeting for the summer months and bring back a

recommendation at a future meeting related to the distribution of grants. Director Reno questioned how the Foundation was involved in the grant process in years past. Chairman Dagostino recognized Ms. Gigi Gleason, Community Member who clarified the Foundation's past role in the grant process. Director Reno questioned if the district has a right to give away public funds in the form of grants. Board Counsel Mr. Coffey stated it is perfectly legal for healthcare districts to award grants as long as it is focused on the healthcare needs of the community.

Chairman Dagostino stated the Ad Hoc Committee believes the Governance & Legislative Committee is a job for the full Board rather than a committee. Director Schallock suggested that the Board reserve the right to appoint an Ad Hoc committee to review Board Policies and Bylaws prior to coming to the full Board. Director Grass stated the Ad Hoc Committee discussed the process for Board Policies and Bylaws and were in agreement with Director Schallock's comments.

The maker of the motion moved to amend the motion to reflect that the Chairman will appoint an Ad Hoc Committee as needed to review Board Policies and Bylaws. Director Mitchell seconded the amendment.

With regard to the Employee Fiduciary Subcommittee Chairman Dagostino stressed the importance of having full Board oversight. Chairman Dagostino suggested information from the Pension Plan be presented to the full board at a Special Meeting on a quarterly basis. Director Schallock stated he is supportive of this recommendation as it is beneficial if the entire Board has a perspective on how the plan is operating.

Director Grass stated many duties of the Human Resources Committee are functions that need to remain with Administration and Board oversight.

Chairman Dagostino explained that the recommendations presented reflect the Board's desire to streamline our activities and be respectful of both Board and Administrative time. In addition these changes will allow the opportunity for greater transparency.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Old Business

Adoption of Amendment to the Conflict of Interest Code

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the proposed Amendment to the Conflict of Interest Code. Director Schallock seconded the motion.

Director Reno questioned if the amendment to the Conflict of Interest Code was reviewed by legal counsel. Ms. Donnellan explained the Resolution to amend the Conflict of Interest Code was presented to the Board in March, 2018 and was reviewed with prior Board Counsel Greg Moser. The proposed amendment was then sent to the county and noticed to the public for 45 days for comment. At the closing of the 45 day period there were no comments or request for a public hearing. Therefore, the amendment is brought to the Board today for ratification by the Board. Director Reno questioned if in house counsel or the Chief Compliance Officer have reviewed the amendment.

Board Counsel Colin Coffey explained the State of California requires that the Conflict of Interest Code be reviewed every two years and is customized for our District. We are required to advise the County Board of Supervisors whether an amendment is needed due to changes in the personnel structure. In this case the County informed the District that they would like local agencies within San Diego County to file with their local agency versus the county except for the elected Board and the CEO. It is simply a change in where the Form 700s are filed annually and therefore our Conflict of Interest Code is being proposed for amendment to accommodate that request by the county. He further explained that the amendment is brought back here today to approve the amendment at the county's request and submit the new and revised Conflict of Interest Code to the Board of Supervisors.

Director Schallock stated this is a perfunctory task that is performed every two years and often includes amending titles of new individuals who are required to complete a Form 700.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Chief of Staff

a. Consideration of May Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on May 28, 2018.

It was moved by Director Reno that the Tri-City Healthcare Board of Directors approve the May Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on May 28, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell,**
Reno		**Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Proposed Criteria for Medical Staff Membership

Item was previously pulled from Agenda.

c. Categories of AHPs Eligible to Apply for Clinical Privileges

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the Categories of AHPs Eligible to Apply for Clinical Privileges as recommended by the Medical Executive Committee at their meeting on May 28, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Kellett seconded the motion.

It was moved by Director Dagostino to pull item 20 D) 21. Approval of an agreement with BB&T. Director Nygaard seconded the motion.

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

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Director Dagostino who pulled item 20 D) 21 Approval of an agreement with BB&T for TCHD's Excess General & Professional Liability Insurance; Property Insurance; Management Liability Insurance; Automobile Insurance; Cyber, Crime, Pollution, Volunteers, Heli-Pad, and Employed Lawyers for an annual term of 12 months, beginning July 1, 2018 through June 30, 2019 for an annual cost of $1,605,517 and a total cost for the term of $1,605,517 clarified that the figure on the agenda was incorrect and should reflect $1,605,517. Chairman Dagostino questioned if someone could speak to the huge increases we have had with D&O and E&O and Western Litigation.

Chairman Dagostino recognized Mr. Tim Mooney of BB&T who came to the podium to address those questions. He stated there was a reduction of close to 10% or $165,000 year over year reduction in total insurance costs. He explained the components rest in mainly three policies: 1) General Liability; 2) Management

Liability; and 3) Property Insurance. He stated there has been an increase in management liability which includes your Directors and Officers due to recently filed suits as well as employment practice insurance and fiduciary insurance. He noted a $75,000 increase in that coverage line. In addition there was an increase in property coverage of $100,000. He noted the recent fires and mudslides in California contributed to those increases. Mr. Mooney stated locally here at the hospital we unfortunately had an issue with some infrastructure piping that caused some significant problems and we were notified by Travelers who had been a long time carrier that they were non-renewing. BB&T went out to market to find a suitable carrier for the hospital. AIG was the most competitive bid however it was a $100,000 increase in premium although still far more competitive than what other carriers were willing to do. They have also provided a "carve back" coverage on future claims that may occur for infrastructure piping that wasn't available from Travelers.

It was moved by Director Kellett to approve the agreement with BB&T for TCHD's Excess General & Professional Liability Insurance; Property Insurance; Management Liability Insurance; Automobile Insurance; Cyber, Crime, Pollution, Volunteers, Heli-Pad, and Employed Lawyers for an annual term of 12 months, beginning July 1, 2018 through June 30, 2019 for an annual cost of $1,605,517 and a total cost for the term of $1,605,517. Director Kellett seconded.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Reports - None

23. Legislative Update

Chairman Dagostino reported he had the opportunity to attend the American Hospital Association meeting in Washington, D.C. He commented on the letter in the Board's agenda packet related to 340B and the Opioid crisis and how it would affect Tri-City directly. Chairman Dagostino referred to Mr. Aaron Byzak, Governmental & External Relations Officer for more information on 340B Legislation.

Mr. Byzak provided a summary of his background and experience. He stated he is working on producing a Government Affairs Plan for Tri-City that is comprehensive and focused on our federal, state and local priorities. Mr. Byzak explained the four goals of the Government Affairs Plan and Government Affairs activities are to try to influence legislative decisions that minimize negative fiscal impacts and promote positive revenue into the organization so that we can meet our mission and vision and to understand the impact of the Affordable Care Act and the myriad decisions that come as a result of that at both the federal state and at the local level. To that end, Chairman Dagostino accompanied Mr. Byzak to Sacramento to advocate on 340B along with a delegation of other hospital executives and leaders and met with all of our elected officials throughout the state level and we were able to hopefully influence the decision. Mr. Byzak stated we expect that 340B might come back at the end of

the legislative session in negotiations with the Governor's Office for the budget but we will continue to make sure they understand the impact that this has on our hospital and other hospitals and try to stave off those cuts. Chairman Dagostino stated it is a significant blow to the organization like ours that serves a healthy portion of the underserved and benefits from the 340B program.

24. Comments by Members of the Public

There were no comments by members of the public.

25. Additional Comments by Chief Executive Officer

There were no additional comments from the Chief Executive Officer.

26. Board Communications

Reports from Board Members

Director Schallock had no comments.

Director Kellett congratulated the nurses on their selections. He stated nurses are the doctor's best friends in the hospital because the patients do better when they have good nurses available and we have a lot of fine nurses.

Director Kellett also commented on the Trump Administration's plan to do something about the opioid crisis and the response was so mild that the stock price on pharmaceutical companies went up 2.8%.

Director Reno expressed her appreciation to all the nurses who participated in Nurse's Week and in particular those that were honored to be our front runners of the year.

Director Reno read into the record a statement regarding the allegations made against her (a copy of which is attached to the file copy of these minutes). Director Reno also read into the record a letter dated October 9, 2015 from the Fair Political Practices Commission (a copy of which is attached to the file copy of these minutes).

Director Nygaard had no comments.

Director Grass expressed her appreciation to all who helped and sponsored the Nurse's Appreciation Tea. She stated she was fortunate to attend and it was beautifully decorated and held with great class. She acknowledged Dr. Souza for his efforts.

Director Grass also congratulated the four nurses who were chosen as Nurse's of the Year and well as Mrs. Salano who was chosen for the Patient Care Support Staff Employee of the year.

Director Grass stated June 10-17 is Nurse Assistant Week. She encouraged everyone to thank them for their patience, their humor and their great attitude that impact the life of our patients and our families.

Director Grass welcomed Mr. Aaron Byzak, the Chief of Governmental & External Affairs Officer.

Director Mitchell echoed Director Grass's comments related to Nurse's Week and also welcomed Mr. Byzak.

26. Report from Chairperson

Chairman Dagostino stated it was wonderful to recognize our nurses and support staff today and enforces his belief that we are a community institution. He commented on Dr. Johnson's presentation and how he rallied the physicians to work on something that would provide better care for the patient.

Chairman Dagostino commented that he had prepared several statements in regard to the Reno matter but determined the best statement is the one you don't make.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:40 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

May 24, 2018 – 1:00 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 1:00 p.m. on May 24, 2018.

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

Director James J. Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Susan Bond, General Counsel
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Governmental Relations Officer
Jeremy Raimo, Senior Director
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 1:00 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Nygaard led the Pledge of Allegiance.

2. 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 unanimously (7-0).

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

   Chairman Dagostino made an oral announcement of the item listed on the May 24, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets with a variety of disclosure dates.

6. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Mitchell to go into Closed Session at 1:05 p.m. The motion passed unanimously (7-0).

8. Open Session

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

Chairman Dagostino reported no action was taken in closed session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 4:40 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Leigh Anne Grass
Secretary

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

June 7, 2018 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on June 7, 2018.

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

Director James J. Dagostino, DPT, PT
Director Leigh Anne Grass
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Cyril F. Kellett, M.D.

Also present were:

Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Susan Bond, General Counsel
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Governmental Relations Officer
Jeremy Raimo, Senior Director, Business Development
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Nygaard led the Pledge of Allegiance.

2. 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 Reno to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (6-0-0-1) with Director Kellett absent.

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

Chairman Dagostino made an oral announcement of the item listed on the June 7, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets with a variety of disclosure dates.

6. Motion to go into Closed Session

It was moved by Director and seconded by Director Mitchell and Schallock seconded to go into Closed Session at 10:05 p.m. The motion passed (6-0-0-1) with Director Kellett absent..

8. Open Session

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

Chairman Dagostino reported no action was taken in closed session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 11:26 a.m.

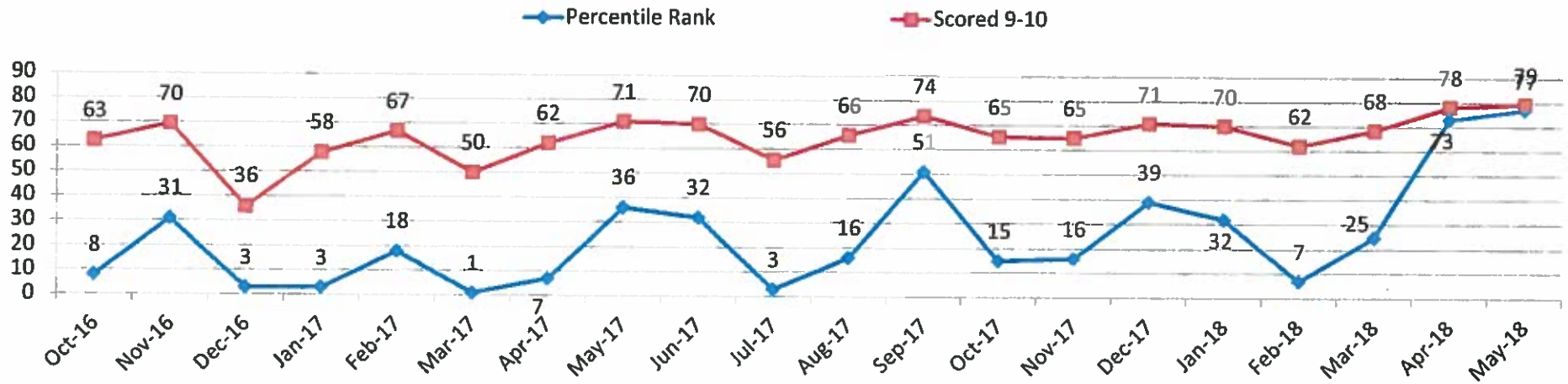
_____
James J. Dagostino
Chairman

ATTEST:

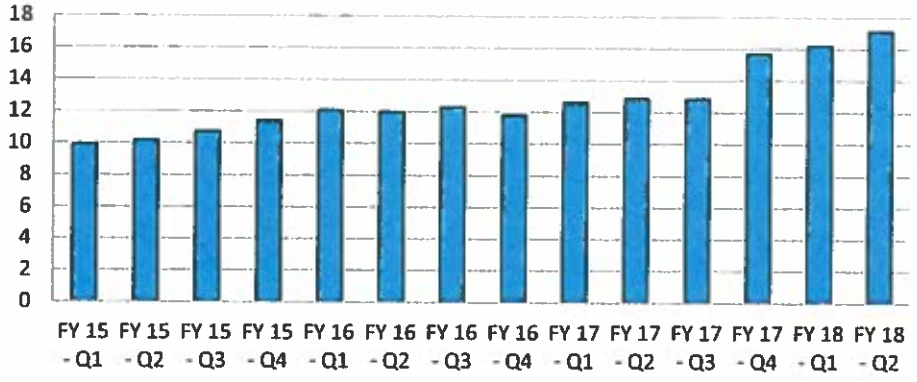
_____
Leigh Anne Grass
Secretary

Stakeholder Experiences

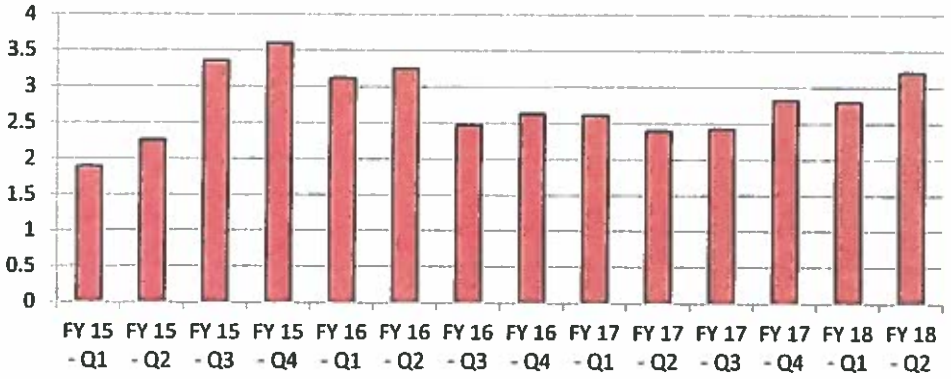
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



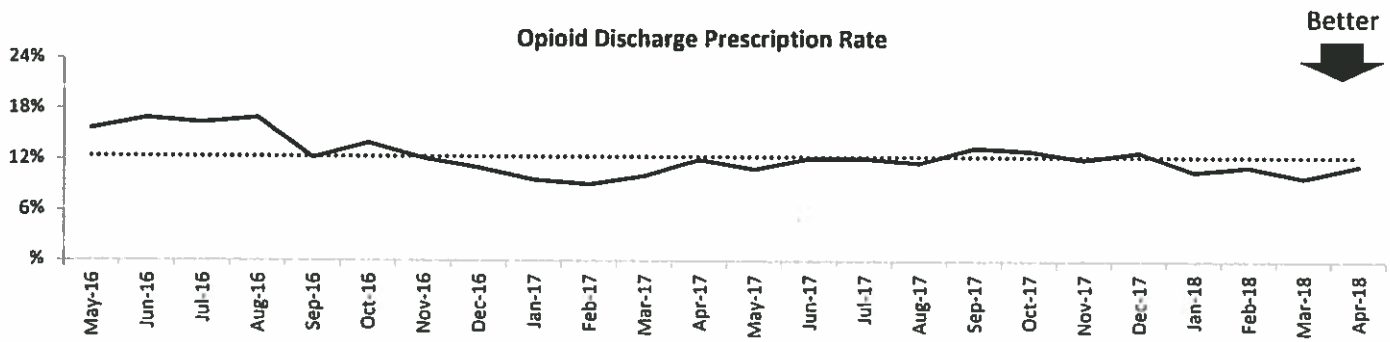
Involuntary Employee Turnover Rate



Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target

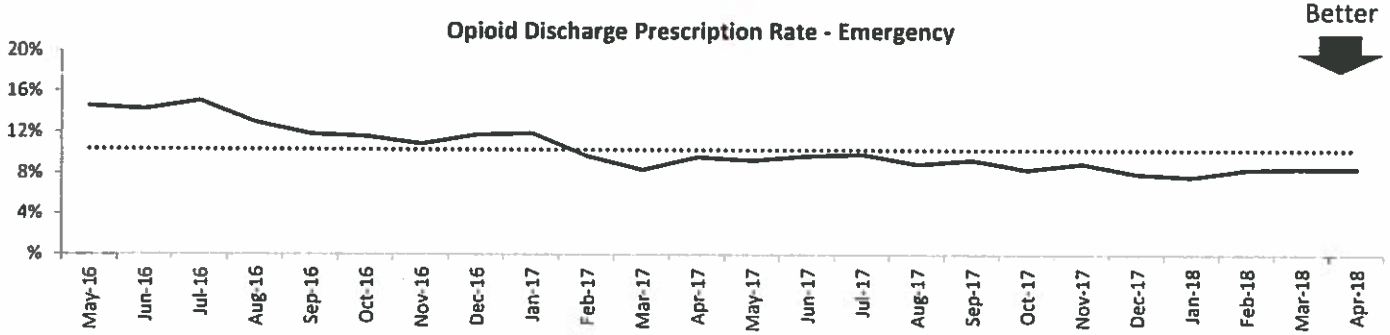
Opioid Discharge Prescription Rate



Action Plan

April rate remains below the mean. No Action Necessary at this time. Continue to monitor.

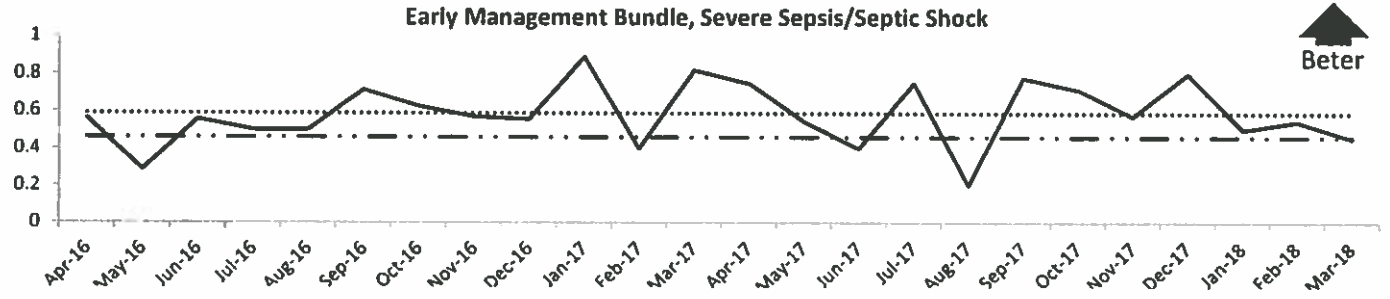
Opioid Discharge Prescription Rate - Emergency



Action Plan

April rate remains below the mean. No Action Necessary at this time. Continue to monitor.

Early Management Bundle, Severe Sepsis/Septic Shock



Action Plan

1.) Implementation of Sepsis Predictive platform to start June 2018 to help identify and treat sepsis patients. 2.) Build rules/alerts in Vigilanz for CDI identifying discrepencies in documentation for concurrent queries. 3.) Continue to identify education opportunities for processes/documentation.

Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	26	28	23	20	27	27	22	23	24	20	20		255
FY17	28	22	13	25	27	23	19	24	25	25	30	20	261

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	14	6	7	13	7	15	14	8	12	7	10		113
FY17	9	9	5	13	12	11	10	8	15	8	12	10	112

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	11	12	12	14	16	18	23	12	15	15	16		164
FY17	8	11	8	13	12	8	12	10	12	11	17	21	122

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	15	20	20	16	23	15	15	19	23	11	20		197
FY17	18	18	17	14	20	22	20	16	18	13	17	19	193

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	48	37	38	32	26	38	29	24	30	38	38		368
FY17	31	35	29	42	34	29	31	30	31	37	28	41	357

Performance compared to prior year: Better Same Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0		14.4
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	C/M YTD
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7	7.5	7.1	6.6		7.7
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	6.3

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2		12.7
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	14.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4	163.2	161.9		176.9
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	181.1

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	210	222	194	206	184	166	209	169	186	156	163		2,065
FY17	223	239	274	230	197	200	217	197	202	172	188	175	2,339

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	12	11	11	11	11	18	16	5	7	16	15		133
FY17	12	11	12	16	11	14	15	11	6	15	12	18	135

Performance compared to prior year: Better Same Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	4	7	7	3	4	3	2	4	8	2	7		51
FY17	4	4	6	6	5	7	2	2	7	9	6	1	58

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	8	7	7	11	3	14	11	10	4	10	8		93
FY17	10	9	8	7	6	9	8	6	16	9	6	6	94

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	1.85	1.86		1.77
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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6		48.3	48-52
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1	46.5	49.5	

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	78.8	83.2	89.2		82.9	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	83.2	

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)	($337)	($679)	($408)		($7,380)	$3,418
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$371	

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%	-1.09%	-2.31%	-1.31%		-2.23%	1.01%
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%	0.12%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900		$6,885	$18,345
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	$14,305	

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%	3.13%	1.95%	2.90%		2.08%	5.42%
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%	4.61%	

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	5.86	6.29	6.42		6.26	6.23
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18	6.56	6.11	

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	$49.4	$42.7	$41.5		
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9	$64.0	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending May 31, 2018

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.48	(a)	44,164.55	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	Approx 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)	10,231.22	04/01/16	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	10,218	$2.50	(a)	30,480.05	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road 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	02/01/15	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	15,184.80	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
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
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)	10,423.03	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	$1.10	(a)	5,135.39	10/28/13	10/31/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Total				**$ 186,867.05**			

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

Education & Travel Expense
Month Ending May 2018

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	CCRN RENEWAL	41318	120.00	78192	JOY LITTLE
6070	RNC-NIC CREDENTIAL	42818	325.00	82456	MARISA LANGSTON
6183	AMERICAN SOCIETY OF ANESTHESIOLOGY-PHS PROCESS	52118	770.36	80084	COURTNEY NELSON
6185	CANCER BASICS ONCOLOGY NURSING SOCIETY	42018	220.00	12044	KATHRINE WYLIE
6185	CANCER BASICS ONCOLOGY NURSING SOCIETY	42618	220.00	83250	CHRISTINE BWAMBOK
7290	CAHSAH ANNUAL CONFERENCE - TRAVEL EXPENSE	50718	256.96	82008	MONICA TRUDEAU
7290	CAHSAH ANNUAL CONFERENCE - TRAVEL EXPENSE	50718	256.96	82655	CYNTHIA BOATRIGHT
7290	CAHSAH ANNUAL CONFERENCE - REGISTRATION	22718	755.00	14369	M TRUDEAU/C BOATRIGHT
7420	CNOR CERTIFICATION	42318	395.00	80260	ALISA SUITOR
7420	ASPAN NATIONAL CONFERENCE	50318	873.68	82947	VANESSA VRIENS
8340	ASPEN 2018 NUTRITION SCIENCE CONFERENCE	112817	1,875.47	77946	KELLI GECEWICZ
8381	IAHCSMM ANNUAL CONFERENCE	52118	801.08	79820	DEBRA MENDEZ
8390	MODERN CONCEPTS IN PHARMACOTHERAPY	41718	113.23	82662	JINOO LEE
8390	HEALTH CONNECT PARTNERS - PHARMACY TRAINING	50918	207.57	79349	TORI HONG
8390	NATIONAL PHARMACY PURCHASING ASSOC CONFERENCE	42518 BALL	275.00	78696	LAURA BALL
8460	CSHE ANNUAL MEETING - TRAVEL EXPENSE	50318	1,144.72	12307	STEVE BERNER
8460	CSHE ANNUAL MEETING - TRAVEL EXPENSE	50318	1,778.73	81655	CHRIS MIECHOWSKI
8510	CA NOTARY TRAINING/EXAM	51018	666.70	82623	WINITA PHOGNSAMRAN
8610	VIZIENT BOARD MEETING - TRAVEL EXPENSE	50318	465.03	81508	STEVEN DIETLIN
8610	DHLF BOARD MEETING - TRAVEL EXPENSE	50218	703.38	81508	STEVEN DIETLIN
8631	AFP CONFERENCE - TRAVEL EXPENSE	33118	614.00	79486	GLEN NEWHART
8631	AICPA NOT FOR PROFIT CONTINUING EDUCATION	33118	639.00	79486	LILY YIN
8740	SAN DIEGO EMERGENCY CARE SUMMIT	51018	110.00	40750	BARBARA MCCANN
8740	ALZHEIMERS DISEASE EDUCATION	51018	110.54	83253	PAOLO MIGUEL MACARANDANG
8740	911 CONFERENCE - ENA	51018	115.00	80678	LISA BECKER
8740	911 CONFERENCE	50418	115.00	82646	CECILIA DIBELKA-MCELHANEY
8740	2018 CPQCC COOL TOPICS IN NEONATOLOGY	51818	125.00	78458	LESLIE SEMANA
8740	2018 CPQCC COOL TOPICS IN NEONATOLOGY	42018	125.00	81839	MARIA DALISAY RANOLA
8740	ACLS RENEWAL	51818	155.00	77472	KRISTEN D'ELISEO
8740	GASTROINTESTINAL NUTRITION	50418	191.95	81649	BENILDA MILAN-AGLUGUB
8740	ADVANCED COMPETENCY IN HOME HEALTH	42018	200.00	62499	DAWN SITLER
8740	CCMC CERTIFICATION RENEWAL	51818	200.00	78664	TJ GRUNNAN RN
8740	DBT SKILLS TRAINING	50418	200.00	81769	KRISTINA DITULLO
8740	RN-BSN PROGRAM	50418	2,500.00	82377	CYNTHIA LEON
8740	MSN - NURSING EDUCATION	50418	4,245.00	77556	HEATHER HUNTER
8750	PUBLIC CONTRACTING REQUIREMENTS SEMINAR	50118	299.00	83103	SUSAN BOND

**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.

June 14, 2018

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

Governance Forum, California Hospital Association, June 14, 2018 Sacramento, California

I attended the Governance Forum of CHA. The Governance Forum is a subcommittee of the CHA board that allows trustees input into the legislative agenda. This forum represents both public and private hospitals along with CHA staff and board members.

A good portion of the day was spent on reviewing the legislative update for CHA. ABP 2798 continues to move along the process. It would allow projects proposed to SDPH to be approved in 30 days and not a project with a temporary approval status of 18 months until the department proves a license. SB 1152 is a bill that requires onerous requirements treating a homeless patient. Such things as a specific written homeless patient discharge policy, logging of homeless patients, and providing referral to social service agencies, clothing and feeding the patient, and transporting the patient to their residence are all of proposed regulations. The Bill although severely amended continues through the process. Many of the owners employment labor builds are in the suspense file. Single-payer Bill SB 562 is in the Assembly Rules Committee that many of the mental health bills remain alive.

The Governor's budget has dropped 340 B language so that continues through next year. Per CHA staff we do need to work out some of the bugs regarding double dipping for rebates or 340 B will be an issue next year. Monies for graduate medical education have been restored and most of the $16.6 million in positive revenues will be placed in the rainy day fund.

Most importantly it seems as if new CEO Carmelo Coyle is revamping the government relations program for CHA. She wants to move it from purely defensive operation finding what CHA stands for and work on positive bills for healthcare. Presentation of this program will be made soon but it involves four pillars which are partnership, value, access, and affordability of California healthcare.